Universal Health Care for Children: Two Local Initiatives

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Over the past decade, expansions under Medicaid and the State Children’s Health Insurance Program (SCHIP) have brought a significant infusion of federal dollars into state and county health systems and have produced a variety of state-level programs. Yet, the expansion of public health insurance programs at the state level has had mixed success in providing coverage and improving access to care for children. In some cases, states have fallen short of their enrollment projections because of barriers such as some children remaining ineligible for coverage or families finding programs difficult to access.

In response to these barriers, counties and local communities have increasingly emerged as “hubs of innovation” by using creative strategies to make insurance coverage and access to care available to children who do not meet the state eligibility criteria. This article describes the programs of two counties that have attempted to expand access to care for children: the Children’s Health Initiative in Santa Clara County, California; and the Kids Get Care program in King County, Washington. The Santa Clara County Children’s Health Initiative (CHI) adopted an insurance expansion model through its local initiative health plan, while the King County Kids Get Care (KGC) program is a service coordination model that directly links the child to a community-based “medical homes.” The article begins by describing these two county-level programs and comparing the approach each has taken, then draws on these experiences to outline important elements for counties that want to create universal health care for children and families: committed leadership, health systems infrastructure, multiple financing sources, and community support.

Two Models for Improving Children’s Health Care Access in a Patchwork System

The Santa Clara County and King County initiatives were selected for study in this article for a variety of reasons. First and foremost, they took differing approaches to improving children’s access to care, and the programs are at least 12 months into their implementation. In addition, both counties are home to highly diverse populations and have publicly financed delivery systems with the capacity to support activities proposed under each initiative. Finally, each county also has a major city with a moderate to high concentration of uninsured children—the city of San Jose in Santa Clara County and the city of Seattle in King County.

The counties are using two different approaches to move toward universal health care for children in otherwise patchwork health systems. The Santa Clara County CHI is a health insurance expansion with a focus on integrating funding and service delivery, while the King County KGC program is a services-based initiative that directly links the child to a community-health care provider.
based, integrated continuum of care. This section provides a more detailed description of the two counties and their children’s health initiatives.

**The Santa Clara County Children’s Health Initiative**

Located at the southern end of the San Francisco Bay Area, Santa Clara County is home to 1,736,722 residents; about 462,000 of them are under age 18. Approximately 925,000 of the county’s residents live in San Jose, the biggest and most populous city in the county. The county has also witnessed tremendous growth in its racial and ethnic populations. Latinos currently comprise about 25% of the county’s population, Asians and Pacific Islanders 20%, and African Americans about 4%. Santa Clara County, home to the original Silicon Valley and the high-tech industry, has been described as having an hourglass-shaped economy. While Santa Clara is a relatively affluent county with a large number of families earning above the national median household income, many low- and moderate-income families struggle with escalating housing costs and the basic costs of living, including the cost of health insurance. In 2001, about 147,000 residents, or about 10% of the county’s non-elderly population, were uninsured. The most widely cited estimates indicate that 15% of the county’s children (approximately 71,000) lack health insurance coverage. Approximately 20% of the county’s children are in families with incomes up to 300% of the federal poverty level (FPL).

The Santa Clara County CHI is an insurance coverage expansion created through a unique public-private partnership involving county and city governing bodies, the local health and hospital system and social services agency, labor-affiliated and faith-based organizations, and private foundations. It seeks to provide health insurance coverage to all children in the county with family incomes up to 300% of the FPL.

The community advocacy groups (Working Partnerships USA, a labor-affiliated organization, and the faith-based People Acting in Community Together) mobilized their constituents and placed the issue of uni-
Counties and local communities...[are]...using creative strategies to make insurance coverage and access to care available to children who do not meet the state eligibility criteria.

universal coverage for children on the local policy agenda. In 2000, health system leaders and community activists convened to initiate discussions on the need for broad-scale change to address the county’s growing uninsured population. These meetings led to a series of hearings with county and city governing bodies, culminating in the allocation of several million dollars annually from public and private funding sources to the CHI.

Launched in January 2001, the CHI aims to provide comprehensive health, dental, and vision coverage to all children in the county under age 18 whose family incomes are at or below 300% of the FPL, or $52,950 a year for a family of four in 2002. (See Table 1.) To accomplish this goal, the initiative created a subsidized, private insurance program called Healthy Kids for low-income, uninsured children who do not qualify for Medicaid or SCHIP. The program also created a “single point of entry” model for enrolling children, whereby an entire family can enroll in health coverage through the CHI. The Healthy Kids program offers comprehensive health, dental, and vision benefits that are managed through the county’s local Medicaid managed care plan, the Santa Clara Family Health Plan. In turn, the plan coordinates with the county’s ambulatory facilities and affiliated community health centers to provide preventive and primary care services. Enrollees requiring specialty care or hospitalization are referred to one of seven local hospitals. The plan also contracts with private physicians throughout the county for primary and preventive services. By using coordinated outreach and enrollment through county district offices, health centers, and community-based organizations, the CHI enrolled more than 10,900 children in Healthy Kids by August 2002.10

The King County Kids Get Care Program

King County is the largest county in the state of Washington, with a total population of 1,737,034, of which nearly 400,000 are children (ages 0 to 17).11 In 2000, about 9% of these children, or about 35,000, were uninsured, and more than 100,000 were estimated as underinsured.12 The city of Seattle is a major metropolitan area and is home to more than 560,000 of the county’s residents.13 In recent years, King County has experienced a 13% increase in its total population and a 15% increase in ethnic minority residents. Census 2000 data indicate that approximately 27% of the county’s children belong to an ethnic minority group, and 21% are in families with incomes below 250% of the FPL.14 The KGC program targets its activities in the three geographic areas with the highest number of children in this income category: Seattle’s Central Area, East King County, and South King County.

The KGC program emerged in the wake of the state’s failed attempt at health care reform, coupled with rising concerns about families’ confusion in navigating among several public programs, including the state’s Basic Health Plan.15 The KGC program focused on strategies to connect the county’s children to medical homes, in response to the fact that many were not accessing services, although a relatively high percentage of them had health insurance coverage.16 The benefits of a medical home, which can be a physician’s office, hospital outpatient clinic, community health clinic, or school-based clinic, are improved health outcomes through continuity of care with a known and trusted provider.17 Nonetheless, program sponsors estimate that nearly 70,000 children in the three geographic regions lack a medical home.

In 2001, the program was developed by a coalition of 30 organizations called the King County Health Action Plan. (See Table 1.) The program was conceptualized in two phases. In the initial phase of the program, networks were created to directly link child care providers and children’s programs to community-based health centers in South, Central, and East King County.18 Providers were trained through the KGC program to screen children for developmental, oral, and behavioral health conditions. Children and families then are connected to the nearest participating safety net clinic (“hub site”) for appropriate services and assistance with enrollment in public programs. Children with special health needs received referrals to specialty care.
### Table 1

**Key Features of Two County Initiatives to Reach Uninsured Children**

<table>
<thead>
<tr>
<th>Implementation Launched</th>
<th>Santa Clara Children’s Health Initiative, Santa Clara County, California</th>
<th>Kids Get Care Program, King County, Washington</th>
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<tbody>
<tr>
<td>Services</td>
<td>Outpatient primary and specialty care; inpatient care; emergency, dental, pharmacy, vision, mental health, and preventive care services</td>
<td>Comprehensive primary care and referral to specialty care, with an emphasis on integrated, preventive oral, physical, and developmental services. Community-based risk assessment, screening, linkages, and provider training</td>
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<tr>
<td>Cost Sharing</td>
<td>Monthly premiums are set between four dollars to six dollars per child, depending on family income, with five dollars co-payments for office visits, prescription drugs, outpatient mental health visits, and physical therapy</td>
<td>Cost sharing varies depending on the program and the clinic. There is no cost sharing for Medicaid, and the Basic Health Plan’s monthly premium varies. Each hub site has a sliding fee scale for children who are ineligible for public programs</td>
</tr>
<tr>
<td>Eligibility</td>
<td>Children ages 0 through 18 with family incomes less than 300% of the FPL, regardless of immigration status</td>
<td>Children ages 0 through 18, regardless of insurance and immigration status; first-year emphasis on birth through age 5</td>
</tr>
<tr>
<td>Financing</td>
<td>$11 million to $12 million annually: $3 million from the county’s share of the National Tobacco Settlement, $2 million from the Children and Families First Commission, $1.2 million from the city of San Jose, $1 million from the Santa Clara Family Health Plan, and $4 million from private foundations</td>
<td>$989,170 first-year funding from the HRSA Community Access Program, $240,000 from the city of Seattle, and $113,700 for the first of three possible years from the Washington Dental Service Foundation to expand its oral health component</td>
</tr>
<tr>
<td>Key Partners</td>
<td>Santa Clara Valley Health and Hospital System, Santa Clara Social Services Agency, Santa Clara Family Health Plan, Working Partnerships USA, People Acting in Community Together, Santa Clara Board of Supervisors, City of San Jose, Community Health Partnership, The Health Trust, The David and Lucile Packard Foundation</td>
<td>King County Health Action Plan, Public Health–Seattle and King County, Washington Health Foundation, Washington Dental Service Foundation, Community Health Centers of King County, Central Area Health Care Center, Children’s Hospital and Regional Medical Center, City of Seattle, Harborview Medical Center</td>
</tr>
<tr>
<td>Number of Children Served</td>
<td>10,900 children enrolled</td>
<td>18,000 children screened and 3,000 children connected to a medical home</td>
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Through this process, parents were encouraged and assisted in establishing a health care home for their children, and the KGC program offered subsidized services for children who were ineligible for public coverage. The program sought to connect approximately 3,000 children to medical homes through the KGC pilot in the first year of the project, and an additional 4,000 in the second year.19 By August 2002, the KGC program had screened 18,000 children and connected 3,000 to one of three designated safety net clinics.20

During the second phase of the program, which began in July 2002, the KGC program will enhance efforts for early detection of children’s mental health needs and expand the oral health component to an additional 7 sites in King County, with the goal of offering the entire program at 10 safety net clinics by 2004.21

**Program Similarities and Differences**

The CHI and KGC programs share a number of features, such as a vision of expanding access to care for all children in their geographic areas, a reliance on existing safety net providers, and a foundation built from public-private collaboration. Both programs aim to provide health care access by expanding existing infrastructure, and each is connected to a public entity. Yet, differences between the programs emerge in their methods of financing, scope of services, and enrollment systems.

**Financing and Costs**

The two programs relied on different funding sources for their initiatives, which had implications for the time needed to implement the programs.

The Santa Clara initiative began when local constituencies mobilized to secure public funding for the cost of Healthy Kids premiums through the county of Santa Clara, the city of San Jose, and the county Children and Families First Commission, and then pursued private foundation and corporate funding.22 Program developers continue to seek additional private funding through corporate employee match programs.23

Funding for the KGC program was launched primarily through a federal grant from the Health Resources and Services Administration (HRSA) and private foundation support. To date, most of the children receiving care through the KGC program are eligible for—or have insurance through—existing public programs but do not have a medical home.

The Santa Clara County CHI differed from the KGC program in its experience of building political momentum, developing its program structure, and expanding its core support with county and city tobacco settlement dollars. The convergence of these events led to a very short “ramp up” period—about 6 months—between the program’s design and implementation phases. King County, however, was unable to pursue tobacco settlement dollars, as the state controls the allocation of these resources and had already earmarked these dollars for the Basic Health Plan. Instead, the architects of the program developed their program over a 12-month period with the assumption that it would need to be supported almost entirely through public and private funding sources.

**Scope of Services**

The scope of services offered by the CHI and the KGC programs varies significantly because of the different approach each took to expanding children’s access to care. The KGC program follows an enhanced service-delivery model by providing comprehensive primary care and referrals to secondary and tertiary care through its safety-net-clinic hub sites. The program also emphasizes integrated preventive services, including oral and developmental health screenings for enrollees. The first year of HRSA funding was used to
establish the screening and referral networks, enhance case management, and subsidize comprehensive preventive services. The long-term goal for the program is to link all children in King County to a medical home.

In contrast, the CHI approach follows an insurance coverage model by providing and marketing to all children in lower-income families a comprehensive benefit package comparable to the SCHIP program. These services include outpatient primary and specialty care; inpatient care; and emergency, pharmacy, dental, vision, mental health, and preventive care services.

**Enrollment Systems**

In an effort to streamline enrollment processes, both programs are working to create paperless, computer- or Web-based enrollment systems. In addition, King County is taking the next step by trying to create a system that allows families to simultaneously apply for a number of public benefits for their children.

The KGC program used some of its first-year funds to link to a management information system that coordinates and enhances existing Web-based programs being piloted in Seattle and other parts of the state. The new system brings together Web-based eligibility-determination tools developed by the state Department of Social and Health Services. These technologies enable application workers to assess children’s preliminary eligibility for a range of public benefits, including Medicaid, SCHIP, food stamps, housing assistance, child care, and the earned income tax credit. Although the system is still being refined, the average turnaround time for enrollment has been reduced from 28 to 14 days. However, state and local deficits in 2002 and 2003 may jeopardize the continuity of this system.

In Santa Clara County, plans are also underway to use a Web-based application and eligibility-determination program called Health-e-App, a paperless system that would allow for real-time eligibility determination. This technology also allows state-certified application workers to help families apply for public health insurance programs.

As in King County, plans are underway for a few counties to adapt the Health-e-App program to facilitate screening and eligibility determination for families in other public programs.

**What Does It Take to Innovate?**

Based on the experiences of these two programs, three elements seem crucial to moving toward a universal health care program for children—bringing together committed leadership and infrastructure, generating diverse community support, and leveraging public and private funding sources.

**Bringing Together Committed Leadership and Infrastructure**

Both counties have a safety net infrastructure with a public hospital, a network of community health clinics, and leadership that was actively involved in the planning, design, and early implementation phases of their respective programs. The executive director of the Santa Clara County health and hospital system was one of the driving forces behind the initiative and engaged the support of the county board of supervisors for children’s access a year before the program was ultimately launched. In King County, a brainstorming session with key health leaders about why increased enrollment was not resulting in better access for children ultimately led to the creation of the KGC program.

Having a publicly financed delivery system probably also facilitated these conversations and action plans, but having the system alone would not have stimulated these initiatives. Counties with the administrative capacity, financial resources, and provider networks experienced in working with low-income communities are more likely to develop these types of innovative expansions. Health, government, and community leaders, working collaboratively and with a steadfast commitment to the larger goal of expanding health access to all children, were the “sparks” that made these programs a reality.

**Generating Diverse Community Support**

Community leaders and organizations played a catalytic role in developing and advocating for their respective programs. In Santa Clara County, two community groups, the labor-affiliated Working Partnerships USA and the faith-based People Acting in Community Together, championed the goal of 100% coverage for every child living in the county and exercised their political influence to promote this goal with county and city officials. They also mobilized hundreds of residents to testify at public hearings. With the initiative already 18 months underway,
both organizations continue to be actively engaged in the program’s implementation and evaluation.

In King County, the active leadership of Health Action Plan partners such as the health department and the Washington Health Foundation continues to develop local support for future program expansion. While the role of local stakeholders will certainly differ in every county, capacity to generate the political will to launch a broad-based children’s health initiative is crucial.

**Leveraging Public and Private Funding Sources**

Piecing together a viable funding strategy is another key component to these programs’ inception and to their intermediate and long-term survival. Santa Clara and King Counties each managed to strategically access local revenue sources and leverage those dollars in an effective manner. Both programs have developed intermediate financing strategies that access foundation and corporate matching support, build from diverse public-private partnerships, and maximize available city and county revenues. In addition, both programs have already begun to strategize about how best to leverage local public and private funding sources to secure sustainable state and federal funding for their children’s access programs.

**Sustaining the Momentum**

In the face of severe budget shortfalls and new security and bioterrorism requirements following the terrorist attacks on September 11, 2001, local governments face greater constraints in shaping social programs. Yet, opportunities still exist for those concerned about guaranteeing children’s access to appropriate and affordable health care. The Santa Clara County CHI and the King County KGC program are two models moving toward universal care that focus on integrating local health care delivery systems and aligning diverse resources to improve children’s health.

The convergence of leadership and infrastructure, community catalysts, and funding was instrumental to the creation and sustenance of the CHI and the KGC programs. Each is a model in which local solutions were developed to address the problem of expanding access to care for low-income children. These local efforts, however, still face the ongoing challenge of securing long-term funding to sustain their activities. Financing options include efforts to access state or federal matching funds, organize the passage of a local tax initiative, and develop multiple strategies to attract private funding.

Because these programs are relatively new, data on their success in improving children’s health outcomes or utilization of services are limited. Once evaluation data become available from the CHI and the KGC programs, each initiative’s effectiveness in expanding children’s access to care and improving their health outcomes will be better understood. Nonetheless, states and counties pursuing similar types of innovation can learn and benefit from the two different but successful approaches used by Santa Clara and King Counties to create universal health care for children. The strategies developed by these initiatives, and those that evolve from the programs that follow, will guide and inform the nation as policymakers and the public continue to grapple with the complex challenge of responding to the health care needs of uninsured children and families.

2. Due to state eligibility criteria, some children are not eligible for public programs because of their legal status or because their family income is too high.

3. The American Academy of Pediatrics defines a medical home as “medical care for infants, children and adolescents that is accessible, continuous, comprehensive, family centered, coordinated, compassionate and culturally effective. It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate all aspects of pediatric care. These services include continuous access to medical care, referrals to pediatric subspecialists and surgical specialists, interaction with early intervention programs and child care programs, early childhood education programs and schools to ensure that the special needs of the child and family are addressed.”


6. The region’s commitment to high technology has given Silicon Valley the highest median income in the United States at $87,000.


14. See note 12, Office of Financial Management. Although the point estimate is 21.3%, the actual percentage with 95% confidence is between 20% and 22.6%.

15. Washington’s Basic Health Plan is a state-sponsored program that provides health care coverage to low-income Washington residents through eight private health plans. Monthly premiums are based on family size, income, age, and the health plan selected. Co-payments are required for most services, but there are no deductibles or coinsurance. For those who qualify for Basic Health, state funds are used to help pay a portion of the monthly premium.


19. See note 18, Public Health–Seattle and King County.

20. See note 16, King County Health Action Plan. See also Susan Johnson, director, King County Health Action Plan, September 1, 2002.

21. See note 20, Johnson.

22. California voters passed the California Children and Families First Act (Proposition 10) in November 1998 to levy a 50-cent tax on every pack of cigarettes purchased in the state, as well as comparable taxes on other tobacco products. Since 1999, the nearly $700 million Proposition 10 has generated annually has been dedicated to developing and implementing programs for young children and their families across the state. To facilitate the statewide focus on early care and development, the California Children and Families First Commission (CFFC) was formed at the state level, and a CFFC was created in each of California’s 58 counties.


24. See note 20, Johnson.

25. Health-e-App is an automated Web-based application to enroll low-income children and pregnant women in public health insurance programs. Using a Web-enabled device, state-certified application assistants enroll eligible applicants in California’s SCHIP and children and pregnant women in the state Medicaid program.

26. See note 8, Wong, p. 3.