EXPANDING COVERAGE FOR CALIFORNIA'S EVER-GROWING UNINSURED POPULATION

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Despite California's booming economy, the proportion of the state's residents who are uninsured against medical expenses continues to grow. Lack of insurance has been growing in the late 1990s despite slight increases in private health insurance coverage obtained through employment or privately purchased in the individual market. The driver of this problem has been rapidly declining coverage by Medi-Cal, California's federal-state Medicaid program for many poor and low-income persons. As a result of these trends, the number of Californians without health insurance grew by nearly 50,000 per month in 1997 to more than 7 million residents. This chapter examines lack of health insurance coverage in California and ways that public policy can effectively address the problem.

The Problem

The strong economy has increased the access of some residents to health insurance obtained through their own or a family member's employment. As the economy recovered from the recession of the early 1990s, employment expanded in firms that offer coverage. The proportion of California workers whose employer offers health benefits to at least some workers increased slightly from 78.1% in 1995 to 79.4% in 1997. The growing economy increased workers' opportunities for full-time employment throughout the year, making more Californians eligible for health benefits through their jobs. In addition, their rising disposable incomes enabled them to pay the share of premiums that employers require from their workers. As a result, the proportion of children and nonelderly adults covered by employment-based health insurance increased a very modest 1 percentage point between 1995 and 1997, from 57.2% to 58.2% (Exhibit 1).[1]

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[1] Brown, E.R., "7 Million Californians Are Uninsured: An Overview of Health Insurance Coverage," and Brown, E.R., Rice, T., "Employees' Access to Job-Based Insurance," in Schauffler, H.H., Brown, E.R., et al., *The State of Health Insurance in California, 1998*, Berkeley and Los Angeles: Health Insurance Policy Program, January 1999.

Exhibit 1. Health Insurance Coverage of Californians, Ages 0-64, 1995 and 1997

Health Insurance Coverage	1995	1997	Change
Uninsured	22.7%	23.8%	1.1%*
Job-Based Insurance	57.2%	58.2%	1.0%*
Privately Purchased Insurance	4.4%	4.8%	0.4%*
Medi-Cal	14.0%	11.4%	-2.6%*
Other Public	1.7%	1.8%	0.1%
Total	100%	100%	

Source: Analyses of March 1996 and 1998 Current Population Survey by the UCLA Center for Health Policy Research

* The difference between the years shown is statistically significant ($p < .05$).

However, this small gain in job-based insurance has been more than offset by public policy changes that have driven down the number of Californians covered by Medi-Cal. Between 1995 and 1997, the proportion of nonelderly Californians with Medi-Cal coverage fell 2.6 percentage points (from 14.0% to 11.4%). Very slight increases in privately purchased health insurance, the most expensive and unstable form of coverage, did not compensate for Medi-Cal's decline. As a result, the uninsured rate rose 1.1 percentage points—from 22.7% of nonelderly Californians in 1995 to 23.8% in 1997. The proportion of Californians who are uninsured is one-third higher than the average for the rest of the United States.

This increase in the uninsured rate and the number of Californians who are uninsured is worrisome for two reasons. First, it was expected that, as California emerged from the recession, job-based insurance coverage would rise sufficiently to reduce the proportion of the population that had no health insurance. However, labor market and economic opportunities for job-based insurance seem limited by two factors. Historically high-coverage industries in California, such as large-scale manufacturing in aerospace, auto assembly, and other industries, declined while the use of contingent workers grew in most economic sectors, from office work to the entertainment industry. Second, employers seem to take advantage of the state's plentiful supply of noncitizen workers who have low educational attainment by keeping wages low and not offering health benefits. Nearly half (45%) of noncitizen employees in California report that their employer does not offer health insurance coverage to any worker, approximately three times the proportion for U.S.-citizen workers.[2]

[2] Brown and Rice, "Employees' Access to Job-Based Insurance," in Schauffler, Brown, et al., *The State of Health Insurance in California, 1998*, January 1999.

Falling Medi-Cal Coverage

The decline in Medi-Cal coverage most likely has resulted from a combination of continued improvement in the labor market as well as the enactment and implementation of welfare reform, known nationally as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. As the economy continued to improve, some families and individuals who formerly relied on Medi-Cal may have obtained low-wage jobs that provided some access to health benefits or they earned more money that enabled them to pay the employee's share of premiums.

Other Medi-Cal beneficiaries, however, may have been pushed out of CalWORKs, California's public assistance program for families with children, into low-wage jobs without health benefits. Under welfare reform, beneficiaries are supposed to receive transitional Medi-Cal coverage for a year when they leave public assistance, a policy that advocates argue is not adequately being implemented. In addition, even some CalWORKs recipients may not be receiving Medi-Cal coverage, which no longer is provided automatically with CalWORKs as it was in the previous AFDC program (Aid to Families with Dependent Children).

Finally, many noncitizen families have refrained from applying for Medi-Cal or the new Healthy Families Program (California's version of the national Children's Health Insurance Program, or CHIP), even for their U.S.-citizen children. They fear that they will be labeled a "public charge" if they enroll themselves or even their children in these means-tested programs, and that this classification will be used against them when they try to renew their visas, return to the United States from abroad, or apply for citizenship.[3] For immigrant parents who are undocumented, fear of the Immigration and Naturalization Service (INS) may deter them from applying for either program, even when their children are U.S. citizens and thus fully eligible on the same basis as other citizens. Along with other aspects of welfare reform, these provisions are most likely responsible for much of the net increase in the uninsured rates among noncitizen families from 1995 to 1997. Medicaid/Medi-Cal coverage declined in the face of relatively flat job-based coverage.

This trend may be moderated by recent policy changes, issued in May 1999 by the INS. The new policy specifies that noncitizens will not be classified as a "public charge" if they or their children enroll in Medicaid or CHIP (except those who receive long-term care under Medicaid). This policy change should help assure families that they do not have to fear these programs. Despite these moderating policy changes, the most recent data on health insurance coverage suggest that the decline in Medicaid coverage nationally and in California has not yet been reversed.[4]

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[3] Perry, M.J., Stark, E., Valdez, R.B., *Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment: Findings from Eight Focus Groups in California with Parents of Potentially Eligible Children*. Menlo Park, CA: Henry J. Kaiser Family Foundation, 1998.

[4] Campbell, J.A., *Health Insurance Coverage: 1998* (P60-208), Washington, D.C.: U.S. Bureau of the Census, October 1999.

Consequences of the Problem

California's growing uninsured population has no financial protection against medical expenses, and they have much less access to essential health care services than do residents who are insured. The uninsured receive:

- less care for acute conditions, such as infectious diseases and injuries, often lengthening time lost from work or school;
- less care for chronic conditions, such as high blood pressure and asthma, which may develop into more serious and limiting health problems if they are not promptly treated and managed effectively;
- fewer screenings that can detect serious chronic and life-threatening diseases at earlier and more treatable stages; and
- less preventive care that could reduce their disease burden overall.[5]

The widespread lack of health insurance thus adversely affects the development of California's children and the productivity and quality of life for California's adults.

Unaffordability of Health Insurance

More than eight out of 10 uninsured Californians are in families headed by a working adult, but they are overwhelmingly low-income adults and children. Seven in 10 uninsured persons have incomes below 200% of the federal poverty guidelines.[6] Employees, on average,

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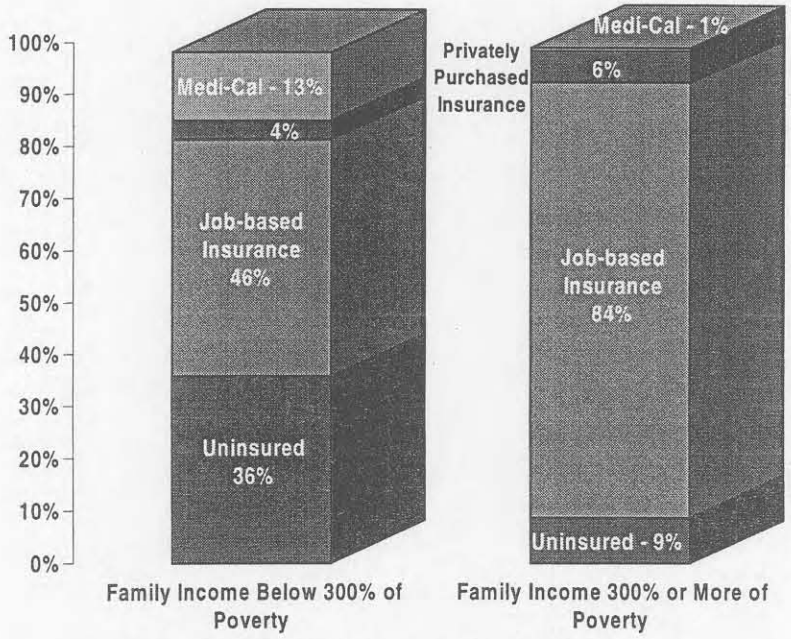
5 Berk, Marc L., Claudia L. Schur and Joel C. Cantor, "Ability to Obtain Health Care: Recent Estimates from the Robert Wood Johnson Foundation National Access to Care Survey," *Health Affairs*, Fall 1995; 14(3): 139-46; Schoen, Cathy, Barbara Lyons, Diane Rowland, Karen Davis, and Elaine Puleo, "Insurance Matters for Low Income Adults: Results from a Five State Survey," *Health Affairs*, 1997; 16(5): 163–171; Millman, Michael, ed., *Access to Health Care in America,* Washington: National Academy Press, Institute of Medicine, 1993.

6 Brown, E.R., "7 Million Californians Are Uninsured: An Overview of Health Insurance Coverage," in Schauffler, Brown, et al., *The State of Health Insurance in California, 1998*, January 1999. The federal poverty *guidelines*, published by the U.S. Department of Health and Human Services (DHHS), are used to determine financial eligibility for federal programs, including Medicaid and California's Healthy Families Program. A person's level in the poverty guidelines depends on total family income and the number of persons in the family. In 1997, the poverty level in the guidelines was $7,890 for a family of one, $10,610 for a family of two, $13,330 for a family of three, and $16,050 for a family of four. The federal poverty guidelines differ from the poverty thresholds, developed by the Social Security Administration and updated annually by the Census Bureau, which are used for statistical purposes: to determine, for example, the number of persons living below poverty.

are required by their employers to pay $1600 to $1800 a year for family coverage,[7] an unaffordable sum for many working families.

The high cost of employees' required shares of premiums for job-based insurance and the even higher cost of privately purchased health insurance disproportionately affects low- and moderate-income working families. More than one-third of adults and children in working families below 300% of poverty are uninsured, and less than half receive job-based insurance (Exhibit 2). This group is far more disadvantaged in their coverage than persons above that income level, 84% of whom have job-based coverage and only 9% of whom are uninsured.

Exhibit 2. Health Insurance Coverage by Family Income Below or Above 300% of Federal Poverty Guidelines, Ages 0-64, California, 1997



Source: March 1998 Current Population Survey

[7] Rice, T., Pourat, N., Levan, R., Silbert, L., Brown, E.R., Gabel, J., et al., *Trends in Job-Based Health Insurance Coverage*, Los Angeles: UCLA Center for Health Policy Research, June 1998.

Public Policies Can Expand Health Insurance Coverage

The continuing increase in lack of insurance coverage during the recent peak period of economic performance should cause great concern. If the economy contracts, it is likely that coverage for many groups will decline, leaving still more Californians uninsured. And if California and the nation do not address this problem when the economy is strong and fiscal resources are growing, it is unlikely that they will do so when the economy and fiscal resources decline.

California, like other states, has tried to expand coverage in the private health insurance market by removing barriers to coverage that are not related simply to ability to pay. Although these reforms have been helpful to many individuals and small firms, they have not completely eliminated discriminatory marketing practices such as exclusionary underwriting practices of some insurers targeted at individuals and medium-sized businesses. California can do more to open these markets to individuals and employers. However, these strategies by themselves will not substantially increase the number of people with coverage.[8] To make health insurance affordable for low- and moderate-income individuals and families, subsidies will be needed. Such subsidies can come only from employers and/or government.

California has developed a series of subsidized coverage programs for poor and near-poor people who fit into certain categories. These include Medi-Cal for poor families with children, the Healthy Families Program for near-poor children, Medi-Cal and Access for Infants and Mothers (AIM) for poor and near-poor pregnant women, and Medi-Cal for poor disabled adults. Most of these programs are funded by a combination of state and federal funds. But the state has yet to make maximum use of available federal matching funds to provide affordable coverage for families and individuals who need it. It makes enormous policy and fiscal sense to expand coverage through programs in which the federal government picks up half or two-thirds of the cost. The options described below could greatly expand coverage by maximizing use of federal options and funding under Medicaid and CHIP.

Fixing Medi-Cal and Healthy Families Programs for Children

At the beginning of 1999, 1.1 million of the 1.85 million uninsured California children were eligible for, but not enrolled in, Medi-Cal or Healthy Families (see Exhibit 3). Enrollment in these programs lagged for a variety of reasons.

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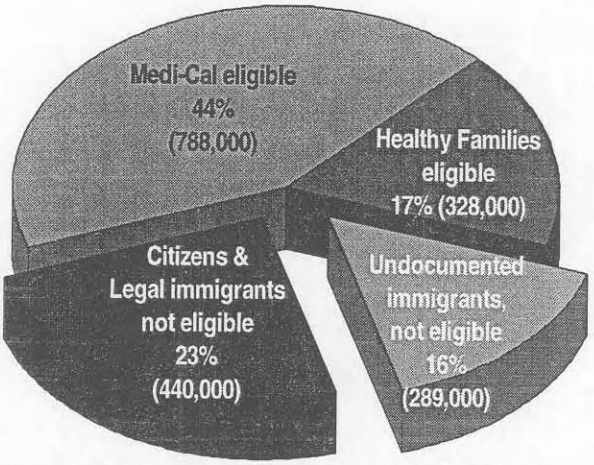
[8] Sloan, F.A., Conover, C.J., "Effects of State Reforms on Health Insurance Coverage of Adults," *Inquiry*, 1998; 35: 380–293.

Exhibit 3. Eligibility for Medi-Cal and Healthy Families, Uninsured Children, California



Source: Estimates by UCLA Center for Health Policy Research, based on March 1998 Current Population Survey

One barrier that discourages parents from enrolling their children in Medi-Cal is the stigma that long has been associated with public assistance programs. This legacy of Medicaid's welfare-based origins generated a guiding philosophy that seemed to be "keep out ineligible children." The result was elaborate application procedures and stigmatizing means tests in welfare offices.[9] Both California and the federal government have adopted a policy goal of covering all eligible children. But California has yet to implement fully administrative policies that will achieve that goal. Such a goal should focus administrators on creating the simplest applications and procedures designed to enroll all children who are eligible, with errors cleaned up after the fact by administrative analysis rather than by creating administrative barriers to enrollment.

California has taken some steps to simplify the joint application for children's Medi-Cal and Healthy Families coverage, and to improve outreach. The original 28-page application booklet required applicants to complete a lengthy form, compute and document income, and

[9] Perry, Stark, and Valdez, *Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment*, 1998.

document immigration status. Stung by severe criticism, officials have shortened and simplified the application to four pages plus three pages of instructions. But California could join a number of other states that have adopted one- or two-page greatly simplified applications to encourage enrollment, and it could eliminate verification of all information except immigration status for noncitizens, as other states have done.[10] California also has increased the participation of community-based organizations, churches, schools, and other community agencies in the outreach and enrollment campaigns. The recent INS policy change that reassures immigrant families that they would incur no risk of being classified as "public charges" for enrolling their children or themselves in public health insurance programs is likely to have a very positive effect. If it is communicated widely by trusted community-based organizations and leaders, the effect will be enhanced.

Expanding Medi-Cal and Healthy Families Programs for Children

California could expand enrollment of children under current income eligibility policies. For example, the state could extend eligibility for Medi-Cal and Healthy Families to children who are already qualified for free or reduced-price school lunch programs, food stamps, or the Supplemental Food Program for Women, Infants and Children (WIC). The state also could extend children's Medi-Cal eligibility to 12 months before recertification is needed, as California has done with the Healthy Families Program; this policy change would eliminate the onerous requirement for recertification every three months, which unnecessarily reduces program participation and adds administrative cost.

California was expected to spend about $332 million ($223 million in federal funds that matches $110 million in state funds) in fiscal year 1999 on its children's Medi-Cal and Healthy Families programs. But if that level of spending continues into the next fiscal year, it will leave on the table about $2.3 billion in federal CHIP funds that are available to California in fiscal year 2000.[11] Making maximum use of these unallocated federal funds, which will match two federal dollars for every dollar of state spending, would enable California to expand health insurance coverage for children.

However, California unnecessarily restricted income eligibility far more than federal law and regulations would allow. The Healthy Families Program was established in 1997 to cover children up to 200% of the poverty guidelines (in 1997, about $32,000 for a family of four). In 1999, the State expanded coverage of children by increasing the Healthy Families Program's income eligibility limits to 250% of the poverty guidelines (about $41,700 for a family of four in 1999), a provision that will add about 130,000 children to eligibility.

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[10] *Opening the Door: Improving the Healthy Families/Medi-Cal Application Process*, Washington, DC, and Oakland, CA: The Center on Budget and Policy Priorities and the Medi-Cal Policy Institute, October 1998.

[11] Senate Budget and Fiscal Review Committee, Subcommittee No. 3 on Health, Human Services and Veterans Affairs, March 8, 1999.

California could, as legislative leaders had wanted, further expand eligibility for children up to 300% of poverty (up to about $50,000 for a family of four), using the provisions of section 1902(r)(2) or section 1931 of the Social Security Act.[12] This expansion would add about 100,000 more children to eligibility, offering eligibility to a total of 1.4 million uninsured children, 88% of those who are citizens or legal immigrants. Seven other states now cover children with family incomes over 200% of poverty, including four that cover those with incomes up to 300% of poverty.[13]

Expanding Existing Coverage Programs to Uninsured Adults

In addition to California's 1.85 million uninsured children, nearly 5.2 million nonelderly adults also are uninsured. To make health insurance affordable to most of these predominantly low- and moderate-income uninsured working adults, California will need to offer them subsidies. Expanding coverage for working Californians through Medi-Cal is an effective and efficient way to provide those subsidies. Many of these adults have uninsured children who are eligible for Healthy Families or Medi-Cal. To cover parents of children eligible for Medi-Cal or Healthy Families, California can modify its state plan based on the provisions of section 1931 of the Social Security Act, which allows states considerable flexibility in setting income eligibility for family Medicaid coverage.[14] Expanding coverage to working adults using federal matching funds would offset state costs with savings generated by reducing state and county expenditures on indigent medical care. Wisconsin, Rhode Island, Delaware, Hawaii, Maine, Massachusetts, Minnesota, Missouri, Vermont, and the District of Columbia all have used the family coverage option of Section 1931 or other Medicaid provisions to cover parents up to or above the poverty level.[15]

In 1999, California expanded eligibility for adults whose children are eligible for Medi-Cal—from about 80% of the poverty guidelines to 100%. This very small expansion will open the program to only a fraction of the 350,000 uninsured parents who are citizens or legal immigrants and have children eligible for Medi-Cal. Another 230,000 uninsured have children eligible for the Healthy Families Program. If children's eligibility for Healthy Families were expanded to 300% of poverty and their uninsured parents were also eligible, a total of approximately 810,000 uninsured adults could be covered.

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[12] Guyer, J., Mann, C., *Taking the Next Step: States Can Now Take Advantage of Federal Medicaid Matching Funds to Expand Health Care Coverage to Low-Income Working Parents*, Washington: Center on Budget and Policy Priorities, August 1998.

[13] Riley, T., Pernice, C., *How Are States Implementing Children's Health Insurance Plans?* Second edition. Portland, ME: National Academy for State Health Policy, September 1998.

[14] Guyer and Mann, *Taking the Next Step*, August 1998. See also section 1931(b)(2)(c) of the Social Security Act.

[15] Mann, C., Center on Budget and Policy Priorities, Testimony before the California Assembly Health Committee, Sacramento, March 16, 1999.

Beyond opening up existing children's coverage programs to their parents, California could restructure its Medi-Cal and Healthy Families programs. It could open them also to people who do not meet traditional requirements of having very low income and fitting public assistance categories (such as being in a family with dependent children, being a disabled nonelderly adult, or being over age 65). With a Medicaid section 1115 waiver, the state could enable any uninsured families and individuals who meet eligibility criteria under current programs to enroll at no cost or low cost to them, and allow those who do not qualify for current programs to buy into them by paying an income-adjusted premium. Four states now enable families above the Medicaid or CHIP income eligibility levels to buy into the program.[16]

Restructuring the Medi-Cal and Healthy Families programs to open them to uninsured adults without children would provide a vehicle to offer subsidized coverage to the more than 2 million uninsured citizens and legal immigrants with family incomes below 300% of the poverty guidelines. Although such an arrangement entails costs to the state, it is an effective method to expand affordable coverage, drawing in federal contributions for all enrollees who are eligible for them, obtaining contributions from enrollees themselves based on their ability to pay, and supplementing these with state and possibly employer contributions. And California's costs for such coverage would be offset partially by further savings in indigent care spending.

Take Health Care Out of Welfare

Many of the problems associated with Medi-Cal and Healthy Families are a legacy of Medicaid's welfare-based origins. Welfare programs tend to rely on stigmatizing means tests, usually conducted in welfare offices. To make these programs acceptable to a large number of working families, California would need to end the role of welfare agencies in reviewing and processing applications for public health care programs. Avoiding this unnecessary review by welfare agencies would also save administrative costs for eligibility determination that could help offset the costs of expanded coverage.

Taking subsidies for health insurance coverage of low- and moderate-income persons out of the welfare system also would reduce one inequity between low- and moderate-income workers and their more affluent counterparts. The current exemption of employer-paid health insurance for largely middle- and upper-income workers cost the federal government about $79 billion in 1998—a health insurance subsidy program that no one calls welfare.[17] Removing the welfare stigma from Medicaid and other coverage programs would give similar benefits to those who do not have access to employment-based health insurance.

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[16] Riley and Pernice, *How Are States Implementing Children's Health Insurance Plans?*, September 1998. The waiver option is found in section 1115 of the Social Security Act.

[17] *Reducing the Deficit: Spending and Revenue Options*, Washington, DC: U.S. Congress, Congressional Budget Office, March 1997, p. 348.

Integrate Public Coverage Programs to Form a Seamless System

Currently, the state operates several different coverage programs, divided among several state agencies. Medi-Cal, California Children's Services (CCS), and Child Health and Disability Prevention (CHDP) are separate programs operated by the Department of Health Services, while the Healthy Families Program, AIM, and the Major Risk Medical Insurance Program (MRMIP) are operated by the Managed Risk Medical Insurance Board (MRMIB). These programs have different eligibility criteria and target different, but often overlapping, population groups.

Medi-Cal covers infants up to 1 year of age with family incomes up to 200% of poverty, children ages 1-5 with family incomes up to 133% of poverty, and children ages 6-18 with incomes up to 100% of poverty. The Healthy Families Program now covers children ages 2-18 with incomes above the Medi-Cal eligibility levels but below 251% of poverty. CHDP pays for mental and physical health screening of children up to age 21 with family incomes up to 200% of poverty and treatment of conditions identified during screening. AIM provides subsidized coverage to pregnant women with incomes 200%-300% of poverty and their infants. CCS covers children up to age 21 with serious disabling conditions if their families have incomes below $40,000 or if the costs of care exceed 20% of adjusted gross income. MRMIP subsidizes health insurance coverage for people who have been turned down by commercial insurers due to a pre-existing condition.

These programs provide a patchwork that fragments coverage for families and individuals who must navigate multiple systems. The patchwork disrupts continuity of coverage and health care for eligible persons as their circumstances change, even when they are eligible for another program. Many lower-income families that find themselves eligible for a program such as Healthy Families in one year may experience a loss of income in the next year and find themselves eligible for a different program, such as Medi-Cal. Many low-income families and individuals also experience large gaps in coverage. This patchwork system increases administrative costs for multiple bureaucracies needed to administer differing programs, rules, and application and eligibility determination processes.

California could integrate the Medi-Cal, Healthy Families, MRMIP, and AIM programs to create a seamless system. A Medicaid section 1115 waiver, in addition to enabling California to expand coverage to new groups, would provide the flexibility needed to integrate and simplify the eligibility criteria and process. Such a structural integration of the programs would have many benefits.

Families and individuals would apply with one application, and all family members would be covered within the same visible program (even if funding came from separate federal programs). Enrollees would not need to switch programs or lose coverage when their circumstances change (if they still fall within coverage limits of all included programs). Such integration also would provide broader and more continuous coverage and greater opportunities to obtain federal funding for many beneficiaries. Finally, it would substantially reduce

administrative costs by unifying eligibility and other administrative functions. Simplifying application rules and procedures, ending welfare office review, and integrating these programs would save an estimated $127 million each year in administrative costs alone.[18]

California faces a difficult challenge to extend coverage to its seven million uninsured residents, but it can go a long way toward this goal. It can make affordable coverage available to the great majority of them by improving and expanding existing programs and maximizing the state's use of available federal funds.

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[18] Rabovsky, D., *A Model for Health Coverage of Low-Income Families*, Sacramento, CA: Legislative Analyst's Office, June 1, 1999.