Seamless Coverage Systems:
Innovative State and Local Approaches

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INTRODUCTION

Many states and localities, including California, are struggling to develop "seamless" systems of coverage for low income persons to access health care funded by federal, state and private sector revenue streams. There is a strong consensus that the current system is exceedingly complex and fragmented, fails to reach many of its intended eligible beneficiaries, and is hindered by complex administrative procedures that are a constant source of aggravation for participating providers and health plans.

While no state has attained an ideal seamless coverage system, some have made considerable progress. Those states now have clear patterns of programmatic simplification strategies employing a variety of incremental modifications to facilitate access and enrollment. California has adopted a number of such approaches and the legislature debated a number of new initiatives during the past session.

This study addresses the issue of seamless coverage systems and recommends a much bolder simplification strategy. Using income as the primary eligibility criteria, this strategy would reduce the current bewildering array of federal, state and county categorical aid programs to two basic publicly funded systems--one for persons with incomes below the federal poverty level and one for persons with incomes above the poverty level. We believe that only a major programmatic restructuring of the publicly funded health insurance system will develop a truly seamless system of care in California, one that will increase access for more eligible patients and encourage more widespread and continuing participation by providers and health plans.

PROJECT GOALS AND OBJECTIVES

The overall purpose of this study was to examine approaches being taken in other states and localities to develop seamless systems of coverage for low income persons using federal, state and private funding or combinations thereof, and to analyze these approaches for possible replication in California. The initial research questions addressed both strategic and programmatic issues, specifically:

- What have other states and localities done or what are they proposing to do, to:

1) Simplify eligibility;
2) Streamline enrollment procedures;
3) Consolidate existing programs; and
4) More effectively use federal funding.

- How did these states and localities accomplish their changes?

1) State legislative actions
2) Federal waivers
3) Local agreements and ordinances
4) Private sector involvement

To go beyond descriptive research and produce actionable information for California health policy makers, another purpose of the study was to describe a model seamless system of care from the point of view of its principal participants--patients, providers and health plans. We sought to articulate guidelines and to identify the principal program elements of a simpler, more user-friendly system.

RESEARCH ACTIVITIES AND METHODS

We began this study by interviewing a select group of local experts with expertise in state and county Medi-Cal and Healthy Families program administration. This group included current and former program administrators, providers, health plan executives and consultants. These discussions generated additional insights on how the current structure of the various programs affects key participants and underscored the need for program streamlining and simplification. A list of persons interviewed for this project is included as Appendix 1.

To identify states and communities that have developed or are proposing seamless coverage systems, we reviewed the literature and conducted expert interviews to develop a focused summary of the latest available information (summer and fall 2001). Sources reviewed included:

- Federal and national health policy center publications;
- State and county health policy position papers and reports, legislative analyses, planning grants and Medicaid waiver requests; and
- Related ongoing work by the authors for the "Insure The Uninsured Project" and a set of policy recommendations developed for the State of California Department of Health Services in response to SB 480.[1]

The conceptual model for this study was to identify states and localities with "best practices" that are leading efforts to develop seamless or at least significantly integrated systems of publicly funded healthcare, including but not limited to simplifying eligibility requirements and application processes, consolidating programs and pooling funding sources. We reviewed pertinent literature and asked state and local program officials:

- What are the major elements of these systems?

[1] SB 480 (Solis) was enacted in November 1999. It calls for the California Health and Human Services Agency to submit a report to the Legislature by December 1, 2001 examining the options for providing universal health care coverage for California residents. The Agency commissioned a series of policy feasibility studies from leading health policy experts, including one from Mr. Wulsin. The Department of Health and Human Services' Health Resources and Services Administration (HRSA) provided funding for the policy studies as part of a state planning grant program to develop state plans extending health insurance coverage to all uninsured citizens.

- How do they simplify participation in public programs for patients, providers and health plans (if applicable)?
- How are these programs working? What information is/will be available about their effectiveness?

We also reviewed recent efforts in California to move toward a more integrated coverage system, focusing on legislative proposals to streamline the Medi-Cal and Healthy Families application process, the Children's Partnership/100% Campaign recommendations for creating a unified health insurance program for California's lower-income children and their parents, and the SB 480/HRSA policy planning initiative described above.

Additionally, we reviewed and updated information from key public and private sector players in several bellwether California counties that have developed efforts to either provide health insurance coverage to all children or to consolidate programs to care for the indigent and Medi-Cal populations in their communities.

The study narrative synthesizes the literature review and interviews described above, and also includes (See appendices 3-5) a series of tables that provide a comparative overview of the various state and local systems. We focus on the characteristics of these systems (e.g., simplified eligibility, streamlined enrollment, program consolidation, and leveraging federal funds); the methods used to accomplish them (e.g., federal waivers, state legislation, local agreements/ordinances); and the degree of private sector involvement. We identify the strengths and weaknesses of each system and consider their applicability for California.

Our conclusion and recommendations include guidelines for a seamless coverage system, including an analysis of how such a system would differ from the current patchwork system in terms of eligibility, provider payments and plan participation. We also discuss the principal ways that such a system would benefit patients, providers and health plans.

FINDINGS

Administrative And Structural Problems With The Current System

California provides health care coverage to low income families with minor children primarily through Medi-Cal, California's Medicaid program (Title 19 of the Social Security Act) and Healthy Families, California's separate State Child Health Insurance Program (SCHIP, authorized in 1997 by Title 21 of the Social Security Act). The Access for Infants and Mothers (AIM) program covers pregnant women and children up to age 2; California Children's Services (CCS) funds treatment for children with special health care needs; and the Child Health and Disability Prevention Program provides health screenings, immunizations and limited follow-up treatment services for uninsured low income children. Provision of care or coverage to medically indigent, non-disabled and

non-elderly childless uninsured adults is a county responsibility, with considerable variation among counties for both eligibility criteria and the scope of covered benefits.

These programs target children, pregnant women, and the poorest California residents but do not generally cover working poor uninsured adults. In a 1999 report designed to assist the California Legislature in evaluating options to expand coverage to low income families, the Legislative Analyst's Office observed:

> *Most working parents--particularly in two-parent families--do not qualify for Medi-Cal and Healthy Families only covers children. Many children, although eligible for either Medi-Cal or Healthy Families, are not enrolled in these programs (and therefore do not have health coverage), in part due to complex and confusing eligibility requirements and procedures. Furthermore, the complexity of the current eligibility requirements produces seemingly arbitrary results--similarly situated families are treated differently (some are eligible for coverage while others are not), depending on their particular work histories, marital status and history, and subtle differences in vehicle ownership.*
>
> *The existing system also results in episodic coverage, with people not enrolling until they have significant health problems. Waiting until a health problem becomes acute often results in less effective treatment and higher costs. In addition, the episodic nature of the coverage, along with the general complexity of the system, results in high administrative costs*[2].

In Fiscal Year 1998-99, combined state, federal and county expenditures for Medi-Cal administration translated into an annual cost of about $600 per beneficiary. This figure provides no health care services--it only covers administrative expenditures such as outreach, eligibility determination and renewal, record review and case management.[3]

In a November 1999 California Program on Access to Care (CPAC) study addressing state health policy options for expansion of health care to the working poor, Lucien Wulsin, Jr. noted:

> *California has high levels of coverage through its Medi-Cal program, a broad array of other state programs for the uninsured, and extensive county health programs. California pays providers using a multiplicity of disconnected programs and revenue streams…**California needs to connect its myriad state, federal and county health programs so that eligible residents access and maintain coverage seamlessly.** Many individuals lose eligibility and become uninsured at the intersections of programs, when they are bounced off one eligibility category without being enrolled in another program. A number of county leaders, state officials, and health plans are making good-faith efforts to extend coverage; the mind-boggling complexity of state and county financing*

[2] Rabovsky, D. (1999) **A Model for Health Coverage of Low income Families.** Sacramento, CA: Legislative Analyst's Office.
[3] *Ibid.,* p. 11-12.

structures nearly paralyzes these efforts. These innovative efforts need a more flexible and receptive response from state regulators and policymakers.

***California needs to overhaul its Medi-Cal eligibility system**. The eligibility rules are based on a now-abandoned welfare system, and have become so complex as to defy common description and understanding.…California should take advantage of federal opportunities to extend continuous eligibility and simplify the cumbersome eligibility rules and processes.*[4]

Medi-Cal is the most complicated of all the state public benefit programs. It has over 100 different program sub-categories, all with different eligibility rules--a patchwork quilt of programs with varying qualification requirements with respect to age, resource levels and income limits.[5] One reason for its complexity is that public assistance beneficiaries move from one sub-program to another while still retaining eligibility for Medi-Cal.

Simplification efforts are difficult to implement. For example, the legislature mandated a mail-in application in 1999, and it took two years instead of the one allowed in the statute to develop the application. Automation creates another barrier to implementing new regulations. There is often a limited time period between passage of a bill and its implementation date for the state to write the implementing regulations. Counties feel they have insufficient time to publish their instructions, train staff and carry out the legislation at the operational level. Automation has not necessarily reduced this timeframe; it typically takes at least 6 months to get new instructions programmed. Some counties have not included Section 1931(b) eligibility provisions in their automated systems, which means the computer program incorrectly determines Medi-Cal eligibility and the worker has to manually recalculate eligibility on all family cases.[6]

The Healthy Families Program, which is designed to provide coverage for children of families who do not qualify for no-cost Medi-Cal, is administered through the Managed Risk Medical Insurance Board. (MRMIB). In many ways it is a less complex program than Medi-Cal. However, it is difficult for families unfamiliar with means-testing procedures to understand the income eligibility qualification criteria for public programs. Also, because within the same family there may be (adult or child) members who are eligible for Medi-Cal and children who are eligible for Healthy Families, there is a joint application for Healthy Families and Medi-Cal. The joint application goes to a single point of entry (SPE) screening agency. If the child is eligible for Healthy Families, the agency sends the application to MRMIB. If the family income is lower than the Healthy Family floor (100 - 250% of Federal Poverty Guidelines[7], depending on the child's age

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[4] Wulsin, Jr. L. (1999) Opportunities to Increase Health Coverage. **Expansion of Health Care to the Working Poor.** Berkeley, CA: California Policy Research Center. Retrieved October 27, 2001 from the World Wide Web: http://www.ucop.edu/cprc/Hcexpansion.html.

[5] Bonin, B. (2001). Personal communication.

[6] Lynch, L. (2001). Personal communication.

[7] The U.S. Department of Health and Human Services (DHHS), in a statement accompanying the 2001 DHHS poverty guidelines, recommends the use of this term instead of the more commonly used term, "federal poverty level (FPL)". See http://aspe.hhs.gov/poverty/01.htm, February 27, 2001. Appendix 2 contains a copy of the 2001 guidelines.

and whether or not the parent applying is pregnant), the application is forwarded to the local county Department of Social Services. However, families who qualify for Medi-Cal often want Healthy Families coverage; there is still a stigma factor with Medi-Cal and a legacy perception of poor treatment by Department of Social Services.

The most difficult part of applying for either Medi-Cal or Healthy Families is documenting income, especially for families with irregular income or with workers who are paid in cash. Certified Application Assisters (CAAs), typically bilingual/bicultural individuals with strong community ties, play a vital role in encouraging families to apply and assisting them to complete the application. While CAAs can help pregnant women or parents of eligible children apply for Medi-Cal, eligible parents who want Medi-Cal for themselves have to apply to the Department of Social Services.[8]

Barriers to Provider Participation in State Funded Health Programs

Providers who want to participate in Medi-Cal and other state programs also face a daunting and lengthy application process. Medi-Cal is by far the most cumbersome program in terms of provider application length and requirements. There are seven different forms to fill out, each of which requires much of the same information. The disclosure statement is the most difficult of all (13 pages plus attachments); not just the physician but everyone in the Medi-Cal corporation must provide information.

The California Participating Physician Application (CPPA) standardized medical provider applications for private plans, and a $25 software program allows for easy updating. Unfortunately, none of the state public programs accept this application. Instead, each state program has its own set of forms that bears no relation to any other program set, although much of the same information is required by each separate state program.

Not only does Medi-Cal lack an online application process, there is no way to save the downloaded application to an electronic file; these forms must be printed out and completed manually. The applicant must also provide certified copies of incorporation documents from the Secretary of State, which adds at least another month to the process. All Medi-Cal forms must be notarized--something no other program requires. All in all, the application process takes 9-12 months. Yet all physicians have to apply, since all the other payers require a Medi-Cal provider number.[9]

Every time a physician opens a new office s/he has to obtain a whole new set of provider numbers for the new location. And, if s/he doesn't use the number for a given amount of time, the provider number is deactivated, and must be reactivated before it can be used again.

[8] Martinez, E., Busa, L. and Leon, M. (2001) Personal communication.
[9] Hanson, M. (2001). Personal communication.

Health Plan Perspectives

Representatives of health plans that enroll both Medi-Cal and Healthy Families members recognized that there were advantages and disadvantages of a separate eligibility process. One plan with separate marketing staff for Healthy Families and Medi-Cal noted that health plans were allowed to do a little more direct marketing under Healthy Families, and they would like to be able to engage in similar activities for Medi-Cal. Because many Medi-Cal eligible families want to enroll their children in Healthy Families and do not want Medi-Cal because of its negative associations with public assistance, families should have the right to choose if they are eligible for both programs.[10]

From the plan point of view, the different benefits offered under Healthy Families and Medi-Cal and AIM are not a major concern, since health plans already offer a variety of benefit packages for the commercial market. On the other hand, quality measures are an area where differing regulatory requirements generate more administrative expense. Commercial payers want HEDIS measures (Health Employer Data Information Set, a standardized set of managed care quality indicators) and the Department of Health Services and the Managed Care Medical Insurance Risk Board ask for other data that may be different. However, representatives of one plan that participates in Healthy Families, AIM and Medi-Cal felt that the different quality studies generated useful data and were not unduly burdensome. .Plans, providers and consumers benefit when a plan participates in all of the public programs as well as offering a commercial product, since, as family members' eligibility varies, they can move easily between plans and continue to receive care from the same providers.[11]

State Streamlining/Simplification Options

Recent expansions in Medicaid coverage for children (Medi-Cal) and the State Children's Health Insurance Program (SCHIP nationally, Healthy Families in California) have created an unprecedented opportunity to expand health insurance to nearly all low income children and their parents.

The federal government and some other states are attempting to simplify and streamline their publicly funded healthcare systems. By October 2000, 36 states had expanded income eligibility to children with family incomes below 200% of Federal Poverty Guidelines.[12] A December 2000 analysis of census data indicates that 94 percent of low income uninsured children in the nation now qualify for either Medicaid or SCHIP.[13]

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[10] Sheila Martz (2001). Personal communication.
[11] Mead, K. and Lazenby, J. (2001). Personal communication.
[12] Cohen Ross, D. and Cox, L. (2000). **Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures. Findings from a 50-State Survey.** Washington, DC: Center on Budget and Policy Priorities.
[13] Broaddus, M. and Ku, L. (2000). **Nearly 95 Percent of Low income Uninsured Children Now Are Eligible for Medicaid or SCHIP: Measures Need to Increase Enrollment Among Eligible But Uninsured Children.** Washington, DC: Center on Budget and Policy Priorities, December 6, 2000. Retrieved June 18, 2001 from the World Wide Web: http://www.cbpp.org/12-6-00schip.htm.

Two federal waiver programs, Sections 1115 and 1931 of the Social Security Act, provide states with considerable flexibility to modify their Medicaid and SCHIP programs consistent with federal law. Section 1115, enacted in 1962 (predating Medicaid), is quite broad in permitting the Secretary of the Department of Health and Human Services to authorize many types of demonstration projects that will promote the objectives of state grant programs included in the Social Security Act.

Section 1931 addresses Medicaid and was established as part of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. This legislation ended the previous automatic link between Medicaid and cash assistance (welfare benefits) for families and children. Of particular relevance to this study is the Transitional Medical Assistance program that continues Medicaid benefits for up to one year to those who transition from welfare to work and language allowing states to use "less restrictive" methods to determine eligibility.[14] States have used this flexibility to extend eligibility to more low income families by disregarding income and/or assets and by indexing income and asset limits to inflation since July 1996.[15]

States have used both of these waiver programs, especially Section 1115 demonstrations, to substantially redesign their Medicaid and SCHIP programs. A study for the Kaiser Commission on Medicaid and the Uninsured noted that, "While in theory, the objective of Section 1115 is to test unique approaches to program design and administration, in reality, once a state demonstration has been approved, numerous states have sought approval to conduct nearly identical demonstrations. As a result, Section 1115 has become a means for achieving general program changes outside of the legislative process. Indeed, many of the changes that have taken place in Medicaid and other programs over the decades have been presaged by Section 1115 demonstrations."[16]

Approval for these demonstrations has allowed states to design and test innovations and receive federal financial participation. Through demonstrations, states have modified benefits, cost sharing requirements, provider participation/compensation, and beneficiary freedom of provider choice to adopt managed care delivery systems. They have also expanded eligibility to include previously ineligible populations such as non-elderly, non-disabled low income adults without children and have redirected federal funding from one area to another such as from Disproportionate Share Hospitals to primary care clinics[17] and from inpatient services to outpatient visits and public-private partnerships with community clinics.

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[14] Smith, K. Ellis, E. and Chang, C. (2001). **Eliminating the Medicaid Asset Test for Families: A Review of State Experiences.** Washington, DC: Kaiser Commission on Medicaid and the Uninsured, p. 3.
[15] Academy for Health Services Research and Health Policy (2001). Medicaid Section 1931. **State Coverage Initiatives.** Washington, DC: Author. Retrieved October 20, 2001 from the World Wide Web: http://www.statecoverage.net/section1931/htm.
[16] Lambrew, J. (2001) **Section 1115 Waivers in Medicaid and the State Children's Health Insurance Program: An Overview.** Washington, DC: Kaiser Commission on Medicaid and the Uninsured, p. 2.
[17] Ibid, p. 3-4.

The following table displays Section 1115 demonstrations by state, type of demonstration and the target population, except for 12 states with family planning demonstrations.

Table 1: Medicaid and SCHIP Section 1115 Demonstrations[18]

State	Demonstration Type	Target Population[19]
Arizona - AHCCCS and Healthy Arizona	Managed care delivery system; eligibility expansion	Medicaid population Adults <65, <100% FPG
Arkansas ARKids First	Eligibility expansion	Uninsured children <19, <200% FPG
California (Los Angeles County Only)	Delivery system restructuring to increase outpatient care	Medicaid beneficiaries Medically indigent
Delaware - Diamond State Health Plan	Eligibility expansion	Adults
District of Columbia	Health insurance expansion	HIV population
Hawaii QUEST	Eligibility expansion	Adults related to AFDC eligibles; General Assistance eligibles; State Health Insurance Program population
Kentucky Health Care Partnership Plan	Managed care delivery system	Medicaid population in 16 counties around Louisville
Maine	Targeted benefits	HIV population Prescription drug discount
Maryland - Health Choice	Managed care delivery system Case management program	Medicaid population Rare & expensive disease patients
Massachusetts MassHealth	Health insurance expansion	Adults & pregnant women; children, families and disabled <150% FPG
MinnesotaCare	Eligibility expansion	Parents & childless adults (Medicaid) Parents (SCHIP) & children <275% FPG
Missouri Managed Care Plus (MC+)	Eligibility expansion	Parents and uninsured adults, 100%-300% FPG depending on status
New Mexico	Health insurance expansion	Children 186-235% FPG
New Jersey	Health insurance expansion	Parents & pregnant women (SCHIP)
New York - Family Health Plus	Eligibility expansion	Parents <150% FPG Childless adults <100% FPG
Oklahoma - Sooner Care	Managed care delivery system	Medicaid population
Oregon - Oregon Health Plan (OHP)	Eligibility expansion	Uninsured adults <65, <100% FPG
Rhode Island - RIte Care	Health insurance expansion; eligibility expansion	Parents (Medicaid) Parents & pregnant women Children <18 <250% FPG (SCHIP)
Tennessee - TennCare	Health insurance expansion	Uninsured
Vermont - Vermont Health Access Plan (VHAP)	Eligibility and health insurance expansion	Uninsured adults <150% FPG and children 225-300% FPG Prescription drug discount
Wisconsin - BadgerCare	Health insurance expansion; eligibility expansion	Parents (Medicaid and SCHIP) Uninsured families <185% FPG, up to 200% for re-enrollment

[18] Combined information from Lambrew, *Op. Cit.,* p. 6 and Academy for Health Services Research and Health Policy, *Op. Cit.*

[19] < is used to note that eligible beneficiaries must be younger than a given age or have a family income level less than a given multiplier of Federal Poverty Guidelines (FPG) .

With funding from The Robert Wood Johnson Foundation, the Academy for Health Services Research and Health Policy tracks all state health coverage initiatives. A copy of the State Coverage Matrix is included as Appendix 3.[20]

Of particular interest is the Los Angeles County waiver granted to California in 1995 and renewed in 2000 for an additional five years. The purpose of this waiver was to move a significant amount of patient care and funds from the Los Angeles County Department of Health Services' county-owned and operated hospitals and clinics into community care sites. The waiver emphasizes the county's intention to provide more primary and outpatient care and less hospital-based care to the county's low income and medically indigent patients.

Section 1906 of the Social Security Act authorizes states to operate Health Insurance Premium Payment (HIPP) programs to purchase employer-sponsored private insurance with Medicaid funds for Medicaid-eligible working parents and their dependents when it is cost-effective to do so compared with the cost of providing regular Medicaid coverage. States may use Medicaid funds for premiums, deductibles and coinsurance payments for the private coverage, and must provide "wraparound" coverage or supplemental benefits if the commercial benefit package is more limited than Medicaid. Just three states (Iowa, Texas and Pennsylvania) have strong HIPP programs, and these states' programs cover less than one percent of the total eligible Medicaid population.[21]

The Bush administration launched the Health Insurance and Flexibility and Accountability (HIFA) initiative in summer 2001. It allows states more flexibility in expanding Medicaid and SCHIP coverage using savings from other program areas and unspent SCHIP funds. However, this waiver limits Medicaid benefit reductions to optional populations and optional services.[22]

Overview of Principal State Streamlining and Simplification Activities

State streamlining/simplification activities fall into five main areas:

1. Innovative outreach and enrollment approaches to actively encourage more eligible children and adults to enroll in Medicaid or SCHIP and receive benefits to which they are entitled.
2. Application, enrollment and renewal processes to make it easier to apply for, enroll in and remain in the Medicaid or SCHIP program;

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[20] Academy for Health Services Research and Health Policy (2001). **State Coverage Matrix.** Washington, DC: Author. Retrieved from the World Wide Web November 6, 2001: http://www.statecoverage.net/matrix.htm.

[21] Sillow-Carroll, S., Anthony, S. and Meyer, J. (2000). **State and Local Initiatives to Enhance Coverage for the Working Uninsured.** New York: The Commonwealth Fund.

[22] National Academy of State Health Policy. **Summary of Meeting Proceedings: Invitational Summit on Medicaid and SCHIP.** Washington, DC: February 2002, pp. 4-5. Retrieved from the World Wide Web May 13, 2002: http://www.nashp.org/progs/prog0001.htm

3. Eligibility determination rules that reduce the amount of documentation required to pass the means test, both for income and assets;
4. Presumptive eligibility procedures to enable qualified Medicaid providers to facilitate temporary enrollment for children in Medicaid and SCHIP; and
5. "Deeming" arrangements to allow low income people already eligible for other federal or state programs to automatically qualify for Medicaid or SCHIP.

A recent study commissioned by The Kaiser Commission on Medicaid and the Uninsured found that efforts are underway in nearly all states to increase health insurance for children and that the enrollment and application policies are continually being modified.[23] The Department of Health and Human Services conducted an extensive review of state application and eligibility requirements for Medicaid (for families and children) and SCHIP.[24] Appendix 4 contains summary tables from the analyses of these programs. Appendix 5 contains another set of tables from the Center on Budget and Policy Priorities summarizing state income eligibility guidelines for Medicaid and SCHIP; eligibility criteria simplification activities; income verification; and eligibility redetermination procedures.[25]

Simplification options are discussed in more detail in the following section, with examples of specific state programs that appear to be working well, as well as some innovative local programs. California has adopted or considered many, though not all of these simplification options; we also note recent legislative initiatives (successful and unsuccessful) by the California legislature and discuss the pending 1115 waiver application. Appendix 6 contains a summary description of California state legislative proposals during the 2001-02 legislative session related to state health program integration and Appendix 7 summarizes 2001 policy changes in Medi-Cal and Healthy Families coverage for low income populations.

Innovative outreach and enrollment approaches. Community-based outreach is a critical success factor for effective enrollment, but there is no single approach that works uniformly well in all communities. Varying types of collaborative efforts with providers, health plans and all types of community organizations are underway in many states. Although most states have also included public media campaigns, community advocacy organizations in many areas expressed concerns that these campaigns were not well targeted to low income and ethnic minority populations.[26]

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[23] Cohen Ross, D. and Cox, L.(2000). **Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures.** Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

[24] Center for Medicare and Medicaid Services (2001). **Continuing the Progress: Enrolling and Retaining Low income Families and Children in Health Care Coverage.** Baltimore, MD: Author. Retrieved August 10, 2001 from the World Wide Web: http://www.hcfa.gov/medicaid/werefhmpg.htm.

[25] Cohen Ross, D. (2000). **Start Healthy, Stay Healthy: Free and Low Cost Health Insurance.** Washington, DC: Center on Budget and Policy Priorities. Retrieved June 15, 2001 from the World Wide Web: http://www.cbpp.org/shsh.

[26] O, Brien, M. et al. (2000). **State Experiences with Access Issues under Children's Health Insurance Expansions.** New York: The Commonwealth Fund, p. 23.

Low income families who are eligible for other publicly funded programs such as food stamps and free school lunches are likely to also be eligible for Medicaid or SCHIP. The income eligibility guidelines are similar. For programs not administered by the county social services department, the application process is also generally less cumbersome.

California initially emphasized a statewide media campaign to market the Healthy Families program, but responded to community-based organizations and advocacy groups concerns by establishing a substantial grant program for these organizations to conduct more targeted outreach. However, the uncertainty of the annual budget process has posed challenges for the administrators of these programs.[27]

California is among the states that have conducted outreach and enrollment initiatives in collaboration with school lunch programs to recruit and enroll children in Medi-Cal and Healthy Families. Families who apply for the school lunch program also receive a separate Request for Information (RFI) form indicating their interest in learning about and receiving an application for health insurance for their children. By December 2000, school districts in California had requested about 1 million RFI forms and approximately 44,500 families returned them to the state. The school lunch program is currently the leading source of requests for Healthy Families and Medi-Cal applications.[28]

Outstationed eligibility workers and application assisters. The presence of publicly funded program eligibility workers in community settings (especially in hospitals and community health centers) has long been a feature of the Medicaid program, although there has been considerable variation in its use. The use of well trained, culturally and linguistically competent community agency staff as application assisters is an extremely important element in an effective outreach approach.

California's Department of Health Services has developed an extensive grant program to fund community agencies and community coalitions to conduct grass-roots outreach efforts and, using Certified Application Assisters (CAAs), provide personalized assistance to applicants for Healthy Families and Medicaid. Most of the CAAs are bilingual and bicultural, and have strong community ties. Furthermore, California pays CAAs a per application fee of $50, increased from $25 when Healthy Families was first launched, and $25 for renewal applications.

Joint Medicaid/SCHIP application. Coordinating applications for Medicaid and SCHIP is a vital first step for simplification. It has been a major challenge for states, like California, that have developed separate SCHIP programs rather than implementing the SCHIP program as an expansion of Medicaid.

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[27] Busa, L. (2001) **Insure the Uninsured Project** Regional Work Group for San Diego and Orange Counties. Personal communication..

[28] Cohen Ross, D. (2001). **Enrolling Children in Health Coverage: It Can Start With School Lunch.** Washington, DC: Center on Budget and Policy Priorities, p. 13-14.

California is among the 28 states with separate SCHIP programs that use joint applications; only four states use separate applications.[29]

Medi-Cal and SCHIP program administrators interviewed for this study felt that there were advantages to both separate and joint applications for the various programs. They also noted the responsibility to notify applicants about and encourage them to apply for other programs (e.g., Temporary Assistance for Needy Families cash assistance and food stamps) for which they might be eligible. Some states have developed Medicaid-only applications (primarily but not exclusively for pregnant women) as well as joint program applications, and specialized administrative units to process them.

Shortened application. Forty-one states have reduced the length of their Medicaid and/or SCHIP initial applications to five pages or less.

California's application form is four pages; MRMIB, Department of Health Services staff and advocacy group representatives worked intensively to shorten and simplify the original application, which was approximately seven times as long at 27 pages.

Mail-in applications. Elimination of the previous requirement for an in-person application interview is a major convenience factor for working families and those lacking transportation. Nearly all states except New Mexico, New York, Texas, Utah, West Virginia and Wisconsin allow mail-in applications. New Mexico and New York allow for completion of the face-to-face interview at locations other than the social services agency office and require outstationed sites. West Virginia waives the interview requirement if the joint Medicaid/SCHIP application is used and is referred to Medicaid.[30] Texas just announced the launch of a bilingual web site to help residents determine eligibility for Medicaid and SCHIP, but the site does not offer online enrollment in the programs.[31]

California uses a mail-in application for both Medi-Cal and Healthy Families and has begun testing an interactive Internet-based process. The California HealthCare Foundation, in partnership with the California State Health and Human Services Agency, pilot tested an electronic application in San Diego County for a four-week period in January 2001. Both applicants and Certified Application Assisters gave **Health-e-App** high ratings for ease of use and indicated a strong preference to continue using **Health-e-App** in the future. **Health-e-App** reduced the time required to complete the initial application, and also lowered the elapsed time between submission of the application and eligibility determination by several days through a combination of saved processing time and elimination of mail time.[32] The Davis administration has announced plans for statewide implementation of **Health-e-App** by the beginning of the fall school term in

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[29] Cohen Ross, D. and Cox, L. *Op. Cit.,* p. ii.
[30] Center for Medicare and Medicaid Services, *Op. Cit.*
[31] Texas Launches Bilingual Web Site Allowing Residents to Determine Eligibility for Public Programs. **California Healthline,** 11/05/2001.
[32] Atlas, B., Chimento, L. and Shukla, P. (2001). **Business Case Analysis of Health-e-App.** Falls Church, VA: The Lewin Group.

2002. The county rollout schedule for the spring and summer begins with counties that consistently submit the highest volume of paper applications.[33]

Resource verification and documentation. Applicants and advocacy agencies consider these rules and procedures the biggest single barrier for families applying to public benefit programs. It is especially difficult for families with irregular incomes or whose income and purchases are in cash or barter transactions (e.g., shared housing in exchange for child care), a common practice among ethnic and kinship groups. Families now must not only document their income from employment and other sources (earned and unearned income); they must also answer questions about all sorts of other types of potentially deductible expenses and excludable income. Applicants must also demonstrate or declare that they do not possess assets valued over an allowable limit that varies by family size. Then eligibility workers or application assisters undertake a series of calculations that is both time-consuming and easily subject to error.

Differences in state income standards for Medicaid and SCHIP programs are built in to the programs, but they confuse applicants and complicate joint program application and enrollment processes. Even more confusion results when states use net income to determine Medicaid eligibility and gross income for SCHIP.

A few states accept applicants' self-declaration of their income for Medicaid and/or SCHIP, and a survey of their experience found few problems. For questionable situations (e.g., an address in an exclusive neighborhood of single-family homes), states retain the right to request verification. Also, for Medicaid the federal government requires states to retroactively review state databases to verify applicants' income and resources reported to other agencies. While there are no such requirements for SCHIP, HCFA encourages states to adopt program integrity assurance practices.[34]

Most states have eliminated the asset test as a determinant of Medicaid eligibility for children, but only a few have done so for parents. Nine states and the District of Columbia that were among the first to eliminate the asset test for adults in Medicaid families considered this policy successful for a number of reasons. It expedited the eligibility determination process for families, reduced the administrative workload of the Medicaid agency, saved eligibility staff time, and facilitated automation of the eligibility determination process. Elimination of the asset test also made application less onerous and intrusive for families, and helped differentiate Medicaid from welfare as a public benefit. No state reported an increase in its Medicaid eligibility error rate after eliminating the asset test.[35]

As noted above, Section 1931 Medicaid eligibility expansions allow states to increase the amount of income they will disregard. This flexibility contains both benefits and risks for states. "This provision effectively grants states the ability to cover parents at any level of

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[33] "Health-E-app." California Department of Health Services. Retrieved May 8, 2002 from the World Wide Web: http://www.dhs.ca.gov/health-e-app

[34] Cohen Ross, D. and Cox, L. (2001). **Making It Simple,** *Op. Cit.,* p. 15.

[35] Smith, V., Ellis, E. and Chang, C. (2001). *Op. cit.*, p. 3.

income…In contrast to the 1115 waiver, the 1931 expansions need not be budget neutral, and they do not require approval of a waiver. On the downside, Section 1931 expansions only reach parents of minor or dependent children, and they create an entitlement to the full Medicaid program for all qualified individuals, which creates a more open-ended financial exposure for the state."[36]

California now requires Medi-Cal parents to document all types of income and list detailed assets but does not impose an asset test for children in either Medi-Cal or Healthy Families. California's SCHIP waiver application contains no assets test for parents of HF children. The legislature considered legislation eliminating the asset test for Medi-Cal parents with income <100% FPG during the 2001-02 state budget negotiation process.[37] Until 2001, California used net income for Medi-Cal eligibility and gross income for Healthy Families. Now both programs use gross income with a set of consistent deductions for such expenses as child care.[38]

Presumptive eligibility. The Balanced Budget Act of 1997 allows states to authorize qualified entities (typically traditional safety net Medicaid providers such as hospitals and community or school-based health centers) to conduct a preliminary eligibility screening and temporarily enroll children in Medicaid. More importantly, they can immediately begin delivering care to these children and be assured of payment for services provided during the presumptive eligibility period. The applicant receives a temporary enrollment card and is responsible for submitting all necessary verification to the state agency before the presumptive eligibility period ends. Qualified entity staff also provides continuing follow-up assistance to ensure that the families complete the application process. Just eight states have adopted this option for Medicaid and four in their separate SCHIP programs.[39]

Continuous eligibility. Most states require families to reapply for Medicaid or SCHIP annually, and a few redetermine eligibility twice a year. Federal law permits states to allow children who would otherwise be uninsured to retain coverage in both programs when a change in family circumstances affects their eligibility for either program. States can simplify the eligibility redetermination process by reviewing all information already available before contacting the applicant family or individual, and by use of pre-printed renewal forms so that applicants only need inform the eligibility worker of changes. The case for reducing or eliminating documentation requirements for renewal and allowing mail-in applications is stronger when a beneficiary has already established eligibility. Proactive retention efforts by states include written renewal notices, phone calls, and support for community-based application assisters to find enrollees and help them remain eligible.

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[36] Milligan, C. (2001). **Section 1115 Waivers and Budget Neutrality: Using Medicaid Funds to Expand Coverage.** Washington, DC: Academy for Health Services Research and Health Policy.
[37] Quacinella, L. (2001) **2001 Policy Changes: Medi-Cal and Healthy Families Coverage for Low Income Children, Youth, and Parents and Medically Indigent Adults."** Los Angeles: UCLA Center for Health Policy Research.
[38] Lynch, L. (2001). Personal communication.
[39] Cohen Ross, D. and Cox, L. (2001) **Making It Simple,** *(Op. Cit.),* p. 9 and 5.

In California, Medi-Cal adults must report changes in income within 10 days in eligibility redeterminations; children have 12-month continuous eligibility in both Medi-Cal and Healthy Families. The SCHIP waiver would extend 12-month continuous eligibility for parents of Healthy Families child enrollees; parents in Medi-Cal will have continuous eligibility only if their income and assets remain the same.[40]

Recent California efforts to simplify and streamline public health benefit programs. Since implementation of the Healthy Families program in 1998, the legislature and the Davis administration have taken many steps to expand eligibility, simplify the application process and reduce procedural barriers to enrollment in both Medi-Cal and Healthy Families. Among the most important are:

- Extensive state-funded outreach and education efforts, with allocations totaling over $77 million between fiscal years 1998-99 and 2000-01, with emphasis on grants to community based organizations and efforts to target underserved population subgroups.
- Expansion of Medi-Cal eligibility for children up to age 18 and parents with incomes up to 100% FPG.
- Elimination of requirements for face-to-face interviews for Medi-Cal, assets test for children and quarterly earnings reports.
- Adoption of 12-month continuous eligibility for children's coverage.
- Establishment of county guidelines promoting eligibility for Transitional Medi-Cal to provide continuing Medi-Cal coverage to previous cash aid (CalWorks) beneficiaries.
- Successive efforts to shorten and simplify the joint Medi-Cal and Healthy Families application and to create and improve a single point of entry for processing applications for both programs.[41]

During the first year of the 2001-02 legislative session, the California legislature debated a number of initiatives related to state health program integration (see Appendix 6 for a list and brief description of these proposals.) Most were held over and will be reintroduced when the legislature reconvenes for the second year of this session in January 2002. This section highlights key measures that were passed, related unsuccessful efforts, and proposals that have generated strong support for reconsideration in the forthcoming year.

New Laws

SB 493 (Sher) concentrates on creating outreach and enrollment linkages between the Medi-Cal and Healthy Families and the Food Stamp programs. The bill requires each county health department to develop a data list of family members in eligible food stamp households who are not enrolled in either program and to notify these individuals that they may be eligible for benefits in these programs at the time of the food stamp household's annual recertification. The legislation further specifies that the notice be

[40] Quacinella, L. (2001), *Op. Cit.*
[41] California Budget Project (2001). **Losing Ground: Declining Medi-Cal Enrollment after Welfare Reform.** Sacramento, CA: Author.

written in culturally and linguistically appropriate language and at an appropriate literacy level. Counties will receive reimbursement from the State Mandates Claims fund of up to $1 million for the cost of administering this state-mandated local program.[42]

AB 59 (Cedillo) establishes a statewide pilot project to expedite Medi-Cal enrollment for children receiving free school lunches through the federal National School Lunch Program. School districts are required to include notification with the school lunch application that if the child qualifies for free school lunches s/he may qualify for free or low-cost health insurance coverage. The notice will also include permission to allow release of the information provided on the school lunch application to Medi-Cal and Healthy Families for use in health program enrollment. After July 1, 2002 school districts may implement a process to share information provided on the school lunch program application with the local Medi-Cal program for eligibility determination.[43]

AB 495 (Diaz and Cohn) establishes the Children's Health Initiative Matching Fund to provide grants to a county agency or organization to provide health insurance to children in low income families (up to 300% FPG) who are ineligible for publicly funded health benefit programs. It will be administered by the Managed Risk Medical Insurance Board in collaboration with the State Department of Health Services "for the express purpose of allowing local funds to be used to facilitate increasing the state's ability to utilize federal funds available to California." County health departments, local initiatives (quasi-governmental Medi-Cal managed care plans in the 12 largest California counties) and county organized health systems (public entities that enroll all Medi-Cal beneficiaries in a county in a county-operated health plan) may submit proposals to MRMIB to provide comprehensive health coverage. The legislation leverages state and local contributions combining local funds with an equal amount of state funds to draw down the allowable amount of federal funds under SCHIP, which is currently double the amount that a state expends. Thus, the state and county would together contribute one third of program dollars (one-sixth each) and federal funding would contribute two thirds.

This bill was designed to encourage counties to adopt the Santa Clara Valley Children's Health Initiative to insure all low to moderate income children in other California localities. The Santa Clara Valley initiative combines funds from city and county tobacco settlement funds, Proposition 10 (tobacco tax funds to support health programs for young children) allocations, and contributions from corporations and the Santa Clara Family Health Plan local initiative. Children are enrolled in existing public health insurance programs for which they qualify; those ineligible for the publicly funded health benefit programs receive coverage equivalent to Healthy Families. Implementation is contingent upon securing a federal waiver and use of unexpended SCHIP funds allocated to California.[44]

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[42] California State Legislature (2001). **SB 493.** Retrieved October 8, 2001 from the World Wide Web: http://www.leginfo.ca/gov.
[43] California State Legislature (2001). **AB 59.** Retrieved October 8, 2001 from the World Wide Web: http://www.leginfo.ca/gov.
[44] California State Legislature (2001). **AB 495.** Retrieved October 8, 2001 from the World Wide Web: http://www.leginfo.ca/gov.

AB 430 (Cardenas), the state budget health trailer bill, contains several provisions to modify current Medi-Cal and Healthy Families, all contingent upon federal waiver approval. Section 14.5 increases the family income eligibility level for Healthy Families to 250% FPG, allows for self-declaration of income and expands eligibility to uninsured parents of Healthy Families children. Section 16.5 creates the Medi-Cal-to-Healthy Families Bridge Benefits Program to provide a two-month period of coverage under Healthy Families for children previously eligible for Medi-Cal and vice versa. Section 31 extends 12 months of continuous eligibility to parents in Healthy Families. Section 35 directs the Department of Health Services to accelerate enrollment of children in Medi-Cal.[45]

Legislation Pending for 2002

SB 615 (Ortiz) would establish presumptive eligibility for Medi-Cal and allow participating providers to grant temporary eligibility to uninsured patients seeking care pending a complete eligibility determination to the local Medi-Cal administering agency. Originally, this bill also established the same presumptive eligibility for Healthy Families. However, Department of Health Services and Managed Risk Medi-Cal Insurance Board staff opined that federal matching funds would be available for only a minority (fewer than half) of those given temporary eligibility. Senator Ortiz then amended her bill to eliminate all provisions for Healthy Families temporary presumptive eligibility.[46]

AB 32 (Richman, Figueroa, Chan) establishes a new Cal-Health Program to seek a Section 1115 Medicaid waiver provide comprehensive health coverage to all Californians with family incomes below 250% FPG, including childless adults. It would coordinate the administration of Medi-Cal and Healthy Families by making the least restrictive rules for each program apply to both. The assets test would be eliminated and providers would be able to accept applications and grant temporary presumptive eligibility at the point of enrollment or service.[47]

Best Practices: Streamlining and Simplification Approaches in Other States

Some state programs with streamlining or simplification features that appear to be working well are noted in the following section.

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[45] California State Legislature (2001). **AB 430.** Retrieved November 4, 2001 from the World Wide Web: http://www.leginfo.ca/gov.
[46] California State Legislature (2001). **Appropriations Committee Fiscal Summary: 615 (Ortiz).** Retrieved November 4, 2001 from the World Wide Web: http://www.leginfo.ca.gov.
[47] California State Legislature (2001). **AB 32.** Retrieved October 8, 2001 from the World Wide Web: http://www.leginfo.ca.gov.

Arizona was the last state to establish a Medicaid program, but in 1982 the Arizona Health Care Cost Containment System (AHCCCS) attracted national attention for its structure as a statewide Medicaid managed care demonstration project under Section 1115 waiver authority. The initial waiver focused on allowing the state to restrict choice of provider to AHCCCS health plans and long term care contractors. Subsequent waivers allowed for expansions such as providing home and community based services to individuals with up to three times the allowable income limit for Supplemental Security Income (SSI).[48] In 1998, Arizona expanded AHCCCS to cover children under SCHIP; its KidsCare program delivers services through the same group of health plans serving its Medicaid beneficiaries under AHCCCS. Operation as a separate state program under the same state agency and delivering care through the same providers means that transfer of children between Medicaid and KidsCare is relatively easy.[49] Arizona uses a universal application for Medicaid, KidsCare and state-funded programs, and has trained KidsCare outreach staff regarding all programs.[50] In December 2001 Arizona became the first state to obtain federal approval for a HIFA initiative to use unspent SCHIP and tobacco settlement funds to cover parents and children with incomes up to 200% FPG and childless adults up to 100% FPG.[51]

Georgia operates PeachCare as a separate SCHIP with important links to Medicaid. Both programs use the same rules to determine income eligibility, accept self-declaration of income, and have no assets test. While there are still separate applications for PeachCare and Medicaid, the PeachCare application can be used to apply for Medicaid.[52] The PeachCare application is one page long and enrollment is handled entirely by mail or phone.[53]

Kansas provides health insurance to low income children through two programs, Medicaid and the separate SCHIP-funded HealthWave. By using a simplified joint application and single point of entry, aligning income and asset rules and instituting continuous eligibility for both programs, and co-locating workers responsible for both programs, Kansas has employed the most common coordination strategies. Officials from the Kansas Department of Social and Rehabilitation Service describe the redetermination process as "seamless": *A child who is no longer eligible for the program in which he or*

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[48] State Health Care Reform Demonstration Fact Sheets (2001). **Arizona Statewide Health Reform Demonstration Fact Sheet**. Baltimore, MD: Health Care Financing Administration.
[49] Health Care Financing Administration (2001). **Arizona Title XXI Program Fact Sheet.** Baltimore, MD: Author.
[50] Arizona Health Care Cost Containment System. **2001 AHCCCS Overview: Chapter 4: KidsCare Program.** Retrieved from the World Wide Web May 8, 2002: http://www.ahcccs.state.az.us
[51] National Academy of State Health Policy. **Summary of Meeting Proceedings: Invitational Summit on Medicaid and SCHIP.** Washington, DC: February 2002, pp. 4-5. Retrieved from the World Wide Web May 13, 2002: http://www.nashp.org/progs/prog0001.htm
[52] Mann, C., Cox, L. and Cohen Ross, D. (2000). **Making the Link: Strategies for Coordinating Publicly Funded Health Care Coverage for Children.** Washington, DC: Center on Budget and Policy Priorities, p. 27.
[53] Georgia Department of Community Health. **PeachCare forKids Annual Report.** Retrieved from the World Wide Web May 8, 2002: http://www.communityhealth.state.ga.us/.

she is enrolled will automatically be enrolled in the other program, if appropriate. There is no lapse in coverage or additional paperwork.[54]

Massachusetts covers children under eligible for SCHIP and families eligible for Medicaid under its MassHealth Family Assistance program, and uses a single application form to determine eligibility for these and all other state health programs. "MassHealth has moved far toward being a single, seamless system of coverage. Although separate categorical funding programs compose MassHealth, enrollment and administration are jointly administered, and underlying complexities are seldom visible to applicants or enrollees…Enrollment procedures are designed to place all MassHealth applicants in the most generous program of coverage for which they qualify, including those not run by the state." MassHealth includes a total of six programs with different funding sources that provide assistance to several sub-groups of the low-income population with varying conditions (disability, homelessness, unemployment) and in varying income strata.[55]

While family income determines whether SCHIP or Medicaid funds an individual child's coverage, the family applies for MassHealth and the MassHealth eligibility technician screens and enrolls the child (and parents, if applicable) into the appropriate program. Families with incomes between 150 and 200% of Federal Poverty Guidelines (FPG) must pay a portion of the premium and have slightly fewer benefits than those with incomes less than 150% FPG. An important benefit of this approach is that if family income changes the child remains eligible for and enrolled in MassHealth, with no need for any type of program or coverage change. The funding source may change, but there is a minimal impact on the beneficiary.[56] Furthermore, MassHealth uses the same provider network, enrollment/membership card and recertification system for all enrollees. In state fiscal year 2001, Massachusetts designed and implemented a plan to automatically screen all Medicaid transitional assistance beneficiaries for MassHealth eligibility.[57]

Minnesota, also long a leader in state health insurance expansion initiatives, implemented a limited children's health insurance program in 1987 for children up to 185% FPG. In 1992, the state established MinnesotaCare as part of a health reform initiative that both expanded benefits and also extended coverage to adults. In 1993, the children's health program was discontinued and the program was extended to cover families with incomes up to 275% FPG. In 1994, MinnesotaCare expanded eligibility to include single and childless adults with incomes up to 125% FPG.[58]

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[54] Mann et al., *Op. cit.,* p. 29.
[55] Bovbjerg, R. and Ullman, F. **Recent Changes in Health Policy for Low-Income People in Massachusetts.** Washington, DC: The Urban Institute, March 2002, pp. 9-13.
[56] Cohen Ross, D. and Cox, L. *Ibid,* p. 12.
[57] Massachusetts Department of Public Health. **MassHealth 1115 Demonstration Project Annual Report SFY2001.** Retrieved from the World Wide Web May 8, 2002: http://www.state.ma.us/dma/researchers/res_IDX.htm
[58] **History of MinnesotaCare.** (2001). St. Paul, MN: Minnesota Department of Human Services. Retrieved from the World Wide Web November 27, 2001: www.dhs.state.mn.us/hlthcare/asstprogram/mncare/history.htm

In 1997, Minnesota implemented SCHIP as an expansion of MinnesotaCare and increased income limits for single and childless adults with incomes up to 175% FPG. Workers without access to employer-based coverage may purchase private coverage comparable to Medicaid, paying a portion of the premium based on income and family size. Under a later SCHIP waiver, Minnesota also receives federal matching funds at the SCHIP matching rate to cover some parents of SCHIP children.[59]

Minnesota has made efforts to simplify its generous but rather complex array of publicly funded health programs in recent years after a review of program rules and structure. These changes include shortening application and renewal forms, simplifying documentation requirements, delinking cash and medical assistance, and coordinating program renewal dates for families with beneficiaries in different programs.[60]

New York has long been a leader in efforts to expand children's health insurance after establishing its Child Health Plus plan in 1988. First enacted with benefits limited to primary care, CHP expanded over the years to offer an even more comprehensive benefit package than Medicaid for children in families with incomes up to 200% FPG. It served as a model for the federal legislation establishing the SCHIP program, and was "grandfathered" into Title XXI for federal financial participation.[61]

In December 1999 New York enacted the Health Care Reform Act, expanding eligibility for state funded health insurance to as many as 1 million of the state's uninsured residents through two new programs, Family Health Plus and Healthy New York. Family Health Plus is a Medicaid Section 1115 waiver expansion to cover parents of Child Plus children (up to 150% FPG) and childless adults up to 100% FPG. Healthy New York is a basic benefit health plan with a limited subsidy for small businesses with at least 30% of uninsured workers and their dependents earning less than 250% FPG. Employers must pay at least half the premium and must offer coverage to all employees; employees pay up to half of the premium, depending on their incomes, plus substantial copayments. The 1999 legislation also created a state reinsurance fund that pays insurance carriers up to 90% of annual enrollee claims ranging from $30,000 to $100,000.[62]

New York uses a community-based system of enrollment for both Medicaid and Child Health Plus. The Women, Infants and Children (WIC) program is a particularly extensive outreach contact point, distributing child health insurance flyers through the network of neighborhood stores that accept WIC food vouchers.[63] New York established a "facilitated enrollment" initiative in 2000. Community based organizations such as WIC assist families with a joint application for Medicaid or CHPlus and enrollers employed by

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[59] Lambrew, J. (2001), *Op. Cit.*
[60] Long, S. and Kendall, S. **Recent Changes in Health Policy for Low-Income People in Minnesota.** Washington, DC: The Urban Institute, March 2002, p. 14.
[61] Gottfried, R. (2000). **New York State's New Programs for the Uninsured: How and Why We Got There.** Portland, ME: National Academy for State Health Policy.
[62] Haslanger, K. (2000). **From Promise to Practice: Expanding Health Insurance for New Yorkers.** New York: United Hospital Fund.
[63] O'Brien, M. et al. (2000), *Op. Cit.,* p. 26.

these organizations helps the family complete the enrollment process into the appropriate program.[64]

The **Oregon** Health Plan (OHP) begun in 1989 includes several key elements. Its Medicaid demonstration waiver covers everyone in the state with incomes up to 170% of FPG. [65] The legislature recently passed a bill that would increase the income limit to 185% FPG,[66] but may repeal or postpone implementation of this measure when it convenes for a special session in January.[67] Medicaid and SCHIP fund people eligible for these programs, and the Family Health Insurance Assistance Program, funded entirely by tobacco taxes, provides subsidies for purchase of private insurance to uninsured individuals ineligible for Medicaid.[68] Subsidies vary by income level, ranging from 95% for those with incomes under 133% FPG to 70% for those with incomes approaching 170% FPG. As in Massachusetts, the eligibility determination for children is conducted behind the scenes, and if a child is eligible for coverage the cost is charged either to SCHIP or Medicaid depending on the family income level.[69] For the Family Health Assistance Program, however, there is currently a waiting list and a limited number of funded beneficiaries so applicants must apply for a spot on the reservation list and await notification of openings before their applications can be accepted.[70]

Rhode Island's RIteCare is a Section 1115 Medicaid waiver program originally implemented in 1994 to expand eligibility to low income pregnant women and younger children (up to 250% FPG) and shift its delivery system to a managed care model[71]. Rhode Island implemented SCHIP as a Medicaid expansion to receive enhanced federal financial participation for coverage provided to children in the higher income range, and subsequently increased income limits to 250% FPG for children under 19, to 185% FPH for their parents and to 350% FPG for pregnant women.[72] A pending Medicaid waiver expansion amendment would increase the income eligibility limits for children under 19

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[64] Coughlin, T. and Lutzky, A. **Recent Changes in Health Policy for Low-Income People in New York.** Washington, DC: The Urban Institute, March 2002, p. 12.
[65] Reby, J. Personal communication, November 20, 2001.
[66] Office for Oregon Health Plan Policy and Research (2001). **Health Policy and Reimbursement Legislation Enacted in the 2001 Legislative Session.** Salem, OR: Author. Retrieved August 20, 2001 from the World Wide Web: http://www.ohppr.state.or.us.
[67] Hughes, T. (2001). Personal communication.
[68] Office for Oregon Health Plan Policy and Research (2000). **The Oregon Health Plan and Oregon's Health Care Market: A Report to the 71st Legislative Assembly.** Salem: Author. Retrieved November 4, 2000 from the World Wide Web: http://www.ohppr.state.or.us.
[69] Cohen Ross. D. and Cox, L., *Op. Cit.,* p. 30.
[70] Insurance Pool Governing Board (2001). **Family Health Insurance Assistance Program.** Salem, OR: Author. Retrieved from the World Wide Web November 27, 2001: www.ipgb.state.or.us/Docs/fhiapgen.htm.
[71] Gehshan, S. (1998) **State Options for Expanding Children's Health Insurance.** Washington, DC: National Conference of State Legislatures. Retrieved from the World Wide Web September 25, 2000: http://stateserv.hpts.org.
[72] Rhode Island Department of Health Services (2001). **RIte Care Health Insurance.** Retrieved from the World Wide Web November 19, 2001: http://www.dhs.state.ri/us/dhs/famchild/mrtcare.htm.

to 300% FPG.[73] Concurrent with these eligibility expansions, the state streamlined the enrollment process by cutting the application form to one page, reduced the number of documents required for verification from 11 to 3, and substituted a mail-in application for the previously required in-person interview. In addition, the state Medicaid agency implemented an aggressive outreach program that paid 32 community based organizations for enrollment on a performance basis.[74] Rhode Island received a federal waiver in January 2001 to cover parents of SCHIP enrolled children.[75]

Tennessee used its Section 1115 waiver to create TennCare, an extremely ambitious large scale managed care program that has undergone substantial modification since its inception in 1994. Originally, TennCare provided subsidized coverage to low income residents and also allowed uninsured people with incomes up to 400% FPG to buy into the program.[76] The first waiver was extended for an additional five years and is set to expire in December 2001. TennCare covers approximately 800,000 people eligible for Medicaid, and another 500,000 included in the "expansion population," including low-income children enrolled in TennCare for Children, Tennessee's SCHIP program. Coverage for the expansion population became the focus of considerable concern when TennCare experienced serious financial problems in the late 1990s. State officials developed a series of changes in the benefit design, cost sharing, contracting and risk sharing provisions of the program, now known as TennCare II.

A state commission convened in 2000 recommended continuing TennCare as a managed care program and articulated a continuing intent to avoid destabilizing the coverage that TennCare II now provides to the expansion population. The commission's recommendations for future restructuring included creation of two new products to substitute for the current TennCare coverage of the uninsured and uninsurable: "TennCare Assist, a premium assistance program to assist certain low-income Tennesseans to buy into employer-sponsored coverage, including family coverage, when it is available to them…[and] TennCare Standard, a second TennCare product for individuals who do not have access to employer-sponsored health insurance and/or individuals who are uninsurable from an underwriting standpoint."[77]

Vermont used its Section 1115 Medicaid waiver in 1995 to develop the Vermont Health Access Plan to expand health coverage for uninsured adults up to 150% FPG by enrolling them in a Primary Care Case Management Program, PC Plus, administered in

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[73] National Conference of State Legislatures Health Policy Tracking Service (2001). **News from the States.** Washington, DC: Author. Retrieved from the World Wide Web November 19, 2001: http://stateserv.hpts.org.

[74] Byrnes, Pamela J. **RIte Share Design and Implementation: Lessons Learned in Phase I.** Providence, RI: Rhode Island Department of Human Services, March 20, 2002, p. 5.

[75] National Academy of State Health Policy. **Summary of Meeting Proceedings: Invitational Summit on Medicaid and SCHIP.** Washington, DC: February 2002, p. 5. Retrieved from the World Wide Web May 13, 2002: http://www.nashp.org/progs/prog0001.htm

[76] Lambrew, J. , *Op. Cit.*

[77] Commission on the Future of TennCare (2000). **Report on the Future of TennCare.** Nashville, TN: Author.

conjunction with the Medicaid program.[78] In 1999, Vermont amended its Section 1115 waivers for SCHIP and Medicaid to cover households of uninsured children with family incomes up to 300% FPG with a monthly cost sharing requirement ranging from $2 to $12 per household. A pending amendment submitted in 2000 would raise family premium payments to between $10 and $24 per household per month.[79]

Washington has a long history of leadership in efforts to expand health insurance to all the state's residents. The state established the Basic Health Plan in 1987, which subsidizes low income (up to 200% FPG) individuals, families and employers to purchase insurance coverage (through managed care plans) on a sliding fee scale. In 1996, Washington increased the Medicaid income eligibility levels for all children up to 19 to 200% FPG. People with incomes above 200% FPG are not eligible for subsidized coverage but may buy into the Basic Health Plan and pay the full premium. If a parent is eligible for BHP and the children are eligible for Medicaid, the children can enroll in BHP+ instead of Medicaid, and the Medicaid program pays to cover them. This allows children to enroll in the same plan as their parents and receive the full range of Medicaid benefits and services. [80] This arrangement provides a common program umbrella for a family, albeit with slightly different benefits for children than for parents.

The Basic Health Plan enrolled about 217,000 individuals as of June, 2000. The largest portion (about 131,000) were in the "regular subsidized" program, which includes both individual subscribers and people sponsored by a variety of groups such as providers, Indian tribes, employers, foster parents and home care workers; and 56% of these enrollees had incomes below 100% FPG. State funding for the subsidized program is limited, and has resulted in an enrollment cap of about 133,000 people. When enrollment reaches this cap, the program will delay processing applications until slots become available through enrollee attrition.[81]

The second largest subgroup of BHP enrollees are children (funded by Medicaid and enrolled in BHP+). Another small nonsubsidized subgroup of about 2,300 enrollees pay the full premium. This group is declining and withering by attrition because insurance carriers that have experienced adverse selection have withdrawn from most markets, and as of 2000 offered this option in only one county.[82]

When SCHIP was enacted a year after Oregon established BHP, the state first elected not to apply for Title XXI funds because to do so would have required an expansion of eligibility to 250% FPG. Washington established a separate SCHIP program in 2000, for children with family incomes between 200-250% FPG. This program, called CHIP, provides Medicaid benefits with small copayments and premiums. Both Medicaid and

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[78] Office of Vermont Health Access (2001). **Vermont Access Health Plan History.** Burlington, VT: Author. Retrieved November 4, 2001 from the World Wide Web: http://www.state.vt.us/health.
[79] Office of Vermont Health Access (2001). **Vermont Health Access Plan Amendments since January 1, 1999.** Burlington, VT: Author. Retrieved November 4, 2001 from the World Wide Web: http://www.state.vt.us/health.
[80] O'Brien, M.J. *Op. Cit,.* pp. 9-10.
[81] Sillow-Carroll, S., Anthony, S. and Meyer, J. (2000). *Op. cit.,* p. 40.
[82] *Ibid.*

CHIP are administered by the same state agency, use a joint program application with self-declaration of income and the same income determination methods.[83]

Table 2 displays the key features and benefits of the "best practice" state approaches discussed in the preceding section.

Table 2: Best Practice State Streamlining and Simplification Approaches

State and Program Name	Program Type	Simplification Approaches
Arizona Health Care Cost Containment System - KidsCare	Separate SCHIP program, uses Medicaid managed care system for children eligible under SCHIP	Same state administrative agency and contracted health plans for KidsCare & Medicaid; universal application; combined outreach
Georgia PeachCare	Separate SCHIP program	Same eligibility rules for Medicaid & SCHIP; PeachCare application can be used for Medicaid
Kansas HealthWave	Separate SCHIP program	Simplified joint application and single point of entry (SPE); aligned income/asset rules; continuous eligibility and automatic inter-program transfer
Massachusetts - MassHealth Family Assistance Program	Single Medicaid/SCHIP program	Single application form; child remains eligible for MassHealth regardless of family income fluctuations; adult coverage.
Minnesota – MinnesotaCare	Single Medicaid/SCHIP program	Expanded child & adult coverage; shortened application & renewal forms; aligned program renewal dates for households with members in different programs.
New York –Child Health Plus, Family Health Plus, Healthy New York	Expanded SCHIP program	Community based outreach and facilitated enrollment process, parental coverage, state subsidies for small employers, individuals
Oregon – Oregon Health Plan, Family Health Insurance Assistance Program	Single Medicaid/ SCHIP program	SPE; state subsidies for low income uninsured; universal coverage for low-income adults and children <170% FPG
Rhode Island – RIte Care	Single Medicaid/SCHIP program	1-page mail-in application, reduced verification; SCHIP parental coverage
Tennessee – TennCare, Tenn Care for Children	Single Medicaid/SCHIP program	SPE, joint application; subsidized buy-in for uninsured <400% FPG
Vermont – Vermont Health Access Plan	Comprehensive Medicaid/SCHIP program	Joint application; covers families up to 300%, adults to 150% FPG
Washington – Basic Health Plan, CHIP	Single Medicaid program for all persons < 200% FPG; "CHIP" program for kids 200-250% FPG	Single state administering agency, joint application with same income determination rules, including self-declaration; variable premiums, fees for adults

[83] Holohan, J. and Pohl, M. **Recent Changes in Health Policy for Low-Income People in Washington.** Washington, DC: The Urban Institute, p. 16.

Local Innovations Underway in California Counties and Communities

Alameda Alliance for Health (AAH) is a local initiative health plan established in 1994 following the adoption of the California Department of Health Services' strategic plan to transition the majority of Medi-Cal beneficiaries in California's largest counties to a managed care delivery system. AAH began operations in 1996, and as of November 2001 served approximately 78,000 members, of whom almost 6,000 are Healthy Families children (AAH is the community provider plan in Alameda County), about 3,400 are commercial members of the plan's subsidized Family Care product, and 1,500 are commercial members of Alliance Group care. The remainder, about 67,000, are Medi-Cal beneficiaries.

The Alliance established Family Care as a subsidized individual commercial product to provide affordable coverage for low income (up to 300% FPG) uninsured families with allocations from the plan's internal reserves. As of November 2001 AAH has committed over $14 million for its support, and the AAH board has expressed its intention to continue to support the subsidized product to the extent it has surplus funds. Alameda County has designated $1 million from tobacco settlement funds to expand coverage to the uninsured poor who do not qualify for other public programs. The California Endowment contributed $400,000 to cover undocumented uninsured children. The pending federal waiver application to extend coverage to parents of Healthy Families children will, if implemented, allow AAH to transition Family Care members who qualify into Healthy Families and free up funds to cover more people who do not qualify for public programs. The Family Care target population is the parents and siblings of the plan's Healthy Families and Medi-Cal members, immigrant families and undocumented children who are ineligible for publicly funded programs. The benefit package and provider network is similar to that for Healthy Families (without vision), and there are modest copays and premiums ($10 per month for children, $20 for adults). Future modifications include development of a vision benefit, and potential modification of premiums and copays to mirror Healthy Families, especially for families below 250% FPG.[84]

One of the first counties to develop a health plan, **Contra Costa County Health Plan** has enrolled medically indigent adults in its ABC (Adult Basic Care) program since 1983. In May 2001 the county instituted a new product to cover low income in-home support services (IHSS) workers and their children for a $7 monthly premium using the county's Medi-Cal service provider network. CCCHP also has a mobile health van, modeled after San Joaquin County's program. The plan operates CHDP clinics and has placed enrollment assisters in most county schools.[85] The West Contra Costa Unified School District organized a very aggressive effort to enroll children in Medi-Cal and Healthy Families through the school lunch program. A community-based coalition, Communities in Schools, used $37,000 in state funding to recruit and train 30 parents and volunteers,

[84] Maruyama, N. (2001) **Alameda Alliance for Health: Family Care Update November 2, 2001.** Los Angeles, CA: Presentation to The California Endowment Undocumented Uninsured Children Project Grantees.
[85] Beverly Jacobs (2001). Personal communication.

most of whom were bilingual/bicultural, as Certified Application Assisters; six were hired as school district employees. These CAAs contacted 80 percent of the families that submitted Request for Information forms, and enrolled children from 700 families in either Medi-Cal, Healthy Families, or California Kids (a program operated by a private nonprofit foundation that provides coverage for low income children not eligible for public programs). In the second year of the program the County Department of Social Services assigned an eligibility worker to the district.[86] In May 2002 the county approved an expansion of the ABC program, renamed Basic Health Care, to include all county residents with incomes under 300% FPG ineligible for public programs. These new members will pay monthly premiums based on income of $25, $50 or $75.

Kern County. Kern Health Systems operates Kern Family Health Plan, the local initiative in that county. Plan and county officials are extremely interested in learning from what Santa Clara, Alameda and other local initiatives and counties are doing in order to expand its scope of activity to cover more uninsured children.[87]

Los Angeles County continues to struggle to implement the provisions of its Section 1115 Medicaid waiver extension, under which the county will continue to receive federal funding through 2005. However, the federal contribution is reduced and the state and county are partially offsetting these reductions. The basic thrust of the waiver continues to be on reducing inpatient care and increasing primary and outpatient care. The county has achieved a substantial shift in the ratio of expenditures for inpatient to outpatient care, from $16/1 in fiscal year 1995-96 to $8/1 in 1998-99. While county funds will not be used to expand ambulatory visits as under the previous waiver, more than half of the county's tobacco settlement funds are dedicated to support for ambulatory care services the waiver includes a target of at least 3 million ambulatory visits. The federal government has also set enrollment targets for increasing Los Angeles County enrollment in Medi-Cal and Healthy Families--150,000 in the first year and an additional 5 percent increase for each of the next four years. This will require a substantial increase in county eligibility staff in the Social Services Agency.[88]

Community clinics note the success of the Public Private Partnership program through which the county contracts with clinics to provide primary care for medically indigent uninsured. The program has helped the clinics provide more care and to offer a broader range of services. The clinics also worked with the county on a succession of Community Access Program grants to reduce barriers to care, and have increased funding from $25 million the first year (1999-2000) to $125 the second (2000-01); $102 million has been proposed for fiscal year 2001-02. Grantees were community coalitions, usually comprising county health departments, disproportionate share hospitals and community clinics. Projects included a mobile eye clinic and a collaborative effort between the

[86] Cohen Ross, D., *Op. Cit.,* p. 13.
[87] Eaton, S. (2001). Personal communication.
[88] Santiago, R. (2000). Presentation to ITUP work group on Clinics, Counties and the Uninsured. Los Angeles, CA.

community clinics and the county hospitals to develop a coordinated disease management program for diabetes patients.[89]

LA Care, the local initiative health plan for Los Angeles County, in early 2002 allocated $4 million from its surplus revenues to fund coverage for 5,000 uninsured children through California Kids for two years.

In **Napa and Solano Counties**, the Solano Kids Insurance Partnership (SKIP) is part of a 12-year old health collaborative funded by the California HealthCare Foundation, Children's Defense Fund, a state outreach grant and Medicaid 1931(b) waiver funds. The Partnership Health Plan is a county organized health system with approximately 45,000 members. The collaborative is working with the Board of Supervisors to plan how to best spend tobacco tax and settlement funds, and on a Community Access Program grant targeting the county indigent population. There are approximately 15,000 - 20,000 uninsured children in the county. SKIP employs a social marketing model to enroll eligible children in Medi-Cal and Healthy Families, and has also purchased enrollment for some undocumented children in California Kids, a program for uninsured low income children ineligible for public programs. Part of the social marketing effort is a "tough love" stance by the county's community clinics, requiring patients to either enroll their children in public programs for which they are eligible or pay (more than a token amount) for their care at the clinics. A popular and very effective symbol is the "Skipper Dog" mascot, who appears at many community events and in public service announcements saying, "Kids without health insurance have it RRRRough!" When needed, SKIP staff will also link sick uninsured children with providers for immediate attention.

Orange County has developed a very strong community based outreach and enrollment assistance program coordinated by CalOPTIMA, the county organized health system in which all Medi-Cal beneficiaries are enrolled. The Orange County Health Care Agency delegated Medicaid 1931(b) funds to CalOPTIMA for this purpose. CalOPTIMA developed a map of school districts, hospitals, clinics and community agencies that were already doing outreach and emphasized building on this infrastructure and enhancing ongoing efforts through a "train the trainer" approach. CalOPTIMA also rewards providers and clinics for meeting enrollment targets. These rewards are of nominal value (movie tickets, lunch) but they seem to mean a lot and encourage the front line staff to continue to spread the word about Medi-Cal and Healthy Families.[90]

CalOPTIMA also is the lead agency in a collaborative grant project recently funded by the federal Human Resources and Services Association to design two related pilot projects to expand coverage to the county's uninsured residents. The first is for health insurance coverage for uninsured low income children ineligible for publicly funded programs that will be modeled on the Santa Clara Initiative. The second is a job based subsidized coverage project for small employers with a high proportion of low wage

[89] Johnson, M (2001). Personal communication.
[90] Martinez, E. (2001). Personal communication.

workers that would supplement and work with the proposed Healthy Families expansion to parents.[91]

San Diego County is one of two California counties (the other is Sacramento County) operating as a Geographic Managed Care model for Medi-Cal managed care. Seven commercial health plans in the county contract with the Department of Health Services to deliver services to Medi-Cal beneficiaries; most also offer Healthy Families. The stakeholder group that developed the GMC model, "Healthy San Diego," has been institutionalized as an advisory body to the Board of Supervisors called the Program Management Committee. This committee persuaded the supervisors to dedicate all of the county's tobacco settlement funds to health related programs for fiscal year 2000-01. The Committee also developed a legislative proposal, AB 1547, to create a Business Health Access Resource Center for small businesses and low income employees to obtain information on all types of health insurance resources and to facilitate enrollment in publicly sponsored programs by their workers. Although the legislature passed the measure, Governor Davis subsequently vetoed it. The Health-insurance Access Through Schools (HATS) program allows local school districts to have outstationed bilingual outreach workers for Medi-Cal and Healthy Families outreach assistance.[92]

The County Department of Health Services operates a multilingual community outreach and telephone hot line program, San Diego Kids Health Assurance Network (SD-KHAN, pronounced "San Diego Can") to link uninsured children and their families with health plans and providers. It is an extension of the existing Maternal and Child Health Hotline. SD-KHAN staff also network extensively with providers and community organizations that serve low income populations. Funding comes from the federal Maternal and Child Health Bureau.[93] The University of California San Diego Department of Community Pediatrics operates the Health-insurance Access Through Schools (HATS) program funded by the Robert Wood Johnson and the County of San Diego. The University provides school districts with funding to hire outreach workers as Certified Application Assisters outstationed at schools in low income communities.[94]

San Francisco City and County. The Department of Public Health and the San Francisco Health Plan local initiative are key players in this effort to ensure universal children's health care coverage. It aims to fill the gaps between other publicly funded programs to assure coverage of all children in families with incomes below 300% FPG. An estimated 5,000 children appear eligible for the "Healthy Kids" city/county subsidized product.[95] Notable is the City and County of San Francisco's longstanding and explicit policy commitment and voter validation for universal health insurance coverage and continuing public benefits for undocumented residents. The "Healthy Kids" children's

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[91] Frazer, H. (2001). Personal communication.
[92] Wulsin, Jr. L. (2001). **Briefing Notes, Orange and San Diego County Regional Work Group**. Santa Monica, CA: Insure the Uninsured Project.
[93] Williams, D. (2000). **Outreach Early Lessons from San Diego Kids Health Assurance Network (SD-KHAN).** Bethesda, MD: Healthy Tomorrows Partnership for Children Project Directors Meeting.
[94] Wulsin, Jr. L. (2001) **Insure the Uninsured Project Regional Work Group - San Diego and Orange Counties Briefing Paper**. Santa Monica, CA: Insure the Uninsured Project.
[95] Fraser, J. and Soos, J. (2001). Personal communication.

initiative builds on prior initiatives to cover uninsured low income in-home supportive service workers and to require firms that contract with the city to provide or pay for health insurance. All City contractors must either: (1) provide health insurance coverage; or (2) pay the City $1.50 per hour per worker to cover the City's expenses of providing care to uninsured workers; or (3) participate in a purchasing pool that will be developed in 2002.[96]

San Joaquin County. The Health Plan of San Joaquin is a local initiative with close ties to community-based organizations and the public hospital. The provider network includes county clinics, two school-based clinics, contracted specialist and ancillary providers, and the public hospital. In addition to serving about 50,000 Medi-Cal beneficiaries, Healthy Families child enrollees and county employees, the Health Plan of San Joaquin also operates a rural health "Access" demonstration project. This project delivers free care through county clinics and a mobile van that travels 5 days a week to the fields. Dental care will be a part of the next two-year project grant, reflecting the great unmet need for oral health services among the target population of both adults and children. The "Access" project is funded by tobacco tax funds. The mobile van outreach seems to work well in this rural county; St. Joseph Hospital has a traveling clinic van, and the county health department recently purchased one. These mobile clinics also dispense a 90-day supply of medication and patients can go to community clinics for refills. The county library partners with the plan for literacy outreach efforts, and the Service Employees International Union and schools actively support plan efforts to enroll children in Healthy Families and Medi-Cal.

Health Plan of San Joaquin contributed $1 million from its surplus to provide free care for a year to 1,000 parents of children enrolled in Healthy Families at an estimated cost of $1,000 per parent per year. This enrollment target was reached within two months. The Healthy Parents program is not insurance; instead, eligible parents receive a card entitling them to free care for a year through the Health Plan of San Joaquin. Participants have a designated primary care physician from a county clinic and access to the full plan provider network. Utilization is strong, especially for routine primary care. Problems with the enrollment contractor have made retention an issue because of the cumbersome recertification process.

Anticipating Healthy Families' expansion to include parents, Health Plan of San Joaquin will continue this demonstration project until it can transition these parents to Healthy Families. Through MRMIB, the plan also received continuation funding for 2 years for a rural health demonstration project to cover migrant children, and will be adding a dental and vision component this year.[97] The local initiative and County board of supervisors have pledged continuing support for Healthy Parents through June 2002.[98]

San Mateo County Department of Health Services obtained a grant from the federal Health Resources and Services Administration (HRSA) Community Access Program to

[96] Soos, J. (2001). Personal communication.
[97] Cox, S. (2001). Personal communication.
[98] Gardner, A. (2001). Personal communication.

integrate existing publicly funded health programs. The first effort involves creating health access teams to maximize Medi-Cal and Healthy Families enrollment, develop a more user-friendly application process and increase program retention. Department officials are also working closely with the San Mateo Labor Council on work site health promotion and Medi-Cal/Healthy Families enrollment. Other aspects of the Community Access Program grant include expanding a chronic disease management program and contracting with the Health Plan of San Mateo, the county organized health system that enrolls all Medi-Cal beneficiaries, as a Third Party Administrator (TPA) to manage care for the medically indigent. (The county hospital and clinics as part of County Health Services provide care for the indigent through the WELL program. As of now, the Health Plan of San Mateo does not serve the WELL population. However, the plan does currently oversee emergency room Medi-Cal patients.) A longer range goal is to develop a low cost insurance product for low income uninsured county residents. San Mateo County health officials hope to increase the level of local political interest in expanding health insurance coverage.

Santa Clara County has attracted statewide interest for its ambitious Children's Health Initiative to provide health insurance coverage to all children within its borders. The Initiative developed from a collaborative effort led by a faith-based community advocacy organization, a union coalition and the county's local initiative health plan.

People Acting in Communities Together (PACT) served as the lead agency in the Santa Clara Children's Initiative organizing effort. PACT is a grass-roots, faith-based organization comprising approximately 30,000 families in the Bay Area, and part of a national network (PICO) of a million families. PACT conducted a "health justice survey" in the San Jose area and discovered that up to 45% of the respondents were uninsured; of these, 85% had at least one family member working full time. PACT first used these data to advocate for a $50 million increase in state funding for community health centers in state fiscal year 2000.

PACT joined forces with Working Partnerships USA, the public policy council of the South Bay Labor Council (AFL-CIO) in articulating a100% coverage goal for the estimated 56,000 uninsured adults and 14,000 uninsured children in Santa Clara County. The projected cost of coverage was $1,000 per child per year. A critical first step in achieving this covrage goal was to capture tobacco tax funds from both the city of San Jose and the county. The mayor of San Jose originally opposed the idea. However, with support from the county and Working Partners as the voice of organized labor, the proposal grew from a $7M city project to a $14M county-wide initiative.[99] To date, approximately $10M in funding has been lined up from Prop. 10 ($2M), Santa Clara Family Health Plan ($1M), and city and county tobacco tax settlement funds. The California Endowment has helped both PACT and Working Partners with outreach and enrollment efforts.

The "Healthy Kids" product is a new, subsidized private insurance product administered by the Santa Clara Family Health Plan local initiative for children up to 300% FPG who

[99] Hammer, M. and Brownstein, B. (2001). Personal communication.

do not qualify for publicly funded programs. Healthy Kids began operations in January 2001, and has enrolled almost 7,000 children as of November 2001.[100] Healthy Kids is a Healthy Families 'lookalike' product, with the same benefits and network and a monthly premium of $4-8 per child. It is available to all children in families with incomes below 300% FPG regardless of immigration status, with very flexible means for proving income eligibility; however, those with existing coverage are not eligible. Of the initial group of enrollees approximately 80% are from families with incomes <250% FPG and 20% in the 250-300% range.

The Packard Foundation is supporting a professional fund raising team to pursue corporate contributions and ensure ongoing community support for the program, as well as an evaluation by UCLA. All of the state's major health foundations are keenly interested in the Santa Clara Children's Partnership and helping to fund different aspects of it for both research and program support.[101] A recently published study (Long, Kaiser Family Foundation) highlights key lessons learned from the early results that have important implications for state and local health policy:

- *In the absence of Federal and state leadership, counties can take action to reduce the number of uninsured children.*
- *Labor and faith-based communities can redefine health insurance debates at the local level.*
- *Programs that address the health insurance needs of all children in a family appear to stimulate enrollment.*
- *Rethinking outreach and enrollment strategies can pay dividends through increased enrollment.*[102]

Another research team that examined San Joaquin and Santa Clara County's programs as examples of county innovations to expand health care access for the uninsured found that counties enjoy some important advantages when they are willing to commit local resources to develop innovative programs. With fewer decision points, policy development at the county level can be faster and easier than at the state or federal level, and greater community involvement generates strong support for new initiatives. Also, counties such as Santa Clara and San Joaquin that have both a Medi-Cal Local Initiative health plan and a strong local public health care system can build on existing administrative capacity and technical expertise to develop and implement these programs.[103]

Table 3 displays these local innovations in a summary chart format.

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[100] Butler, L. (2001). Personal communication.
[101] Diringer, J. (2001). Personal communication.
[102] Long, P. (2001). **A First Glance at the Children's Health Initiative in Santa Clara County, California.** Washington, DC: Kaiser Commission on Medicaid and the Uninsured.
[103] Gardner, A. and Kahn, J. (2001). **County Innovations in Meeting the Needs of the Uninsured: Preliminary Findings.** San Francisco: Institute for Health Policy Studies, University of California San Francisco.

Table 3: Local Innovations in California Counties

County and Program	Key Features and Funding Source(s)
Alameda Alliance for Health – Family Care	Subsidized individual commercial product for people <300% FPG ineligible for public programs; funded by LI surplus, county, TCE
Contra Costa County Health Plan – Basic Health Care	County health plan enrolls Medi-Cal, HF, medically indigent adults; new expansion for all <300% FPG with sliding premiums.
Los Angeles County - LA Care	County DHS Medicaid 1115 waiver funds partnerships with community clinics for primary care; LA care funds CalKids coverage for 5,000 children ineligible for public programs
Napa and Solano Counties – Solano Kids Insurance Partnership	Collaborative public (Medicaid 1931 waiver, state outreach) and foundation funds for Medi-Cal, HF outreach and purchases CalKids coverage for uninsured children ineligible for public programs.
Orange County – CalOPTIMA	County delegated Medicaid 1931 to county organized health system plan for outreach and enrollment; designing two related pilot projects to expand coverage to children ineligible for public programs and uninsured low wage workers in small firms.
San Diego County – Healthy San Diego	School-based outreach/enrollment workers; telephone hot line to link uninsured persons with health plans and providers
San Francisco City & County, San Francisco Health Plan– Healthy Kids	Subsidized coverage for children <300% FPG; coverage for in-home support service (IHSS) workers; mandatory health insurance/payment for City/County contractor employees
San Joaquin County – Health Plan of San Joaquin	Rural health "Access" project delivers free care through county clinics and mobile health van; Local initiative plan funds coverage for 1,000 parents of HF child members; county also contributes
San Mateo County	Health access teams to maximize Medi-Cal, HF enrollment, simplify application process, increase program retention.
Santa Clara County, Santa Clara Family Health Plan – Healthy Kids	Children's Health Initiative guarantees health insurance coverage for all children <300% FPG. Funded by local initiative health plan, city & county tobacco tax (Prop. 10) and tobacco settlement, foundation and corporate contributions

Private Sector Initiatives

Three private organizations in California have also developed noteworthy and innovative programs for coverage to low income uninsured children and working people. Two are statewide in scope, while one is limited to San Diego County.

CaliforniaKids Healthcare Foundation is a nonprofit charitable foundation founded in 1992 from the conversion of Blue Cross of California from a nonprofit to a for-profit corporation. It offers a set of primary care, preventive and emergency care services to low income children with family incomes less than 200% FPG who do not qualify for public programs and thus serves primarily undocumented children. There is a simple, one page application and families pay an annual enrollment fee of $25, with modest co-pays for emergency room use and physician visits. California Kids currently serves about 20,000 children statewide, with strong continuing demand for the program. Thanks to a grant from the UniHealth Foundation, CalKids has recently instituted a member education and retention program.

CalKids' focus is now on sustainability, with emphasis on developing new alliances with public and private organizations in counties with the highest number of uninsured undocumented children. The organization's long term goal is to transition ongoing responsibility for providing coverage to undocumented child residents to entities such as the Santa Clara County Children's Health Initiative. CalKids has ceased enrollment in that county, which frees up funds to serve children in other areas. CalKids has also received allocations from Proposition 10 funds in some counties.

An extensive evaluation of the Los Angeles CalKids program provides much useful information on expanding health coverage to uninsured low-income uninsured children, especially those in working poor families who are not yet eligible for publicly funded programs due to immigration status. This study showed that low income immigrant families will enroll their children in formal health insurance programs. Grass-roots, personalized outreach activities and word-of-mouth referrals from a health care provider or trusted source (family member or school personnel) were the most effective enrollment methods. Enrollment site outreach workers were cross-trained on eligibility requirements for Medi-Cal and Healthy Families and assisted families to enroll children eligible for these programs. An interesting finding was that although more than 90% of CalKids enrollees had no prior health insurance coverage, nearly all had a regular source of care, most often a community clinic. There was only a slight increase in use of medical care services before and after enrollment, but the surge in dental service use in the first six months of enrollment suggests strong pent-up demand and the attractiveness of the dental benefit. Use of hospital emergency room declined slightly but significantly during the initial enrollment period. A troubling finding was the low re-enrollment rate: almost half of all enrollees failed to renew their coverage after one year. Mobility is likely a factor in the low retention rate, as indicated by the finding that over 30% of enrollees changed phone numbers since completing the initial enrollment form. However, overall customer satisfaction with the program was very high; more than 90 percent of surveyed respondents rated CalKids very good to excellent.[104]

Kaiser Permanente (KP) is California's largest HMO, with over 6 million members of whom approximately 160,000 are Medi-Cal beneficiaries, 33,000 are Healthy Families children and 2,500 are AIM mothers and infants. The rest of the enrollees are commercial and Medicare members. Kaiser Permanente is a group model HMO that delivers care through an exclusive provider arrangement with The Permanente Medi-Cal Group and Kaiser Foundation hospitals, supplemented by contractual arrangements with specialized community hospitals such as academic medical centers, children's hospitals, skilled nursing facilities and other ancillary providers.

Kaiser Permanente operates three subsidized programs. STEPS enables Kaiser members who have lost eligibility for group coverage to retain health insurance by paying a share

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[104] Melnick, G. et al. (2002) **Evaluation of the Los Angeles CalKids Program: Full Report.** Oakland, CA: California Health Care Foundation. Retrieved from the World Wide Web May 13, 2002: .
http://admin.chcf.org/documents/chcf/CalKidsEvaluationFullReport.pdf

of the premium that increases from 20% in the first year to 80% in the fourth year. The KP Cares for Kids Child Health Plan I covers children statewide with family incomes between 250 and 300% of FPG, and a newly implemented Child Health Plan 2 is a pilot program for undocumented children in three heavily Latino communities of Los Angeles. Child Health Plan-2 pilot program benefits are quite comprehensive, and very similar to KP Healthy Families coverage, including dental benefits.

Sharp Health Plan, established in 1992, is owned by Sharp HealthCare, a large nonprofit integrated delivery system in San Diego County. Total membership is approximately 90,000, about evenly divided between Medi-Cal and commercial lives, including Healthy Families children and AIM mothers and infants. Sharp launched FOCUS in April 1999 with a grant from the Alliance Healthcare Foundation to offer small businesses with low wage workers affordable coverage. The employer pays a portion of the premium, the employee contributes between 1-4% of family income and the Alliance subsidizes the remainder of the cost. Sharp Health Plan contributes administrative expenses.

FOCUS currently enrolls about 1700 individuals in over 200 businesses. Approximately a third of FOCUS current enrollees are children, and 90% of these are in families with incomes below 250% of FPG. These child enrollees would, by virtue of the FOCUS family income guidelines, be eligible for Medi-Cal or Healthy Families. FOCUS requires all members of a subscriber's family to have health insurance, whether as FOCUS members or as enrollees of another plan. These parents' decision to enroll their children in FOCUS (at a higher cost and with time-limited coverage compared to the publicly funded programs) suggests that these children are probably ineligible for Medi-Cal or Healthy Families because of immigration status. Thus, FOCUS assumes most of its already enrolled child members are undocumented. In 2000, The California Endowment contributed $400,000 to FOCUS to support the enrollment of undocumented children. In 2001, the California HealthCare Foundation contributed $1 million to provide transitional coverage for FOCUS enrollees and support Sharp's continuing efforts to offer affordable health care coverage after the FOCUS demonstration project ends.

RECOMMENDATIONS

The research and discussions reported in this study involve incremental efforts by states and localities to simplify and streamline an extraordinarily complex series of publicly funded health programs for low income people. While each is a worthwhile component, even combined they are insufficient to achieve the goal of a seamless system of care. To move to this ideal requires a more aggressive effort to modernize and restructure current programs.

The Legislative Analyst's Office issued a proposal for dramatically restructuring health coverage programs for low income families in 1999, with a model program unifying Medi-Cal and Healthy Families coverage and eliminating many of the barriers to enrollment discussed earlier in this study. It also called for sliding scale premiums of 2-3% of family income for working beneficiaries in the upper range of the income eligibility limit (250% FPG). The Family Coverage Model also included provisions for employers to buy into the program.[105]

The 100% Campaign, a collaborative of Children Now, Children's Defense Fund and The Children's Partnership, proposed the One Door Plan in March 2001 as a strengthened Healthy Families program for low income California children and their parents. It focused on aligning rules and procedures for Medi-Cal and Healthy Families, expanding coverage to parents and eliminating all verification and documentation requirements to the extent permitted by federal law. Under the One Door plan, Medi-Cal would cover all children and parents below 133% FPG and pregnant women and infants from 134-200% FPG. Healthy Families would cover children 1-18 and parents from 134-250% FPG as well as pregnant women and infants from 201-250% FPG.[106]

We propose further simplifying the current array of federal, state and county health programs into essentially two programs: one for uninsured persons with incomes below poverty (133% FPG) and one for uninsured persons with incomes above the agreed upon poverty guideline. People below poverty would receive fully subsidized coverage; those with higher incomes (up to 200% FPG) would share part of the cost of coverage. The following section summarizes key elements of a proposal recently submitted to the California Health and Human Services Agency by Lucien Wulsin, Jr. that incorporates recommendations and ideas from hundreds of California stakeholders over the past five years.[107]

Income should serve as the benchmark eligibility criteria for health benefits, instead of parental status or age.

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[105] Rabovsky, D., *Op. Cit.*
[106] Horner, D. and Lazarus, W. (2001). **Healthy Families: Family Health Insurance Through One Door.** Oakland, CA: 100% Campaign.
[107] Wulsin, Jr. L. et al. (2001). **SB 480 Health Care Options Paper.** Santa Monica, CA: Insure the Uninsured Project.

- **Medi-Cal benefits for low income adults and children below 133% of FPG.** These persons in the lowest income stratum would receive Medi-Cal managed care coverage for the full range of Medi-Cal benefits. This would improve access and choice of providers, increase benefits and reduce waits for care.

- **Healthy Families benefits for low income adults and children over 133% of FPG.** Members of these mostly working poor families would receive Healthy Families managed care coverage for the full range of Healthy Families benefits. This program includes higher copays and a somewhat smaller benefit package than Medi-Cal coverage.

Mechanisms for expanding coverage would extend public programs currently limited to children and their parents to all adults and also utilize private insurance already available to some low income workers.

- **Medi-Cal and Healthy Families managed care coverage for low income adults.** This proposal would use the existing Medi-Cal and Healthy Families programs for low income adults eligible under the federal Medicaid waiver. In *Two Plan* counties such as Alameda, Santa Clara, San Bernardino, adults with incomes below the 133% poverty level would choose between the county Local Initiative and its commercial competitor. In *Geographic Managed Care* (GMC) counties such as Sacramento and San Diego, adults with incomes below the 133% poverty level would choose between the already contracting commercial managed care plans. In *County Organized Health System* (COHS) counties, such as Orange and San Mateo, adults with incomes below the poverty level would be eligible for the COHS. In *small counties* without mandatory Medi-Cal managed care such as Shasta or Merced, adults with incomes below the 133% poverty level would be eligible for fee for service Medi-Cal coverage. In all counties, adults with incomes above the 133% poverty level would be eligible for Healthy Families for the same choice of plans currently contracted to cover the Healthy Families children and parents.

- **Employment based coverage and access to purchasing pools for uninsured low wage workers and their families.** This proposal uses refundable tax and purchasing credits to increase the numbers of small employers offering and the rates of low wage workers accepting offered employment based coverage. We prefer that small employers use purchasing pools and they become a more efficient vehicle to increase coverage, but would not limit the subsidies to those employers using purchasing pools.

- **Purchasing pools, market reforms and improved access to employment based coverage for flex workers**. Flex workers (nearly half of uninsured workers) fall into job categories not typically offered health coverage by an employer. This proposal would set up a new structure for them to purchase coverage: purchasing pools, underwriting reforms and a tax subsidy. It would give them an option to purchase coverage through purchasing entities in the individual market or to use their refundable tax credit/voucher through group purchasing.

The ***financing mechanism*** for this proposal adds and shifts financial resources to maximize coverage for low income people.

- **Federal match for adults**. This proposal adds new federal funding for care to low income adults and allows California to access its unspent federal SCHIP allocation. It requires a federal Section 1115 Medicaid waiver to cover adults without Medicaid or SCHIP linkage. Oregon, Arizona, New York, Massachusetts and Tennessee already have such waivers. The waiver must be cost neutral--i.e. not cost the federal government more than it otherwise would have spent in the absence of a waiver. The federal government has approved such waivers from the states in conjunction with the implementation of managed care, prioritizing health benefits, consolidating and simplifying programs and transforming institutional subsidies into coverage. We recommend that California meet the cost neutrality test by implementing managed care for the exempt categories (disabled adults), consolidating and simplifying coverage and, to some extent, transforming Medi-Cal institutional subsidies into coverage.

  For California, Medicaid has a federal matching rate of 1/1 and SCHIP has a matching rate of 2/1 that is subject to an expenditure cap. California should seek a 1/1 match for adults below 133% of FPG and a 2/1 match for adults over the federal poverty level for expenditures up to the federal SCHIP spending cap for California. Thereafter, for any additional spending above the cap it should seek a 1/1 match.

- **County match for adults.** All counties currently provide care and coverage for uninsured adults with a mixture of state, federal and county funds that varies from county to county. As adults are enrolled by the state Medi-Cal and Healthy Families programs, the necessary matching funds should be transferred up to a cap. We suggest that the cap be the three year average of funds the county spent on the population covered by the state programs. The cap should grow based on the growth in the county health funding streams through realignment and Proposition 99.

- **State match for adults**. The state pays for care and coverage for uninsured adults with state general funds. State spending should be transferred into the new program as eligible individuals are enrolled. The state should also be responsible for the growth in program costs above the county spending cap.

- **Tax credits with incentives for employer and employee premium contributions.** This proposal uses refundable tax credits to create financial incentives for uninsuring small employers and uninsured individuals to create financial incentives to obtain coverage. The proposed tax credits subsidize some low income insured persons and employers who already offer coverage; some might discontinue coverage as a result of economic conditions but for the subsidy.

- **Decreased state tax revenues due to refundable tax credits, matched by increased employer and employee contributions.** A refundable tax credit is a cost

to the general fund, and the state needs to ensure that the tax credit approach not be more costly than expanding coverage using federal matching funds for public programs. In general, we suggest that the state refundable tax credits not exceed 50% of premium cost. Under the new federal Health Insurance Flexibility and Accountability (HIFA) guidelines, it appears possible to secure federal matching to subsidize employment based coverage for those uninsured with incomes below 200% FPG. Under SCHIP it is possible to secure 2/1 matching funds for the purchasing credit for uninsured working families who are offered but have not taken up coverage due to the cost.

Beneficiary and employer premium subsidies would be based on income and employment status, business size and workforce wages.

- **100% for low income adults below 133% of FPG enrolling in Medi-Cal.** 100% is the same formula used by the state Medi-Cal program for parents with incomes below 100% of FPG. We propose increasing this to 133%.

- **90% for low income adults above 133% of FPG enrolling in Healthy Families**. The 90% premium subsidy for adults enrolling in the Healthy Families program is the same subsidy available to children and parents already enrolled or proposed to be enrolled.

- **50% for small employers covering low wage employers**. A refundable tax credit is proposed for 50% of the premiums of low wage employers of small employers. This is the same pre-tax purchasing subsidy now available to high income wage earners. The target is low wage workers of employers of 200 or fewer employees with one third or more making less than twice the state's minimum wage ($12.50 an hour).

- **Phased out tax credit/voucher for flex and other uninsured workers.** A refundable tax credit/voucher is proposed for flex and other uninsured workers. The tax credit would be for roughly 80% of the premium for low income uninsured workers and then phase down and out as family income increases. The standard we recommend to qualify for the tax credit is when the employer does not offer coverage. The flex worker should be able to use the tax credit/voucher to purchase coverage in the group or individual market place.

- **Variable premium subsidy for low wage working families who are offered but did not take up employment based coverage.** This proposal uses the Healthy Families program to provide premium assistance to low wage working families who are offered but do not sign up for coverage in the work place. We would not use the tax credit mechanism because of the difficulty in targeting and administering the credit for low wage working families.

This proposal has expanded coverage as its cornerstone, with administrative simplification an integral feature and principal benefit.

- **Ends overlapping responsibility between state and counties for health coverage of the low income population.** Ending California's bifurcated system between the state and counties as to financial responsibility for the low income population will simplify program participation for patients, providers and federal, state and county administrators.

- **Simplifies state and county Medi-Cal and Healthy Families enrollment processes**. We propose to:
  - Draw a bright line (133% of FPG) between Medi-Cal and Healthy Families.
  - Consolidate all the different Medi-Cal categories for coverage of children, parents and families. The National Governors Association has identified changing federal law to allow states to define Medicaid eligibility by income level, without regard to arbitrary eligibility categories, as a key policy option to allow states to cover more low income uninsured persons.[108]
  - Eliminate all the special rules for counting and disregarding income and assets in favor of some basic simple and consistent rules for all the programs: All net income counts; no assets count; work income is subject to standard deductions for child care
  - Eliminate the distinctions in coverage between adults based on their levels of disability, disease or chronic illness.

- **Allows entire family to enroll in subsidized coverage either through the workplace or through public programs**. Under the current system a low wage working family's coverage may be split between public and private coverage and within public programs between three or four different programs. This proposal would allow the family to stay together in one plan, whether at the workplace or in a public program.

- **Together, these elements will improve and simplify financing and delivery of care to the uninsured.**
  - Persons with incomes below 133% of poverty eligible for Medi-Cal.
  - Persons with incomes up to 200% of FPG eligible for Healthy Families. Persons with Healthy Families eligibility may use the program to pay their employee premium contributions for coverage through the work place.
  - Small employers with more than one third of workforce earning less than twice the state minimum wage may access 50% premium subsidy through quarterly refundable tax credits.
  - Flex and other uninsured workers eligible for public programs up to 200% FPG and for private coverage with phased down premium subsidy up to individual income of $35,000 and family income of $70,000.
  - Eligible families with ineligible family members may buy the ineligibles into public coverage by paying the cost of public coverage for uncovered members.

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[108] Smith, V. (2002). **Making Medicaid Better: Options to allow States to continue to participate and to bring the program up to date in today's health care marketplace.** Washington, DC: National Governors Organization. Retrieved from the World Wide Web May 13, 2002: http://www.nga.org

Major ***federal and state statutory and regulatory changes*** are needed to implement this proposal.

- **Federal waiver to cover adults in Medi-Cal and Healthy Families**. California needs to secure an 1115 waiver to cover unlinked adults through Medi-Cal and Healthy Families, in addition to the Healthy Family parents covered under the recently approved SCHIP expansion waiver. The waiver must assure cost effectiveness (otherwise known as federal cost neutrality). The waivers approved to date in other states have achieved cost neutrality through managed care, prioritization of services, transmutation of other state, local and federal funding and other changes. For California to meet cost effectiveness it should propose to include the disabled in managed care; collapse a series of different federal, state and county programs into expanded managed care coverage; and, as needed, transform institutional safety net subsidies into coverage.

  The Bush Administration has to date indicated that it intends to encourage more state flexibility through its Section 1115 waivers under the Health Insurance Flexibility and Accountability (HIFA) standards, but with tight control on federal cost increases. The HIFA waivers may be able to cover the costs of the refundable tax credit/voucher for persons with incomes below 200% FPG. The waiver we are proposing shifts portions of Medi-Cal into the Healthy Families program.

- **State legislation to cover adults and set state and county financial participation requirements.** California needs to pass legislation authorizing coverage of adults through Medi-Cal and Healthy Families if federal financial participation is forthcoming. One contentious aspect of such legislation will be the respective proportions of state and county match.

  State legislation to enact tax credits for small employers, low wage workers and flex workers, co-ordinate with federal tax subsidies. California would need to pass legislation authorizing refundable tax credits for small employers, low wage workers and flex workers, and co-ordinate with federal subsidies. The purchasing credit authorized for low wage working families needs to be refined to make it workable for plans, purchasing pools, employers, employees and benefit program administrators. Tax credits need to be targeted to low wage small employers (our proposed definition of small is up to 200 employees and our definition of low wage is 1/3 of the workforce making less than twice the minimum wage -- $12.50 an hour). Our proposed definition of flex worker includes the classes of workers not offered coverage on the job. We phase out the subsidy so that it ends at $70,000 for families and $35,000 for individuals. Flex worker premium subsidies need to be coordinated with refundable tax credits being considered at the federal level. We are suggesting a tax subsidy of 50% of premium for low wage small employers and phased out premium subsidies for flex workers, starting at 80-90% of premiums. We suggest that tax subsidies be linked to and capped at a reasonable market price, for example the average of the lowest HIPC/PacAdvantage rates.

- **State legislation to enact underwriting reforms and purchasing pool for individual market.** California needs to pass legislation enacting underwriting reforms and purchasing pool(s) for the individual market. Tax subsidies will add significant new enrollment to the individual market. Those who purchase in the individual market need certain protections: assurance of the ability to purchase and retain coverage, clear and consistent prices that can be compared between plans and between benefit packages.

- **State and federal legislation expanding group purchasing opportunities for small employers, individuals and flex workers.** California and Congress need to pass legislation expanding group purchasing opportunities for small employers, individuals and flex workers. Group purchasing offers the potential (not yet completely realized) for administrative and benefit cost savings plus broader and more informed choices of plans. California needs to allow associations greater flexibility to form, to purchase and to negotiate price with health plans, and it needs to form, foster and incubate new group purchasing for individuals and flex workers. Congress needs to pass the legislation authorizing health marts, and exempt these entities from state benefit mandates, but not from state underwriting and marketing rules governing the small employer market.

A seamless system of care for low income Californians is not impossible to achieve, but it will require a sustained and focused effort. We believe the goal is both attainable and worthwhile.

Appendices/Attachments

8. List of persons providing information for this project
9. Federal Poverty Guidelines 2002
10. State Health Program Matrix (AHSRP/State Coverage Initiatives)
11. State Simplification Activities (Health Care Financing Administration)
12. State Simplification Summary Tables (CBPP)
13. 2001-02 California Legislation Related to State Health Program Integration
14. 2001 Policy Changes: Medi-Cal and Healthy Families Coverage for Low-Income Children, Youth, and Parents and "Medically Indigent Adults"