Title
Who Signs Up? Family Participation in Medi-Cal and Healthy Families

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Who Signs Up?

Family Participation in Medi-Cal and Healthy Families

Report to the
California Program on
Access to Care

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Executive Summary

Introduction

In 2001, there were nearly one million uninsured children under age 19 in California.[1] Three hundred and fifty-five thousand (355,000) of these children were eligible for the Medi-Cal (MC) program but remained uninsured. Another 301,000 children were eligible for the Healthy Families (HF) program but were not enrolled in any health insurance plan.[2] When compared to their insured counterparts, uninsured children are less likely to receive preventive care and immunizations, often lack access to primary care, and may not receive treatment when they need it.[3] If, in 2001, we could have enrolled uninsured children in *existing* programs for which they *already qualified*, we could have reduced the number of uninsured children in California by two thirds.[4]

About 87% of eligible children were enrolled in the Medi-Cal (MC) program and about 62% of eligible children were enrolled in the Healthy Families (HF) program at the time their parents were interviewed, based on data from the 2001 California Health Interview Survey. MC and HF program participation rates differed by county of residence and by certain parental characteristics, including race/ethnicity, languages spoken in the home, English language proficiency, and immigration status.

More recent data indicates that the number of uninsured children in California had dropped to 700,000 in 2003. This gain was primarily due to an increase in coverage under the Medi-Cal and Healthy Families programs and occurred in spite of a decrease in employer-based coverage among children. In addition, 50,000 children gained coverage under comprehensive children's health insurance coverage initiatives (CHIs) [5]

Finding 1: Some regions and counties do better at enrolling children in the Medi-Cal and Healthy Families programs than others.

Combined program participation rates for Medi-Cal and Healthy Families ranged from 89% in the Sacramento area to 71% in the Central Coast region.[6] Among individual counties,

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[1] E. Richard Brown, Ninez Ponce, Thomas Rice, Shana Alex Lavarreda. *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey*. UCLA Center for Health Policy Research. Los Angeles. June 2002.

[2] Brown, Ponce, Rice, Lavarreda. *The State of Health Insurance in California.*

[3] Peter Feld, Courtney Matlock, David Sandman. *Insuring the Children of New York City's Low-Income Families. Focus group findings on barriers to enrollment in Medicaid and Child Health Plus*. New York: The Commonwealth Fund, December 1998; and Cathy Schoen and Catherine DesRoches, *New York City's Children: Uninsured and At Risk, Findings from the Commonwealth Fund Survey of Health Care in New York City, 1997*. New York: The Commonwealth Fund, May 1998.

[4] Brown, Ponce, Rice, Lavarreda. *The State of Health Insurance in California.*

[5] E. Richard Brown, Shana Alex Lavarreda, Thomas Rice, Jennifer R. Kincheloe, Melissa S. Gatchell. *The State of Health Insurance in California: Findings from the 2003 California Health Interview Survey.* UCLA Center for Health Policy Research. Los Angeles. August 2005.

[6] The Sacramento Region includes Sacramento, Placer, Yolo, and El Dorado Counties. The Central Coast includes Ventura, Santa Barbara, Santa Cruz, San Luis Obispo, Monterey, and San Benito counties.

Merced had the highest combined program participation rate with 88% of eligible children enrolled in the program. Tulare, San Joaquin, Madera, Fresno, and San Luis Obispo also had rates that were statistically very close to Merced's relatively high rate. Ventura, Monterey, and San Benito had the lowest combined program participation rate with only 65% of eligible children being enrolled in the program and 35% of eligible children remaining uninsured.

Finding 2: Large numbers of Latino children are eligible for the Medi-Cal or Healthy Families programs, but remain uninsured.

Only 83% of Latino children were enrolled in MC—the lowest participation rate of any ethnic group. Because large numbers of Latino children qualified for MC, and because program participation by Latino families was relatively low, large numbers of eligible Latino children remained uninsured. An estimated 239,000 Latino children under 18 years of age were eligible for MC but were not enrolled in any insurance plan. This is compared with 52,000 White children and only 7,000 Asian Pacific Islander American children.

Although the Latino participation rate in HF was only slightly below the state average, Latinos still made up the bulk of HF eligible, uninsured children. There were approximately 175,000 uninsured Latino children, 61,000 uninsured White children, and 13,000 uninsured Asian Pacific Islander American children who were eligible for the HF program, but were not enrolled. In addition, 11,000 children whose parents did not identify with any one ethnic group were eligible

Finding 3: Parents who speak Spanish at home or who have limited English proficiency are less likely to enroll their children in Medi-Cal.

Only 79% of MC eligible children who speak *only* Spanish at home were enrolled in the program. This is compared to 92% of children from homes where *only* English is spoken. About 83% of eligible children whose parents report that they do not speak English or do not speak English well were enrolled in MC. However, 90% of eligible children whose parents report speaking English "very well" were enrolled in MC. The effect of a parent's language and English language proficiency on children's participation in the HF program appears less pronounced than on MC program enrollment.

Finding 4: Children with US-born parents are more likely to enroll in Medi-Cal.

Eligible children with at least one US born parent were enrolled in MC about 92% of the time. This is compared to children of non-citizen parents without green cards who participated about 86% of the time. In the HF program, children's participation rates were about the same regardless of their parent's immigration status.

Finding 5: Lack of knowledge about the Medi-Cal and Healthy Families programs is a barrier to program enrollment across all racial and ethnic groups.

About 49% of parents reported not enrolling their eligible child due to lack of knowledge about the Medi-Cal or Healthy Families program.[7] These findings were consistent across racial and ethnic groups.

Conclusion

California could greatly improve insurance coverage in the state by enrolling nearly 700,000 uninsured children in programs for which they already qualified. Families need assistance in order to take advantage of the Medi-Cal and Healthy Families programs for children. Parents need to be aware that the programs exist and that their children may be eligible. Families need to be engaged through community-based outreach and enrollment support that is culturally and linguistically appropriate.

[7] This includes 39% who believe they are not eligible or don't know they are eligible and 10% who did know the program existed.

Introduction

In 2001, there were nearly one million uninsured children under age 19 in California.[8] Three hundred and fifty-five thousand (355,000) of these children were eligible for the Medi-Cal (MC) program but remained uninsured. Another 301,000 children were eligible for the Healthy Families (HF) program but were not enrolled in any health insurance plan.[9] More recent data indicates that the number of uninsured children in California had dropped to 700,000 in 2003, and over half of these uninsured children were eligible for either the Medi-Cal or the Healthy Families program. This gain in coverage was primarily due to an increase in Medi-Cal and Healthy Families program enrollment, and occurred in spite of a decrease in employer-based coverage among children. In addition, 50,000 children gained coverage under comprehensive children's health insurance coverage initiatives (CHIs) [10]

When compared to their insured counterparts, uninsured children are less likely to receive preventive care and immunizations, often lack access to primary care, and may not receive treatment when they need it.[11] If we could enroll uninsured children in *existing* programs for which they *already qualify*, we could reduce the number of uninsured children in California by more than half. This report is the first of a two-part series exploring how children who are

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[8] E. Richard Brown, Ninez Ponce, Thomas Rice, Shana Alex Lavarreda. *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey*. UCLA Center for Health Policy Research. Los Angeles. June 2002.

[9] Brown, Ponce, Rice, Lavarreda. *The State of Health Insurance in California.*

[10] E. Richard Brown, Shana Alex Lavarreda, Thomas Rice, Jennifer R. Kincheloe, Melissa S. Gatchell. *The State of Health Insurance in California: Findings from the 2003 California Health Interview Survey.* UCLA Center for Health Policy Research. Los Angeles. August 2005.

[11] Peter Feld, Courtney Matlock, David Sandman. *Insuring the Children of New York City's Low-Income Families. Focus group findings on barriers to enrollment in Medicaid and Child Health Plus*. New York: The Commonwealth Fund, December 1998; and Cathy Schoen and Catherine DesRoches, *New York City's Children: Uninsured and At Risk, Findings from the Commonwealth Fund Survey of Health Care in New York City, 1997*. New York: The Commonwealth Fund, May 1998.

enrolled in the MC and HF programs differ from children who are eligible, yet remain uninsured. By learning the characteristics of eligible children who remain uninsured, we can better tailor outreach and enrollment policies to serve them and their families.

This report provides estimates of program participation expressed as the ratio of children who are enrolled in either the MC or the HF programs to the total number who are eligible to participate in the programs and who do not have private or employer sponsored health insurance coverage. Program participation rates are provided by geographic region and by county (where sample size permits). Because parents are the decision makers regarding children's health insurance enrollment, this report also highlights the disparities in children's enrollment by parental characteristics including ethnicity, immigration status, English language proficiency, and language spoken in the home. By learning about the parents of uninsured eligible children, we can better target them with outreach programs. We also provide the most frequent reasons parents give for not enrolling their eligible children in the programs, by ethnicity.

Throughout the report, we provide point estimates (single number estimates)[12] of program participation rates as well as ranges. The estimates are based on relatively small sample sizes; thus we consider the point estimates for some groups and geographic areas to be *approximations*. However, we are confident that 95% of the time, the true value lies within the range provided. When confidence intervals (ranges) are wide, we focus on the range rather than on the point estimate.

[12] A point estimate is a single number estimate. However, estimates are also expressed as a range of numbers or a "confidence interval." Statistically, the real world value that we are estimating will be within the range given 95% of the time. There is a 5% chance that the true value will lay outside the range.

Methods

This report is based on data from the 2001 California Health Interview Survey (CHIS 2001), a telephone survey of more than 55,000 households drawn from every county in California —the largest population-based state health survey ever conducted in the United States. The CHIS 2001 random-digit dial (RDD) sample was drawn from 41 sampling strata. It includes 5,801 adolescents (ages 12-17) and 12,598 younger children (under age 12, for whom information was reported by the "most knowledgeable adult" in the family) who are associated with the 55,428 sample adults (age 18 and over). For each selected household, CHIS interviews one randomly selected adult, and in those households with children, one adolescent (ages 12-17) and one parent proxy of a sample child (under age 12). They were interviewed between November 2000 and September 2001.

This study focuses on children under age 18 who are eligible for either the MC or the HF program, and who are not enrolled in any other health insurance plan[13]. Excluding children with private, employer-sponsored, or "other governmental"[14] insurance coverage, there are 1,431 children in the CHIS 2001 sample who are HF eligible, and 3,831 children who are MC eligible. For this report, data on children and teens were linked with data on their parents' characteristics.

Participation rates were calculated using CHIS 2001 estimates of children's enrollment in and eligibility for the MC and HF programs. Enrollment estimates are based on parents' responses to CHIS 2001 survey questions on their child's insurance status and their families'

[13] Although individuals age 18 are eligible for both the MC and the HF programs for children, 18 year old respondents are excluded from this study. This is due to a data limitation. In CHIS, 18 year-old respondents are treated as adults and are administered a different questionnaire than respondents under age 18 and their proxies. Their parents are not interviewed, and thus we have no data on their parent's characteristics.

[14] A government insurance program other than Medi-Cal or Healthy Families

participation in public programs at the time of the interview, rather than on administrative data from the Department of Health Services or the Managed Risk Medical Insurance Board.[15]

In addition, parents were asked a series of detailed questions that were included in the CHIS 2001 survey for the express purpose of determining their eligibility and their children's eligibility for the MC and HF programs.[16] These questions were used to construct a variable categorizing each respondent as eligible for MC, eligible for HF, or not eligible. About 100 contributing variables were used in the construction of the final eligibility variable.

Population-based estimates of program enrollment and eligibility were created by weighting the responses from each person in the sample to reflect the number of similar persons in the population in 2000 that that individual represented. Participation rates were calculated using the following formula:

$$\text{Participation Rate} = 100 \times \frac{\text{Number Enrolled}}{(\text{Number Enrolled} + \text{Number Eligible but Uninsured})}$$

The *number enrolled* consists of weighted estimates of the number of children who are enrolled in MC, or who are enrolled in HF, or the number enrolled in both programs combined, depending on whether we are estimating MC participation, HF participation or combined participation rates. The *number eligible but uninsured* consists of weighted estimates of the number of uninsured children who are eligible for MC or HF or both programs (again depending on which participation rate we are calculating), yet who are not enrolled. Children who are eligible, but who have insurance coverage through programs other than MC or HF are excluded

[15] The CHIS 2001 estimates of Medi-Cal enrollment for ages 0-18 is 2,206,000, compared to an administrative data count of 2,700,000 enrollees (based on data from the California Department of Health Services reports for the midpoint during the period in which CHIS was conducted). Therefore, although CHIS captures a greater number of enrollees than previous surveys, the CHIS 2001 estimates of Medi-Cal enrollment are lower than numbers derived from administrative data. This is an ongoing issue with population-based surveys, one which the UCLA Center for Health Policy Research is addressing in a current research project.

[16] Parents' eligibility for the Healthy Families program has been put on hold due to the current state budget crisis,

from that calculation. For more information on CHIS, including information on sample weights, please visit *www.chis.ucla.edu*.

Differences that are described in the text as "significant" or "statistically different" are statistically significant at the $p<0.05$ level, unless otherwise indicated.

Findings

MC and HF program participation rates differ by county of residence and by certain parental characteristics, including race/ethnicity, languages spoken in the home, English-language proficiency, and immigration status.

Finding 1: Some regions and counties do better at enrolling children in Medi-Cal and Healthy Families

Exhibit 1 presents combined participation rates for the MC and HF programs by region and, where sample size permits, by county.[17] Participation rates were calculated for children eligible for the MC program combined with children eligible for the HF program in order to increase the sample sizes for counties and allow for county-level estimates.

Overall, about 81% (range: 80% to 83%) of eligible children were enrolled in the MC and HF programs. However, some regions and counties enroll a larger proportion of their eligible children than others. The Sacramento region enrolled the greatest proportion of their eligible children, with about 89% (range: 83% to 94%) of MC and HF eligible children enrolled in the programs. The Greater Bay Area and the Northern and Sierra Counties did relatively well with participation rates of 86% (range: 82% to 90%) and 84% (range: 80% to 87%), respectively. The San Joaquin Valley achieved a rate of 83% (range: 80% to 86%), and Los Angeles a rate of 81% (range: 79% to 84%). The Other Southern California region, which comprises southern counties

although Governor Davis signed legislation to cover the parents of eligible children who enroll in the program.

excluding Los Angeles, had a participation rate of 79% (range: 75% to 83%). The Central Coast region achieved a rate of 71% (range: 63% to 77%) of eligible children enrolled in the programs, and about 29% of eligible children remaining uninsured. Statistically, this participation rate falls significantly below the state average.

Among individual counties included in this analysis, Merced had the highest point estimate for program participation, with an estimated 88% (range: 78% to 94%) of eligible children enrolled in either the MC or the HF program. However, several counties, such as Tulare, San Joaquin, Madera, Fresno, and San Luis Obispo counties had rates that were statistically similar to those in Merced County. Ventura and Monterey Counties had program participation rates that were statistically far below the state average, with only 65% (range: 51% to 78%) of eligible uninsured children being enrolled and about 45% of eligible children remaining uninsured.

The fact that some counties have been more successful at enrolling eligible uninsured children than others warrants further investigation and is the focus of the second report in this series. By identifying county-level policy and program environmental factors that affect program enrollment, we can identify factors that, if adopted in other counties, could increase children's participation in the MC and HF programs. Environmental factors are often mutable through policy change whereas family characteristics, such as ethnic identity or language, are not. Although we would not want to change most family characteristics that are associated with low MC and HF enrollment, it is useful to learn the characteristics of families with uninsured children who are eligible for the programs so that we can target these families with outreach that is tailored to meet their specific needs.

[17] Like counties were grouped into regions to maximize sample size and improve estimate stability.

Exhibit 1: Combined Program Participation in Medi-Cal and Healthy Families by County, Ages 0-17, California 2001

	Program Participation Rate	
Northern And Sierra Counties	**84%**	**(Range: 80%-87%)**
Butte, Shasta, Humboldt, Del Norte, Siskiyou, Lassen, Trinity, Modoc, Mendocino, Lake, Tehama, Glenn, Colusa, Sutter, Yuba, Nevada, Plumas, Sierra, Tuolumne, Calaveras, Amador, Inyo, Mariposa, Mono, Alpine		
Greater Bay Area	**86%**	**(Range: 82%-90%)**
Santa Clara, Alameda, Contra Costa, San Francisco, San Mateo, Sonoma, Solano, Marin, Napa		
Sacramento Area	**89%**	**(Range: 83%-94%)**
Sacramento, Placer, Yolo, El Dorado		
San Joaquin Valley	**83%**	**(Range: 80%-86%)**
Fresno	85%	(Range: 77%-91%)
Kern	77%	(Range: 69%-84%)
San Joaquin	87%	(Range: 79%-92%)
Stanislaus	79%	(Range: 67%-88%)
Tulare	86%	(Range: 78%-91%)
Merced	88%	(Range: 78%-94%)
Kings	79%	(Range: 70%-85%)
Madera	86%	(Range: 77%-92%)
Central Coast	**71%**	**(Range: 63%-77%)**
Ventura	65%	(Range: 51%-76%)
Santa Barbara	80%	(Range: 69%-88%)
Santa Cruz	80%	(Range: 65%-90%)
San Luis Obispo	85%	(Range: 72%-93%)
Monterey, San Benito	65%	(Range: 48%-78%)
Los Angeles	**81%**	**(Range: 79%-84%)**
Other Southern California	**79%**	**(Range: 75%-83%)**
Orange	78%	(Range: 70%-84%)
San Diego	76%	(Range: 67%-83%)
San Bernardino	82%	(Range: 75%-88%)
Riverside	82%	(Range: 72%-88%)
Imperial	78%	(Range: 70%-84%)
TOTAL	**81%**	**(Range: 80%-83%)**

Source: 2001 California Health Interview Survey

Finding 2: Large numbers of Latino children are eligible for the Medi-Cal or Healthy Families programs, but remain uninsured.

Only 83% (range: 81% to 85%) of Latino children who were eligible for MC enrolled in the program, giving them the lowest program participation rate of any ethnic group (Exhibit 2). A higher percent of eligible White children participated in the MC program: 89% (range: 86% to 92%). Children whose parent reported Asian American/Pacific Islander, African American, or American Indian/Alaska Native ethnicity participated at similarly higher rates: 96% (range: 92% to 98%), 98% (range: 96% to 99%) and 97% (range: 93% to 98%), respectively. These rates were significantly higher than the rate for White and Latino children.

Because California's Latino families are more likely to be poor, the children of Latino parents make up a large share of the MC enrolled population. As noted in an earlier report from the UCLA Center for Health Policy Research, 57% of children enrolled in MC are Latino.[18] However, *eligible, uninsured children are disproportionately Latino:* about 73% of children who are *uninsured* and *eligible* for MC are Latino. This is compared to White children who make up 20% of the MC enrolled population and only 17% of the uninsured eligible population. Asian American/Pacific Islander children make up 8% of children enrolled in MC and only 4% of the eligible uninsured population.

Because large numbers of Latino children qualify for MC, and because program participation by Latino families is relatively low, the number of eligible Latino children who are uninsured is also large. An estimated 239,000 (range: 204,000 – 274,000) Latino children under 18 years of age were eligible for MC but were not enrolled in any insurance plan. This is compared with 52,000 (range: 34,000 – 69,000) White children and only 7,000 (range: 2,000 – 12,000) Asian American/Pacific Islander children who were eligible, but remained uninsured.

Estimates of the number of African American, American Indian/Alaska Native children and those in other ethnic groups were unstable due to small sample sizes, and are therefore not reported.[19]

Exhibit 2: Eligibility for and Participation in Medi-Cal by Parent's Ethnicity, Ages 0-17, California 2001

	Enrolled **in Medi-Cal**	***Uninsured,*** **but Medi-Cal Eligible**	**Program Participation Rate**
White	**439,000** (395,000 – 483,000)	**52,000** (34,000 – 69,000)	**89%**
Latino	**1,191,000** (1,108,000 – 1,275,000)	**239,000** (204,000 – 274,000)	**83%**
Asian American/ Pacific Islander	**169,000** (138,000 – 200,000)	**7,000** (2,000 – 12,000)	**96%**
African American	**219,000** (184,000 – 54,000)	*	**98%**
American Indian/ Alaska Native	**15,000** (10,000 – 20,000)	*	**97%**
Other & Multiple Race	**63,000** (43,000 – 84,000)	*	**83%**
TOTAL	**2,097,000** (1,993,000 – 2,200,000)	**316,000** (275,000 – 356,000)	**87%**

* This estimate is not statistically stable (the coefficient of variation exceeds .30).
Source: 2001 California Health Interview Survey

Overall, program participation is lower for the HF program than for the MC program. While 87% of MC eligible children were enrolled in the program, only about 62% of HF eligible children were enrolled in this newer program. In part, this difference may be due to MC being an older, more established program with greater program recognition. One in four (23%) parents of

[18] Brown, Ponce, Rice, Lavarreda, *The State of Health Insurance in California*.

[19] Coefficient of variation exceeds .30

HF eligible uninsured children reported that they did not enroll their child because they didn't know the program existed. By contrast, less than one percent of the parents of uninsured MC eligible children reported that they did not know the program existed.[20] Also, families receiving TANF are automatically enrolled in MC, thus boosting the program participation rate.

Exhibit 3: Children's Participation in Healthy Families by Parent's Ethnicity, Ages 0-17, California 2001

	Enrolled **in Healthy Families**	***Uninsured,*** **but Healthy Families Eligible**	**Program Participation Rate**
White	**95,000** (78,000 – 111,000)	**61,000** (48,000 – 74,000)	**61%**
Latino	**261,000** (228,000 – 295,000)	**175,000** (146,200 – 204,000)	**60%**
Asian American/ Pacific Islander	**54,000** (39,000 –68,000)	**13,000** (7,000 – 19,000)	**81%**
African American	**13,000** (6,000 – 21,000)	*****	**78%**
American Indian/ Alaska Native	*****	*****	**44%**
Other & Multiple Race	**13,000** (7,000 – 19,000)	**11,000** (4,000 – 18,000)	**54%**
TOTAL	**437,000** (396,000 – 478,000)	**266,000** (232,000 – 299,000)	**62%**

* This estimate is not statistically stable (the coefficient of variation exceeds .30).
Source: 2001 California Health Interview Survey

Latino children who were eligible for the Healthy Families program were enrolled at rates similar to White children: about 60% (range: 55% to 65%) and 61% (range: 54% to 67%), respectively (Exhibit 3). Latino children weare more likely to be *eligible* and *uninsured* than

[20] Brown, Ponce, Rice, Lavarreda, *The State of Health Insurance in California*.

were Asian American/Pacific Islander children, about 81% (range: 70% to 88%) of whom were enrolled.

Although the Latino participation rate in HF was only slightly below the state average for all ethnic groups, Latinos still made up the bulk of HF eligible, uninsured children. There were approximately 175,000 (range: 146,000 to 204,000) uninsured Latino children, 61,000 (range: 48,000 to 74,000) uninsured White children, and 13,000 (range: 7,000 to 19,000) uninsured Asian American/Pacific Islander children who were eligible for the HF program, but were not enrolled. In addition, approximately 11,000 (range: 4,000 to 18,000) children whose parents did not identify with any one ethnic group were eligible for HF, but were uninsured. Due to small sample size, estimates of the number of uninsured eligible children who are African American or Native American/Alaska Native were deemed unstable and therefore are not reported.[21] Thus, about two-thirds of uninsured children who are eligible for the HF program are Latino.[22]

Latinos make up the majority of uninsured children eligible for either the MC or the HF program. Outreach efforts must target Latino parents if California is to substantially reduce children's uninsurance by increasing participation in the MC and HF programs.

Finding 3: Parents who speak Spanish at home or who have limited English proficiency are less likely to enroll their children in MC.

Exhibit 4 presents program participation rates for both the MC and the HF programs by language spoken at home and by self-rated English-language proficiency of the respondent parent. For MC eligible children, the highest program participation was among those who speak only English at home and those who speak Asian or other languages at home. Both groups participated at similar rates: 92% (range: 89% to 94%) and 93% (range: 89% to 96%),

[21] Coefficient of variation exceeds .30

[22] Brown, Ponce, Rice, Lavarreda, *The State of Health Insurance in California*.

respectively. These participation rates were significantly higher than the 79% rate for children who come from homes where only Spanish is spoken (range: 75% to 83%), and the 86% rate for those whose parents speak both English and Spanish in the home (range: 83% to 88%).

Children from households where only English is spoken were disproportionately enrolled in MC, while children from households where only Spanish is spoken were disproportionately *not enrolled*. Children with parents who speak only English at home comprised 33% of all MC enrolled children but only 19% of uninsured eligible children (data not shown in table). By contrast, children whose parents speak only Spanish at home made up 24% of the enrolled population, but a much greater proportion — 40% — of the eligible uninsured population. Those whose parents speak an Asian or other language at home were more likely to participate, making up 11% of the enrolled population and only 5% of the eligible uninsured population.

Among those who speak a non-English language in the home, those whose parents report speaking English "very well" had the highest program participation rate at 90% (range: 86% to 93%). Those with somewhat less proficiency (who report speaking English "well") participated at a somewhat lower rate: 85% (range: 79% to 90%). Among children with the most limited English-proficient parents (those who report not speaking English or who report speaking English "not well"), 83% (range: 80% to 85%) participated — a rate that is significantly lower than those whose parents speak only English or who speak English "very well." While children of parents who don't speak English at all or who speak English "not well" comprised 44% of the MC enrolled population, they made up almost 60% of the eligible but uninsured population (data not shown in table).

The effect of a parent's language on children's participation in the HF program appears less pronounced than on MC program enrollment. Three-fourths of those who speak Asian or

other languages at home (76%, range: 66% to 84%) participated in the HF program, significantly higher than the rate of 62% among those from homes where only English is spoken.

A parent's English language proficiency also appears to have less impact among HF-eligible children than among MC-eligible children. Children participated in HF at about the same rate, regardless of their parent's English language proficiency, suggesting that outreach for this program has been more successful in overcoming language barriers.

Exhibit 4. Children's Participation in Medi-Cal and Healthy Families by Language Spoken at Home and Parent's English Language Proficiency, Ages 0-17, California 2001

Language Spoken at Home	Medi-Cal Program Participation Rate	Healthy Families Program Participation Rate
Only English at Home	**92%**	**62%**
English and Spanish at Home	**86%***	**57%**
Spanish Only at Home	**79%***	**65%**
Asian or Other Languages at Home	**93%**	**76%***
English Language Proficiency		
Speaks Only English	**92%**	**62%**
Speaks English Very Well	**90%**	**59%**
Speaks English Well	**85%***	**67%**
Speaks English Not Well/ Not at All	**83%***	**61%**

* Significantly different from Only English at Home at p<.05

Source: 2001 California Health Interview Survey

Although HF participation rates were *not* lower for children from Spanish speaking homes than for children from homes where only English is spoken, large numbers of eligible Latino children remained uninsured. There are 171,000 uninsured HF eligible children (age 0-18) who come from homes where both Spanish and English are spoken and another 32,000 from

Spanish-only homes.[23] In addition, 179,000 MC eligible children were uninsured and from homes where both Spanish and English are spoken, and 87,000 were from households in which only Spanish is spoken. In order to enroll the maximum number of eligible children, outreach efforts must specifically target Spanish-speaking parents.

Finding 4: Children with US-born parents are more likely to enroll in Medi-Cal

All children eligible for full-scope MC or the HF program are, in fact, citizens or legal residents. However, participation rates of eligible children vary considerably by their parents' citizenship and immigration status.

More than nine out of 10 (92%, range: 90% to 94%) eligible children with at least one US-born parent participated in MC (Exhibit 5). This rate was significantly higher than the rates for eligible children with at least one naturalized citizen foreign-born parent (88%, range: 84% to 91%) as well as for children whose parents are non-citizens with a "green card" (77%, range: 72% to 81%) and children of non-citizen parents without green cards (86%, range: 81% to 89%).

Outreach efforts that include specific targeting of children whose parents are not citizens with a "green card" will reach the largest group of eligible uninsured children. These children comprised 18% of the MC enrolled population but twice that proportion — 37% — of eligible uninsured children (data not shown). In the HF program, children's participation rates were about the same regardless of their parent's immigration status. However, because outreach for the children's MC and HF programs is linked through the joint application process, MC and HF outreach should clearly reassure non-citizen parents that enrolling their eligible children in either program will not have any adverse effect on their own or their children's immigration or citizenship status.

[23] Brown, Ponce, Rice, Lavarreda, *The State of Health Insurance in California*.

Exhibit 5. Program Participation And Parents' Self Reported Immigration Status Among Children Eligible for Medi-Cal or Healthy Families, Ages 0-17, California 2001

Immigration Status	Medi-Cal Participation Rate	Healthy Families Participation Rate
At Least One Parent US Born	92%	62%
At Least One Parent Naturalized Citizen, Neither Parent US Born	88%*	63%
At Least One Parent Green Card Holder, Neither Parent A Citizen	77%*	61%
Non-Citizen Parents, No Green Card	86%*	63%

* Statistically, this estimate is significantly different from the estimate for At Least One Parent US Born at the p<.05 level.

Source: 2001 California Health Interview Survey

Finding 5: Lack of knowledge about the Medi-Cal and Healthy Families programs is a barrier to program enrollment across all racial and ethnic groups.

About 39% of parents reported that the main reason they did not enroll their uninsured, eligible child in either the MC or the HF program is that they believed the child was not eligible, or they didn't know whether the child was eligible, for the programs (see Exhibit 6). Another 10% did not know the programs existed. Thus, a total of 49% of parents reported not enrolling their child due to lack of knowledge about the programs. These findings were consistent across racial and ethnic groups. Also notable is that very few people in any ethic/racial category (about 3% overall) reported not enrolling their child in MC or HF because they don't believe in or do not need insurance. Problems with the programs themselves, such as difficult paperwork or a dislike for "welfare" were reported by only 7% of parents. Although the point estimates reported in Exhibit 6 vary somewhat by racial and ethnic category, statistically the estimates are not different.

The pattern of responses differs somewhat for families that are eligible for MC and families that are eligible for the HF program. Parents of children eligible for HF were much more

likely than those eligible for MC to say they hadn't heard about the program, while those whose children were MC eligible were more likely to complain about program characteristics, such as excessive paperwork or stigma.[24] We have combined responses here because of the small sample size.

Exhibit 6: Reasons Parents Give for Not Enrolling Their Uninsured Eligible Child in Medi-Cal and Healthy Families by Ethnicity, Ages 0-17, California 2001

	Latino	Asian American / Pacific Islander	American Indian/ Alaska Native	African American	White	Total
Believe They Are Not Eligible / Don't Know If They Are Eligible	**39%**	**36%**	**39%**	**30%**	**41%**	**39%**
Didn't Know The Program Existed	**11%**	**7%**	**4%**	**3%**	**7%**	**10%**
Paperwork Too Difficult Or Don't Like/Want Welfare	7%	11%	8%	10%	6%	7%
Don't Believe In/Don't Need Health Insurance	4%	0%	0%	0%	1%	3%
Other	39%	46%	51%	57%	45%	41%
Total	100%	100%	100%	100%	100%	100%

Source: 2001 California Health Interview Survey

Finding 6: A parent's race/ethnicity appears to be a driving factor in program enrollment.

A parent's race/ethnicity is a stronger predictor of children's enrollment than factors related to immigration, including languages spoken in the home, a parent's English-language proficiency, the number of years a parent has been living in the United States, or a parent's immigration status. We determined this by controlling for other important parental

[24] For statewide estimates of the reasons why parents don't enroll their eligible children in the Medi-Cal program and separate estimates for why parents don't enroll their eligible children in the Healthy Families program, see

characteristics, including age, marital status, educational level, number of hours worked per week, mental wellbeing, rural vs. urban residence, number of children in the family, and household income. In addition, we controlled for the age, health status, and gender of the child. The effect of race and ethnicity on enrollment may be due to many factors, including residential and cultural segregation which discourage people from interacting with groups other than own. Outreach efforts would do well to capitalize on the insights, resources, and credibility of community-based organizations that serve specific ethnic and racial groups within communities.

Public Policies to Increase Children's Enrollment

California's more than 700,000 uninsured children have the same health care needs as their classmates and friends who have insurance, but their access to care is seriously compromised. Young children who are eligible for MC or HF, but who are uninsured, are more likely to delay or not get care than children who are enrolled in the programs.[25]

Ongoing budget concerns challenge California's political will to ensure that all children are covered by health insurance. The State's costs of maintaining or expanding children's coverage in MC and HF compete for State General Fund tax revenues along with all other State services and programs. However, because every state dollar spent on MC draws down one federal matching dollar and every state dollar spent on HF draws down two federal dollars, increasing MC and HF coverage for children remains a good investment for California.

Twenty-seven counties have developed, or are planning, comprehensive children's health insurance coverage initiatives (CHIs) that will help to enroll more eligible children in MC and

Brown, Ponce, Rice, Lavarreda, *The State of Health Insurance in California*, pp. 51-52.

[25] Moira Inkelas, Neal Halfon, Kim Uyeda, Greg Stevens, Janel Wright, Sue Holtbe, E. Richard Brown, *The Health of Young Children in California: Findings from the 2001 California Health Interview Survey*, Los Angeles and Sacramento: UCLA Center for Health Policy Research and First 5 California, July 2003.

HF and fill in gaps in existing State programs. These county-level programs, also called Healthy Kids Programs, enable more children in low- to moderate-income families to obtain subsidized coverage, including children who do not qualify for MC or HF due to their immigration status and, in a few counties, some parents as well. California enacted Assembly Bill (AB) 495 in 2001, allowing counties to use expansion program expenditures to draw down a two-to-one federal match through the State Children's Health Insurance Program (SCHIP), but only for documented children with household incomes between 250 and 300 percent of poverty. Under the provisions of this law, the State obtained federal permission through a State Plan Amendment (SPA) to enable four CHIs (Alameda, Santa Clara, San Mateo and San Francisco) to provide funds to draw down federal matching funds through SCHIP. In 2005, a SPA was submitted that would allow a second wave of CHIs to participate in the federal match. These county-level initiatives thus enable coverage expansion without additional State General Fund dollars. However, current funding for CHIs is not sustainable and most CHIs have enrollment caps. State legislative action is needed to assure the long-term funding and success of these initiatives.

Some of the CHI funds are used for outreach to enroll eligible children in existing State programs and newer locally based expansion programs. Anecdotal and research evidence suggests that counties with expansion programs in place have seen a "spill-over" effect — more children enrolling in MC and HF alongside those children who enroll in the expansion program. This may be due to increased outreach and to the prevalence of families who have both native-born and immigrant children — families with mixed documentation status (and thus mixed eligibility). Trenholm found a sizeable spillover effect among new applicants to both the Medi-Cal and Healthy Families program in Santa Clara County, and a statewide study by Kincheloe found a spillover effect among all Medi-Cal eligible children, but not among children eligible for

the Healthy Families program. This may be because Medi-Cal program eligibility is determined at the county-level enabling follow-up at the county-level through coordination with CHIs.[26,27] In contrast, eligibility for the Healthy Families program is determined at the State level. CHI workers in Alameda County reported difficulty following up with Healthy Families applications due to barriers posed by State-level eligibility administration.[28]

The few CHIs that include coverage for parents may also generate higher participation rates by eligible children, based on evidence from several other states. Researchers at the Urban Institute found that four state programs (Minnesota, New Jersey, Rhode Island and Wisconsin) that cover parents of SCHIP children experienced strong success enrolling parents, and also realized substantial improvements in child enrollment in both Medicaid and SCHIP.[29]

However, reductions related to the State's fiscal crisis are likely to reduce these gains. Outreach money for the MC and HF programs was cut in fiscal year 2002-03 and only restored to the budget in 2005-2006. The effect of county expansion programs on MC and HF program enrollment will be difficult to assess in this larger context of policy change. But these local-level initiatives warrant further study and assessment.

In 2005, AB 772 and AB 1199 were approved by the Legislature and would have created a statewide Healthy Kids Program to extend eligibility for public health insurance to every uninsured child in California, regardless of income or immigration status. Children from

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[26] Trenholm, C. *Santa Clara: Impacts on Medical and Dental Care; Impacts on Enrollment in Medi-Cal and Healthy Families.* Presented June 10th, 2005 at the Child Health Policy Research Symposium, USC Keck School of Medicine.

[27] Kincheloe J. The Determinants of Participation in California's Medi-Cal and Healthy Families Programs by Eligible Children. University of California, Los Angeles, 2004.

[28] Alameda County Health Care Services Agency Report of the SCHIP Project Results, 2002

[29] Embry M. Howell, Ruth A. Almeida, Lisa Dubay, and Genevieve M. Kenney, *Early Experience with Covering Uninsured Parents Under SCHIP*, Washington, DC: Urban Institute, May 31, 2002. Available at: www.urban.org (accessed October 10, 2003).

families with higher incomes would pay higher premiums, and children above 300% of poverty would pay the full cost of Healthy Families coverage. County CHIs would be invited to provide premium support to children whose families had difficulties making the payments.

These bills, which were vetoed by Governor Schwarzenegger, featured policies to increase program participation as well as eligibility, and would have streamlined the Healthy Families and Medi-Cal programs under a single, seamless administrative overlay. That is, all participating children, regardless of the funding stream that paid for their coverage, would be enrolled in the Healthy Kids Program. These bills also contained provisions to: reduce documentation requirements; simplify enrollment, recertification, and transfer between the Medi-Cal and Healthy Families programs; and expedite enrollment for children who qualify for food stamps, WIC, the Child Health and Disability Prevention Program, or free or reduced school lunches. These reforms, coupled with universal eligibility for children, would likely have a dramatic positive impact on program participation among uninsured children currently eligible for Medi-Cal or Healthy Families. Once all children are eligible for public coverage, no parent will mistakenly assume that their child does not qualify.

In 2006 the California Senate will again consider legislation to create a state-wide Healthy Kids Program in the form of SB 437, a twin bill to the vetoed AB 772. In addition, an initiative that would create a statewide Healthy Kids Program will be on the ballot in November. The Tobacco Tax, Disease Prevention, and Children's Health Insurance Act of 2006 would raise the state cigarette tax by $1.50 per pack in order to fund a statewide Healthy Kids Program.

California's economic slump coupled with State budget pressures and the threat of federal Medicaid cuts in response to Hurricanes Katrina and Rita make it even more important that limited resources for outreach be applied in a strategic and cost-effective manner in order to

enroll the maximum number of children. A number of clear findings from this study and related studies suggest issues that need to be addressed:

Findings:

- In 2001, about 355,000 uninsured children were eligible for Medi-Cal. Another 301,000 uninsured children were eligible for Healthy Families.[30]

- Some regions and counties do better at enrolling children in Medi-Cal and Healthy Families. While 88% of eligible kids in Merced County were enrolled in either MC or HF, only 65% of eligible kids in Ventura, Monterey and San Benito counties were enrolled.

- Large numbers of Latino children were eligible for the Medi-Cal or Healthy Families programs, but remained uninsured.

- Parents who speak Spanish at home or who have limited English proficiency were less likely to enroll their children in MC.

- Children with US-born parents were more likely to enroll in Medi-Cal.

- Parent's race/ethnicity appears to be a driving factor in program enrollment. The children of Latino and White parents have lower participation rates relative to the children of Asian and African American parents.

- Lack of parental knowledge about the Healthy Families and Medi-Cal programs and parental perceptions that a child is not eligible are barriers to program enrollment across all racial and ethnic groups.

Based on these findings, we offer a number of recommendations to enhance enrollment of eligible children in the MC and HF programs.

POLICY RECOMMENDATIONS:

- **Continue state funding for MC and HF outreach.**

  In order to enroll their children in MC and HF, parents need to know that the programs exist and that their children may be eligible. Lack of knowledge about the MC and HF programs and perceptions that a child is not eligible are the primary reasons parents give

[30] Brown, Ponce, Rice, Lavarreda, *The State of Health Insurance in California*.

for not enrolling their eligible, uninsured children. Outreach programs play a critical role in educating parents about the programs and their children's potential eligibility.

- **The State should more fully engage community-based organizations, schools and churches in culturally sensitive outreach and expand funding for these efforts.**

  Target outreach to specific racial/ethnic communities, especially Latino families who make up the bulk of eligible uninsured children. Target parents with limited English language proficiency, Spanish speakers, and immigrant families who have lower rates of MC program participation. Community-based organizations, schools, and faith-based organizations are often the most trusted messengers and most effective at communicating with these groups.

- **Implement the expansion of Healthy Families to include the parents of eligible children, drawing federal matching funds into the State and relieving the financial burden on county programs for the medically indigent.**

  California approved an expansion of HF eligibility to include the parents of eligible children, but it was put on hold. Expanding the HF program to include parents would likely increase the number of children who enroll, as well as provide a coverage opportunity to an estimated 377,000 parents who are currently uninsured and who have limited or no opportunities for coverage.[31] When these adults become ill, county programs for the medically indigent, safety net providers, and hospital emergency rooms pick up the tab for their care. Expanding HF to include parents would draw down two federal match dollars for every one State dollar invested in the HF program.

[31] Brown, E. Richard, Lavarreda, Shana Alex, Rice, Thomas, Kincheloe, Jennifer R., and Gatchell, Melissa S., *The State of Health Insurance in California: Findings from the 2003 California Health Interview Survey*, Los Angeles: UCLA Center for Health Policy Research, August 2005, p. 47; and Howell, Embry M., Almeida, Ruth A., Dubay, L. and Kenney, Genevieve M. *Early Experience with Covering Uninsured Parents Under SCHIP.*

- **Fully implement Express Lane Eligibility to expedite enrollment for children who are participating in the School Lunch, WIC, and Food Stamps programs.**

  "Express Lane Eligibility" expedites enrollment in MC and HF for children who are already enrolled in programs with comparable income-eligibility provisions. Although California has already adopted Express Lane Eligibility, its implementation was deferred by Governor Davis until 2005. Express Lane Eligibility is featured in both SB 437 and the Tobacco Tax, Disease Prevention, and Children's Health Insurance Act of 2006, legislation and a ballot initiative respectively that would create the state-wide Healthy Kids Program

- **Simplify enrollment by streamlining Medi-Cal and HF under a single administrative overlay, such as the Healthy Kids Program.**

  Negotiating the complexities of California's public health insurance programs is challenging for researchers, not to mention low income families that may have limited English language proficiency and/or low literacy levels. Because program eligibility is determined by age, income and immigration status, children from one family could potentially be enrolled in three different programs (MC, HF, and a local Children's Health Initiative). Without a smooth mechanism for program transfer, children can lose coverage when they lose eligibility for one program and become eligible for a different program because they grow a year older, their income changes, or they move between counties. Offering families a "single door" to health insurance coverage for all their children would reduce the fragmentation and confusion that currently serve as barriers to coverage.

- **Reduce documentation requirements to the minimum required by federal law.**

Studies show that gathering paper work to document income is a barrier to program enrollment for families, and federal law does not require it. [32] As of November 2001, 13 states had eliminated income documentation requirements for Medicaid. Available evidence suggests that these methods are reliable and do not adversely affect error rates.[33]

- **Extend affordable coverage to undocumented children and uninsured children in families who earn too much to qualify for MC or HF.**

  Local Children's Health Initiatives that cover children who are not eligible for either MC or HF reduce the number of uninsured children in California and, both anecdotal and research evidence suggest, help identify more eligible children in MC and Healthy Families, thus boosting enrollment in those programs. The vast majority of children enrolled by CHIs are Latino. This "spill-over effect" may be attributed to counties casting their outreach net more broadly, including to families having both native-born and undocumented children. Families may be more willing to enroll their citizen children in MC or HF when they can also receive coverage for their undocumented children through a complementary program. Also, parents of Medi-Cal and Healthy Families eligible children may be more likely to realize that their child is eligible for coverage if all children are eligible for coverage.

In 2006, California will decide whether to create a statewide Healthy Kids Program (HK) modeled after local children's health insurance expansion initiatives and expanding

[32] Michael Perry, Susan Kannel, R. Burciaga Valdez and Christina Chang, *Medicaid and Children Overcoming Barriers to Enrollment Findings from a National Survey*, The Kaiser Commission on Medicaid and the Uninsured, January 2000.

[33] Cox L. Allowing Families To Self-Report Income: A Promising Strategy for Simplifying Enrollment in Children's Health Coverage Programs. The Center on Budget and Policy Priorities. Washington D.C., December 2001.

eligibility for public health insurance programs to all uninsured children residing in California. The senate will consider SB 437, a bill to create a state-wide HK program, and the people will vote on the Tobacco Tax, Disease Prevention, and Children's Health Insurance Act of 2006, a ballot initiative which would create a similar program. Universal eligibility for public health insurance coverage would likely have a strong positive effect on enrollment by uninsured children who are currently Medi-Cal and Healthy Families eligible because parents would no longer be uncertain about their child's eligibility.

Conclusion

In 2001, nearly 700,000 uninsured children were eligible for either the Medi-Cal or the Healthy Families program. That number dropped to 450,000 in 2003 because the state changed public policies to retain children longer in Medi-Cal, county-based public-private coalitions created new programs to expand coverage opportunities for children, and broad coalitions of public agencies, provider organizations, advocacy groups, and foundations conducted effective outreach programs to uninsured children and their families. But there is still room for considerable improvement.

California could greatly improve insurance coverage in the state by enrolling uninsured children in programs for which they already qualify. The majority of these uninsured, eligible children are Latino. Most come from Spanish-speaking homes. Children with foreign-born parents and parents with limited English proficiency are less likely to be enrolled.

Families need assistance in order to take advantage of the Medi-Cal and Healthy Families programs for children. Lack of knowledge about the program is an enrollment barrier for parents of every racial and ethnic group. Parents need to know that the programs exist and that their

children may be eligible. One of the best ways to communicate this information and understanding is through culturally and linguistically appropriate community-based outreach and enrollment support, including well-trained outreach workers.

This report is the first of a two-part series exploring the factors that affect children's enrollment in the MC and HF programs. While this report focuses on the relationship between parental characteristics and children's enrollment, the second report focuses on the effects of county characteristics on children's enrollment to identify the characteristics of local outreach and enrollment programs that are associated with high rates of participation in MC and HF.