California
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Assessing County Capacity to Meet the Needs of California's Uninsured: 2004 Survey Findings

Prepared for
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by
Annette Gardner, Ph.D., M.P.H.
James G. Kahn, M.D., M.P.H.

Institute for Health Policy Studies
University of California, San Francisco

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About the Authors

Annette Gardner, Ph.D., M.P.H., is a senior research associate at the Institute for Health Policy Studies (University of California, San Francisco) where she has conducted research on California's safety net since 2001. Her research focuses on county-level programs to increase access to health care for the uninsured (financing, coverage and service expansions), as well as the role of clinic consortia in strengthening the safety net. She can be contacted at algard@itsa.ucsf.edu or 415.514.1543.

James G. Kahn, M.D., M.P.H., is a professor of health policy and epidemiology at UCSF. His research focuses on economic issues in the provision of health care services to vulnerable populations and on health insurance issues.

About the Foundation

The **California HealthCare Foundation,** based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care.

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I. Introduction

In California, counties are responsible for addressing the health care needs of the uninsured, a challenge that includes reducing barriers to care and ensuring appropriate use of services. The last several years have witnessed significant initiatives in many counties to create and launch county-level health care access initiatives, such as insurance expansions targeted to children (for example, the Healthy Kids programs of Santa Clara and San Francisco Counties) and service expansions (for example, new clinic facilities). The California HealthCare Foundation commissioned researchers at the UCSF Institute for Health Policy Studies to investigate how willing counties are to develop new initiatives and what factors were involved to support or hinder their efforts. This report details the findings of a survey completed in 2004 and compares those results with the original survey of 2002.

In 2002, UCSF administered a 58-county survey to inventory access programs and key determinants, as well as assess county unmet needs to launch access programs. The total number of counties responding was 44. Overall, the goal was to increase the understanding of how funders and policymakers might best support counties in their efforts to expand access and thus increase the likelihood of program success. This study broadened understanding of county-level efforts to increase access to care for the uninsured by surveying efforts throughout the state. California counties as a whole have made progress in connecting people to insurance and services. A major challenge is to create insurance coverage programs in an environment that supports coverage expansion in theory but in practice fails to provide adequate resources to launch and/or maintain these efforts. Thus, counties are exploring various strategies, weighing expansion or strengthening of their health systems against coverage approaches.

Since UCSF conducted this study in 2002, California counties have experienced some serious financial setbacks that could stymie their efforts to increase access to care for the uninsured. The recent repeal of the vehicle license fee tax increase and hence potential $4 billion shortfall to counties will intensify local debates on the allocation of resources. It is critical to know how these conditions influence counties that were intending to pursue coverage expansions. Many counties are continuing to pursue coverage for children using their Prop 10

funds (tobacco tax funds dedicated to children's services). Additionally, the 2002 survey surfaced some questions on the type of coverage expansion approaches being used and actual number of enrollees.

To address these issues and deepen our understanding of county capacity to engage in significant reform under adverse economic conditions, from March to June 2004, the Institute for Health Policy Studies (IHPS) administered a modified version of its 2002 survey on county capacity to meet the health care needs of the uninsured. The survey was sent to officials in all 58 California counties. There were two study aims: (1) to inventory county programs to increase access to health care for the uninsured and (2) to assess current constraints and opportunities for insurance coverage programs. This survey provides an updated and more detailed inventory of coverage expansions and their respective funding sources, as well as information on key stakeholders and barriers to increased access. The recent data is compared to responses collected in 2002. In June, IHPS conducted follow-up interviews with representatives from 6 counties that indicated high willingness to pursue coverage expansions for children and/or adults in their 2004 survey. This report examines survey responses from 44 California counties and the six follow-up interviews.

Overall, the prospects for increasing access to health care for the uninsured at the county level are encouraging despite significant financial constraints. Continued growth can be anticipated in insurance coverage programs for uninsured children, suggesting new possibilities in program types and willingness by a growing number of counties to engage in coverage expansions. However, there may be limited growth in coverage programs for adults. Also, some counties may be stalled in their efforts to enroll people in existing or new coverage programs. Last, service expansions may be slowing as competing priorities and budget constraints slow spending. The results of the funding questions suggest a "leave no stone unturned" approach; counties are diversifying their strategies. However, the question remains as to whether these funding sources are adequate to address the cost of expansions and increase in the uninsured. The good news is that access to care for the uninsured as an issue continues to increase in importance and has a constituency to support it at the local level (Boards of Supervisors, county agencies, access coalitions, and Prop 10 commissions).

II. Methods

RESEARCHERS POSTED AN INTERNET-BASED SURVEY and invited responses from representatives of county health agencies (including public health and human services) in all 58 California counties. Our goal was one completed survey per county, with particular emphasis on those counties that had completed a survey in 2002. The first section of the survey asked about county programs to expand access to the uninsured that are underway or being proposed. Researchers asked respondents to identify the resource streams used to fund these services or programs and whether counties would deploy these resources to the four main types of access programs in the future. Additionally, respondents were asked to indicate which organizations and stakeholders played an important role in launching these programs, including whether their county had a coalition that focuses on access. Last, they were asked to list local barriers to increasing access to care that are not readily addressed through capacity building as well as the county's top health issue.

The 15-minute survey was completed by agency staff in 44 counties (75.9 percent). While comparable to the 2002 data, seven surveys were completed by counties that did not respond in 2002. Responses appear representative of California counties, including: counties from across the state; rural and urban; provider and non-provider; and all Medi-Cal managed care models. (See Appendix A for a list of responding counties.)

Table 1. Respondent County Characteristics (n=44)

CHARACTERISTIC	COUNTIES
Location	
Rural	26
Urban	18
Medi-Cal Model	
Fee-for-Service	22
Two-Plan	12
COHS	8
GMC	2
County Health Care Provider*	
Yes	13
No	31
Local Coalition	
Yes	26
No	14
Don't Know	4

*County-run hospital present.

As in 2002, it was found that some counties had difficulties completing the survey because they had to consult multiple staff in the agency, particularly for the funding questions. In 2002 and 2004, some counties reported coverage programs for children and adults that were state-initiated (for example, Healthy Families) or were not insurance programs per se (for example, outreach and enrollment programs). These programs were excluded in the reporting of the data.

Quantitative tabulation (ratios and percentages) was done electronically by Zoomerang.com. Qualitative data were clustered by question by Zoomerang. The researchers reviewed these data by county and cross-tabulated most responses by Medi-Cal managed care model, county provider status, presence of a coalition, and urban/rural classification. For the qualitative data, the research team created categories that best described the data and counted the data accordingly.

III. Summary of Findings

County Approaches

- ***Diverse.*** Most counties use diverse approaches to increase access to care. All responding counties in the 2002 and 2004 surveys reported having one or more types of access programs underway, with an average of 4.8 program types per county.
- ***Growth.*** There has been moderate growth in insurance coverage expansions "in place" for children (13 counties, up from 9) and adults (11 counties, up from 7) since 2002. Children's coverage programs include Healthy Kids programs, California Kids (Cal Kids), Kaiser Permanente's Child Health Plan-1, and expansions of county programs for the Medically Indigent. Adult coverage programs tend to be more diverse in their target populations and smaller in scope. Moreover, there are more programs for children being "proposed" than for adults (12 counties versus 6), fueled in large part by the availability of Prop 10 funding. The data suggest that growth in coverage expansions will continue to occur but children's programs will dominate (25 counties). Many respondents (28 counties) indicated some reluctance to pursue coverage expansions for adults in the future. The interview data from 6 counties corroborate this finding. Respondents identified more reasons for launching a children's coverage program than an adult program, particularly: availability of funding, feasibility, high political support, and low funding needs (compared to adult programs).
- ***Medi-Cal managed care plans.*** These plans appear useful in launching coverage programs for children and adults. Twelve of the 22 Two-Plan, COHS, and GMC counties offered an insurance program for uninsured children whereas only 1 Fee-for-Service county had a coverage program for children "in place." However, this is not a strictly limiting factor: some counties without a public plan are proposing coverage expansions for children (8 counties) and adults (4 counties). This suggests that there are new possibilities to insuring people such as building on the California Kids (Cal Kids) program or transforming a county's program for the Medically Indigent into a commercial insurance product.

- ***Access coalition.*** Presence of an access coalition was noted as playing an "important role" or "very important role" by many respondents (29 counties), as in 2002, and counties with a coalition had more coverage expansions underway than those counties without coalitions. While many of these counties also have a Medi-Cal managed care plan (Two-Plan or COHS), there are a significant number of Fee-for-Service (FFS) counties that have access coalitions (11 counties).

- ***Urban vs. rural.*** Urban counties with coverage programs (11 counties) outnumbered rural counties with insurance programs for uninsured children and adults (three counties). However, many of these urban counties (10 counties) have a Medi-Cal managed care plan. On the other hand, many rural counties without a Medi-Cal plan are proposing coverage expansions for children and/or adults (8 counties). Other differences are limited; rural counties were more active in some areas like consumer education and transportation assistance than urban counties.

- ***Steady systems.*** Similar to 2002, nearly all study counties have established and/or maintained their systems or programs to enroll and retain people in existing public insurance programs (39 counties). Many counties (23) indicated they had experienced an increase in outreach/enrollment/retention activities since 2002.

- ***Service expansion.*** Service expansions in the majority of study counties suggest a continued willingness to meet the strong and sometimes growing health services demand among the uninsured. Many (22 counties) indicated they had increased services since 2002. However, some service expansions, such as "increase in providers," are experiencing less activity than in 2002. Also, counties were equally split on whether they were considering expanding services in the future (20 counties each).

Key Organizations and Stakeholders

- ***Public sector.*** There continues to be significant public sector and nonprofit participation in mobilizing, launching, and supporting access initiatives at the local level. However, most responsibility for spearheading access initiatives continues to rest with the county health department (29 counties said it played a "very important" role).

- ***Boards of Supervisors.*** The findings from the 2004 survey are mixed on the importance of the Board of Supervisors, ranging from "minor role" (30 percent) to "important role" (23 percent) and "very important role" (36 percent). The findings from the interviews with representatives from 6 counties suggests that support by the Board of Supervisors can be key to launching a coverage expansion program, including "no resistance" to coverage expansions and participation in the planning and implementation of a program.

- ***Coalitions.*** Similar to 2002, many (26 counties) indicated they had a coalition that specifically focuses on access issues. As noted above, 29 counties thought the coalition played an "important role" in launching or supporting access initiatives generally.

- ***Private sector.*** With the exception of private funders (foundations), which were thought to play an "important role" (15 counties), private sector stakeholders were noted as playing a "minor role" (including insurers, private providers, and the business community).

Financing Access Initiatives

- The findings from the interviews with 6 counties suggests that many counties are "stretched" financially, though to different degrees. However, these counties indicated that they are committed to expanding coverage, particularly for children, and will pursue these expansions even in the face of county cutbacks. Assisted in large part by the availability of Prop 10 funding and an existing provider safety net, these counties demonstrate significant political willingness to allocate and maintain funding for coverage programs.

- The majority of funding streams dedicated to access initiatives are state funds that may be vulnerable to significant cutbacks. However, newer, discretionary funds like Prop 10 funds (tobacco tax funds dedicated to children's services) and foundation grants are being dedicated to access initiatives, with an average of 5.5 funding streams being used (or intended to be used) by counties.

- Counties have access to a number of resources and strategies, including securing federal funds like HRSA Cap Grants, leveraging existing funds like Prop 10 funds to attract new funding, and increased grant-writing. However, these funding streams are vulnerable to other competing priorities and counties are engaging in multiple strategies, with an average of 3.5 strategies being adopted by counties.

- The findings from open-ended survey questions and interviews with 6 counties suggest funding for coverage expansions varies in type and number. Some counties use two or three funding streams such as Prop 10 (Children and Families First Commission) and County General Fund Support and other counties cobble together multiple funding streams including Prop 10, County General Fund Support, funding from the Local Initiative, foundation funding, and federal grants (HCAP). Except for the use of Prop 10 funds for children's coverage expansions, there does not appear to be one widely used funding approach. Similarly, very few respondents indicated their county had developed a sustainable model for funding coverage expansions.

Barriers to Expansion

- While funding limitations were mentioned by 8 counties, "rural issues," such as poor transportation between areas, were the most highly rated barrier to access initiatives (32 counties). This was followed by "competing priorities" and "cultural/social barriers" (25 counties respectively). One interpretation is that political benchmarks like policymaker commitment have been achieved in many counties, as have resolving service delivery issues, leaving challenges that are more practical and systemic. Interestingly, five of the six county interview respondents mentioned state-level factors that had impeded their efforts to launch coverage expansions (for example, proposed cuts to the Medi-Cal program).

- Access to health care services for the uninsured is considered "very important" by 26 counties, having increased in importance in many counties since 2002 (27 counties). It is likely to continue to be an important issue for county officials. It was the second most important health issue mentioned by respondents (10 counties), after diseases and/or chronic conditions (14 counties). The six interviews corroborated this finding; however, counties may vary in their strategy to address the needs of the uninsured, with some counties more committed to universal coverage and others committed to increased access more broadly defined.

IV. Local Programs to Increase Access to Care

Overview of Activity at the County Level

In 2002 and 2004, UCSF researchers asked study informants to indicate whether their county had implemented or was proposing to launch a variety of coverage and services expansions. Counties were also asked if there was "no activity" in each area. While only a snapshot of activity, these data provide baseline information against which to compare later on. Also, the "proposed" response category gives us a sense of what to anticipate in the near future.

As demonstrated in Table 2 on the following page, access is being taken seriously in nearly all responding counties. All 44 counties reported access initiatives underway, with an average of 4.8 program types in place per county ("proposed" = 2.0 and "no activity" = 4.9).[1] The following discussion details each expansion category.

Insurance coverage. As indicated in Table 2, we are seeing increased coverage for children and coverage for adults following close behind. However, unlike 2002, in 2004 there are more "proposed" programs for covering children (12 counties versus 4), speaking to the presence of new funding mechanisms like the California HealthCare Foundation's Step By Step Initiative and Prop 10 funding. Also, fewer counties in 2004 report "no activity" or limited intention to insuring children (19 counties). See Table 3 on page 13 for a listing of counties that have coverage programs "in place" and "proposed" for children and adults. The 2004 findings include all the "in place" coverage programs for children: 7 Healthy Kids programs (Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, and Santa Clara); 3 Cal Kids[2] programs (Orange, Solano, and Marin); 1 county that uses an insurance approach to their programs for the Medically Indigent (Contra Costa); and 2 counties that have insurance programs targeted to families (Alameda and San Diego).

Table 2. County Innovations in Place or Proposed to Increase Access to Care for the Uninsured

	In Place		Proposed		No Activity	
PROGRAM	2002	2004	2002	2004	2002	2004
Insurance coverage for children (Healthy Kids, CalKids, MI)	20% (9)	30% (13)	9% (4)	27% (12)	70% (31)	43% (19)
Insurance coverage for adults (e.g., IHSS Workers)	16% (7)	25% (11)	9% (4)	14% (6)	74% (32)	55% (24)
Managed care for the county indigent	Not Asked	30% (13)	Not Asked	16% (7)	Not Asked	52% (24)
Premium subsidies for small employers	Not Asked	2% (1)	Not Asked	5% (2)	Not Asked	70% (31)
Information on coverage options	75% (33)	61% (27)	11% (5)	5% (2)	14% (6)	16% (7)
Outreach/enrollment/retention in public insurance programs	84% (36)	89% (39)	5% (2)	5% (2)	12% (5)	0% (0)
Consumer education (e.g., use of prevention services)	91% (40)	61% (27)	9% (4)	18% (8)	0% (0)	14% (6)
Facilities expansions (e.g., clinics)	36% (16)	39% (17)	34% (15)	30% (13)	30% (13)	30% (13)
Increase in providers (e.g., specialists)	27% (11)	20% (9)	49% (20)	25% (11)	24% (10)	45% (20)
Increase in clinic hours (e.g., weekends)	27% (12)	32% (14)	32% (14)	18% (8)	41% (18)	36% (16)
Assistance with transportation (e.g., mini-vans)	44% (19)	36% (16)	21% (9)	9% (4)	35% (15)	48% (21)
Appointment system changes	43% (19)	36% (16)	23% (10)	18% (8)	34% (15)	25% (11)
"Insurance-like" programs (e.g., bundling of county health services, lower out-of-pocket fees)	Not Asked	20% (9)	Not Asked	9% (4)	Not Asked	55% (24)

Table 3. County-Level Insurance Coverage for Children and Adults Ineligible for Public Insurance

CHILDREN		ADULTS	
In Place (13)	**Proposed* (12)**	**In Place (11)**	**Proposed (6)**
• Alameda (Family Care)	• Del Norte[†]	• Alameda	• El Dorado
• Contra Costa (Basic Care)	• El Dorado[†]	• Contra Costa	• Lassen
• Los Angeles (Healthy Kids)	• Kern	• Los Angeles[†]	• San Bernardino
• Marin (CalKids)	• Mendocino	• Napa	• Santa Barbara[†]
• Orange[†] (CalKids)	• Plumas	• Sacramento	• Sutter
• Riverside (Healthy Kids)	• Sacramento	• San Diego	• Tuolumne
• San Bernardino (Healthy Kids)	• San Benito	• San Francisco	
• San Diego (Child Health Plan-1[‡], FOCUS[§])	• San Luis Obispo[†]	• San Joaquin	
• San Francisco (Healthy Kids)	• Santa Barbara	• San Mateo	
• San Joaquin (Healthy Kids)	• Santa Cruz[†#]	• Santa Clara	
• San Mateo (Healthy Kids)	• Sonoma[†]	• Solano	
• Santa Clara (Healthy Kids)	• Ventura		
• Solano (CalKids)			

* The 2004 survey precluded reporting of coverage expansions that were "in place" and "proposed" such as the coverage expansions for youth that are underway and being proposed in Santa Clara, Orange, and Los Angeles. Combining the 2004 survey results and information on counties in the planning stages from the Child and Family Coverage Technical Assistance Center, in all likelihood the number of "proposed" coverage expansions for children ranges from 16 to 23 counties.

† Step by Step Planning and Implementation Grantees. Except for Ventura and Fresno, most respondents appeared to be familiar with the Step by Step programs being proposed in their county.

‡ Child Health Plan-1, a Kaiser Permanente program available to children with incomes between 250 and 300 percent of FPL, is accepting enrollees from San Diego County.

§ The FOCUS program is unique in that it receives no public support and is an employer-based health insurance program for low-income employees and their families. The program is closed to enrollment at this time.

Since the 2004 survey findings were tabulated, Santa Cruz has implemented its insurance program for children.

Managed care for the county indigent. This was a new category in the 2004 survey. The findings corroborate the observation in 2002 that counties do have some flexibility with their CHIP/CMSP programs and are willing to engage in reforms such as enrolling the indigent in managed care plans (13 counties).

Premium subsidies for small employees. This was a new category for the 2004 survey. There is limited activity to provide premium assistance to small employers, reducing the barriers to coverage for adults and their dependents (1 county).

Access to information. While many study counties may not offer coverage for children and/or adults, most counties in 2002 and 2004 try to connect people to public and private insurance programs by providing information on options (27 counties).

Outreach, enrollment and retention. Mirroring the 2002 results, many study counties have outreach/enrollment/retention programs in place, probably driven in large part by the Healthy Families program (39 counties).

Consumer education. Similar to 2002, most study counties in 2004 reported being involved in educating consumers on accessing the health care system, such as using preventive services (27 counties).

Service expansions. There continues to be quite a bit of activity underway or proposed in all types of service expansions, though many like "increase in providers" and "assistance with transportation" have a higher level of "no activity." Expansions related to clinics appear to be an area of increased activity compared to the 2002 data (14 to 17 counties).

"Insurance-like" programs. This was a new category in the 2004 survey. We inventoried county programs that on the surface resemble insurance programs; that is, they have enrollees and bundle county services but do not have insurance premiums. Interestingly, there is moderate activity in this area ("in place" and "proposed"), suggesting interim strategies to coverage expansions (9 counties).

Other programs. Eighteen counties cited "other" approaches to increasing access to care for the uninsured, including:

- Expansions on existing coverage programs (2 counties and 4 programs)
- Dental expansions (2 counties and 2 programs)
- Service expansions (2 counties and 2 programs)
- Pharmacy expansions (3 counties and 3 programs)

Key Factors for Having Programs "In Place"

In 2002, we sorted the data by Medi-Cal managed care model, provider status (whether a county has a public hospital), and presence of an access coalition, to examine whether these factors were important in launching a particular type of access initiative. For the 2004 survey, we added another variable — rural/urban — and ran a series of cross-tabulations to see which variables might be important for the proposing and implementing the 13 access program types described above (see Table 5). The findings are divided by factors important to "in place" programs and factors that are important to "proposed" programs. It is important to note, however, that there is overlap in some of these factors; that is, many counties that have a Medi-Cal managed care plan also have a county-run hospital, making it difficult to clearly attribute change in a county access program to a particular factor in some cases. For example, 8 Two-Plan counties also have an access coalition, making it difficult to ascribe more responsibility for one factor than another (see Table 4). However, there are some cases where one factor dominates, suggesting it plays a role in formulating or implementing a particular type of access approach.

Table 4. Key County Factors by Medi-Cal Model

	Location		Provider?		Access Coalition?		
MODEL	Urban	Rural	Yes	No	Yes	No	Don't Know
FFS	2	20	2	20	11	9	2
Two-Plan	10	2	9	3	8	3	1
COHS	4	4	2	6	6	2	0
GMC	2	0	0	2	1	0	1

Table 5. Key Factors in Determining Access Approaches—In Place Programs, 2004

	Medi-Cal Model				Provider		Access Coalition		Location	
IN PLACE PROGRAM	FFS (22)	Two-Plan (12)	COHS (8)	GMC (2)	Yes (13)	No (31)	Yes (26)	No (14)	Urban (18)	Rural (26)
Insurance coverage for children (not incl. S-CHIP or Medi-Cal)	1	8	3	1	9	4	11	1	11	2
Insurance coverage for adults (e.g., IHSS Workers)	0	6	3	2	7	4	9	1	9	2
Managed care for the county indigent	4	3	5	1	3	10	9	3	6	7
Premium subsidies for small employers	0	0	0	1	0	1	1	0	1	0
Information on coverage options	12	7	8	2	8	19	20	5	12	15
Outreach/enrollment/retention in public insurance programs	18	12	7	2	12	27	24	12	16	23
Consumer education (e.g., use of prevention services)	15	8	3	1	7	20	14	10	8	19
Facilities expansions (e.g., clinics)	7	6	4	0	8	9	10	4	9	8
Increase in providers (e.g., specialists)	6	3	0	0	4	5	5	2	4	5
Increase in clinic hours (e.g., weekends)	6	6	2	0	5	9	9	3	6	8
Assistance with transportation (e.g., mini-vans)	9	5	2	0	5	11	12	2	6	10
Appointment system changes	6	7	3	0	9	7	8	0	9	7
"Insurance-like" programs (e.g., bundling of county health services, lower out-of-pocket fees)	2	6	1	0	5	4	3	1	6	3

Medi-Cal Model

Insurance coverage. In 2002, we found that counties with a public plan (Two-Plan and County Organized Health System, or COHS) were more likely to have an insurance program for children and/or adults compared to Fee-for-Service (FFS) counties. The preliminary results from the 2004 survey are similar. Of the 22 Two-Plan, COHS, and Geographic Managed Care (GMC) counties, 12 offered an insurance program for uninsured children whereas only 1 FFS county (Marin) had a coverage program for children "in place." The results were roughly the same for coverage programs for adults, with 11 Two-Plan, COHS, and GMC counties offering coverage programs for adults. No FFS counties reported having a coverage program for adults.

While many counties with a public plan (Two-Plan or COHS) are also provider counties and/or have a local access coalition, many of these counties (10 out of 13 counties) with "in place" coverage programs for children rated the County Medi-Cal Plan as "very important" in launching or supporting access initiatives. Similarly, many Two-Plan and COHS counties (14 counties) indicated they had experienced increased activity

in insurance coverage for children since 2002 compared to FFS counties (6) and provider counties (7). Last, more counties with a public plan indicated they were considering future coverage programs for children (14 counties) compared to FFS counties (10) and provider counties (9). In short, having a public plan is important for launching a children's coverage program but it may not be the limiting or only factor. Counties without a public plan can also consider expansions via the CalKids program or their program for the Medically Indigent.

Managed care for the county indigent. More counties with public plans had programs in place (9 counties) compared to FFS counties (4) though the difference isn't as great as that seen with coverage for children and adults. This approach holds potential for all types of counties.

Premium subsidies for small employers. No or minimal activity across all county types.

Access to information. There were modest differences among the four Medi-Cal model types in 2002 and 2004, with all types of counties reporting access initiatives underway.

Information, outreach, and education. There were modest differences among the four model types of counties in 2002 and 2004, with all types of counties reporting efforts to reduce the barriers to coverage programs.

Service expansions. In 2002, Two-Plan counties reported more activity underway in many service expansion areas compared to COHS and FFS counties. However, many of these counties are also provider counties and have a public hospital. In 2004, service expansions of all types are fairly common in all types of counties. Medi-Cal model type may play a limited role in this regard.

Insurance-like programs. Two-Plan counties are the most active in this area, though it could be those counties with a public hospital.

Provider Status

We also cross-tabulated the coverage/services data by county provider type, specifically whether a county had a public hospital or not.

Coverage expansion. In 2002, more counties with public hospitals reported having more coverage programs for children and adults than non-provider counties. This was probably due to the fact that most provider counties also had public plans (10 out of 15 counties). However, in 2004, this trend was not so pronounced, with some non-provider counties having or proposing coverage programs (for example, 4 non-provider counties have youth coverage programs "in place"). Additionally, representatives from counties without a public hospital indicated they have experienced an increase in activity to cover children (7 out of 20 counties) and adults (3 out of 6 counties). Having a public hospital may be less important than other factors.

Managed care for the county indigent. This was a new category in the 2004 survey. More counties without a county hospital had programs "in place" than provider counties (10 versus 3).

Premium subsidies for small employers. This was a new category in the 2004 survey. There was minimal activity in this area.

Information, outreach, and education. Like the Medi-Cal model data, there was a modest difference between the two types of counties, with many counties of both types reporting initiatives underway in 2002 and 2004.

Service expansions. As would be expected, of the 13 counties that have a county-run health care delivery system, 8 counties indicated they have service expansions "in place." Unlike 2002, non-provider counties had service expansions underway in many categories (9 counties). Also, 11 counties were "proposing" facility expansions. This may be an area where counties have greater flexibility in contracting with private-sector providers.

Insurance-like programs. This was a new category in the 2004 survey. Provider and non-provider counties were equally active, which spoke to the relative ease of bundling county services.

Presence of an Access Coalition

We were also interested in the role played by local coalitions that focus on access and whether they make a difference in the level of activity being reported.

Insurance coverage. Counties with an access coalition have significantly more coverage activity underway targeted to adults and children than those counties without a coalition. While the difference is striking, many counties that have an access coalition also have a public Medi-Cal Plan (14 out of 20). Though these results are inconclusive, counties with insurance programs for children "in place" indicated that a local coalition played an "important role" or "very important role." More counties with an access coalition also reported increased activity to insure children than counties without a coalition (15 versus 4). Similarly, many counties that have a local coalition indicated they were considering pursuing coverage programs for children and adults (7). In short, having an access coalition may facilitate coverage expansions, particularly for children.

Managed care for the county indigent. Similar to the coverage expansions, counties with a coalition were more active in this area.

Premium subsidies for small employers. There were limited differences, with no counties engaging in this activity.

Information, outreach, and education. Though counties with and without access coalitions indicated they are very involved in these activities, counties with an access coalition were more active in providing "information on coverage options" compared to counties without an access coalition.

Service expansions. Counties with coalitions were moderately more involved in service expansions than counties without coalitions. However, 10 of these counties also provide county-run health care services.

Insurance-like programs. Counties with access coalitions were the only ones active in this area, though it might be due to having county-run health care services (3 counties).

Urban Versus Rural Counties

We were also interested in whether being an urban or rural county made a discernable difference to the access approaches undertaken. There were modest differences across all programs types, with urban counties sometimes being more active in some areas (insurance coverage and some service expansions) and rural counties being more active in other areas (outreach/enrollment/retention and some service expansions). Many urban counties with coverage expansions also had Medi-Cal managed care plans (9 counties). The most noticeable difference was in the number of rural counties "proposing" coverage expansions, with 8 counties without a Medi-Cal managed care plan indicating they were considering or planning coverage expansions.

V. Key Leaders and Stakeholders

To better understand the origins of these access programs and whether there has been any change in the key players since 2002, we asked study respondents in the 2004 survey to indicate the importance of key organizations or stakeholders in mobilizing, launching, and supporting access initiatives. As described in Table 6 on the following page, with the exception of the important role being played by Prop 10 Commissions, there have been modest changes since 2002. Public agencies and policymakers continued to be cited as playing an "important role" or "very important role." Of the 16 counties that said the Board of Supervisors played a "very important role," 10 counties had a children's coverage program "in place." While the Boards of Supervisors continued to play a "very important role," more counties in 2004 thought Supervisors played a "minor role" than in 2002, including two counties with a coverage program for children.

Nonprofit organizations such as community health centers and CBOs continued to play an "important role." With the exception of private funders, the private sector including insurers, providers and the business community played "no role" or a "minor role." The only noticeable change was a decrease in the perceived importance of the Community at Large, shifting from an "important role" in 2002 to a "minor role" in 2004.[3]

Table 6. Importance of Roles in Mobilizing, Launching, and Supporting Initiatives

ORGANIZATION / STAKEHOLDER	No Role		Minor		Important		Very Important		N/A	
	2002	2004	2002	2004	2002	2004	2002	2004	2002	2004
Board of Supervisors	7% (3)	7% (3)	20% (9)	30% (13)	28% (12)	23% (10)	43% (19)	36% (16)	2% (1)	5% (2)
County Health Agency	2% (1)	0% (0)	2% (1)	7% (3)	25% (11)	27% (12)	70% (31)	66% (29)	0% (0)	0% (0)
County Human Services Agency	2% (1)	2% (1)	16% (7)	16% (7)	27% (12)	45% (20)	41% (18)	34% (15)	11% (5)	2% (1)
County Medi-Cal plan (e.g., LI, COHS)	14% (6)	14% (6)	14% (6)	5% (2)	16% (7)	23% (10)	25% (11)	30% (13)	27% (12)	30% (13)
Non-county community health centers	5% (2)	5% (2)	12% (5)	11% (5)	36% (16)	39% (17)	36% (16)	41% (18)	7% (3)	5% (2)
Community-based organizations	2% (1)	0% (0)	14% (6)	25% (11)	48% (21)	50% (22)	36% (16)	23% (10)	0% (0)	2% (1)
Local coalition	7% (3)	11% (5)	5% (2)	9% (4)	43% (19)	36% (16)	34% (15)	30% (13)	11% (5)	14% (6)
Prop 10 Commission	Not Asked	5% (2)	Not Asked	11% (5)	Not Asked	48% (21)	Not Asked	34% (15)	Not Asked	2% (1)
Private insurers	34% (15)	32% (14)	20% (9)	27% (12)	18% (8)	14% (6)	2% (1)	9% (4)	20% (9)	18% (8)
Private providers	14% (6)	27% (12)	41% (18)	27% (12)	32% (14)	25% (11)	7% (3)	7% (3)	5% (2)	14% (6)
Private funders (e.g., foundations)	23% (10)	23% (10)	30% (13)	25% (11)	33% (14)	34% (15)	7% (3)	7% (3)	7% (3)	11% (5)
Business community	39% (17)	41% (18)	39% (17)	39% (17)	9% (4)	7% (3)	2% (1)	0% (0)	9% (4)	14% (6)
Community-at-large	16% (7)	27% (12)	36% (16)	41% (18)	39% (17)	18% (8)	2% (1)	2% (1)	5% (2)	11% (5)

Similarly, we asked respondents in 2002 and 2004 to identify the agency or organization responsible for spearheading access initiatives in their counties. Again, public sector involvement dominates, lead by the local health care or public health agency. However, the county agency is joined by many other organizations as indicated in Table 7. Community clinics or related organizations like clinic consortia were more frequently mentioned in 2004 than 2002.

Table 7. Key Organizations in Launching Access Initiatives

	2002*	2004†
Health care or health services agency	26%	58%
Prop 10 commission	10%	47%
Community health centers or related organizations	8%	21%
Public health department	10%	18%
Medi-Cal public plan	5%	18%
Coalitions or collaboratives	13%	16%

* Respondents were not required to answer this question in 2002 but they were in 2004, resulting in a significantly larger sample of respondents in 2004 (38 counties).

† These represent very rough estimates. Some respondents listed organizations that were not easily categorized because of an ambiguous name.

We inquired about the existence of cross-organization coalitions that focus specifically on access issues in the 2002 and 2004 surveys. The findings in Table 8 are very similar to the 2002 findings, with 55 to 60 percent of responding counties indicating their county has an access coalition. As we indicated in our earlier study, these coalitions may serve as a good target for capacity building activities, mobilizing support, and creating momentum for change.

Table 8. Presence of an Access Coalition

	2002	2004
Yes	53% (23)	59% (26)
No	35% (15)	32% (14)
Unsure	12% (5)	9% (4)

In summary, while public sector players, particularly the health care agencies, are the key players in spearheading access initiatives, they are joined by many stakeholders from the public and nonprofit sector. With the exception of private funders, United Way, hospitals and safety-net clinics, the private sector continues to be largely unrepresented in access initiatives.

VI. Funding Programs to Increase Access to Care

In 2002 and 2004, we asked respondents to check those funding streams used to finance access programs. Listed in order of highest response rate in Table 9, we see that there are few changes from 2002, with Prop 10 funds once again in the lead. Counties rely on multiple funding streams (average of 5.4). The only noticeable changes are the increased importance of private foundation funds and federal funds. New funding streams such as hospital, United Way, and Local Initiative (LI) funds are also of importance. Eight respondents included "other" funding streams including state and federal funding, specific foundations, and local funders. (See Appendix B for a description of these funding streams.)

If we separate each funding stream by its origin — federal, state, county/local and private — we see that funding for access initiatives is coming mostly from the state and local levels, though federal funding is increasingly important. Business community contributions are modest, with limited increase since 2002.

We were also interested in knowing whether funding streams varied by county type, particularly those counties undertaking coverage expansions for children or adults, Medi-Cal model, presence of an access coalition, and provider type. Our cross-tab analysis indicated that there were a few differences among county types. Interestingly, more counties with an access coalition said they used foundation funds and federal funds compared to those counties without a coalition. Additionally, more FFS counties rely on Realignment funding than counties with a Medi-Cal managed care plan. Last, nearly all county types were pursuing foundation funding. (See Appendix C.)

Table 9. Key Funding Streams for Access Initiatives

FUNDING STREAM	Responses 2002	Responses 2004	Response Rate 2002	Response Rate 2004
Prop 10 — Children and Families First Commission	35	35	81%	80%
Realignment Funds	33	29	77%	66%
CHIP/CMSP (Medically Indigent)	33	29	77%	66%
Tobacco Settlement Funds	23	24	53%	55%
Private Foundation Funds	22	27	51%	61%
Other County General Funds	20	19	47%	43%
Federal funds (e.g., HRSA Cap Grants)	18	29	42%	66%
Hospital or hospital district funds	N/A*	14	N/A	32%
United Way	N/A	10	N/A	23%
Business community contributions	5	7	12%	16%
Other	15	7	35%	16%
Local Initiative or COHS Savings	N/A	6	N/A	14%

*Not asked during 2002 survey.

In the 2004 survey, we asked respondents to characterize the resources to which they had access. The findings in Table 10 mirror the findings in Table 9, providing a more nuanced description of how counties are securing funds. Leveraging Existing Funds and Increased Grant Writing were checked off by most of the respondents. Additionally, the findings suggest that many counties are employing multiple strategies (3.5 strategies). Interestingly, though the business community is perceived as playing a minor role in access initiatives, it is being approached by a significant number of counties (14) to fund these initiatives. Last, eight

Table 10. Resources/Strategies to Fund Access Programs, 2004

RESOURCE/STRATEGY	Responses	Response Rate
Leveraging existing funds, like Prop 10 funds, to attract new funding	35	80%
Increased grant writing (e.g., local foundations)	34	77%
Recommending allocation of Tobacco Settlement funds	22	50%
Securing federal funds (e.g., HRSA HCAP grants)	18	41%
Approaching the business community	14	32%
Using Healthy Families unused funds to leverage federal funds	11	25%
Applying savings from other areas (e.g., from the Local Initiative)	7	16%
Other	8	18%
Tapping into existing county funds that haven't been used in the past	6	14%

respondents mentioned "other" strategies to which their county had access, some of which may merit monitoring for the future such as local measures, privatization of county clinics and ancillary services, and Medi-Cal Administrative Activities (MAA) funding.

Next, we asked respondents in the 2004 survey to indicate how they were intending to deploy these resources and whether they would fund coverage and service expansions. The findings in Table 11 reinforce the findings described above, namely, children's coverage programs are more likely to be undertaken than adult coverage programs. Outreach/enrollment/education programs were holding steady. Service expansions are anticipated in less than half of the respondent counties.

In summary, while counties still have some funding sources from which to choose and they are working to expand these choices; that is, they are shifting their sights to private donors such as foundations. Additionally, counties are resourceful in how they secure these dollars; using strategies like leveraging, grant writing, and influencing the allocation of funds. Also, there is still some willingness to deploy these resources for coverage programs but it appears to be limited to children's programs. Finally, many counties were not proposing service expansions, which spoke to diminishing resources or decreased unmet need due to increased spending in this area in recent years.[4]

Table 11. Programs Being Considered by Respondent Counties, 2004

PROGRAM	YES	NO	DON'T KNOW
Insurance coverage for children	57% (25)	27% (12)	16% (7)
Insurance coverage for adults	16% (7)	64% (28)	20% (9)
Outreach/enrollment/retention	66% (29)	32% (14)	2% (1)
Service expansions (e.g., clinics, providers)	45% (20)	45% (20)	9% (4)

VII. Barriers to Expansions

In 2002, we asked respondents to identify the barriers that could not be addressed through capacity-building resources such as structural hurdles, low political commitment, etc. We clustered responses by six types of barriers:

- Funding/resource limitations (15)
- Health care delivery system (8)
- Political barriers (7)
- Providers (6)
- Public insurance (5)
- Target population/consumer (5)
- Geography (3)

To get a more precise understanding of how many counties are challenged by these barriers, we asked respondents in the 2004 survey to check of those barriers that applied to their county. Interestingly, as described in Table 12, rural issues are important in urban and rural counties, outweighing the other barriers. The second most cited barrier, competing priorities, suggests that there is increased competition for increasingly limited resources. Also, political barriers are less of a barrier than other barriers, suggesting that engagement and commitment of local policymakers have been addressed in many counties though it remains a significant barrier in others. Twelve respondents mentioned "other" barriers, primarily lack of resources or funding (8 counties) and lack of services; for example, declining specialist participation in indigent care (4 counties).

Table 12. County-level Barriers to Increasing Access to Care for the Uninsured: 2004

BARRIER TO ACCESS INITIATIVES	Responses	Response Rate
Rural issues (e.g., poor transportation between areas)	32	74%
Competing priorities	25	58%
Cultural/social barriers (e.g., language barriers)	25	58%
Health care delivery system (e.g., difficulty in developing coverage contracts)	20	47%
Political barriers	17	40%
Other	12	28%
Low stakeholder engagement (e.g., lack of coalition focused on access)	11	26%
Limited technical expertise	9	21%

Additionally, we asked respondents to identify their top health issue because this may influence their choice of access initiatives. While diseases and chronic conditions like obesity and cancer were most frequently cited (14 counties), access to health care services (9) and access to insurance coverage (5), and access more generally (4) were mentioned by counties. Other issues included: adequate funding (6 counties), availability of health care services (3), and demographics, such as an aging population (1).

To get a sense of the relative importance of access to health care services for the uninsured to other health issues, we asked respondents to rate access to health care services on a scale of 1 to 4, where 1 means not important and 4 means very important. The results in Table 13 suggest that access to care for the uninsured continued to carry significant weight.

Table 13. Importance of Access to Care for Uninsured Relative to Other Health Issues

	RESPONSES	RATE
Not important	0	0%
Less important	2	5%
Important	16	36%
Very important	26	59%

Additionally, we asked respondents whether access to health care for the uninsured had changed in importance since 2002 when the state budget was less of an imminent threat to county budgets and the earliest coverage expansions were just being launched. Many respondents (25 counties) indicated that access to health care had increased in importance. A lesser number (16 counties) indicated “no change” since 2002. Two respondents indicated that access to health care for the uninsured had decreased in importance since 2002.

In summary, while access to care for the uninsured is high on the county health agenda, systemic and geographic barriers may impede progress in this area. Growing competition from other sectors and increased willingness to seek resources from new funding sources suggest counties are under greater fiscal pressure than they were in 2002. However, access to care for the uninsured continues to grow in importance in the face of these constraints, increasing the likelihood of hard trade-offs if economic relief is not forthcoming.

VIII. County Coverage Expansions

In the 2004 survey, we asked respondents to describe their coverage expansions that were underway and those being considered. Specifically, we asked them to describe the target populations, funding sources, and role of the Medi-Cal managed care plan where applicable. Though these results were not representative of counties as a whole (23 out of 44 respondents completed this section of the survey), they corroborated many of the findings above, including:

- Most programs underway for children tend to resemble Santa Clara's Healthy Kids program though there are other expansions (for example, dental or CalKids).
- Programs for adults are more varied by target population. Some adult coverage programs are CMSP/CHIP expansion and some are targeted to IHSS workers.
- Additionally, most children's programs involve multiple funding sources but this is not always the case for adult coverage programs, with foundation support not being mentioned.
- Though the Medi-Cal public plan is an important player, expansions are underway or being considered in FFS counties that do not have a public plan.

Table 14. Counties Where Coverage Is Underway and/or Being Considered

CHILDREN'S INSURANCE PROGRAMS		ADULT INSURANCE PROGRAMS	
Underway (9)	**Being Considered (11)**	**Underway (5)**	**Being Considered (4)**
• Alameda (2)	• Del Norte	• Alameda	• Lassen
• Marin	• El Dorado	• El Dorado	• Mendocino
• Riverside	• Kern	• Sacramento	• Sacramento
• San Bernardino	• Mendocino	• San Francisco	• San Francisco
• San Francisco	• Orange	• Solano	
• San Mateo	• Sacramento		
• Santa Clara	• San Francisco		
• Solano	• Santa Barbara		
• Tuolumne (Dental)	• Santa Cruz*		
	• Sonoma		
	• Tuolumne		

* Since the 2004 survey findings were tabulated, Santa Cruz has implemented its insurance program for children.

IX. Follow-up Interviews

To better understand why some counties continue to pursue coverage expansions under adverse financial conditions, we interviewed representatives from 6 counties that have maintained (or increased) their commitment to launching insurance programs for uninsured children and/or adults. Using the 2004 survey data, we identified 6 counties that met the following the criteria:

- Had implemented or were proposing an insurance program;
- Had experienced an increase in coverage activity during the last two years; and
- Had indicated they were considering allocating resources on coverage in the future.

We identified the following counties:

Adults

- El Dorado (proposing, FFS County)
- San Francisco (implemented, Two-Plan County)

Youth

- El Dorado (proposing, FFS County)
- Kern (proposing, Two-Plan County)
- Marin (implemented, FFS County)
- Riverside (implemented, Two-Plan County)
- San Francisco (implemented, Two-Plan County)
- Santa Cruz (proposed, COHS County)

We conducted 30-minute phone interviews with representatives from the county health agency or First Five Commission (Kern County), specifically those individuals that completed the 2004 survey. All interviews were transcribed, coded, and analyzed for cross-cutting themes and commonalities/differences. The following is a summary and discussion of these findings.

Facilitating Factors in Last Two Years

Respondents mentioned five factors that had facilitated their efforts:

1. Political support (5 counties); e.g., high Board of Supervisors commitment to increased access or universal coverage

2. Availability of funding (5 counties); e.g., First Five Commission, foundation, County General Funds
3. Commitment more generally (3 counties); e.g., cross-organizational desire to address health needs of children early on
4. Involvement of Medi-Cal managed care plan (2 out of 4 counties); e.g., Santa Cruz and San Francisco[5]
5. Alignment of Key Factors (2 counties); e.g., good alignment between First Five Commission and county desire to expand access

Additionally, all respondents spoke to a deep commitment to increased access to care for the uninsured, with three counties indicating they were committed to universal coverage (Marin, San Francisco, and Santa Cruz. While El Dorado may be in the "proposed" stages, it has not made a firm commitment to developing an insurance product. Similarly, some counties like Kern and Riverside are focusing primarily on children and have expressed a high commitment to maintaining or expanding health care services. This could be an important distinction and may be useful in determining the likelihood of coverage expansions for children and adults.

Why Pursue Coverage Expansions?

In addition to having a strong desire to address the needs of the uninsured more generally, our respondents indicated they were very committed to reducing the barriers to health care for children, citing the following reasons:

- Children are seen as a good investment
- High political willingness to "leave no child behind"
- "People can get behind youth"
- Children were identified in a county assessment study
- Children are cheaper and easier to insure
- The importance of addressing health issues of younger generation, e.g., immunizations
- The importance of an early success in expanding coverage more broadly

Other reasons for pursuing coverage expansions more generally included:

- Availability of funding
- Primary care services in place

County Political Environment

All respondents indicated their county enjoyed policymaker (Board of Supervisor) support though this support varied from "no resistance" to being a "trend-setter." There were modest differences in their commitment and involvement, with one respondent indicating that coverage expansion was something a conservative Board could support because of the impetus from constituents.

Other dimensions of the political environment noted by respondents included:

- Agency involvement
- Recognition and support for addressing needs of the uninsured
- Policymaker willingness to allocate resources

Changes in County Ability to Finance Coverage Expansions

We asked respondents to comment on whether their county had experienced any changes in their ability to finance coverage expansions in the last two years, such as decreased funding or appearance of new funding. Not surprisingly, 4 counties (Marin, Santa Cruz, Riverside, and San Francisco) described their county as "stretched" or challenged financially. However, all counties indicated there was continued commitment to finance coverage expansions. Only Riverside County reported that it had capped its Healthy Kids Program.

There were some differences across counties in the number and type of funding sources being dedicated to coverage expansions, with Kern County indicating that Prop 10 funds are the *only* funds available to them. Two counties mentioned leveraging funds; that is, Tobacco Settlement funds, cobbling together funds from different sources, and grant-writing.

Interestingly, only one respondent, San Francisco, spoke to developing a sustainable model for funding its coverage expansions, relying on County General Fund Support and Prop 10 funding (not Realignment or Tobacco funds). The county has increased funding for its Healthy Kids program in the face of significant budget cutbacks, suggesting that the program may be less vulnerable to cuts. However, San Francisco may be unique because of its combined city/county structure and enjoys some structural and political advantages. By comparison, Riverside County has a similar funding stream approach—County General Fund Support, Local Initiative, and a local foundation—but it indicated its county funds are at risk.

Facilitating Factors

Respondents identified a handful of external factors that had facilitated county-level coverage efforts:

- Availability of funding/Prop 10 Commission (2 counties);
- Presence/assistance from other counties like Santa Clara (2 counties);
- Role of technology (1 county);
- Availability of Federal funds; e.g., Healthy Communities Access Program (HCAP) and clinic Federally Qualified Health Center 330 expansion grants (1 county).

Impeding Factors

Nearly all counties (5) mentioned state-level factors that have impeded their efforts to expand coverage, including:

- Proposed cuts to the Medi-Cal program (3 counties)
- State budget; e.g., repeal of the Vehicle License Fees increase and give back to the state (1 county)
- Limited state capacity; e.g., working on waivers submitted to the federal government (1 county)

Only 1 county (Kern) indicated there were *no* factors stopping or impeding its progress and 1 county (Riverside) mentioned changing demographics.

In summary, the findings from the interviews corroborate many of the 2004 survey findings, namely that there are fewer barriers to coverage expansions for children though the state budget and county finances may impede these efforts. Interestingly, while most coverage programs for youth are modeled on the Santa Clara Healthy Kids program, there are some significant differences in funding these programs, ranging from relying on two or three sources of funding to assembling multiple sources of funding. However, they all share in common the use of Prop 10/First Five funding. Similarly, there is no one sustainable funding approach though San Francisco's model holds promise. Last, coverage expansions in general may enjoy a limited "immunity" to larger financial pressures—there are other available funding sources and at worst, the county response has been to cap the Healthy Kids program (Riverside and Santa Clara).

X. Conclusion: Future Expansions

LAST, WE WERE INTERESTED IN ASSESSING THE likelihood of future expansions, particularly coverage program. In 2002, the study findings suggested that counties that had assets that directly contribute to coverage and/or service expansion such as a local plan or public hospital were likely to proceed with these expansions. However, the 2004 data on "proposed" programs suggest that counties that don't have these assets ARE also willing to expand coverage for children and adults. We cross-tabulated the access program types with the key factors to see whether some counties were more predisposed than others to expand specific types of programs. As indicated in Table 15, 8 Fee-for-Service counties are proposing to launch an insurance program for children and 4 FFS counties are considering coverage expansions for adults. Having a Medi-Cal public plan may be less important as other insurance models are considered such as piggybacking on CalKids to expand coverage for children. Having a county-run hospital and being an urban/rural county may be less important to proposing a coverage program for children and adults than the availability of funding like Prop 10 funding. Also, having an access coalition may be moderately important in those counties proposing to expand coverage. Similarly, service expansions are being considered by FFS and non-provider counties.

Table 15. Key Factors in Determining Access Approaches – Proposed Programs, 2004

	Medi-Cal Model				Provider		Access Coalition		Location	
PROPOSED PROGRAM	FFS (22)	Two-Plan (12)	COHS (8)	GMC (2)	Yes (13)	No (31)	Yes (17)	No (7)	Urban (18)	Rural (26)
Insurance coverage for children (not incl. S-CHIP or Medi-Cal)	8	1	2	1	2	10	8	3	5	7
Insurance coverage for adults (e.g., IHSS Workers)	4	1	1	0	2	4	4	1	2	4
Managed care for the county indigent	4	2	0	1	1	6	4	2	3	4
Premium subsidies for small employers	2	0	0	0	0	2	2	0	0	2
Information on coverage options	0	2	0	0	1	1	1	1	1	1
Outreach/enrollment/retention in public insurance programs	1	0	1	0	0	2	2	0	1	1
Consumer education (e.g., use of prevention services)	3	2	2	1	3	5	6	1	6	2
Facilities expansions (e.g., clinics)	6	3	2	2	1	12	9	3	4	9
Increase in providers (e.g., specialists)	5	2	3	1	1	10	8	2	3	8
Increase in clinic hours (e.g., weekends)	4	1	2	1	1	7	7	1	3	5
Assistance with transportation (e.g., mini-vans)	2	1	0	1	1	3	1	2	2	2
Appointment system changes	5	2	0	1	1	7	4	3	2	6
"Insurance-like" programs (e.g., bundling of county health services, lower out-of-pocket fees)	2	1	0	1	1	3	4	0	2	2

Additionally, we asked respondents in the 2004 survey to indicate whether their county had experienced a change in the amount of activity since 2002 in the four major types of access programs. As described in Table 16, while some counties experienced "decreased" activity in the four program types, many counties experienced "increased" or "no change" in activity in all areas. Coverage for adults saw the least amount of change compared to the other three areas.

Interestingly, some counties experienced a decrease in outreach/enrollment/retention activities, which could be due to significant success and decreased need for these programs or difficulty in securing funding for these activities.

Table 16. County Perception of Change in Access Activities Since 2002

PROGRAM	Decreased Activity	Increased Activity	No Change	Unsure
Insurance coverage for children	11% (5)	45% (20)	36% (16)	7% (3)
Insurance coverage for adults	16% (7)	14% (6)	57% (25)	14% (6)
Outreach/enrollment/retention	20% (9)	52% (23)	18% (8)	9% (4)
Service expansions (e.g., clinics, providers)	16% (7)	50% (22)	30% (13)	5% (2)

More broadly, the data suggest that we can anticipate continued growth in insurance coverage for children and modest growth in insurance coverage for adults. Also, while having a Medi-Cal managed care plan may facilitate coverage expansions in these counties, an increasing number of FFS counties are offering coverage and are restructuring their programs for the Medically Indigent. Also, most counties have established systems or programs to connect people to existing public insurance programs. Last, the continued emphasis on service expansions in all county types suggests growing demand and a willingness to meet this demand in most areas. Significant public support for expanding access to care using coverage approaches and new funding sources may be expanding the possibility for coverage expansions beyond what was anticipated in 2002.

Appendix A: Responding Counties

Alameda
Butte
Contra Costa
Del Norte
El Dorado
Fresno
Glenn
Humboldt
Kern*
Kings
Lassen
Los Angeles
Marin
Mendocino
Merced
Mono*
Monterey
Napa
Orange
Plumas
Riverside
Sacramento
San Benito*
San Bernardino
San Diego
San Francisco
San Joaquin
San Luis Obispo
San Mateo
Santa Barbara
Santa Clara
Santa Cruz
Shasta*
Siskiyou*
Solano
Sonoma
Stanislaus*
Sutter
Tehama
Tulare
Tuolumne
Ventura
Yolo
Yuba*

*Responded to 2004 survey only.

Appendix B: Funding Stream Definitions

Business Community Contributions

Some counties like Santa Clara are approaching the business community and are securing contributions.

CHIP/CMSP (Medically Indigent)

"CHIP" refers to the California Healthcare for the Indigents Program. It is funded with Prop 99 funds (tobacco funds) and includes 24 participating counties — typically the more populated, urban counties. "CMSP" refers to the County Medical Services Program. It is funded primarily with Realignment funds and county general funds, and includes 34 rural counties. Both programs reimburse providers for uncompensated services for medically indigent patients — individuals who cannot afford care and for whom no other source of payment is available.

Federal Funds

Federal funds like the Bureau of Primary Health Care's Healthy Communities Access Program (HCAP) are being used by counties to plan and develop a variety of access programs, including coverage expansions.

Hospital or Hospital District Funds

Some access programs are receiving funding from hospitals or hospital districts.

Local Initiative or COHS Savings

Medi-Cal managed care plans are also a source of funding, with some savings being re-allocated to coverage expansions for children and adults.

Other County General Funds

Some counties such as San Francisco have earmarked county general funds for coverage expansions for children and adults. These are non-Realignment, local funds.

Private Foundations

Foundations such as Packard, The California Endowment, and the California HealthCare Foundation have provided funds to launch coverage expansions for children and adults. In some cases, funding for premium subsidies has been provided.

Prop 10 — Children and Families First Commission

Enacted in 1998, Prop 10 uses revenues generated by increases in the state excise taxes on tobacco products to fund childhood development programs that are carried out by state and county commissions. Many counties are using these funds to launch health care insurance programs for uninsured children up to 18 years of age.

Realignment Funds

Enacted in 1991, "Realignment" refers to a funding mechanism that gives counties greater flexibility and responsibility for funding health, mental health, and social services. This funding source is a combination of vehicle license fees (VLF), sales tax revenues and county matching health and mental health dollars. It is used to fund county programs targeted to the medically indigent.

Tobacco Settlement Funds

Under the 1998 Master Tobacco Settlement, tobacco companies are required to make payments to the states through 2025. In California, the counties receive half of the funds, having significant discretion in the types of programs and services they can fund. Some counties like Santa Clara have allocated these funds for coverage expansions for uninsured children.

United Way

A new player, United Way has recently contributed coverage expansion funding in the Sacramento area.

Appendix C: Funding Used to Finance Access Programs

FUNDING STREAM (RESPONSES)	In Place Coverage		Medi-Cal Model				Access Coalition		Provider	
	Youth (13)	Adult (11)	FFS (22)	Two-Plan (12)	COHS (8)	GMC (2)	Yes (26)	No (14)	Yes (13)	No (31)
Business Community Contributions (7)	3	4	1	3	2	1	5	1	2	5
CHIP/CMSP (29) (Medically Indigent)	8	8	17	6	4	2	18	8	8	21
Federal Funds (29) (e.g., HRSA Cap Grants)	10	9	13	7	7	2	21	6	10	19
Hospital/Hospital District Funds (14)	4	6	2	2	4	2	10	2	3	11
Local Initiative/COHS Savings (6)	6	0	6	6	0	0	6	0	6	0
Other County General Funds (19)	9	7	10	6	3	0	14	4	8	11
Private Foundation Funds (27)	11	10	11	7	7	2	20	5	9	18
Prop 10 — Children & Families First Commission (35)	12	9	18	10	5	2	22	9	11	24
Realignment Funds (29)	6	6	18	6	5	0	19	8	7	22
Tobacco Settlement Funds (24)	11	9	10	7	5	2	18	4	9	15
United Way (10)	2	5	1	1	3	1	7	0	3	7

Appendix D: Survey Instrument

In 2002, the California HealthCare Foundation administered a 58-county survey on existing and proposed programs to increase access to health care for the uninsured, as well as county needs in designing and implementing these programs. The findings from this survey contributed to the design and launch of the Foundation's Step by Step Initiative, providing technical assistance to counties in planning and implementing insurance coverage programs for uninsured children and adults. The Foundation is interested in updating its understanding of county efforts to increase access to health care for the uninsured, including current and proposed access and coverage programs and barriers to launching these programs. Please take 15 minutes to complete the following survey. The results of the survey will assist the Foundation in developing services and assistance to support local expansion efforts. All responses will be reported anonymously. Your completion of the survey implies you are providing your consent to participate in this study. The deadline for completing the survey is March 19, 2004. If you have questions regarding the survey, please contact Annette Gardner, PhD, MPH, Study Director, Institute for Health Policy Studies, University of California, San Francisco at 415.514.1543 or algard@itsa.UCSF.edu.

Section A: Access Programs

1. **Please indicate the types of county-level programs that are currently underway or are being considered to increase access to health care for the uninsured. Check one box per program type that best describes your county's situation:**

	In Place	Proposed	No Activity	Don't Know
a. Insurance coverage for children (children not eligible for Healthy Families, Medi-Cal, e.g., CalKids, Healthy Kids)	☐	☐	☐	☐
b. Insurance coverage for adults (e.g., IHSS workers)	☐	☐	☐	☐
c. Managed care for the county indigent	☐	☐	☐	☐
d. Premium subsidies for small employers	☐	☐	☐	☐
e. Information on coverage options	☐	☐	☐	☐
f. Outreach/enrollment/retention in public insurance programs	☐	☐	☐	☐
g. Consumer education (e.g., use of prevention services)	☐	☐	☐	☐
h. Facilities expansions (e.g., new clinics)	☐	☐	☐	☐
i. Increase in providers (e.g., specialists)	☐	☐	☐	☐
j. Increase in clinic hours (e.g., weekends)	☐	☐	☐	☐
k. Assistance with transportation (e.g., mini-vans)	☐	☐	☐	☐
l. Appointment system changes (e.g., same-day appointments)	☐	☐	☐	☐
m. "Insurance-like" programs (e.g., bundling of county health services, lower out-of-pocket fees, no premiums)	☐	☐	☐	☐

2. **Please list other programs to increase access to care that are not listed above.**

3. **Has your county experienced a decrease/increase/no change in activity since 2002 in any of the following areas?**

   a. Insurance coverage for children (not incl. Healthy Families, Medi-Cal)

   b. Insurance coverage for adults

   c. Outreach/enrollment/retention in public insurance programs

   d. Service expansions (e.g., clinics, providers)

4. **We are interested in knowing what organizations or stakeholders have played a key role in mobilizing, launching, and supporting access initiatives, be coverage and/or services expansions, in your county. Please rate each participant on a scale of 1 to 4 (1 = no role, 4 = very important role, N/A = does not apply to our county, e.g., county public plan).**

a. Board of Supervisors	1	2	3	4
b. County health agency	1	2	3	4
c. County human services agency	1	2	3	4
d. County Medi-Cal Plan (e.g., LI, COHS)	1	2	3	4
e. Non-county community health centers	1	2	3	4
f. Community-based organizations	1	2	3	4
g. Local coalition	1	2	3	4
h. Prop 10 Commission	1	2	3	4
i. Private insurers (e.g., KP Cares for Kids)	1	2	3	4
j. Private providers	1	2	3	4
k. Private funders (e.g., foundations)	1	2	3	4
l. The business community	1	2	3	4
m. Community-at-large	1	2	3	4

5. **Which agency or organizations are responsible for spearheading access initiatives in your county? Please list the top three in order of importance:**

   a. ______________________

   b. ______________________

   c. ______________________

6. **Does your county have a coalition that specifically focuses on access issues (not including the county Prop 10 Commission)?**

   Yes No Don't Know

7. **We are interested in knowing the type of funding your county has used to finance the access programs checked off above. Please check the funding streams that your county has used or is intending to use. Check all that apply.**

   a. Prop 10 — Children and Families First Commission ☐

   b. CMSP/CHIP — Medically Indigent funds ☐

   c. Tobacco Settlement funds ☐

   d. Realignment funds ☐

   e. Other county general funds ☐

   f. Private foundation funds ☐

   g. Business community contributions ☐

   h. Federal funds (e.g., CAP Grants, MAA, AB 495) ☐

   i. Local initiative or COHS savings ☐

   j. Hospital or hospital district funds ☐

   k. United Way ☐

   l. Other, please specify:

   ____

Section B: Barriers to Access Initiatives

Since this survey was administered in 2002, there have been many economic changes at the state and local level, such as the repeal of the Vehicle License Fee tax increase, that may challenge counties. The California HealthCare Foundation is interested in knowing about the opportunities and barriers to increasing access to care for the uninsured that exist in your county.

8. Please check the following resources and strategies to which your county has access:

a. Tapping existing county funds that haven't been used in the past ☐

b. Approaching the business community

c. Securing federal funds like HRSA Cap Grants ☐

d. Leveraging existing funds like Prop 10 funds to attract new funding ☐

e. Increased grant-writing (e.g., local foundations) ☐

f. Applying savings from other areas (e.g., from the Local Initiative) ☐

g. Using Healthy Families S-CHIP unused funds to leverage federal funds ☐

h. Recommending allocation of Tobacco Settlement funds ☐

i. Other, please specify:

____

9. Is your county considering using any of the strategies and resources listed in Question 8 to fund the following types of access programs?

	Yes	No	Don't Know
a. Insurance coverage for children (not incl. Healthy Families, Medi-Cal)	☐	☐	☐
b. Insurance coverage for adults	☐	☐	☐
c. Outreach/enrollment /retention in public insurance programs	☐	☐	☐
d. Service expansions (e.g., clinics, providers)	☐	☐	☐

10. There are some barriers to access initiatives that can not be readily addressed using resources. Please check off any barriers that exist in your county:

a. Political barriers (e.g., low political commitment) ☐

b. Cultural/social barriers (e.g., language barriers) ☐

c. Limited technical expertise (e.g., difficulty in developing coverage contracts) ☐

d. Health care delivery system (e.g., high unmet need) ☐

e. Rural issues (e.g., poor transportation between areas) ☐

f. Low stakeholder engagement (e.g., lack of coalition focused on access) ☐

g. Competing priorities (e.g., transportation, security) ☐

h. Other, please specify:

____

11. We understand counties may be confronted with very different health issues. Please indicate your county's top health issue:

____

12. From the perspective of a county official, please rate the importance of access to health care services for the uninsured in your county relative to other health issues on a scale of 1 to 4 (1=not at all and 4=very important).

1 2 3 4

13. From the perspective of a county official, has the issue of access to health care for the uninsured decreased/increased/not sure in importance since 2002?

Decreased Increased Not Sure

Section C: Local Health Insurance Coverage Expansions

14. The California HealthCare Foundation is interested in knowing more about your county's efforts to expand insurance coverage for uninsured youth and/or adults. Please complete the following information for each program that is *currently underway.* Please indicate "Don't Know" for any program characteristics that you are not aware of.

Insurance Programs for Uninsured Children (children not eligible for Healthy Families, Medi-Cal)

Program 1:

a. Program name: ________________

b. Program launch date: ________________

c. Program target populations (e.g., undocumented children up to 300% FPL):

____

d. Number of people enrolled in program as of January 2004: ________________

e. If available, program funding source(s):

____

f. If available, amount of funding secured:

____

____

g. Key stakeholders important in program design and launch:

____

h. If applicable, did the Local Initiative or COHS play a key role?

Yes No Don't Know

Program 2: (repeat above)

Insurance Programs for Uninsured Adults:

Program 1:

a. Program name: ________________

b. Program launch date: ________________

c. Program target populations (e.g., adults up to 300% FPL): ________________

d. Number of people enrolled in program as of January 2004: ________________

e. If available, program funding source(s):

____

f. If available, amount of funding secured:

____

g. Key stakeholders important in program design and launch:

____

h. If applicable, did the Local Initiative or COHS play a key role?

Yes No Don't Know

Program 2: (repeat above)

15. The California HealthCare Foundation is interested in knowing more about programs being considered by your county to expand insurance coverage for uninsured youth and/or adults. Please complete the following information for each program that is *being considered.* Please indicate "Don't Know" for any program characteristics that you are not aware of.

Insurance Programs for Uninsured Children (children not eligible for Healthy Families, Medi-Cal)

Program 1:

a. Program name: ____________________

b. Program launch date: ______________

c. Program target populations (e.g., undocumented children up to 300% FPL):

____

d. Number of people enrolled in program as of January 2004: _______________

e. If available, program funding source(s):

____

f. If available, amount of funding secured:

____

g. Key stakeholders important in program design and launch:

____

h. If applicable, did the Local Initiative or COHS play a key role?

Yes No Don't Know

Program 2: (repeat above)

Insurance Programs for Uninsured Adults:

Program 1:

a. Program name: ____________________

b. Program launch date: ______________

c. Program target populations (e.g., adults up to 300% FPL): _________________

d. Number of people enrolled in program as of January 2004: _______________

e. If available, program funding source(s):

____

f. If available, amount of funding secured:

____

g. Key stakeholders important in program design and launch:

____

h. If applicable, did the Local Initiative or COHS play a key role?

Yes No Don't Know

Program 2: (repeat above)

Respondent Information

16. First name ____________________
17. Last name ____________________
18. Position ____________________
19. Organization ____________________
20. Address ____________________
21. City ____________________
22. State ____________________
23. Zip code ____________________
24. County ____________________
25. Phone ____________________
26. Fax ____________________
27. Email ____________________
28. County type: Check one

   ☐ Rural ☐ Urban

29. County Medi-Cal Program Type: Check one

   ☐ Fee-for-Service ☐ COHS

   ☐ Two-Plan ☐ GMC

30. Does your county have a county-run hospital? Yes No

Endnotes

1. In 2002, respondents were asked to identify coverage programs from a list of 10 program types. In 2004, we expanded this list to 13 program types.
2. CaliforniaKids (CalKids) offers coverage for uninsured children in 39 counties. Enrollment is capped in all counties except for Orange, Marin, and Solano — 3 counties that counted these programs as "in place" coverage programs for children in their surveys.
3. The data are very sensitive to modest changes in the number of responses and could understate the importance of some stakeholders.
4. For a more detailed analysis of recent cut-backs in county services, see the study by Baldassare et al., *The State Budget and Local Health Services in California: Survey of County Officials,* at: www.ppic.org/content/pubs/OP_504MBOP.pdf.
5. Having a Medi-Cal managed care plan may not necessarily suggest that the plan will be involved with coverage expansions, as appears to be the case in Kern County.

California HealthCare Foundation

476 Ninth Street
Oakland, California 94607
Tel: 510.238.1040
Fax: 510.238.1388
www.chcf.org