



# A Model for Health Coverage of Low-Income Families

## The Issue

Roughly two million low-income children and their parents, primarily in working families, do not have health coverage in California. Most working parents do not qualify for Medi-Cal (California's Medicaid Program). Many uninsured children, although eligible for either Medi-Cal or the Healthy Families Program, are not enrolled in those programs (and therefore lack health coverage), in part due to complex eligibility requirements. Lack of coverage reduces access to preventive care, can result in poorer health outcomes, and strains California's "safety net" institutions that provide health care to the uninsured.

## LAO Model

Recent federal changes provide the state with new options to expand health coverage for low-income families, and a number of proposals to expand family coverage currently are pending in the Legislature. In order to assist the Legislature in evaluating these proposals, we have developed a "Family Coverage Model" as a benchmark of comparison. Our model includes the following features:

- ❖ **Covers Working Families.** The model combines and restructures features of Medi-Cal and Healthy Families to provide simplified coverage to families with incomes up to 250 percent of the poverty level—resulting in an additional 0.9 million to 1.4 million persons obtaining health coverage.
- ❖ **Includes Features to Hold Down State Costs.** The model maximizes federal funding. Its expanded coverage also achieves significant administrative savings by simplifying eligibility. We estimate that net state costs would range from \$188 million to \$385 million annually when fully implemented.
- ❖ **Works with Job-Based Health Coverage.** The model includes sliding-scale premiums and other features to minimize "crowd-out"—the replacement of private coverage with public coverage. It also includes an innovative "buy-in" approach that lets uninsured low-income families participate in employer coverage at a reasonable cost, while using the employer contribution to reduce state costs.
- ❖ **Promotes Competition and Choice.** The model incorporates competitive rates and offers families a selection of health plans.



## INTRODUCTION

### THE ISSUE

California currently provides publicly funded health care coverage to low-income children and parents primarily through two programs—Medi-Cal and Healthy Families. These programs currently cover about 3.6 million low-income children and parents, two-thirds of whom are in families on welfare and automatically receive Medi-Cal coverage.

Nevertheless, roughly two million low-income children and parents, primarily in working families, do not have health coverage for a variety of reasons. Most working parents—particularly in two-parent families—do not qualify for Medi-Cal and Healthy Families only covers children. Many children, although eligible for either Medi-Cal or Healthy Families, are not enrolled in those programs (and therefore do not have health coverage), in part, due to complex and confusing eligibility requirements and procedures. Furthermore, the complexity of the current eligibility requirements produces seemingly arbitrary results—similarly situated families are treated differently (some are eligible for coverage while others are not), depending on their particular work histories, marital status and history, and subtle differences in vehicle ownership.

The existing system also results in episodic coverage, with people not enrolling until they have significant health problems. Waiting until a health problem becomes acute often results in less effective treatment and higher costs. In

addition, the episodic nature of the coverage, along with the general complexity of the system, results in high administrative costs.

### Expanding and Simplifying Health Care Coverage

Health coverage in the United States is more fragmented than in other developed nations. Most people obtain coverage from their employer or from the two major federally funded health programs, Medicare and Medicaid, but some coverage also is purchased individually. The extent and cost of coverage varies widely, however, and a significant number of people are uninsured.

Over the last few years, a wide array of proposals have been put forward to expand and simplify health coverage. Some approaches would have greatly expanded the government's direct involvement in providing coverage. For example, under a universal coverage/single-payer approach, the government would cover everyone, set rates, and pay health care bills. Other approaches involve government less directly. For example, employers could be mandated to provide health coverage to their employees. Alternatively, the government could offer tax incentives or vouchers for families to purchase health care coverage.

These approaches address the problems of health care coverage broadly, but they generally require significant changes in federal laws and programs in order to be feasible from a state perspective. For example, federal law currently

prohibits states from imposing employer mandates, and tax incentives for health care coverage generally do not qualify for federal funding. Furthermore, financing a system of universal coverage requires consolidating both coverage and funding that now are provided by employers and a variety of government health programs in order to minimize the amount of new funding needed.

While global solutions to health care coverage face considerable barriers, recent changes in federal law and regulations provide the state with an opportunity to take a more modest step by expanding and simplifying coverage for low-income families using federal funds to cover more than half of the cost.

Currently, a number of legislative proposals are pending before the Legislature that would expand health coverage for low-income families in order to reduce the number of uninsured children and parents. These measures include several comprehensive proposals to expand eligibility for children and parents in the existing Medi-Cal and Healthy Families Programs, including a three-bill package in the Assembly (AB 43 [Villaraigosa], AB 93 [Cedillo], and AB 1015 [Gallegos]) as well as two Senate bills—SB 106 [Polanco] and SB 780 [Burton]. Other pending legislation is targeted at easing specific eligibility restrictions in the Medi-Cal and Healthy Families Programs.

### **Reducing the Number of Uninsured Families—A Family Coverage Model**

How much health care the state should provide, to whom, in what manner, and how it should be funded are all basic policy decisions for the Legislature. In order to assist the Legislature, however, in its evaluation of pending proposals to expand and simplify health coverage for families, we have developed a model to provide health coverage for families of low incomes. The Legislature could use this model as a benchmark of comparison. Our “Family Coverage Model” restructures the existing Medi-Cal and Healthy Families Programs in order to address a number of the shortcomings of these programs, expand coverage, and maximize the use of federal funding. By restructuring and simplifying these programs, our model also achieves significant administrative savings that offset a portion of the cost of expanded coverage.

The model is designed to work *with*, rather than “crowd out,” job-based coverage. It includes sliding-scale premiums and excludes families that already have job-based coverage from participating, in order to target the program at the uninsured and minimize crowd-out—the replacement of private coverage with public coverage. The model, however, also includes an innovative “buy-in” approach that lets uninsured low-income families participate in coverage offered by their employer at a reasonable cost to the family while using the employer contribution to reduce state costs. Finally, the model promotes competition and choice by offering families a selection of health plans.



## CALIFORNIA'S UNINSURED

### WHO ARE THE UNINSURED IN CALIFORNIA?

Millions of Californians are uninsured—they do not have regular, ongoing health coverage, whether job-based, privately purchased, or provided through a public program such as Medi-Cal (California's Medicaid Program). The Health Insurance Policy Program (HIPP) of the University of California estimates (in *The State Of Health Insurance in California*, 1998) that 7 million nonelderly Californians are uninsured. Estimates by the Urban Institute are somewhat lower at about 5.6 million uninsured in the state. These figures include both single persons and families.

Researchers agree that California has a significantly greater proportion of uninsured persons than the nation as a whole. This results from a lower rate of job-based coverage compared with other states. This lower rate of job-based coverage more than offsets a higher rate of coverage by Medi-Cal relative to most other states' Medicaid Programs. (California's higher Medi-Cal coverage rate is partly due to the state's relatively large welfare caseload.) Consequently, in California, uninsured families are primarily working

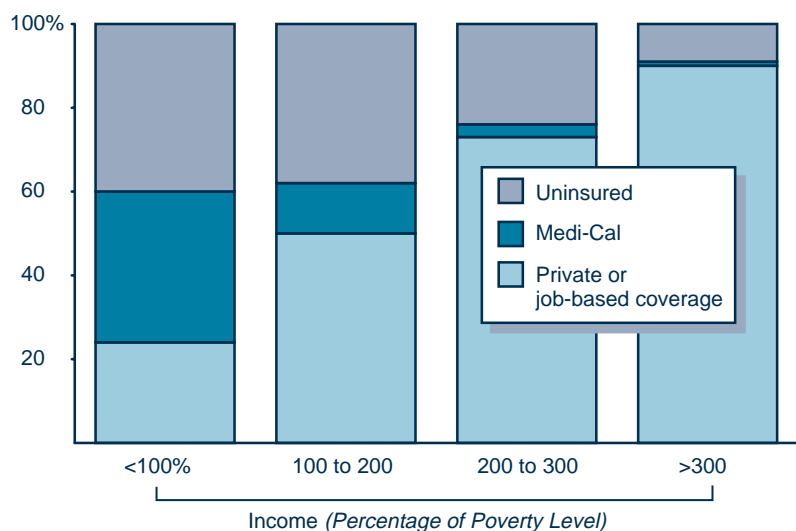
families. For example, almost 80 percent of all uninsured children in California are in families with a full-time or self-employed worker.

Most of the uninsured, not surprisingly, have low incomes. About half have incomes that are less than the federal poverty level (FPL)—currently \$1,392 per month for a family of four—and three-fourths of the uninsured have incomes below 200 percent of the FPL, according to HIPP estimates. Overall, roughly 40 percent of nonelderly Californians with incomes less than 200 percent of the FPL are uninsured.

Figure 1

### Health Insurance Coverage Nonelderly Californians

By Family Income, 1997



Source: *The State of Health Insurance in California, 1998*, Schauffler and Brown, Health Insurance Policy Program, University of California.

As income rises, health insurance coverage increases dramatically, as shown in Figure 1. More than 90 percent of the nonelderly persons in families with incomes above 300 percent of the

FPL (\$4,176 per month for a family of four) have coverage, generally through an employer. (Most elderly persons have Medicare coverage, which pays for many, but not all, health services.)

## FOCUS ON FAMILIES— UNINSURED CHILDREN AND PARENTS

Estimates of the number of uninsured children in California range from 1.3 million (based on the Urban Institute data) to 1.8 million (HIPPI). Like the uninsured generally, most uninsured children are in low-income families (75 percent in families with incomes under 200 percent of the FPL). They are less likely to have a regular source of health care than insured children, and the care that they do receive is more likely to be episodic—treatment for an immediate disease or injury in an urgent-care or emergency room setting. Regular and consistent care is particularly important for children, not only to prevent and treat common childhood diseases and injuries, but also to detect and correct conditions that can impair a child's growth and development and the ability to learn and participate fully in normal activities.

***Uninsured Children Usually Are Unenrolled Children.*** Most uninsured low-income children (those in families with incomes under 200 percent of the FPL) are *eligible* for coverage under Medi-Cal or the new Healthy Families Program. These *eligible*, but uninsured, children are not *enrolled* in those programs for a variety of reasons. These include complex Medi-Cal eligibility requirements, association of Medi-Cal with welfare, concerns

that enrollment will adversely affect the immigration status of a family member, and a lack of knowledge about the programs and about the need for regular care even for those children who are generally healthy.

***Most Uninsured Parents Are Not Eligible for Medi-Cal.*** Unlike their children, most uninsured parents in low-income families are not eligible for Medi-Cal coverage. Although families on welfare (the California Work Opportunity and Responsibility to Kids [CalWORKs] Program) receive Medi-Cal coverage for both parents and children, Medi-Cal eligibility is much more limited for low-income working parents who are not on welfare. Parents in working, two-parent families generally do not qualify for Medi-Cal, and the new Healthy Families Program covers only children. In families with incomes under 200 percent of the FPL, about 40 percent of the parents are uninsured versus 27 percent of the children. The lower rate of coverage for parents reflects their limited eligibility for Medi-Cal—only about one-fourth of the parents in these low-income families are enrolled in Medi-Cal (including parents in CalWORKs families) versus almost one-half of the children.



For working parents, lack of health coverage threatens their ability to support their families. They have less access than the insured to care that prevents or manages diseases, and so they face an increased risk of income loss or unemployment from illness. Although county indigent care programs and charity providers offer some care at little or no cost, working parents may have difficulty using these services due to long waits and limited locations.

***Welfare Reform May Result in More Uninsured Families.*** California's welfare rolls are declining due to the state's strong economy and welfare reform, which emphasizes moving recipients from welfare to work in the CalWORKs Program. As a result, fewer low-income families are on welfare which provides automatic Medi-Cal coverage, and more are working—often in relatively low-wage jobs that do not offer affordable health coverage benefits. This trend makes it likely that the number of uninsured low-income families will grow unless they apply for, and obtain, public coverage through Medi-Cal and Healthy Families. However, the complexity of the existing Medi-Cal eligibility process and eligibility restrictions, particularly for working parents, make it unlikely that increased enrollment by working families will fully offset the decline in automatic Medi-Cal coverage resulting from reduced welfare participation.

## **WHY IS HEALTH INSURANCE IMPORTANT?**

Results of a recent survey by the Urban Institute (reported in the Institute's *Snapshots of America's Families*, January 1999) illustrate two reasons for concern about the lack of health insurance among low-income Californians. The survey found that low-income nonelderly adults (under 200 percent of FPL) were three times more likely to classify themselves in fair or poor health as those with higher incomes (18 percent versus 6 percent). Low-income children were more than six times as likely to be classified in fair or poor health as children in higher-income families (9.1 percent versus 1.5 percent). The survey also found that the parents of almost one out of five low-income children were not confident of their ability to get needed medical care for those children, compared with only one out of 22 children in families with incomes over 200 percent of the FPL.

There also is evidence linking lack of coverage with poor health outcomes. For example, a New Jersey study found that uninsured women with breast cancer faced a 49 percent greater risk of death compared with privately insured women due to delayed diagnosis of the disease.

## MEDI-CAL AND HEALTHY FAMILIES: FRAGMENTED COVERAGE FOR WORKING FAMILIES

### WHAT ARE THE PROBLEMS WITH THE CURRENT SYSTEM: AN OVERVIEW

The federal Medicaid Program began as a system of health coverage for welfare recipients, and California's equivalent, the Medi-Cal Program, still retains that basic orientation for families. That is, eligibility for Medi-Cal is very similar to that for welfare (formerly Aid to Families With Dependent Children [AFDC] and now CalWORKs)—the family must have very low income and be headed by either a single parent or an unemployed parent.

Over time, changes in federal and state law have significantly expanded eligibility for children (including creation of the new Healthy Families Program) and for pregnant women. Furthermore, Medicaid and Medi-Cal revisions associated with welfare reform allow families that meet the initial enrollment requirements to remain enrolled when their earnings increase. The interaction of these cumulative changes has made coverage for families and children a hodgepodge of seemingly arbitrary and inconsistent eligibility categories and requirements.

Even with the recent welfare reform changes, Medi-Cal eligibility for working parents remains restricted, and the eligibility rules for Medi-Cal coverage have become even more complicated and confusing.

The problems with California's current health care system are summarized in Figure 2 (see

page 8) and discussed in detail in the following pages.

Because our approach restructures the existing programs, we begin by describing the existing eligibility requirements for families and children in Medi-Cal and Healthy Families, as well as other programs that provide health care services to low-income families and children. We note, however, that our Family Coverage Model includes provisions to simplify eligibility and unify family coverage so as to address the problems described above.

### FAMILY COVERAGE UNDER EXISTING PROGRAMS

Figure 3 (see page 9) summarizes the current eligibility requirements for coverage of *families* in Medi-Cal.

The Medi-Cal Program provides coverage to families through two eligibility categories—the “Medically Needy Family” category and the new “Section 1931(b)” category (this latter category includes CalWORKs recipients). These two categories cover both the parents and the children in qualifying families. In order to be covered, families must meet eligibility requirements similar to those for the CalWORKs program. In families that do not meet these eligibility requirements, Medi-Cal provides coverage for children and pregnant women (but not other adult parents) through a number of special eligibility categories.



## Medically Needy Family Coverage

**Who Qualifies as Medically Needy?** Single-parent families or unemployed two-parent families (and families with a disabled parent) qualify for Medi-Cal as “medically needy” if their income is very low (less than about 80 percent of the FPL), have less than \$3,300 in assets, and meet additional restrictions on vehicles and other property. Medically Needy Family coverage includes both parent(s) and children. These qualifications for Medi-Cal family coverage

are similar to those for families applying for CalWORKs welfare benefits (although the CalWORKs income limit is somewhat lower—about 70 percent of the FPL).

**Share-of-Cost Coverage.** Medi-Cal also provides coverage on a “share-of-cost” basis to families with incomes above the medically needy limit but who meet all of the other medically needy eligibility requirements. In these cases, Medi-Cal pays the portion of qualifying medical expenses that exceeds the family’s share of cost, which is the difference between the family’s income and the medically needy income limit.

Figure 2

### What Are the Problems With California's Health Care Coverage System for Families and Children?

- ✓ **A large number of low-income families have no regular health coverage, private or public.**
- ✓ **Eligibility is complex and confusing, resulting in:**
  - Eligible families not applying for coverage.
  - High administrative costs.
  - Seemingly arbitrary rules—some families qualify for coverage while others with similar incomes do not.
- ✓ **Coverage is episodic—many people don't enroll until they have acute health needs, resulting in:**
  - Higher treatment and administrative costs.
  - Poorer health outcomes.
- ✓ **Children in the same family can be enrolled in different programs thereby subjecting them to different requirements and choices of providers.**

**“100-Hour Rule” Excludes Most Working Families.** In order to meet California’s unemployment test for Medi-Cal (or CalWORKs), a family’s principal wage earner must work less than 100 hours per month—this is known as the 100-hour rule. Consequently, two-parent families with at least one full-time worker do not qualify for Medically Needy Medi-Cal. Furthermore, even single-parent families (who are not subject to the 100-hour rule) generally cannot qualify without a share of cost if the parent works full time and earns more than about the minimum wage. The 100-hour rule and the low level of allowable income preclude most working families from



qualifying for Medically Needy Family coverage, unless a major illness or injury results in unemployment or disability.

**Section 1931(b) Family Coverage**

This new category of family coverage was created by the 1996 federal welfare reform legislation. It makes anyone eligible for Medicaid who would have met the former requirements for AFDC—the predecessor to CalWORKs. Section

1931(b) also allows states to expand Medicaid eligibility for low-income families by adopting income and asset limits that are more liberal than their former AFDC standards.

California has used this flexibility to provide Medi-Cal coverage to all CalWORKs recipients (in effect, maintaining automatic linkage between welfare and Medi-Cal). However, Section 1931(b) eligibility is not limited to welfare recipients.

**Figure 3**

**Medi-Cal Eligibility for Family Coverage**

	Income Limits <sup>a</sup>		Allow Working Two-Parent Families?	Asset Limits <sup>a</sup>	
	Monthly Amount	Percentage of Poverty		Value	Vehicle Exemptions
<b>Section 1931(b)</b>					
Applicant	\$1,032	74%	No	\$3,300	• Vehicle needed for business/employment or transport of disabled person.
Ongoing	2,124	153%	Yes	• \$3,300 plus \$5,000 restricted to home purchase, education, or business startup.	• \$4,650 of value for each other vehicle.
<i>Transitional Medi-Cal</i>					
First 6 months	No limit	NA	Yes	No limit	NA
Next 18 months	\$2,575	185%	Yes	No limit	NA
<b>Medically Needy</b>					
Family	\$1,190 +SOC <sup>b</sup>	86% +SOC <sup>b</sup>	No	\$3,300	One vehicle.

<sup>a</sup> Requirements for a family of four, effective July 1999. Section 1931(b) applicant and Medically Needy Family amounts include a \$90/month work expense deduction. Up to \$175 per child per month (\$200 if under age 2) additional deduction allowed for child care expenses.

<sup>b</sup> Share of Cost (SOC)—families with higher incomes may pay a share of cost. If a family member is disabled, then earnings are subject to an additional deduction of \$65 plus half of the earnings.



Families who meet Section 1931(b) requirements are eligible for Medi-Cal regardless of whether they are on welfare. California's Section 1931(b) category went into effect on January 1, 1998 (concurrently with CalWORKs implementation), but implementation for nonwelfare families is not yet complete.

### **Coverage for Families Who Go Back to Work**

*Applicants* for Medi-Cal's Section 1931(b) coverage must be single-parent, or unemployed two-parent, families with incomes less than about 70 percent of the FPL (the CalWORKs entry requirement) and have less than \$3,300 in assets. Generally, families that meet these requirements also would meet the requirements for the Medi-Cal Medically Needy Family Program. However, *after* initial enrollment, California's Section 1931(b) category, like CalWORKs, provides work incentives. The 100-hour rule is waived and earned-income "disregards" enable families to earn incomes slightly over 150 percent of the FPL without losing their Medi-Cal coverage. Thus, Section 1931(b) provides some coverage for working low-income families, including two-parent families. Furthermore, families whose earnings increase beyond the Section 1931(b) limits are eligible for up to two years of transitional Medi-Cal coverage with no income limit for the first six months and a limit of 185 percent of FPL for the subsequent 18 months.

Section 1931(b) eligibility and transitional Medi-Cal allow CalWORKs families who leave welfare for work to maintain their Medi-Cal coverage for a

significant period of time. However, California's current Section 1931(b) coverage is less well-suited to other low-income working families, especially those with modest, but steady, earnings. A family with steady earnings of 125 percent of the FPL, for example, would not qualify for Section 1931(b) Medi-Cal. However, a similar family with the same annual income but a seasonal work pattern could qualify during their slack season and then remain on Medi-Cal indefinitely. Perhaps more importantly, the differences in eligibility criteria for Section 1931(b) *applicants* versus ongoing *enrollees* are likely to be confusing and appear arbitrary to working families, limiting their use of this new Medi-Cal category.

### **CHILDREN AND PREGNANT WOMEN**

Medi-Cal includes special eligibility categories for children and pregnant women, as illustrated in Figure 4. These women and children may be in any type of family, including working, two-parent families.

#### **Medically Indigent**

This category covers comprehensive health care services for poor pregnant women and for children and young adults through age 20. The Medically Indigent category has the same family income and asset restrictions as the Medically Needy Family category (but without the unemployment or single-parent limitations). Like the Medically Needy Family category, the Medically Indigent category allows participation at higher income levels on a share-of-cost basis.

**“Poverty-Level” Programs**

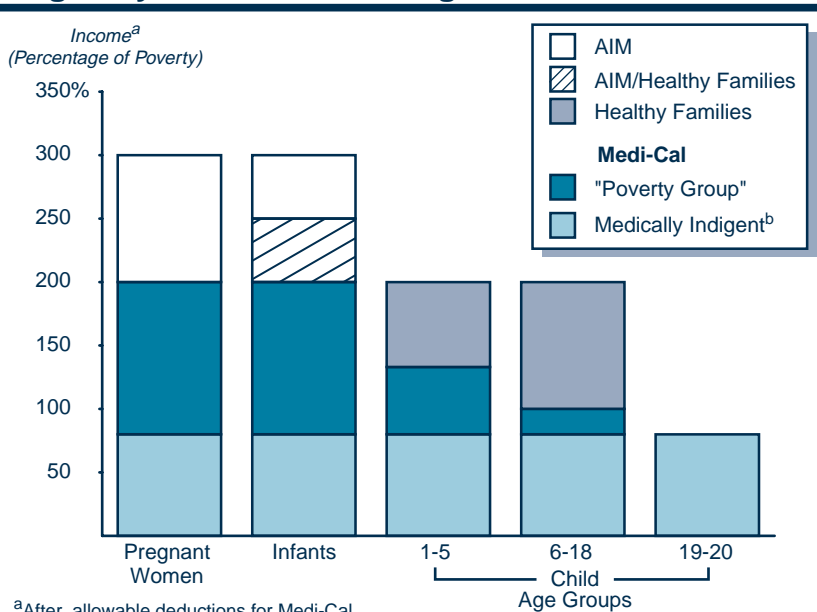
Medi-Cal has three special eligibility categories that provide no-share-of-cost coverage to pregnant women or children in families with incomes up to a specific percentage of the poverty level. These categories have no asset limitations and allow the use of a simplified mail-in application form, which is also used by the Healthy Families Program (discussed below).

- ◆ **200 Percent Program for Pregnant Women and Infants.** Medi-Cal provides no-share-of-cost coverage for pregnant women (limited to pregnancy, labor, and delivery services) and infants (full coverage) in families with incomes up to 200 percent of the FPL.
- ◆ **133 Percent Program for Young Children.** Medi-Cal provides no-share-of-cost coverage for children ages 1 through 5 in families with incomes up to 133 percent of the FPL.
- ◆ **100 Percent Program for Older Children.** Medi-Cal provides no-share-of-cost coverage for children ages 6 through 18 in families with incomes up to 100 percent of the FPL.

**COMPLEX ELIGIBILITY RULES RESULT IN LARGE ADMINISTRATIVE COSTS**

The complexity of the current Medi-Cal eligibility process results in large administrative costs. The Governor’s budget estimates that the state General Fund cost for county administration of the Medi-Cal eligibility process (excluding eligibility determinations for welfare recipients) will be \$367 million in 1998-99, and matching federal funds bring total county administration cost up to about \$1 billion. These figures translate into an annual cost per average monthly Medi-Cal enrollee (excluding welfare recipients) of about \$600 (\$200 General Fund). This spending provides no actual health care. It only covers the cost of determining eligibility for Medi-Cal, maintaining

**Figure 4**  
**Children and Pregnant Women Eligibility for Health Coverage**



<sup>a</sup>After allowable deductions for Medi-Cal.  
<sup>b</sup>Provides share-of-cost coverage at higher incomes, and also has asset limits.



case files, and providing some outreach and case management services.

## HEALTHY FAMILIES PROGRAM

The Healthy Families Program—California’s version of the federal Children’s Health Insurance Program (CHIP)—began operation in July 1998. It provides coverage for children through age 18 in families with incomes up to 200 percent of the FPL (250 percent for infants enrolled through the Access for Infants and Mothers Program). The Healthy Families Program has no restrictions on two-parent families or hours of work, and it has no asset limits. Applicants for Healthy Families coverage use the simplified mail-in application also used by the Medi-Cal poverty-level programs. However, children eligible for Medi-Cal with no share-of-cost are not eligible for Healthy Families coverage. Therefore, Healthy Families covers infants between 200 percent and 250 percent of the FPL, children ages 1 through 5 between 133 percent and 200 percent of the FPL, and children ages 6 through 18 between 100 percent and 200 percent of the FPL. (The actual income ranges for Healthy Families are somewhat smaller because Medi-Cal allows certain income deductions currently not allowed by the Healthy Families Program.)

***Differences Between Medi-Cal and Healthy Families Can Be Confusing.*** Although the Medi-Cal poverty-level programs for children and the Healthy Families Program have many similarities, they also have a number of important differences.

- ◆ Both offer broad coverage, but Healthy Families coverage has some limitations

that Medi-Cal does not have. The Early and Periodic Screening, Diagnostic and Treatment provision of federal Medicaid law, for example, requires states to provide corrective or ameliorative treatment for *any* physical or mental illness or defect of a child, regardless of whether a state’s Medicaid Program normally covers those services. The Healthy Families Program has no such requirement.

- ◆ Healthy Families requires families to pay modest premiums and copayments. Medi-Cal has no out-of-pocket costs (for those without a share of cost).
- ◆ Choices of health plans and providers differ between Medi-Cal and Healthy Families. In San Bernardino County, for example, Medi-Cal offers a choice of two plans while Healthy Families offers six, with only one plan available in both programs. Furthermore, even when both programs offer the same health maintenance organization (HMO), the specific doctors who are available through the plan may differ between the programs.
- ◆ Although both programs use the same short application form, Healthy Families enrollment is annual and applications are processed by a state contractor, while Medi-Cal enrollment is processed by county welfare departments, and families must file quarterly reports to maintain coverage.

- ◆ Different state agencies administer the two programs—the Department of Health Services administers Medi-Cal and the Managed Risk Medical Insurance Board (MRMIB) administers Healthy Families.

***Some Families Must Use Both Programs.***

Because the Medi-Cal income limit decreases for older children, a family may have children in both programs. For example, a family with an income of 125 percent of the FPL and two children ages 4 and 6 would have to enroll the younger child in Medi-Cal and the older child in Healthy Families. The younger child's application would be processed by the local county welfare office, while that for the older child would be processed by the state contractor in Sacramento. The family would need to file quarterly reports with the county welfare office for the younger child, but not for the older child. The two children might have to be enrolled in different health plans or see different doctors in the same plan. Coverage for the older child continues until the end of the enrollment year even if family income increases beyond 200 percent of the FPL, but coverage for the younger child would end with the next quarterly report.

**PROGRAMS THAT SERVE THE UNINSURED**

Medi-Cal and a variety of other state and county programs currently provide some health care coverage and services to children and families who are uninsured. However, this coverage is often episodic—people enroll when they have specific health needs, but do not maintain enroll-

ment when they or their children are generally healthy. The episodic nature of much of the care provided to the uninsured makes it relatively costly. This is because episodic treatment (1) addresses health problems once they have become acute, rather than emphasizing preventive care, (2) tends to occur in more expensive settings, such as hospital emergency rooms, and (3) increases administrative costs to process short-term enrollments.

**Medi-Cal Episodic and Major Medical Coverage**

Medi-Cal enrollment is often episodic due to a number of factors. First, the administrative requirements of the program result in an episodic approach to the program by families. Maintaining enrollment in Medi-Cal requires annual eligibility determination and quarterly reports. The information that applicants and enrollees must provide can be extensive—dealing with personal identification, residence, income, assets, and immigration status. Usually, the application and annual determination require a trip to the county welfare office. This contrasts with job-based coverage, which generally requires little or no ongoing paperwork for the employee (other than for changing plans).

Episodic use of Medi-Cal also is encouraged by the availability of “retroactive” coverage. Medi-Cal covers qualifying health costs for up to three months *prior* to enrollment, provided that the enrollee would have met Medi-Cal eligibility requirements during that time.



Furthermore, as noted above, Medi-Cal provides no-share-of-cost coverage for pregnant women (for pregnancy, labor, and delivery) and infants in families with incomes up to 200 percent of the FPL. Since childbirth and infant care are the most common major medical expenses of younger families, this provision and the availability of retroactive coverage provide a form of major medical and catastrophic coverage for many uninsured families, and particularly for children.

Medi-Cal also helps to cover many major medical costs for low-income working families with incomes above normal Medi-Cal limits by allowing those families to participate with a share of cost if they meet other eligibility requirements. Although eligibility requirements generally exclude parents in two-parent working families, these parents may qualify for coverage for major illnesses or injuries that result in unemployment or disability.

The use of Medi-Cal for episodic and major medical coverage is evident from the turnover in enrollment. For the year ending September 1998, for example, about 2.5 million parents and children were enrolled in Medi-Cal *at some time* during the year (excluding welfare recipients). This figure is about 900,000 individuals (54 percent) greater than the average monthly caseload of about 1.6 million for these enrollment categories. Only a third of these Medi-Cal participants were enrolled for the full 12-month period. Clearly, most non-CalWORKs families enroll in Medi-Cal on an intermittent, rather than continuous basis, and

Medi-Cal actually provides some coverage to many of those who are counted as “uninsured.”

### **Special Programs for Children**

Two special programs provide certain health care services to uninsured children.

**California Children’s Services (CCS).** This program provides diagnostic, treatment, and therapy service to children under age 21 who have qualifying medical conditions, such as genetic diseases, chronic health problems, or major traumatic injuries. Counties provide case management and coordinate care. Medi-Cal and the Healthy Families Program cover the cost of CCS services for children enrolled in those programs. However, CCS also provides treatment services for uninsured children in families with annual incomes up to \$40,000 (or above if medical expenses exceed 20 percent of income) and school-based therapy for children in families of any income, using funds provided equally by the state and the counties (a total of \$107 million for treatment and therapy in 1998-99).

**Child Health Disability Prevention Program (CHDP).** This program provides free health screens, vaccinations, and some follow up treatment services to uninsured children in families with incomes up to 200 percent of FPL. Screening and vaccination costs will total \$84 million in 1998-99, primarily funded by a combination of state General Fund and Proposition 99 tobacco tax funds. Counties provide follow up treatment for health problems identified in the screens, generally using a portion of their state allocations of Proposition 99 funds or realignment funds.

### County Indigent Health Programs

Counties either directly provide or help fund (along with private charity care) necessary medical services for uninsured indigent persons who are not covered by any other program. Eligibility criteria and the scope of services vary by county. Total reported spending for county indigent patients was about \$1.2 billion in 1996-97 (the most recent year available). Counties fund these costs primarily by using state realignment allocations, Proposition 99 funds, Medi-Cal disproportionate share hospital (DSH) funding, and county general-purpose funds. About 90 percent of this spending is for services to nonelderly adults, but it is not clear how many of these adults are parents. About \$100 million of county indigent care spending is for services to persons under 21 years of age.

### Community Clinics

California has many nonprofit community clinics in both urban and rural areas. These clinics provide primary care services to a mix of Medi-Cal and uninsured low-income patients. For uninsured patients, the clinics provide services for a modest fee based on a sliding scale or, sometimes, for free. The state administers several grant programs that currently provide a total of \$35 million to subsidize services at community clinics. Early Access to Primary Care is the largest of these programs, with smaller programs targeting rural clinics and farmworker and Native American health care. Clinics also receive direct federal grants and participate in many county indigent care programs. Furthermore, clinics receive cost-based rates for services to Medi-Cal enrollees, which usually exceed the regular Medi-Cal payment rates.

## STRATEGIES FOR INCREASING COVERAGE

Because Medi-Cal enrollment tends to be episodic, many low-income families move in and out of coverage over time. They may receive significant health care services through a variety of programs even when they are uninsured. Furthermore, the uninsured include some families who usually have job-based coverage, but are temporarily uninsured when they are unemployed or between jobs. Thus, the uninsured population is not a homogeneous or constant group. For this reason, efforts to reduce the number of uninsured families require a combination of two strategies:

increasing participation in existing programs and expanding eligibility for coverage.

***Increasing Participation.*** As noted above, many uninsured low-income families, particularly children in those families, currently qualify for either Medi-Cal or Healthy Families coverage, but are not enrolled in those programs. Improving program participation is one way to reduce the number of uninsured children and parents. This involves providing ongoing coverage for those who currently enroll on an episodic basis, as well as encouraging enrollment by eligible uninsured



persons who have not used these programs—by simplifying enrollment, for example.

**Expanding Eligibility.** Recent changes in federal laws and regulations provide the state with much more flexibility to expand eligibility for health care coverage of low-income families through the Medi-Cal and Healthy Families Programs. The state can increase income limits, allow coverage of parents in two-parent working families, and modify or eliminate asset restrictions, for example. These changes would allow coverage of uninsured low-income parents and children who currently do not qualify for Medi-Cal or Healthy Families.

**Using the Strategies in Combination Is Most Effective.** Increasing participation and expanding eligibility have a strong linkage to each other. This is because the complexity of Medi-Cal eligibility is, in itself, a major barrier to participation. Expanding eligibility provides opportunities to simplify the enrollment process. The recent implementation of a simplified mail-in application for children is an example of the linkage between simplification and eligibility expansion. As part of simplifying the application, the enabling legislation (Chapter 624, Statutes of 1997 [SB 903, Lee]) eliminated Medi-Cal family asset restrictions for children. This was important in simplifying the application because Medi-Cal asset restrictions are very complex.

## **MINIMIZING ADDITIONAL STATE COST**

Increasing health care coverage to low-income working families would require significant additional state funding, but there are a number of strategies that could be used to minimize this cost. Expanding coverage provides an opportunity to

simplify eligibility requirements and processes, which could substantially reduce existing administrative costs. These strategies are summarized below.

- ◆ **Use Available Federal Funding.** The federal Medicaid Program and CHIP provide about half or two-thirds, respectively, of the funding for covered services to eligible persons. Accordingly, it is important to structure coverage expansions so that they qualify for these programs wherever possible, consistent with state priorities. These programs offer the state a great deal of flexibility in covering families and children.
- ◆ **Include Existing Programs.** Including existing programs, such as CCS, in an expanded family health coverage program offers opportunities to obtain federal funding for these programs, broaden benefits, and reduce administrative overlap and costs.
- ◆ **Simplify Eligibility to Reduce Administrative Costs.** As noted earlier, the complexity of the current Medi-Cal eligibility process results in large administrative costs. Simplifying eligibility rules and requirements can reduce those costs significantly for both current Medi-Cal enrollees and the expansion population.
- ◆ **Discourage Crowd-Out.** The potential for crowd-out, or displacement, of job-based coverage by public coverage becomes



more of a concern as public coverage is extended to families with higher incomes. Employers who offer health coverage generally require employees to contribute to the cost of premiums, and private health plans usually require copayments. These costs would make it attractive for many employees to switch from, or decline, job-based coverage in favor of free, or very low cost, public coverage. Employers also

would find it easier to drop coverage or increase employee contributions knowing that low-income employees have the option of public coverage. If the purpose of expanding public coverage is to reduce the number of uninsured families, rather than simply substituting public coverage for job-based coverage, then the expansion must include strong provisions to discourage crowd-out.

## A FAMILY COVERAGE MODEL

If the Legislature wishes to reduce the number of uninsured families, the state could use the strategies outlined above and replace the current fragmented coverage offered by Medi-Cal and Healthy Families with a new *family* health plan that would unify Medi-Cal and Healthy Families coverage. Such an approach could expand eligibility, improve participation, and simplify administration—while also incorporating strategies to minimize the additional state cost of expanding coverage. Below, we present a model plan which, we believe, meets these objectives. Our approach builds on many of the features of the current Healthy Families Program. The coverage expansion features included in the model would make most uninsured families eligible for coverage. At the same time, these expansion features are essentially those necessary to simplify eligibility and achieve significant administrative savings.

### OVERVIEW OF THE FAMILY COVERAGE MODEL

Figure 5 (see page 18) summarizes the key features of the LAO Family Coverage Model, which we discuss below.

***Restructure Medi-Cal and Healthy Families Into Unified Family Coverage.*** For the great majority of low-income families with children, the model would consolidate and unify the existing family and child eligibility categories in Medi-Cal and Healthy Families into a family coverage category. Thus, eligibility would be determined on a family basis and coverage would include both children and parents. All family members would have access to the same benefits (adult or child) and choice of health plans. These changes would simplify eligibility, promote participation, and reduce administrative costs. Existing Medi-Cal share-of-cost coverage and special programs for disabled children



would remain available in order to ensure that there is no loss of coverage for families with high-cost or special health care needs.

**Expand Coverage to Families With Incomes up to 250 Percent of the Poverty Level.** Expanding coverage to 250 percent of the FPL would make most uninsured families eligible for coverage. Furthermore, this income limit enables the Family Coverage Model to use a simple gross income test for the great majority of families (thereby eliminating complicated Medi-Cal income deductions) without adversely affecting existing eligibility. This is because 250 percent of the FPL is above the highest current income limits for Healthy Families and Medi-Cal (200 percent of the FPL), including the value of the most common Medi-Cal income deductions. For example, 250 percent of the FPL for a family of four is \$41,750 annually, compared with the Medi-Cal limit of \$41,080 at 200 percent of the FPL in combination with the work expense deduction and the maximum allowable child care deductions for three children.

**Eliminate the 100-Hour Rule to Cover Working Families.** Increasing the family income limit makes little difference unless the 100-hour rule also is eliminated since the great majority of families with incomes over the poverty level have at least one full-time worker (over 160 hours of work per month). Until recently, federal regulations required states to use the 100-hour rule to determine whether families met the unemployment test. However, those regulations were revised in 1998

**Figure 5**

### Key Features of the LAO's Family Coverage Model

- Restructure Medi-Cal and the Healthy Families Program to provide unified family coverage.
- Expand coverage to families with incomes up to 250 percent of the poverty level.
- Eliminate the 100-hour rule to cover full-time, working families.
- Eliminate asset limits.
- Simplify the eligibility process—use mail-in applications and replace quarterly reports with a semiannual one-page update.
- Encourage regular and preventive care by limiting retroactive coverage.
- Coordinate with the CCS<sup>a</sup> and CHDP<sup>b</sup> programs to maximize federal funding and simplify access.
- Set health plan rates competitively, but with safety net protections.
- Minimize "crowd-out" by using sliding-scale premiums and buy-ins to maximize use of employer health coverage.

<sup>a</sup> California Children's Services.

<sup>b</sup> Child Health Disability Prevention Program.

and now allow states to use alternatives to the 100-hour rule. For example, the state can define “unemployment” as having earnings below a certain amount (such as 250 percent of the FPL), for the purpose of qualifying for family eligibility in the Medi-Cal Section 1931(b) and Medically Needy Family categories.

***Eliminate Asset Limits for Parental Coverage.***

No asset limits currently apply to children in Medi-Cal or Healthy Families or to pregnant women in Medi-Cal. Eliminating complex Medi-Cal asset limits for low-income families would simplify eligibility rules and the application process.

***Simplify the Eligibility Process.*** Two additional changes would help to simplify enrollment, encourage participation, and reduce administrative costs.

- ◆ ***Mail-In Applications.*** By simplifying the rules for family coverage, the need for face-to-face interviews is eliminated. Instead, families would use a mail-in application similar to that currently available for children and pregnant women in the Medi-Cal and Healthy Families Programs. Program integrity would be maintained by requiring documentation of income by pay stubs or tax returns as in the current Health Families Program, and by requiring Social Security Numbers to verify identity.
- ◆ ***Eliminate Quarterly Reports.*** Eliminating the detailed Medi-Cal quarterly reports encourages families to remain enrolled for

ongoing care and prevention services. It also reduces eligibility administrative costs by (1) eliminating the processing of those reports and (2) reducing reenrollment intakes for families that fail to file their quarterly report and then reenroll at a later date, often when an acute health problem occurs. Instead, families would reapply annually (as required by federal law).

- ◆ ***Semiannual Update.*** Between annual applications, families would be asked to (1) return a one-page six-month update of their address, enrolled family members, and health plan; and (2) indicate whether they have had any significant change in their income or whether any enrolled family members have obtained job-based or other private coverage since the most recent application. The six-month verification would allow disenrollment of families that move out of the state and help ensure that families who move out of their original plan's coverage area switch to a plan serving their current area. For families subject to premiums (discussed below), the premium billings would eliminate the need for a separate verification.

***Encourage Regular and Preventive Care by Limiting Retroactive Coverage.*** One of the major purposes of expanding health coverage for families is to provide them with regular ongoing care, including preventive and health improvement services. Currently, however, the availability of retroactive coverage reduces eligible families'



incentive to enroll in Medi-Cal for regular care since they can simply wait until health problems occur and obtain coverage for any significant health expense on a retroactive basis. As in the current Healthy Families Program, however, our model would limit retroactive coverage to child health screening and necessary short-term follow-up treatment. Full retroactive coverage would remain available to those who meet regular Medi-Cal eligibility requirements (with or without a share of cost). (This would continue to provide some catastrophic coverage to unenrolled families, and it would ensure continued Medi-Cal funding for hospitals and others who provide emergency and safety-net care.)

***Coordinate With CCS Program and CHDP.***

The great majority of uninsured children who qualify for CCS treatment services also would qualify for regular health coverage under our model. Consolidating the application for CCS services with the application for family coverage would ensure that the state receives two-thirds federal funding for CCS services for all qualifying children and that these children receive coverage for a full range of health care services. There also would be state and county savings in CHDP since there would be fewer uninsured children.

***Use Competitive Rates With Safety-Net Protections.*** Our model relies on competition and choice as the best ways to assure that coverage is cost effective and provides quality care in ways that meet families' needs. The current "rate-band" approach used by MRMIB for Healthy Families appears to be a good method that could be

extended to the Family Coverage Model. Under this methodology, all health plans that meet the coverage requirements and have rates within a 10 percent band above the average of the two lowest rate bids qualify for inclusion in the program at the standard premium rate. Enrollees may choose any of these plans or they may choose a more expensive qualifying plan above the rate band, with the family paying the additional premium cost. Protection for safety-net providers and Medi-Cal managed care "local initiative" plans could be provided by (1) continuing to favor them in the "default" enrollment of enrollees who decline to choose a plan, as is currently done in the Medi-Cal Program; and (2) providing a premium discount to families who enroll in a safety-net provider plan, similar to the "community provider" plan discount now offered in Healthy Families.

**THE IMPORTANCE OF  
MINIMIZING CROWD-OUT**

As mentioned above, crowd-out is the substitution of public coverage for private coverage. Historically, most Medi-Cal beneficiaries have been welfare recipients or the poor, who have little access to job-based coverage. Accordingly, crowd-out has not been a major concern in the Medi-Cal Program. Expanding coverage to include working families with incomes up to 250 percent of the FPL, however, makes crowd-out a serious concern and makes the inclusion of features to minimize crowd-out crucial to controlling the cost of expanded coverage.

***Job-Based Coverage Rises With Income.*** The proportion of families with private, group health

coverage (generally job-based) rises rapidly with income, as shown in Figure 6. Below 100 percent of the FPL, fewer than one-fifth of the children and parents have private group coverage. In families with incomes between 100 percent and 200 percent of the FPL, about half of the parents and children have private group coverage; and for families between 200 percent and 250 percent of the FPL, the proportion with private coverage rises to about two-thirds.

**Employer and Employee Share Cost of Health Coverage.** Health coverage is a significant employee benefit, the cost of which is typically shared by the employee and employer. Monthly premium costs for the least expensive HMO plans (excluding dental and vision care) offered by the California Public Employees' Retirement System (CalPERS) to state employees are about \$160 for the employee only and about \$425 for full family coverage (the employee and two or more dependents). Most employers require employees to pay

a share of the cost of coverage, and this employee contribution generally increases substantially for family coverage (if offered). According to a 1995 survey of major U.S. employers (those with more than 1,000 employees) reported by the U.S. General Accounting Office (GAO), the median employee share of monthly premiums was \$27 (employee only) and \$85 (family coverage). The employee's share varies widely among employers and many employees pay significantly more than the median amount. Another survey cited by the GAO found that 16 percent of employees paid \$150 per month or more for family coverage in 1992. Private health coverage also generally requires copayments for doctor's visits and prescriptions and has some coverage limitations.

In contrast with private coverage, Medi-Cal generally is "free" (most enrollees do not pay a share of cost), does not require copayments, and covers a very wide range of services, especially for children. The Healthy Families Program, which serves children in families with somewhat higher incomes, charges modest monthly premiums capped at \$14 (family incomes under 150 percent of the FPL) or \$27 (family incomes between 150 percent and 200 percent of the FPL) for coverage of all eligible children in a family. Healthy Families has copayments, but not for preventive care, and the program limits the annual cost of copayments for families.

**Crowd-Out Can Greatly Increase Costs.** Employers and most employees have a significant financial incentive to switch from job-based coverage to free or very low cost public coverage.

**Figure 6**

**California Children and Parents Job-Based Coverage Increases With Income**

1997<sup>a</sup>

	Percentage Covered	
	Children	Parents
<b>Family Income Percentage of Poverty Level</b>		
Under 100 percent	17%	17%
100 percent to 200 percent	48	49
200 percent to 250 percent	72	62

<sup>a</sup> Based on data from the March 1998 Current Population Survey.



Furthermore, Medi-Cal and Healthy Families now offer access to some of the same mainstream commercial health plans (in addition to traditional safety-net providers) that serve the private market, which diminishes perceived differences between public and private coverage. The majority of children and parents in families above the poverty line have job-based health coverage; consequently, the potential impact of crowd-out on the cost of expanding public coverage to families in this income range, absent any restraints, could be larger than the cost of covering those families that are uninsured. This is the reason why minimizing crowd-out is crucial in controlling the cost of expanding coverage.

## **STRATEGIES TO MINIMIZE CROWD-OUT**

There are a variety of strategies that we have incorporated in the LAO model in order to minimize crowd-out, some of which are used in the existing Healthy Families Program.

### **Premiums**

Premiums are a direct means of discouraging crowd-out. If premiums for public coverage are set equal to typical employee contributions for job-based health coverage, then employees will not have any financial incentive to switch from private to public coverage (assuming roughly comparable coverage). Recognizing that poorer families have less ability to pay premiums (and less access to job-based coverage), however, premiums for the Family Coverage Model use a sliding scale with the existing Healthy Families premium structure as a base. For example, the current Healthy Families monthly premium of \$27 (from 150 percent to

200 percent of the FPL) for three or more children could be increased to perhaps \$40, including the parents. The premium could then increase to a maximum of about \$80 per month at 250 percent of the FPL (2.3 percent of this income for a family of four), which would be similar to the typical employee contribution for job-based coverage. Sliding-scale premiums also function as a means to phase out public coverage as income increases.

### **Black-Out Periods**

Healthy Families currently has a three month black-out period—children who have had employer-sponsored coverage within the previous three months are not eligible (unless the coverage was terminated for reasons beyond the family’s control). Our model also includes this feature. Black-out periods prevent families from dropping job-based coverage and switching directly to a public program.

### **Buy-Ins for Job-Based Coverage**

Under a buy-in approach, the state would pay a portion of the employee’s share of premium costs for job-based coverage that is equivalent to that offered through the Family Coverage Model. The state payment would be the difference between the employee’s share and the premium for the Family Coverage Model. Potentially, a buy-in option could be one of the most effective means of preventing crowd-out because it maximizes the use of benefits available from employers. Existing state and federal law authorize buy-ins in both Medi-Cal and Healthy Families, but these have been used in a very limited way (in Medi-Cal) or not implemented at all (in Healthy Families).

**Problems With Existing Buy-In Programs.** There are two reasons for the lack of success to date with buy-ins. First, Medicaid has served a primarily poor and nonworking population with little access to job-based coverage. The second is the diversity of employer health plans, which vary in both coverage and financial participation requirements (copayments and deductibles). This variability is the main barrier to using buy-ins for working families because federal law requires that the coverage obtained using a buy-in be essentially the same as the public coverage with respect to the scope of benefits, premiums, and copayments.

Medi-Cal and Healthy Families provide broader coverage than most employer plans. As a result, in order to use employer plans the state must augment them with “wrap-around” coverage to make them equivalent to Medi-Cal or Healthy Families plans. This is straightforward if the difference simply is a lack of dental or vision coverage, which the state can provide as a separate add-on. However, it is much more difficult to deal with differences in copayments, deductibles, limits on hospital days, medical procedures or equipment, and drug coverage since these vary so much and cannot be addressed by any standard add-on coverage. In practice, the difficulty of using employer plans to provide coverage that meets Medicaid or CHIP requirements usually prevents the use of buy-ins.

### **Making Buy-Ins Practical**

We believe, however, that the state could require health plans and insurers to take the following two steps in order to make buy-in coverage feasible.

- ◆ **Offer a Model Family Plan.** Each health plan organization or insurer in the state would have to offer a coverage package for medical services that meets the model family plan requirements. (It is likely that most major managed care organizations would participate directly in the state’s family coverage program and therefore already would offer a qualifying plan for that purpose.)
- ◆ **Calculate Conversion Premiums.** For every other type of health plan or policy sold to employers, the health plan organization or insurer would calculate (using accepted actuarial principles) an additional monthly premium amount that would convert that plan or policy into a model plan. This “conversion premium” would enable the state to easily calculate the cost of a buy-in for uninsured employees who have access to job-based coverage in order to determine whether a buy-in is more cost-effective than providing model family coverage directly.

These changes would enable the state to make buy-in decisions by comparing the buy-in cost—the cost (if any) of subsidizing the employee contribution (if higher than the premium for the model plan) plus the cost of the conversion premium and any add-on coverage—versus the cost of providing direct public coverage. Based on this calculation, the state would authorize buy-ins when they are cost-effective. Figure 7 (see box on page 24) presents an illustration of a buy-in comparison.



## EVALUATING A BUY-IN OPTION

In this example, a family of four with an income of 250 percent of the FPL has applied for coverage under the Family Coverage Model. At their income level, this family would pay a monthly premium of \$80 for coverage. Assuming that the monthly rate paid by the state to health plans for this coverage is \$400, the net

governmental cost (to the state and federal governments) of providing direct coverage is \$400 less the \$80 family premium payment, or \$320 per month.

The family in this illustration also is assumed to have access to employer medical coverage with a monthly employee contribution of \$120. The state buy-in, therefore, will require a monthly premium subsidy of \$40 for the employee (the difference between the \$80 premium under the model plan and the \$120 employee contribution for employer coverage). The employer's plan in this example, however, is less comprehensive than the medical coverage in the model plan offered by the state, and converting this plan to the model plan requires the state to pay a monthly conversion premium, assumed to be \$70. The state also would purchase required add-on dental and vision coverage (since the employer offers only a medical plan) for an assumed monthly cost of \$40. The total monthly cost of the buy-in option is \$150, which consists of the premium subsidy of \$40 plus the \$70 conversion premium and \$40 for dental and vision coverage. The \$150 cost of the buy-in option is \$170 less than the net monthly cost of direct coverage. In this illustration, therefore, the state would save \$170 each month (less administrative costs) by using the buy-in approach.

**Figure 7**

### LAO Family Coverage Model Example of a Buy-In Cost Comparison

*(Amounts Are Monthly)*

Cost to Government				Savings From Buy-In
Buy-In for Employer Coverage		Direct State Coverage		
Employee contribution	\$120	Cost of coverage	\$400	
Less premium paid by family	<u>-80</u>	Less premium paid by family	<u>-80</u>	
<b>Premium subsidy</b>	<b>\$40</b>		<b>\$320</b>	
Conversion premium	70		—	
Add-on dental and vision coverage	<u>40</u>		<u>—</u>	
<b>Total cost</b>	<b>\$150</b>		<b>\$320</b>	<b>\$170</b>



## ADVANTAGES OF THE LAO MODEL

To the extent that the Legislature wishes to reduce the number of uninsured families, the LAO Family Coverage Model has a number of significant advantages compared with the current fragmented coverage that Medi-Cal and Healthy Families provide for children and parents. Figure 8 summarizes these advantages.

## TOOLS TO CONTROL SPENDING

The ability to control spending is a significant concern with public benefit programs. Our model uses competitive rates, managed care, and administrative simplification to reduce costs and limit their growth. However, the cost of providing health coverage is subject to many uncertainties over which the state has no direct control. These include general trends in the cost of health care and changes in the availability and terms of job-based health coverage. These types of external factors could result in spending growth that is faster than had been anticipated. Furthermore, state resources and spending priorities change over time. For this reason, it is important that the Legislature

include the following tools to limit program spending:

- ◆ **Enrollment Cap.** A cap would allow the state to close enrollment to new applicants in order to keep spending within budget. Enrollment in regular Medi-Cal eligibility categories would remain open as an entitlement, however, to those who qualify.
- ◆ **Premium Increase.** Increasing premiums would tend to reduce enrollment to some

**Figure 8**

### Advantages of the LAO Family Coverage Model Versus Current Medi-Cal and Healthy Families Coverage

- ✓ Results in increase in coverage, thereby encouraging ongoing and preventive care.
- ✓ Results in administrative simplification, thereby reducing administrative costs.
- ✓ Covers parents as well as children.
- ✓ Unifies family coverage and enables family members to use the same health plan and doctors.
- ✓ Makes it easier for families to apply for and maintain coverage.
- ✓ Maximizes use of available federal funds.
- ✓ Lessens pressure on safety-net providers by reducing the number of uninsured.
- ✓ Coordinates public health coverage with job-based coverage to leverage employer benefits and limit "crowd-out."



extent, as well as generate some additional revenue for the program.

- ◆ **Reduce Benefits.** The state could limit costs by eliminating or restricting selected benefits or increasing copayments.

These tools would enable the Legislature to exercise some budgetary control over the program. We recognize, however, that these tools do not provide a painless way to control spending, particularly during economic downturns, when there may be less access to job-based coverage.

## IMPLEMENTATION

The Family Coverage Model represents a significant change in the way that the state provides health coverage to families and children. Its implementation, moreover, would require significant changes in existing programs and organizations and therefore would be a major task.

**Timing.** Implementation would require operational changes at both the state and county levels, as well as efforts in the areas of specific program design, outreach, and negotiations with the federal government and with health plans. These tasks probably would require a minimum of one year between enactment of legislation and implementation of all of the major features of the program. Some limited but important features of the model could be implemented earlier, however, because they can be applied to the existing Medi-Cal eligibility structure. These include the following changes, each of which would expand eligibility and simplify program administration:

- ◆ Eliminate the 100-hour rule.
- ◆ Waive Section 1931(b) asset tests.
- ◆ Increase the current Section 1931(b) applicant income limit to the Medically Needy level.

## Federal Waiver

As explained earlier, existing federal law and regulations enable the state to expand coverage to working families using Medicaid Section 1931(b) authority. Under such an approach, federal funding would be provided at the regular Medicaid matching rate (about half of the cost) for parents and most children who meet current Medi-Cal eligibility requirements and at the enhanced CHIP rate (about two-thirds of the cost) for newly eligible children. This type of expansion would be subject to all of the requirements and restrictions that govern Medicaid.

Under our approach, however, the Family Coverage Model combines the family coverage potential of Medicaid with the much more flexible coverage and enrollment provisions of Healthy Families, which is a non-Medicaid CHIP program. In order to do so, the state would need to obtain a “Section 1115” demonstration project waiver from the Secretary of the federal Department of Health and Human Services (HHS). Features of the Family Coverage Model that would require a federal waiver include the following:

- ◆ Using a family gross income test without complicated deductions and stepparent and stepchild income allocations.

- ◆ Limiting coverage to the uninsured and requiring blackout periods to qualify as uninsured.
- ◆ Requiring premiums and obtaining federal matching funds for the portion of premiums associated with coverage of parents.
- ◆ Limiting retroactive coverage.
- ◆ Allowing enrollment caps (if needed, to control spending).

In January 1999, the Secretary of HHS granted a Section 1115 waiver to the State of Wisconsin to implement its new “Badger Care” program, which expands coverage to working families by combining Section 1931(b) Medicaid eligibility with CHIP flexibility. Our Family Coverage Model shares many of the features of Badger Care, so it appears likely that California could obtain a similar waiver.

### **SAFETY NET STILL NEEDED**

Our Family Coverage Model is not universal coverage. It would not cover families with in-

comes above 250 percent of FPL, single adults, or parents with adult children. Unless they are disabled or elderly (age 65 or older), these persons generally are not eligible for coverage under the major federal health coverage programs (Medicaid, Medicare, or CHIP).

Furthermore, our approach would not provide automatic coverage—families would have to enroll to obtain coverage, and many would be subject to premiums and copayments. Consequently, expanded family coverage would not eliminate the need for safety-net institutions, such as county hospitals and community clinics. It would, however, reduce the size of the uninsured population. This is important because the number of uninsured in California has been growing, while federal disproportionate share hospital (DSH) payments—an important source of indigent care funds—are scheduled to decrease by 20 percent over the next few years.

## **ENROLLMENT AND COST ESTIMATES FOR THE LAO FAMILY COVERAGE MODEL**

We have estimated the net state cost of the Family Coverage Model using two alternative scenarios for participation by the uninsured. Our estimates should be viewed as approximate indicators of the cost of the program because of the many uncertainties in the data on which they are based and because they necessarily rely on a number of significant assumptions.

### **1.8 MILLION UNINSURED CHILDREN AND PARENTS**

Currently, Medi-Cal and Healthy Families cover (that is, enroll) on the order of 70 percent of the children and 50 percent of the parents in families with incomes under 250 percent of the FPL who do not have *other* health coverage. The higher



coverage rate for children reflects their broader eligibility under the two programs.

Our Family Coverage Model would increase health coverage in two ways. First, it would expand eligibility beyond current limits, particularly for parents. Second, it would increase the participation of currently eligible, but unenrolled, persons by unifying family coverage and simplifying the application process.

We estimate that about 902,000 uninsured children and 927,000 uninsured parents would be eligible for coverage under our approach—a total of 1.8 million persons. About 90 percent of these children currently are eligible for coverage under existing Medi-Cal or Healthy Families eligibility rules, but are not enrolled. In contrast, only a small proportion of the uninsured parents that would be eligible for coverage under our model could qualify for coverage under current Medi-Cal rules. We estimate that one-third of the potentially eligible uninsured parents have children who are currently enrolled in Medi-Cal.

Both the effectiveness of our Family Coverage Model in increasing coverage and the cost of the program would depend to a large extent on the proportion of eligible families who decide to participate. Actual participation rates would depend on many factors, including the specific details of the program's design and operation as well as the terms of both job-based coverage and health care services from safety-net providers. Given these uncertainties, we have developed two participation scenarios that, we believe, establish a reasonable range for estimating costs.

**Scenario 1: 80 Percent Coverage of Children.**

Scenario 1 assumes that 80 percent of the children without private coverage in families with incomes below 250 percent of the FPL are enrolled in the Family Coverage Model (or regular Medi-Cal). The current coverage rate is a little over 70 percent. Thus, under this scenario, the percentage of children without coverage would decline by one-third (from 30 percent to 20 percent).

**Scenario 2: 90 Percent Coverage of Children.**

This scenario is the same as Scenario 1, except that the proportion of covered children increases to 90 percent. Thus, the percentage of children without coverage declines by two-thirds.

**Parents of Medi-Cal Children Fully Enrolled in Both Scenarios.**

Both scenarios assume that all uninsured parents who currently have children enrolled in Medi-Cal will enroll in expanded family coverage. This assumption recognizes that these parents already have sought and obtained Medi-Cal coverage for their children and generally were excluded from coverage themselves due to the more restrictive eligibility requirements for parental coverage. With respect to parents of currently *uninsured* children, each of the two scenarios assumes that their coverage will increase in proportion with the coverage of uninsured children in that scenario.

**PROJECTED COVERAGE INCREASE—  
0.9 MILLION TO 1.4 MILLION PERSONS**

Using the two scenarios described above, we have estimated the number of additional children and parents who would be covered under our

Family Coverage Model, as shown in Figure 9. These estimates indicate the increase in coverage over 1999-00 Medi-Cal enrollment (as estimated in the May Revision to the 1999-00 Governor's Budget) and anticipated enrollment in the existing Healthy Families Program.

In both scenarios, Figure 9 shows that more than 80 percent of the increase in coverage would be for families with incomes under 200 percent of the FPL, and that parents in those families would account for more than half of the additional coverage. The total increase in coverage would range from about 865,000 in Scenario 1 up to about 1.4 million in Scenario 2. For comparison, Medi-Cal currently covers an average of about 3.5 million parents and children.

### ANNUAL NET STATE COST— \$188 MILLION TO \$385 MILLION

Figure 10 (see page 30) shows our estimate of the net state cost of the LAO Family Coverage Model, based on the projected increase in coverage under our two participation scenarios. The annual increase in benefit costs and administration for the increased enrollment would be between \$758 million and about \$1.2 billion, depending on participation. The federal government would pay about half of the benefit costs for parents and for children who meet regular Medi-Cal requirements, about two-thirds of the benefit costs of other children, and half of the administrative costs. After deducting the federal contribution, the state share of these costs would be between \$358 million and \$564 million annually.

Our estimated benefit and administration costs incorporate two significant cost reductions.

- ◆ **Benefit Costs Recognize Current Medi-Cal Use.** For families below 200 percent of the FPL, our estimate of the increase in benefit costs excludes hospital inpatient costs. This recognizes that most family members in this income range (even if not regularly enrolled in Medi-Cal) are currently

<b>Figure 9</b>			
<b>LAO Family Coverage Model Estimated Increase in Health Coverage For Children and Parents<sup>a</sup></b>			
<i>Comparison of Two Participation Scenarios</i>			
<b>Family Income (Percentage of the Poverty Level)</b>	<b>Children</b>	<b>Parents</b>	<b>Totals</b>
<b>Scenario 1 – 80 percent coverage of children</b>			
Under 200 percent	232,000	493,000	725,000
200 to 250 percent	55,000	85,000	140,000
<b>Totals</b>	<b>287,000</b>	<b>578,000</b>	<b>865,000</b>
<b>Scenario 2 – 90 percent coverage of children</b>			
Under 200 percent	522,000	733,000	1,255,000
200 to 250 percent	73,000	109,000	182,000
<b>Totals</b>	<b>595,000</b>	<b>842,000</b>	<b>1,437,000</b>

<sup>a</sup> Based on estimated 1999-00 Medi-Cal caseloads, population, and insurance coverage, and with the anticipated level of full enrollment in the existing Healthy Families Program.



eligible for Medi-Cal coverage when they incur major medical costs, either through retroactive coverage or eligibility for pregnancy coverage. Consequently, our estimate does not include any *additional* cost for these services for this population.

- ◆ **Simplification Reduces Eligibility Administration Costs.** Our estimated eligibility administration costs per enrollee under the LAO model are about half of the current cost of county eligibility administration for Medi-Cal. This reduced cost reflects simplification due to elimination of quarterly reports, asset tests, complex eligibility categories and income deductions, and the use of a simplified mail-in application. Nevertheless, even using these reduced eligibility cost factors, our estimate includes the equivalent of about \$300 annually for eligibility administration for a family of four enrolled in the model plan.

**Cost Offsets Reduce Net State Cost.** Our estimate includes the following three types of cost offsets, which reduce the net state cost of expanded coverage under the Family Coverage Model by a total of about \$180 million annually:

- ◆ **Maximize Federal Funds for CCS—\$17 Million.** By enrolling all eligible CCS children in family coverage, we estimate that the state could shift \$17 million of costs currently shared by the state and the counties to the federal government. Our

**Figure 10**

**LAO Family Coverage Model  
Estimated Range of Net Annual Cost<sup>a</sup>  
Under Two Participation Scenarios**

(In Millions)

	Scenario 1		Scenario 2	
	Total	State Share	Total	State Share
<b>New Costs</b>				
Health benefits <sup>b</sup>	\$707	\$325	\$1,109	\$509
Eligibility administration	51	33	85	55
<b>Subtotal</b>	<b>\$758</b>	<b>\$358</b>	<b>\$1,194</b>	<b>\$564</b>
<b>Savings</b>				
Maximize federal funds for CCS	—	-\$17	—	-\$17
Net premium revenue <sup>c</sup>	-\$33	-26	-\$48	-35
Eligibility administration savings for existing Medi-Cal caseload	-253	-127	-253	-127
<b>Subtotal</b>	<b>-\$286</b>	<b>-\$170</b>	<b>-\$301</b>	<b>-\$179</b>
<b>Net Annual Cost</b>	<b>\$472</b>	<b>\$188</b>	<b>\$893</b>	<b>\$385</b>

<sup>a</sup> Estimated annual cost increase over existing programs, using 1999-00 caseload and cost factors from the May Revision to the 1999-00 Governor's Budget. Amounts assume full implementation of all components, including eligibility expansion, simplification, premium, and buy-in provisions.

<sup>b</sup> Monthly benefit costs: for families under 200 percent of the FPL—\$71 for parents and \$42 for children, based on 1999-00 Medi-Cal costs excluding inpatient costs. For families above 200 percent of the FPL—\$108 for parents (the Medi-Cal cost for CalWORKs recipients) and \$87 for children (the budgeted Healthy Families cost, including mental health funding).

<sup>c</sup> Premiums net of estimated \$5 monthly premium billing and administration cost per family.

estimate applies all of these savings to offset the additional cost of expanded coverage.

- ◆ **Net Premium Revenue—\$26 Million to \$35 Million.** Our estimate assumes that families pay monthly premiums on a sliding scale. For a family of four, these premiums would average \$30 for families with incomes between 150 percent and 200 percent of the FPL and \$60 for families between 200 percent and 250 percent of the FPL (the maximum premium amount would be \$80 at 250 percent of the FPL). Net premium revenues have been reduced by \$5 per family to reflect offsetting monthly administrative costs for billing and payment processing.
- ◆ **Simplification Savings for the Existing Medi-Cal Caseload—\$127 Million.** The simplified eligibility requirements of our Family Coverage Model will apply to most of the *existing* Medi-Cal caseload of children and families (other than CalWORKs recipients who will continue to qualify for Medi-Cal through the CalWORKs enrollment process), as well as to the expanded coverage population. We estimate that the simplified eligibility requirements will result in fewer breaks in eligibility for people who go off and back on Medi-Cal, which will reduce intakes by about 30 percent. We also assume, as

noted above, that the simplified requirements and the use of mail-in applications will reduce the current intake processing cost and the monthly case maintenance cost by half (to \$60 and \$11, respectively). Our estimate assumes that the model's provisions to control crowd-out (such as premiums and buy-ins) are effective and therefore it includes no crowd-out costs.

**Savings to CHDP and County Indigent Care Savings Would Help Absorb Anticipated Funding Declines.** Our estimate does not assume any state capture of county savings from reduced costs for CHDP follow-up treatment or indigent care services that would result from the implementation of the Family Coverage Model. There also would be reduced state costs for CHDP child health screens and vaccinations (\$84 million in 1998-99) for the same reason. The annual county savings are difficult to estimate, but probably would total from tens of millions of dollars up to \$100 million statewide. The annual state savings could be up to tens of millions of dollars. These savings would help offset anticipated declines in Proposition 99 tobacco tax revenues, which help support county health services and state CHDP screening costs, and scheduled declines in California's allocation of federal DSH funds, which help support county hospitals.



## CONCLUSION

Despite California's current robust economy, the state has a large and growing number of persons without health coverage, including many parents and children. Estimates of the state's uninsured population range from 5.5 million to 7 million. Recent changes in federal law and regulation provide an opportunity for the state to use federal funding to cover more than half of the cost of expanding health coverage for low-income working families.

As the Legislature evaluates proposals to reduce the number of uninsured families in California, our Family Coverage Model represents an approach to expanding coverage and improving participation by those eligible for existing programs that incorporates a number of features to limit state costs.

Our model (1) unifies coverage for parents and children under the Medi-Cal and Healthy Families Programs, (2) expands coverage to families with incomes up to 250 percent of the poverty level, (3) simplifies eligibility to reduce administrative costs, (4) coordinates family coverage with other health programs to provide better care while reducing state and county costs, and (5) includes sliding-scale premiums and buy-ins for job-based coverage to minimize crowd-out.

We estimate that between 900,000 and 1.4 million additional parents and children would obtain health coverage under our model. The net state cost of providing this additional coverage would range from about \$188 million to \$385 million annually, depending on enrollment.

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