DOCUMENT RESUME

ED 433 130 PS 027 848

AUTHOR O'Sullivan, Maryann; Burgmaier, Michael; Freeman, Patricia; Reich, Jessica

TITLE California's Working Families and Their Uninsured Children: A Big Problem with an Affordable Solution.

INSTITUTION Children Now, Oakland, CA.

SPONS AGENCY Robert Wood Johnson Foundation, Princeton, NJ.; David and Lucile Packard Foundation, Los Altos, CA.

PUB DATE 1997-03-00

NOTE 93p.; Funding also provided by the Atlas Family Foundation and the Ralph M. Parsons Foundation.

AVAILABLE FROM Children Now, 1212 Broadway, 5th Floor, Oakland, CA 94612; Tel: 800-CHILD-44 (Toll Free), Tel: 510-763-2444; Fax: 510-763-1974; Web site: www.childrennow.org

PUB TYPE Reports - Evaluative (142)

EDRS PRICE MF01/PC04 Plus Postage.

DESCRIPTORS *Child Health; *Children; *Employed Parents; Federal Programs; *Health Insurance; Health Needs; Health Programs; Low Income Groups; *Parents; Public Health; *Public Policy; State Programs

IDENTIFIERS *California

ABSTRACT

Although California lags behind other states in insuring children of low-income working families, the state could provide assistance by building on existing public health programs. This report provides a primer on the problems of low-income uninsured children and explores the public policy building blocks needed to adequately and affordably insure them. Chapter 1 discusses the problems that arise when working parents are unable to afford health insurance, including trends in insurance coverage that work against working families and the lack of enrollment of eligible children in the Medi-Cal program. Chapter 2 deals with the impact of lack of health insurance on children and presents findings relating lack of insurance to limited access to a broad range of health services, lack of medical care, and lowered likelihood of having a known health care provider to follow the child's development. Chapter 3 documents gaps in the public health system leaving uninsured children without basic health care. Chapter 4 presents a potential solution to the problem, including increasing enrollment for Medi-Cal eligible children and working with the federal government to expand coverage for uninsured children. Incorporated into the report are vignettes detailing common child and adolescent health problems and difficulties in obtaining health care. Nine appendices include lists of pivotal policy decision points, the California government roster, and descriptions of public health care programs for children in California. Contains 67 references. (KB)

California's

Working Families & Their Uninsured Children:

A Big Problem With An Affordable Solution

California's

Working Families & Their Uninsured Children:

A Big Problem With An Affordable Solution

This report was made possible by grants from:
The Atlas Family Foundation
The Robert Wood Johnson Foundation
The David and Lucile Packard Foundation
The Ralph M. Parsons Foundation

Errata

The following names were inadvertently excluded from the Health Policy Advisory Committee list on page vi. Children Now sincerely regrets these omissions.

Astrid Heger, Director, Center for the Vulnerable Child
Nancy Rubin, Executive Officer, Los Angeles Department of Health Services

Table of Contents

List of Graphs & Tables

List of Stories

Children Now Health Policy Advisory Committee

Children Now extends sincere gratitude to the Health Policy Advisory Committee for their dedication to this project. For six months, the Committee members actively participated in conference calls and meetings, patiently fielded our questions, and graciously provided us with guidance and support. No formal recommendation for specific policy solutions was given by the Committee, nor did the group discuss how the policy issues in this report should be framed. Above all, this Committee impressed us with their passion and commitment to improving the health and well-being of all children.

Erin Aaberg
Owner
Erin Aaberg and Associates

Denise Adams-Sims
Project Director
California Black Health Network

Linda Barthauer
Clinical Scholar's Program
UCLA Department of Medicine

E. Richard Brown
Director
UCLA Center for Health Policy Research

Linda Burden
Maternal - Child Health Consultant

Beth Capell
Legislative Analyst

Michael Cousineau
Associate Director for Public Health
USC School of Public Health Administration

Jeanne Finberg
Senior Policy Analyst
Consumers Union

Mark Finucane
Director
Los Angeles County Health Department

George Flores
Director of Public Health
Sonoma County Department of Health

Jim Forde
Executive Director
California Black Health Network

Ruth Given
Dir., Department of Health Care Policy
California Medical Association

Alfredo Gonzalez
Project Manager
Latino Issues Forum

Neal Halfon
Dir., Child and Family Health Program
UCLA School of Public Health

Peter Hansel
Consultant
California Senate Office of Research

Dana Hughes
Senior Policy Associate
UCSF Health Policy Institute

Lucy Johns
Independent Consultant
Health Care Planning and Policy

David Kears
Chief Executive Officer
Alameda Alliance for Health

Michael Koch
Executive Director
CaliforniaKids

Wendy Lazarus
Director
The Children's Partnership

Larry Levitt
Senior Manager
The Lewin Group

Jack Lewin
Senior Exec. Vice President and CEO
California Medical Association

Bruce Livingston
Executive Director
Health Access

Nina Maruyama
Dir. of Development & Govt. Relations
Alameda Alliance for Health

Paul Newacheck
Professor, Health Policy & Pediatrics
UCSF Health Policy Institute

Gil Ojeda
Principal Analyst
Latino Coalition for a Healthy California

Lucy Quacinella
Staff Attorney
Western Center on Law and Poverty

Helen Schauffler
Principal Investigator
UC Berkeley School of Public Health

Paul Sims
Interim Clinical Director
Charles R. Drew University of Medicine

Peter Sybinsky
Senior Vice President & Chief Operations Officer
California Medical Association

Reed Tuckson
President
Charles R. Drew University of Medicine

Robert Valdez
Deputy Assistant Secretary for Health
Dept. of Health and Human Services

Alan Watahara
Executive Director
California Partnership for Children

Lucien Wulsin
Private Attorney
Santa Monica, CA

**Organizations for identification purposes only*

Executive Summary

Introduction

The time has come to solve the problem of 1.6 million medically uninsured children in California. No barrier should stand between California's children and access to adequate health care. Young people today face many complex problems; for this one, a solution is within reach. Children are affordable to insure and federal dollars are available to match the dollars California is willing to invest in this worthy issue.

Federal law already requires California to cover most of its poorest children, but the state lags far behind other states in insuring the children of low-income working families. By building on the state's existing public health programs, California could provide tremendous relief to the state's uninsured children—more than eight out of ten of whom have parents who work.

While promising solutions remain unexplored, uninsured children of California's low-income working families suffer. These children live in a nation with an abundance of the world's most sophisticated health technologies, but often cannot reach basic preventive and primary health services. Even when their children are sick or injured, families often find health care unaffordable and out of reach.

Low-income working parents face choices most parents would find unthinkable. Taking a job, often for employers who do not provide health insurance, can mean becoming *ineligible* for the health coverage provided to the state's poorest families. And low-wage working parents cannot purchase their own coverage or pay major health care bills without sacrificing essentials—like rent or utility bills.

This report is intended to educate and motivate Californians by providing a primer on the problem and exploring the public policy building blocks needed to adequately and affordably insure California's low-income uninsured children.

Statement of Purpose

Children Now's Health Policy Advisory Committee developed the following statement of purpose to help guide the development of a solution for uninsured children.

All children should receive the health care they need to support the achievement of their full physical, cognitive, and emotional potential. To reach this goal, all children should have access to a choice of affordable, comprehensive, coordinated, and continuous systems of health care services of acceptable quality. Such systems will empower families to take responsibility for their children's health care. While access to health care is only one of many issues affecting children's healthy development, universal health insurance coverage for children is a critical component for promoting the well-being of our children.

Working Parents Unable to Afford the Basics

Uninsured children are by and large caught in an unforgiving gap. Surprisingly, many are not the children of the state's poorest families. In most cases, their parents earn too much to be eligible for public health insurance, but too little to make the purchase of private insurance or basic health services possible.

Many of these parents work all day filling the jobs that make California run. They work in bakeries and barber shops, book stores and florists. They are waitresses, health care workers and hotel staff; they pump gas and they pick crops. Unfortunately, this hard work does not provide them with what it takes for a California family to get by.

- *One in six California children, 1.6 million, has no health insurance;*[1] only eight states in the country have worse rates.[2]
- The parents of California's uninsured children most often work for a living but cannot afford insurance for their children:
  - *89% of uninsured children have at least one parent who works;*[3] *and*
  - *60% of uninsured children have a parent who works full-time throughout the year.*[4]
- *Almost three out of four (73%) of California's uninsured children come from families with incomes below 200% of the federal poverty level (FPL).*[5] (In 1996, 200% of the FPL was $25,960 for a family of three.)[6]
- *Only 53% of California children have job-based insurance.*[7]

Vulnerable and Developing: Uninsured Children Pay for Their Parents' Economic Misfortunes

Childhood is a special time of growth and development. Health insurance helps assure access to appropriate health services that can monitor a child's cognitive, physical and emotional development. However, for low-income families who cannot afford health insurance, regular care is out of reach. Frequently, the only medical attention their children receive comes from crowded emergency rooms.

Parents want their children to receive routine preventive care, to have a place to go when they are sick and to have a health provider monitor their child's development. Parents want someone to explain children's allergies, to help manage their asthma or to say when glasses or psychological counseling are needed. Studies show that uninsured children, surrounded by the most expansive and expensive health system in the world, frequently cannot find their way to the care they need. Compared to insured children, uninsured children receive only limited access to health services.

- *Overall, uninsured children receive only 70% of the outpatient visits received by their insured peers,*[8] *81% of the hospital inpatient days,*[9] *and just 71% of the care for serious injuries.*[10]
- *Uninsured children under six years of age were almost three times more likely than privately insured children to use no health services, including provider visits or prescription drugs, throughout one year.*[11]
- *One national study found that, of uninsured children with serious conditions, nearly two-thirds (63%) failed to see a doctor for severe sore throats, and one-half (49%) failed to see a doctor for acute earaches.*[12]
- *Forty percent of uninsured children ages six to 17—compared to 14% of their privately insured peers—used no health services throughout one year.*[13]
- Many uninsured children do not have a consistent provider who can monitor their development. *Uninsured children are three times more likely than insured children to be without a regular source of care.*[14]

Gaps in the Public System Leave Uninsured Children without Health Care Basics

California's current public system for children is a confusing array of programs. Each program has its own eligibility criteria and enrollment processes, leaving low-income children with uncertain or no coverage depending on their age and health condition. Small fluctuations in their parent's income can jeopardize eligibility. Many uninsured children slip through the gaps in this fragmented system and suffer from needless developmental delays, untreated injuries and preventable illnesses.

- *In 1994 approximately 500,000 uninsured children in California met the family income eligibility requirements for Medi-Cal but were not enrolled in the program.*[15] *These children composed roughly one-quarter of California's uninsured children in 1994.*
- Among uninsured children who met the age requirements for the federally mandated federal poverty level programs (children under age 11 in 1994), about one-half met the income requirements for Medi-Cal but were not enrolled in the program.[15a]
- California's Access for Infants and Mothers (AIM) program only covers children until their second birthday.[16] Then, regardless of their income or whether they have any source of insurance or care, the program drops them. *Each month 350 to 400 children lose AIM coverage when they turn two.*[17]
- California's Children's Treatment Program, a companion program to the state's Child Health and Disability Prevention program (CHDP), provides care only for conditions identified as "new" and only when identified at a CHDP screening.[18]

- California's counties are, by law, required to provide health care for low-income children[19] but, in reality, their systems *are underfunded and unable to adequately provide for all of the state's uninsured children.*

Where California Can Go From Here: An Affordable Solution

California's uninsured children are relatively inexpensive to cover. The federal government offers a fifty-fifty funding match to insure them, and if consolidated, many existing state health dollars would be eligible for the match. While California has established public programs to help the state's poorest children, little has been done to help provide coverage for children of low-income working families. California policy makers need to knit together the gaps in the system and build on the state's existing programs to give working families the basic peace of mind that health insurance for their children would bring. The facts point the way to a realistic solution for California's uninsured children. Moreover, the public appears ready to support change in the system for children.

- *California can take advantage of hundreds of millions of available federal dollars to extend health insurance for low-income children.* Forty-seven of the 50 states receive higher Medicaid payments than California, per person in poverty.[20]
- Many of these federal funds could become available at no extra cost to the state if California consolidated dollars from several state public health programs' funding streams, which now do not receive a federal match.[21] *These state dollars would then be matched one-to-one by the federal government. Their purchasing power would double.*
- California children with the most costly medical conditions are already covered by Medi-Cal and various other state programs. *The remaining uninsured population of children is a very low-cost group.*
- Using data provided by the California Department of Health Services (DHS), under current reimbursement rates, providing a full-benefit Medi-Cal service package for uninsured children could only cost about $50 per month per child, plus administrative costs.[22]
- If all uninsured children under age 19 in households under 300% of the federal poverty level were insured through a Medi-Cal expansion, the entire total state share of costs could range between $544 and $665 million. *Health insurance for each child would cost the state between $376 and $458 annually. Many of these dollars may already be in the system today.*[23]

Conclusion

Children of low-income working families face a number of complex problems. There is little controversy about whether these children all deserve to have the basics necessary for survival and good health. Providing health insurance is one of these basics and a solution is affordable and practical. The state need only galvanize the political will to take advantage of federal offers of matching funds to expand Medi-Cal to cover the children of California's low-income working families.

Endnotes

[1] US Bureau of the Census, Current Population Survey, March, 1996, calculations by UCLA Center for Health Policy Research ("1996 CPS, calculations by UCLA CHPR.") (Note: all CPS estimates reflect data gathered in the prior year.) The Current Population Survey estimates of uninsured children cited in this report include only children who reportedly received no coverage throughout the entire year prior to the survey. Comparisons with another health insurance coverage survey, the Survey of Income and Program Participation, however, suggest that the CPS estimates of uninsured individuals more accurately reflect the number of people who were uninsured for at least a portion of the previous year. Bennefield, R. (1996). *A Comparative Analysis of Health Insurance Coverage Estimates: Data from CPS and SIPP.* Paper presented at the Joint Statistical Meetings, Chicago, Illinois, August 6, 1996.

[2] 1995 CPS, unpublished calculations by The Urban Institute.

[3] 1996 CPS, calculations by UCLA CHPR.

[4] 1996 CPS, calculations by UCLA CHPR.

[5] 1996 CPS, calculations by UCLA CHPR.

[6] All federal poverty level amounts in this paper are for 1996.

[7] 1996 CPS, calculations by UCLA CHPR.

[8] Marquis, M., Long, S. (1994/1995). *The Uninsured Access Gap: Narrowing the Estimates.* Inquiry. 31:405-14. This study is based on the 1987 National Medical Expenditures Survey. Although the NMES is based on data gathered in 1987, many current studies draw from the NMES data because it provides a uniquely comprehensive database of medical expenditures and utilization data.

[9] Marquis, M., Long, S. (1994/1995). *The Uninsured Access Gap,* Op. Cit.

[10] Overpeck, M., Kotch, J. (1995). *The Effect of US Children's Access to Care on Medical Attention for Injuries.* American Journal of Public Health. 85:402-404.

[11] Lefkowitz, D., Monheit, A. (1991). *Health Insurance, Use of Health Services, and Health Care Expenditures* (AHCPR Publ. No. 92-0017). 1987 National Medical Expenditure Survey Research Findings 12, Agency for Health Care Policy and Research. Rockville, MD: Public Health Service.

[12] Stoddard, J., St. Peter, R., Newacheck, P. (1994). *Health Insurance Status and Ambulatory Care for Children.* New England Journal of Medicine. 330(20):1421-25. This study also is based on data from the 1987 National Medical Expenditures Survey.

[13] Lefkowitz, D., Monheit, A. (1991). *Health Insurance, Use of Health Services,* Op. Cit.

[14] Holl, J., *et. al.* (1995). *Profile of Uninsured Children in the United States.* Archives of Pediatric and Adolescent Medicine. 149:398-406.

[15] 1993, 1994, and 1995 March Current Population Surveys. Calculations by the Center on Budget and Policy Priorities. This estimate includes all children who met the age and family income eligibility requirements for Medi-Cal during those years. Because Medi-Cal's Federal Poverty Level programs impose some additional eligibility requirements, such as a maximum assets test for children over one year of age, some income-eligible children may not have qualified for the program. Only children under age 11 were considered because, in 1994, Medi-Cal's Federal Poverty Level Programs covered only children in this age group.

[15a] 1993, 1994, and 1995 CPS. Op. Cit.

[16] Managed Risk Medical Insurance Board (1996). *Access for Infants and Mothers.* April-June, Sacramento, CA.

[17] Conversation with Richard Figueroa, Deputy Director, California Managed Risk Medical Insurance Board (which administers AIM), November, 1996.

[18] Department of Health Services, Office of County Health Services (1992). *Children's Treatment Program, Medical Services, Policies and Procedures Manual* (Addendum added January 1995).

[19] California Welfare and Institutions Code, Section 17,000.

[20] Government Accounting Office (1996). *Federal Medicaid Payments, Average Census Poverty Counts, and Payments per Person in Poverty.* Backup information for GAO/HEHS-96-164R; from GAO analyst Greg Dybalski.

[21] Some funding streams include state-only CHDP, County indigent funds, and AIM.
[22] At Children Now's request, DHS ran a random sample report aggregating data from July 1995 through June 1996 providing the average monthly cost per Medi-Cal eligible for four distinct age groups: under 1, 1-6, 7-12, and 13-18. Because infants up to age one are already covered under Medi-Cal up to 200% of the FPL and offered coverage through AIM between 200% and 300% of the FPL, their costs were not included here.
[23] These estimates assume that 100% of all currently uninsured children under age 19 would enroll in a new program. When the Department of Health Services proposed an expansion of coverage in 1995, they assumed that 70.6% of eligible children would enroll. The high estimate assumes full current Medi-Cal intake and administration costs; the lower estimate assumes administrative costs could be halved; both estimates assume $50/month in benefit costs. If the state utilized the 1902(r)(2) option under the Social Security Act, total federal and state costs would be shared (49.77% state; 50.23% federal as of 10/96. On 10/1/97, the federal share will increase to 51.23%). There are 239,000 uninsured children under age 19 above 300% of the FPL. These children are not covered under this assumption. (See Chapter Four for further discussion of these projections.)

Introduction

The time has come to solve the problem of 1.6 million medically uninsured children in California. No barrier should stand between California's children and access to adequate health care. Young people today face many complex problems; for this one, a solution is within reach. Children are affordable to insure and federal matching dollars are available to match the dollars California is willing to direct to this worthy issue.

Federal law already requires California to cover most of its poorest children, but lags far behind other states in helping insure the children of the state's low-income families. A solution could provide tremendous relief to California's 1.6 million uninsured children—eight out of ten of whom have parents who work. As elected officials, parents, teachers, business leaders and clergy all seek answers to the tough problems facing today's youth, this need awaits only the political will sufficient to open the doors to our health system a little wider by building on the state's already functioning public health programs.

While promising solutions remain unexplored, uninsured children of California's working poor families suffer. This report is peppered with studies and stories of innocent children who live in a nation with an abundance of the world's most sophisticated health technologies, but who often cannot reach basic preventive and primary health services. Even when their children are sick or injured, families frequently find health care unaffordable and out of reach.

Low-income working parents face choices most parents would find unthinkable. Taking a job, often for employers who do not provide health insurance, can mean becoming *ineligible* for the health coverage provided to the state's poorest families. And low-wage working parents cannot purchase their own coverage or pay major health care bills on their own without leaving other essentials—like rent or utility bills—unpaid.

Children's Health Principles

Children Now's Health Policy Advisory Committee developed the following principles to help guide the development of a solution for uninsured children.

1. All children (birth through 18) residing in California should have health insurance.
2. Every child should have access to essential children's health services, with an emphasis on preventive services.
3. Health insurance coverage should protect families from health care costs they cannot afford.
4. Families should have choices among systems of care and among pediatric providers of care in those systems.
5. Services should be culturally and linguistically appropriate.
6. Continuity of coverage should be assured.
7. Appropriate cost containment strategies should be incorporated.
8. The health care system should support appropriate use of services.

California has not yet taken advantage of the many opportunities the federal government offers states to bring in federal dollars to expand coverage to low-income working children. The state ranks 47 out of 50 states in terms of federal Medicaid dollars paid per person living in poverty. Even when California has expanded eligibility, the state has maintained bureaucratic barriers to getting children covered, thus limiting the state's access to federal matching funds. The result: hundreds of thousands of California's 1.6 million uninsured children are eligible for the state's Medi-Cal system, but remain unenrolled.

This report is intended to educate and motivate Californians by providing a primer on the problem and exploring the public policy building blocks that could be assembled to adequately and relatively inexpensively insure California's low-income uninsured children.

Working Parents

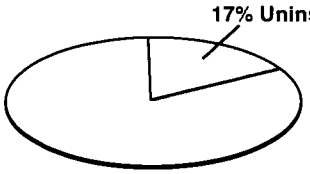
Unable to Afford the Basics

Chapter Highlights

- One in six (1.6 million) California children has no health insurance. Only eight states in the country have worse rates.
- California's uninsured children have parents who work for a living, but cannot afford insurance for their children: 89% of uninsured children have a parent who works and 60% of uninsured children have a parent who works full time.
- By and large, uninsured children fall into a gap between families who qualify for public assistance and those that are insured through the workplace: almost three in four uninsured children come from families with incomes below 200% of the federal poverty level.[1] (Two hundred percent of the federal poverty level is $25,960 for a family of three.)
- Low-income families do not have the discretionary income necessary to purchase health insurance. On a regular basis, they must make choices between paying for basics such as rent and utilities and purchasing health care for their children.
- Only 53% of California children have job-based insurance.
- Among children eligible for Medi-Cal, the state's public insurance system, hundreds of thousands remain unenrolled.

Graph 1

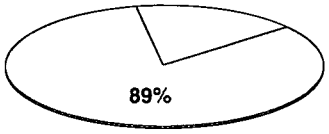
Uninsured children in California in 1995



1996 CPS, calculations by UCLA, CHPR

Graph 2

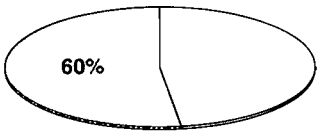
Uninsured children in California in 1995 with at least one working parent



1996 CPS, calculations by UCLA, CHPR

Graph 3

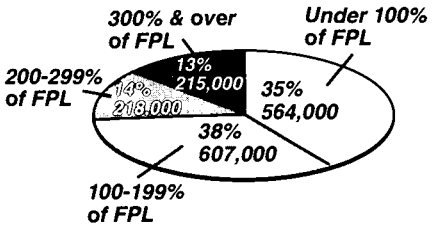
Uninsured children in California in 1995 with at least one parent who works full-time, full-year



1996 CPS, calculations by UCLA, CHPR

Graph 4

California's uninsured children, by Federal Poverty Level Group, 1995



1996 CPS, calculations by UCLA, CHPR

Section 1

Children With Working Parents and No Health Insurance

One in six (1.6 million) children in California (**Graph 1**) has no health insurance—neither private nor public.[2],[3] Surprisingly, most of these children do not come from the state's poorest families; overwhelmingly, they are children of working, low-income families. For their parents, work provides less and less of the resources adequate for their family's basic survival:

- nearly nine out of ten (89%) uninsured children live with at least one parent[4] who works;[5] (**Graph 2**)
- sixty percent of uninsured children live in families with at least one parent working *full-time* throughout the year;[6] and (**Graph 3**)
- almost three out of four (73%) of California's uninsured children come from families whose incomes are below 200% of the federal poverty level (FPL).[7] (Two hundred percent of the FPL is $25,960 for a family of three.) (**Graph 4**)

1996 Federal Poverty Level:

Number of persons in family	100% of FPL (Annual income)	133% of FPL (Annual income)	200% of FPL (Annual income)	300% of FPL (Annual income)
Two	$10,380	$13,779	$20,720	$31,140
Three	$12,980	$17,264	$25,960	$38,940
Four	$15,600	$20,748	$31,200	$46,800
Five	$18,220	$24,233	$36,440	$54,660

Section 2

Low-Income Working Parents Struggle Unsuccessfully to Afford Health Care for Their Children

Many low-wage working parents labor all day doing the work that makes California run. They work in bakeries and barber shops, book stores and florists. They are waitresses, health care and contruction

workers, and hotel staff; they pump gas and pick crops. Unfortunately, this hard work does not provide them with what it takes for a California family to get by.

Low-income working families commonly earn too much to qualify for Medi-Cal,[8] but too little to purchase their family's health insurance. Often their employers do not provide coverage for their workers. Even the most inexpensive, bare-bones, children-only health insurance policies are out of reach when a family has no discretionary income with which to purchase it. (See Appendix I.)

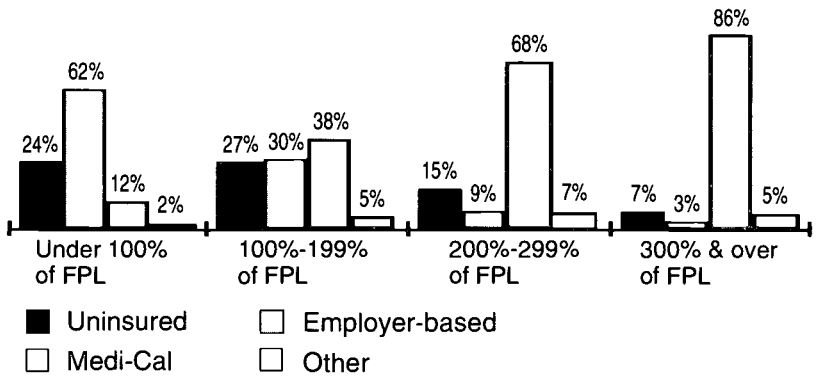
Over one-quarter of all children under 200% of the FPL are uninsured. **(Graph 5)** Below is a glance at the insurance status of California's children between 100% and 200% of the FPL:

- just 30% of the children in these families receive Medi-Cal benefits;[9]
- only 38% of their children obtain employer-based coverage;[10] and
- sadly, 27%—about 607,000 children—have no coverage at all.[11]

Some working parents cannot afford the peace of mind that comes from taking a sick child to the doctor. For parents with adequate resources to provide the basics for their children, it is difficult to imagine the unthinkable choices that parents must make and live with when they are surviving at the edge.

Graph 5

Children's health insurance sources, by Federal Poverty Level, 1995



1996 CPS, calculations by UCLA, CHPR

One Story

Two Parents, Three Jobs, No Health Insurance

For Wendy Johnson, the task of getting health care for her six children is an ongoing struggle. Her children, ages 13, 14, 15, 17, 20 and 21 have been uninsured for about ten years. During that time, Wendy has run a child care center and her husband has worked as a taxi driver, chauffeur and tax advisor, often holding down more than one job at a time. However, none of these jobs has offered health insurance coverage for their children. "I know I could get Medi-Cal if my husband and I quit our jobs—but we want to keep working. It seems unfair that our children can't get health care because we want to keep our jobs."

Wendy often cannot get health care for her children until their illnesses deteriorate enough to merit a trip to the emergency room. Wendy tries to treat their medical conditions herself whenever she can. Since no provider offers consistent care for her children, the children's medical records are scattered throughout several different clinics, emergency rooms and medical offices, making it very difficult for Wendy to monitor their health care and make sure theyreceive proper preventive care, and making it impossible for any health provider to monitor the growth and development of the children.

* To protect the confidentiality of the uninsured children described in these stories, all names have been changed.

When low-income parents know that the entire cost of care will have to be paid out of pocket, they may decide, albeit with great trepidation and anxiety, to postpone a visit to a specialist or not to pursue a recommended medical test. These parents are forced to choose priorities from among the essentials—rent, utilities, food and health care.

A 1987 Gallup poll found that more than one half (56%) of all families with incomes between 100% and 150% of the FPL reported that, at some point during the year, they were unable to afford food, clothing or medical care. More than a third (34%) of those with incomes between 150% and 200% of the FPL reported the same experience.[12] **(Graph 6)**

In 1994, over 1.2 million[13] children in California lived with a parent who earned less than $5.75 per hour, the state minimum wage which will take effect on March 1, 1998.[14] At $5.75 per hour, a family of four with one full-time worker earns an annual wage of just $11,500—$4,100 below the 1996 FPL. Even with two full-time minimum wage earners, the family income would be only $23,000 per year or $1,917 per month. For children of minimum-wage workers, the chances of having private health insurance, or discretionary income to purchase health services, are slim.

Monthly household budget for a California family of four with two full-time minimum wage earners[15]

Income	$1917
Expenditures	
Rent	$700
Utilities	$100
Food	$520
Child Care	$400
Transportation	$130
Clothing	$ 30
School Supplies & Activities	$ 37
All Other Expenses	$ 0
Total	$1917

(The "All Other Expenses" category includes: health care, baby-sitters, children's allowances or other spending money, cleaning supplies, books, lessons, toys, birthday and holiday presents, furniture, utensils, postage, haircuts, movies, ball games, any public establishment that charges admission, cable TV, vacations, appliance repair, emergencies or other unanticipated major expenses.)

One Story

Families Facing Tough Economic Decisions May Sometimes Make the Wrong Choice

Kate's family earns too much to qualify for Medi-Cal, but not enough to pay for their own insurance. So when their three-month-old visited a community clinic with symptoms suggesting meningitis, the doctors decided to observe her progress there instead of sending her immediately—and with great cost—to the emergency room.

Three hours later, the doctors saw that Kate needed tests available only in a hospital. Again, keeping costs in mind, the doctors substituted the ideal procedure (ordering an ambulance) with a more affordable option: Kate's parents were to drive her immediately to the hospital.

But soon after the family left the clinic, Kate's father considered that within the next few hours he would be taking on an enormous debt. Each night his daughter spent at the hospital would cost thousands of dollars. Could one more night at home make that much difference? He persuaded his wife that it wouldn't, and they drove home.

The next morning, Kate's condition had clearly worsened and her parents rushed her to the emergency room. Kate was admitted to the intensive care unit. A tube was inserted to help her breathe, but she developed aspiration pneumonia (when stomach contents enter the lungs). This complication increased the number of days the infant had to stay in the hospital, driving up the cost of her care even further. As her clinician says, "Kate's care was compromised by her lack of insurance."

"I feel very guilty for not buying the insurance, but sometimes I can't cover our rent... I just keep my fingers crossed."

—Story of a working mother who can't afford health insurance for her five-year-old boy

Section 3

The Odds Are Worse for Children, Depending on Where Their Parents Work

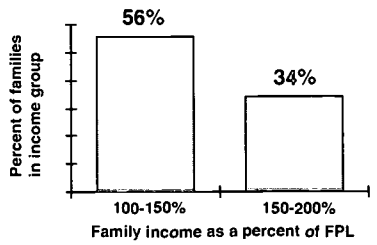
It is not how hard you work that determines whether your child will have health insurance, it is where you work. Children whose parents work in personal services, entertainment and recreation services, construction, agriculture, forestry and fishing are particularly likely to be uninsured, as are children whose parents work for smaller firms. However, low-income workers in firms of all sizes are at risk.

- Children with parents who work for smaller firms face the highest risk of being uninsured. Twenty-nine percent of children with parents working for firms with less than 10 employees lack coverage.[16] **(Graph 7)**
- Of all uninsured children with employed parents, more than one-third (35%) live with parents working for small firms (under 10 employees).[17] Large firms, however, also play a significant role; one-quarter (26%) of all uninsured children with employed parents are dependents of workers in firms with more than 100 employees.[18] **(Graph 8)**

Not all low-income uninsured children come from homes where the parents work. Some uninsured children have parents who are ready, willing and able to work but cannot find a job. Others may be illiterate or lack job skills. Some parents of uninsured children are themselves sick and unable to produce the income necessary to provide health insurance. Others neglect their children's basic needs. Regardless of how they came to be uninsured, every child needs and deserves the benefits of adequate health care.

Graph 6

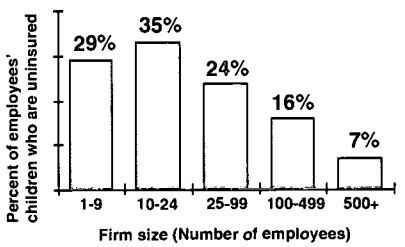
Families who reported being unable to afford food, clothing or medical care sometime during 1987



Schwartz, J., Volgy, T. (1992) The Forgotten American. New York, NY: W.W. Norton & Company, Inc.

Graph 7

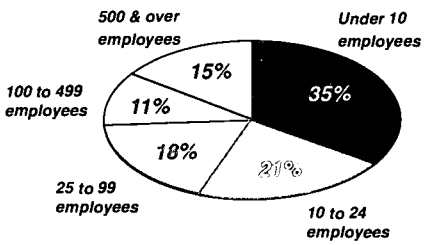
Percent of employee's children who are uninsured in California, 1995



1996 CPS, calculations by UCLA, CHPR

Graph 8

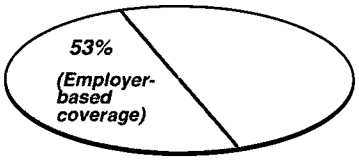
Uninsured California children with working parents, by size of parent's employer, 1995



1996 CPS, calculations by UCLA, CHPR

Graph 9

Children in California with employer-based insurance, 1995



1996 CPS, calculations by UCLA, CHPR.

Graph 10

Forty-one states had lower rates of uninsured children in 1994 than California

☐ States with lower rates of uninsured children than California

☐ States with higher rates of uninsured children than California

1995 CPS, calculations by the Urban Institute.

Section 4

Trends In Insurance Coverage Work Against Working Families

While marketplace reforms are spurring rapid changes in health care finance and delivery, some working families have lost job-based coverage for their children. This national trend started at least two decades ago:

- currently, the national percentage of children with job-based coverage is 58%;[19]
- California's percentage of children covered by job-based health insurance is even lower than national rates: only 53% of children have job-based health insurance coverage;[20] **(Graph 9)**
- from 1977 to 1987, national rates of children with employer-based coverage declined from 68% to 63%. This decline in employer-based coverage accounted for the bulk of the 40% national increase (about 3.1 million children) in the number of uninsured children during this period.[21]

Medi-Cal: Slowing the Increase in Uninsured Children

In recent years, increases in the number of children covered by Medi-Cal helped offset the erosion of job-based coverage. The percentage of children enrolled in Medi-Cal jumped from less than one in five (19%) of all California children in 1989 to one in four in 1995.[22] This shift resulted from children who lost employment-based coverage and also from Medi-Cal eligibility expansions.[23] Increasing poverty also pushed more children into Medi-Cal. In 1989, 22% of children lived below the poverty level; in 1994 that percentage swelled to 28%.[24]

Even though Medi-Cal expansions extended coverage to more children in low-income working families, the problem was by no means solved for this population. Sixty percent of uninsured children in California live with at least one parent who works full-time.[25]

Absent major changes in public policy, many children will remain uninsured. Despite some income-based Medi-Cal expansions, a large portion of uninsured children remain ineligible for Medi-Cal. Moreover, both proposed and recently enacted federal and state legislation jeopardize the coverage for thousands of currently enrolled children. (See Chapter 4 for a discussion of public policy building blocks for expanding Medi-Cal.)

Section 5

Hundreds of Thousands of Uninsured Children of Low-Income Working Families are Entitled to Medi-Cal but are Not Enrolled

In 1994, approximately 500,000 uninsured children in California met the family income eligibility requirements for Medi-Cal, but were not enrolled in the program.[26] These children composed roughly one-quarter of California's uninsured children in 1994. Most of these eligible-but-unenrolled children live in working families. A national study of Medicaid in 1993 found that 80% of children who were entitled to Medicaid but unenrolled had at least one working parent, and 43% had at least one parent working full-time.[27]

Many parents may be unaware their children are eligible for public insurance. One study in North Carolina and Tennessee found that, in those states, 41% of Aid to Families with Dependent Children (AFDC)[28] recipients and 23% of former AFDC recipients did not understand that a parent could work full-time and receive Medicaid for his or her child.[29] Working parents in California may be especially unlikely to realize their children qualify for Medi-Cal: the state recently raised the income that families on Medi-Cal may earn, but has not conducted the outreach necessary to inform these working families. (See Chapters 3 and 4 for further discussion of this issue.)

Important Facts about California's Uninsured Children

- Children in California are particularly likely to grow up without health insurance coverage; 41 states have lower rates of uninsured children than California.[30] **(Graph 10)**
- Most uninsured children live in two-parent families.[31]
- Children of color are disproportionately likely to be uninsured. Latino children face the greatest risk of being uninsured, with 29% lacking coverage. Twelve percent of Asian-American children are uninsured, while African-American and Anglo children are about equally likely (10%) to be uninsured.[32]
- Not all uninsured children come from low-income families. Twenty-seven percent of California's uninsured youth (433,000) have family incomes above 200% of the FPL.[33] (Two hundred percent of the FPL is $25,960 for a family of three.)

One Story

A Working Mom Balances Housing Against Health Care

Nancy Peterson is one of a growing number of American workers who puts in long hours at her job but, as a temporary employee, remains ineligible for a company benefits package. She's not concerned about herself, but she is worried about her five-year-old son Jeremy. "It's scary not having insurance for him," she says. "I just keep my fingers crossed."

The temp agency Nancy works through offers health insurance, but she would have to pay for the coverage for both herself and her son. At more than $200 each month, Nancy can't afford the policy. "I feel very guilty for not buying the insurance, but sometimes I can't cover our rent."

Nancy wishes she had a regular source of care for her son, who is having severe problems adjusting to school. Less than one month into the school year, he had already been sent to the principal's office several times for acting out aggressively. Nancy bought books about parenting and child development, but they didn't help.

If Jeremy were enrolled in Medi-Cal, he'd automatically be eligible for counseling services. Nancy has thought about taking lower paying jobs so that she would qualify for Medi-Cal for her son, but doesn't think that's right. She says that she's frustrated because she knows that her son's problem could quickly spiral out of control without immediate help, but she doesn't know what to do.

One Story

Slipping Through the Cracks: Lost First By His Family — Second By The System

Peter lives on the streets and in the abandoned buildings of Hollywood. He has some emerging psychological disorders, but can still get himself to a clinic for his health care. During one of his recent examinations, the doctor noticed a lump in one of Peter's testicles, a sign that Peter might have testicular cancer.

The doctor sent Peter to a county hospital for evaluation and treatment. He called ahead to his colleagues there, alerting them to Peter's case and asking them to look out for the teenager. Peter went to the hospital twice, each time waiting for 12 to 14 hours in the crowded, confusing, sometimes hostile environment of the emergency room. He couldn't afford to buy any food at the hospital and he had to hitch rides back to his Hollywood neighborhood at night. Giving up on that hospital, Peter called his doctor for another referral. He went to this second hospital, but with the same result.

As far as the doctor knows, Peter never received treatment.

Summary

Uninsured children are by and large caught in an unforgiving gap. In most cases their parents work and are not eligible for public health insurance. They work in low-wage jobs making the purchase of private insurance or basic health services prohibitive. These working parents face unthinkable choices as they balance one necessity—rent or utilities—against others—child care, health care and food.

Endnotes

[1] All federal poverty level amounts in this paper are for 1996.

[2] In 1995, approximately 1,605,000 children under age 18 in California lacked health insurance. U.S. Bureau of the Census, Current Population Survey, March, 1996, calculations by UCLA Center for Health Policy Research ("1996 CPS, calculations by UCLA CHPR"). (Note: all CPS estimates reflect data gathered in the prior year.) More than 6.6 million Californians under age 65 lack insurance coverage. CPS, 1995, calculations by UCLA CHPR . Nationally, about 10 million children, or 14% of all youth, lack insurance coverage. Government Accounting Office (1996). *Health Insurance for Children: Private Insurance Coverage Continues to Deteriorate.* GAO/HEHS-96-129. Of all non-elderly Americans in 1993, about 40.9 million lacked coverage. Fronstin, P. (1995). *Children Without Health Insurance: An Analysis of the Increase of Uninsured Children Between 1992 and 1993.* Inquiry. 32: 353-359.

[3] The Current Population Survey estimates of uninsured children cited in this report include only children who reportedly received no coverage throughout the entire year prior to the survey. Comparisons with another health insurance coverage survey, the Survey of Income and Program Participation, however, suggest that the CPS estimates of uninsured individuals more accurately reflect the number of people who were uninsured for at least a portion of the previous year. Bennefield, R. (1996). *A Comparative Analysis of Health Insurance Coverage Estimates: Data from CPS and SIPP.* Paper presented at the Joint Statistical Meetings, Chicago, Illinois, August 6, 1996.

[4] In this report, the term "parent" includes adults living in a child's household who could be covered by the same insurance policy as the child.

[5] 1996 CPS, calculations by UCLA CHPR.

[6] 1996 CPS, calculations by UCLA CHPR.

[7] 1996 CPS, calculations by UCLA CHPR.

[8] Medi-Cal is this state's version of the federal Medicaid program.

[9] 1996 CPS, calculations by UCLA CHPR.

[10] 1996 CPS, calculations by UCLA CHPR.

[11] 1996 CPS, calculations by UCLA CHPR. The remainder have CHAMPUS (Veteran's Affairs/military), privately purchased insurance, or Medicare.

[12] Schwartz, J., Volgy, T. (1992). The Forgotten Americans. NY, New York: W. W. Norton & Company, Inc.

[13] 1995 CPS, calculations by the California Budget Project.

[14] The current federal minimum wage is $4.25 per hour. The California minimum wage law, passed in the November 1996 election, will raise the minimum wage to $5.00 per hour on March 1, 1997 and to $5.75 per hour on March 1, 1998.

[15] Assumes a minimum wage of $5.75 (which takes effect in California on March 1, 1998); a 40 hour work week; and 50 working weeks per year.

[16] 1996 CPS, calculations by UCLA CHPR.

[17] 1996 CPS, calculations by UCLA CHPR.

[18] 1996 CPS, calculations by UCLA CHPR.

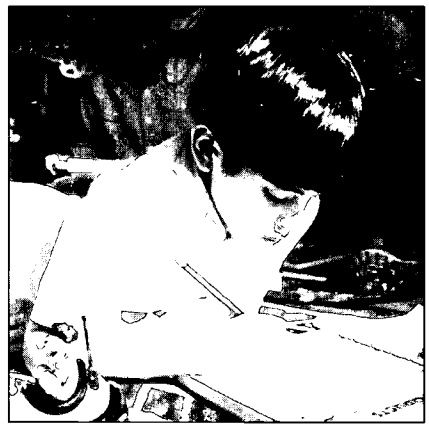
[19] 1996 Current Population Survey, calculations by the Employee Benefit Research Institute.

[20] 1996 CPS, calculations by UCLA CHPR.

[21] Monheit, A., Cunningham, P. (1992). *Children Without Health Insurance.* The Future of Children. 2:154 -170.
[22] 1996 CPS, calculations by UCLA CHPR.
[23] See Appendix D on public programs for children for a detailed description of Medi-Cal eligibility requirements.
[24] Children Now (1996). *California: The State of Our Children '96, Report Card Supplement.*
[25] 1996 CPS, calculations by UCLA CHPR.
[26] 1993, 1994 and 1995 March Current Population Survey. Calculations by the Center on Budget and Policy Priorities. This estimate includes all children who met the age and family income eligibilty requirements for Medi-Cal during those years. Because Medi-Cal's Federal Poverty Level programs impose some additional eligibility requirements, such as a maximum assets test for children over one year of age, some income-eligible children may not have qualified for the program. Only children under age 11 were considered because, in 1994, Medi-Cal's Federal Poverty Level programs covered only children in this age group.
[27] Government Accounting Office (1995). *Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion.* GAO/HEHS-95-175.
[28] AFDC was California's primary government benefits program for low-income families. The recently enacted federal welfare reform law has replaced AFDC with the Temporary Assistance for Needy Families (TANF) program.
[29] Shuptrine, S., Grant, V., McKenzie, G. (1994). *A Study of the Relationship of Health Coverage to Welfare Dependency.* Columbia, SC: Southern Institute on Children and Families.
[30] 1995 CPS, calculations by The Urban Institute.
[31] Government Accounting Office (1995). *Health Insurance for Children: Many Remain Uninsured,* Op. Cit.
[32] 1996 CPS, calculations by UCLA CHPR.
[33] 1996 CPS, calculations by UCLA CHPR.

Vulnerable and Developing

Too Often Uninsured Children Pay for Their Parents' Economic Misfortunes



Chapter Highlights

- Parents who want regular health services for their children have a hard time getting care if their children are uninsured. Compared to insured children, uninsured children receive only 70% as many outpatient visits and just 81% as many hospital inpatient days.
- One national study found that among uninsured children with serious conditions, nearly two-thirds (63%) failed to see a doctor for severe sore throats and one-half (49%) failed to see a doctor for acute earaches.
- Uninsured children are three times more likely than insured children to have no regular source of care.
- Uninsured children receive only limited access to health services. Forty percent of uninsured children ages six to 17—compared to 14% of privately insured children in that age group—used no health services, including provider visits or prescription drugs, during a year of study.
- Children are in a stage of accelerated development—physically, cognitively and emotionally; consistent monitoring of children by trained health providers may deliver rewards throughout a lifetime.

Section 1

Uninsured Children's Access to a Broad Range of Services is Sorely Limited

Childhood is a time of accelerated physical, cognitive and emotional development, and parents often appreciate the positive impact regular health care can have on their child's growth. Unfortunately, for too many uninsured children, cost is a barrier to the care and monitoring our health system can provide. Parents without access to insurance and to the care their children need are often plagued with fear and uncertainty. They live surrounded by the most expansive and expensive health system in the world, but frequently cannot find a way in for their children.

Parents want their children to receive routine preventive care, to have a place to go when they are sick, and to have a health provider monitor their child's development. Parents want someone to explain children's allergies, to help manage their asthma or to say when glasses or psychological counseling are needed. This kind of help is too often out of reach for low-income working families.

Compared to insured youth, uninsured children receive only limited access to medical services, including both preventive and sick care.[1] Analyses of the 1987 National Medical Expenditures Survey (NMES) turn up an alarmingly broad deficit in the care received by uninsured children:

- forty percent of uninsured children ages 6 to 17—compared to 14% of privately insured children in that age group—used no health care services, including provider visits, prescription medicine, hospital care, dental and vision services, and medical equipment, during an entire year;[2]
- one in five uninsured children under six years of age—compared to one in 14 of their privately insured peers—used no health services during the year studied;[3] and **(Graph 11 refers to this and the previous bullet)**
- overall, uninsured children received only 70% of the outpatient visits that they would have received if they were insured and just 81% of the hospital inpatient days.[4] **(Graph 12)**

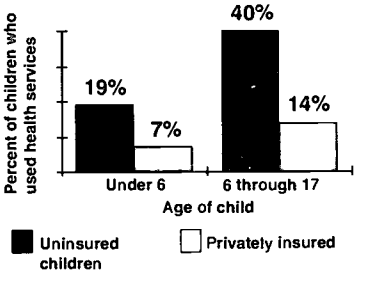
One Story

An Untreated Ear Infection, a Partially Deaf Third Grader

Shortly after Maria entered a new school as a third grader, her progress reports from her teacher indicated that she seemed to be performing far below her potential. A health examination arranged by the school Healthy Start program revealed that Maria had suffered multiple ear infections — probably over a period of several years. Maria's father ran a small yard maintenance business, but was not able to afford health insurance for her. As a result, her parents were unable to obtain treatment for her ear infections. Without timely and thorough medical attention, scar tissue within her ear had built up, causing her to become deaf in one ear and suffer hearing loss in the other.

Graph 11

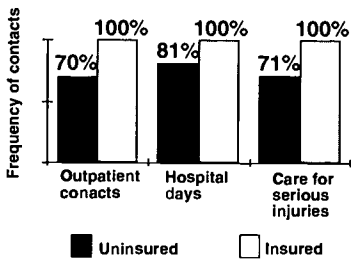
Children who used no health services throughout one year



Lefkowitz, D. and Monheit, A. (1991). *Health Insurance, Use of Health Services, and Health Care Expenditures.* (AHCPR Publ. No. 92-0017). 1987 National Medical Expenditure Suvey Research Findings 12, Agency for Health Care Policy and Research. Rockville, MD: Public Health Service.

Graph 12

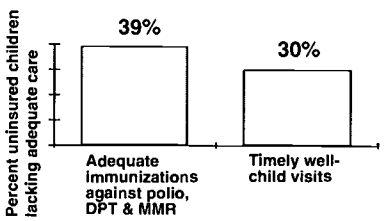
Frequency of contact with health care system (uninsured vs. insured children)



Marquis, M., Lang, S. (1994/1995). *The Uninsured Access Gap: Narrowing the Estimates.* Inquiry. 31: 405-14 (hospital days & outpatient contacts); Overpeck, M. Kotch, J. (1995). *The Effect of U.S. Children's Access to Care on Medical Attention for Inquiries.* American Journal of Public Health. 76: 178-184.

Graph 13

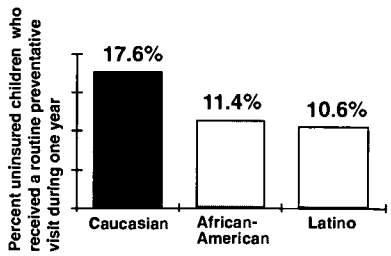
Uninsured children who fail to receive adequate preventive care



Hall, J., et. al. (1995). *Profile of Uninsured Children in the United States.* Archives of Pediatric and Adolescent Medicine. 149: 398-406 (well child visits); Himmelstein, D., Woolhandler, S (1995). *Care Denied: U.S. Residents Who are Unable to Obtain Needed Medical Services.* American Journal of Public Health. 85: 341-344 (immunizations).

Graph 14

Uninsured children who receive a routine preventive visit during one year, by ethnicity



Cornelius, J. (1993). *Barriers to Care for White, Black and Hispanic American Children.* Journal of the National Medical Association. 85(4): 281-288.

Uninsured children also are less likely to receive regular preventive care. One study showed that about 30% of uninsured children nationwide, 2.6 million youth, are not up-to-date on their well-child care visits.[5] Immunizations, a central component of well-child visits, are the single most medically effective and cost-effective intervention to reduce childhood diseases and deaths.[6] **(Graph 13)**

Uninsured children of color are even less likely than uninsured Anglo children to get health care. One national study found that while 18% of uninsured Anglo children received a routine preventive visit during one year, just 11% of both African American and Latino uninsured children received such care.[7] **(Graph 14)**

Children Paying the Price, A Case Study: Children with Whooping Cough

Uninsured children are less likely than insured children to be fully immunized.[8] One study found they lacked appropriate immunizations three times more often.[9] The national rate of properly immunized children under two sits at an already low 75% —California's rate is an even lower 72%.[10] Without adequate immunizations, children are much more vulnerable to a variety of dangerous, vaccine-preventable diseases, such as diphtheria, tetanus, measles, mumps, rubella, *Haemophilus influenzae* type b (Hib), hepatitis B virus and whooping cough (pertussis).

Whooping cough, a highly contagious and sometimes deadly respiratory disease, has an effective and readily available vaccine for children with access to health services. Whooping cough causes severe spasms of coughing that interfere with a child's breathing and cause vomiting and exhaustion. Infants face the highest risk of catching whooping cough and of developing related complications including: otitis media, anorexia, dehydration and pneumonia. Because the coughing attacks can cut the oxygen supply to the brain, children can also suffer seizures and encephalopathy (a neurologic disorder of the brain). Approximately 41% of all whooping cough cases are hospitalized, including 69% of infant cases. This preventable disease can be fatal in children under one year of age.[11]

In 1995 in California 445 cases of childhood whooping cough were reported. Among these children:

70 had pneumonia;
16 had seizures;
3 had encephalopathy; and
4 children died.[12]

Much of this suffering—and its related expenses—could be eliminated by providing children insurance and thereby expanding their access to immunizations for whooping cough and a range of vaccine-preventable diseases.

28

Section 2

Uninsured Children May Not Receive Medical Care Even When They Are Sick, Injured or Chronically Ill

Many Californians probably assume that uninsured children will at least receive medical attention when they are injured or ill. However, even children with urgent needs are less likely to receive crucial care. A national study found that, of uninsured children with serious conditions, nearly two-thirds (63%) of those with severe sore throats and one-half of those with acute earaches or asthma failed to see a doctor.[13] (**Graph 15**) Untreated, these uninsured children faced higher risks of long term complications, including hearing loss, speech and language deficits, and respiratory failure.

Children with injuries also are less likely to get medical care if they lack insurance. One study estimated that uninsured children were only 73% as likely as insured children to receive medical care for an injury. Even more alarming, among children under six with serious injuries,[14] uninsured children received medical attention only 57% often as insured children.[15]

Uninsured Children with Asthma: Access to Effective Care Out of Reach

Children with chronic illnesses receive less care if they are uninsured and often pay a high price for this neglect. For example, uninsured children with asthma (the most common chronic illness for children)[16] are twice as likely to receive no medical care and seven times more likely to lack a regular source of care.[17] The prevalence of asthma is increasing, and is particularly high among low-income children,[18] a population more likely to be uninsured and therefore medically underserved.

With proper preventive care, the suffering associated with asthma can be significantly eased. Programs that help families better manage a child's asthma have reduced the related number of emergency department visits and days spent in the hospital. These programs improved health and saved money.[19] Without insurance, however, asthmatic children are less likely to receive medical care that could minimize their symptoms and asthma attacks.

One Story

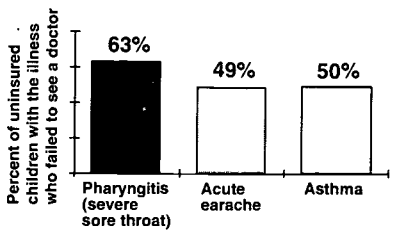
Even Dramatic Injuries Sometimes Don't Get the Care They Need

Sixteen-year old Lawrence came to the school nurse's office at his high school in Fresno after injuring his hand at soccer practice. His hand was severely swollen and the nurse suspected it was broken, so she told his parents to take him immediately to the emergency room for an X-ray and follow-up treatment. His parents, both of whom work, could not afford to take the nurse's advice. They knew that if they went to the emergency room, their son would incur not only X-ray charges, but also a radiologist fee and a doctor's visit fee — charges they could not pay. A nearby clinic does provide care to some uninsured people, but it does not offer X-ray services.

A week later, when Lawrence returned to the school nurse, he was still experiencing extreme pain and the swelling in his hand had not subsided at all. Because swelling generally is reduced within a day or two, the nurse considered the continued swelling further evidence that Lawrence's hand was seriously injured and probably broken. To the knowledge of the school nurse, Lawrence never received care for his injury.

Graph 15

Uninsured children who fail to see a doctor despite suffering a condition that needs a physician's care



Stoddard, J., St. Peter, R., and Newacheck, P. (1994). *Health Insurance Statistics and Ambulatory Care for Children.* New England Journal of Medicine. 330 (20): 1421-25.

One Story

A Chronic Need for Care Drives a Family into Chronic Debt

Jane is an eight-year-old girl with asthma. Like many asthmatics, she needs routine care and daily medication to manage her condition. But unlike asthmatics with insurance, her access to care is severely limited.

Since Jane's parents don't have insurance and can't afford to pay for doctors' visits or medication, Jane only gets treated during acute episodes. For medication, Jane must rely on hospital samples, which help her regulate her condition, but only when she's able to get them.

When Jane's asthma flares up, her parents bring her to an emergency room. Sometimes, the doctors will treat Jane for free, but at other times her parents are charged for their daughter's care. The family can rarely afford to pay these bills.

As a result, over the past few years, Jane's parents have accumulated overwhelming debts at many of the local hospitals. Each time their daughter has a serious asthma attack, they have to find a new hospital where they don't owe any money. Although they try to pay some of their hospital balances every month, they are constantly in debt and behind on payments.

Section 3

Uninsured Children Are Less Likely to Have a Provider They Know and Trust to Follow Their Growth and Development

Children with a usual source of health care receive higher quality care.[20] With regular care, families can develop trust in a familiar physician that may make them more comfortable in divulging information and more responsive to their doctor's recommendations.[21] Similarly, family physicians may be more sensitive to relatively subtle clues regarding the nature of a child's condition.[22] Accumulated knowledge about a child's family and health history can help a physician more accurately assess a young patient's problem. When children consistently see the same medical team, providers are more likely to recognize behavior problems in the children.[23]

Unfortunately, those without health insurance are less likely to have a usual source of health care.[24] For many low-income working families, routine health care becomes an unaffordable luxury. For these families, when their children get very sick, and home remedies clearly will not work anymore, the emergency room becomes the primary source of care for their children. In these emergency rooms, children with ear infections often compete with stab wound and car accident victims for the attention of stressed staff. Consistent care and attention from a regular health provider remain unreachable goals:

- uninsured children are three times less likely to have a regular source of care;[25] **(Graph 16)**
- children without a usual source of care are less likely to be completely immunized and have lower rates of well-child visits;[26]
- children with a regular source of primary care are twice as likely to keep follow-up appointments[27] and to take medications prescribed to them.[28] They are also less likely to contract preventable illnesses.[29]

A three-year study of children enrolled in Medicaid found that those who remained with the same provider had fewer hospital admissions and lower overall costs than those who changed providers.[30]

Access to Dental Care Is a Serious Problem for Children Without Insurance

Dental care is also a serious concern for children who lack insurance:

- a study conducted by the California Department of Health Services found that more than one in four (26%) preschool children studied had no dental insurance;[31]
- each year more than three of four uninsured children go without dental care.[32] Insured youth, in contrast, are more than twice as likely to obtain oral health services.[33]

Preventive dental care is crucial to children's oral and general physical health. Early treatment of baby bottle tooth decay, for example, which results from the misuse of a baby bottle for feeding, is essential to prevent further tooth destruction and pain.[34] Neglecting children's oral health can not only cause severe pain and tooth loss, but also lead to other health problems, such as malnourishment in children who cannot chew their food, severe psycho-social problems, pneumonia and systemic infection.[35]

Uninsured Children Also Face Non-Financial Barriers to Care

In part, uninsured children receive fewer health services because families cannot afford to pay for care.[36] Parents of uninsured children face many additional obstacles to obtaining medical care for their children. For example, they are more likely to face a travel time of 30 minutes or more, to encounter waiting periods of at least one hour, and to have a usual source of care that lacks after hours emergency care.[37]

Section 4

Childhood—The Time When Health Care Can Make the Difference between a Head Start and a Rough Start

When children fail to receive consistent monitoring of their development[38] or are not promptly treated when they are ill or injured, they can not only suffer the effects of the immediate problem, but also risk delayed or permanently impaired development. On the other hand, when a child is fortunate enough to receive prompt and consistent care, the rewards affect many aspects of the child's maturation. Numerous studies demonstrate the importance of timely and consistent care:

One Story

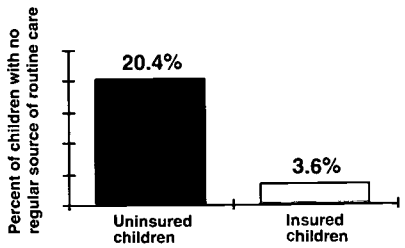
Cost Effective Prevention Is Unaffordable for Some Families

Andrew, who lives near Porterville, California, hadn't slept for nearly a week because of a toothache. He'd been complaining of the pain for two months, but his parents hadn't taken him to the dentist earlier because they couldn't afford the care. Just five years old, Andrew had two lower teeth that were severely infected and five others that were in an advanced stage of decay.

Andrew's family did not have health insurance, but qualified for the clinic's sliding scale program. In one visit, two of the infected teeth were removed. The family made an appointment for work on the other decayed teeth, but didn't keep it. The dentist believes that the family didn't feel right about returning until they could pay off their balance. In the mean time, Andrew's teeth will just get worse.

Graph 16

Insured and uninsured children with no regular source of routine care



Holl, J., et. al. (1995). *Profile of Uninsured Children in the United States*. Archives of Pediatric and Adolescent Medicine. 149: 398-406.

"Without timely and thorough medical attention, scar tissue within Maria's ear had built up, causing her to become deaf in one ear and suffer hearing loss in the other."

— Story of an uninsured, partially deaf child

- especially for families of pre-school age children, the health care system often acts as the first point of entry to a network of community services for children and their families, providing referrals to a wide range of valuable services, including nutritional counseling, injury prevention, parenting skills and developmental issues;[39]
- primary care providers can monitor a child's growth and identify developmental or behavioral disorders, psycho-social issues related to chronic illness, educational problems and signs of child abuse;[40]
- when health care providers fail to identify health conditions that could impair learning, the child's family and teachers may miss opportunities to adapt a child's education and living environment;
- health care providers can offer teens crucial counseling about a wide range of health-related behaviors and conditions, including drug abuse, sex, violence and depression. In a recent poll, 82% of youth ages 11 to 17 said they would be willing to discuss health and safety concerns with their health professional. Seventy-five percent would trust a doctor "a lot"—a significantly higher rate than that for teachers (44%) or television shows (5%);[41]
- children are more susceptible to environmental toxins than adults, and exposure to toxins can often be detected only through laboratory screens. For example, lead poisoning, which can cause learning disabilities, is generally only identifiable through a blood test;[42] and
- failure to treat recurrent ear infections can lead to hearing loss and related learning disabilities.[43]

Summary

Childhood is a time of growth when access to appropriate health providers can strengthen children's cognitive, physical and emotional development. However, for low-income families who cannot afford health insurance, regular care is often unaffordable and, according to numerous studies, unavailable. Frequently, the medical attention uninsured children of low-income families receive is in crowded emergency rooms.

"He'd been complaining of the pain for two months, but his parents hadn't taken him to the dentist earlier because they couldn't afford the care."

– Story of an uninsured five-year-old boy with infected teeth

Endnotes

[1] In addition to insurance status, many other factors influence children's access to medical care, such as ethnicity and income. To isolate the effects of being uninsured, this report has, whenever possible, cited research findings that adjust for other factors that affect health status and medical service utilization.

[2] Lefkowitz, D., Monheit, A. (1991). *Health Insurance, Use of Health Services, and Health Care Expenditures* (AHCPR Publ. No. 92-0017). National Medical Expenditure Survey Research Findings 12, Agency for Health Care and Policy Research. Public Health Service: Rockville, MD. Although the NMES is based on data gathered in 1987, many current studies are based on the NMES data because it provides a uniquely comprehensive database of medical expenditures and utilization data.

[3] Lefkowitz, D., Monheit, A. (1991). *Health Insurance, Use of Health Services,* Op. Cit.

[4] Marquis, M., Long, S. (1994/1995). *The Uninsured Access Gap ,* Op. Cit.

[5] Holl, J., *et. al.* (1995). *Profile of Uninsured Children in the United States.* Archives of Pediatric and Adolescent Medicine. 149:398-406.

[6] US Congress, Office of Technology Assessment (1988). *Healthy Children: Investing in the Future.* Washington, DC: US Government Printing Office (OTA-H-345).

[7] Cornelius, J. (1993). *Barriers to Medical Care for White, Black, and Hispanic American Children.* Journal of the National Medical Association. 85(4):281-288.

[8] Wood, D., *et. al.* (1990). *Access to Medical Care for Children and Adolescents in the United States.* Pediatrics. 86:666-73.

[9] Humiston, S., *et. al.* (1993). *Decision Rules for Predicting Vaccination Status of Preschool-age Emergency Department Patients.* Journal of Pediatrics, 123:887-92.

[10] Califorina Department of Health Services, Immunization Branch (1996). *Immunization Update.* August 8, 1996.

[11] Centers for Disease Control and Prevention (1995). *Epidemiology of Vaccine-Preventable Diseases.* Department of Health and Human Services.

[12] Phone conversation and faxed confirmation with Karen Swanson, Research Analyst with the California Department of Health Services, Immunization Branch, December 6, 1996.

[13] Stoddard, J., St. Peter, R., Newacheck, P. (1994). *Health Insurance Status and Ambulatory Care for Children.* New England Journal of Medicine. 330(20):1421-25. This study also is based on data from the 1987 National Medical Expenditures Survey (NMES). (See endnote 2 for a discussion of NMES.)

[14] Serious injuries were those that resulted in restricted activity, bed days, surgery, hospitalization, or substantial pain.

[15] Overpeck, M., Kotch, J. (1995). *The Effect of US Children's Access to Care on Medical Attention for Injuries.* American Journal of Public Health. 85:402-404.

[16] Weitzman, M. *et. al.* (1992). *Recent Trends in the Prevalence and Severity of Childhood Asthma.* Journal of the American Medical Association. 268 (19): 2673-77, citing Newacheck, P., Budetti, P., Halfon, N. (1986). *Trends in Activity Limiting Chronic Conditions Among Children,* American Journal of Public Health. 76: 178 - 184.

[17] Holl, J., *et. al.* (1995). *Profile of Uninsured Children,* Op. Cit.

[18] Weitzman, M. *et. al.* (1992). *Recent Trends in the Prevalence and Severity of Childhood Asthma,* Op. Cit.

[19] Lewis, C., *et. al.* (1984). *A Randomized Trial of Asthma Care Training for Children.* Pediatrics. 74:478-86; McNabb, W. *et. al.* (1985). *Self-management Education of Children with Asthma: AIR WISE.* American Journal of Public Health. 75:1219-20, cited in Taylor, W., Newacheck, P. (1992). *Impact of Childhood Asthma on Health.* Pediatrics. 90(5):657-662.
[20] Starfield, B.(1992). Primary Care: Concept, Evaluation, and Policy. New York, NY: Oxford University Press.
[21] Starfield, B. (1992). Primary Care, Op. Cit.
[22] Starfield, B. (1992). Primary Care, Op. Cit.
[23] Becker, M., Drachman, R., Kirscht, J. (1972). *Predicting Mothers' Compliance with Pediatric Medical Regimens.* Journal of Pediatrics. 81:843-854; Kogan, M., *et. al.* (1995). *The Effect of Gaps in Health Insurance on Continuity of Care Among Preschool-aged Children in the United States.* Journal of the American Medical Association. 274(18):1429-35.
[24] Wood, D., *et. al.* (1990). *Access to Medical Care for Children and Adolescents,* Op. Cit.
[25] Holl, J., *et. al.* (1995). *Profile of Uninsured Children,* Op. Cit.
[26] McDaniel, D., Patton, E., Mather, J. (1975). *Immunization Activities of Private-Practice Physicians: A Record Audit.* Pediatrics. 56(4):504-507; Alpert, J. *et. al.* (1976). *Delivery of Health Care for Children: Report of an Experiment.* Pediatrics. 57:917-930, cited in Kogan, M., *et. al.* (1995). *The Effect of Gaps in Health Insurance,* Op. Cit.
[27] Spivak, H., Bonanno, R. and Cracknell, M. (1980). *Patient and Provider Factors Associated with Selected Measures of Quality of Care.* Pediatrics. 65:307-13, cited in Starfield, B. (1992). Primary Care, Op. Cit.
[28] Becker, M., Drachman, R., Kirscht, J. (1972). *Predicting Mothers' Compliance with Pediatric Medical Regimens,* Op. Cit.
[29] Gordis, L. (1973). *Effectiveness of Comprehensive Care Programs in Preventing Rheumatic Fever.* New England Journal of Medicine. 289:331-35, cited in Starfield, B. (1992). Primary Care, Op. Cit.
[30] Flint, S. (1987). *The Impact of Continuity of Care on the Utilization and Cost of Pediatric Care in a Medicaid Population.* Unpublished doctoral dissertation, University of Chicago, cited in Starfield, B. (1992). Primary Care, Op. Cit.
[31] California Department of Health Services, Maternal and Child Health Branch (1995). *Our Children's Teeth: Beyond Brushing and Braces.* Sacramento, CA.
[32] Agency for Health Care Policy and Research (1994). *Children Without Health Insurance: Use of Health Services in 1977 and 1987.* Intramural Research Highlights, National Medical Expenditure Survey, No. 30.
[33] Agency for Health Care Policy and Research (1994). *Children Without Health Insurance: Use of Health Services in 1977 and 1987,* Op. Cit.
[34] California Department of Health Services, Maternal and Child Health Branch (1995). *Our Children's Teeth,* Op. Cit.
[35] US Department of Health and Human Services, Public Health Service (1991). *Healthy People 2000: National Health Promotion and Disease Prevention Objectives — Full Report with Commentary,* 349-64, Washington DC, DHHS Publ. No. (PHS)91-50212.
[36] Holl, J., *et. al.* (1995). *Profile of Uninsured Children,* Op. Cit.
[37] Newacheck, P., Hughes, D., Stoddard, J. (1996). *Children's Access to Primary Care: Differences by Race, Income, and Insurance Status.* Pediatrics. 97(1):26-32.
[38] The Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics (AAP) recommends that children receive a series of "well-child" visits, including eight visits during the first year of life, six over the next four years, visits every other year to age 11, and then annual visits until age 21. (American Academy of Pediatrics (1996). *Recommendations for Preventive Pediatric Health Care.* Pediatrics. 96(2). At these visits, children receive developmental and behavioral assessments, physical examinations, and immunizations.
[39] Perrin, J., Guyer, B., Lawrence, J. (1992). *Health Care Services for Children and Adolescents.* Future of Children. 2(2):58-77.
[40] Perrin, J., Guyer, B., Lawrence, J. (1992). *Health Care Services for Children,* Op. Cit.
[41] Children Now and Kaiser Permanente (1995). *Campaign for Children's Health and Safety, Poll Summary.* Oakland, CA: Children Now.
[42] Needleman, H. (1994), *Preventing Childhood Lead Poisoning.* Preventive Medicine. 23:634-637
[43] Stoddard, J., St. Peter, R., Newacheck, P. (1994). *Health Insurance Status,* Op. Cit.

Gaps in the Public System

Leave Uninsured Children without Health Care Basics

Chapter Highlights

- California's public health system for uninsured children consists of a puzzling array of programs, each with varying eligibility criteria and enrollment processes that leave low-income children with uncertain or no coverage depending on their age, health condition, and small fluctuations in their parent's incomes.
- About one in four of California's uninsured children is income-eligible for Medi-Cal but not enrolled.
- California's Access for Infants and Mothers (AIM) program only covers children up to age two. Then, regardless of their income or whether they have any source of insurance or care, the program drops their coverage. Each month 350 to 400 children lose AIM coverage on their second birthdays.
- California's Children's Treatment Program, a companion program to the state's Child Health and Disability Prevention program (CHDP), provides limited funding to care only for conditions identified as "new" and only when they are identified at a CHDP screening.

Section 1

The Gaps within and between Many State Health Programs

Publicly funded health care services for children in California are provided through a fragmented patchwork of programs that leave 1.6 million mostly low-income children uninsured and without needed health care. Recognizing the crisis in 1991, the California Legislature directed the Department of Health Services to devise a plan for better organizing health services to women and children. A Steering Committee of health experts,[1] appointed by the state's own Department of Health Services to advise the Department, reported on the existing "puzzling array" of programs:

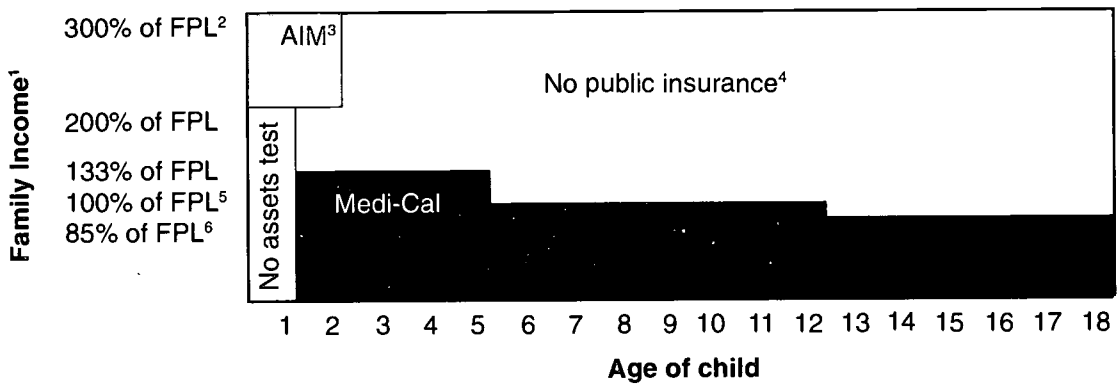
> [The system] is composed of a number of programs which focus on certain health problems for special populations, rather than address overall health care needs....[T]hey frequently have confusing eligibility criteria, enrollment processes, payment levels, billing methods, and covered services. The result is a puzzling array of programs that place the burden on families and providers to piece together comprehensive care. To make matters worse, these programs have been chronically underfunded, and therefore, are unable to serve all who are eligible for them. For these, and other reasons, large numbers of women and children in California who need and are entitled to health care are unable to obtain it.
>
> —Delivering the Future: Recommendations from the AB 99 Steering Committee Regarding Health Care for Women, Children, and Adolescents in California. (1992)

Many of these gaps are in the largest public health programs for low-income California children. Medi-Cal, Access for Infants and Mothers (AIM), the Child Health and Disability Prevention program (CHDP), the Children's Treatment Program (CTP), California Children's Services (CCS), the Regional Center Programs and county health systems together reach millions of children. Some children receive a comprehensive set of benefits. Others receive sporadic care, limited in scope and at times available only when particular medical conditions arise. A close look at eligibility criteria, enrollment processes and variations in benefits reveals irrational systems with critical gaps not only within each program, but also among programs. **(Graph 17)**

One such example of a gap *between* programs is the poorly coordinated eligibility criteria between Medi-Cal and AIM. As the chart of public programs above shows, AIM covers children during their second year of life if they have family incomes between 200% and 300% of the FPL. Medi-Cal, however, covers children in that age range only if their families earn no more than 133% of the FPL. Children with family incomes between these two ranges (between 133% and 200% of the FPL) illogically qualify for neither.[2] Irrationally, and sometimes tragically, these young children remain uninsured.

Graph 17

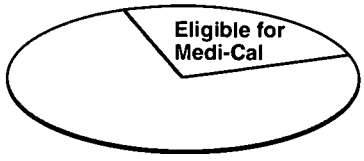
California Public Health Insurance Programs for Children, Ages 0-18



[1] Families also must show their assets and property are valued below a certain amount. This "test" is waived for pregnant women and children under one year old.
[2] FPL - Federal Poverty Level.
[3] Access for Infants and Mothers. Families must pay 2% of gross family income for the child's first year, plus $100 for the child's second year of coverage.
[4] Children with family incomes not exceeding 200% of the FPL qualify for the Child Health and Disability Prevention Program (CHDP), which provides health assessments and screens. The state-funded Children's Treatment Program (CTP) provides limited follow-up treatment for new conditions identified in CHDP screens. Because of program and funding limitations, however, the CTP program fails to meet many children's health needs. See Section 5 for a full discussion.
[5] Children over five years old with family incomes up to 100% of the FPL are covered by Medi-Cal if they were born after September 30, 1983. In 1996, this expansion covers children between the ages of 6 and 12 and some 13 year olds. Under current federal law, older children will be gradually phased-in until 2002, when all children through age 18 with family incomes under the FPL should be covered.
[6] Medi-Cal's Medically Needy and Medically Indigent programs cover children after their family has spent on the child's medical care any non-exempt income they have earned each month above Medi-Cal's "Monthly Maintenence Need Level (MMNL):. The MMNL varies depending on family size, and ranges from 93% of the FPL for one person to 76% for a family of ten. Most families' MMNL is between 80% (seven person family) to 87% (2 person family) of the FPL.

Graph 18

Approximately one-quarter of all uninsured children are eligible for but not enrolled in Medi-Cal



1993, 1994, 1995 March Current Population Surveys, U.S. Census Bureau, (pooled data), calculations by the Center on Budget and Policy Priorities.

Section 2

Medi-Cal

Medi-Cal, California's participation in the federal Medicaid program, covers more than 2.5 million children[3] with a comprehensive insurance package (See Appendix D.) About one quarter of the state's 9 million children receive Medi-Cal benefits.[4]

Over the years Medi-Cal patients have found access to fee-for-service physicians difficult. In 1993 the state decided to move AFDC Medi-Cal recipients into managed care. This change presents a new set of challenges to Medi-Cal patients and the providers who traditionally served this population. The Medi-Cal discussion herein confines itself to a brief survey of some of the system's esoteric eligibility and application rules that have served to keep many low-income and needy children out of the Medi-Cal system.[5]

1. Medi-Cal's arcane application process, its welfare stigma and its lack of outreach leave hundreds of thousands of eligible children needlessly uninsured.

California could provide coverage to a significant percentage of uninsured children simply by making sure that children who already are eligible for Medi-Cal actually enroll in the program. Approximately 500,000 uninsured children in California in 1994 met the family income eligibility requirements for Medi-Cal but were not enrolled in the program. These children represented approximately one-quarter of California's uninsured children in 1994. (**Graph 18**) Among all uninsured children young enough to qualify for Medi-Cal's income-based Federal Poverty Level Program (children under 11 in 1994), about one-half were income-eligible for Medi-Cal but not enrolled in the program.[6]

The overwhelming majority of uninsured children live with parents who work for low wages—many of these parents may be unaware that their children could be eligible for Medi-Cal. In recent years, California expanded Medi-Cal eligibility to cover some children from the state's poorest working families, including many who do not qualify for cash benefits. According to some studies, far too often families incorrectly believe they cannot receive public health insurance for their children if they work full-time, live in a two-parent family,[7] or do not receive cash assistance.

For the fortunate families who discover they may qualify, the next hurdle to enrollment occurs through a logistically complex, time-consuming application process. In fact, according to a study in three Southern states, about one-half of Medicaid application denials are made for procedural reasons.[8] Specific obstacles to enrollment include:

A. *The application process is long and complex.*

The long and complex Medi-Cal application form requires applicants to list separately each type of income and asset available to them including, for example, the value of any clothing the applicant receives either for free or in exchange for work. Applicants also must provide extensive supporting documentation for most information provided on the form.

The complexity of the application process is due, in part, to Medi-Cal's historical link with the welfare system. In an effort to minimize fraudulent applications for cash benefits, the welfare system imposes extensive requirements to gather and verify applicant information. Because Medi-Cal benefits were historically provided almost exclusively to welfare recipients, the application processes for both programs have been combined, requiring non-cash assistance Medi-Cal applicants to go through the same cumbersome procedures as people applying for cash assistance.

B. *Welfare offices, where families generally are required to apply, are frequently difficult and stigmatizing for low-income working parents to visit.*

To apply for Medi-Cal, families must complete an interview with a Medi-Cal eligibility worker who helps them complete the application form. While a limited number of eligibility workers are stationed in hospitals and other community-based locations, most families must travel to a welfare office to complete an interview. Transportation poses a significant barrier for many parents, who may need to take several buses to get to the office. Parents also may need to find and pay for child care and take time off from low-wage jobs, which generally means losing dollars critical to making ends meet.

"Tony's mother is concerned that [the nose bleeds] are signaling a more serious illness but...[s]ince his family can't afford the cost of a doctor's visit, and he isn't yet allowed another CHDP appointment, Tony will have to wait to receive his care."

— Story of a family relying on CHDP, but not receiving necessary care

"Ironically, the more Eileen's parents work the less likely they are to have insurance that actually helps their child."

— Story of a girl whose working parents cannot afford the costs of her health care

The current application process also exacerbates the stigma associated with government benefits programs. By making families travel to a welfare office, complete a lengthy interview with an eligibility worker, fill out a long form and supply extensive supporting documentation—all to obtain health insurance for their children—the state unnecessarily deepens the internal conflicts many families feel when applying to government programs.

2. ***Medi-Cal only serves those children from the poorest families and in limited age groups.***

Medi-Cal serves only some children from the poorest families, leaving many children from very low-income working families ineligible for coverage. For example, the following groups of children generally do *not* qualify for Medi-Cal:

- children ages one through five with family incomes above 133% of the FPL; and
- children over five with family incomes above 100% of the FPL.[9]

For example, a single parent with a seven and an eight year old who makes $12,980 or more a year would not be able to obtain Medi-Cal coverage for her children. This would also be true for a single parent of a four year old if she made $13,779 or more annually. Families earning such low incomes do not have the discretionary income to purchase health insurance and they are highly unlikely to get health insurance coverage for themselves or their children through their employers. (See Chapter One.)

3. ***For low-income children, even those with big medical needs, Medi-Cal coverage can be sporadic and undependable.***

Some children with higher family incomes can qualify for Medi-Cal's Medically Needy and Medically Indigent programs—but only during the months their families have spent almost all of their income[10] on medical expenses. The income families can keep, while still receiving Medi-Cal benefits for the month, constitutes about 80% to 87% of the FPL, depending on family size.[11] These families, in other words, must impoverish themselves each month before they qualify for assistance.

Whenever a parent gets a job, a raise, or fails to update a Medi-Cal form properly, their child risks rejoining the ranks of the uninsured. All Medi-Cal recipients must frequently complete paperwork to retain their continued eligibility for the program. Families of children in AFDC/TANF[12]-linked Medi-Cal need to complete updated forms each month. Families of children who receive only Medi-Cal, with no cash assistance, must turn in updated forms every three months. In addition, as soon as any change occurs that disqualifies the child—such as a parent's raise—families must immediately notify Medi-Cal.

As a result of this and other Medi-Cal eligibility wrinkles, children on Medi-Cal are less likely than those with private insurance to remain continuously insured. Nationally, the average child on Medicaid remains continuously enrolled in the program for only about eight or nine months.[13] One national study of preschool children found that those with public insurance were three times more likely than privately insured children to be insured for only part of the year.[14]

The erratic nature of Medi-Cal coverage seriously undermines children's access to health care services. Compared to privately insured children, children covered by Medicaid are less likely to receive hospital care, ambulatory care, dental and vision services, and prescribed medications[15] and are more likely to lack a regular source of care.[16]

Section 3

Access for Infants and Mothers (AIM)

Through the state's Access for Infants and Mothers program (AIM), families with incomes between 200% and 300% of the FPL can purchase subsidized private insurance for pregnant mothers and children until they reach their second birthday. Families contribute two percent of their family income for the first year of coverage and $100 for the child's second year. During September 1996, AIM insured 3,000 women and 6,000 children. Annual costs for AIM for the 1994/95 fiscal year were $39 million for women and $13.5 million for children.

One Story

For One Father, Working Harder Means Receiving Less Help When His Child Needs It the Most

Two-year-old Eileen has a severe case of baby bottle tooth decay. Most of her teeth have rotted away. Since she's so young and the problem is so extensive, she'll have to undergo surgery with general anesthetic in a hospital. Both of her parents work and have an annual family income of just over $30,000. They earn too much for full-coverage Medi-Cal, but neither of their jobs provides insurance.

The family decided to apply for the Medi-Cal Medically Indigent program. They were accepted, but had to pay a $700 share of the costs of care each month. Although this cost was out of their reach, they realized that their daughter's surgery was necessary and vowed to find ways to pay the initial $700 of Eileen's medical bills.

The month before Eileen's surgery was scheduled to take place, the toddler's father worked more than usual at his construction job. With his increased salary, he had to reapply for the Medi-Cal Medically Indigent program. This time, the program set the share of the costs that the family had to pay at $1600 a month, more than doubling the amount they would have to pay for Eileen's health care before Medi-Cal would contribute any funds. Ironically, the more Eileen's parents work the less likely they are to have insurance that actually helps their child.

- **AIM stops insuring children when they reach their second birthday.**

AIM is a targeted program with a reputation for innovative outreach to identify and bring women in early for prenatal care. Successful at attracting and insuring pregnant women and their new infants, the program, unfortunately, drops these children when they reach the age of two. All two-year old children are dropped from AIM coverage regardless of whether they have any other source of health insurance or care. Each month 350 to 400 children lose AIM coverage on their second birthdays.

Through its array of medical providers, including private pediatricians and other physicians, community clinics, and county clinics and related health facilities, the CHDP program has established a long record of providing important health assessment and immunization services to California's children. However, the availability of follow-up care identified as necessary by CHDP medical providers and the availability of medical care to address episodic illnesses and other medical conditions which are not identified through the CHDP screening process have often been limited. As a result, in many parts of the state, necessary medical care is not provided to children, particularly young children, at the earliest possible time."[18]

— Wilson Administration Report, 1995

Section 4

The Child Health and Disability Prevention program (CHDP)

The Child Health and Disability Prevention program (CHDP) provides periodic health assessments and immunizations to children enrolled in Medi-Cal, and to non-Medi-Cal children with family incomes below 200% of the FPL, and to certain other groups, such as children in Head Start and state preschool programs. In fiscal year 1995/96, CHDP provided 1,186,000 screens to children not enrolled in Medi-Cal. Projected state CHDP costs for fiscal year 1996/97, for non-Medi-Cal children, totals $68.9 million.[17]

- **For children who depend on CHDP, getting follow-up care is a chancy business.**

CHDP provides screening and immunizations at periodic, usually infrequently scheduled visits. These screenings are free to eligible children. However, the CHDP program itself provides no follow-up treatment and no inpatient care. In an attempt to reduce this gap in services, the state funds the Children's Treatment Program (CTP) to provide limited follow-up treatment for children who are eligible for CHDP but not for Medi-Cal.[19] CTP is available only under limited circumstances (See Opposite)

Schedule of CHDP Health Assessment Visits[20]

Age	Number of periodically scheduled CHDP visits
Up to age 1	6 visits
Age 1	2 visits
Age 2	1 visit
Age 3	1 visit
Ages 4 and 5	1 visit
Ages 6, 7 and 8	1 visit
Ages 9, 10, 11 and 12	1 visit
Ages 13, 14, 15 and 16	1 visit
Ages 17, 18, 19 and 20	1 visit

Section 5

The Children's Treatment Program (CTP)

The Children's Treatment Program (CTP)[21] provides follow-up care under particular conditions for some CHDP-eligible children. Counties can either contract with the state to administer CTP in their county or accept a lump sum from the state and assume the obligation to provide CTP follow-up treatment for all eligible children. Some counties may draw from county funds in order to fulfill this responsibility. This program leaves several crucial gaps in care for low-income children:

- **The Children's Treatment Program provides treatment *only under limited circumstances.***

Unlike children receiving Medi-Cal, who are entitled to continuing services for most of their health needs, children enrolled in CHDP alone receive follow-up diagnosis and treatment through CTP only under special conditions:

1. only if the condition is identified during a periodically scheduled CHDP screen; *and,*
2. only if the condition is deemed a "new" condition.

One Story

A Program's Gaps Leave a Child Sick and Waiting

For six-year-old Tony, playing in his Fremont neighborhood is not always fun. Whenever he runs around for more than a few minutes, he gets a nose bleed. His mother is concerned that this symptom is signaling a more serious illness. But Tony's only health care comes through the Child Health and Disability Prevention (CHDP) program. As a result of the program's strict periodicity schedule, the next time he's allowed to see a doctor is in five months. Even then, the Children's Treatment Program will cover treatment only if Tony's provider classifies his condition as "new". Since his family can't afford the cost of a doctor's visit, and he isn't yet allowed another CHDP appointment, Tony will have to wait to receive his care. If his condition deteriorates quickly, he'll probably have to receive care from an emergency room.

One Story

A Sick Teen, An Expensive Test and No One to Pay for It

Martina is a nurse at a public health clinic. She knows that her clinic is a crucial source of care for uninsured children, but recognizes that its limited funding affects the breadth of care it can provide.

Martina remembers one particularly vivid example when her clinic was not able to meet a patient's needs fully. A seventeen-year-old named Lucy came into the clinic saying that she thought she was pregnant: she had stopped menstruating some months ago and her abdomen was beginning toexpand. But when Martina examined Lucy, she couldn't find a fetal heart beat. Further examination revealed that Lucy wasn't pregnant: she had an enormous cyst that was spreading throughout her abdomen.

Lucy needs a CAT scan to determine the exact nature of the cyst, but the clinic doesn't have one. It would be impossible for Lucy to pay for the hospital test herself. Once the CAT scan has been done, an OB/GYN from the clinic will perform the surgery at a sliding scale fee. But the surgery will have to wait until Martina figures out a way to get Lucy the expensive examination.

The first requirement (treatment only for conditions identified during a periodically scheduled CHDP screen) means that if a child becomes sick or is injured between these scheduled visits the parent cannot rely on CTP for care. The number of screens to which a child eligible for CHDP is entitled is limited. While infants during their first year of life receive fairly frequent CHDP visits, assessments for older children are scheduled much less often (see chart in Section 4). Children are not eligible to come in for care for illnesses or injuries that occur between periodically scheduled screens.

The second requirement, that a condition must be "new" to be treated, means that CTP will not reimburse providers if they treat a condition that was "known" before the CHDP exam was conducted.[22] Thus, if a child comes to a CHDP visit with a sprained hand or a sore throat, and the provider considers the problem a "known" condition, the CTP program would not cover treatment. The rationale for this restriction is based on the original purpose of CHDP—to provide *preventive* care and to identify conditions that otherwise would remain undetected.

Low CTP Reimbursement Levels Create Provider Shortage

CTP programs often struggle with a shortage of providers because they pay low reimbursement levels. Currently, for example, the state CTP program reimburses providers at 85% of the Medi-Cal and Denti-Cal reimbursement levels. Previously, the reimbursement rates had been even lower—just 70% of Medi-Cal and Denti-Cal rates.[23]

Inyo County has a serious shortage of dentists willing to treat children through the CTP program. The dentists in the county who accept CTP clients are so overwhelmed that they will agree to see only children with the most severe dental problems, such as large cavities and chronic abscesses. Children with relatively mild dental problems, such as small cavities, gingivitis (red, puffy or tender gums), and moderate plaque and calculus accumulation (oral preventive care recommended) generally cannot receive care. Low CTP reimbursement rates have prevented many children from receiving preventive dental care, forcing them to wait until their conditions deteriorate to severe problems before they can obtain treatment. [24]

Section 6

Programs for Children with Special Health Care Needs are Available but Not all Sick or Disabled Children Meet the Criteria

Public programs including SSI-linked Medi-Cal, California Children's Services (CCS) and the state's Regional Centers provide much-needed specialized health services for children with special health care needs. These programs, however, are limited to children whose conditions fit varying definitions and whose family income and assets are below varying levels.

Section 7

The Struggling County Health System

State law requires California counties to provide care for medically indigent patients.[25] A network of county hospitals and clinics and county agreements with private providers are in place to address this requirement. Unfortunately, the needs of indigent patients usually far exceed the resources available at the county level for indigent care.

Summary

California's current public system for children is a confusing, gap-filled rag-tag of programs. Each program has its own eligibility criteria and enrollment processes, leaving low-income children with uncertain or no coverage depending on their age and health condition. Small fluctuations in their parent's income can jeopardize eligibility. Many uninsured children slip through the gaps in this fragmented system and suffer from needless developmental delays, untreated injuries and preventable illnesses.

Endnotes

[1] The Steering Committee included a wide range of child health professionals and policy experts from both the public and private sectors, state and local government officials, advocates, and representatives of foundations, physician associations such as the American Academy of Pediatrics, and California's schools of public health.

[2] As explained more fully in Appendix D, all children are eligible for Medi-Cal's Medically Needy or Medically Indigent programs—once their families pay a certain "Share of Cost" each month and show they meet a maximum assets test. For most families earning between 133% and 200% of the FPL, the Share of Cost they would need to pay each month is much higher than the $100 annual premium (about $8.00/ month) families must pay for their child's second year on AIM.

[3] Calculations made by the California Department of Health Services reflect the number of children under age 20 enrolled in Medi-Cal during October, 1995.

[4] 1996 CPS, calculations by UCLA CHPR.

[5] Medi-Cal itself, moreover, is tremendously complex. Even the Supreme Court agrees: "The Social Security Act [including Medicaid] is among the most intricate

One Story

A Five Year Old Dies While a Clinic Searches for a Free Specialist

Five-year-old Joseph was brought to the clinic by his mother because his eye was mysteriously red, as if it had been bruised. His family had brought Joseph to the clinic just a few months earlier for his kindergarten physical. His parents don't receive insurance from their employer, but earn too much to qualify for Medi-Cal. They pay all of their medical expenses themselves.

Two days later, Joseph's test results came back. He had leukemia. The clinic began to try to find a hospital hematologist who would see him and provide him with crucial, immediate services. But the clinic couldn't find a hematologist who would agree to take the uninsured child right away.

That weekend, Joseph's condition suddenly worsened. His parents brought him to the local emergency room, where he died.

"If this had happened to someone with insurance," said a clinic nurse, the child would have been immediately taken to a big hospital" and might have had a chance.

"If this had happened to someone with insurance," said the clinic nurse, " the child would have been immediately taken to a big hospital and might have had a chance."

— Story of a five year old uninsured boy who died of leukemia

ever drafted by Congress. Its Byzantine construction . . . makes the [Medicaid] Act 'almost unintelligible to the uninitiated.'" *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981), quoting *Friedman v. Berger,* 547 F.2d 724, 727 n.7 (2nd Cir. 1976). State and federal Medicaid statutes have been found to be the equivalent of "the Serbonian bog" referenced in John Milton's *Paradise Lost,* Book II, line 592 (1667) ("A gulf profound as that Serbonian bog . . . [w]here armies whole have been sunk." in *Cherry by Cherry v. Mangnant,* 832 F.Supp. 1271, 1273 fn 4 (S.D. Ind. 1993). *Friedman v. Berger,* 409 F. Supp. 1225, 1225-26 (S.D. N.Y 1976) called it an "aggravated assault on the English language, resistant to attempts to understand it. . ." (Quotes assembled by Protection and Advocacy, Inc. (1996). *Medi-Cal: Service Rights and Entitlement Programs Affecting Californians with Disabilities.*)

[6] 1993, 1994, and 1995 March Current Population Survey, U.S. Census Bureau, calculations by the Center on Budget and Policy Priorities.

[7] Shuptrine, S., Grant, V., McKenzie, G. (1994). *A Study of the Relationship of Health Coverage to Welfare Dependency,* Op. Cit.

[8] Government Accounting Office (1994). *Health Care Reform: Potential Difficulties in Determining Eligibility for Low-Income People.* GAO/HEHS-94-176. The procedural reasons for application denials were: 1) the applicant could not or did not provide the basic documentation needed to verify their eligibility or 2) the applicant did not appear for all the eligibility interviews.

[9] Children older than five with family incomes below 100% of the FPL are covered if they were born after September 30, 1983. (As of October, 1996, this program covered children through age 13.)

[10] When calculating income, Medi-Cal does not consider a few types of "exempt" income, such as a capped amount of child care expenses.

[11] The income a family can keep varies depending on family size, and ranges from 93% of the FPL for one person to 76% for a family of ten. Most families can keep between 80% (seven person family) to 87% (2 person family) of the FPL.

[12] The recently-enacted federal welfare reform law replaced AFDC with the Temporary Assistance for Needy Families (TANF) program. See Appendix D for a discussion of AFDC/TANF-linked Medi-Cal.

[13] Rosenbaum, S. (1996). *Children and the Health Care System: An Overview.* Prepared for the Carnegie Foundation.

[14] Kogan, M., *et. al.* (1995). *The Effect of Gaps,* Op. Cit.

[15] Lefkowitz, D., Monheit, A. (1991). *Health Insurance, Use of Health Services,* Op. Cit.

[16] Kogan, M., *et. al.* (1995). *The Effect of Gaps,* Op. Cit.

[17] When combined with a federal Maternal and Child Health grant of $6.3 million, total federal and state spending for services for non Medi-Cal CHDP children equals $75.2 million.

[18] Pete Wilson, Governor of California; Sandra R. Smoley, R.N., Secretary, Health and Welfare Agency; and S. Kimberly Belshé, Director, Department of Health Services. *California REACH Program: California Reaching Early Access for Children's Health.* January 10, 1995. Sacramento, CA.

[19] Children who are enrolled in one of Medi-Cal's "Share of Cost" programs, such as the Medically Needy Program, qualify for CTP if they have not yet met their Share of Cost for the month during which they need follow-up treatment.

[20] California Department of Health Services (1996). *Primary Care and Family Health: Annual Report Fiscal Year 1994-1995.* Sacramento, CA.

[21] Counties that administer their own programs use different names for this program, but this paper will use the term "Children's Treatment Program" to refer to both the state and the county-run programs to provide follow-up treatment to children who receive CHDP but not Medi-Cal.

[22] California Department of Health Services, Office of County Health Services (1992). *Children's Treatment Program, Medical Services, Policies and Procedures Manual* (Addendum added January 1995).

[23] California Department of Health Services, Office of County Health Services (1992). *Children's Treatment Program, Medical Services, Policies and Procedures Manual* (Addendum added January 1995); phone conversation with James Ford, Chief, Contract Back Unit, Office of County Health Services, California Department of Health Services, November, 1996.

[24] Phone conversation with Tamara Pound, Clinical Services Director, Inyo County Health and Human Services, September, 1996.

[25] California Welfare and Institutions Code, Section 17,000.

An Affordable Solution

Where We Go From Here

Chapter Highlights

- Since many California children with the most expensive medical conditions are already covered, the remaining uninsured population of children is a very low-cost group.
- California has failed to take advantage of hundreds of millions of federal dollars available to the state for extending health insurance for children and ranks 47 out of the 50 states in terms of federal Medicaid payments per person in poverty.
- Many new federal funds could become available at no extra cost to the state if California consolidated dollars from several funding streams which now do not receive a federal match.
- Under current California Department of Health Services (DHS) reimbursement rates, providing a full-benefit Medi-Cal service package for uninsured children could cost only about $50 per month per child, plus the cost of administration.
- If every uninsured child under age 19 in households under 300% of the federal poverty level were insured through a Medi-Cal expansion, the entire total state share of costs could range between $544 and $665 million. Each newly insured child would cost the state between $376 and $458 annually. Many of these dollars already exist in the system today.

Purpose and development of this chapter

The first three chapters in this report demonstrated the need for a more accessible public health insurance system for children. This chapter establishes the feasibility of creating such a system. While this chapter does not recommend one particular solution, it does set out some of the broad issues that need to be addressed. For a breakdown of policy decision points required for a policy solution, see Appendix A. Further analysis of each of these building blocks will be provided in another Children Now publication, "California's Working Families and Their Uninsured Children: Policy Building Blocks for Change."

Development of this chapter included:

- establishment of an advisory committee of California health care experts;[1]
- interviews with reformers from other states; and
- extensive consultation with the California Department of Health Services.

America's health financing and delivery systems have undergone rapid political and market-place changes in recent years. Unlike comprehensive proposals under consideration in the early 1990s, 1996 saw incremental, bipartisan reform at both the national and state level.[2] Incremental changes with bipartisan support may now be possible in California. It is important that incremental health insurance expansions, at either the state or federal level, meet the principle: *Incremental reform options should advance and not undermine future comprehensive reform to expand coverage to all groups.*

Section 1

Increasing Enrollment Among Uninsured Children Who Already are Eligible for Medi-Cal

California could cover a significant portion of uninsured children simply by making sure that all children who already qualify for Medi-Cal actually enroll in the program. (See Chapter 3, Section 2 for further discussion.) To increase enrollment of these eligible-but-unenrolled children, the state could:

1. Streamline the Application Process

California could make it much easier for families to apply for Medi-Cal by creating a streamlined application process for families of children eligible for the Federal Poverty Level programs (see Appendix D). Potential streamlining steps include:

- **Create a simplified application form.** Because the eligibility requirements for the Federal Poverty Level programs are more simple than those for other Medi-Cal programs, the state could create a simplified application form for these applicants.
- **Eliminate the assets test.** Eliminating the assets test for children in the Federal Poverty Level programs would further simplify the application form and significantly reduce the amount of supporting documentation required. *Forty other states already have waived the assets test for these programs.*[3]
- **Allow applicants to apply via a mail-in form.** With a simplified Federal Poverty Level program application form, California could waive the requirement of a face-to-face interview and instead allow families to apply via a mail-in application. *Twenty-one other states already have taken this step.*[4] A simple mail-in form could be made widely available in locations frequented by low-income families, such as schools and child care centers.

These steps would eliminate many logistical barriers to enrollment, reduce administration costs and eliminate much of the welfare-related stigma inherent in the current application process.

2. Conduct Outreach to Potentially Eligible Families

Since many families of eligible children may not know they qualify for Medi-Cal, the state could further increase enrollment by conducting more outreach to potentially eligible families. The state, for example, could:

- **Conduct Public Education.** A state-wide public education campaign could implement many creative strategies, such as radio and television announcements and fliers distributed through churches, schools and other organizations serving low-income families. A simplified mail-in form would strengthen these outreach efforts because it could be distributed along with basic information about Medi-Cal.

- **Increase Outstationing of Eligibility Workers.** Federal law requires the state to place outstationed Medi-Cal eligibility workers in Federally-Qualified Health Centers and Disproportionate Share Hospitals. This allows families to complete the application process at certain health provider locations, without traveling to a welfare office. Some counties also place outstationed workers in other community-based locations, such as school-linked health centers. These programs could be expanded to many other locations serving low-income families. In addition, the state could train and compensate staff at these locations to: 1) identify and refer potentially eligible children; 2) help families obtain the necessary documentation; and 3) help families complete the application form. Federal matching funds are available for these expenses.[5]

Section 2

Insuring California's Children–An Affordable Solution

- **Currently uninsured children are inexpensive to cover**

Uninsured California children would be among the least expensive populations to insure in the state. Medi-Cal and various other state programs already exist to care for the state's most medically expensive children.[6] (See Appendix D for a thorough description of programs.)

Some might fear that extending health coverage to uninsured children would attract high-risk, high-cost children. Evidence from other states suggests otherwise. When the United States General Accounting Office (GAO) examined five major state expansions of children's health insurance, every program manager reported that "the children served were not significantly sicker and did not use services more than privately insured children."[7] If California expanded coverage to the uninsured children of low-income working families, it should expect the same.

- **Estimating the costs—benefits and administration**

Providing health insurance involves two major costs: (1) benefits (visiting doctors, treatment, etc.); and (2) intake and administration (signing up for the program, updating eligibility, overhead, administrative work involved in reimbursing providers, etc.).

1. Benefits—children are inexpensive to cover

The California Department of Health Services ran reports detailing the cost of providing Medi-Cal benefits to AFDC non-foster care children,[8] a group that closely resembles California's currently uninsured children (low-income children with relatively low health risks). The total cost of benefits (both federal and state share) for these children ages one through 18 was $50 per month per child. This finding confirms that not all children are expensive to cover. Other Medi-Cal populations and other sources of insurance also provide care at low costs as well. For example:

- strictly income-eligible children (federal poverty level program) ages one through five cost Medi-Cal $42/month;[9] and
- CaliforniaKids, which uses private funds to provide comprehensive outpatient services (no inpatient benefits) to children who do not qualify for Medi-Cal, costs under $33/month per child.[10]

All of these groups consist of low-cost children from working families—just like the large majority of California's uninsured children.[11]

2. Intake and administration costs—room for improvement

Intake costs are those associated with signing up new beneficiaries; administration costs include ongoing verification of eligibility, overhead, and costs associated with paying providers. Fiscal year 1996/97 Medi-Cal intake costs are $120 per new enrollee; monthly administration costs exceed $20 per member.[12]

In 1995, when the California Department of Health Services proposed expanding outpatient and preventive health coverage for children ages one through five, they proposed a streamlined intake and case maintenance system based on experience from the CHDP and AIM programs. Projections for intake, semi-annual income reporting, program development, and fiscal intermediary costs were estimated around $70 annually per eligible child[13]—quite different from the then-current Medi-Cal system costs of $115 for intake plus monthly $18 administration costs per member—a potential savings of over $240 a year per child.[14]

"The inability of the federal government to enact broad based health care reform makes it clear that the laboratory for targeted health care reform efforts is at the state level."[18]

—Wilson Administration Report, 1995

- **Streamlining the Medi-Cal Application Process for Children**

Medi-Cal's complicated and cumbersome welfare-linked application process bloats intake and administration costs and creates unnecessary barriers to enrollment. On their own, Medi-Cal intake and administration/ renewal costs are equal to more than one-half of the annual service costs for a $50/month insurance package. De-linking the Medi-Cal application process for children from the welfare system[15] —as many other states have done—could dramatically streamline the application process and reduce intake costs. (See Chapter Three, Section Two for further discussion of Medi-Cal's application process.)

Several options exist not only to save dollars by cutting intake and administrative expenses but—also of great importance—to make it easier for families to enroll in Medi-Cal. Potential actions include developing a low-cost, quick-response eligibility verification system. See Section One for futher discussion of streamlining options.

- **Cost-out Projections**

If every uninsured child under age 19 in households under 300% of the federal poverty level were insured through a Medi-Cal expansion, the entire total state share of costs could range between $544 and $665 million. If Medi-Cal were expanded to cover all children under age 19 with family incomes up to 200% of the federal poverty level, the total state share of costs could range between $454 and $555 million. Each newly insured child would cost the state between $376 and $458 annually.[16] Many of these dollars already exist in the system today. Appendix F walks through several cost-out projections for major children's health insurance expansions.

Section 3

Working with the Federal Government to Expand Coverage for California's Uninsured Children

The Medicaid program (Medi-Cal in California) serves as the primary method for providing health coverage for low-income children. This program involves a cost-sharing partnership between the state and the federal government—with the federal government paying half the cost.[17]

- **California can take advantage of existing federal options to change Medi-Cal and tap into additional federal funds.**

Two federal options exist for changing the way California provides health insurance for children — the 1902(r)(2) option and the 1115 waiver.

1. The 1902(r)(2) option: use broader income and age requirement tests for Medi-Cal eligibility and receive federal matching funds.

Use of the 1902(r)(2) provision of the Social Security Act, enacted in 1988 and further amended in 1989 and 1990, would allow California to extend Medicaid coverage to children under the age of 19 by using broader income and assets eligibility requirements than those applied to cash-assistance populations.[19] The federal government would match state funds used to insure this new group of children.

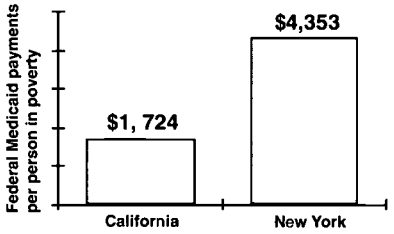
California uses this option for a limited population; as shown in Table 1 below, several other states have used it to significantly open coverage for children.

Table 1. Examples of states exercising the 1902(r)(2) option:

State	Eligibility extended up through age:	Eligibility extended up to federal poverty level of:
California	1	200%
Connecticut	13	185%
Hawaii	18	300% [20]
Kansas	15	150%
Maine	6; 6-18	185%; 125%
Michigan	16	150%
Minnesota	18	275% [21]
New Hampshire	18	185%
New Mexico	18	185%
Vermont [22]	18	185%
West Virginia	18	150%
Washington	18	200%
Wisconsin	6	185%

Graph 19

Federal Medicaid dollars per person in poverty received by New York and California



U.S. General Accounting Office, Greg Dybalski.

California, compared to other states, has failed to make use of available Medicaid dollars. In 1995, New York received 250% more per person in poverty ($4,353) than California ($1,724).[23] **(Graph 19)** In terms of Medicaid payment per person in poverty, California ranks 47 out of the 50 states. If California just received the national average of $2,381 per person in poverty, the federal government would send California an additional $3.5 billion annually.[24]

2. The 1115 waiver: option to pool funding, change benefits package, allow co-premiums, and change other core program characteristics.

Section 1115 of the Social Security Act allows states to waive provisions of Medicaid law to test new concepts and implement innovative changes congruent with the goals of the Medicaid program—as long as the solutions do not add to the federal spending share (are federal "budget neutral"). Significant, system-wide changes are possible under this provision.

Among other things, with an 1115 demonstration waiver California could pool funds already in the public health care system; initiate co-premiums; allow employer-buy-in; and make changes in the benefits package, the number of enrolled, and income eligibility restrictions. Several states have used the 1115 waiver to creatively change their health care system, including Minnesota, Tennessee, Oregon, Hawaii, Kentucky, and Rhode Island.

Hawaii: Combining the 1902(r)(2) option with an 1115 waiver

Even though an 1115 waiver assumes federal budget neutrality, a state's Medicaid baseline might be raised through a "hypothetical" 1902(r)(2) expansion. In Hawaii's 1115 waiver, the state increased its federal baseline by arguing that in the absence of the waiver it would have expanded eligibility through another allowable provision (the 1902(r)(2) option), which does not have federal budget neutrality stipulations.[25] This method enabled Hawaii to secure additional federal funds beyond the original federal budget baseline to cover newly eligible children.

Massachusetts: 1996 Bipartisan Children's Health Insurance Expansion

On July 24, 1996, with a large bipartisan coalition, the Massachusetts Legislature voted to expand children's health insurance coverage. The new legislation:[26]

- authorizes expanded Medicaid coverage for children up to age 12 at or below 200% of the FPL and for adolescents aged 13 through 18 at or below 133% of the FPL;[27]
- expands a managed care program providing primary and preventive health care services to children through age 18 with free coverage below 200% of the FPL;
- opens sliding-scale fee availability from 200%-400% of the FPL and full cost availability over 400% of the FPL; and
- obtains funding for these services through increased federal Medicaid funding and various new taxes on tobacco.

A broad, bipartisan, and inter-generational coalition supported this expansion. Supporters included children's advocates, senior advocates, disability rights advocates, health care providers, health insurers, HMOs and much of the state's business community.[28]

A Concern With Solutions: Potential Crowd Out of Private Insurance

The Concern. To the highest extent possible, policy-makers want to assure that any expansion in coverage targets only the currently uninsured and does not promote a shift of those currently insured from job-based plans to public programs. "Crowd out" refers to this substitution of public coverage (Medicaid) for employer-sponsored coverage. This substitution can occur in one of two ways: (1) an employer who currently provides health coverage for children might stop covering dependents; or (2) employees who pay a share of cost for covering their children might shift from their employer-sponsored or private coverage to a new publicly-funded health insurance program.

Solutions Exist. While the vast majority of uninsured children have no access to employer-sponsored coverage, crowd out is, nonetheless, a valid concern. When expanding coverage to children, many states (for example, Minnesota, Tennessee, Wisconsin and Florida) have taken several proactive and successful steps to mitigate potential crowd out. (See Appendix H for possible options to discourage potential crowd out.)

The Crowd Out Concern is Not Unique to Health Care. To some degree, crowd out occurs in every social insurance program. Targeting benefits precisely to only those who most need them presents both practical and political difficulties. For example, some argue that Social Security displaces private savings. In addition, all people who put money into an individual retirement account (IRA) receive a tax subsidy but some would have put money away anyway. For these people, the IRA crowds out taxable savings accounts.[29]

Section 4

Principles for Financing Expanded Coverage for Children

With will and perseverance, finding necessary funds to cover a children's health insurance expansion can be accomplished. Children are inexpensive, many needed dollars already exist in the system, and federal matching funds sit available and waiting. Children Now's Health Policy Advisory Committee developed the following principles to help guide the development of a solution for uninsured children:

General Financing Principles:

1. Health coverage for children should be sufficiently and fairly financed.
2. The financial burden should be spread broadly according to ability to pay but should not be an impediment to access.
3. Sufficient money should be allocated to provide an adequate benefits package.
4. The state should take appropriate steps to encourage enrollment of all children eligible for public programs.
5. Resources currently used to provide care to uninsured children should be folded into the funding stream, assuming these children are covered in the new program (See further discussion below.)

Cautions for re-directing existing funds

Money should only be redirected to an insurance expansion to the extent the expansion reduces the need for an existing program. Also, funds should not be re-directed if it would result in reduced services for children. Special concern should be paid to children with special health needs.

Section 5

Finding the Appropriate Sources of Funding

The 1902(r)(2) option discussed above could be used to increase the federal contribution to California's health insurance programs. In addition, the state will need to direct its own funding towards expanded health insurance coverage for California's uninsured children. These funds could come from three areas: (1) new funds covered through surplus general fund revenues; (2) redirecting dollars from existing programs that had become duplicative; and (3) new revenue.

1. Potential surplus general fund revenues: an economy in recovery

As 1997 begins, California's economy continues to grow. In Governor Wilson's May 1996 revision to the January budget submitted for fiscal year 1996/97, updated General Fund revenue estimates reflected new surpluses of $2.7 billion over three years.[30] Due to Proposition 98, a substantial portion of this budget surplus ($1.9 billion) went to schools; the bulk of the remaining funds were used to cover anticipated federal actions which did not occur but were assumed by Governor Wilson's original budget.

In the midst of economic expansion, 1.6 million children, 89% from working families, remain uninsured. California's vastly improved fiscal standing could be used to help working families by enabling them to provide security and health care for their children—an investment in the continued growth of California. However, Proposition 98 and other competing forces (higher education, corrections, welfare changes, local assistance, normal state operations) may also place claims on any surplus. Clearly, General Fund moneys alone will not be enough to fund increased children's health insurance.

2. Potential existing revenue to incorporate into expansion

This section presents seven current funding streams from which some dollars could be redirected for an expansion in children's health insurance. Each source currently provides necessary services to needy populations (See Appendix D for a description of programs.) In each case, careful, in-depth thought must occur prior to any potential redirection, especially with special needs children. The ideas presented here are intended to spark discussion. Funding for a major expansion of health coverage for children could come from redirecting some of the funding from the following sources:

- non-Medi-Cal Child Health and Disability Prevention program (CHDP);
- Access for Infants and Mothers (AIM);
- County Indigent Funds;[31]
- the Children's Treatment Program (CTP);
- non-Medi-Cal California Children's Services (CCS)(CCS provides many services not covered by Medi-Cal; no funds should be diverted from this program unless all eligible children remain enrolled in CCS and continue to receive the full range of CCS benefits);[32] and
- Proposition 99.[33]

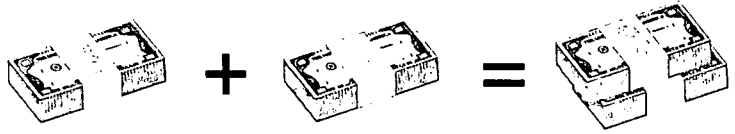
Cautions for Redirecting Funds from Existing Programs

Funds should be redirected from existing programs to a Medi-Cal expansion only to the extent the expansion duplicates coverage of children served by current programs and only if funding is maintained for services not covered by Medi-Cal.

A Unique Opportunity to Double Spending Power

If any portion of current funds used for non-Medi-Cal CHDP, non-Medi-Cal CCS, AIM, CTP, Prop 99, and county indigent services were utilized for a new Medi-Cal expansion using the 1902(r)(2) option (See Section 3), each of these state dollars could be matched with federal dollars—their purchasing power would double:[34]

State/County Spending Now | Federal Match | New Value



Another possible funding source for covering uninsured children could come from Disproportionate Share Hospital (DSH) funds to private hospitals. California designed two programs (SB 855 and SB 1255) that provide supplemental medical payments to hospitals that provide a disproportionate share of services to low-income patients. The largest and most controversial of the two programs, SB 855, was crafted to allocate funds based on a dual definition of "low-income"—patients reimbursed by Medi-Cal and uninsured patients. This dual definition allows hospitals which treat low levels of uninsured patients (but a high level of Medi-Cal patients) to receive SB 855 funds.

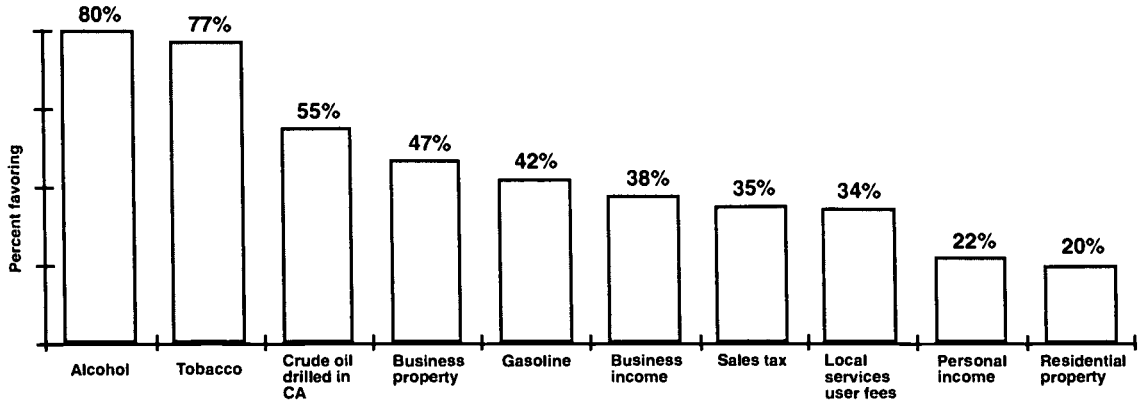
Since SB 855 was enacted in 1991, the net benefit of the program has shifted from public to private hospitals. At the same time, the level of uncompensated care provided by the public hospitals *grew* while the level of uncompensated care provided by private hospitals *fell*.[35] Opportunities may arise to target DSH funds for uninsured children as the state and federal government re-visit controversial DSH allocations.

3. Potential new revenue sources

After exhausting new General Fund surpluses, redirecting appropriate funding from current programs, and possibly obtaining federal matches for current state and county dollars, it may still be necessary to capture new state revenues to fund increased health insurance

Graph 20

Raising state revenue – Californians favoring an increase in each tax (if taxes have to be raised)



Field Research Institute, 1995[36]

coverage for children. To help lawmakers and advocates in their decision-making, Appendix G lists potential new revenue sources; where information was available, potential first year revenues were also estimated. Graph 20 (opposite) provides a sampling of how Californians feel about increasing different potential revenue sources.

Funding With Multiple Purposes: Sliding-Scale Co-Premiums for Higher-Income Families

Many states have introduced sliding-scale co-premiums for higher-income recipients. Minimal monthly premiums for families well above the federal poverty level could have several benefits: (1) a disincentive for employers to drop coverage and/or employees to switch from employer-based to public coverage; (2) a method to keep membership information up-to-date; (3) a sense of ownership and pride for recipients; and (4) a small stream of revenue to help cover costs.

Many states use subscriber co-premiums, including Minnesota's MinnesotaCare; Massachusetts' Children's Medical Security Plan; Pennsylvania's Children's Health Insurance Program; Florida's Healthy Kids; New York's Child Health Plus; Wisconsin's W-2 ("Wisconsin Works") Medicaid program; TennCare; and Washington's Basic Health Plan.

Table 2 illustrates some potential examples of sliding-scale co-premiums.

Table 2. Examples of Sliding-Scale Co-Premiums For a Household of Three with Income 200% - 300% of the 1996 Federal Poverty Level (FPL).

Percent of FPL ($)	Annual 1996 FPL of gross income($)	Monthly fee at 1% of gross income ($)	Monthly fee at 1.5% of gross income ($)	Monthly fee at 2% ($)	Uniform set fee
200%	25,968	22	32	43	20
220%	28,565	24	36	48	20
240%	31,162	26	39	52	20
260%	33,758	28	42	56	20
280%	36,355	30	45	61	20
300%	38,952	32	49	65	20

Summary

This chapter presents several important conclusions:

- uninsured children are a low-cost group to insure;
- hundreds of millions of new federal dollars could be available to California through Medicaid;
- many new federal funds could become available at no extra cost to the state if California consolidated dollars from several funding streams which now do not receive a federal match;
- California's Medi-Cal enrollment process is cumbersome and costly— substantial room for improvement exists; and
- concerns of potential crowd out of private insurance can be properly addressed through proactive state action.

The information and the opportunities exist to provide timely and needed health care for children; now we only need the political will to make it happen. For a more in-depth look at the issues presented in this chapter, contact Children Now and ask for "California's Working Families and Their Uninsured Children: Policy Building Blocks for Change."

Endnotes

[1] This group of experts became known as the "Children Now Health Policy Advisory Committee" (see page vi for a listing of committee members). No formal recommendation or endorsement for a specific policy model for state-sponsored health insurance for children was solicited from the group. Children Now is grateful for their advice concerning this chapter.

[2] Congress: Kennedy/Kassebaum (H.R. 3103) and Domenici/Wellstone (S. 2031). State: Massachusetts (Chapter 203 of the Acts and Resolves of 1996. See Section 3.).

[3] 1996 Phone Survey by Center on Budget and Policy Priorities.

[4] 1996 Phone Survey by Center on Budget and Policy Priorities.

[5] 42 Code of Federal Regulations 435.904.

[6] Some include infants, blind and disabled children, AFDC foster-care children, and those in the Medically Needy program.

[7] Government Accounting Office (1996). *Health Insurance for Children: State and Private Programs Create New Strategies to Insure Children.* GAO/HEHS-96-35.

[8] At Children Now's request, DHS ran a random sample report aggregating data from July 1995 through June 1996, providing the average monthly cost per Medi-Cal eligible for four distinct age groups: 0-1, 1-6, 7-12, and 13-18. Because infants up to age one are already covered under Medi-Cal up to 200% of the FPL and offered coverage through AIM between 200% and 300% of the FPL, their costs were not included here.

[9] "Strictly-income eligible" (or "federal poverty level" program) means that these children's eligibility is non-categorically-based—their qualification for Medi-Cal is based on age and income, not whether they are linked to a category such as AFDC, SSI/SSP or are foster care children. This number also excludes children receiving coverage through the Medi-Cal Medically Needy program.

[10] As of October 1996, CaliforniaKids covered 8,300 children. Michael Koch, Executive Director, CaliforniaKids.

[11] When DHS proposed expanding coverage to children up to age six to 200% of the FPL, proposal costs were based on actual costs from Medi-Cal strictly income-eligible children up to 133% of the FPL.
[12] Lee Kemper, Associate Director for Policy Development, Department of Health Services.
[13] These costs also include $1.5 million for first-year program development and $3.5 million for fiscal intermediary functions (claims processing costs for a fee-for-service system). Lee Kemper, Associate Director for Policy Development, Department of Health Services.
[14] Lee Kemper and Fiscal Forecasting, Department of Health Services.
[15] Although Medi-Cal applicants could apply through a simplified system independent of cash benefit programs, children who receive TANF or SSI benefits should remain automatically eligible for Medi-Cal. (See Appendix D.)
[16] These estimates assume that 100% of all currently uninsured children under age 19 would enroll in a new program—when Department of Health Services proposed an expansion of coverage in 1995, they assumed that 70.6% of eligible children would enroll. The high estimate assumes full current Medi-Cal intake and administration costs; the lower estimate assumes administrative costs could be halved (see Section 1, this chapter, for how this could occur); both estimates assume $50/month in benefit costs. If the state utilized the 1902(r)(2) option under the Social Security Act, total federal and state costs would be shared (49.77% state; 50.23% federal as of 10/96 — on 10/1/97, the federal share will increase to 51.23%). See Section Two for a discussion of 1902(r)(2). There are 239,000 uninsured children under age 19 above 300% of the FPL. These children are not covered under this assumption.
[17] The actual current share is 49.77% state and 50.23% federal — as of 10/1/97, the federal share will increase to 51.23%.
[18] Pete Wilson, Governor of California; Sandra R. Smoley, R.N., Secretary, Health and Welfare Agency; and S. Kimberly Belshé, Director, Department of Health Services. *California REACH Program: California Reaching Early Access for Children's Health.* January 10, 1995. Sacramento, CA.
[19] Rajan, S., Coughlin, T., Ku, L., Holahan, J., Lipson, D. (1994). *Increasing Insurance Coverage through Medicaid Waiver Programs: Case Studies.* Publ. No. 06433-005-02. Washington, D.C.:The Urban Institute.
[20] See "Hawaii" in Section 3.
[21] Minnesota was also granted an 1115 waiver in 1995. Use of the 1902(r)(2) option was enacted in 1992. Wenz,K. *Access: State Children's Health Insurance Programs.* American Academy of Pediatrics. This information is updated annually in AAP's "State Legislation Report."
[22] For children up to age 18 who do not qualify for Medicaid, a more limited health care program (Dr. Dynosaur) is available up to 225% of the FPL. Vermont Medicaid agency.
[23] Government Accounting Office (1996). *Federal Medicaid Payments, Average Census Poverty Counts, and Payments per Person in Poverty.* Backup information provided by GAO analyst Greg Dybalski.
[24] Calculation: ($2381-$1725)*(5,363,826 people in poverty). Based on GAO data.
[25] Holahan, J., Coughlin, T., Ku, L., Lipson, D., Rajan, S. (1995). *Insuring the Poor Through Section 1115 Medicaid Waivers.* Health Affairs. Spring, 201-209.
[26] Chapter 203 of the Acts and Resolves of 1996: An Act Providing Improved Access to Health Care.
[27] Expansions of Medicaid benefits occur through authorization of components of the Section 1115 Medicaid Research and Demonstration Waiver approved in April, 1995, and additional expansions of Medicaid not requiring federal approval.
[28] Children's Defense Fund (1996). *Update: Massachusetts Health Reform.*. August 19, 1996. Washington, DC; and interview with Steve Barnard, Fiscal Policy Supervisor, Massachusetts Budget Bureau, December 2, 1996.
[29] Center for Health System Change Issue Brief (1996). *Medicaid Eligibility Policy and the Crowding-Out Effect: Did Women and Children Drop Private Health Insurance to Enroll in Medicaid.* No. 3.
[30] $1.1 billion for FY95/96; $1.5 billion for FY96/97; and $100 million for FY97/98.

[31] County health care program expenditures for the medically indigent for state fiscal year 1993/94 (the latest data available) amounted to $1.29 billion; individuals under 21 account for 28.5% (423,319 individuals) of county indigent clients but they only account for under 10% ($124 million) of expenditures. Medically Indigent Care Reporting System (MICRS) Actual Annual Data. Medically Indigent Services Section, Department of Health Services.

[32] CCS provides many services today which Medi-Cal does not; it would be inappropriate to move any of these funds if these specialty services did not continue for these children. Money should be redirected only if any of these dollars could become Medi-Cal reimbursable from an expansion of coverage.

[33] Funded with a 25 cent tax on packs of cigarettes, Proposition 99 funds a variety of health care programs through a variety of complicated mechanisms.

[34] Some of the funding for non-Medi-Cal CHDP and AIM comes from Proposition 99 tobacco funds; current language in Proposition 99 forbids the use of these funds in part, whole, or in conjunction with a federal program. This language would need to be amended (through a 4/5 vote) prior to these funds becoming available for a federal match.

[35] From 1991/92 to 1994/95, the net benefit from SB 855 to public hospitals fell $205 million and the net benefit to private hospitals increased $199 million. In 1994, public DSH hospitals provided $1.4 billion in uncompensated care (a 25% increase from 1992); on the other hand, private hospitals provided $102 million in uncompensated care in 1994 (a 6% decline from 1992). Senate Office on Research (1995). *Disproportionate Share Hospital (DSH) Payment Program: Background Paper.* Task Force on SB 855, Senator Mike Thompson, Chair, Assemblymember Brett Granlund, Chair. Sacramento, CA. August 28, 1995.

[36] California Center for Health Improvement (1996). *Living Well: Californians Consider Public Policies That Foster Better Health.* Sacramento, CA.

Conclusion

For uninsured children in California, the stories, statistics and policy building blocks in this paper represent both heartbreak and hope. Their stories highlight the needless suffering uninsured children endure, but our final chapter demonstrates that straightforward and affordable solutions lie within our reach. Insuring these children would be affordable, the state could obtain federal matching dollars for funds invested in these youth, and California's existing public health programs could provide the foundation for expanded children's coverage.

The public wants children to have health insurance. Eighty-two percent of Americans in 1994 agreed that health care reform should guarantee complete health care coverage for all children.[1] In 1995, 75% of Americans said they would be less likely to vote for someone who had cut children's health programs.[2] Public support for expanded children's coverage can only deepen as more people learn that the overwhelming majority of uninsured children live with low-income parents who have chosen to work—even when that has meant losing publicly funded health insurance.

Every Californian who cares about children—parents, community leaders, elected officials, advocates, policy experts, teachers, and business leaders—has the power to spark a solution. Call on your elected officials for action. (See Appendix C for a roster of California elected officials). Educate members of your community group about the promising policy options California could pursue. Establish a program at your workplace to inform low-income employees and customers about Medi-Cal programs for children in working families. Join forces with Children Now and other groups to demonstrate that voters across the state consider health coverage for all children a top priority.

California's uninsured children have sacrificed enough. They are waiting for each of us to act.

[1] Wirthlin Group Survey, presented to the Children's Health Fund, September, 1994.
[2] Lake/Tarrance Poll, Coalition for America's Children, 1995.

References

Agency for Health Care Policy and Research (1994).*Children Without Health Insurance: Use of Health Services in 1977 and 1987.* Intramural Research Highlights, National Medical Expenditure Survey, No. 30.

Alpert, J. *et. al.* (1976). *Delivery of Health Care for Children: Report of an Experiment.* Pediatrics. 57:917-930.

Becker, M., Drachman, R., Kirscht, J. (1972). *Predicting Mothers' Compliance with Pediatric Medical Regimens.* Journal of Pediatrics. 81:843-854.

Bennefield, R. (1996). *A Comparative Analysis of Health Insurance Coverage Estimates: Data from CPS and SIPP.* Paper presented at the Joint Statistical Meetings, Chicago, Illinois, August 6, 1996.

Berk, M., Albers, A., Schur, C. (1996). *The Growth in the US Uninsured Population: Trends in Hispanic Subgroups, 1977 to 1992.* American Journal of Public Health. 86(4):572-576.

Brown, E., *et. al.* (1994). *Health Insurance Coverage of Californians, 1989-1992.* Los Angeles, CA: UCLA Center for Health Policy Research.

California Assembly Revenue and Taxation Committee. *Options to Increase Revenues.* Estimates for 1994-95 and 1995-96.

California Center for Health Improvement (1996). *Living Well: Californians Consider Public Policies That Foster Better Health.* Sacramento, CA.

California Department of Health Services, Immunization Branch (1996). *Immunization Update.* August 8, 1996.

California Department of Health Services, Maternal and Child Health Branch (1995). *Our Children's Teeth: Beyond Brushing and Braces.* Sacramento, CA.

California Department of Health Services, Office of County Health Services (1992). *Children's Treatment Program, Medical Services, Policies and Procedures Manual* (Addendum added January 1995).

California Department of Health Services (1996). *Primary Care and Family Health: Annual Report Fiscal Year 1994-1995.* Sacramento, CA.

Center for Health System Change Issue Brief (1996). *Medicaid Eligibility Policy and the Crowding-Out Effect: Did Women and Children Drop Private Health Insurance to Enroll in Medicaid?* 1996:3.

Centers for Disease Control and Prevention (1995). *Epidemiology of Vaccine-Preventable Diseases.* Department of Health and Human Services.

Children Now (1996). *California: The State of Our Children '96, Report Card Supplement.* Oakland, CA.

Children Now and Kaiser Permanente (1995). *Campaign for Children's Health and Safety Poll Summary.* Oakland, CA: Children Now.

Children's Defense Fund (August 19, 1996). *Update: Massachusetts Health Reform.* Washington, DC: Children's Defense Fund.

Cornelius, J. (1993). *Barriers to Medical Care for White, Black, and Hispanic American Children.* Journal of the National Medical Association. 85(4):281-88.

Flint, S. (1987). *The Impact of Continuity of Care on the Utilization and Cost of Pediatric Care in a Medicaid Population.* Unpublished doctoral dissertation, University of Chicago. Cited in Starfield, B. (1992). Primary Care: Concept, Evaluation, and Policy. New York, NY: Oxford University Press.

Fronstin, P. (1995). *Children Without Health Insurance: An Analysis of the Increase of Uninsured Children Between 1992 and 1993.* Inquiry. 32:353-59.

Gordis, L. (1973). *Effectiveness of Comprehensive Care Programs in Preventing Rheumatic Fever.* New England Journal of Medicine. 289:331-35.

Government Accounting Office (1996). *Federal Medicaid Payments, Average Census Poverty Counts, and Payments Per Person in Poverty.* Backup information for GAO/HEHS-96-164R.

Government Accounting Office (1996). *Health Insurance for Children: Private Insurance Coverage Continues to Deteriorate.* GAO/HEHS-96-129.

Government Accounting Office (1996). *Health Insurance for Children: State and Private Programs Create New Strategies to Insure Children.* GAO/HEHS-96-35.

Government Accounting Office (1996). *Medicaid Funding Formula Changes.* GAO/HEHS-96-164R.

Government Accounting Office (1995). *Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion.* GAO/HEHS-95-175.

Government Accounting Office (1994). *Health Care Reform: Potential Difficulties in Determining Eligibility for Low-Income People.* GAO/HEHS-94-176.

Hill, I. (1992). *The Role of Medicaid and Other Government Programs in Providing Medical Care for Children and Pregnant Women.* The Future of Children. Winter: 2(2):134-153.

Holl, J., *et. al.* (1995). *Profile of Uninsured Children in the United States.* Archives of Pediatric and Adolescent Medicine. 149:398-406.

Holahan, J., *et. al.* (1995). *Insuring the Poor Through Section 1115 Medicaid Waivers.* Health Affairs. Spring:14(1).

Humiston, S., *et. al.* (1993). *Decision Rules for Predicting Vaccination Status of Preschool-age Emergency Department Patients.* Journal of Pediatrics. 123:887-92.

Hughes, D. (1992). *Delivering the Future: Recommendations From the AB 99 Steering Committee Regarding Health Care for Women, Children and Adolescents in California.* Sacramento, CA: California Department of Health Services, Maternal and Child Health Branch.

Klerman, K., Grazier, K., Thomas, K. (1994). *The Role of the Public Sector in Providing Children's Health Care.* In: Schlesinger, M., Eisenberg, L., eds. Children in a Changing Health Care System. Baltimore, MD: The Johns Hopkins University Press.

Kogan, M., *et. al.* (1995). *The Effect of Gaps in Health Insurance on Continuity of Care Among Preschool-aged Children in the United States.* Journal of the American Medical Association. 274(18):1429-35.

Lazarus, W., *et. al.* (1996). *America's Uninsured Children and the Changing Policy Environment: A Strategic Audit of Activities and Opportunities.* Santa Monica, CA: California Children's Partnership.

Lefkowitz, D., Monheit, A. (1991). *Health Insurance, Use of Health Services, and Health Care Expenditures* (AHCPR Publ. No. 92-0017). 1987 National Medical Expenditure Survey Research Findings 12, Agency for Health Care Policy and Research. Rockville, MD: Public Health Service.

Lewis, C., *et. al.* (1984). *A Randomized Trial of Asthma Care Training for Children.* Pediatrics. 74:478-86.

Managed Risk Medical Insurance Board (1996). *Access for Infants and Mothers.* April - June, Sacramento, CA.

Marquis, M., Long, S. (1994/1995). *The Uninsured Access Gap: Narrowing the Estimates.* Inquiry. 31:405-14.

National Health Law Program, National Center for Youth Law and National Senior Citizens Law Center (1996). *An Analysis of the New Welfare Law and its Effects on Medicaid Recipients.* Los Angeles, CA, National Health Law Program.

McNabb, W., *et. al.* (1985). *Self-management Education of Children with Asthma: AIR WISE.* American Journal of Public Health. 75:1219-20.

Monheit, A., Cunningham, P. (1992). *Children Without Health Insurance.* The Future of Children. 2:154-170.

National Center for Health Statistics (1990). *Health: United States 1989.* Hyattsville, MD: National Center for Health Statistics. 1990:16-17. Publication PHS 90-1232.

Needleman, H. (1994). *Preventing Childhood Lead Poisoning.* Preventive Medicine. 23:634-637.

Newacheck, P., Budetti, P., Halfon, N. (1986). *Trends in Activity-limiting Chronic Conditions Among Children.* American Journal of Public Health. 76:178-184.

Newacheck, P., Hughes, D., Cisternas, M. (1995). *Children and Health Insurance: An Overview of Recent Trends.* Health Affairs. Spring:244-254.

Newacheck, P., Hughes, D., Stoddard, J. (1996). *Children's Access to Primary Care: Differences by Race, Income, and Insurance Status.* Pediatrics. 97(1):26-32.

Overpeck, M., Kotch, J. (1995). *The Effect of US Children's Access to Care on Medical Attention for Injuries.* American Journal of Public Health. 85:402-404.

Protection and Advocacy, Inc. (1996). *Medi-Cal: Service Rights and Entitlement Programs Affecting Californians with Disabilities.* Sacramento, CA.

Perrin, J., Guyer, B., Lawrence, J. (1992). *Health Care Services for Children and Adolescents.* Future of Children. 2(2):58-77.

Rajan, S. *et. al.* (1994). *Increasing Insurance Coverage Through Medicaid Waiver Programs: Case Studies.* Publ. No. 06433-005-02.Washington, DC: The Urban Institute.

Rosenbaum, S. (1996). *Children and the Health Care System: An Overview.* Prepared for the Carnegie Foundation.

Schwartz, J., Volgy, T. (1992). The Forgotten Americans. New York, NY: W.W. Norton & Company, Inc.

Senate Office on Research (August 28, 1995). *Disproportionate Share Hospital (DSH) Payment Program: Background Paper.* Sacramento, CA.

Shuptrine, S., Grant, V., McKenzie, G. (1994). *A Study of the Relationship of Health Coverage to Welfare Dependency.* Columbia, SC: Southern Institute on Children and Families.

Spivak, H., Bonanno, R., Cracknell, M. (1980). *Patient and Provider Factors Associated with Selected Measures of Quality of Care.* Pediatrics. 65:307-13.

Starfield, B. (1992). Primary Care: Concept, Evaluation, and Policy. New York, NY: Oxford University Press.

Starr, P. (1992). The Logic of Health Care Reform. New York: Whittle Books.

Stoddard, J., St. Peter, R., Newacheck, P. (1994). *Health Insurance Status and Ambulatory Care for Children.* New England Journal of Medicine. 330(20):1421-25.

Summer, L., Parrot, S., Mann, C. (1996). *Millions of Uninsured and Underinsured Children are Eligible for Medicaid.* Washington, DC: Center on Budget and Policy Priorities.

Taylor, W., Newacheck, P. (1992). *Impact of Childhood Asthma on Health.* Pediatrics. 90(5): 657-662.

US Congress, Office of Technology Assessment (1988). *Healthy Children: Investing in the Future.* Washington, DC: US Government Printing Office (OTA-H-345).

US Department of Health and Human Services, Public Health Service (1991). *Healthy People 2000: National Health Promotion and Disease Prevention Objectives — Full Report with Commentary,* 349-64, Washington, DC, DHHS Publ. No. (PHS)91-50212.

Weitzman, M., *et. al.* (1992). *Recent Trends in the Prevalence and Severity of Childhood Asthma.* Journal of the American Medical Association. 268(19):2673-77.

Western Center on Law and Poverty (1996). *Overview of the Impact on Medi-Cal of the New Federal Welfare Reform Bill (H.R. 3734).* Sacramento, CA.

Wilson, P., Smoley, S., Belshé, S. (1995). *CaliforniaREACH Program: California Reaching Early Access for Children's Health.* Sacramento, CA.

Wood, D., *et. al.* (1990). *Access to Medical Care for Children and Adolescents in the United States.* Pediatrics. 86:666-73.

Acknowledgments

Our heartfelt thanks to the Health Policy Advisory Committee listed on page vi for all of their contributions and support.

We would also like to thank the families who, while struggling to provide for their children, allowed us to step into their lives and freely shared their stories with us. This report is dedicated to them and their children, and uninsured children throughout California.

To the many providers who told us stories about the uninsured children they serve, we thank you for your support of our work and hope that our efforts will in turn support the vital services you provide.

Many people from the California Department of Health Services provided us with valuable insight into the workings of publicly funded health insurance programs, both historically and at present. We would particularly like to acknowledge the consistent support from LeeKemper, the former Associate Director for Policy Development; Bill Maxfield, Research Program Specialist; Joseph (Doug) Porter, Acting Deputy Director of Medical Care Services; and John Rodriguez, Deputy Director of Medical Care Services. Our thanks are extended as well to:

Randy Baker
Department of Finance

Marge Buzdas
Medi-Cal Eligibility Branch

Anthony Dario
Medi-Cal Eligibility Branch

Gayle Duke
Children's Medical Services Branch

Mary Fermazin
Medi-Cal Managed Care Division

Diane Ford
Office of County Health Services

James Ford
Office of County Health Services

Teri Hodges
Medi-Cal Eligibility Branch

Robert Isman
Dental Contract Section

Triva Iverson
Medi-Cal Eligibility Branch

Richard Kreutzer
Environmental Health Investigations Branch

Frank Martucci
Medi-Cal Eligibility Branch

Carolyn Michaels
Medi-Cal Policy Division

Gary Miller
Office of County Health Services

Cynthia O'Malley
Immunization Branch

Douglas Park
Administration

Denise Sewart
Office of County Health Services

Karen Swanson
Immunization Branch

Lisa Tanaka
Medi-Cal Managed Care Division

David Topp
Director's Office
The Office of Fiscal Forecasting

Representatives from other sectors of government also assisted us in clarifying fine details as well as discussing broader themes.

Madeline Stanionis
[formerly with] Alameda County Department of Public Health

Diane Van Maren
Senate Committee on Budget and Fiscal Review

Brad Williams
Legislative Analysts Office

Federal officials readily supplied us with practical, detailed information about the Medicaid waiver process and other aspects of health care financing. We are particularly grateful for their patience with our questions and their support for our mission.

Grantland Johnson
Region IX, United States Department of Health and Human Services

Richard Chambers
Health Care Financing Administration, Division of Medicaid

Bruce Alan Campbell
Health Care Financing Administration, Division of Medicaid

Karen Fuller
Health Care Financing Administration, Division of Medicaid

Edna Ray
Health Care Financing Administration, Benefits Coordination Group

Sharon Yee
Health Care Financing Administration, State Coordination Group

Office of Senator John Kerry [MA]

Numerous local, state, and national organizations were generous in sharing their research methods and results, strategies and insights, and day-to-day experience with advocating for increased health insurance coverage—all of which were crucial to our ability to produce this report.

Karen Bodenhorn
California Center for Health Improvement

Tanya Broder
National Immigration Law Center

Donna Cohen-Ross
Center on Budget and Policy Priorities

Martha DiSario
California Medical Association

Stan Dorn
Children's Defense Fund

Lisa Dubay
The Urban Institute

Cheryl Fish-Parcham
Families USA

Linda Giannareli
The Urban Institute

Lenny Goldberg
California Tax Reform Association

Vicki Gottlich
National Senior Citizens Law Center

Steve Graham
Kaiser Permanente Medical Center

Jon Gruber
Massachusetts Institute of Technology

David Hayes-Bautista
UCLA School of Medicine
Center for the Study of Latino Health

Nancy Krause
Los Angeles County Office of Education

Peter V. Lee
Center for Health Care Rights

Eugene M. Lewit
The David And Lucile Packard Foundation Center for the Future of Children

Barbara Masters
California Association of Public Hospitals

Karen Obermaier
[formerly with] The Urban Institute

Jane Perkins
National Health Law Program

Tamara Pound
Inyo County Health & Human Services

Judith Reigel
California Medical Association

Jean Ross
California Budget Project

Marsha Sherman
California Child Care Health Project

Sarah C. Shuptrine
The Southern Institute on Children and Families

Frank Ullman
National Governors' Association

Karlene Wenz
American Academy of Pediatrics

Marcy Whitebook
National Center for the Early Childhood Workforce

Cindy Young
California School Employees Association

Staff at The Council of State Governments

Representatives of the legal services community shared their expertise about Medicaid, both what the laws require and how they operate on a daily basis. No formal recommendations were solicited from these individuals, nor did they discuss how the policy issues in the report should be framed. While helping us to grasp the legal complexities, they also enabled us to deepen our understanding of the needs of low-income working families.

Laurel Blankenship
Legal Services

Alice Bussiere
National Center for Youth Law

Susan Fogel
California Women's Law Center

Anne Gayles
Legal Services

Marilyn Holle
Protection & Advocacy

Lynn Kersey
Maternal & Child Health Project

Mike Keys
Legal Assistance

Denise Mahoney
Legal Services

Beth Osthimer
Neighborhood Legal Services

Lucy Quacinella
Western Center on Law & Poverty

Catherine Teare
National Center for Youth Law

State health programs throughout the United States provided us with a surplus of information about the day-to-day process of expanding health insurance coverage, working with local legislators and federal agencies, and building community support.

Arizona

Arizona Health Care Cost Containment System (AHCCCS)
Lynn Martinez
Diane Ross

California

City of Berkeley
Child Health and Disability Prevention Program
Carol Brown

Managed Risk Medical Insurance Board
Sandra Shewry
Soap Dowell
Richard Figueroa
John Grgurina
Irma Michelle
John Ramey

CaliforniaKids
Michael Koch

The staff of the Child Health and Disability Prevention Program

The staff of the California Children's Services Program

Florida

Healthy Kids
Paula Kieger

Maine

Bureau of Family Independence
Barbara Feltes

Massachusetts

Children's Medical Security Plan
John Hancock Mutual Life Insurance Company
Linda D. Balzotti

Executive Office for Administration and Finance
Massachusetts Budget Bureau
Steve Barnard

The Office of Representative
John McDonough

Coalition to Improve Health Care Access
Health Care For All
Jackson Hall
Allison Staton

Minnesota

MinnesotaCare
Kathryn J. Lamp
Jeanyne Slettom

New York

Children Health Plus
Susan Moore

New Mexico

Medical Assistance Division
Liz Martinez

Tennessee

Bureau of TennCare
Ginger Parra
George Woods

Metropolitan Government of Nashville and Davidson County
Metropolitan Health Department
Betty J. Thompson

Vermont

Office of Vermont Health Access
Mary Smith

Washington

Washington State Health Care Financing Authority
Keenan Konopaski

Medicaid
Judy Maginnis

Wisconsin

Wisconsin State Department of Public Health

Appendix A

Policy Decision Points for Expanding Children's Health Isurance Coverage

Throughout this appendix, a check mark (√) identifies pivotal decision points for policy-makers as they design a plan to expand health insurance coverage for children.

An expansion of children's health insurance could occur in many forms. So far, other states have expanded coverage in several different manners. Some consolidated all programs with an 1115 waiver, some expanded Medicaid through the 1902(r)(2) option, and others created new statewide programs with preventive-service benefits packages for children not currently eligible for Medicaid. No two initiatives mirror each other exactly. At this point, all these options exist for California.

A. Eligibility

California programs today leave 1.6 million children uninsured. Graph 17 depicts children by age and poverty level status covered and not covered in 1996.

- √ To what age should subsidized coverage be extended?
- √ Up to what Federal Poverty Level should coverage be provided?
- √ Should eligibility be based solely on household income (no assets test)?

B. Financing Methods

- Federal. The 1902(r)(2) option would allow California to extend Medi-Cal coverage to all children under 19 years of age and receive federal matching dollars on a one-to-one ratio. This simple method is the only way to leverage additional federal dollars for expanding coverage for children.
  - √ Should California extend coverage utilizing the 1902(r)(2) option?
  - √ If California utilizes the 1902(r)(2) option, what, if any, current state and county funds should be consolidated to double their purchasing value with a federal match?
  - √ Can California work with the federal government to combine a 1902(r)(2) option with an 1115 waiver?
- State. Money should only be redirected from an existing program to an insurance expansion if the expansion itself decreases the need for the existing program. After pooling appropriate existing funds, remaining necessary revenue could come from general fund revenues or a variety of new sources.
  - √ What state and county funds should be consolidated?
  - √ Should new general fund revenues be incorporated?
  - √ If new funds are needed, where should they come from?

C. Co-Premiums and Individual and Business Buy-in

- √ Should participants be charged co-premiums?
- √ At what federal poverty level (FPL) should parents begin to contribute?
- √ What amounts should the co-premiums be?
- √ Should families not eligible for subsidies be allowed to purchase the package at full cost?
- √ Should businesses be allowed to purchase the package at full cost?

D. Benefits Package

- √ What should be in the benefits package?

E. Delivering Services

Medi-Cal is in the midst of great transition. Competition between private plans and local initiatives with the two-plan model and geographic managed care offer both hope and caution. When deciding how new services for children can be delivered, the potential impact upon counties already in the midst of transition must be thought through carefully.

- √ Should services be provided through the Medi-Cal infrastructure?
- √ If services are not delivered through the Medi-Cal infrastructure, who should provide them?
- √ Will the chosen structure build off existing programs or create new ones?
- √ How should consumers be offered adequate choices of plans?
- √ Should DHS administer the program? Should another entity, such as the Medical Risk Insurance Board (which administers AIM), be in charge?
- √ Should group purchasing alliances be used to leverage volume discounts from private plans?[1]

F. Cost of the Package

The cost of the package consists of three major components: service, administration, and intake.

1. Service Costs

   The benefits package, reimbursement level, age of beneficiary, and delivery structure will all determine service costs.

   √ Can service savings be achieved?

2. Administration Costs

Administrative structure and procedures determine costs.

√ How can administrative costs be reduced?

3. Intake Costs

Intake costs include paperwork, card issuance, general overhead, facility maintenance, computer systems, required labor, and information verification.[2]

√ What administration, renewal, and intake procedures should be used?

√ If Medi-Cal is used for the expansion, how can intake costs be reduced?

G. Participation Rate

When the Department of Health Services proposed CalREACH in 1995, they estimated that 70.6% of eligible children would participate, based on then-current CHDP utilization data.[3]

√ What participation rate should be assumed?

See Children Now's publication "California's Working Families and Their Uninsured Children: Policy Building Blocks for Change" for a further discussion of these issues.

[1] The state could define a benefits package and plans could compete for delivery.
[2] Interview with David Topp, Special Assistant for Health Policy, Department of Health Services, October 8, 1996.
[3] Among other things, the participation rate will be affected by: (1) the attractiveness of the benefit package; (2) ease or difficulty with the enrollment procedures; (3) manner in which potential crowd out is addressed; and (4) whether or not and in what amounts sliding-scale premiums are implemented.

Appendix B

Key Contacts

For readers interested in learning more about the problem of uninsured children and different policy approaches, we have included a list of some of the key contacts in California and throughout the United States. Individuals' areas of expertise are specified when not readily apparent.

California

Tanya Broder
Staff Attorney
National Immigration Law Center
(213) 938-6452
[welfare reform]

Marge Buzdas
Associate Governmental Program Analyst
California Dept. of Health Services
Medi-Cal Eligibility Branch
(916) 657-2941
[Medi-Cal eligibility rules]

Donna Cohen-Ross
Dir., Earned Income Credit Program
Ctr. on Budget and Policy Priorities
(202) 408-1080
[increasing enrollment of eligible children in Medi-Cal]

James Ford
Chief, Contract Back Unit
Office of County Health Services
California Dept. of Health Services
(916) 324-1120
[Children's Treatment Program]

John Grgurina
Deputy Director of Administration and Fiscal Integrity Managed Risk Medical Insurance Board
(916) 324-4695
[AIM program]

Michael Koch
Executive Director
CaliforniaKids
(818) 703-4947 ext. 237
[public/nonprofit sector coverage of uninsured children]

David Topp
Special Assistant for Health Policy
California Dept. of Health Services
(916) 653-2223

Lucy Quacinella
Staff Attorney
Western Ctr. on Law and Poverty
(916) 442-0753
[welfare reform]

Arizona

Diane Ross
Assistant Director in the Division of New Membership
Arizona Health Care Cost Containment System (AHCCCS)
(602) 417-4590

Florida

Jill Meenan
Deputy Dir., National Program Office
Florida Healthy Kids Corporation
(904) 224-KIDS

Hawaii

Matt Matoi
Data Processing Systems Analyst
Health Information Systems Office
(808) 586-4467

Kentucky

Holly Waird
Communication Specialist
Planning and Analysis Branch
(502) 564-5053

Massachusetts

Linda D. Balzotti
Provider Relations
Children's Medical Security Plan
John Hancock Mutual Life Insurance Company
(508) 474-5100

Oregon

Chuck Sigman
Executive Analyst
Oregon Health Plan Admin. Office
(503) 378-2422

Rhode Island

Murray Brown
Senior Consultant
RIte Care Managed Care Office
(401) 464-2501

Vermont

Mary Smith
Managed Care Administrator
Office of Vermont Health Access
(802) 241-2880

Washington

Keenan Konopaski
Financial Analyst
Washington State Health Care Financing Authority
(360) 923-2808

Judy Maginnis
Program Manager
Division of Client Services / EPPS Medicaid
(360) 664-2309

National Organizations

The Center on Budget and Policy Priorities
(202) 408-1080

The Children's Defense Fund
(202) 628-8787

Families USA
(202) 737-6340

The Urban Institute
(202) 833-7200

Appendix C

California Government Roster

U.S. Senate

Boxer, Barbara (D)	(415) 403-0100
Feinstein, Dianne (D)	(415) 249-4777

U.S. House of Representatives

Becerra, Xavier (D) Los Angeles	(213) 550-8962
Berman, Howard L. (D) Panorama City	(818) 891-0543
Bilbray, Brian (R) San Diego	(619) 291-1430
Bono, Sonny (R) Palm Springs	(619) 320-1076
Brown Jr., George E. (D) Colton	(909) 825-2472
Calvert, Ken (R) Riverside	(909) 784-4300
Campbell, Tom (R) Campbell	(408) 371-7337
Capps, Walter (D)	(805) 899-3578
Condit, Gary (D) Modesto	(209) 527-1914
Cox, Christopher C. (R) Newport Beach	(714) 756-2244
Cunningham, Randy (R) Del Mar	(619) 737-8438
Dellums, Ronald V. (D) Oakland	(510) 763-0370
Dixon, Julian C. (D) Los Angeles	(213) 678-5424
Dooley, Calvin M. (D) Visalia	(800) 464-4294
Doolittle, John T. (R) Roseville	(916) 786-5560
Dornan, Robert K. (R) Garden Grove	(714) 971-9292
Dreier, David (R) Covina	(818) 339-9078
Eshoo, Anna G. (D) Atherton	(415) 323-2984
Farr, Sam (D) Monterey	(408) 649-3555
Fazio, Vic (D) Woodland	(916) 666-5521
Filner, Bob (D) San Diego	(619) 422-5963
Gallegly, Elton (R) Simi Valley	(805) 485-2300
Harman, Jane (D) Marina Del Rey	(310) 348-8220
Herger, Wally (R) Chico	(916) 893-8363
Horn, Steve (R) Long Beach	(310) 425-1336
Hunter, Duncan (R) Coronado	(619) 579-3001
Kim, Jay C. (R) Diamond Bar	(909) 988-1055
Lantos, Tom (D) Hillsborough	(415) 342-0300
Lewis, Jerry (R) Redlands	(909) 862-6030
Lofgren, Zoe (D) San Jose	(408) 271-8700
Martinez, Matthew G. (D) Alhambra	(818) 458-4524
Matsui, Robert T. (D) Sacramento	(916) 498-5600
McDonald, Juanita (D) Carson	(202) 225-7924
McKeon, Howard P. (R) Santa Clarita	(805) 254-2111
Miller, George (D) Pleasant Hill	(510) 602-1880
Packard, Ron (R) San Clemente	(714) 496-2343
Pelosi, Nancy (D) San Francisco	(415) 558-4862
Pombo, Richard W. (R) Tracy	(209) 951-3091
Radanovich, George (R) Fresno	(209) 248-0800
Riggs, Frank (R) Napa	(707) 254-7308
Rogan, James (R)	(818) 247-8445
Rohrabacher, Dana (R) Huntington Beach	(714) 847-2433
Roybal-Allard, Lucille (D) Los Angeles	(213) 628-9230
Royce, Ed (R) Fullerton	(714) 992-8081
Sherman, Brad (D)	(818) 999-1990
Stark, Fortney P. (D) Hayward	(510) 247-1388
Tauscher, Ellen (D)	(510) 932-8899
Thomas, William M. (R) Bakersfield	(805) 327-3611
Torres, Esteban E. (D) West Covina	(310) 695-0702
Waters, Maxine (D) Los Angeles	(213) 757-8900
Waxman, Henry A. (D) Los Angeles	(213) 651-1040
Woolsey, Lynn (D) Santa Rosa	(707) 542-7182

State Assembly Roster

72	4116	**Ackerman**, Richard (R) Fullerton	7448
61	320	**Aguiar**, Fred (R) San Bernardino	1670
5	5155	**Alby**, Barbara (R) Sacramento	4445
22	4117	**Alquist**, Elaine (D) San Jose	4253
14	5135	**Aroner**, Dion (D) Berkeley	7554
32	5136	**Ashburn**, Roy (R) Bakersfield	8498
62	5119	**Baca**, Joe (D) San Bernardino	7454
77	3123	**Baldwin**, Steve (R) El Cajon	3266
80	5016	**Battin**, Jim (R) Palm Desert	5416
67	4177	**Baugh**, Scott (R) Huntington Beach	6233
33	3120	**Bordonaro**, Tom (R) San Luis Obispo	7795
53	2158	**Bowen**, Debra (D) Torrance	8528
10	4016	**Bowler**, Larry (R) Sacramento	7402
70	3126	**Brewer**, Marilyn (R) Irvine	7222
7	3013	**Brown**, Valerie (D) Santa Rosa	8492
31	2188	**Bustamante**, Cruz M. (D) Fresno	8514
46	3141	**Caldera**, Louis (D) Los Angeles	4843
71	2117	**Campbell**, Bill (R) Orange	2778
39	3146	**Cardenas**, Tony (D) Panorama City	1616
26	4139	**Cardoza**, Dennis (D) Modesto	8570
24	2174	**Cunneen**, Jim (R) Campbell	8305
76	5160	**Davis**, Susan (D) San Diego	7210
79	6026	**Ducheny**, Denise Moreno (D) San Diego	7556
50	2179	**Escutia**, Martha M. (D) Huntington Park	8188
20	4164	**Figueroa**, Liz (D) Fremont	7874
35	2148	**Firestone**, Brooks (R) Santa Barbara	8292
55	4005	**Floyd**, Richard (D) Carson	3134
28	5158	**Frusetta**, Peter (R) Salinas	7380
57	2111	**Gallegos**, Martin (D) El Monte	7610
75	2136	**Goldsmith**, Jan (R) Poway	2484
65	6005	**Granlund**, Brett (R) Yucaipa	7552
56	2003	**Havice**, Sally (D) Bellflower	6047
40	4162	**Hertzberg**, Bob (D) Los Angeles	7644
23	6031	**Honda**, Mike (D) San Jose	8243
25	2141	**House**, George (R) Modesto	7906
74	2163	**Kaloogian**, Howard (R) Carlsbad	2390
27	3091	**Keeley**, Fred (D) Santa Cruz	8496
42	3147	**Knox**, Wally (D) Los Angeles	7440
41	5128	**Kuehl**, Sheila (D) Santa Monica	4956
54	3098	**Kuykendall**, Steven (R) Long Beach	9234
15	3173	**Leach**, Lynne (R) Walnut Creek	6161
21	4015	**Lempert**, Ted (D) Palo Alto	7632
63	2176	**Leonard**, Bill (R) Ontario	8490
17	5175	**Machado**, Mike (D) Stockton	7931
59	4102	**Margett**, Bob (R) Arcadia	7234
49	6011	**Martinez**, Diane (D) Alhambra	7852
6	4153	**Mazzoni**, Kerry (D) San Rafael	7783
38	4126	**McClintock**, Tom (R) Northridge	8366
13	2002	**Migden**, Carole (D) San Francisco	8077
60	6025	**Miller**, Gary R. (R) Diamond Bar	7550
69	4140	**Morrissey**, Jim (R) Santa Ana	7333
73	6027	**Morrow**, Bill (R) Carlsbad	7676
47	4167	**Murray**, Kevin (D) Los Angeles	8800
58	5164	**Napolitano**, Grace F. (D) Santa Fe Springs	0965
34	4112	**Olberg**, Keith (R) Victorville	8102
4	2196	**Oller**, Thomas "Rico" (R) Placerville	8343

9	4158	**Ortiz**, Deborah (D) Sacramento	1611
64	2130	**Pacheco**, Rod (R) Riverside	0854
19	3151	**Papan**, Lou (D) South San Francisco	8020
16	5150	**Perata**, Don (D) Oakland	7442
29	2114	**Poochigian**, Charles (R) Fresno	2931
30	4017	**Prenter**, Robert (R) Fresno	7558
68	219	**Pringle**, Curt (R) Garden Grove	8377
3	448	**Richter**, Bernie (R) Chico	7298
36	4005	**Runner**, George (R) Palmdale	7498
44	3104	**Scott**, Jack (D) Pasadena	8211
12	3152	**Shelley**, Kevin (D) San Francisco	8253
1	4130	**Strom-Martin**, Virginia (D) Eureka	8360
18	2016	**Sweeney**, Michael (D) San Leandro	8160
37	2013	**Takasugi**, Nao (R) Camarillo	7827
66	4146	**Thompson**, Bruce (R) Fallbrook	1676
8	4144	**Thomson**, Helen (D) Fairfield	8368
11	6012	**Torlakson**, Tom (D) Richmond	7890
45	2160	**Villaraigosa**, Antonio (D) Los Angeles	0703
51	2137	**Vincent**, Edward (D) Inglewood	7533
52	2175	**Washington**, Carl (D) Compton	7486
78	2170	**Wayne**, Howard (D) San Diego	2112
43	3160	**Wildman**, Scott (D) Glendale	8364
2	4098	**Woods**, Tom (R) Redding	7266
48	5144	**Wright**, Roderick (D) Los Angeles	2363

State Senate Roster

39	4061	**Alpert**, Dede (D) San Diego	3952
32	5108	**Ayala**, Ruben (D) Rancho Cucamonga	6868
31	3074	**Brulte**, James (R) Upland	3688
3	5035	**Burton**, John (D) San Francisco	1412
30	313	**Calderon**, Charles M. (D) Montebello	327-8315
16	2054	**Costa**, Jim (D) Fresno	4641
38	3070	**Craven**, William (R) Carlsbad	3731
28	5050	**Dills**, Ralph (D) Gardena	5953
6	2082	**Greene**, Leroy (D) Sacramento	7807
23	2080	**Hayden**, Tom (D) Los Angeles	1353
36	4082	**Haynes**, Ray (R) Riverside	9781
25	5114	**Hughes**, Teresa (D) Inglewood	2104
34	305	**Hurtt**, Rob (R) Garden Grove	5831
4	5087	**Johannessen**, K. Maurice (R) Redding	3353
35	4074	**Johnson**, Ross (R) Irvine	4961
5	5066	**Johnston**, Patrick (D) Sacramento	2407
27	5082	**Karnette**, Betty (R) Redondo Beach	6447
37	3082	**Kelley**, David G. (R) San Diego	5581
17	2066	**Knight**, William (R) Palmdale	6637
8	2057	**Kopp**, Quentin (I) South San Francisco	0503
9	5080	**Lee**, Barbara (D) Oakland	6577
1	4081	**Leslie**, Tim (R) Roseville	5788
33	3063	**Lewis**, John R. (R) Lewis	4264
10	205	**Lockyer**, Bill (D) Hayward	6671
14	5052	**Maddy**, Ken (R) Fresno	9600
15	4039	**McPherson**, Bruce (D) Monterey	5843
12	2048	**Monteith**, Dick (R) Modesto	1392
29	4062	**Mountjoy**, Richard (R) Arcadia	2848
18	2187	**O'Connell**, Jack (D) Santa Barbara	5405
40	5064	**Peace**, Steve (D) La Mesa	6767
22	2032	**Polanco**, Richard (D) Los Angeles	3456
20	4070	**Rosenthal**, Herschel (D) Van Nuys	7928
21	5061	**Schiff**, Adam (R) Glendale	5976
11	4032	**Sher**, Byron (D) Redwood City	6747
7	3086	**Smith**, Jeff (D) Concord	6083
24	4090	**Solis**, Hilda (D) El Monte	1418
2	3056	**Thompson**, Mike (D) Santa Rosa	3375
13	5100	**Vasconcellos**, John (D) San Jose	9740
26	4040	**Watson**, Diane (D) Los Angeles	5215
19	4052	**Wright**, Cathie (R) Simi Valley	8873

78

Appendix D

Public Health Care Programs for Children in California

The following are brief descriptions of key California public health programs serving children.

Medi-Cal[1]

Medi-Cal is California's component of the federal Medicaid program and is the primary funder of health care and related services for low-income families. Medi-Cal finances a comprehensive range of health benefits, including inpatient and outpatient hospital services, physician and laboratory services, preventive care, family planning services and limited mental health care. All Medi-Cal recipients, except pregnant women and children under one year of age who are receiving benefits under Medi-Cal's Pregnant Women and Children Program, must meet an assets test.

The primary Medi-Cal programs serving children are:

- **Categorically Needy (AFDC/TANF & SSI)**

  All children who receive Social Security Income (SSI) benefits (for children with disabilities) automatically qualify for Medi-Cal (see discussion below). Prior to passage of the welfare reform bill, all children who received Aid to Families with Dependent Children (AFDC) benefits (cash assistance for low-income families) also automatically qualified for Medi-Cal. For a family of three, the maximum amount a family could earn and still qualify for AFDC was approximately $16,284 (about 125% of the FPL). Children also had to meet the "family circumstances" requirements (do not have the support or care of one parent because of his/her absence, death, incapacity, or unemployment). People who qualify through these categorically needy programs are not required to pay a "share of cost" (explained below).

  As a result of HR 3734,[2] the recently enacted federal welfare reform law, California's AFDC program has been replaced with the Temporary Assistance for Needy Families (TANF) program, which limits eligibility for cash assistance. In addition, California now has the option to stop making all children who receive TANF benefits automatically eligible for Medi-Cal. The state has not yet decided whether it will exercise this option.

  The welfare reform legislation, however, requires states to provide Medi-Cal to all children who would have qualified for AFDC under the rules in effect on July 16, 1996. As a result, the state's replacement of AFDC with TANF should not reduce the number of children who qualify for Medi-Cal. However, it probably will reduce the number of children who actually enroll in the program, since families of children who would have qualified for AFDC but do not qualify for TANF will need to: (1) find out their children still qualify for Medi-Cal; and (2) complete a separate application for Medi-Cal.

- **Pregnant Women and Children (PW&C)**

  The Pregnant Women and Children (PW&C) program, also known as the Federal Poverty Level (FPL) program, covers certain groups of children living in families with incomes below a certain percentage of the FPL. Their families need not meet any of the "program linked" requirements (such as AFDC) and have no share of cost (see "medically needy" below) requirements. For children over one year old, families must show they do not own property and assets above a certain amount. This program serves children:

  - under one year old with incomes at or below 200% of the Federal Poverty Level (FPL) (200% of the FPL is $25,960 for a family of three.) (These children need not meet a property/assets test.)
  - ages one through five with incomes at or below 133% of the FPL (133% of the FPL is $17,284 for a family of three).
  - ages six through 18 with incomes at or below 100% of the FPL ($12,980 for a family of three), if they were born after September, 1983. As of October, 1996, this program covered children between six and 13. (Note: as explained more fully below, many of the children not yet "phased-in" under this program are eligible through the Medically Needy program.)

- **Medically Needy/Medically Indigent Programs**

  Children in California can qualify for either the Medically Needy[3] or Medically Indigent[4] Medi-Cal programs, regardless of family income, if their families meet an assets test and "share of cost" requirements.[5] The Medically Indigent program does not impose "family circumstances" requirements, so children in two-parent families can qualify. To meet the assets test, a family of three must show it does not own personal property worth more than $3,150.[6] The family also must first contribute or incur debts equal to its share of cost toward the child's medical expenses each month before Medi-Cal will begin covering the rest of the child's health care costs. A family's share of costs equals its monthly income,[7] minus its "Monthly Maintenance Need" ($934/month or $11,208/year for a family of three). *In other words, a family of three must have spent or incurred debt equal to any income over $934 each month (87% of the FPL for a family of three) before Medi-Cal will cover the rest of the child's expenses for that month.*

  Many children will qualify for more than one of these programs. Medi-Cal therefore has a priority system to assign children to programs which do not impose a share of cost requirement and/or enable the family to receive benefits as a family unit.

Additional Medi-Cal programs also serve certain groups of children. These programs include:

- **Transitional Medi-Cal**

  The recently enacted federal welfare reform law preserves the transitional Medi-Cal program, which continued Medi-Cal benefits for a limited period after families lost eligibility for AFDC benefits due to increased income. For example, if a child *would have* received AFDC benefits under the old AFDC rules and lost eligibility because of an increase in his or her parent's earned income, the family probably will continue to qualify for Medi-Cal for one year and possibly two years.[8]

- **Minor Consent Program**

  Youth under age 21 may apply for "minor consent services" without parental consent or notification and regardless of their family's income. These services include those related to sexual assault, family planning and pregnancy. Children over 12 years old also can receive services related to substance abuse and sexually transmitted diseases. In addition, youth over 12 can receive outpatient mental health care if: (1) they need those services to prevent harm to themselves or others or (2) there is an allegation they have suffered incest or other child abuse.

Access for Infants and Mothers (AIM)[9]

AIM covers pregnant women and children up to two years of age if they have family incomes between 200% and 300% of the FPL. Participating families must contribute two percent of their income, plus $100 for the child's second year. Benefits include: outpatient and inpatient physician services; hospital care; infant care (such as well baby visits); prescription drugs and diagnostic tests.

AIM is administered separately from Medi-Cal. The Managed Risk Medical Insurance Board administers AIM and purchases insurance from several private plans. Funding for AIM comes from the Perinatal Insurance Fund and, initially, Proposition 99 (tobacco tax) funds.[10] AIM is not an entitlement program; enrollment is limited to the number of women and infants who can be served with the funds appropriated. The program suspended enrollments between January and September of 1994 due to lack of funds.

Related Health Programs for Children That Do Not Provide Comprehensive Health Insurance

- **Child Health and Disability Prevention (CHDP) Program**[11]

  CHDP provides regular health assessments and immunizations to eligible children. Unlike Medi-Cal and AIM, CHDP focuses on preventive care and does not provide a full range of health insurance benefits. Eligible children include: (1) those who qualify for Medi-Cal; (2) non-Medi-Cal-eligible children up to age 19 from families with incomes up to 200% of the FPL; and (3) young children in Head Start and state preschool programs. CHDP served over 1.9 million children in 1994-95.

- **Follow-up Treatment Programs**

  Children enrolled in Medi-Cal receive necessary follow-up diagnoses and treatment for all conditions identified by a CHDP screen through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Children eligible for CHDP, but not for Medi-Cal, also receive some follow-up treatment through a state-funded program. Initially funded through Proposition 99 funds this program provides follow-up treatment for new medical conditions if they were initially identified in a CHDP screen. In the smaller counties, this program is administered by the State through the "Children's Treatment Program." Many larger counties administer their own programs.[12]

- **Programs for Children with Special Health Care Needs**

  Several programs provide benefits for children with chronic illnesses and/or disabilities. These include:

  - Supplemental Security Income/ State Supplementary Program (SSI/SSP)

    The Federal Social Security Administration administers the SSI program, which provides cash assistance to children with disabilities. All children who receive SSI are automatically eligible for Medi-Cal. In addition, SSI helps parents buy equipment and services that will enable children to remain at home, rather than in residential facilities. The state SSP program supplements the federal SSI payments.

    The recently enacted federal welfare reform law narrowed the eligibility requirements for SSI for children. To qualify, a child must have a medically determinable physical or mental impairment that (1) results in marked and severe functional limitations and (2) is expected to result in death or which has or is expected to last for at least 12 months.[13] A child's family cannot have nonexempt[14] resources valued above $5,000[15] (for a family with two parents and one child). To receive cash benefits, a child's monthly family income must be less than his or her grant amount.

  - California Children's Services (CCS)[16]

    CCS provides specialized medical care and rehabilitation services for children with serious physically handicapping conditions. Examples of qualifying conditions include: deafness; orthopedic conditions due to infection, injury, or congenital malformation; hemophilia; cystic fibrosis; and conditions resulting from accidents or poisoning which may be potentially handicapping, such as complicated fractures and brain and spinal cord injuries. Benefits include diagnoses, medical treatment, medical equipment, medically necessary physical and occupational therapy in public schools and case management services. To be eligible, families must have incomes of $40,000 or less or out-of-pocket medical expenditures that exceed 20% of their income. In 1994-95, CCS served approximately 131,000 children.

- Regional Centers[17]

Regional Centers are private nonprofit community agencies that contract with the state to provide services to individuals with certain developmental disabilities. To qualify, a child must have a diagnosis, or possible diagnosis, of mental retardation, cerebral palsy, epilepsy, autism, or other condition similar to mental retardation, which require treatment similar to that required by persons with mental retardation. Children under three years of age who are at risk of being developmentally delayed also are eligible.

Regional Center Services include case management, assessments and counseling. Much of the funding for costs of care comes from SSI. Regional Centers also purchase directly some services when no other private or public funding is available, such as durable medical equipment not covered by CCS and out-of-home residential care. Families with an adjusted gross income in excess of $71,000 (for a family of two) may be charged a fee for case management services.

---

[1] Much of this summary is drawn from Protection and Advocacy, Inc. (1996). *Medi-Cal: Service Rights and Entitlement Programs Affecting Californians with Disabilities.* Sacramento, CA.

[2] Under the new federal welfare reform law, California will be required to deny or limit Medi-Cal benefits for several groups of children and may exercise several options to further reduce Medi-Cal coverage. See Western Center on Law and Poverty (1996). *Overview of the Impact on Medi-Cal of the New Federal Welfare Bill (H.R. 3734).* August 20, 1996. Sacramento, CA.

[3] The Medically Needy program serves children who meet the program requirements for SSI or AFDC (i.e.: chronic disability or deprived of support of one parent) but whose families earn too much to qualify for these programs.

[4] The Medically Indigent program serves children who do not meet the SSI or AFDC program requirements.

[5] Some groups of children in the Medically Indigent Program do not need to pay a share of cost, such as children who are eligible for adoption assistance benefits.

[6] Some types of property are exempt from these tests, such as one's house.

[7] Certain types of income are not counted in calculating a family's share of cost, such as a $90 work incentive allowance and limited child care expenses.

[8] A family would be eligible for Medi-Cal for the next six months regardless of income if, under the former AFDC rules, the family would have received AFDC benefits in three out of the prior six months. In addition, the family could receive Medi-Cal for another six months if their income, after deductions for child care, is at or below 185% of the FPL. Protection and Advocacy Inc. (1996). *Medi-Cal Service Rights and Entitlement Programs Affecting Californians with Disabilities,* Sacramento, CA. Also, as part of the 1996 state budget agreement, the legislature approved an additional 12 months of eligibility for such transitional Medi-Cal families. However, before this second 12 month extension can take effect, federal approval of the waiver appeal is necessary.

[9] Much of this summary is drawn from Managed Risk Medical Insurance Board (1996). *Access for Infants and Mothers.* April-June. Sacramento, CA.

[10] The tobacco tax funds have been threatened by a court decision prohibiting the use of part of that money for health services.

[11] California Department of Health Services (1996). *Primary Care and Family Health: Annual Report Fiscal Year 1994-1995.*

[12] Department of Health Services, Office of County Health Services (1992). *Children's Treatment Program, Medical Services, Policies and Procedures Manual* (Addendum added January 1995); phone conversation with James Ford, Chief, Contract Back Unit, Office of County Health Services, California Department of Health Services.

[13] National Health Law Program, National Center for Youth Law and National Senior Citizens Law Center (1996). *An Analysis of the New Welfare Law and its Effects on Medicaid Recipients.* Los Angeles, CA: National Health Law Program.

[14] Exempt resources include: one's home, clothing and personal effects not exceeding $2,000 in value; wedding and engagement rings; one's car; and property essential to self-support (e.g.: farmland, tools and a bank account necessary for business).

[15] SSI resource limits are: 1) $2,000 for a single parent or $3,000 for a couple and 2) $2,000 for the child on SSI.) Protection and Advocacy, Inc. (1996). *Medi-Cal Service Rights and Entitlement Programs Affecting Californians with Disabilities.* Sacramento, CA.

[16] California Department of Health Services (1996). *Primary Care and Family Health: Annual Report Fiscal Year 1994-1995.* This number includes both children enrolled in Medi-Cal and those who are enrolled only in CHDP.

[17] Regional Center of the East Bay Fact Sheet.

Appendix E

Benefit Costs for a Representative Medi-Cal Population

The California Department of Health Services ran reports detailing the cost of providing Medi-Cal benefits (including EPSDT) on a fee-for-service basis for AFDC non-foster care children.[1] This Medi-Cal group was selected because they most mirror uninsured children (low-income children with relatively low-cost health risks).

The total benefit service costs (both federal and state share) for AFDC non-foster care children were $50.32 per month for children ages one through eighteen. Sub-component costs of this package are detailed below.

Monthly Total Paid:	**$50.32**
Components:	———
• inpatient hospital	10.01
• dentist	9.79
• physician	8.15
• outpatient hospital/clinic	7.33
• pharmacy	5.96
• Short-Doyle (mental health)	3.10
• e.p.s.d.t.	1.85
• clinical laboratory	1.44
• optometrist/optician	0.68
• local education agency	0.50
• medical transportation	0.27
• podiatrist	0.22
• psychologist	0.20
• speech therapist/audiologist	0.06
• snf/icf[2]	0.05
• state hospital — develop. disabled	0.04
• acupuncturist	0.03
• prosthetist/orthostist	0.03
• home health agency	0.03
• hearing aid dispenser	0.01
• in-home medical care	0.01
• all other	0.54

Source: California Department of Health Services, Medical Care Statistics Division.
Report run date: 9/20/96.

[1] At Children Now's request, the Department of Health Services ran a random sample report aggregating data from July 1995 through June 1996 providing the average monthly cost per Medi-Cal-eligible for four distinct age groups: 0-1, 1-6, 7-12, and 13-18. Because infants 0-1 are already covered under Medi-Cal up to 200% of the FPL and offered coverage through AIM between 200% and 300% of the FPL, their costs were not included here.

[2] Skilled nursing facilities (snf) and intermediate care facilities (icf).

Appendix F

Cost Estimates for Expanding Health Insurance to Uninsured Children

This appendix presents four cost-out projections for expanding health insurance to California children. It may be that none of these projections represents actual future costs; these costs will depend on a number of factors yet to be decided. Each projection assumes:

- expansion up to 300% of the FPL for all children under age 19[1]; and
- 51.23% federal financial participation[2] through utilization of a 1902(r)(2) option.

Also, each option includes costs for covering a large number of children residing in households under 100% of the FPL—most of these children are *already eligible for Medi-Cal; they are just not enrolled* (see Chapter Three, Section Two for a larger discussion of eligible but unenrolled). Therefore, almost all of the costs associated with providing coverage to children under 100% of the FPL are not true expansion costs.

The four projections briefly defined are:

1. Full Medi-Cal Intake and Administration Costs and 100% Participation—State Annual Cost of $458 Per Child Insured. Under this scenario, every uninsured child under 300% of the FPL would enroll. Full 1996/97 Medi-Cal intake and administration/ renewal costs are assumed. Benefit costs per month are assumed at $50 per enrollee.
2. Reduced Medi-Cal Intake and Administration Costs and 100% Participation—State Annual Cost of $376 Per Child Insured. This scenario mirrors projection one, except intake and administration costs are reduced. (See Chapter 4, Section Two to see how this can occur.)
3. Full Current Medi-Cal Intake and Administration Costs and Probable Participation—State Annual Cost of $458 Per Child Insured. This scenario assumes that only 70% of children will participate. Full 1996/97 Medi-Cal intake and administration/ renewal costs are assumed.
4. Reduced Medi-Cal Intake and Administration Costs; Sliding Co-premiums Above 200% of FPL; and Probable Participation—State Annual Cost of $355 Per Child Insured. This example mirrors projection three except intake and administration costs are reduced and co-premiums for enrollees in households above 200% of the FPL are included.

[1] While most of the studies and statistics cited in this report are based on children under age 18, all cost-out projections assume expansions to cover children under age 19.
[2] The current federal participation is 50.23%; it will increase to 51.23% on 10/1/97.

...st Estimates for Expanding Health Insurance to Uninsured Children Up to Age 19 up to 300% of the FPL.

Projection One: Full Medi-Cal Intake and Administration Costs and 100% Participation—State Annual Cost of $458 Per Child Insured.

Federal Poverty Level	Number of Uninsured Children	Participation Rate	Newly Insured	Benefit Costs per Month	Admin. Costs per Month	Enrollee Costs per Month	One-time Intake Costs	Annual State and Federal Cost Per Enrollee	Total Federal and State Cost for All Newly Enrolled	Total State Cost for All Newly Enrolled
<100	585,000	100%	585,000	50	20	70	120	940	$549,900,000	$268,186,230
100-124	140,000	100%	140,000	50	20	70	120	940	$131,600,000	$64,181,320
125-149	222,000	100%	222,000	50	20	70	120	940	$208,680,000	$101,773,236
150-174	161,000	100%	161,000	50	20	70	120	940	$151,340,000	$73,808,518
175-199	102,000	100%	102,000	50	20	70	120	940	$95,880,000	$46,760,676
200-249	165,000	100%	165,000	50	20	70	120	940	$155,100,000	$75,642,270
250-299	75,000	100%	75,000	50	20	70	120	940	$70,500,000	$34,382,850
Total	1,450,000		1,450,000							$664,735,100

Projection Two: Reduced Medi-Cal Intake and Administration Costs and 100% Participation—State Annual Cost of $376 Per Child Insured.

Federal Poverty Level	Number of Uninsured Children	Participation Rate	Newly Insured	Benefit Costs per Month	Admin. Costs per Month	Enrollee Costs per Month	One-time Intake Costs	Annual State and Federal Cost Per Enrollee	Total Federal and State Cost for All Newly Enrolled	Total State Cost for All Newly Enrolled
<100	585,000	100%	585,000	50	10	60	60	770	$450,450,000	$219,684,465
100-124	140,000	100%	140,000	50	10	60	60	770	$107,800,000	$52,574,060
125-149	222,000	100%	222,000	50	10	60	60	770	$170,940,000	$83,367,438
150-174	161,000	100%	161,000	50	10	60	60	770	$123,970,000	$60,460,169
175-199	102,000	100%	102,000	50	10	60	60	770	$78,540,000	$38,303,958
200-249	165,000	100%	165,000	50	10	60	60	770	$127,050,000	$61,962,285
250-299	75,000	100%	75,000	50	10	60	60	770	$57,750,000	$28,164,675
Total	1,450,000		1,450,000							$544,517,050

Projection Three: Full Current Medi-Cal Intake and Administration Costs and Probable Participation—State Annual Cost of $458 Per Child Insured.

Federal Poverty Level	Number of Uninsured Children	Participation Rate	Newly Insured	Benefit Costs per Month	Admin. Costs per Month	Enrollee Costs per Month	One-time Intake Costs	Annual State and Federal Cost Per Enrollee	Total Federal and State Cost for All Newly Enrolled	Total State Cost for All Newly Enrolled
<100	585,000	70%	409,500	50	20	70	120	940	$384,930,000	$187,730,361
100-124	140,000	70%	98,000	50	20	70	120	940	$92,120,000	$44,926,924
125-149	222,000	70%	155,400	50	20	70	120	940	$146,076,000	$71,241,265
150-174	161,000	70%	112,700	50	20	70	120	940	$105,938,000	$51,665,963
175-199	102,000	70%	71,400	50	20	70	120	940	$67,116,000	$32,732,473
200-249	165,000	70%	115,500	50	20	70	120	940	$108,570,000	$52,949,589
250-299	75,000	70%	52,500	50	20	70	120	940	$49,350,000	$24,067,995
Total	1,450,000		1,015,000							$465,314,570

Projection Four: Reduced Medi-Cal Intake and Administration Costs; Sliding Co-premiums Above 200% of FPL; and Probable Participation—State Annual Cost of $355 Per Child Insured.

Federal Poverty Level	Number of Uninsured Children	Participation Rate	Newly Insured	Benefit Costs per Month	Admin. Costs per Month	Co-Premiums Applied Above 200% of FPL	Enrollee Costs per Month	One-time Intake Costs	Annual State and Federal Cost Per Enrollee	Total Federal and State Cost for All Newly Enrolled	Total State Cost for All Newly Enrolled
<100	585,000	70%	409,500	50	10	0	60	60	770	$315,315,000	$153,779,126
100-124	140,000	70%	98,000	50	10	0	60	60	770	$75,460,000	$36,801,842
125-149	222,000	70%	155,400	50	10	0	60	60	770	$119,658,000	$58,357,207
150-174	161,000	70%	112,700	50	10	0	60	60	770	$86,779,000	$42,322,118
175-199	102,000	70%	71,400	50	10	0	60	60	770	$54,978,000	$26,812,771
200-249	165,000	70%	115,500	50	10	20	40	60	530	$61,215,000	$29,854,556
250-299	75,000	70%	52,500	50	10	25	35	60	470	$24,675,000	$12,033,998
Total	1,450,000		1,015,000								$359,961,616

** Notes: All examples assume 51.23% federal financial participation and overstate total intake costs because each assumes annual intake for each enrollee, not a likely proposition.
One month of administration costs is included within intake costs. The number of uninsured based on 1996 CPS data calculations by the UCLA Center for Health Policy Research.

Appendix G

Potential New Revenue Sources

If California extends health insurance to uninsured children, new state revenue may be needed. Potential revenue sources and first-year revenue estimates (when available) include:

- Tobacco taxes (a 25 cent per pack cigarette tax would raise $425 million).[1]
- Alcohol taxes (a 10 cent per gallon increase in the beer and wine tax would raise $70 million; a one dollar increase per gallon for distilled spirits would raise $38 million).[2]
- Sales tax increase (a one quarter of one percent increase in the state's sales tax would bring in roughly $800 million in new revenue).[3]
- Tax on services (a one percent gross receipts tax on all services, except medical and educational services, would raise $600 million).[4]
- Oil severance tax (a six percent oil severance tax would generate $200 million).[5]
- Cap tax deduction of health care benefits.[6]
- Provider/hospital assessments.[7]
- Ten percent surtax on individuals with taxable incomes of more than one million dollars (would raise $235 million).
- Tax on carcinogens.
- Tax on firearms and ammunition.

[1] California's current rate is 37 cents per pack; fifteen states and the District of Columbia have higher rates. Washington has the highest rate at 82.5 cents per pack. The Tobacco Institute, July 1996.

[2] California taxes alcohol per gallon at: $0.20 for beer and wine; $0.30 for sparkling wine; and $3.30 for distilled spirits. Calculations based on data from 1996-97 *Governor's Budget Summary*. Nineteen other states tax beer at higher rates than California. (Hawaii has the highest at $0.89 per gallon). Research Institute of America, Inc., as cited in: California Center for Health Improvement (1996). *Living Well: Californians Consider Public Policies That Foster Better Health.*

[3] California Assembly Revenue and Taxation Committee. *Options to Increase Revenues*. Estimates for 1994-95 and 1995-96.

[4] California Assembly Revenue and Tax Committee. *Options to Increase Revenues*. Estimates for 1994-95 and 1995-96.

[5] California Tax Reform Association. *Confronting California's Vast Budget Hole: Revenue Options '93/'94.*

[6] Currently, employers are allowed to deduct the full amount they pay for employees' health coverage. This creates a regressive tax subsidy which disproportionately helps the affluent at the expense of the less well-off and the uninsured. For example, a 1991 study determined that the average value of the tax break to a family with a $100,000 income was $1500, while the benefit to families with incomes below $10,000 averaged $50. (Lewin-VHI, 1991 estimate. Cited in Starr, P. (1992). The Logic of Health Care Reform. New York: Whittle Books.) If the state limited the dollar amount employers could deduct tax free, the inequality of this subsidy would diminish and the state could generate revenues to expand coverage to the uninsured.

[7] Use of these types of assessment fees was upheld by the Supreme Court in 1995. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company,* 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995).

Appendix H

Possible Options to Discourage Potential Crowd Out of Private Insurance

Option 1:

A child must be uninsured for at least 4 months prior to applying for new Medi-Cal expansion categories (does not apply to low-income children—defined as 150% of the FPL by Minnesota). This reduces the incentive for those who purchase insurance for their own dependents to substitute public care and reduces incentives for employers to drop coverage because these children will become uninsured for a period of time. (Based on Minnesota's program)

Pros
- Could prevent employers from dropping coverage
- Could prevent employees from switching to public coverage

Cons
- Could leave children above 150% of the FPL uninsured for a period of time

Option 2:

Have sliding-fee monthly co-premiums as a condition of enrollment starting at 200% of the FPL. (Based on several state plans)

Pros
- Could prevent employers from dropping coverage
- Could prevent employees from switching to public coverage
- Could increase public sense of fairness, helping program not be viewed as a government hand-out

Cons
- Has no effect under 200% of FPL
- Fees could be too high for some families, leaving children uninsured

Option 3:

Change the California tax code making it illegal for all employers to discriminate by wage as to whether or not they provide dependent coverage and at what share of cost they contribute to that coverage. This would force employers to treat all employees the same in terms of dependent coverage, regardless of their wages. (Based on state extension of current federal ERISA prohibitions)[1]

Pros
- Could prevent employers from dropping coverage
- Could prevent employees from switching to public coverage

Cons
- Employers do not like to be regulated
- Could raise the cost of conducting business
- This legal change could create an additional barrier to implementation

Option 4:

Set a date, retroactive to when expansion begins, and establish that, if a dependent child had been covered or had been offered coverage before that date, and the parent is still working for the same employer, the child is not eligible for the expansion. (Based on Tennessee's program)[2]

Pros
- Could prevent employers from dropping coverage
- Could prevent employees from switching to public coverage

Cons
- Limits eligibility for the new program
- Could leave many children uninsured for a period of time
- Crowd out could increase incrementally over time with people not affected by retroactive date

Option 5:

An enrollee must not have been offered employer-subsidized health coverage for the 18 months prior to application (defined as an employer covering more than 50% of a dependent's coverage). This does not apply to children:

(a). who are in households with incomes under 150% FPL;
(b). whose parents lose coverage as a result of an involuntary layoff not due to employee musconduct;
(b). whose parents lose employer-subsidized coverage due to misconduct or voluntary separation fromemployment; and
(c). lose coverage due to the death of an employee or divorce.[3]
(Based on Minnesota, Wisconsin and Florida programs)[4]

Pros
- Could prevent employers from dropping coverage
- Could prevent employees from switching to public coverage

Cons
- Could force low-income workers to purchase expensive COBRA coverage for 18 months
- Could leave children above 150% of FPL uninsured for a period of time

[1] Under the tax code, self-insured employers (those regulated by ERISA) may not discriminate based on employee income in their payments for health benefits. In other words, self-insured employers may not offer different packages to employees (i.e., some which cover dependents and others which do not) based on employee wages.

[2] TennCare started 1/1/94; individuals who had been covered or offered coverage as of 7/1/93 are not TennCare eligible. COBRA coverage counted as coverage and someone could not become TennCare eligible until all 18 months of COBRA eligibility had been exhausted. Ginger Parra, TennCare, phone interview, October 11, 1996.

[3] Options (a),(b), (c), and (d) come from: Minnesota House of Representatives, Research Department (1996). *The MinnesotaCare Program.* The 18 months is tied to the amount of time an employee can purchase COBRA coverage.

[4] In Wisconsin, families are ineligible for the W-2 health care program if they have access to employer-based insurance that pays at least 50% of the cost of a family plan; families are also limited to one year of participation in the health care plan if they have access to employer-based insurance that pays any of the cost of a family plan. These restrictions do not apply to pregnant women, children under age six with incomes up to 165% of the FPL, or to children between ages six and 12 with incomes under 100% of the FPL. Source: Kaplan, T. (1996). *The W-2 Health Care Plan.* FOCUS. 18(1). Madison, WI: University of Wisconsin at Madison, Institute for Research on Poverty. In Florida, individuals and families are only eligible for the Florida Health Security Plan (FHSP) if they have been uninsured for 12 months or recently disenrolled from Medicaid.

89

Appendix I

Children-Only Health Plans Available in California

In November 1996, Children Now surveyed the following health plans operating in California to determine if they offered children-only coverage.[1]

Aetna Health Plans of California (510-746-6574) offers no individual plans.

Blue Cross of California/Wellpoint Health Networks, Inc. (800-777-6000) offers a variety of children-only plans from $39 to $120 per month, depending on age, region, and type of plan.[2]

Blue Shield (800-734-2442) offers children-only plans from $17 to $76 per month, depending on age, region, and type of plan.

CIGNA Health Care of California (800-344-0557) offers children-only plans from $65 to $90 per month, depending on age, region, and type of plan (plus a $15 enrollment fee and monthly administrative fees of $6).

Contra Costa County Health Plan (510-313-6070) offers children-only plans for county residents from $53 to $70 per month, depending on the type of plan.

Foundation Health Plan (800-621-7526) offers children-only plans statewide from $40 to $150 per month, depending on age, region, and type of plan.

FHP Health Care (800-275-4347) offers children-only plans in some Southern California counties ranging from $50 to $75 per month, depending on age and county.

Health Net (510-465-9600) does not offer children-only plans.

Kaiser Foundation Health Plan (800-464-4000) offers children-only plans from $42 to $71 per month, depending on age, region, and type of plan.

PacifiCare of California (800-577-0001) offers children-only plans from $69 to $86 per month, depending on age, region, and type of plan.

Prudential Health Care Plan of California, Inc. (800-804-3820) does not offer children-only plans.

Watts Health Foundation, Inc./ United Health Plan (800-624-4318) does not offer children-only plans.

[1] Information from health plan brochures and telephone inquiries, compiled for Children Now by Elizabeth Burr and Cassie Coleman.

[2] For example: $39 per month for a one-year-old in Fresno County on Blue Cross' California Care HMO Saver plan, vs. $120 for a child age birth to 18 in Los Angeles County for $20 co-pay plan. Note: Many HMOs charge an additional $5 administrative fee for monthly billing services.

Abbreviations Used in this Report

1. AFDC ..... Aid to Families with Dependent Children
2. AIM ..... Access for Infants and Mothers
3. CCS ..... California Children's Services
4. CHDP ..... Child Health and Disability Prevention
5. CPS ..... Current Population Survey
6. CTP ..... Children's Treatment Program
7. DHS ..... [California] Department of Health Services
8. DSH ..... Disproportionate Share Hospital
9. EPSDT ..... Early and Periodic Screening, Diagnosis and Treatment
10. FPL ..... Federal Poverty Level
11. GAO ..... General Accounting Office
12. HCFA ..... Health Care Financing Administration
13. MRMIB ..... Managed Risk Medical Insurance Board
14. NMES ..... National Medical Expenditure Survey
15. PW&C ..... Pregnant Women and Children
16. SSI ..... Supplemental Security Income
17. SSP ..... State Supplemental Program
18. TANF ..... Temporary Assistance to Needy Families

About Children Now

Children Now is a nonpartisan, independent voice for America's children. Paying particular attention to the needs of children who are poor or at risk, our mission is to improve conditions for all children by making them the top priority across the nation. Using innovative research and communications strategies, Children Now pioneers solutions to the problems facing children. To bring about positive change, our programs build partnerships with parents, lawmakers, business, media, and community leaders. Founded in 1988, Children Now's work is national in scope with special depth in California.

About this report

This report is one of three Children Now publications about uninsured children in California:

- California's Working Families & Their Uninsured Children: A Big Problem with an Affordable Solution—In Brief
- **California's Working Families & Their Uninsured Children: A Big Problem with an Affordable Solution**
- California's Working Families & Their Uninsured Children: Policy Building Blocks for Change

Please call (510) 763-2444 to order additional titles.

Acknowledgments

Children Now staff members Maryann O'Sullivan, Michael Burgmaier, Patricia Freeman, and Jessica Reich conducted the principal research, writing and analysis for this report. Administrative support was provided by Yolanda Adebiyi and Maisah Pradia.

Children Now has been graced with talented, thoughtful, and energetic interns: Diana Barroeta, Elizabeth Burr, Karen Chen, Cassie Coleman, Sandra Hernandez, Aimee Jungman, Kwixuan Maloof and Carolyn Schwartz.

The report was designed by Demetrio Roldán and Dennis Johnson.

Photography by Janet Delaney ©1997.

Offices

Oakland
1212 Broadway, 5th Floor
Oakland, CA 94612
tel. (510) 763-2444
fax (510) 763-1974
children@dnai.com

Sacramento
926 "J" Street, Suite 1400
Sacramento, CA 95814
tel. (916) 441-2444
fax (916) 268-1994
cnow@sna.com

Los Angeles
2001 S. Barrington Avenue,
Suite 100
Los Angeles, CA 90025
tel. (310) 268-2444
fax (310) 268-1994
cnla@leonardo.net

New York
800 3rd Avenue, 40th Floor
New York, NY 10022
tel. (212) 446-9325
fax (310) 268-1994
children@inch.com

1-800-CHILD-44

www.childrennow.org

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

NOTICE

REPRODUCTION BASIS

☒ This document is covered by a signed "Reproduction Release (Blanket) form (on file within the ERIC system), encompassing all or classes of documents from its source organization and, therefore, does not require a "Specific Document" Release form.

☐ This document is Federally-funded, or carries its own permission to reproduce, or is otherwise in the public domain and, therefore, may be reproduced by ERIC without a signed Reproduction Release form (either "Specific Document" or "Blanket").

EFF-089 (9/97)