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How Can California Policymakers Help Low-Income Children Benefit from National Health Reform?

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Cover California's kids

Contents

Executive Summary

Medicaid and the Children's Health Insurance Program (CHIP) now cover at least one in three children and more than half of low-income children, both in California and nationally. Compared to private insurance, Medicaid and CHIP offer children broader benefits and lower out-of-pocket costs; however, these programs' lower reimbursement rates can limit access to many providers. While they cover over 80 percent of eligible children, more than two-thirds of currently uninsured children qualify for Medicaid or CHIP but are not enrolled. Furthermore, many low-income children with coverage have uninsured parents. For example, less than 18 percent of poor children are uninsured, both nationally and in California, but more than 44 percent of poor parents lack coverage.

The Patient Protection and Affordable Care Act (ACA) offers a number of important potential gains for low-income children:

- First, their parents will experience a substantial reduction in uninsurance, which will help children by increasing the likelihood that they will gain coverage and improved access to care.

- Second, more uninsured children who already qualify for public programs will participate because of outreach and enrollment efforts surrounding the ACA's roll-out.

- Third, many currently ineligible, uninsured children will gain coverage because of new subsidies and the ACA's requirement for individuals to obtain insurance.

Several factors will determine whether these gains fully materialize for children in California and across the nation. In California, outdated and cumbersome eligibility methods used for Medi-Cal, the state's Medicaid program, can burden applicants and prevent eligible families from enrolling. Also, limited Medi-Cal provider reimbursement and networks could diminish the access to care received by both children and newly eligible parents. These two factors will be particularly important to address under the Governor's proposal to move children from Healthy Families, California's separate CHIP program, into Medi-Cal. In addition, while subsidies in the new health insurance exchange will provide meaningful assistance to many who would otherwise be uninsured, they will probably be insufficient to make coverage and care afford-

able for some low-income parents. Finally, unless Congress extends CHIP funding, federal allotments will end after 2015. This could force publicly covered children into employer-sponsored insurance or subsidized coverage in the exchange, possibly increasing their health care costs and reducing their benefits.

Whether policymakers address these factors effectively will profoundly shape how California's low-income children fare under reform. Regardless of how the Legislature responds to Governor Brown's proposal for ending Healthy Families, coverage will reach much higher levels if California uses new federal resources to apply information technology that makes enrollment more data-driven and family-friendly, particularly if the primary responsibility for eligibility determination shifts from counties to the state. To safeguard access to care, whether in Medi-Cal or Healthy Families, the state could consider such options as raising rates in a tightly targeted manner, reducing providers' administrative burdens related to claims submission and prior authorization, increasing the use of telemedicine, strengthening the capacity of safety-net providers in particular low-income communities, and broadening the scope of practice for mid-level practitioners. California could also consider implementing the Basic Health Program option within ACA. BHP structured like Medi-Cal or Healthy Families could make coverage and care much more affordable for many low-income parents and, if federal CHIP allotments end, their children.

In sum, low-income children and parents in California and elsewhere are likely to experience gains in coverage and access to care under the ACA. But the extent of those gains will depend, in large part, on key decisions made by state policymakers that go beyond today's budget debate.

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Introduction

After passing the country's first law establishing a health insurance exchange, California is once again in the front ranks of innovative states moving forward on health reform, despite the state's daunting budget challenges. This paper explores California's options to continue implementing reform, centered on one specific population: low-income children. We highlight how health reform could increase coverage and access to care for both low-income children and their parents,[1] identifying some of the key policy choices that will influence the extent of those gains in California.

We begin by describing some key features of the Patient Protection and Affordable Care Act (Affordable Care Act or ACA). We then summarize the current status of low-income children's health coverage, both nationally and in California. After exploring possible gains for low-income children under the federal legislation, we describe factors that could determine whether such gains fully materialize. Finally, in light of those factors, we analyze how the state can maximize improvements in coverage and access to care.

To keep this discussion manageable, we will not analyze the full range of health reform issues affecting children. In particular, we have left for another day an exploration of the Brown Administration's proposed shift of Healthy Families children into Medi-Cal (2011).[2] Whether or not that proposal is enacted, the issues raised in this report are likely to have an enormous impact on the coverage and care that California's low-income children receive under reform.
Other issues outside the scope of this paper involve home visitation services; school-based health clinics; pediatric accountable care organizations; insurance reforms (including limitations on discrimination against children with preexisting conditions); general access and quality concerns affecting California children; and the continuation of immigration-status-related limits on federal funding for non-emergency health care. Even putting aside these topics, California policymakers face key decisions, explored here, that could make a major difference in how the state's low-income children and families fare under health reform. While this report focuses on California, most of the issues we analyze apply throughout the country.

I. Highlights of the Affordable Care Act

Comprehensive descriptions of the ACA are available elsewhere.[3] But for purposes of this paper, some of the main provisions that become effective in 2014 include the following:

- In each state, a health insurance exchange (operated either by the state or the federal government) offers a choice of health plans to small firms and individuals. Plans must meet minimum federal standards, such as those that require coverage of minimum essential benefits, including pediatric services (including oral and vision care). Out-of-pocket (OOP) cost-sharing is not permitted for preventive care. Tax credits that help pay premiums and susidies for OOP costs are available for low-income people who (a) are ineligible for Medicaid and the Children's Health Insurance Program (CHIP) and (b) are not offered employer-sponsored insurance (ESI) that meets the ACA's minimum standards of affordability and comprehensiveness.[4] Paid in advance as monthly insurance premiums are due, tax credits are available for households with incomes at or below 400 percent of the federal poverty level (FPL), and OOP cost-sharing subsidies are offered on a sliding scale up to 250 percent FPL. If annual income, as reflected on federal tax returns, turns out to differ from the income estimates on which tax credits were based, a reconciliation process applies. If the tax credit amounts advanced on behalf of a consumer turns out to have been too high, the consumer must repay the excess, up to a "safe harbor" maximum that varies by income.

- Medicaid coverage extends to 138 percent FPL[5] for children through age 18. This eliminates the current "stair-step" eligibility through which mandatory eligibility reaches 133 percent FPL for children under age 6 and drops to 100 percent FPL for children ages 6-18. Medicaid coverage will likewise reach 138 percent FPL for non-elderly adults who are either citizens or have maintained satisfactory immigration status for at least 5 years. Adults who newly qualify for Medicaid will have 100 percent of their costs paid by the federal government during 2014 through 2016. Beginning in 2017, the federal share will gradually decline, reaching 90 percent in 2020 and thereafter.

- For purposes of Medicaid, CHIP, and subsidies in the exchange, income is determined based on "Modified Adjusted Gross Income," or MAGI—that is, "adjusted gross income," under federal income tax law, plus tax-exempt interest and tax-exempt foreign earnings.

Exceptions to MAGI include Express Lane Eligibility, if implemented in a state;[6] Medicaid eligibility categories involving foster-care children, adoptive children, seniors, and people with disabilities; and waivers under Section 1115 of the Social Security Act.

- Above 138 percent of FPL, the Medicaid and CHIP income eligibility thresholds that were in place for children as of December 2009 may not be cut back until 2020. This maintenance-of-effort requirement includes eligibility rules,[7] limits on premiums, and methods used to expedite enrollment and retention.

- While 2009 Medicaid and CHIP eligibility levels remain intact through 2019, federal CHIP allotments are currently authorized only through the end of federal fiscal year 2015. Whether they continue beyond that point depends on whether Congress reauthorizes the program. Starting in federal fiscal year 2016, federal matching rates for CHIP dollars will rise by 23 percentage points. If Congress does not reauthorize CHIP, and a state's federal allotment runs out, children who now qualify for a separate CHIP program will probably be treated like adults with incomes above Medicaid levels—that is, they will be eligible for subsidies in the exchange if their income is at or below 400 percent FPL and they lack an affordable offer of comprehensive ESI.[8]

- As a general rule, everyone who is obligated to file federal income tax returns must have health insurance. For example, married couples under age 65 were required to file in 2010 if their 2009 gross income exceeded $18,700, or 85 percent of FPL for a family of 4.[9] Exceptions to the individual mandate include people who would have to pay more than 8% of their income for insurance, people who show that purchasing insurance would constitute a hardship (under rules not yet defined by the federal government), undocumented immigrants, members of Indian tribes, and those with religious objections to health insurance coverage.

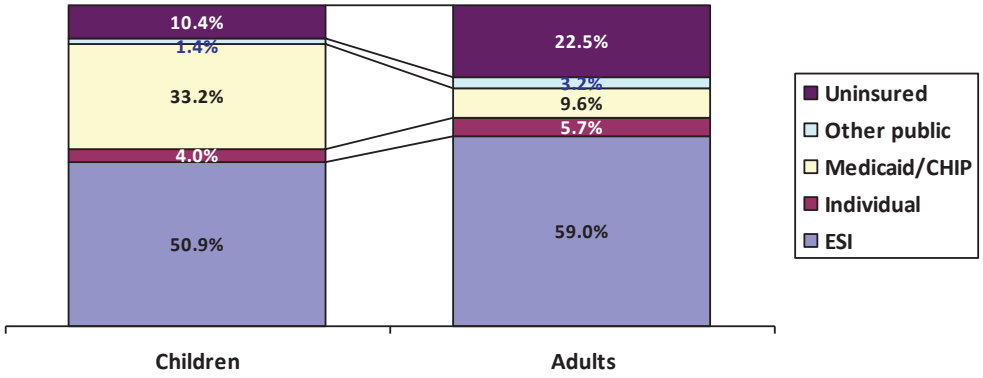
- In charging premiums, issuing coverage, and defining covered benefits, insurers may not discriminate on the basis of health status.

II. An overview of current coverage for low-income children

A. Nationally

Compared to adults, children are much more likely to have publicly subsidized coverage, much less likely to be uninsured, and less likely to have ESI or individual coverage (Figure 1).

Figure 1. National distribution of health coverage, children vs. adults under age 65: 2009



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2010 Current Population Survey, Annual Social and Economic Supplement (ASEC).

Notes: Other public coverage includes coverage for active duty military and veterans. These estimates do not adjust for the underreporting of Medicaid and CHIP coverage.

1. Public programs

In 2009, Medicaid and CHIP together covered more than 26 million children, according to Census Bureau data. Approximately 33 percent of all children and 59 percent of low-income children were enrolled in one of those programs.[10] Medicaid and CHIP also cover a disproportionate share of children from racial and ethnic minorities and those with chronic health problems (Kenney and Dorn 2009).[11]

Compared to private insurance, Medicaid and CHIP offer low-income children many advantages as well as certain disadvantages. One advantage is that both public programs tend to offer broader benefits. Medicaid, in particular, covers Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), which includes any care that may be needed for children's healthy development. This avoids denials of service for reasons that are appropriate for adults but not

children. Medicaid also covers interpretation, translation, and case management that connects children to social supports as well as necessary medical care. Private insurance rarely covers these services, which were designed to address the needs of many low-income families. Along similar lines, cost-sharing, including premiums, copayments, coinsurance, and deductibles, tends to be much lower with Medicaid than under private insurance (Ku and Broaddus 2008; Banthin, Cunningham, and Bernard 2008; Galbraith et al. 2005; Zuckerman and Perry 2007). For children with incomes at or below 150 percent of FPL, most Medicaid programs do not charge out-of-pocket (OOP) cost-sharing or premiums (Kaiser Commission on Medicaid and the Uninsured 2010).

While the benefit and cost-sharing requirements under federal law are stricter for Medicaid than for CHIP, CHIP programs much more closely resemble Medicaid than private coverage (First Focus 2009; Hill 2000; Hill et al. 2001). Some CHIP plans (including those that are not Medicaid expansions) use Medicaid benefits and cost-sharing rules, and most others cover broad benefits and limit cost sharing to nominal levels, providing much more generous assistance than is minimally required by the federal CHIP law. [12]

Federal and state governments share the financial responsibility for Medicaid and CHIP. The precise percentage of health care costs paid by the federal government varies by state, based on state per capita income, but it averages 57 percent for Medicaid and 70 percent for CHIP. During economic downturns, when state revenues decline and caseloads for need-based programs rise, states, facing legal requirements for balancing their budgets, often feel great pressure to cut their spending on these programs. During both the current and the previous economic downturn, federal lawmakers provided states with enhanced Medicaid funding, conditioned on states' maintaining their previous level of Medicaid eligibility.[13] The current round of enhanced funding is slated to end in July 2011.

In most states, perhaps the most important disadvantage children may experience in Medicaid and CHIP, compared to private plans, is reduced access to care, resulting from lower reimbursement rates that can discourage participation by many providers (Jeffrey and Newacheck 2006; Kenney, Ko, and Ormond 2000; Gold and Mittler 2003). Some fear that low reimbursement also leads to lower quality of care (Zuckerman, Williams, and Stockley 2009; Cunningham and Nichols 2005; Landon et al. 2007; Gold and Kuo 2003; Berman et al. 2002). On the other hand,

numerous studies find that low-income children are more likely to receive preventive care in Medicaid and CHIP than under private coverage and that low-income families are more likely to report financial barriers to care with private insurance than with publicly sponsored coverage (Perry and Kenney 2007; Dubay and Kenney 2001; Selden and Hudson 2006; Kenney and Dorn 2009).

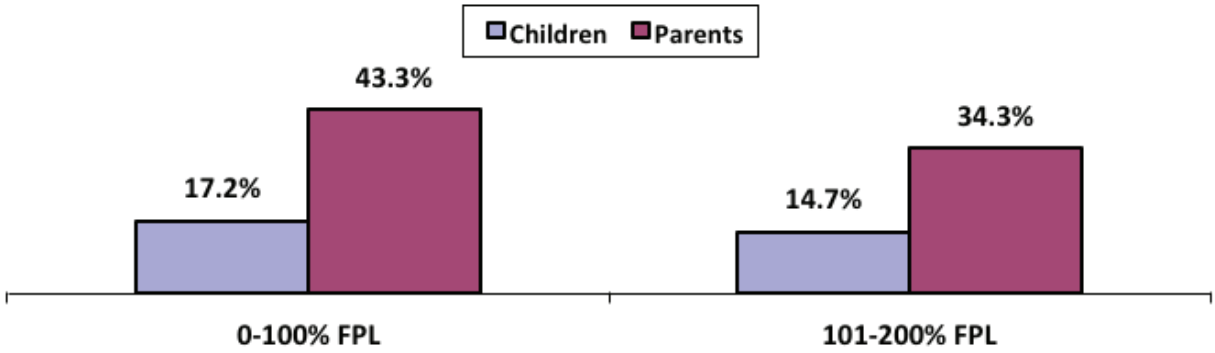
2. Uninsured children and parents

An estimated 7.3 million children were uninsured on the average day during 2008. And although most eligible children—82 percent—participate in Medicaid or CHIP, approximately two-thirds of all uninsured children qualify for these programs but are not enrolled (Kenney et al. 2010). National research indicates that most parents with low-income, uninsured children would like to enroll their children in Medicaid or CHIP but don't think their children qualify, don't know about the programs, don't know how to apply, or perceive enrollment procedures to be difficult (Kenney, Cook, and Dubay 2009).

Another serious issue facing low-income children is that, even when they have Medicaid or CHIP, their parents are often uninsured (Kenney and Cook 2007). The most important cause is that these programs set considerably lower eligibility levels for parents than children. As of January 2011, median income-eligibility is 241 percent FPL for children and 64 percent and 37 percent FPL for working and non-working parents, respectively (Haberlein et al. 2011).

It is thus no surprise that, compared to their children, low-income parents are much more likely to lack coverage. For example, in poor families, 17.2 percent of children were uninsured in 2009, compared to 43.3 percent of parents. Among families with incomes between 100 and 199 percent FPL, the uninsured comprised 14.7 percent of children and 34.3 percent of parents (Figure 2). Uninsurance among parents affects not only their own health and access to care but also their children's likelihood of receiving coverage and necessary services (Davidoff et al. 2003; Dubay and Kenney 2003).

Figure 2. Among low-income children and parents nationally, the percentage without coverage, by income level: 2009



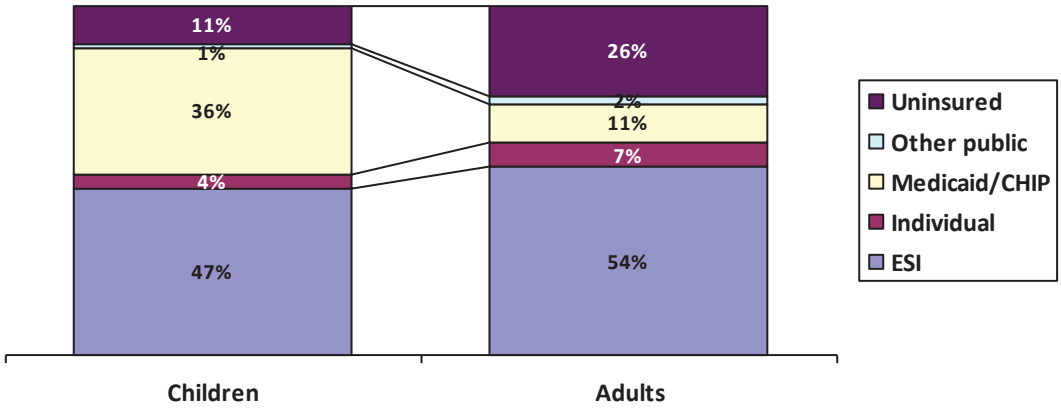
Source: Urban Institute tabulations of the 2010 ASEC Supplement to the Current Population Survey.

Notes: Excludes persons age 65 and older and those in the Armed Forces. Children include all individuals under age 19; parents are individuals over age 18 who live with their own children under age 19. These estimates do not adjust for underreporting of Medicaid/CHIP coverage. Differences in uninsurance rates between children and parents at each income level are statistically significant at the .05 level.

B. California

The basic picture of health coverage for low-income children in California resembles that for the nation as a whole. Compared to adults, California children are much less likely to be uninsured and much more likely be covered through Medi-Cal (California's Medicaid program) or Healthy Families (California's CHIP program) (Figure 3). Although California extends Medi-Cal eligibility for parents above many other states' Medicaid income eligibility levels, low-income families in California are more likely to have "mixed" immigration status—that is, to include citizen children who qualify for coverage and parents (perhaps siblings as well) whose status precludes eligibility.

Figure 3. Distribution of California health coverage, children vs. non-elderly adults: 2008–2009



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2010 Current Population Survey, Annual Social and Economic Supplement (ASEC).

Notes: Other public coverage includes coverage for active duty military and veterans. These estimates do not adjust for the underreporting of Medicaid/CHIP coverage.

Among California children with incomes at or below 200 percent of FPL, 61 percent are enrolled in Medi-Cal or Healthy Families and 17 percent are uninsured, according to Census Bureau data.[14]

1. Public programs with joint Federal and State funding

Medi-Cal reported covering 3.7 million children as of March 2011.[15] The program's upper income eligibility threshold is set at 200 percent of FPL for infants under age 1, 133 percent FPL for children ages 1 through 5, and 100 percent FPL for children ages 6 through 18. Healthy Families, California's CHIP program, covered 870,000 children in March and April 2011, down from 920,000 before an enrollment freeze and waiting list were applied from July through December 2009 (California Managed Risk Medical Insurance Board 2011). Layered atop Medi-Cal, Healthy Families serves children through age 18 in families with income at or below 250 percent FPL.

Healthy Families' covered benefits exceed the generosity of typical private insurance but fall slightly below the level furnished through Medi-Cal. Healthy Families does impose cost-sharing—in the form of premiums and copayments—and is among the minority of CHIP programs to do so even for families earning less than 150 percent of poverty. Nevertheless, Healthy Families

coverage has an actuarial value (AV) of 98 percent—that is, it covers 98 percent health care costs for a standardized, typical population—with less than $50 in average annual out-of-pocket costs per child (First Focus 2009) and copayments generally falling between $5 and $15 per service.

While less expansive than Medi-Cal, Healthy Families is more generous than either typical private insurance today or the coverage that the ACA will subsidize in the exchange. According to a national study by the Actuarial Research Corporation, employer-sponsored insurance (ESI) averages 84 percent, 89 percent, and 94 percent AV for fee-for-service plans, PPOs, and HMOs, respectively (Yi and Mays 2009). From 1996 to 2002-2003, the average AV for all ESI nationally fell from 86 to 82 percent (Eibner and Marquis 2008). While comparable trend information does not continue beyond 2003, other research shows continuing erosion in the generosity of employer-sponsored health benefits,[16] suggesting a growing gap between private insurance and Healthy Families. In California, small group coverage and individual coverage in 2006 averaged 83 percent and 55 percent AV, respectively (Gabel et al. 2007).

Under the ACA, subsidies will provide coverage with various levels of AV, depending on income. Each subsidized level falls far below the 98 percent AV offered by Healthy Families, which includes no individual deductible and copayments of $15 or less per service. For example:

- Under 150 percent FPL, subsidized coverage in the exchange will have an AV of 94 percent. Such coverage might have, for example, a $200 individual deductible and 5 percent co-insurance, or no deductible and 8 percent co-insurance.[17]

- Between 150 and 200 percent FPL, an 87 percent AV will apply. The most highly-subscribed plan covering federal employees is an example of coverage at this level, featuring a $250 deductible, $15 office visit copays, 10 percent coinsurance for hospital visits, and 25 percent coinsurance for prescription drugs.

- Between 200 and 250 percent FPL, subsidies will provide coverage with 73 percent AV. This could involve, for example, a $3,200 individual deductible and no coinsurance or a $1,750 individual deductible and 25 percent coinsurance.

- Between 250 and 300 percent FPL, subsidies will pay for plans with 70 percent AV and a cap on out-of-pocket costs. This coverage might involve, for example, a $2,050 individual deductible and 30 percent coinsurance.

Despite their generous coverage, programs like Medi-Cal and Healthy Families have kept overall spending well below private levels, primarily by limiting provider reimbursements (Hadley and Holahan 2003/2004). Medi-Cal, for example, has physician payment rates that are consistently among the lowest in the nation—the fourth-lowest of any state in 2008.[18] One survey found that, in 2008, 57 percent of California physicians were accepting new Medi-Cal patients, compared to 73 percent who did so with Medicare; and that roughly 25 percent of all physicians served 80 percent of all Medi-Cal beneficiaries (Bindman, Chu, and Grumbach 2010). Medi-Cal's fee-for-service dental program—Denti-Cal—reportedly provides beneficiaries with particularly poor access, with payment levels far below average amounts for Medicaid programs nationally (California HealthCare Foundation 2007; Zuckerman, Williams, and Stockley 2009). On the other hand, Medi-Cal payments for federally-qualified health centers and some hospitals are based on cost, as a matter of federal law, and so can sometimes exceed payments from private insurers. Less information is available about provider payment and participation in Healthy Families, though some observers suggest that levels may be higher than in Medi-Cal (Wulsin 2011; Mittler and Gold 2003).

Notwithstanding their many operational similarities, Medi-Cal and Healthy Families are governed by federal statutes that differ on important issues, with the federal Medicaid statute providing greater security of coverage, as noted earlier. Children who qualify for Medicaid are guaranteed enrollment; federal law tightly limits the costs that may be imposed on families; and through EPSDT, children are guaranteed the full range of necessary care. The federal CHIP statute, by contrast, permits benefits that are based on commercial coverage; allows costs to be charged above nominal levels, particularly in families with income that exceeds 150 percent FPL; and, before the ACA, let states place eligible children on waiting lists rather than enroll them into coverage. ACA's maintenance-of-effort requirements now bar such waiting lists, along with other steps (such as increased premiums) that might decrease Healthy Families enrollment. For children in families with incomes above 150 percent FPL, the federal CHIP statute caps children's health care and coverage costs at 5 percent of family income—a relatively high threshold, given that only children's costs are subject to the limit.

The federal law governing Healthy Families thus permits California lawmakers to reduce the generosity of covered benefits and to increase total out-of-pocket cost-sharing. The state could conceivably take such steps in response to either general budget pressures or the possible lapse of the state's funding for Healthy Families. Some of this funding is now provided outside the General Fund through Proposition 10 dollars and special taxes on Medi-Cal managed care plans. Major proposed changes to both programs are now before the Legislature, including significant increases in Medi-Cal copayments and, as noted above, the movement of all Healthy Families children into Medi-Cal.

2. Other programs

Although Medi-Cal and Healthy Families serve by far the largest numbers of low-income California children, other programs—public and private—also provide relatively comprehensive coverage. The latter are funded by federal, state, and local resources as well as private philanthropy. Specifically, in order of total enrollment:

- Kaiser Permanente's Child Health Plan covers uninsured children living below 300 percent FPL. Kaiser opens and closes enrollment based on available funding. As of March 2011, Kaiser covered nearly 80,000 children.[19]

- Since 2003, a growing number of county-based Children's Health Initiatives (CHIs) have designed and implemented Healthy Kids programs that typically mimic Healthy Families in their design but explicitly cover children who are ineligible for Medi-Cal and Healthy Families. These children do not qualify for federally matched coverage because of either income or immigration status. Core funding comes from county First 5 Commissions, which have committed significant portions of their Proposition 10 tobacco tax revenues to pay premiums for enrollees through age five. For 6- to 18-year-olds, funding comes from a variety of public and private sources. As of September 2010, 24 Healthy Kids programs covered more than 50,000 children. All but one of these Healthy Kids programs set their upper income eligibility threshold at 300 percent FPL, but most enrollees are very poor, im migrant children (California Coverage and Health Initiatives 2010).

- Since 1992, the Access for Infants and Mothers (AIM) program has provided state-funded coverage for pregnant women and their infants with incomes between 200 and 300 percent

FPL. As of April 2011, the program served approximately 7,000 pregnant women and infants (California Managed Risk Medical Insurance Board 2011).

- The CaliforniaKids (CalKids) program, sponsored by Blue Cross of California, provides outpatient care to uninsured children below 250 percent FPL. Enrollment levels vary, depending on funds available from the California Kids Healthcare Foundation. As of September 2010, the program served over 4,200 children (California Coverage and Health Initiatives 2010).

Table 1. Comprehensive Coverage Programs for Children

Program	Number of children enrolled	Core Eligibility Criteria
Medi-Cal	3,720,364 (as of 03/11)	• Citizen or eligible immigrant age 0–18 • California resident • Infants up to 200% FPL; child age 1 to 5 with income up to 133% FPL; child age 6 to 18 with income up to 100% FPL
Healthy Families (HF)	870,970 (as of 04/11)	• Citizen or eligible immigrant age 0–18 • California resident • Income up to 250% FPL
Kaiser Child Health Plan	79,762 (as of 03/11)	• Child age 0–18 • Income up to 300% FPL • Ineligible for ESI, Medi-Cal, and HF
Healthy Kids	50,959 (as of 09/10)	• California county resident child age 0–18 • Income up to 300% FPL • Currently uninsured and ineligible for Medi-Cal/HF
Access for Infants and Mothers (AIM)	7,159 (as of 04/11)	1. California resident pregnant woman or infant to age 1 with income between 200–300% FPL 2. Uninsured or coverage has deductible/copayment >$500
CaliforniaKids (CalKids)	4,220 (as of 09/10)	a) Child age 2 to 18 b) Household income up to 250% FPL c) Ineligible for public insurance coverage

Sources: California Department of Health Care Services 2011; California Managed Risk Medical Insurance Board 2011a and b; California Coverage and Health Initiatives 2010; Kaiser Permanente Community Benefit Office, personal communication, May 3, 2011.

Largely outside the scope of this paper are publicly funded programs for children that do not provide comprehensive insurance. These include funding for school-based health centers; the Child Health and Disability Prevention (CHDP) program, which uses state funds to provide preventive services and related care to children who are ineligible for Medi-Cal, and which includes California's version of EPSDT; Family Planning, Access, Care, and Treatment (Family PACT), which provides comprehensive family planning services; and California Children's

Services (CCS), the state's Children with Special Health Care Needs program under Title V of the Social Security Act, which furnishes specialty and supportive care to certain children with chronic illnesses and disabilities.

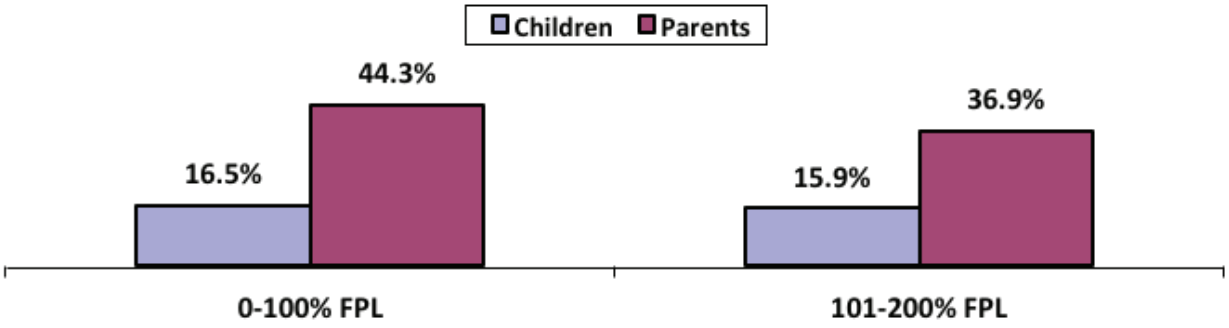
3. Uninsured children and parents

In recent years, the number of uninsured California children has fallen, even as the combination of a worsening economy and an ongoing erosion of ESI increased the proportion of uninsured adults.[20] As with many other Medicaid and CHIP programs across the nation, Medi-Cal and Healthy Families have been very successful in reaching their target population, covering an estimated 82 percent of eligible children in 2008 (Kenney et al. 2010). At the same time, more than two-thirds of all uninsured children in California were eligible for these programs but not enrolled.[21] Altogether, approximately 15 percent of the country's eligible and uninsured children live in California (Kenney et al. 2010).

To address the challenge of reaching eligible children, California has been a national leader in its Certified Application Assistance (CAA) program. Since 1998, the CAA program has provided ongoing training and performance-based reimbursement to community-based organizations, providers, and others who provide hands-on assistance to families and succeed in enrolling their eligible children. Despite evidence of this program's effectiveness,[22] the state responded to severe budget pressures by suspending CAA payments in June 2009 (Healthy Families Program 2009).

California also resembles the rest of the country in that many low-income children, including those enrolled in public coverage, live with parents who are uninsured. As noted above, these parents may be ineligible for Medi-Cal because of either immigration status or income. While only 16.5 percent of poor California children lacked coverage in 2009, fully 44.3 percent of poor parents were uninsured. In families with incomes between 100 and 200 percent of FPL, 15.9 percent and 36.9 percent of children and parents, respectively, lacked coverage, according to survey data (Figure 4).

Figure 4. Among low-income children and parents in California, the percentage without coverage, by income level: 2009



Source: Based on data from the 2010 ASEC Supplement to the Current Population Survey. Notes: Excludes persons aged 65 and older and those in the Armed Forces. Children include all individuals under age 19; parents are age 19 and over who live with their own children age 18 and under. These estimates do not adjust for underreporting of Medicaid/CHIP coverage. Differences in uninsurance rates between children and parents at each income level are statistically significant at the .05 level.

In terms of the percentage of children without coverage in particular areas of the state, 16 out of the 34 California counties that could be assessed with the American Community Survey (ACS) fell below the state average by a statistically significant amount in 2008–2009, and 7 exceeded the average (Table 2). More than three in ten (31.5 percent) of all uninsured children lived in Los Angeles County, and nearly two-thirds (64.9 percent) lived in just five counties (Los Angeles, San Diego, Orange, Riverside, and San Bernardino) (Table 3). Attached as an appendix to this report is a table showing children's health coverage information for each county capable of assessment through the ACS.

Table 2. Percentage of children age 0–18 without health coverage, selected California counties: 2008–2009

County		Percentage of children without coverage
Percentage of uninsured children in county is significantly below the state average	Placer	3.7
	Yolo	4.2
	San Mateo	4.9
	Santa Clara	5.0
	San Francisco	5.1
	Alameda	5.1
	Sonoma	5.2
	Sacramento	5.4
	El Dorado	6.1
	Butte	6.2
	Merced	6.7
	Marin	6.8
	Santa Cruz	6.9
	Solano	6.9
	Contra Costa	7.1
	San Joaquin	8.0
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Percentage of uninsured children in county is significantly above the state average	Tulare	14.8
	Shasta	13.8
	Imperial	13.8
	Riverside	12.1
	San Bernardino	11.5
	Los Angeles	11.3
	San Diego	11.2

Source: Urban Institute Tabulations of 2008 and 2009 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS). Note: This table is limited to counties where the percentage of children under age 19 without coverage was greater or less than the statewide average of 9.6 percent by a statistically significant margin at the 5 percent level.

Table 3. In the five most populous counties, the percentage of all California children and all uninsured California children: 2008–2009

County	Percentage of all California children	Percentage of all uninsured California children
Los Angeles	26.9	31.5
Orange	8.1	8.6
San Diego	8.0	9.2
Riverside	6.3	8.0
San Bernardino	6.3	7.5
Total:	**55.6**	**64.9**

Source: Urban Institute Tabulations of 2008 and 2009 ACS data from the Integrated Public Use Microdata Series (IPUMS). Note: Children are under age 19. Totals may not sum exactly to bottom line numbers due to rounding.

III. Possible gains for low-income California children under the Affordable Care Act

For low-income children in California, the ACA could improve access to care in three ways:

- Previously uninsured, low-income parents will gain coverage and access to care, thus improving their children's likelihood of coverage, access to care, and health status;

- Children who currently qualify for Medi-Cal and Healthy Families will be more likely to enroll; and

- Uninsured children who are currently ineligible for assistance will receive coverage.

This section of the paper describes these potential gains in an order that reflects the number of low-income children who could potentially be affected. Later sections identify factors that could affect the extent to which such gains materialize and explore policy options through which California's leaders could address those factors to maximize eligible families' receipt of coverage and necessary care.

A. Increased parental coverage

For the many low-income children who now participate in Medi-Cal or Healthy Families, the Affordable Care Act's greatest benefit may be that their uninsured parents obtain health coverage. As of 2014, Medi-Cal eligibility levels for parents will reach 138 percent FPL. In addition, federal subsidies through the exchange will be available up to 400 percent of FPL. Subsidies will also go to immigrant parents with incomes below 138 percent FPL who are ineligible for full-scope Medi-Cal because they received lawful status within the past five years. Parents eligible under current law may also be more likely to enroll. This will result from the ACA's requirement for individuals to obtain coverage and streamlined methods for eligibility determination, enrollment, and retention, which later sections of this report analyze in detail. As noted above, when parents have health insurance, their children are more likely to receive coverage and care; and when parents receive necessary services (including mental and behavioral health care), their children are more likely to thrive. [23]

B. Increased enrollment by children who currently qualify for help

Many features of the ACA will increase enrollment among children who qualify for Medi-Cal and Healthy Families under current law. Prompting such increased participation will be—

- The mandate to purchase insurance; [24]
- The above-described increase in parental coverage;
- ACA's potential streamlining of enrollment into all subsidized programs, including Medi-Cal and Healthy Families (as discussed in more detail below);
- The reduced number of families whose children are divided between Medi-Cal and Healthy Families because of Medi-Cal income thresholds that vary by age; [25]
- The elimination of premium charges for children shifted from Healthy Families to Medi-Cal; and
- Wide publicity for new programs that increases enrollment into existing programs. Such a "woodwork" or "welcome mat" effect was observed when the launch of Healthy Families spurred significant enrollment of Medi-Cal children (Hill et al. 2004; Trenholm and Orzol 2004).

C. Increased coverage for children ineligible for Medi-Cal and Healthy Families

ACA will also cover uninsured children who, in the past, were ineligible for Medi-Cal and Healthy Families. As noted earlier, subsidies in the exchange will extend to 400 percent FPL, offering help to many uninsured children with household incomes too high to qualify for Healthy Families or county-based programs (where such programs exist). Moreover, the individual mandate will encourage parents of all income levels to take advantage of available coverage, including that offered by employers.

IV. Factors that could affect gains in coverage and access to care

The previous section suggests that both low-income children and their parents could see major

improvements in coverage and access to care under the ACA. But the extent of those gains could be limited by several factors, including:

- The system California uses to determine Medi-Cal eligibility;
- The provider network that serves low-income communities;
- The accessibility and affordability of subsidized coverage in the exchange; and
- The possible end of federal CHIP allotments after federal FY 2015.

A. Medi-Cal eligibility determination

With the ACA's major expansion in Medi-Cal eligibility scheduled for 2014, county social service offices will experience a significant increase in demand for their services. They may have great difficulty coping with this demand if eligibility and enrollment procedures remain labor-intensive and paper-based, imposing large burdens on consumers and administrative costs on counties and the state.

Such approaches could also create equity problems in the contrast with subsidies in the exchange, eligibility for which will be determined using data-driven methods. For example, the ACA specifies that data from prior-year tax returns automatically establish eligibility for subsidies in the exchange, unless applicants decide to provide updated information. If Medi-Cal chooses to retain traditional, time-consuming procedures through which applicants must present paper documentation that agency staff must manually verify, not only will public sector administrative costs rise, the very poorest uninsured will face a more difficult, time-consuming, and ultimately less successful process of enrollment and eligibility determination than will apply to the new subsidy program serving consumers with higher incomes.

Moving away from traditional eligibility procedures, whether by federal mandate or state policy choice, will require a substantial reengineering of eligibility workers' business processes and office culture. [26] The diffusion of responsibility for eligibility determination among social service offices in 58 California counties will greatly complicate implementation of such reforms. To avoid a comparable challenge, New York State decided to make a five-year transition

through which responsibility for Medicaid and CHIP eligibility determination is shifting from county social service offices to the state health agency. [27] New York officials described several key motivations for this change, identifying factors that surely apply in California as well:

While the federal and state governments establish the policy that governs Medicaid eligibility, local departments of social services have latitude in how those policies are implemented.... Some local districts embrace a culture of coverage and have initiated local outreach, data matching and other activities to increase the enrollment of the eligible uninsured. Other counties view Medicaid as a welfare program and increases in enrollment more negatively. Some counties add forms and documents that are not required by the state. Frequent requests for additional information result in people giving up on their application and remaining uninsured. Similarly, some local districts have embraced [community-based] facilitated enrollers as an extension of their own staff while others distrust them and are suspicious of applications submitted by them... Tracking such local practices and working to eliminate those that are contrary to federal and state policy is labor intensive. (New York State Department of Health 2010)

Although future guidance from federal officials is expected to resolve important questions about the extent to which states can continue to apply traditional eligibility methods, it is already clear that the legislation will require major changes. According to ACA's statutory language:

- The state's insurance exchange will screen applicants for Medi-Cal and Healthy Families eligibility. If such screening establishes their eligibility, they will be enrolled in Medi-Cal and Healthy Families (HHS Office of Consumer Information and Insurance Oversight 2010b).

- A single application form, promulgated by the federal government, [28] will be used for Medi-Cal, Healthy Families, and subsidies in the exchange. The form can be filed by mail, in person, on-line, or by phone. However and wherever the form is filed, state agencies and the exchange work together seamlessly, "behind the scenes" to determine the applicant's eligibility for all subsidy programs. These agencies determine eligibility based on available data whenever possible, conducting data matches with multiple state and federal sources of information. Once that process is complete, the applicant will learn of the program (if any) for which he or she qualifies, without any need to provide additional information. [29]

- Applicants can seek a determination of subsidy eligibility based entirely on data matching, without filing an application form. Instead, a consumer can simply authorize the disclosure of personal information already in government hands (such as income tax data) for purposes of qualifying for Medi-Cal, Healthy Families, or subsidies in the exchange. [30]

- The exchange can contract with Medi-Cal to determine eligibility for all subsidies, provided that Medi-Cal meets applicable federal standards (which have not yet been developed). [31]

- Starting in 2014, Medi-Cal and Healthy Families will need to provide the U.S. Treasury Department with information each January identifying every recipient of coverage during the prior year, including the specific months of enrollment and the Social Security Number (or other Taxpayer Identification Number) for each beneficiary. [32]

Beyond the general challenges facing Medi-Cal's eligibility determination system in reaching these ACA standards, two specific issues warrant special discussion: the state's need to ramp up its information technology to meet the performance requirements of the Affordable Care Act; and Medi-Cal application procedures for parents and other adults.

1. Information technology (IT)

California's eligibility-related IT system will require major change for the state to meet the ACA's requirements and provide consumers with a simple and streamlined process for enrollment, eligibility determination, and retention. Currently, three consortia of California counties operate different and largely incompatible systems to determine Medi-Cal eligibility. A separate vendor administers another system for Healthy Families, and the state administers a fifth record-keeping system for health and human services programs (Belshé 2011). Moreover, the systems used by Medi-Cal are outdated, and local social service offices routinely rely on paperwork submitted by applicants rather than data matches to establish and verify eligibility.[33]

Several recent federal actions give California a chance to transform its IT systems used for eligibility determination.

1. **Section 1561 of the Affordable Care Act** has led the U.S. Department of Health and Human Services (HHS) to adopt "interoperable and secure standards and protocols to facilitate electronic enrollment of individuals in Federal and State health and human services

programs."[34] Based on these standards (HIT Policy and Standards Committee 2010), the following steps are now being taken:

- **Software application models** are under development, by both the federal government and several states that received "Early Innovator" grants to develop IT needed for the operation of exchanges (HHS Office of Consumer Information and Insurance Oversight 2010a). These models should be able to accomplish multiple functions. For example, after an applicant provides core identifying information (name, Social Security Number, date of birth, and address), a federal data hub will automatically gather information about the applicant that is available from all relevant federal sources, including the Internal Revenue Service, the Social Security Administration, etc. The software may also query relevant state databases, potentially including eligibility records for public benefit programs, state workforce agency data, birth certificate records, and the like. Based on these data, business rules housed outside the underlying eligibility system can be applied to determine eligibility for Medi-Cal, Healthy Families, and subsidies in the exchange. Such business rules could also, without manual intervention, be used to identify any additional information needed from the applicant.

- **A common definition of core data elements** will streamline data exchange between state Medicaid and CHIP agencies, health insurance exchanges, the reference software application model, and databases containing information relevant to eligibility. Based primarily on the existing National Information Exchange Model developed by the Department of Homeland Security and the Department of Justice, this common definition resolves issues like the following: whether date of birth is recorded in one field or three separate fields; whether this data element is called "date of birth" or "birth date"; etc. California will thus need to develop "translation" routines that let its Medi-Cal and Healthy Families eligibility systems answer queries and report information using this common definition of core data elements.

2. Federal financial support for eligibility-related IT development is now available to states and localities at substantially increased levels. In April 2011, the federal government issued a final rule under which, through 2015, it will pay 90 percent of development costs for eligibility-related IT that helps Medicaid implement the above-described Section 1561 standards (Centers for Medicare and Medicaid Services 2010). Once such IT is in place, the federal government will

pay 75 percent of operating costs. HHS also specified that, through the end of 2014, federal grants to establish and operate exchanges will cover IT costs necessary for data-based eligibility determination.[35] States are expected to allocate their IT development costs between these two funding streams.

Although the federal government is offering to pay between 90 and 100 percent of initial investments needed to implement the more data-driven eligibility system envisioned by the ACA, California will need to pay some of those initial expenses. Such costs will probably be substantially outweighed by savings in ongoing administrative expenses over time; in 2009–2010, the latter expenses cost the state General Fund $750 million (Bland et al 2010).

Unlike IT-related investment and operating costs that, if consistent with ACA Section 1561, will qualify for 90 percent and 75 percent federal matching payments, respectively, traditional Medi-Cal eligibility determination requires the state to pay 50 percent of all administrative expenses. As a result, even if up-front IT investments equaled the cost of all later operational savings, California would come out far ahead financially. And even before this new decision by the federal government to increase its share of initial IT development, other states and benefit programs have found that moving to a more data-driven, less manual approach to eligibility determination generated ongoing administrative savings that exceeded initial investment costs.[36]

To access these new federal resources for IT development, however, California will need to implement an eligibility process that HHS describes as follows:

> We expect IT systems to support a first-class customer experience, as well as seamless coordination between the Medicaid and CHIP programs and the Exchanges and between the Exchanges and plans, employers, and navigators..... For most people, this routing and enrollment in the Exchange, Medicaid or CHIP will happen in real time.... States should aim to provide the same customer experience to all individuals seeking coverage, regardless of source or amount of subsidy for which they may qualify or whether they enter the process through the Exchange, Medicaid, or CHIP. ....Customers should experience this process as representing the highest level of service, support, and ease of use, similar to that experienced by customers of leading service and retail companies and organizations

> doing business in the United States.... Most individuals will be evaluated for eligibility in the Exchange, Medicaid and CHIP using a coordinated set of rules; as a result, we expect common systems and high levels of integration to avoid duplication of costs, processes, data, and effort on the part of either the state or the beneficiary. (HHS Office of Consumer Information and Insurance Oversight 2010a)

Meeting these standards is likely to require a radical change in the information technology systems that support eligibility determination for Medi-Cal and Healthy Families.

2. Medi-Cal application procedures for parents and other adults

Medi-Cal eligibility for adults has long been based on much more than income. Except for so-called "mini-programs" that serve discrete populations like patients with breast cancer or HIV, even the poorest adults have been denied Medi-Cal unless they were seniors, pregnant women, people with disabilities, or parents caring for dependent children. And regardless of how low their income, California parents have been denied Medi-Cal unless they prove asset valuation below specified levels.

Beginning in 2014, these factors will no longer be relevant to Medi-Cal eligibility for parents and other non-elderly adults with incomes at or below 138 percent FPL. This creates the opportunity for substantially streamlining the application process. Simply eliminating the asset test, for example, is likely to boost participation rates, as the requirement to document asset valuation can be among the most burdensome aspects of applying for need-based assistance (Summer and Thomas 2004; Lewin Group 2003; Kronebusch and Elbel 2004a, b).

It remains to be seen, however, how effectively policymakers will respond to this opportunity. Medi-Cal has two reasons for identifying, among eligible adults, those who are "newly eligible" because they would not have qualified for Medi-Cal under state rules in effect on December 1, 2009. First, highly enhanced federal matching funds (starting at 100 percent during 2014–2016) are limited to such newly eligible adults. Second, states can provide newly eligible adults with different benefits from those furnished to other adults.

In theory, California could identify newly eligible adults by asking each Medi-Cal applicant to provide information relevant to two separate sets of eligibility rules: those that apply in 2014

and beyond; and those that were in effect on December 1, 2009. If the state takes this approach, applicants will need to provide evidence about assets, deprivation, the potential application of income disregards used in 2009, etc. If this is done as part of the Medi-Cal application, enrollment will become much more burdensome than if questions were limited to factors that will be relevant to eligibility. Adding such additional questions would increase state and local administrative burdens while reducing participation rates among eligible parents and other adults.

Fortunately, CMS recently made clear that this result can be avoided:

> States should not assume they will have to operate a "shadow eligibility system" for the purpose of claiming appropriate match for Medicaid individuals based on whether they were eligible under state rules in effect prior to 2014 or are "newly eligible." We expect that federal rulemaking will propose other methods for managing appropriate accounting between the federal and state governments. (CMS 2011b)

Some adults can be identified as newly eligible, based purely on status as a childless adult or MAGI a certain margin above Medi-Cal's 2009 income thresholds.[37] For adults outside these categories, California may be able to claim enhanced federal match through statistically valid caseload samples, using procedures like those the federal government has long used to calculate Medi-Cal error rates. Although CMS has not provided guidance on this specific issue, the HHS Departmental Appeals Board has repeatedly approved state claims for federal matching funds based on such sampling.[38]

In terms of covered benefits, California could provide newly eligible adults with the same Medi-Cal benefits that other adults receive.[39] This would avoid the need to distinguish the newly eligible before they are enrolled in coverage.[40]

B. Subsidized coverage in the exchange

As suggested above, the creation of a new eligibility determination system in the exchange offers the possibility of consumer-friendly procedures that lower administrative costs for taxpayers while streamlining enrollment for families. On the other hand, this new infrastructure also poses risks. Not all consumers can qualify for assistance based on data. Many will require

"hands-on" assistance. In fact, much evidence shows the importance of facilitated enrollment to achieving high participation levels in subsidized health coverage and other benefit programs (Summer and Thompson 2008; Wachino and Weiss 2009; Bettinger et al. 2009). In lowering the percentage of uninsured residents below levels ever seen in other states, for example, Massachusetts developed a system through which more than 60 percent of all successful applications now come from community agencies and safety-net providers acting on behalf of consumers, rather than from consumers themselves (Dorn et al. 2009).[41] To accomplish similar results, it will be important for California's exchange to invest resources in providing application assistance as well as guidance to help families select an appropriate health plan after qualifying for assistance.

While state budget woes led to its suspension in 2009, the state's "Certified Application Assistant" program may still furnish a strong base on which to build. The state could fund an expanded version of this program by combining resources from Medi-Cal, Healthy Families, and the exchange. Unfortunately, the Navigator function in the exchange, intended to cover consumer assistance, lacks federal funding through the end of 2014, due to a "glitch" in the ACA's statutory language. Part of this gap could be filled by exchange call center services, which can qualify for federal exchange grants. But other strategies may also be necessary.

Perhaps the most serious concerns about subsidized coverage in the exchange, however, involve the subsidies themselves. A family of three with pre-tax income of approximately $3,000 a month, for example, must pay more than $190 a month in premiums to receive health coverage through which, between deductibles and copayments, families will be expected to pay an average of 13 percent of all health care costs (Table 4). While subsidies in the exchange represent a major improvement in access to coverage for the previously uninsured, prior research shows that even modest premium charges and copayments can reduce enrollment and utilization of essential care by low-income families.[42]

Table 4. Premium and out-of-pocket costs for a three-person family at various income levels receiving subsidies under the ACA

FPL	Monthly pre-tax income	Monthly premium	Average out-of-pocket cost-sharing (%)
150	$2,289	$92	6
175	$2,670	$138	13
200	$3,052	$192	13
225	$3,433	$246	27
250	$3,815	$307	27
275	$4,196	$368	30

Notes: Dollar amounts assume 2010 FPL levels. Out-of-pocket cost-sharing represents the average percentage of covered health care services paid by the consumer, taking into account deductibles, copayments, and co-insurance. It reflects the application of actuarial value standards described earlier in the paper. For example, at 150 percent FPL, subsidized coverage in the exchange furnishes coverage with an AV of 94 percent, which means that the plan covers 94 percent of the health care costs incurred by a standardized population of enrollees. Consumers thus pay the remaining 6 percent of average out-of-pocket costs, which is the percentage listed in this table.

ACA's individual requirement to purchase coverage will surely increase participation above levels in a voluntary system, but these premium costs are still likely to prevent some low-income, uninsured parents from enrolling in coverage. And once parents are enrolled, out-of-pocket charges may prevent some of them from seeking care (except for preventive services, which the ACA exempts from cost-sharing).

Some low-income parents may also be reluctant to apply for tax credits in the exchange because, if annual income turns out to exceed expectations, families will need to repay some of the excess subsidies. While repayment is capped at $600 for a family at or below 200 percent FPL, $1,500 between 200 and 300 percent FPL,[43] and $2,500 between 300 and 400 percent FPL, many low-income households would view these amounts as difficult or impossible to afford in already overstretched household budgets. The risk of similar reconciliation has been one reason why no more than 3 percent of low-income workers who receive Earned Income Tax Credits claim those credits during the year, in advance of filing year-end returns (Stamatiades, Cook, and Larson 2008; GAO 2007). Put simply, both the generosity of subsidies in the exchange and the potential for losing year-end tax refunds or owing money to the IRS could limit the extent to which low-income children gain from the ACA's expansion in parental coverage.

C. Provider networks

According to recent projections, the ACA is likely to raise total Medi-Cal enrollment by 34 percent (Buettgens, Holahan, and Carroll 2001). A major increase in the number of Medi-Cal enrollees could stress the program's provider network. Some of that increase will take place before 2014, through the state's "bridge" waiver program. However, maintenance-of-effort requirements in ACA prevent California from limiting eligibility levels in Medi-Cal and Healthy Families. To reduce Medi-Cal and Healthy Families costs, California is likely to resort to service cutbacks and further reductions in provider payment levels (if such reductions are not disallowed by the courts).[44] The latter reductions could further erode the network serving Medi-Cal beneficiaries.

In assessing the impact of limited provider participation on children, an important question, as yet unanswered, involves the overlap between provider networks that serve Medi-Cal children and adults. To the extent there is an overlap, a greatly increased adult demand for Medi-Cal could reduce the availability of providers serving some Medi-Cal children.

On the other hand, the federal government will pay for raising Medi-Cal reimbursement to Medicare levels during 2013–2014 for primary care providers furnishing evaluation and management services. This increase is far from a panacea, of course. Many providers are unaffected, including dentists and specialists, for example, who often present particularly severe participation problems. Nevertheless, this increase is likely to have a beneficial impact, particularly if Congress decides to continue federal funding for it after 2014.

Other portions of the ACA will affect the resources supporting providers that serve low-income communities. The legislation is projected to reduce the number of California uninsured by 48 percent (Buettgens et al. 2001). This will lower the burden of uncompensated care, likely outweighing the effects on such care resulting from ACA's reduction in federal Disproportionate Share Hospital (DSH) funding.[45] Further, many low-income adults will shift from county-based medically indigent adult (MIA) programs to Medi-Cal, which should increase the level of per capita resources that finance their care. This process has already begun through the state's Low-Income Health Program waiver, but the level of federal funding will increase substantially starting in 2014. Moreover, the ACA appropriates $11 billion in new funding for federally-qualified health centers (FQHCs) and other community health centers, following on the heels of a $2

billion increase included in the American Recovery and Reinvestment Act of 2009 (HHS 2010). While the federal budget agreement for 2011 eliminated $600 million of this funding, thus reducing the extent of center expansion (Morris 2011), FQHCs will nonetheless benefit from the Affordable Care Act's requirement that all private plans in the exchange must contract with them and pay the same cost-based reimbursement that has long been required from Medi-Cal. Health centers are thus likely to emerge as a strengthened network of care for California's low-income communities, which could lessen access problems that would otherwise result from the ACA's increased demand for Medi-Cal providers.[46]

D. The future of federal CHIP funding

The ACA requires Medicaid and CHIP to retain existing eligibility for children through 2019. However, the legislation extended federal CHIP allotments only through September 30, 2015. After that, the federal matching percentage rises by 23 percentage points, reaching 88 percent for Healthy Families.

In future years, Congress will need to decide whether to continue CHIP funding beyond 2015. If Congress fails to do so, any remaining federal allotments are likely to be gone before the end of 2016.[47] If this happens, children eligible for Medi-Cal will be enrolled in Medi-Cal, even if their MAGI exceeds 138 percent FPL. The state will receive standard Medicaid matching rates for these children. However, children who formerly qualified for Healthy Families would most likely be treated like adults at comparable income levels—that is, will be eligible for subsidies in the exchange if they are not offered ESI meeting the ASA's minimum standards for affordability and comprehensiveness.

V. State policy options for improving coverage and access to care

As the previous section makes clear, many factors could affect whether California's low-income children will benefit fully from the Affordable Care Act. In this section, we explore several promising options available to California policymakers that could address those factors. The goal of these interventions is to maximize improvements in coverage and access to care for California's low-income children. These strategies include

- Increasing enrollment and retention for eligible children and parents;

- Improving the affordability of coverage to near-poor families;

- Bolstering the provider infrastructure that serves Medi-Cal and Healthy Families children; and

- Supporting child health programs beyond Medi-Cal and Healthy Families.

A. Maximizing enrollment and retention for children and parents who qualify for help

Efforts to promote enrollment and retention can proceed on multiple fronts. A multifaceted enrollment initiative could address the eligibility determination process for current public programs, California's health insurance exchange, individual consumer assistance, and public education.

Reform eligibility determination systems for Medi-Cal and Healthy Families. California policymakers could consider the following strategies for cutting bureaucratic obstacles to enrollment and retention:

- **Take advantage of new federal resources for IT development** related to eligibility determination, including 90 percent Medicaid matching funds and 100 percent federal administrative funding for exchanges. This will help the state meet the requirements of the ACA while moving towards a more data-driven approach to eligibility determination that increases participation rates by placing fewer burdens on applicants.

- **Grant eligibility for all programs based on recent data, whenever possible,** rather than denying eligibility until consumers have presented paper documentation. For example, other state Medicaid programs, including New York's, use prior-year tax returns to establish current income levels during the first three calendar months of the year. After that point, with the Affordable Care Act's greatly strengthened IT infrastructure, tax data could be supplemented by more recent information about earnings and new hires, yielding at least preliminary eligibility findings without applicants needing to estimate or document income.

- **Expedite renewals of coverage by**
  - Using data to automatically continue coverage, whenever data show a reasonable certainty of eligibility;
  - If data are insufficient to continue eligibility, encouraging families to furnish necessary missing information by phone; and
  - Asking for the completion of redetermination forms only as a last resort, when all else fails.

Louisiana has pursued this approach to substantially reduce losses of coverage at renewal while safeguarding program integrity and greatly lowering administrative costs.[48]

- **Use a single, statewide office within the Department of Health Care Services to process available data and use it to establish eligibility, whenever possible,** for both emergency and full-scope Medi-Cal, Healthy Families, and subsidies in the exchange (potentially also including county-specific and privately-funded coverage). Such clear assignment of responsibility to one statewide office lessens the odds that consumers will "fall between the cracks" at the intersection of multiple programs, including when family circumstances change and beneficiaries move from one subsidy system to another.[49] One place to start would be the above-described streamlined renewal policy; this would borrow a page from New York State, which is beginning its transition from county-based to state-based eligibility with renewals.

  To be clear, this approach leaves room for local social service offices to remain one of several venues through which consumers can submit applications. Such offices will also continue to be important for connecting low-income households to important benefits outside health care, such as Supplemental Nutrition Assistance Program (SNAP, formerly known as, "Food Stamps") and cash assistance. And when data are insufficient to establish eligibility for health coverage, local social service offices can help follow-up with families to obtain necessary information. Effective implementation of the Affordable Care Act would likewise be consistent with local offices continuing to determine eligibility for Medi-Cal categories that do not involve MAGI, such as eligibility based on disability or age over 64. But it is hard to see how California can create an effective, ACA-compliant interface

between Medi-Cal eligibility and the exchange if the state must coordinate with multiple and incompatible legacy eligibility systems used at the county level; in fact, CMS has indicated that it will subject to close scrutiny state requests for enhanced federal IT funding to support multiple eligibility systems within a state.[50]

In analyzing similar issues, New York has seen "a growing consensus that the continued delegation of eligibility responsibilities to local government is challenging, if not impractical, in light of the ACA."[51] Clearly, California will likewise face great difficulty successfully managing the forthcoming wave of Medi-Cal applications if the rapid and consumer-friendly establishment and renewal of eligibility depends on implementing major reforms to business processes and work culture in 58 county social service agencies, none of which is directly accountable to state health officials.

- **Limit Medi-Cal application questions for adults to topics that will be relevant to eligibility.** Rather than use the application process to distinguish between newly eligible and other adults, Medi-Cal could provide all adults with the same benefits in 2014 and beyond, whether or not they would have qualified under the state's 2009 rules. And to claim enhanced federal matching funds based on the proportion of Medi-Cal adults who would have been ineligible under 2009 rules, the state could sample the relevant portion of the adult caseload. Only adults within that sample would need to provide evidence about such issues as assets and deprivation, and families would be asked for information after rather than before eligibility is granted and coverage begins.[52]

- **Use eligibility records of public benefit programs to qualify children and parents for subsidized coverage.** Many parents who will qualify for Medi-Cal or subsidies in the exchange but are not yet enrolled have children who receive Medi-Cal or Healthy Families; their children's eligibility records could be used to qualify the parents for coverage, as states like Wisconsin and New Jersey have already done.[53] And eligibility records from programs like SNAP could play a similar role.[54] Children could qualify for Medi-Cal and Healthy Families through Express Lane Eligibility, and parents' eligibility could potentially be granted, based on SNAP findings, through a federal Medicaid waiver.[55]

- **Convert hospital-based presumptive eligibility into ongoing coverage.** The ACA permits hospitals to grant short-term, presumptive Medi-Cal eligibility to their low-income patients,

based purely on income. Hospitals are likely to implement this policy with great vigor, as it will help them receive compensation for short-term and emergency services. However, families will not receive ongoing coverage unless they complete, in a timely fashion, the full Medi-Cal application process. Without an effective mechanism for routine follow-through

after patients have left the hospital, such presumptive eligibility could easily become a cul-de-sac that quickly ends coverage, rather than an on-ramp to continuing insurance.[56]

Make health insurance exchanges "immigrant friendly." It will be important for California's exchange to work closely with immigrant communities to develop culturally and linguistically competent policies and procedures for outreach and enrollment. Such collaboration would encourage immigrants and their families to enroll into exchange coverage for which they qualify, including subsidized plans, despite the ACA's prohibition against selling individual insurance to the undocumented. Along with efforts by the state's Medi-Cal and Healthy Families programs, this collaborative work could also develop and implement strategies to address fears in the immigrant community. In the past, many immigrants have worried that obtaining subsidized coverage might lead to (a) "public charge" determinations that prevent later immigration status improvements or naturalization; or (b) an obligation for immigration sponsors to repay the cost of health coverage. Efforts directed at immigrant communities would benefit, among others, citizen children in mixed status households, many of whom are eligible for coverage but not enrolled.

Provide individual consumer assistance. As suggested above, hands-on assistance helping consumers complete application forms can have a significant impact on participation. One study that seems particularly relevant to California compared the effect on low-income, Latino families in Boston of (a) standard Medicaid/CHIP outreach versus (b) intensive application assistance provided by community-based case managers who proactively identified potentially eligible families, helped fill out application forms, and tracked applications through to completion, intervening on behalf of low-income families when problems emerged. While the standard outreach methods enrolled 57 percent of eligible children, 96 percent of eligible children targeted by community-based case managers received coverage (Flores et al. 2005).

To develop an intensive program for helping eligible children and adults enroll into Medi-Cal, Healthy Families, and the exchange, California could integrate the forthcoming exchange call

center with an extension of the CAA program (and perhaps contracts with community groups, modeled after the successful Massachusetts effort).[57] State officials could propose to HHS a cost allocation plan to ensure that this effort receives federal Medicaid and CHIP administrative dollars combined with federal funding for the establishment and operation of exchanges.[58]

Such federal funding may need to be supplemented by state and local resources, but private-sector and philanthropic resources could also help fill gaps.[59]

Launch a public education campaign. Another important step to maximize enrollment of eligible families involves public education. With Massachusetts' 2006 reforms, for example, a major effort to inform the public about both subsidies and the individual mandate included the state government, large corporations, foundations, and the Boston Red Sox. As a result, most state residents understood the basic features of reform, and even low-income families exempt from the mandate's enforcement paid great attention to notices from state health agencies. This prompted many low-income consumers to visit community agencies and apply for coverage.[60] California officials could consider a similar approach, potentially funded in part through federal resources provided to establish exchanges.

B. Improving affordability of coverage for near-poor families

The Affordable Care Act permits states to supplement federal subsidies offered in the exchange. In theory, California could thus use its own resources to make coverage in the exchange more affordable to low-income families who are ineligible for Medi-Cal. In practice, until the state's budget problems recede, it is hard to see this approach receiving serious consideration.

To increase affordability of coverage for low-income parents without raising state spending, California could instead consider implementing the ACA's Basic Health Program (BHP) option. BHP covers citizens and legally resident immigrants with incomes at or below 200 percent FPL who are ineligible for Medi-Cal and Healthy Families. Once a state implements this option, BHP members do not receive subsidies in the exchange. Instead, the state contracts with health plans or providers to furnish coverage at least as affordable and comprehensive as the subsidized coverage that would have been offered in the exchange; but nothing prevents a state from providing more generous coverage. To fund these contracts, a state receives 95 percent

of what the federal government would have spent on tax credits and other subsidies for BHP enrollees if they had enrolled in the exchange.

This option may give California the ability, without spending state dollars, to provide coverage modeled after Medi-Cal or Healthy Families to the following groups:

- Parents and other adults with MAGI between 138 and 200 percent of FPL;[61]
- Immigrant parents and other adults with incomes below 138 percent of FPL whose immigration status disqualifies them from federally-matched Medicaid; and
- If federal CHIP allotments are not renewed, Healthy Families children up to 200 percent FPL.

In the average state, federal BHP payments could exceed by nearly 30 percent the cost of Medicaid coverage for non-elderly, non-disabled adults (Dorn 2011), primarily because private plans in the exchange, on which federal BHP funding levels will be based, are expected to pay providers much more than Medicaid.[62] With some of the nation's lowest Medicaid payment rates,[63] California may be more likely than other states to receive BHP payments that exceed the cost of "Medi-Cal look-alike" coverage or "Healthy Families for adults." A recent analysis by Mercer thus found that federal BHP payments are likely to exceed baseline Medi-Cal costs by a considerable margin (Mercer Government Human Services Consulting 2011). On the other hand, the state's decisions about how to structure coverage in the exchange will affect federal subsidy costs, hence BHP payments.[64]

California could implement BHP to (a) give low-income parents and other adults with MAGI between 138 and 200 percent FPL the same benefits and cost-sharing protections that now apply to Medi-Cal or Healthy Families and (b) eliminate the prospect of these low-income families needing to repay excess tax credits to IRS at the end of the year. Affected adults would include some Medi-Cal parents whose income will be evaluated differently under MAGI than with current eligibility methodologies. They would also include pregnant women and other Medi-Cal beneficiaries who might benefit from the state's ability to structure BHP benefits to address their special needs for care.[65]

If it either implements BHP or moves these Medi-Cal adults into the exchange, the state would achieve savings. But using BHP to fund the provision of "Medi-Cal look-alike" coverage or "Healthy Families for adults" would do so without reducing covered benefits or increasing costs for low-income parents and other adults who currently qualify for Medi-Cal.

On the other hand, the main reason why federal BHP payments are likely to exceed Medi-Cal costs is that providers would be paid considerably more by private plans in the exchange, on which BHP amounts are based, than by Medicaid. Accordingly, one concern about this approach is that BHP enrollees would not gain access to the relatively broad provider networks that private plans offer, and an already insufficient pool of Medi-Cal providers would grow even more stressed.

This problem can be lessened, though not eliminated, to the extent that federal BHP payments exceed baseline Medi-Cal costs. Federal law requires BHP payments to be placed in a state-level trust fund and used only to serve BHP members. The most straightforward way to meet this requirement would be to raise capitated rates and provider payments above Medi-Cal levels for BHP members. The above-noted Mercer analysis thus found that federal BHP funding could raise provider payments by 20 to 25 percent above standard Medi-Cal levels. Payments would further rise if covered services included modest out-of-pocket costs like those charged in Healthy Families. BHP could thus allow a restructured Medi-Cal look-alike or "Healthy Families for adults" program to have a stronger provider network than Medi-Cal's, with modest cost-sharing slightly above Medi-Cal levels but below charges in the exchange.

A second concern is that implementing BHP would shrink California's exchange. However, Urban Institute microsimulations have shown that, in the average state, BHP would reduce the proportion of nonelderly residents receiving individual exchange coverage from 8 percent to 6 percent, and an additional 8 percent of residents would continue to use the exchange for group coverage (Buettgens et al. 2010).[66] Consistent with this national analysis, Mercer's California-specific estimates indicate that BHP implementation would reduce the size of California's individual exchange from 2.6 million people to 1.9 million people—put differently, from 8 percent to 6 percent of the state's population under age 65.[67] It seems hard to argue that this would prevent exchange viability.

A third concern is that, if parents and other adults joined Healthy Families, adults as well as children would be divided between Medi-Cal, Healthy Families, and the exchange. The result would be increased complexity and potential disruptions in coverage when household incomes change and adults move between three programs rather than just between Medi-Cal and the exchange. To address these discontinuities, state policymakers could consider integrating funding from Healthy Families, Medi-Cal, and BHP to provide low-income families with a single, continuous system of coverage reaching adults up to 200 percent FPL and children up to 250 percent FPL. This system would involve a common set of health plans, largely consistent benefits, and consumer costs that rise modestly as income increases. Such an approach could fit with Governor Brown's recent proposal to shift Healthy Families children into Medi-Cal, with cost-sharing amounts that grow with income.

Notwithstanding those factors, concerns about the affordability of coverage in the exchange for families with incomes between 138 and 200 percent FPL suggest that the using the Basic Health Program option to provide low-income adults with coverage like that furnished by Medi-Cal or Healthy Families deserves serious consideration as California policymakers plan for reform. It is thus not surprising that the Legislature is now considering legislation that would implement BHP in California.

C. Strengthening the provider infrastructure in low-income communities

For the ACA to achieve its potential positive effects on the lives of children, the provider base serving families in Medi-Cal will need to expand. It will be important for the state to consider a range of options and to try to identify the most cost-effective policy mix to meet the increased demand for care while addressing limitations in Medi-Cal's provider network. Some possible options to consider include the following:

- **Target Medi-Cal payment increases** in categories of care with particularly serious access deficits, such as dental and outpatient specialty care for children. Despite the state's budget woes, some increases may be needed to provide families with adequate access to quality care. Selective contracts to focus scarce resources on increasing provider participation in particular geographic areas may be worth exploring to lower the total cost of reimbursement increases that improve access to care.

- **Maximize federal funding to** increase the capacity of providers that serve low-income communities. This could include new federal grants under the ACA as well as increased allocations under existing programs.

- **Support local and regional planning** through which public and private providers and health plans serving low-income residents come together to analyze future changes in their geographic area, taking into account both increased demand for services as well as changes in available resources. Such efforts would develop coordinated plans to deploy current and new resources as effectively as possible in meeting the increased demand for care under the ACA.

- **Expedite and streamline payment of providers' Medi-Cal claims** by, for example, limiting the circumstances under which treatment authorization requests are required. Claims-processing reforms can increase the number of physicians, dentists, and others who see Medi-Cal patients while spending less than the amount needed to raise payment levels.

- **Enlarge the permitted scope of practice for nurses, physician assistants, dental hygienists,** and other non-physician providers. One potentially promising step could involve licensure for intermediate-level dental care providers, who have greatly improved children's access to services in countries like New Zealand, Great Britain, Australia, and Canada, but who have been little used in the United States (GAO 2010). If changes to the state's general licensure laws are difficult to accomplish because of resistance from providers who fear losing business, such changes could be limited to providers who serve patients in subsidized programs like Medi-Cal and Healthy Families.[70]

- **Increase use of telemedicine** to lessen the impact of provider shortfalls in rural areas. California is already a national leader in this area, so this would be a logical strategy for state officials to pursue (Johnston and Solomon 2008).

As the state's economy and budget situation improve, more expansive measures to increase provider participation may become feasible. This would be particularly true if California can achieve net budget savings by using options in the Affordable Care Act to (a) implement delivery system and payment reforms to slow cost growth for all state-funded health coverage programs (Davis et al. 2010; Dorn 2010) and (b) shift to the

federal government current state and local costs, including for mental health services, medically indigent adult coverage, and uncompensated care.[71]

D. Supporting child health programs outside Medi-Cal and Healthy Families

In addition to covering uninsured children, the ACA's subsidies up to 400 percent FPL could lighten the financial load on California's other programs—state-funded, county-based, and philanthropic—that cover uninsured children who are ineligible for Medi-Cal and Healthy Families. Shifting some of these children from programs like Healthy Kids and the Kaiser Child Health Plan to the exchange may allow such programs' finite resources to go farther in covering children who remain uninsured, including those whose immigration status disqualifies them from federally funded subsidies for non-emergency services. These programs could also redeploy freed-up resources to benefit a broad range of children by helping eligible families enroll into subsidized coverage, including Medi-Cal, Healthy Families, and the exchange. They might also provide targeted supplemental services to meet children's special needs that go unaddressed by commercial benefits that low-income children receive from the exchange or their parents' employers.

Conclusion

California's low-income children are likely to see major improvements in coverage and access to care as a result of the Affordable Care Act. But the extent of these gains will depend, in significant part, on how the state addresses three issues: Medi-Cal provider participation; Medi-Cal eligibility determination; and the affordability of coverage in the exchange. These factors will greatly affect low-income families' coverage and care, whether or not policymakers decide to move Healthy Families children into Medi-Cal.

The state's ongoing budget problems may inhibit, at least in the short term, major improvements to Medi-Cal provider participation, although smaller and more targeted steps could be both feasible and consequential for children and their parents. Fortunately, federal developments have made it much less costly for the state to address the other factors that will determine whether reform achieves its potential. As California moves towards the major changes slated for implementation in 2014 and beyond, the state's choices can make an important contribution to improving low-income families' lives, carving out a path that other states can follow.

Appendix: County-Specific Information about Uninsured Children

Appendix Table: Rate of Uninsurance among California Children and Distribution of Uninsured and All Children by County: 2008-2009

State	Uninsurance			All Children	Uninsured Children
	Rate	90% Confidence Interval			
California	9.63%	9.45%	9.80%		
County	Rate	90% Confidence Interval		Share of State Total	Share of State Total
Alameda	5.08% **	4.36%	5.81%	3.71%	1.96%
Butte	6.17% **	3.92%	8.41%	0.50%	0.32%
Contra Costa	7.12% **	6.06%	8.19%	2.69%	1.99%
El Dorado	6.13% **	3.78%	8.49%	0.43%	0.27%
Fresno	8.80%	7.49%	10.11%	2.89%	2.64%
Humboldt	10.74%	8.34%	13.15%	0.28%	0.31%
Imperial	13.84% **	10.54%	17.14%	0.53%	0.76%
Kern	10.26%	9.10%	11.42%	2.58%	2.75%
Kings	10.51%	8.16%	12.86%	0.43%	0.47%
Los Angeles	11.29% **	10.95%	11.62%	26.88%	31.51%
Madera	7.99%	5.84%	10.13%	0.44%	0.36%
Marin	6.76% **	4.37%	9.15%	0.53%	0.37%
Merced	6.65% **	4.52%	8.79%	0.82%	0.56%
Napa	9.24%	6.37%	12.10%	0.33%	0.31%
Orange	10.26%	9.51%	11.00%	8.09%	8.62%
Placer	3.66% **	2.64%	4.68%	0.84%	0.32%
Riverside	12.12% **	11.18%	13.06%	6.33%	7.97%
Sacramento	5.38% **	4.54%	6.23%	3.80%	2.13%
San Bernardino	11.46% **	10.66%	12.25%	6.33%	7.53%
San Diego	11.15% **	10.40%	11.89%	7.96%	9.22%
San Francisco	5.07% **	3.82%	6.31%	1.26%	0.66%
San Joaquin	7.96% **	6.68%	9.25%	2.09%	1.73%
San Luis Obispo	9.46%	7.37%	11.55%	0.57%	0.56%
San Mateo	4.94% **	3.83%	6.06%	1.70%	0.87%
Santa Barbara	9.80%	7.78%	11.82%	1.07%	1.09%
Santa Clara	5.04% **	4.37%	5.71%	4.57%	2.39%
Santa Cruz	6.91% **	4.94%	8.87%	0.61%	0.44%
Shasta	13.80% **	10.37%	17.23%	0.43%	0.62%
Solano	6.92% **	5.44%	8.40%	1.07%	0.77%
Sonoma	5.18% **	3.92%	6.43%	1.11%	0.60%
Stanislaus	9.38%	7.71%	11.05%	1.57%	1.53%
Tulare	14.84% **	12.49%	17.20%	1.47%	2.26%
Ventura	9.33%	7.83%	10.82%	2.20%	2.13%
Yolo	4.18% **	2.43%	5.93%	0.53%	0.23%
Rest of State*	10.62%	9.50%	11.75%	3.41%	3.76%

Source: Urban Institute Tabulations of the 2008 and 2009 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS); Kenney et al. (2010). Notes: Estimates reflect an adjustment for the underreporting of Medicaid/CHIP on the ACS.

**Indicates that county estimate is statistically different from the state mean at the 0.05-level.

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Notes

[1] For a previous exploration of these issues at the national level, see Kenney and Pelletier (2010).

[2] Others have suggested eliminating Healthy Families, as a separately managed program. Under this approach, the exchange would contract with plans that furnish Healthy Families children with services and cost-sharing limits that meet Healthy Families standards.

[3] See, for example, Kaiser Family Foundation (2010).

[4] Someone offered ESI can nevertheless receive subsidies in the exchange if either (a) the worker share of premium exceeds 9.5 percent of income or (b) the actuarial value of coverage offered by the employer is less than 60 percent.

[5] The nominal income threshold is 133 percent of FPL. However, in determining income, 5 FPL percentage points are subtracted from gross income. Accordingly, the effective income-eligibility limit is 138 percent FPL.

[6] Express Lane Eligibility allows a state to grant children Medicaid or CHIP eligibility based on findings already made by another need-based program or based on state income tax records.

[7] The transition from current eligibility methods to MAGI will require adjustment to the nominal income thresholds for children's health coverage. CMS is planning to issue standards explaining how states can translate 2009 eligibility levels into MAGI amounts. The goal of this effort is to permit states to obtain the operating efficiencies of MAGI without reducing public program eligibility for children.

[8] The Congressional Budget Office (CBO) has thus concluded that, without CHIP coverage, large numbers of CHIP-eligible children would go into the exchange, large numbers would move to ESI, and some would become uninsured (CBO, Cost Estimate: H.R. 1683, State Flexibility Act, May 11, 2011). However, it is not clear how to square the CBO's reading of the ACA with Social Security Act §2105(d)(3)(B), added by ACA §2101(b). The latter section provides that, if a state's CHIP allotments run out, in the case of children who qualify for a separate CHIP program, "the state shall establish procedures to ensure that the children are enrolled in a qualified health plan that has been certified by the Secretary" to offer benefits and cost-sharing limits like those of the state's CHIP program.

[9] Because filing thresholds are based on fixed dollars amounts and filing status, without any adjustment based on family size, those thresholds can not be stated as a single percentage of FPL. For example, if a family of three files as a married couple, the same dollar filing threshold mentioned in the text would apply, even though, for such a family, it would equal 102 percent of FPL. A single parent acting as head of household must file a tax return if he or she receives at least $12,000 in gross income, which amounts to 82 percent FPL for a family of two, 65 percent FPL for a family of three, etc. (see Internal Revenue Service, Your Federal Income Tax For Individuals, for use in preparing 2009 returns, November 24, 2009, IRS Publication 17, Catalog Number 10311G).

[10] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates for 2009, based on the Census Bureau's March 2010 Current Population Survey, Annual Social and Economic Supplement.

[11] In California, CPS and CHIS data suggest that Medicaid and CHIP cover a disproportionate share of Hispanic but not black children (who also represent a much smaller share of the population of children in California than in the nation), which is different from the national pattern. However, data from the American Community Survey (ACS) suggests that Medicaid and CHIP in California cover a disproportionate share of both Hispanic and black children.

[12] The median state with a separate CHIP program has an actuarial value of 100 percent—that is, the program covers 100 percent of average health costs for children at 175 percent FPL. At 225 percent FPL, the median state covers slightly less—98 percent of children's average health costs (First Focus 2009). CHIP premiums are typically modest, with the median charge for two children in a family of three at 200 percent of FPL equaling $40 per month, or 1.3 percent of family income (Ross et al. 2009).

[13] See, for example, Dorn (2009); Dorn et al. (2008).

[14] Urban Institute Tabulations of the 2009 and 2010 CPS. CHIS estimates from 2009 indicate that 35.8 percent of all children and 70.2 percent of low-income children were enrolled in Medicaid/CHIP at any given point in time.

[15] State of California, Department of Health Care Services, "Medical Beneficiaries, Summary Pivot Table, Most Recent 24 Months, May 2011" (DHS Medi-Cal Report), http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Medi-Cal_Beneficiaries_Most_Recent_24_Months.xls.

[16] For example, Mercer's annual surveys of employer-sponsored insurance show that the "median individual deductible rose from $250 to $400 [from 2000 to 2009], while among employers with 10-499 employees, it rose from $250 to $1,000" (Blakely 2010). See generally Kaiser Family Foundation and the Health Research and Educational Trust, *Employer Health Benefits Annual Survey Archives (1998-2010),* http://www.kff.org/insurance/ehbs-archives.cfm.

[17] Examples of policies with various levels of AV are taken from Levitt and Claxton (2011) and Peterson (2009).

[18] This states California's rank in terms of Medicaid physician fees as a percentage of Medicare reimbursement (Zuckerman et al. 2009).

[19] Kaiser Permanente Community Benefit Office, personal communication, May 3, 2011.

[20] CPS data, for example, show a statistically significant reduction in the percentage of uninsured California children age 0-18 from 12.3 percent in 2006–2007 to 11.1 percent in 2008–2009. ACS data likewise show a statistically significant drop from 10.0 percent uninsured in 2008 to 9.3 percent in 2009 among California children under age 19. According to CHIS data, the proportion of California children age 0–18 who were uninsured at some point during the year fell from 10.7 percent in 2005 to 10.2 percent in 2007 to 9.9 percent in 2009, although the survey's one-year samples mean that these changes are not statistically significant. Preliminary estimates that the number of California's uninsured children rose in 2009 were superseded by later CHIS data. Personal correspondence, Shana Alex Lavarreda, May 2011. See Lavarreda et al. (2010). According to all of these surveys, uninsurance among California adults rose during comparable time periods. For example, the ACS showed a 2008–2009 increase from 5.1 million to 5.5 million uninsured adults age 19–64, or from 23.0 to 24.7 percent; CPS data indicate an increase from 24.1 percent in 2006–2007 to 25.9 percent in 2008-2009 for adults age 19-64; and CHIS shows an increase among adults age 18-64 without insurance at some time during the year from 23.8 percent in 2007 to 26.6 percent in 2009.

[21] Analysis of Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model, based on data from the 2008 American Community Survey.

[22] See, for example, Hill et al. (2004); Jacobson and Buchmueller (2007); Aizer (2007).

[23] For a discussion of parental depression, its effects on children's well-being, and how expanded health coverage can reduce its incidence, see Golden and Fortuny 2011.

[24] As noted above, the individual mandate will apply at surprisingly low income levels, encompassing many (but not all) uninsured children who qualify for Medi-Cal or Healthy Families. Even families unaffected by the mandate, however, are likely to see an increase in enrollment; the fine details of mandate legislation may not be well-understood, so families that are exempt may nevertheless pay much more attention to state correspondence about health coverage than would have been the case in the past. Precisely such results occurred under Massachusetts' individual mandate, even though it was not enforced against state residents with incomes at or below 150 percent of FPL (Dorn, Hill, and Hogan 2009).

[25] Currently, a family with income between 100 and 133 percent FPL could have its preschool children enrolled in Medi-Cal and its school-age children enrolled in Healthy Families. Such a division of family members among programs has been found to reduce participation levels (Hudson 2009). Under the ACA, by contrast, Medi-Cal eligibility will end at the same income threshold for all children over age 1—namely, 138 percent FPL.

[26] For an example of how one state with centralized authority over eligibility determination reformed its culture and business models, see Grant (2010).

[27] In New York City, municipal government, rather than counties, determines eligibility for need-based programs like Medicaid, SNAP, and Temporary Assistance for Needy Families (TANF). In the rest of the state, counties perform these functions.

[28] States have the option of developing their own forms, so long as they are approved by the federal government.

[29] ACA §1413.

[30] ACA §1413(c)(2)(B)(ii).

[31] ACA §1413(d)(2)(A). See also Social Security Act §1943(b)(2), added by ACA §2201.

[32] New Internal Revenue Code (IRC) §6055(d), added by ACA §1502(a).

[33] See, for example, Bland et al. (2010).

[34] Transmittal letter from Paul Tang, Vice Chair, HIT Policy Committee, and Jonathan Perlin, Chair, HIT Standards Committee, to David Blumenthal, National Coordinator for Health Information Technology, September 7, 2010, http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_0_6011_1815_17825_43/http%3B/wci-pubcontent/publish/onc/public_communities/_content/files/hitpc_transmittal_letter_enrollment_wg_9_7_10.pdf.

[35] Letter from Joel Ario and Cindy Mann to State Medicaid Directors, State Health Officials, and State Health Insurance Commissioners, Federal Support and Standards for Medicaid and Exchange Information Technology Systems, November 3, 2010.

[36] See, for example, Dorn, Hill, and Hogan (2009); Kennedy (2007);. For examples of similar effects with other benefits, see GAO (2007); Gleason et al. (2003); Cole (2007); Food and Nutrition Service of the Minnesota Department of Children, Families, and Learning (2002).

[37] Social Security Act Section 1902(e)(14)(A) and (E), established by Section 2002 of ACA, provides for "an equivalent income test" through which MAGI can be compared to income as determined under a state's 2009 rules. While those provisions specifically address maintenance of effort requirements, the same income equivalency analysis could be used to identify the parents whose MAGI effectively exceeds 2009 income levels and

who can therefore be classified as "newly eligible."

[38] New York State Dept. of Social Services, DAB No. 1134 (1990), cited with approval in Connecticut Department of Social Services, DAB No. 1982 (2005). See also Texas Health and Human Services Commission, DAB No. 2237 (2009); Arizona Health Care Cost Containment System, DAB No. 1569 (1996); Illinois Department of Public Aid, DAB No. 1320 (1992); New York State Department of Social Services, DAB No. 1216 (1991); Ohio Department of Human Services, DAB No. 900 (1987).

[39] The ACA requires newly eligible adults to receive "benchmark" or "benchmark-equivalent" benefits. ACA §2001(a)(2), adding §1902(k)(1) to the Social Security Act. However, one category of benchmark coverage is "Secretary-approved coverage," defined as "any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be provided such coverage." Social Security Act Section 1937(b)(1)(D). Both before and after the passage of the ACA, states have received CMS approval to provide full Medicaid benefits as "Secretary approved" benchmark coverage under Section 1937. See undated CMS posting of the State plans ap proved by the Secretary under Section 1937 authority, www.cms.gov/DeficitReductionAct/Downloads/070607benchmarkssection1937.pdf. As one notable example, the very first state receiving HHS approval to cover childless adults under the ACA, Connecticut, is providing such adults with standard Medicaid benefits (HHS Press Office 2010).

[40] It would also avoid state and local administrative costs otherwise required to screen adults to see whether they fall outside the categories for which federal law requires standard Medi-Cal benefits. In addition to pregnant women, such categories include adults who, although they may not meet the disability requirements of Supplemental Security Income (SSI), nevertheless suffer from "serious and complex medical conditions" or "physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living." Social Security Act §1937(a)(2)(B). It may not be simple and inexpensive for California agencies to evaluate each Medi-Cal adult to see whether he or she fits within this category, notwithstanding the possibility of using claims data to identify many adults with serious chronic conditions.

[41] New York's facilitated enrollment system is likewise responsible for 60 percent of successful applications (Bachrach, Boozang, and Dutton 2011). One analysis of New York City enrollment found that, even with that that state's streamlined enrollment procedures, it took at least 30 minutes for families to complete application forms while receiving consumer assistance; but that with help from community organizations and managed care organizations, 80 percent and 60 percent of families, respectively, successfully enrolled into coverage (Fairbrother et al. 2004).

[42] See, for example, Hudman and O'Malley (2003); Wright et al. (2010); Goldman, Joyce, and Zheng (2007); Briesacher, Gurwitz, and Soumerai (2007); Artiga and O'Malley (2005). Of course, this research was done before enactment of an individual mandate, which, all else equal, will increase enrollment.

[43] To pay for various policy changes, these limits have been increased twice since the initial enactment of the ACA. See Medicare and Medicaid Extenders Act of 2010, P.L. 111-309; Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, P.L. 112–9.

[44] The U.S. Supreme Court recently agreed to review a case involving Medi-Cal fees. Bob Egelco, "U.S. Supreme Court to take Medi-Cal lawsuit case," San Francisco Chronicle, January 19, 2011. For a discussion of prior California litigation on this issue, see Rosenbaum (2009).

[45] Before the ACA, federal Medicaid DSH allotments were slated to rise from $9.9 billion in 2014 to $11 billion in 2019. The ACA reduced these pay ments by a small amount during the first few years the coverage expansion will be in full effect, with larger reductions in later years. Cuts are projected to equal $0.5 billion in 2014, $0.6 billion in 2015, $0.6 billion in 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019 and $4 billion in 2020 (Holahan and Dorn 2010). Medicare DSH payments are cut by much larger proportions, but they are refocused to address uncompensated care more than before the ACA (Greater New York Hospital Association n.d.).

[46] Compared to other states, California has above-average overall primary care capacity relative to the state's expected increase in Medicaid enrollment under the ACA (Ku et al. 2011). However, there is no assurance that this capacity matches up well, geographically, with places where more Medi-Cal beneficiaries will enroll. Nor does this solve Medi-Cal's access problems with specialty and dental care.

[47] Matthew Broaddus, Center on Budget and Policy Priorities, personal correspondence, January 2010.

[48] In Louisiana, 19 in 20 children (95.4 percent) have their eligibility continued at renewal, and fewer than 1 in 100 (0.7 percent) loses coverage for procedural reasons. Data for December 2009, personal communication, Ruth Kennedy, 2010. At the same time, federal audits found Louisiana to have a Medicaid eligibility error rate of 1.54 percent—far below the national average of 6.74 percent (Louisiana Department of Health and Hospitals 2009). See also Gregory (2011).

[49] To illustrate the potential risks of such transitions, when a state operates CHIP separately from Medicaid, the likelihood of children losing coverage at the end of an eligibility period, despite retaining eligibility for one of the programs, increases substantially. In states with integrated

Medicaid/CHIP programs, 9.6 percent of children lose coverage annually, despite retaining eligibility, compared to 13.9 percent in states with separate programs. After controlling for multiple factors, a state's decision to use separate rather than integrated programs was found to raise the likelihood of such coverage loss by 45 percent (Sommers 2005).

[50] CMS, Enhanced Funding Requirements: Seven Conditions and Standards Medicaid IT Supplement (MITS-11-01-v1.0), Version 1.0, April 2011.

[51] As Bachrach and colleagues (2011) noted, "Such coordination between the Exchange and the fifty-eight local administrative offices would create significant challenges and burdens for the still-emerging Exchange, including issues of process requirements and information systems. For example, the Medicaid agency and the Exchange will have to establish procedures to share application information collected by either entity to permit eligibility determinations for all state subsidy programs—Medicaid, CHIP, and subsidized coverage through the Exchange. And while Medicaid eligibility in New York is supported by the state's Welfare Management System, local governments have developed their own systems and information technology (IT) tools to supplement this infrastructure. Integrating these subsystems into a statewide patchwork would add enormous cost and complexity to the already daunting systems task before the State. Federal officials have acknowledged such challenges, noting in recent proposed rules that they will 'scrutinize carefully any proposed investments in sub-State systems…performing essentially the same functions within the same state,' when reviewing states' requests for enhanced funding for Medicaid eligibility and enrollment activities." Bachrach and colleagues further point out that, under the "no-wrong-door" requirements of ACA §1413, local social service offices that determine Medicaid eligibility would be required to likewise determine eligibility and enroll consumers in subsidized coverage in the exchange, thereby imposing substantial new burdens and responsibilities on already understaffed agencies. Centralizing eligibility determination at the state level would avoid such local burdens.

[52] Forthcoming CMS guidance may provide other suggestions about how to accomplish the goal of simplifying the application procedures that apply to parents.

[53] For information about Wisconsin's use of data in children's eligibility records to qualify their parents for expanded Medicaid eligibility, see Friedsam et al. (2009).

[54] Among uninsured children who qualified for Medi-Cal or Healthy Families in 2008, 8.4 percent received SNAP (Kenney et al. 2010). Earlier Urban Institute research found that, in 2002, among uninsured parents in the U.S. with incomes at or below 100 percent of FPL, 53 percent had children who received Medicaid or CHIP, and 22 percent received Food Stamps (since renamed, "SNAP"). At or below 200 percent of FPL, those proportions were 52 percent and 15 percent, respectively (Dorn and Kenney 2006).

[55] According to new Social Security Act §1902(e)(14)(D)(i)(I), MAGI does not apply to "individuals who are eligible for medical assistance under … a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other federal or state aid or assistance."

[56] One possible strategy involves, while patients are still in the hospital, requiring hospitals to obtain enough information to establish ongoing, not just presumptive eligibility. A different approach would use managed care organizations (MCOs) to help with this transition. To avoid the kinds of marketing abuses that have sometimes plagued Medi-Cal in the past, this strategy would need to be very carefully structured. A presumptively eligible consumer could receive a notice from the state encouraging completion of the standard application process, along with a request to select an MCO. The notice would provide that, if consumer fails to choose an MCO by a date certain, the state will select a plan by default. After the MCO is chosen, whether by the consumer or by default, the MCO could receive contact information for the consumer. If the MCO successfully obtains a completed application from the consumer, the MCO could begin receiving capitated payments.

New York has successfully used MCOs to conduct outreach in the community, avoiding marketing abuses through careful regulation of MCO behavior. The model we suggest here takes a different approach—that is, it would flatly forbid any MCO involvement until after a plan has been selected. For an example of New York's marketing regulations, see Wellcare (n.d.). State officials enforce these guidelines through methods that include the use of state testers posing as consumers. Similar approaches could apply with current presumptive eligibility procedures in California, including the "CHDP Gateway," which uses well-child visits and screenings as a starting point for enrollment into ongoing Medi-Cal coverage.

[57] Massachusetts' longstanding program of "mini-grants" to community agencies involves "hands-on" facilitated enrollment, with the routine appointment of authorized representatives from community agencies, who receive copies of state correspondence related to eligibility and can help consumers respond; legally sophisticated "back-up" provided by contracting agencies that are independent of the state; regular and ongoing regional events at which community agencies are briefed on new developments; and the systematic use of application assisters to flag emerging problems and bring them to the attention of state policymakers (Dorn et al. 2009).

[58] The following excerpt from the above-referenced OCIIO/CMS guidance may be apropos: "States will need to allocate the costs of their IT systems

proposals, considering OMB Circular A-87, between the Exchanges and Medicaid for those activities in which Medicaid programs are likely to benefit. Cost allocation with CHIP programs may also be needed. Some of the functions that we anticipate will need cost-allocation include but may not be limited to eligibility, enrollment, and possibly, consumer assistance" (emphasis added).

[59] For example, the above-described Massachusetts state contracts with community organizations were supplemented by grants, of approximately equal magnitude, from Massachusetts foundations. Massachusetts policy also caused safety-net providers to invest substantial resources in consumer assistance. The state established a single process for determining eligibility for Medicaid, CHIP, the state's new Commonwealth Care program, and state uncompensated care funding (supported in part by federal DSH dollars). Providers were and continue to be denied funding from all these sources, except for patients who successfully completed the common application form Dorn et al. 2009).

[60] See, for example, Dorn et al. (2009).

[61] This may include some parents who qualify for Medi-Cal under current law. These are parents whose income, calculated based on traditional Medi-Cal methods (using disregards, for example) falls below 100 percent FPL but whose MAGI exceeds 138 percent FPL.

[62] Among working adults, a move from Medicaid to private coverage would raise costs by 29.5 percent, on average, taking into account different risk levels among those covered by Medicaid and private insurance (Hadley and Holahan 2003/2004).

[63] As explained earlier, Medi-Cal payments for physicians and dentists are well below the national average for Medicaid. The same is true of capitated payments to Medicaid HMOs, where California, in 2001, had the third-lowest capitated payments, relative to Medicare levels, among 36 states that operated capitated Medicaid programs and that responded to a national survey (Holahan and Suzuki 2001). What is particularly significant about capitated payments, in this context, is that they include the full range of covered services and accordingly, compared to physician fees, are a better overall measure of program costs for the affected population.

[64] For a longer discussion of this issue, see Dorn (2011).

[65] For example, California could reduce or eliminate its spending on Medi-Cal "mini-programs" that cover such services as maternity care, treatment of breast cancer, family planning, and AIDS drug treatments, but using BHP rather than the exchange to provide such programs' enrollees with comprehensive coverage could let the state retain "unique and important design features at variance with traditional commercial coverage product designs offered in the Exchange, such as the excellent privacy features preserving the confidentiality of family planning services or the nutritional, counseling and health educational services offered to pregnant women in the Comprehensive Perinatal Services Program."

The medically needy are another group for whom the state can reduce its Medi-Cal spending, either through BHP or coverage in the exchange—although in this case, BHP could achieve slightly greater savings. Without eliminating eligibility for "share-of-cost" Medi-Cal, the state will save money when beneficiaries above 138 percent FPL receive comprehensive coverage that greatly delays the point at which they meet spend-down requirements. Medi-Cal savings would increase if the state implements BHP to reduce OOP costs below levels charged in the exchange and to cover some long-term care services that fall outside traditional private insurance. Both of these steps would further delay the point at which beneficiaries meet spend-down requirements.

[66] BHP-eligible consumers are not identified as such in this report, but the estimate in the text identifies them with tax credit recipients who have incomes at or below 200 percent of FPL and who buy individual coverage in the exchange. For a broader discussion of this issue, see Dorn (2011).

[67] Mercer's analysis used a merge of three years of CPS-ASEC data for California, from 2007 to 2009. That same merge shows a total population under age 65 of 32,557,000.

[68] S.B. 703 (Hernandez) would implement BHP, but it is not clear whether enrollees would receive coverage like that furnished by Medi-Cal or Healthy Families.

[69] See, for example, Dower and Christian (2009); Christian and Dower (2008).

[70] This approach raises equity questions about treating low-income consumers differently from others. But those equity issues may be less important than the improved access to care that could follow from expanded scope of practice, even if limited to public program beneficiaries. And whether or not such expanded scope of practice is limited to enrollees in subsidized coverage, patient safety requires that such scope is consistent with the affected providers' training and skills.

[71] The Council of Economic Advisers (2009) concluded that health reform legislation would result in net budget gains for California. For national analyses finding that states as a whole will experience gains that significantly outweigh increased Medicaid costs for low-income adults, see Dorn and Buettgens (2010) and Lewin Group (2010).