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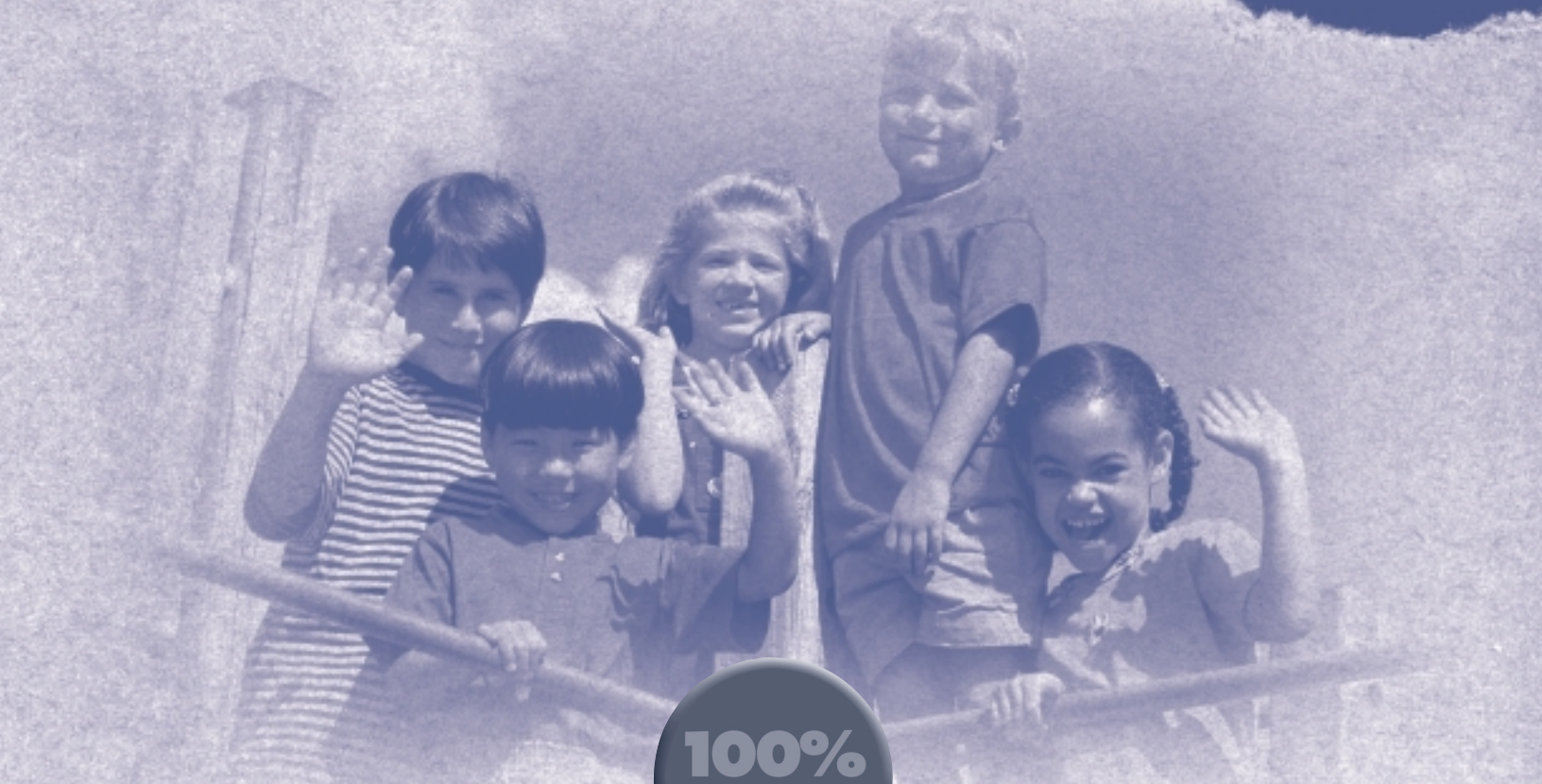
Children Falling Through the Health Insurance Cracks

Early Observations and Promising Strategies for Keeping Low-Income Children Covered by Medi-Cal & Healthy Families



100% CAMPAIGN

Health Insurance for Every California Child

Prepared by
The Children's Partnership *and*
Children Now

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The California Endowment

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Health Insurance for Every California Child

A publication of the 100% Campaign, a collaborative of Children Now, Children's Defense Fund, and The Children's Partnership

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Copies of the report may be obtained by calling The 100% Campaign headquarters at 510-763-2444 x122 or visiting the 100% Campaign Web site at www.100percentcampaign.org.

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Executive Summary

In an effort to provide uninsured children with health care, California and states across the nation have focused most of their attention over the past few years on finding uninsured children and enrolling them in Medicaid and their State Children's Health Insurance Program (SCHIP). They have had considerable success. Now, with millions of children newly enrolled in these public health insurance programs, we face our next major challenge: keeping them covered. While California and other states have begun efforts to ensure that children remain enrolled in the public health programs, a far more systematic and comprehensive approach is called for today. The problem of "Children Falling Through the Cracks" is denying hundreds of thousands of children the health care they need. The remedies are becoming clearer as states experiment with different approaches on this new frontier. Many remedies are surprisingly intuitive and relatively easy to put in place.

California's insurance programs have already begun to make effective strides in keeping children covered by adopting important policies and exploring areas for further improvement. We offer this analysis in order to assist the state in its efforts. This report provides a comprehensive examination of what is happening, and what strategies can work to keep children covered in California's insurance programs, Medi-Cal and Healthy Families. We sought several varying perspectives — all grounded in observations from the field. We analyzed the experiences of other states as well as those of California community-based organizations and health plans that assist families with enrolling and continuing coverage. The central conclusion is that ensuring that children do not fall through the cracks of coverage once they enroll in Medi-Cal and Healthy Families is the next crucial frontier in strengthening children's health in California. It should become a top public policy priority and should be addressed by the public, private, and nonprofit sectors.

More specifically, this report:

- Describes California's public insurance programs for children – Medi-Cal and Healthy Families – and their record in keeping children covered;
- Identifies the critical junctures in the Healthy Families and Medi-Cal process at which children are losing coverage; and
- Recommends ways in which California's insurance programs and policymakers can restructure these junctures in order to keep more children insured.

While the recommendations are directed primarily at California policymakers, our findings also document the crucial roles of other key players: community-based organizations and Certified Application Assistants (CAAs), health plans, and counties. The 100% Campaign has developed a supplemental document to this report, "Helping Children Keep Health Insurance Coverage: The Important Role of Local Partners," to highlight promising strategies pursued by these partners.

WHY CONTINUOUS COVERAGE IS IMPORTANT

Compare health insurance to school attendance: when parents prepare their children for the first day of school, they understand that kindergarten enrollment is only the beginning and that education involves a continuum of learning. Similarly, children benefit from health insurance to the extent that it is there to cover their needs throughout their childhood and adolescence. Continuous coverage means:

1. Children Are Healthier. Children require regularly scheduled checkups, screenings and immunizations for healthy childhood development. Research shows that children who have ongoing health insurance have better access to this type of continuous care and are healthier.

2. Taxpayer Dollars Are Put to Better Use. Continuous coverage also avoids wasting state and county resources. When an eligible child is mistakenly dropped from coverage, a family has to reapply to get their child's coverage back, creating additional hassles for the family and greater expense for taxpayers. It costs about $139 to enroll or re-enroll a child in Medi-Cal, while it costs about $22.50 monthly to "maintain" a case. So, for example, if a child is erroneously dropped from Medi-Cal coverage five months after enrolling, the cost of monthly maintenance and re-enrollment is $252 during that eight-month period, compared to $180 if the child had stayed enrolled continuously.

3. Quality of Care Is Improved. Disruptive coverage creates difficulties for managing a child's health care over time. Specifically, health plans, as part of their contractual relationship with insurance programs, are responsible for certain performance and health outcome results for the children they cover. Health plans have found it difficult to manage the care of children who do not remain covered continuously.

HOW MEDI-CAL AND HEALTHY FAMILIES WORK IN CALIFORNIA

Medi-Cal and Healthy Families (combined) provide health coverage to over 3.5 million children. In addition, two-thirds of California's uninsured children are eligible for the programs. Medi-Cal and Healthy Families are designed to serve children and families with low incomes and, as a result, impose specific eligibility and documentation requirements in order for children to enroll and to keep their coverage.

Enrollment and Renewal Process

Families apply for Medi-Cal or Healthy Families by completing a mail-in application and submitting documentation of their income, assets (for Medi-Cal), residency, immigration status, and in the case of Healthy Families, a birth certificate to verify citizenship. Once children are enrolled, their families must comply with program rules in order to retain coverage. For example, families must pay monthly premiums to keep Healthy Families coverage, and once a year both Medi-Cal and Healthy Families require families to renew their coverage by submitting current information on income and residency and, in the case of Medi-Cal families, assets.

The Vital Role of Partners

The state relies heavily on counties, community groups and health plans to enroll and maintain children in Medi-Cal and Healthy Families.

- Counties: California's 58 counties have primary responsibility for determining eligibility for Medi-Cal. (The state provides counties with funds to perform these functions). Counties, through Medi-Cal eligibility workers (including outstationed workers in the community), assist families in completing Medi-Cal applications, and are responsible for making all final Medi-Cal eligibility determinations for county residents.
- Community Groups: Families can receive assistance in the community with completing their Healthy Families/Medi-Cal mail-in applications and renewal forms. Currently 3,200 community organizations and 22,000 community members statewide provide application assistance. Until recently, the state provided funds to these Certified Application Assistants (CAAs) either through community or school outreach contracts or on a per enrollment fee basis – $50 for Medi-Cal and Healthy Families enrollments. Unfortunately, recent state budget reductions have eliminated the community and school outreach contracts. The state also provides $25 to the assistants to help families with Healthy Families renewals, but not for Medi-Cal.
- Health Plans: While there are certain limitations to their outreach and renewal activities, health plans that serve Medi-Cal and Healthy Families children also have a crucial role to play in connecting children to ongoing care and coverage. Plans have their own retention strategies and are obviously in a unique position to educate families on how to access care through their network.

Other Health Insurance Programs

While Medi-Cal and Healthy Families are available for the majority of uninsured children, about 340,000 children remain uninsured but ineligible for these programs, either because their families have slightly too much income to qualify or because of their immigration status. In California, efforts have been under way by counties to develop health insurance programs for children who are not eligible for Healthy Families or Medi-Cal. These "county initiatives" generally provide comprehensive coverage for children with family incomes below 300 percent of the federal poverty level (FPL), regardless of immigration status. Counties are attempting to connect their programs with Medi-Cal and Healthy Families to ensure a coordinated and seamless enrollment and renewal process, particularly for "split" families in which some children are eligible for a state program while others are eligible for the county insurance program.

CHILDREN LOSING COVERAGE: WHAT WE KNOW TODAY

Although available data systems do not permit us to precisely know what is happening to children's coverage, we do know that a significant number of children lose their health insurance coverage each year. Any insurance program can expect a certain amount of turnover and, in fact, some of the reasons why children would drop coverage are warranted. Some children will lose coverage when they no longer qualify, either because of age or family income. Still others may be switching to other insurance, such as that offered through a parent's employer. What is of particular concern, however, is the group of children who are still eligible but lose Medi-Cal or Healthy Families coverage unnecessarily. Here is what we know about the aggregate loss in coverage and, more importantly, whether these children are still eligible and need coverage.

Healthy Families

- Overall, about 40 percent of children enrolled in Healthy Families lost their coverage after a year — or 60 percent "retained" coverage — based on an analysis by the Healthy Families program. Over the last year, that amounted to nearly 171,000 children losing Healthy Families coverage compared to the 563,000 covered as of June 2002.
- At least 40 of the children losing Healthy Families coverage were still eligible, based on a survey by the National Academy for State Health Policy (NASHP). This estimate is likely even higher because the survey assumes that children are in fact not eligible based on whether their parents *perceived* their children as ineligible.
- According to the NASHP survey, looking at just those families whose children were likely still *eligible*, almost three-quarters (72%) had not intended to leave Healthy Families. In fact, some families did not know their children had lost coverage. Still other families did not know why.

Medi-Cal

- About 36 percent of children enrolled in Medi-Cal lose their coverage after a year— or 64 percent "retained" coverage — based on an analysis by the Department of Health Services.
- Medi-Cal information is not available to indicate the extent to which the children losing Medi-Cal coverage are still eligible.
- A survey of families covered or formerly covered by Medi-Cal reported that 35 percent were dropped by mistake and 18 percent of those who lost coverage did not know why.

It is difficult to compare California's retention rates to other states' Medicaid and SCHIP programs because there is limited data available. However, based on some initial research on SCHIP rates in a sampling of states, California's Healthy Families program seems to fare better than average.

Measuring and Tracking Retention: Where We Are and Where We Need to Be

Adequately tracking who is losing coverage and why is essential for monitoring whether programs are successfully keeping eligible children covered and identifying which points in the process place children at particular risk of losing coverage. While Healthy Families is continuing to build its capacity to track and monitor coverage, Medi-Cal's data and reporting capacity is particularly sparse. The report outlines some key tracking measures that would assist the state in appropriately monitoring and helping ensure children's continued coverage.

FIVE CRITICAL JUNCTURES: KEEPING CHILDREN ENROLLED

California's insurance programs have adopted important policies in an effort to keep eligible children enrolled. However, certain design features of insurance in general still pose a risk that can cause children to unnecessarily lose coverage. California's insurance programs may be more susceptible because the state operates two separate programs. Based on available data and interviews with various constituencies, we identified five places along the enrollment and renewal process of California's programs that put eligible children at the greatest risk of losing coverage. An assessment of these junctures in the health insurance process is as follows.

1. Coordinating and transitioning between insurance programs too often fails for children: Two separate state insurance programs create particular challenges for "split" families, those with some children covered by Medi-Cal and others covered by Healthy Families. In particular, these families must navigate two different renewal processes. Moreover, transferring children between insurance programs is less than seamless when attempting to coordinate a single state-operated system (Healthy Families) with a county-based eligibility system operated by each of the 58 counties (Medi-Cal).

2. Renewals are more complex than they need to be: The state has made efforts to simplify the renewal processes, most notably, by offering 12 months of continued coverage for children. As in most states, however, the renewal process is a significant factor in causing children to lose coverage, including children who are still eligible. In California, completing annual renewals are often as involved and complex as the initial application. California's Medi-Cal and Healthy Families rules require stricter eligibility verifications than are required by federal guidelines, often at the expense of maintaining coverage for eligible children. Other states' insurance programs have balanced program integrity with the benefit of keeping eligible children covered.

3. Premium payments are a common reason children lose needed coverage: While Healthy Families premiums may be affordable, periods of financial hardship can make even modest premiums difficult to pay for low-income families. Other families may be able to afford the payment but, for several reasons, payments are not submitted: some are not aware of easier methods for making payments, they do not understand, or never received, a billing statement, or, in a significant number of cases, the program has lost their payments. Healthy Families offers helpful discounts for easy payment methods. However, the program offers little in the way of leniency for missed payments.

4. Communication with families can be made more effective: Both Medi-Cal and Healthy Families rely on written, mailed correspondence to notify families about renewal requirements (and, for Healthy Families, billing statements for premiums). Some children lose coverage because families did not receive, or understand, the notices.

5. Use of insurance services may enhance chances of renewal: Families may be more likely to jump through the programs' hurdles and renew their children's coverage if they have benefited from the insurance coverage by receiving care. Children who remain insured are more likely, albeit slightly, to have received care compared to children who lost coverage. While anecdotal observations suggest that a correlation exists between service use and coverage retention, further research is needed.

RECOMMENDATIONS FOR KEEPING CHILDREN COVERED

Just as targeted strategies have helped to keep children in school and learning, there is every reason to believe that a concerted effort can also succeed at keeping eligible children enrolled in health insurance programs. This report offers concrete recommendations for what policy-makers and our state programs can do to improve California's retention record for children.

We make two kinds of recommendations: first, we suggest steps that build a basic foundation in California to promote retention through data and tracking systems, research, and the involvement of crucial partners; second, we take each of the five critical juncture points where children now fall through the cracks and suggest changes in program operations to close up these cracks.

Many of the recommendations can be implemented with straightforward administrative changes. Others require policy changes that can be implemented statewide or tested out through pilot projects. All are mindful of striking that important balance between simplifying the process for families while maintaining program integrity. Following are highlights; further details and additional recommendations are in Section 5 of the report.

Building the Foundation: Tracking, Research & Partners

- Implement a combined tracking system to report specific retention information.
- Conduct exit surveys of children losing coverage to answer retention research questions (e.g., To what extent does preventive care affect the likelihood of continued coverage?).
- Support and leverage the unique role of community partners to help keep children covered, starting with reinstating funding for community- and school-based outreach contracts.
- Use state funding to incentivize county efforts to help families maintain Medi-Cal coverage.
- Coordinate Medi-Cal and Healthy Families with county health insurance programs.

Sealing Up the Cracks: The Five Critical Junctures

1 Coordinating Among Insurance Programs

- Synchronize Medi-Cal and Healthy Families renewals for split families through “express,” or “rolling,” renewals.
- Coordinate Medi-Cal/Healthy Families renewals with other public programs by allowing “express,” or “rolling,” renewals.
- Automatically enroll children transferring between Medi-Cal and Healthy Families to create a true seamless bridge.
- Create a bridge for Medi-Cal and Healthy Families children transferring to county insurance programs.
- Make all children in a family, regardless of age, eligible for the same health insurance program (i.e., cover under Medi-Cal all children in families with incomes below 133% of FPL).

2 Simplifying the Renewal Process

- Adopt "fast track" renewals for Medi-Cal and Healthy Families children by conducting "ex parte" reviews prior to sending pre-printed renewal forms to families, requesting only their self-declaration of changes to the information provided. If there are no changes, the family submits nothing (in the purest form of "fast track"), signs a postcard or phones in confirmation.
- Allow families to self-declare income at renewal with sample post-eligibility checks.
- Eliminate the assets test for Medi-Cal families (at renewal at the very least).

3 Making Premiums Easier to Pay

- Rectify the apparent Healthy Families administrative errors in lost payments.
- Offer some leniency when families in Healthy Families face short periods of financial difficulty, such as offering a one-time hardship fund or a payment plan to repay missed payments.
- Notify families about possible eligibility for lower premiums and no-cost Medi-Cal when families fail to pay Healthy Families premiums.
- Simplify and incentivize the payment option to deduct family premiums from a parent's paycheck.

4 Communicating Effectively With Families

- Educate families up front, and often, that they must renew their children's coverage every year. Do so through phone calls, outreach messages and regular correspondence.
- Color code the important notices that require a family's immediate response.
- Keep addresses up to date and ensure notices are in the appropriate language to ensure timely and appropriate delivery of correspondence.

5 Encouraging the Use of Services Once Insured

- Monitor and report children's use of health services when covered.
- Promote preventive care by providing premium discounts for using preventive care.
- Develop a coordinated listing of health plans that are available to "split" families — those families with children in both Medi-Cal and Healthy Families.

CONCLUSION

Many promising strategies are already under development or being implemented in California and in other states. But this work to keep children covered is still new and largely underdeveloped. We hope that the data and observations compiled in this report can provide a useful framework with which to build a more comprehensive strategic plan for providing health insurance coverage that children can count on. It is our vision that within the next five years insurance program retention becomes as continuous, reliable, and easy as staying in school. Both are essential ingredients for children's healthy development.

Section 1

INTRODUCTION

When a parent enrolls a child into the first day of school, they do so believing that he or she will stay in school for the entire school year, and will be easily re-enrolled into the next grade every year thereafter. Parents understand that education involves a continuum of learning — that children must attend school every day over many years to receive the full benefits of an education. Similarly, children benefit from health insurance to the extent that they have continuous coverage throughout their childhood and adolescence.

In 1997, the nation made a commitment to provide its children with health insurance. The creation of the State Children's Health Insurance Program (SCHIP), coupled with the Medicaid program, made it possible for over two-thirds of America's uninsured children at the time to receive health insurance.[1] Over the past few years, states across the nation have focused on finding these uninsured children and enrolling them in the programs. California has been highly successful in this regard; Medi-Cal (California's Medicaid insurance program) covered 3 million children and Healthy Families (California's separate SCHIP) covered approximately 563,000 children as of June 2002.[2,3]

But it is not enough to simply enroll the child. Just as children need to stay in school to learn, the benefits of health insurance are only truly achieved if children remain covered over a continuous period. A child who enrolls in an insurance program in December but loses coverage in May might miss an important immunization or annual dental exam if she has no insurance to cover that care.

In California, as in other states, community groups, advocates, and policymakers have begun to recognize that maintaining coverage for children is as important as their initial enrollment and have begun to balance efforts to enroll children with efforts to ensure continued coverage (commonly referred to as "retention"). Yet, defining retention and developing a strategy to address it is not a straightforward task. Instead, understanding whether and why children are falling through the cracks of health insurance requires an examination not just of disenrollment data and retention rates, but of the motivation behind it. Are the children dropping coverage still eligible for the programs? Are they moving into other insurance or becoming uninsured? If a child drops coverage because of a missed premium, was it the parents' way of intentionally disenrolling or was it due to the family's financial circumstances or the program's administrative problems?

These are just a few of the questions that must be explored. In addition, addressing the problem of retention does not lend itself to one or two distinct strategies. The different solutions must connect to the places along the coverage process where children are at risk for losing coverage, such as annual renewal, important correspondence from the state, and coordination between Medi-Cal and Healthy Families. Strategies also rely on leveraging the assistance of the various community partners to whom families regularly turn to keep their children covered.

This report addresses these issues to broaden our understanding of retention in California's insurance programs. While California is exhibiting better retention rates than other states, this report documents early evidence that suggests a significant portion of children and families are unnecessarily falling through the cracks of the health insurance programs. In addition, it identifies the five critical junctures in the insurance programs' process where children are at potential risk of losing coverage. In an effort to assist California's programs in keeping children covered, this report provides a road map to how the state can improve systems and processes to keep children from falling through the cracks of health coverage. Just as targeted strategies have helped to keep children in school and learning, there is every reason to believe that a concerted effort can also succeed in keeping eligible children enrolled in health insurance programs.[4]

WHY CONTINUOUS COVERAGE IS IMPORTANT

Enrolling children into Medi-Cal and Healthy Families, only to drop them out the back door a few months later, does not fulfill the goal of covering children. If children are falling through the cracks of coverage once they enroll, we will lose out on the programs' ultimate aim: to wisely invest state dollars in quality and preventive health care for California's children so they can become healthy, productive adults. Outlined below are the three primary reasons why continuous coverage is important.

> *"Once they're enrolled, we do whatever we can to make sure those kids stay covered. Otherwise, what's the point?"*
>
> *– Certified Application Assistant*

Children Are Healthier

Children require regularly scheduled checkups, screenings, and immunizations for healthy childhood development. In addition to this routine preventive care, children benefit from receiving guaranteed treatment for unexpected events — the ear infection at age 2; the allergic reaction to a bee sting at age 10; the baseball injury at age 14.

Research shows that children who have ongoing health insurance have better access to this type of continuous care and are healthier.[5] Indeed, gaps in insurance coverage have been associated with the lack of a regular source of care.[6] Children who do not have a regular source of coverage are less likely to receive timely immunizations and are at a higher risk of using the emergency room and requiring hospitalization.[7] In fact, those who experience gaps in coverage have the same difficulties in accessing care and paying bills as those who are continuously uninsured.[8] Consider again the analogy to school attendance: missing even a month or two of school would significantly disrupt a child's learning, as prolonged absences make it difficult to catch up with the rest of the class. Similarly, even short gaps in health care can jeopardize a child's development.

In fact, children's learning is directly affected by whether a child is healthy enough to attend school. Lack of coverage can have a negative impact on the educational status of children, as it is associated with a higher number of school days missed by students.[9]

Taxpayer Dollars Are Put to Better Use

In addition to promoting better health, continuous coverage avoids wasting state and county resources.[10] When an eligible child is dropped from coverage, a family often has to reapply to get their child's coverage back. Re-enrollment creates additional hassles for the family and requires additional processing for program staff, wasting resources that could be better invested in keeping children covered and in actual benefits. As California faces budget deficits, improving retention and using administrative resources efficiently are of particular concern.

Here is an example of wasted resources: Medi-Cal enrollment costs about $139, while maintaining a case costs about $22.50 monthly.[11] Time and resources are particularly wasted if children "churn" on and off coverage over short intervals. For example, if a child loses Medi-Cal coverage five months after enrolling, only to re-enroll three months later, it would cost $252 in that eight-month period (monthly maintenance and re-enrollment), compared to $180 if the child had been continuously covered over that period, a $72 difference. (Admittedly, the cost of maintaining a case over time is greater than if the child was not enrolled at all or only covered for a short period; however, curtailing coverage to reduce costs defeats the entire purpose of the insurance program).

Quality of Care Is Improved

Finally, disruptive coverage creates difficulties in managing a child's health care over time. Specifically, health plans, as part of their contractual relationship with insurance programs, are responsible for certain performance and health outcomes for the children they cover. Health plans have found it difficult to manage the care of a child who must leave the plan because she is dropped from coverage. For example, health plans are less effective in their efforts to ensure that children are receiving all of their scheduled immunizations. Not only is the child denied the advantage of the health plan's outreach efforts, but also the disrupted coverage may distort the health plan's performance in meeting its immunization goals.

ABOUT THIS REPORT

The 100% Campaign's mission is to ensure that all of California's children obtain and retain the health coverage they need to grow up strong and healthy. In order for children to have health insurance coverage that they and their parents can count on, The 100% Campaign supports state policymakers and their partners in finding ways to keep all eligible children covered through Medi-Cal and Healthy Families insurance. As a result, The 100% Campaign set out to answer the following questions:

- What is currently known about why children drop coverage?
- What policies and practices are in place in the California insurance programs to increase children's likelihood of maintaining their coverage, and how successful are these policies?
- At what critical places in the programs' processes are children at risk of losing coverage?
- What program design strategies show promise in keeping children covered?

In order to answer these questions, we examined various sources of information about health insurance retention. We specifically sought multiple perspectives to draw a full picture of the situation families confront when covering their children; we solicited the experiences of community groups and health plans throughout California that assist families at the ground level to enroll in, and stay covered under, Medi-Cal and Healthy Families. In addition, we examined other states' insurance program policies and experiences. (See Appendix B for a more detailed review of the methodology.)

We begin the report with an overview of Medi-Cal and Healthy Families enrollment and renewal processes. Next we review and analyze the data available on retention in California's Medi-Cal and Healthy Families programs to surmise the extent to which children are losing coverage, and most importantly, those children who are still eligible yet become uninsured.

Then, through interviews and a review of literature, we identify elements or target areas that affect children's continued enrollment. For each target area, we highlight key findings and recommendations for policymakers to consider as promising strategies to keep eligible children covered over time. The report also suggests elements for building a foundation for retention strategies — namely demonstration pilots, tracking, and research — to quantify and identify best practices for keeping children covered. While most of the recommendations are directed toward California's insurance programs, they can also provide a general blueprint for other states' and counties' insurance programs.

While the target areas and recommendations are directed primarily toward California policymakers, and policy changes that they might implement to improve the Medi-Cal and Healthy Families programs, this report also recognizes the important roles of other key players: community-based organizations and Certified Application Assistants (CAAs), health plans, and counties, particularly those with their own health insurance initiatives. (For more details on the activities of some of these partners, we will soon be releasing a supplemental report, "Helping Children Keep Health Insurance Coverage: The Important Role of Local Partners.")

Section 2

HOW MEDI-CAL AND HEALTHY FAMILIES WORK IN CALIFORNIA

Two thirds (66%) of California's uninsured children are eligible for California's Medicaid and State Children's Health Insurance Program (SCHIP), called Medi-Cal and Healthy Families.[12] Both programs are designed to serve children and families with low incomes and, as a result, impose specific eligibility and documentation requirements in order for children to enroll and to keep their coverage (See Table 1).

Table 1. Medi-Cal and Healthy Families Eligibility Requirements

Requirement	Medi-Cal for Children and Parents (poverty level programs)		Healthy Families	
	Eligibility	Documentation	Eligibility	Documentation
Income	• Pregnant women and infants: up to 200% FPL • Children ages1-6: up to 133% FPL • Parents and children ages 6-18: up to 100% FPL	Pay stubs, tax filings, or affidavits (in certain circumstances)	• Infants: 201% to 250% FPL • Children ages 1-5: 134% to 250% FPL • Children ages 6-18: 101% to 250% FPL	Pay stubs, tax filings, or affidavits (in certain circumstances)
Assets	For families <$3,000	Bank and stock statements, property and car value	N/A	N/A
Age	Birth to 18*	None	Birth to 18	None
Citizen or Qualified Immigrant	Both**	Citizen: Social Security number Qualified immigrant: proof of immigration status	Both	Citizen: Birth certificate Qualified immigrant: proof of immigration status
CA Resident	Yes	Yes (Also met if proof of income from CA.)	Yes	Yes (Also met if proof of income from CA)
Uninsured	N/A	N/A	No employer coverage in prior three months	None

*Up to age 21 for children leaving foster care, children who are medically indigent or medically needy, or for certain services covered under minor consent.
**Undocumented families are eligible for emergency or limited scope Medi-Cal benefits.

THE ENROLLMENT AND RENEWAL PROCESS

Both Healthy Families and Medi-Cal have made significant strides in simplifying the program rules for families. However, families enrolling in Medi-Cal and Healthy Families still must complete multiple complicated application questions and submit several documents to verify their answers. Families apply for Medi-Cal or Healthy Families by completing a mail-in application and submitting documentation of income, assets (for Medi-Cal), residency, immigration status, and, in the case of Healthy Families, a birth certificate to verify citizenship.

Once children are enrolled, their families must comply with program rules in order to retain coverage. Table 2 outlines the general process families must follow, highlighting the points of potential risk along the way for both programs. For example, similar to some insurance offered by employers, families must pay monthly premiums to keep Healthy Families coverage; if

Table 2. Critical Steps in Keeping Insurance Program Coverage

PROCESS	POINTS OF POTENTIAL RISK OF LOSING COVERAGE	
	Healthy Families (HF)	Medi-Cal (MC)
1. Child enrolls in coverage.		
2. Family receives welcome letter and health plan information.	The chosen health plan may not have their family doctor.	The chosen or default plan may not have their family doctor.
3. Family must pay monthly premiums.	If payment not received within two months, the child loses coverage.	N/A
4. Family must re-enroll annually and receives annual renewal packet.	If family does not know to renew coverage or does not receive the renewal packet, they will not know they need to respond to renew, resulting in their child losing coverage.	
5. If renewal form is completed on time: a) Child is re-enrolled if eligible; b) Child covered by HF "bridge" for two months while forms sent to county for enrollment, if no longer eligible for HF. c) Child covered by MC "bridge" for one month while forms sent to HF for enrollment, if no longer eligible for MC; or d) Child loses coverage if ineligible.	For bridge program (b): HF must successfully transfer renewal forms and county must find child Medi-Cal eligible, or no coverage after two-month bridge. Family must pay HF premium or lose HF bridge coverage.	For bridge program (c): County must successfully transfer renewal forms and HF must find child eligible or no coverage after one-month bridge.
6. If no documentation submitted to verify income information on renewal forms: a) HF/MC contacts family (may call) b) MC checks for other state information on the family to verify renewal information before following up with family.* c) Child loses coverage without verification.	Without verification within two months of anniversary date, child loses coverage, even if eligible. Must reapply. No check of other state information to verify renewal information.	If information check does not verify renewal information, child loses coverage, even if eligible.*

* State guidelines on annual renewal in Medi-Cal are currently under review by the state.

premiums are not paid, the child will lose Healthy Families coverage. Both Medi-Cal and Healthy Families offer 12 months of continued coverage for children even if a family's income changes within the year. As a result, families renew their coverage once a year (compared to more frequent renewals in other states). Families renew coverage by submitting up-to-date information on income and residency and in the case of Medi-Cal, assets. Children lose coverage if the programs do not receive the renewal forms back from their families (with complete verification) or if

they are no longer eligible due to income or age. By contrast, families who are covered by insurance offered at work do not have to re-enroll every year. Once they sign up, their coverage continues.

The state offers a "bridge program" for those children who move from one insurance program to the other.[13] If at renewal a family's income is found to have changed and a Healthy Families child is now eligible for Medi-Cal, the child will continue Healthy Families coverage for two months while the county processes the child's Medi-Cal enrollment. It works the same in the opposite direction, except the bridge from Medi-Cal to Healthy Families was recently limited by the Governor to one month. Healthy Families and Medi-Cal staff must receive and process the transferred application before the child can transfer coverage. The family, if originally in Healthy Families, must also continue to pay premiums. If the application was never forwarded, was lost during the transfer, or the family fails to pay the premiums, the child will lose coverage.

Appendices C and D provide a detailed outline of the Healthy Families and Medi-Cal rules and procedures for continuing coverage.

THE VITAL ROLE OF PARTNERS

The state relies heavily on the counties, community groups, and health plans to enroll and maintain children in its health insurance programs. In fact, each of California's 58 counties has primary responsibility (using state-allocated funds) to administer their Medi-Cal programs. Counties, through Medi-Cal eligibility workers, assist families in completing Medi-Cal applications, including outstationed workers in the community, and are responsible for making all final Medi-Cal eligibility determinations for its county residents. However, while they may forward a child's application to the Healthy Families program, county workers currently are not able to directly enroll children into Healthy Families. (The different administering systems are described further in Section 4 under Coordinating Among Insurance Programs.)

In addition, families can receive assistance in the community with completing their mail-in application and renewal forms. Currently, 3,200 community organizations and 22,000 community members provide application assistance throughout the state.[14] The state trains and certifies Certified Application Assistants (CAAs), which can include assistants at schools, health care providers, faith-based organizations, county agencies, nutritional programs (such as the Women, Infants, and Children (WIC) program), and day care centers. The state provides CAAs with $50 for each family enrollment with which they assisted. The state also provides incentives to the assistants to help families with renewals, paying $25 for Healthy Families renewals. However, assistants do not receive this reimbursement for assisting with Medi-Cal renewals.

Until recently, the state also contracted with selected community or school organizations to conduct community-specific outreach and retention strategies. Unfortunately, recent state budget reductions have eliminated the community and school outreach contracts, which will likely weaken the ability of these communities to assist families in enrolling and in continuing their coverage.

Health plans that serve Medi-Cal and Healthy Families children also play a crucial role in health insurance program application and renewal processes.[15] While there are certain restrictions on their outreach and renewal activities, plans have the ability to publicize Medi-Cal/Healthy Families and often participate in community enrollment fairs. In addition, because of the direct, ongoing contact with the families they serve, health plans can play an important role in contacting families at renewal.

For more information on activities of some of these partners, we will soon be releasing a supplemental report, "Helping Children Keep Health Insurance Coverage: The Important Role of Local Partners."

OTHER HEALTH INSURANCE PROGRAMS

While Medi-Cal and Healthy Families are available for the majority of uninsured children, a third of uninsured California children — 340,000 — are ineligible for the programs.[16] In California, some health plans and private foundations have created regional health insurance programs for children in certain areas of the state. In addition, efforts have been under way by counties to develop health insurance programs for children who are not eligible for Healthy Families or Medi-Cal, either because their family income is too high to qualify or because of their immigration status. "County initiatives" generally provide comprehensive coverage for children with family incomes below 300 percent of the federal poverty level (FPL) regardless of immigration status. These county initiatives usually cover children up to age 18, whereas other programs cover children only up to age 6. Some initiatives include San Francisco's Healthy Kids, Contra Costa's Basic Health Plan, and Santa Clara's Healthy Kids; each provide low-cost comprehensive medical and dental coverage, and in some cases, cover vision, mental health and substance abuse treatment, and prescription drugs for children living in those counties.

As they implement these programs, counties are attempting to connect them closely with Medi-Cal and Healthy Families to ensure a coordinated, seamless enrollment and renewal process. This is particularly important in split families where one child may be eligible for Medi-Cal and the other for the county initiative. In addition, some of these initiatives have developed, or are developing, streamlined enrollment and renewal processes. For example, Santa Clara's county initiative — Healthy Kids — provides two months of Healthy Kids bridge coverage into Healthy Families for those children no longer eligible for the county initiative due to a drop in family income. For descriptions of some promising retention strategies by current county initiative programs, we will soon be releasing a supplemental report, "Helping Children Keep Health Insurance Coverage: The Important Role of Local Partners."

Section 3

CHILDREN LOSING COVERAGE: WHAT WE KNOW TODAY

Any insurance program can expect a certain amount of turnover; in fact, some of the reasons why children would drop coverage are warranted. Some children will disenroll from Medi-Cal and Healthy Families when they no longer qualify, either because of age or family income. Other children, even if still eligible for Medi-Cal or Healthy Families, may be switching to other insurance, such as that offered through a parent's employer.

The problem occurs, however, if children who are still eligible for Medi-Cal and Healthy Families lose coverage unnecessarily. In this report, we examined the extent to which this group exists in California. We reviewed the enrollment data and reports available on the Healthy Families and Medi-Cal programs. We also reviewed research available on California. The most predominant sources were a survey conducted for the National Academy of State Health Policy (NASHP) about children losing State Children's Health Insurance Program (SCHIP) coverage and a Medi-Cal Policy Institute (MCPI) report on families and children's coverage after they leave the Temporary Assistance for Needy Families (TANF; cash assistance) program.[17,18]

While the available data are limited and do not provide precise information, especially for Medi-Cal, the information does provide a small window into the world of children dropping coverage. First, the data show that a large number of children are losing Medi-Cal and Healthy Families coverage. Some data does show that a significant share of those children losing coverage are still eligible. The data also indicate that *eligible* children losing coverage are becoming uninsured. Finally, surveys tell us that the primary reasons eligible children are losing coverage are because of administrative problems, non-payment of premiums, or renewal information not received. These data, coupled with the interviews we conducted with community-based groups that assist families in enrolling in Medi-Cal and Healthy Families, confirm that large numbers of children are losing coverage unnecessarily.

Table 3. Coverage & Retention of Children in Medi-Cal and Healthy Families

	Medi-Cal	Healthy Families
Total children covered*	3.02 million	563,000
Children who lost coverage in a year**	Not available	171,000
Retention Rate***	64%	60%

Source: MRMIB Reporting Data, DHS Medi-Cal Enrollment Data and Continuing Eligibility Analysis.
*January 2002 for Medi-Cal and May 2002 for Healthy Families
**June 2001 through May 2002
***The percentage of children who are still covered 13 months after enrollment (reflecting the effect of annual renewal).

CHILDREN UNNECESSARILY LOSING COVERAGE

We start with the rudimentary question — how many children are leaving coverage within each of the programs? (See Table 3.) To answer whether children are *unnecessarily* losing coverage, we then attempt to discern the extent to which

these children were still eligible for Medi-Cal or Healthy Families. Finally, we look at whether these eligible children, who are in fact losing coverage unnecessarily, are becoming uninsured.

How Many Children Lose Insurance Coverage Within a Year?

Healthy Families. To understand the magnitude to which children are losing coverage, we reviewed state enrollment data on the pure number of children who lost coverage within a year's time. We found that about 171,000 children lost Healthy Families coverage in the last year (June 2001 to May 2002), compared to about 563,000 children enrolled as of June 2002.[19,20] About 40 percent of children covered by Healthy Families lost coverage within a year after enrolling, according to an analysis conducted by the program. Thus, Healthy Families has a "retention rate" — the proportion of children who remained covered a year from when they enrolled — of 60 percent.[21] In comparison, a report of four states (Florida, Kansas, New York, and Oregon) found 12-month SCHIP retention rates from 12 to 61 percent.[22] While California's Healthy Families retention rate appears better than this sampling of other states, an amount as high as 40 percent of children losing coverage a year after enrollment warrants further investigation into what extent that lost coverage was unnecessary.

Medi-Cal. About 36 percent of children lose Medi-Cal coverage within a year after enrolling, according to a recent analysis by the Department of Health Services, for a "retention rate" of 64 percent.[23] Continued Medi-Cal coverage can vary dramatically by county: A Medi-Cal Policy Institute report by the RAND Corporation tracked continued coverage of families who left cash aid: families (not reported for children-only) continued Medi-Cal coverage a year after leaving cash aid at rates ranging from 18 percent to 78 percent, depending on the county.[24]

Are the Children Who Lose Coverage Still Eligible for the Insurance Programs?

Healthy Families. Data suggest that a significant portion of children who lose Healthy Families coverage are still eligible, but to what extent is unclear. According to the Healthy Families program data, only 27 percent of children losing coverage did so because they were no longer eligible: either because they reached age 19 within the year (6%) or their annual renewal showed they were no longer eligible for other reasons, such as income or employer coverage (21%).[25]

Due to the limitations of the program data, we cannot infer that the remaining 73 percent of children who lost coverage were necessarily still eligible. It is unknown whether children who lost coverage for other reasons (e.g. not paying premiums or not completing renewal forms) did so because they were also ineligible. For example, some families may have stopped paying their premiums because they enrolled in employer coverage for their children, which would in effect render their child ineligible for Healthy Families.

However, additional data confirm that a portion of children losing Healthy Families coverage is still eligible. According to the NASHP survey, about 40 percent of Healthy Families children who lost coverage may have been eligible.[26] This estimate likely *underestimates* the percentage of children still eligible due to limitations in the methodology: it assumes that children are in fact not eligible based on whether their parents *perceived* their children as ineligible. However, many families may believe their children are not eligible when in fact they are. For example, an increase in family income might not necessarily mean that the child will no longer be eligible. Previous studies have shown that California families are confused about their eligibility:[27] Children are not enrolled because families do not believe they are eligible when in fact they are.

There is also some additional evidence that eligible children are losing coverage from the fact that some children re-enroll in Healthy Families shortly after dropping coverage. According to Healthy Families, 6 percent of children had lost their coverage within a year of enrollment but later returned. [28]

Medi-Cal. The program does not report, nor have families been surveyed, to assess the extent to which eligible children are losing coverage. However, another RAND Corporation report for the Medi-Cal Policy Institute of children and families found that about 51 percent of children lose Medi-Cal coverage a year after leaving cash aid.[29] It would appear that many of these children remained eligible because Medi-Cal eligibility rules provide for up 12 months of Transitional Medical Assistance even with increased income.

Are Eligible Children *Unnecessarily* Losing Coverage?

The information available to date suggests that many of the eligible children losing coverage are doing so unnecessarily. According to the NASHP survey, of the subgroup of eligible families, almost three-quarters (72%) of eligible families had not intended to leave Healthy Families.[30] In fact, some families did not know their children had lost coverage. Still other families did not know why.[31] Similarly, a survey of families covered or formerly covered by Medi-Cal reported that 35 percent were dropped by mistake and 18 percent of those who lost coverage did not know why.[32]

The NASHP survey found that mistakes in, and misinformation about, program rules significantly contributed to families not sufficiently complying with these rules.[33] Part of the confusion may be that Healthy Families and Medi-Cal insurance is unlike the health insurance that is offered through an employer; once a family signs up for a health plan provided at work, they usually do not need to do anything more to continue coverage. In contrast, Healthy Families and Medi-Cal are not automatically continued each year.

Table 4. Reasons Children Lose Healthy Families

Breakdown of Children Who Lose Healthy Families	
Non-Payment of Premium	24%
Renewal Information Not Received	23%
Renewal Information Received but Not Complete	17%
Citizenship/Immigration Documentation Not Received	1%
Applicant's Request	7%
Ineligible - Reached Age 19	6%
Ineligible - At Renewal	21%

Source: MRMIB Disenrollment Statistics, percentage of families over a 16-month period – February 2001 through June 2002.

In fact, the major reason children lose Healthy Families coverage is due to difficulties in complying with program requirements. Families either 1) did not submit premium payments on time (or payments were sent but lost by the program) or 2) did not complete the annual renewal forms. (See Table 4 for a breakdown of Managed Risk Medical Insurance Board (MRMIB) reported reasons.) NASHP survey results and other state research show similar reasons for children losing coverage in other states' insurance programs.[34]

Some eligible children may be dropping coverage for warranted reasons, the most compelling being that the child has obtained other coverage. However, data show that a large group of eligible children losing Medi-Cal or Healthy Families do not obtain other insurance, and instead become uninsured. The NASHP survey found that of the subgroup of children who were dropped but were probably still eligible (40% of the survey group of those losing coverage), almost two-thirds (61%) became uninsured.[35] MCPI reported that 28% of children leaving cash aid who lost Medi-Cal had become uninsured.[36]

MEASURING AND TRACKING RETENTION: WHERE WE ARE AND WHERE WE NEED TO BE

States, at varying degrees, track and regularly report on whether and why children are losing coverage. Federal agencies and foundations have begun to fund research to calculate SCHIP program "retention rates" — the percentage of children who continue their coverage after a certain period of time.[37] However, an eight-state survey by the Urban Institute for the U.S. Department of Health and Human Services found that varying capacities exist to report children's retention data, with most states only able to provide SCHIP data and not Medicaid data.[38]

While there is no gold standard to determine whether programs are successfully keeping eligible children covered, from our review of what is known about children's continued coverage in California and the research into other states' experiences, it is evident that more systematic data is needed to guide California's retention efforts effectively. Currently, the programs measure and track data as follows:

Healthy Families: Healthy Families monitors and reports monthly the number of children losing coverage (disenrollments) and reasons for dropping coverage. In addition, the program conducts surveys before children lose coverage to identify reasons why families have not yet paid premiums or have not yet returned renewal packets. Healthy Families has conducted a one-time analysis of retention rates.

With regard to the reported reasons for dropped coverage, the program categorizes these reasons into two general groups — "unavoidable" and "possibly avoidable" reasons — as a way to distinguish between reasons that may warrant policy or program changes from those that are beyond the control of the administering program (e.g. eligibility rules). (See Table 5.) While the goal is admirable, the categories and reasons themselves may be misleading. For example, under the "unavoidable" category, if the reason for disenrollment is "citizenship or immigration documentation required," that problem could be avoided if the program would simply allow families to self-declare citizenship, as other states do, rather than require a birth certificate.[39] A better distinction would be "likely eligible" and "likely ineligible."

Table 5. Healthy Families Program's Categories of Disenrollment Reasons

Unavoidable Reasons	Possibly Avoidable Reasons
Applicant request	Non-payment of premium
Citizenship and immigration documentation not provided	Annual renewal information not received
Income too high	Annual renewal information not complete
Income too low	
Obtained other coverage	
Obtained Medi-Cal coverage	
Age out	

Unfortunately, Healthy Families does not track renewal rates — or the percentage of eligible children who remain covered after their annual renewal. Healthy Families has the capability to track children who move from one program to another: The program can track an application to see if it was sent to the county, if the child was successfully enrolled in Medi-Cal after leaving Healthy Families, and to determine how many days the application is pending (before successful enrollment). However, the program does not have the capability to track when counties deny Medi-Cal for those forwarded renewal applications. Healthy Families does not monitor whether children losing coverage become uninsured.

Promising Retention Tracking Strategy — Kansas

Kansas monitors the extent to which children continue their coverage by tracking the percentage of children that remain covered over time from when they enroll. At one point, Kansas' data revealed that over two-thirds of SCHIP children had lost coverage within six months of enrolling, even though the state offers continuous 12-month coverage.[40] State officials searched for an explanation and found that eligibility systems were not adequately updated to handle 12-month continuous eligibility and instead children were dropped from coverage when they were determined ineligible within the year.

Medi-Cal: The eligibility complexities of Medi-Cal and the county-based eligibility system create particular challenges for measuring and monitoring Medi-Cal retention. As a result, the Medi-Cal program (through the Medi-Cal Eligibility Data System — MEDS) does not collect from counties the number of children who lose Medi-Cal or the reasons of dropping coverage. While Medi-Cal's annual reports on continued coverage do not provide retention rates for children, there is good news on the horizon. Medi-Cal recently released an analysis on Medi-Cal retention rates for children and adults, as well as on the status of children transferring from Medi-Cal to Healthy Families through the bridge program. (We would encourage the department to regularly report this information). The program does not track whether children losing Medi-Cal have other sources of coverage, or whether they are uninsured and Medi-Cal does not report the outcomes of annual renewals.

In addition, legislation (SB 344, Ortiz) enacted in 2001 requires the Medi-Cal program to post on its Web site user-friendly tables of county-by-county coverage by eligibility category, including a children's coverage category. These tables will also include 12 months of enrollment data by ethnicity, gender, and age. (Although the legislation required implementation by March 2002, the information has not been made available as of the publication of this report.)

THE FOUNDATION OF A SUCCESSFUL RETENTION INITIATIVE

Based on our research, including a review of other states, simply tracking retention and enrollment/disenrollment data does not constitute a successful retention system. Instead, there are some additional elements that should be included in a retention system for state insurance programs. For example, Rhode Island's *RIte Stats* reports on the number of months a child is covered, any gaps in coverage and their length, and if and when the child returns to RIteCare. Some states with separate programs have coordinated their enrollment tracking to monitor children moving between the programs. Table 6 outlines those elements needed to sufficiently track children's coverage and whether Healthy Families and Medi-Cal track that information. The state would need to implement these basic data tracking elements in order to draw an accurate picture of how children are covered over time and why they switch coverage. At minimum, both programs should have a combined tracking system to regularly track retention rates, the extent to which children are transferring between insurance programs, and whether children losing coverage are likely still eligible or not. In addition, the sample exit surveys are necessary to reveal the true reasons why children are losing coverage (and whether families know in fact that their child lost coverage).

Table 6. Suggested Tracking Elements for a Successful Retention Program

Tracking Elements	Healthy Families (HF)	Medi-Cal (MC)
Retention rates over time	One-time survey	One-time survey
Renewal rates (% re-enrolled at renewal)		
Monthly number of children losing coverage	✔	
Children returning to insurance program and gap length		
Coverage status after leaving insurance program –Employer coverage –Uninsured		
Children switching between insurance programs	Limited*	One-time survey
Reasons for losing coverage**	✔	
Reasons for not renewing**	✔	
Unique identification number for each covered child	✔	Joint application only

*The pending tracking system will have a limited capacity to track applications transferred to MC, particularly if children are denied Medi-Cal coverage.
**Reported disenrollment reasons should be supplemented with more extensive exit surveys of families.

FIVE CRITICAL JUNCTURES: KEEPING CHILDREN COVERED

Section 4

The available data and our interviews with community groups enrolling children into Healthy Families and Medi-Cal point to five critical places in the insurance programs' processes where children are at risk of unnecessarily losing coverage.

1. Coordinating Among Insurance Programs
2. Renewing Coverage
3. Paying Premiums
4. Communicating with Families; and
5. Using Services Once Insured.

In many cases, Medi-Cal and Healthy Families have already begun to implement important policies and practices to target these areas of risk. Both programs continue to examine ways to further improve the process to keep eligible children enrolled. We offer our findings in order to assist the programs in their efforts. The subsections below highlight our findings on how well these five particular process junctures are working to keep children covered, including some insights from families into how the system affects their real-world experience. In addition, we emphasized a number of promising strategies in California and other states that we think could make the juncture points less of a risk for families. Section 5 provides recommendations for addressing our findings.

1 COORDINATING AMONG INSURANCE PROGRAMS

Imagine parents' confusion in trying to maintain coverage for their children when one child is covered by Medi-Cal and another child is covered by Healthy Families. These "split" families must choose a health plan for each child from two separate menus of health plan choices and they must figure out whether both plans contract with their children's pediatrician. Moreover, each child will renew coverage at a different time and through different processes. Imagine parents' further confusion when family income changes or a child turns 6 years old and has to move from one insurance program to the other.

> *"We see a lot of families struggling to understand two programs when their children are put into different programs."*
>
> *– Certified Application Assistant*

These are the intrinsic challenges for families when a state like California operates two different insurance programs for children. The state has made attempts to coordinate the programs, particularly through the creation of a joint Medi-Cal and Healthy Families application for children, which is received and screened through a "Single Point of Entry" (SPE). However, coordination remains a particularly daunting task. Even though an application can be sent to SPE, all Medi-Cal eligibility determinations must be sent to one of the 58 different counties to process. Most recently, the state implemented a system in which children who are screened eligible for

Medi-Cal at SPE receive "accelerated enrollment" into Medi-Cal while the application is forwarded to a county for a formal eligibility determination.[41] However, with each county responsible for administering their Medi-Cal program, the system effectively continues to consist of 58 distinct Medi-Cal eligibility programs that must coordinate among themselves and with the state-operated Healthy Families program.

FINDINGS

According to the Federal Centers for Medicare and Medicaid Services (CMS), "improved coordination between [insurance] programs can be particularly effective in ensuring continued Medicaid coverage for families and children."[42] Even with separate programs, states have significant flexibility in how to administer the programs — for example, a single administration or separate administrations with coordinated enrollment or tracking.

Promising Coordination Strategy — Michigan's Coordination of Separate Programs

Michigan has two separate programs: Healthy Kids (Medicaid) and MIChild (State Children's Health Insurance Program (SCHIP)). The state has found that one of its most promising strategies for keeping children covered is co-locating eligibility workers from each program to serve families who are renewing and may be transferring between programs. [43]

Finding *In our research, however, we found that the design of California's insurance programs has made coordination more complex in comparison to other states with "separate" programs.* Nationally, 15 states and the District of Columbia have combined SCHIP and Medicaid programs for children (through a Medicaid expansion). The remaining 35 states with separate SCHIP programs vary in their coordination between SCHIP and Medicaid.[44] To simplify the bureaucratic maze, some states combine the separate programs' administrations or at least use similar data systems and others provide joint enrollment applications. With regard to coordinated renewals, 21 of the 35 states with separate SCHIP programs use a joint renewal form.[45] In some states, families are automatically transferred from one insurance program to another — making the transfer seamless for families. (See Table 7 for coordination within the 10 sample states studied).

TABLE 7: Efforts to Coordinate the Renewal Process in 10 Sample States.

State	Joint Renewal Form	Automatic Enrollment for Children Transferring Between Programs
California	N	N*
Connecticut	Y	Y
Florida	Y	Y
Kansas	Y	Y
Massachusetts	Y	Y
Michigan	N	Y
New Jersey	Y	Y
New York	Y	N
Oregon	Y	Y
Rhode Island	Same Program	Same Program

*Medi-Cal and Healthy Families offer a bridge program while children transfer between programs.

Promising Coordination Strategy— New York's Uniform Eligibility Standard

New York recently removed the "aged-based" distinction in its Medicaid program so that all children in families with income at or below 133% of federal poverty level (FPL) can enroll in the same program — Medicaid.

Specific coordination issues in California are:

Finding *Separate renewal processes for Medi-Cal and Healthy Families are confusing and overly complex for split families.* Although both Medi-Cal and Healthy Families children have to renew their coverage every year, the programs have separate renewal processes with different forms, even for split families. In addition, the anniversary date to renew coverage does not necessarily occur at the same time. Certified Application Assistants (CAAs) reported that families were often confused by the two different sets of coverage rules, particularly two separate renewal periods each with their separate forms. With data showing that most children lose coverage at renewal, it is particularly important to focus on the renewal process.

> *"I assumed my child had health insurance coverage. When my daughter became very sick, I was told she wasn't enrolled."*
>
> *Tammy* and her daughter Elise* were able to keep their Medi-Cal coverage when they stopped receiving cash assistance. However, when Tammy renewed their coverage a year later, they lost their Medi-Cal coverage because her pay stub included two months of income, making her income appear artificially high. Tammy and Elise were bounced back and forth between Medi-Cal and Healthy Families programs, with both telling Tammy that Elise was not eligible. The county Medi-Cal worker told her she should apply for Healthy Families separately. "This made no sense," said Tammy. "I originally submitted the joint application and couldn't understand why they didn't send it [forward] for me." Healthy Families told her she earned too little and to return to Medi-Cal. Tammy finally received notice that her family was covered by Medi-Cal, but when Elise became very sick, Tammy found out that in fact they were not covered. With Tammy's persistence, she was able to get an emergency Medi-Cal card to cover her daughter's illness while they straightened out their coverage status.*
>
> **fictitious names*

Finding *The Medi-Cal and Healthy Families bridge program is assisting children who are moving from one insurance program to the other, but the process is not seamless.* As mentioned previously, the state has a bridge program for children who are moving from one insurance program to the other. However, the bridge program does not automatically enroll children in the other insurance program, which can lead to gaps in coverage. Instead, Healthy Families and Medi-Cal must receive the transferred application and process it before the child can transfer coverage. A Department of Health Services (DHS) analysis found that of those children in the Medi-Cal bridge program, about one-quarter successfully transferred to Healthy Families. About 44 percent re-enrolled in Medi-Cal coverage under another eligibility category. However, the remaining 31 percent of children were not covered under either Medi-Cal or Healthy Families after leaving the bridge program.[46]

The transfer process relies on counties or SPE knowing to forward applications to the other program and on the applications being received and processed. A successful bridge program will require a thorough tracking system for these transferred applications to ensure that children switch programs without gaps in coverage.

In addition, children moving from Healthy Families to Medi-Cal must continue to pay Healthy Families premiums (despite their Medi-Cal eligibility) during the bridge transition. Given that these families have typically experienced a loss in income, they may find it particularly difficult to pay these premiums.

Finding *California has made strides toward linking initial enrollment in insurance programs with other public programs.* Several "Express Lane Eligibility" proposals and legislation in California indicate that state policymakers see the value in linking children with health insurance through other public programs that have similar eligibility rules. For example, legislation enacted in 2001 would allow children to be "express enrolled" into health insurance programs when they sign up for free school lunches. With the parent's consent, a child's School Lunch application can serve as a screen for eligibility into Medi-Cal. If the child appears eligible, she is "express enrolled" while the School Lunch application is forwarded to the county Medi-Cal office for follow up and a full eligibility determination. (Despite his initial support for this program, the Governor vetoed the implementation of this Express Lane opportunity in the state budget for 2002-2003.) This Express Lane model is expected to begin in July 2003.

Promising Coordination Strategy — Massachusetts Express Renewal

MassHealth (combined SCHIP or Medicaid) offers "express renewal" in a pilot project. A family can renew their MassHealth insurance at 16 community points of service, including primary care providers' offices, early-childhood service providers, or schools. After the express renewal, a family's renewal date is extended for another 12 months.[47]

2 SIMPLIFYING THE RENEWAL PROCESS

As mentioned, insurance program coverage like Medi-Cal and Healthy Families are unlike coverage provided through an employer, since the government programs require families to demonstrate annually that their children are still eligible to continue coverage. In general, even with simplifications, the renewal process is a major contributor to children losing coverage.[48] While the intent of annual recertification is to ensure that only eligible children continue coverage, the concern is that many children who are still eligible are losing coverage as a result of the process for renewing coverage.

Healthy Families and Medi-Cal have made significant strides in simplifying the renewal process but, like most state's renewal experiences, seemingly small problems with renewals can lead to families losing coverage for their children. A survey by Healthy Families found that 18 percent of families did not return their Healthy Families annual renewal forms.[49] Families have reported administrative problems, such as not receiving a renewal package or the packet not being in the appropriate language.[50] Notably, a significant portion of families (14%) was simply unaware that they must renew their health insurance.[51] Also of concern was that a significant portion (14%) of families reported submitting all materials to Healthy Families but the program lost them.[52] Observations by CAAs corroborate these findings.

Most families (73%) need assistance in completing renewal forms.[53] Again, families with eligible children who lost coverage were more likely to report finding the renewal process difficult than were those families whose children continued coverage (36% versus 16%).[54]

FINDINGS

While Medi-Cal and Healthy Families have simplified the renewal process in significant ways and federal flexibility offers California the opportunity to further improve eligible children's chances of continuing coverage. Table 8 highlights some promising approaches for simplifying renewal policies that other states have implemented, including the current status of California's practice.

TABLE 8: Policies to Simplify Medicaid and SCHIP Renewals in Sample States

Sample States	12-Month Continuous Coverage		Ex Parte Review		Pre-Printed Renewal Form		Renewal by Phone		No Income Documentation	
	Medicaid	SCHIP	Medicaid	SCHIP	Medicaid	SCHIP	Medicaid	SCHIP	Medicaid	SCHIP
California	Y	Y	Y	N	N	N*	N	N	N	N
Connecticut	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Florida	Y**	N	Y	N	Y	Y	Y	Y	N**	Y
Kansas	Y	Y	Y	Y	N	N	N	N	N	N
Massachusetts	N	N	Y***	Y***	N	N	Y	Y	N***	N***
Michigan	N	Y	Y	Y	N	Y	N	N	Y	Y
New Jersey	N	N	Y	N	Y	Y	N	N	N	N
New York	Y	N	Y	Y	N	N	N	N	N	Y
Oregon	N	N	Y	Y	N	N	N	N	N	N
Rhode Island	N	N	N	N	Y	Y	N	N	N	N

*Partially pre-printed, does not include income information.
**Seasonal workers are reviewed more frequently. Documentation required for childcare deductions only.
***The state's pilot project in limited sites does not require income documentation if income has remained the same.

Finding *12-Month Continuous Eligibility — Children continue coverage longer if families are not required to renew eligibility as often and are guaranteed coverage through the year.* The more frequent the renewal periods, such as twice a year, the more likely children lose their coverage.[55] The "12-month continuous eligibility" policy can reduce by half the number of children who lose coverage. It can reduce administrative costs as well.[56] California and 16 other states have annual renewals for both Medicaid and SCHIP while also guaranteeing 12-months of continuous eligibility — allowing children to continue insurance for a year even if family circumstances such as increased income change. (Another 13 states provide 12-month continuous eligibility for either Medicaid or SCHIP.)[57]

Data from California's analysis of continuing Medi-Cal coverage suggest that the state's 12-month continuous coverage policy has already had a significant effect on children's continued coverage. After the January 2001 implementation of this policy, the retention rate jumped from 51 percent for children enrolling in August 1999 to 64 percent for those enrolling in August 2000.[58]

Finding *Pre-printed renewal forms would do most of the legwork upfront with families only having to check the accuracy of the information provided.* Federal guidelines also encourage states to provide a pre-printed renewal form that includes information about the family such as income, residency, address, and family size. These pre-printed forms can greatly simplify the renewal process for families. They would only have to review the information on the form, confirm it with a signature, and mail the form back.

In California, neither insurance program provides families with customized pre-printed renewal forms. Healthy Families has the immediate capacity; their renewal forms are already partially customized with the children's names, dates of birth, family member identification number, and address. A fully pre-printed renewal form would also include income data and family size. However, Healthy Families does not currently review other data systems available to the state because the program either does not have access to systems such as Food Stamps or they may not have the child's Social Security number to identify information on other systems. (Social Security number information is optional for Healthy Families applicants.)

Promising Simplified Renewal Strategy and Increased Medi-Cal Retention — California's Senate Bill 87

Starting on July 1, 2001, SB 87 (Escutia) ensured that families would not lose their Medi-Cal coverage merely because their circumstances changed in a way that made them move from one of Medi-Cal's over-200 categories to another (e.g. income increased, household composition changed, or children changed age categories). In other words, when a child is re-categorized into a different Medi-Cal group — but remains eligible — she shouldn't be terminated. Families who are leaving cash assistance (CalWORKs) can benefit from this new law: For example, a family losing CalWORKs will not subsequently lose Medi-Cal. If relevant circumstances change, the family is entitled to a redetermination of eligibility before the county takes any steps to terminate Medi-Cal. The county must check all Medi-Cal eligibility categories to see if they are eligible based on other standards before dropping the families' coverage.

Whenever eligibility is being determined, the county may not request any information or documentation that has been provided previously, that is not subject to change, or that is not absolutely necessary to determining eligibility. The county is required to first check all available information about the family to verify these changes — an ex parte *review — before contacting the family to follow up. This includes a review of not only the Medi-Cal file, but also the CalWORKs file and Food Stamps file and any other information available to the county. The idea is that the burden of proof has shifted away from the family and onto the county – the county cannot terminate benefits until proving the beneficiary ineligible for all Medi-Cal programs. When following up with a family, the county must attempt to phone at least twice, and if that is unsuccessful, the county must send a special form requesting only the information that is missing and necessary to complete the eligibility determination.*

The counties must also apply these same standards as part of the annual renewal process. For example, the legislation requires an ex parte *review prior to contacting the family. If the family must be contacted, the county must follow the SB 87 procedures, limiting requests for information as described above, and may call the families in addition to sending a written request (see Medi-Cal flowchart, Appendix E). The state is currently reviewing its guidance to counties on SB 87 and the renewal process and application.*

SB 87 also promotes county outreach to Medi-Cal managed care health plans and community-based organizations to coordinate retention efforts. In addition, the legislation requires a feasibility study to determine the appropriateness of maintaining and updating contact information and providing renewal dates to health plans in an effort to reach the families to remind them to renew.

Finding Ex parte *reviews can simplify the process for families if the state does some of the information checking.* Medicaid and SCHIP can verify family income information from other government data systems such as Food Stamp enrollment data systems — known as an *ex parte* review. States must notify families that they will use that information. Other sources for compiling family information include state tax returns, employer payroll reporting, or data from the Social Security Administration.[59] Federal rules do not require states to verify income at all for SCHIP, but does encourage random eligibility checks or other procedures "designed to assure program integrity."[60] Under recent legislation (SB 87), California uses *ex parte* reviews in its Medi-Cal program but not in Healthy Families. *(See the "Promising Simplified Renewal Strategy" highlight box.)*

Finding *Not requiring income documentation would greatly mitigate families' difficulty in completing renewal forms.* In California, about 43 percent of families found it difficult to compile the necessary verification of income required to renew Healthy Families

coverage.[61] Notably, those families with children who actually lost coverage were more likely to report difficulties (49%).[62] CAAs report that some families appear overwhelmed by the paperwork.[63] Income documentation can be particularly difficult for families with jobs that do not provide regular pay stubs.[64] In addition in California, Medi-Cal families must also provide proof of assets at application and renewal.

Federal guidelines specifically allow families to "self-declare" income rather than submit documentation, both at initial application and at renewal.[65] Thirteen states (not including California) allow families to self-declare the income they report. Some states allow families to self-declare in certain circumstances at renewal.[66] For example, MassHealth's "express renewal" pilot project allows self-declaration if there is no change in the family's income. In California, Los Angeles County, as part of its 1115 waiver, offers families the opportunity to, in effect, self-declare income at renewal if they report no changes (see L.A. County Simplified Medi-Cal Redetermination Pilot highlight box). In addition, while the state is currently reviewing its Medi-Cal renewal guidance, SB 87 legislation requires a similar simplified renewal process.

To confirm that families are properly declaring their eligibility information, some states annually check eligibility on a random sample of cases post re-enrollment. This is a particularly useful option if states do not ask for Social Security numbers (necessary for accessing some data systems).

Promising Simplified Renewal Strategy—L.A. County Pilot [70]

In July 2001, Los Angeles County implemented a Simplified Medi-Cal Redetermination Pilot as part of its 1115 Waiver. The county uses a simplified four-page renewal form; families are asked only to update information that may have changed, such as income and assets. (The form is not pre-printed with existing information.) This offers families some relief by not requiring documentation in all cases. When the family submits the form, they do not have to include documentation; the county reviews existing data systems through an ex parte review — to verify income and assets. If state data show that family income or assets significantly differ from what was reported, the family is asked to provide appropriate verification.

The county calls to follow up with families that do not submit a renewal form or when other information is needed. When the county cannot locate the family, workers conduct an ex parte review to find a current address or phone number.

Los Angeles County's pilot is in its early stages and has not yet evaluated its impact on families' continued coverage.

Michigan no longer requires families to submit documentation and has found that a greater share of families complete their renewal forms when families are allowed to self-declare.[67] In addition, states evaluating their self-declaration policy found a significant increase in the productivity of workers who process applications (see highlight box to the right). Moreover, in several states, audits reveal that self-declaration has not increased the error rates.[68]

Promising Simplified Renewal Strategy—Self-Declaration of Income

Michigan reported a 25% increase in eligibility worker productivity after allowing "self-declaration." In addition, Michigan's audit found only 2% of children with incomes exceeding eligibility levels and 1% with incomes below—or their incomes were under-reported.

Maryland found that 80% of applications were being processed within 10 days after allowing "self-declaration." Post-eligibility audits found no change in the error rate after implementing self-declaration.

Finding *"Fast Track" (or "passive") renewal would shift most of the administrative work from the families to the programs.* Four states offer Fast Track or passive renewal flexibility, which shows promise for continuing eligible children's coverage through annual renewal.[69] Florida's KidCare (SCHIP) for example, sends families a pre-printed

renewal form, which includes all known information, asking families to return the form *only if* they have changes to the information provided. If there are no changes, children continue coverage under KidCare for another year. Children in KidCare were more likely to remain covered after renewal (95%) compared to other states that required families to fill out and submit renewal forms and documentation (50%-67%).[71] Programs using this passive renewal flexibility have the ability to know whether families are still participating in the program either because they are paying regular premiums or because the insurance offers fee-for-service coverage, which allows the program to know if the child is still receiving services.

Even if states require families to submit eligibility information, the process can still be made easier. For example, families can, under federal guidelines, renew their coverage by mail or over the phone (no paperwork or signature is required). Three out of nine states interviewed provide families with the opportunity to renew state health coverage by phone. California does not offer phone renewals but does provide for renewal by mail.

3 MAKING PREMIUMS EASIER TO PAY

As noted previously, non-payment of premiums is a primary reason why families lose Healthy Families coverage, similar to other state's SCHIP programs with premiums. Requiring families to submit these premiums every month puts them at risk for losing coverage.

FINDINGS

Finding *Healthy Families has created several incentives for families that make it easier for them to make payments.* For example, if families pay three months of premiums in advance, the fourth month's premium is free — a 25 percent annual discount. About one-third of the enrolled families take advantage of this payment option.[72] In addition, Healthy Families recently began offering a 25 percent premium discount for payments made through electronic funds transfer (EFT) from their bank account. Before offering this discount, less than 1,000 families paid through EFTs. Healthy Families received over 1,000 requests for this option in the first two weeks since the discount was offered in July 2002.[73]

> *"If a family misses out on a payment, they should be given a chance to pay. There should be some flexibility. Criminals have three strikes in this state and families have none in Healthy Families. [The six-month penalty] is too extreme. We're talking about kids' health."*
>
> *– San Francisco parent with two children in Healthy Families.*

Finding *California offers little leniency when families do not pay premiums.* Generally, parents feel the premium amount is reasonable; however, there are periods of financial hardship when families find it difficult to pay the monthly premium. An unexpected cost one month, such as a car repair, could create short-term financial difficulty for a low-income family. The National Academy for State Health Policy (NASHP) survey described earlier found that one-third of families with children losing coverage for not paying premiums reported having trouble paying premiums in some months.[74]

While Healthy Families does send out notices and does call families to alert them that their children will lose coverage, the program will disenroll them after the second month. Although the federal guidelines encourage states to take previous payment history into account before dropping coverage, Healthy Families does not offer such leniencies.

In fact, California has had one of the most stringent penalties for non-payment of premiums: the child may not re-enroll for six months. The state just eliminated this six-month penalty and the retroactive break in coverage as part of the recently enacted state budget trailer bill for 2002-2003. The trailer bill language allows the children to re-enroll by using a one-page application and paying outstanding premiums.[75] Several county initiatives, such as those in Santa Clara, Alameda, and San Francisco, have, or are developing, hardship or premium assistance funds to help families maintain coverage in a local initiative health plan. MassHealth allows families to set up a payment plan if they cannot make a premium payment. Healthy Families does not offer this flexibility for Californians.

> *"The process is so frustrating, I understand why some families would rather not deal with it…"*
>
> *Ms. Banks* used to pay her Healthy Families premiums by phone. Because she paid for three months in advance and received the fourth month free, she wasn't concerned when she didn't receive a monthly invoice. When she was notified that her two children had lost coverage, she discovered that her over-the-phone payments had not been transferred to Healthy Families. In one year, Ms. Banks' children lost coverage several times because the program did not receive payment, even though the funds were deducted from her account. Gaps in coverage occurred while her daughter needed a follow-up with her doctor after an emergency room visit and while her son needed care for a dental condition. "It seems so unfair, when the families are following the rules but through some errors in the system they are disenrolled."*
>
> **fictitious names*

Finding *Program errors and lost premium payments significantly contribute to why children lose coverage for not paying premiums.* NASHP survey data found that Healthy Families loses families' premium payments in more than just a few isolated cases — about 5 percent of those dropped for "non-payment" premiums.[76] CAAs agree with these findings. CAAs troubleshoot for families who are on the verge of losing coverage because Healthy Families lost their payments. Families who have to ask their bank to provide proof that their check was cashed to confirm their past premium payments, carry the brunt of this burden.

Finding *Some families do not make payments because they did not receive a billing statement or did not understand it*. CAAs reported that some families have had difficulty reading the Healthy Families billing statement because the statement was not written in their primary language, including a few English-speaking families receiving statements in Spanish.[77] The Healthy Families program survey found that some families (10%) did not receive billing statements or it was not in their appropriate language (3%).[78] Some families are unfamiliar with billing invoices in general and need guidance on how to read an invoice (to learn, for example, that "CR" refers to "credit"). The Healthy Families program has corrected a particularly confusing aspect of the billing statements by eliminating a pro-rated premium amount based on when the child was enrolled. In addition, the program now provides guidance in reading the statement and reminds families about premium discount options. We hope that this guidance will provide families with the necessary information to pay premiums.

> *Promising Payment Strategies — Reminders About Lower Premiums*
>
> *New Jersey's FamilyCare sends notices to families who fail to make their premium payments, reminding them that their children may be eligible for lower premiums or no cost Medicaid if their income has dropped, and providing instruction on how to find out about reduced premiums or no-cost insurance.*

Finding *Families might not know that their children are eligible for lower Healthy Families premiums or for no-cost Medi-Cal when the family income drops.*

When families have not paid their premiums, federal rules urge states to screen for Medicaid and assess whether a family may be eligible for reduced premiums before dropping the child from coverage. Healthy Families has two different premium rates based on income — above and below 150% of FPL. Healthy Families does not provide such screening before dropping a child's coverage, nor does the program alert families who have not paid premiums that their child might be eligible for a lower premium or for no-cost Medi-Cal.

> *"I needed that money to feed my kids."*
>
> *Healthy Families covered Ms. Lopez's* four children, but she dropped the coverage after administrative mistakes at Healthy Families became exhausting and expensive. When Ms. Lopez first enrolled her children, Healthy Families lost her premium payment and notified her that her children would not be covered if she didn't send another payment. Overall, she paid the same premium four times— a total of $108 — none of which was recorded by Healthy Families, although her checks were cashed. She tried to remedy the issue for a year and then gave up.*
>
> **fictitious names*

Finding *Families are not automatically deducting premiums from their paycheck.*

Healthy Families offers workers the opportunity to have their children's premiums automatically deducted from their paychecks. However, Healthy Families has not promoted this payment option and it is difficult for employers to participate. Information about paycheck deductions is not readily available to employers or families. In addition, Healthy Families does not provide employers with viable options for submitting workers' premium payments to the Healthy Families program; employers must either provide their own banking account number to Healthy Families for withdrawals or employers must collect each families' monthly premium statement and submit a check for each. As a result, less than 1% of children with Healthy Families coverage have premiums paid through automatic deductions from their parents' paycheck.

4 COMMUNICATING EFFECTIVELY WITH FAMILIES

> *"You'll never meet any retention targets if the customer service provided is poor."*
>
> *— Certified Application Assistant*

Similar to other states' insurance programs, Medi-Cal and Healthy Families rely almost entirely on written material and the U.S. postal system to communicate with families about their children's coverage. All important notices that require a timely response in order to keep their child's coverage arrive by mail. This method of communication has its particular challenges, as some families may have language or literacy barriers. Critical educational materials and information about the program rules are included in enrollment packets, which can become voluminous.

Families with questions can call either their designated county Medi-Cal eligibility worker or the toll-free Healthy Families member hotline. However, families are not likely to have a regular contact person to call. Both programs send renewal packets or premium statements in advance of the required response deadline, and both will follow up by sending reminders, including courtesy calls from Healthy Families.

CAAs report that they often have to educate families about the various correspondences the family will receive and show them examples of letters and billing statements.

FINDINGS

Finding *Some children lost coverage because important forms to which families must respond were sent to the wrong address.* Of the families who did not to submit a Healthy Families renewal form and subsequently lost coverage for their children, 15 percent reported that they never received a renewal packet.[79] If a family does not receive annual renewal materials, premium statements, or disenrollment notices, they may not know their child is uninsured until they seek health care and try to use their coverage card. Because families communicate with the Medi-Cal program only once a year, for a child's annual renewal, Medi-Cal's contact information is particularly prone to being outdated. Healthy Families has more frequent contact with the family through premium billing and payments.

Finding *Helpful, knowledgeable program staff[80] and timely reminders can make a difference in whether a child stays covered or not.* Parents whose children lose coverage are more likely to experience communication problems with programs than parents whose children are still covered. While most parents found Healthy Families staff to be knowledgeable and helpful, parents losing their children's coverage were more likely to report long waits before hearing back from staff or being given incorrect information.[81] Parents with children covered by Medi-Cal appreciate an ongoing and helpful relationship with their designated county eligibility worker.[82] In contrast, when parents are transferred between county workers, the new worker needs to familiarize herself with the families' case, delaying the assistance that can be provided.

Finding *Many parents do not know they have to renew*. As mentioned, a significant percentage (14%) of parents who lost their children's Healthy Families coverage for not renewing, were *not aware* that they needed to renew every year.[83] While the original enrollment packet is the primary source of information about the program, families could benefit from reminders about key rules such as the need to annually renew coverage.

Finding *Important notices to which families must respond are buried among volumes of program information.* CAAs said that families were often overwhelmed by the amount of material they received from insurance programs and health plans, particularly from Medi-Cal. Too much material renders the information meaningless and families may miss important documents, such as renewal forms, that are included among the volumes of informational materials.

Finding *Healthy Families frequently loses documents, such as pay stubs, that families submit.* CAAs found that paperwork was more likely to be lost by Healthy Families when information was faxed to the program, requiring families to resubmit this information.

Promising Communications Strategies — Reminders

New Hampshire reminds families on their 10th-month premium payment coupon to collect documentation for their upcoming annual renewal.

New Jersey, Rhode Island, and *Connecticut* remind families about their renewal date in all correspondence.

5 ENCOURAGING THE USE OF SERVICES ONCE INSURED

Clearly, a child can only benefit from health insurance if she is able to receive care. While coverage provides children with the opportunity to seek care, parents must first find a provider who participates in the family's health plan, and then make an appointment with that provider.

Currently, there is not much in the way of in-depth research on the correlation between using services and the likelihood of keeping coverage. However, anecdotal observations and survey results indicate that children who use services are more likely to keep their coverage.[84] CAAs speculated that families were more likely to renew their children's coverage if their children had used services within the year. In other words, the extent to which families believe there is a direct benefit from their child's insurance may affect families' willingness to continue coverage for their child. Several factors may affect families' perceptions of whether the child's insurance offers them a benefit.

Promising Health Access Strategy — Promoting Preventive Care

The Florida KidCare program phones a family when a child has a birthday, to wish the child a "happy birthday" and to remind the parents of the importance of preventive care, annual checkups, and immunizations. The program also asks the family if they have any questions about their child's health or the insurance program.[85] The call is a good example of how to educate families about preventive care and when to set up a well-child visit (i.e. when a child has a birthday).

Some preliminary research and anecdotal observations indicate that a child may be more likely to continue coverage depending on whether parents take advantage of preventive care. In Florida, children were slightly more likely to stay covered under KidCare longer when the program encouraged parents to seek preventive care, compared to when the program did not promote preventive care.[86] (See Promising Health Access Strategy - Promoting Preventive Care.)

Some efforts are made to inform families. Healthy Families and Medi-Cal provide basic information about accessing health care and selecting a health plan, with Healthy Families including an immunization schedule and asking the family, as part of their "welcome call," whether their children have accessed care. In addition, health plans also provide materials and education encouraging preventive care. For example, L.A. Care provides community-based training on how to use the health plan, while Blue Cross incorporates information about the importance of insurance and preventive care into their health plan packet. Community Health Group in San Diego sends out newsletters promoting preventive care.

Promising Health Access Strategy — MotherNet

MotherNet, a community-based organization in Compton, California, initiated a Community Health Access Program that provides families with a case manager and a five-week course on how to enroll in health insurance, use health services, and navigate the health system. The case manager follows up with a family after six months and a year after the course. The program will be evaluated to determine if a child is more likely to remain covered and have a medical home after this intensive education.

FINDINGS

Finding *Access to dental benefits was a primary motivator for parents to enroll their children into the programs' coverage, according to CAAs.* While dental benefits may be a major driver of enrollment, the shortage of pediatric dental providers in California has become a common problem of access statewide, including in Healthy Families and Medi-Cal. The 2002 Healthy Families Dental Report stated that only half (56%) of children had an annual dental visit and almost half (44%) of all dental benefit complaints to Healthy Families related to access to a dentist.[87] National Medicaid data indicate that only a third (36%) of children had an annual dental visit in one year.[88] Because many families have indicated that dental coverage was a key reason for enrolling their child in health insurance, limited access to dental care may have a significant impact on whether families will bother to follow through on lengthy renewals to keep their child covered.

> *"My children haven't seen a dentist in years. I'm worried."*
> *– Mother of two who tried to find a dentist that accepted Healthy Families coverage.*

Finding *Despite the information provided by Healthy Families/Medi-Cal and health plans, families still may not understand how to navigate health insurance systems.* CAAs reported that families might be insuring their children for the first time when they enroll in Healthy Families or Medi-Cal. Parents may not fully understand the function of health insurance in the delivery of health care. For example, many of the families served by CAAs have historically received care directly at clinics and have not experienced a third-party payer. For these families, navigating the health care system (i.e. following health plan benefit rules, finding a provider in the health plan network, finding the doctor's office) may be sufficiently daunting. Coverage then does not equate to access to care. Families have sought assistance from CAAs in scheduling their first doctor's visit. In addition, families may not understand that they need to choose a plan that includes their doctor in the plan's network in order for the plan to cover those visits.

Promising Health Access Strategy — Solano Kids Insurance Program (SKIP)

SKIP, a community-based organization, provides families with an educational session to orient them to their child's health plan, and explain how to navigate the Healthy Families and Medi-Cal programs, as well as choose and make an appointment with a doctor.

Finding *Navigating two different health systems poses additional challenges for split families.* Families with a child in Medi-Cal and another in Healthy Families must find their way through two separate menus of health plan choices to determine whether their family doctor is covered under both plans. As mentioned, Medi-Cal and Healthy Families do not provide families with a coordinated listing of health plan options, nor is there any assistance for split families to determine which two plans cover the same doctor.

Section 5

RECOMMENDATIONS FOR KEEPING CHILDREN COVERED

Our findings underscore the fact that there are additional steps for the state to consider to further spare children from inadvertently becoming uninsured and to avoid the cost of re-enrollment for children who never should have lost coverage in the first place. Just as policymakers and community leaders focused intensely over the past few years on finding and enrolling eligible children, it is now time to place equal importance on keeping children insured once they are enrolled. The state programs have already begun implementing important retention policies. We believe the knowledge base is now available to further improve continued coverage for children. In other areas, where less is known, we can and should proceed with focused research.

We make two principle recommendations: first, we suggest steps to build a basic foundation in California to promote retention, including new tools for data and tracking, needed research, and the involvement of crucial partners; second, we take each of the five critical junctures where children now fall through the cracks and suggest changes in program operations to close up the cracks.

At a time when California faces severe budget constraints, it should be noted that some of our recommendations could actually create greater efficiencies through program simplification. For instance, when Michigan allowed families to self-declare their income rather than provide extensive paper documentation, caseworker productivity increased by 25 percent.[89] Some of our other recommendations can be simply and inexpensively implemented without changes in law, such as clarifying notices to families and reporting information on children who lose eligibility according to whether they are "likely eligible" or "likely ineligible," as opposed to Healthy Families' current distinction of "unavoidable reasons" and "possibly avoidable reasons." Still, other recommendations require policy changes that could be implemented statewide or tried out on a pilot basis first.

While the recommendations focus on what the state can do, there is also important work for advocates and community leaders. The 100% Campaign is committed to assisting the state and community partners in implementing these recommendations.

BUILDING THE FOUNDATION: TRACKING, RESEARCH & PARTNERS

Based on our examination, it is evident that there are some basic building blocks for an effective retention program that California can begin to put in place now: tracking and monitoring the extent to which children continue their coverage; pursuing additional research into effective approaches to keeping children covered; and assisting and working with those partners in the community that assist families on an ongoing basis to maintain their children's coverage.

DATA AND TRACKING. More informative data tracking, monitoring, and research is needed, particularly with regard to children's Medi-Cal coverage. We recommend the following:

Strategy 1 Implement a retention tracking system (See Table 6, Page 13). Certain key data elements are necessary to understand the basics about what is happening to a child's coverage over time and determine how to avoid unnecessarily dropping eligible children from coverage.

Strategy 2 Combine the Medi-Cal and Healthy Families tracking and reporting systems. With two separate programs, a combined tracking system is essential to ensure that children do not fall through the cracks as they move between the programs.

Strategy 3 Conduct ongoing sample surveys of families whose children lose coverage. As indicated, program data reporting the reasons for dropped coverage do not tell the full story. Learning why families do not, for example, make a premium payment is much more informative in deciding what policy changes are necessary to avoid inadvertently dropping coverage.

RESEARCH. In addition to tracking data that answer the basic questions about children's coverage, our investigation pinpoints several specific questions that warrant further examination and quantitative analysis:

- Does the use of preventive care affect whether children continue their coverage longer?
- To what extent do coordinated insurance programs increase the likelihood that families will be able to keep their children covered? Are families with children covered in different programs more likely to lose coverage?
- To what extent are children moving between the insurance programs?
- What is happening to children who lose coverage — are they uninsured?
- To what extent do county initiatives increase the likelihood that children enrolled in state insurance programs continue their coverage?
- What lessons can be learned from community organizations' and local initiatives' efforts to keep children covered?

Valuable work is under way to address these core questions. We are pleased that the Medi-Cal Policy Institute has initiated a statewide conversation in California to outline a strategic plan for tackling these issues as well as for coordinating between the state programs themselves. In this forum, California's insurance programs can discuss with advocates and other stakeholders what strategies are feasible and effective and what is not working.

PARTNERS. Partners in the community, such as community organizations, health plans, and counties, have already proved themselves to be valuable to state insurance programs in their effort to assist and enroll families. A relatively modest investment in nurturing these partnerships can help the programs understand the problems families are having keeping their children covered and can continue to attend to families' specific needs. With the recent proposed state reductions in community outreach, it is especially important now to find public and private sources of funds to bolster partners' valuable work.

The state can strengthen its partners' capacity by the following:

Strategy 1 Reinstate funding for community- and school-based outreach contracts. While some assistance remains in the form of Certified Application Assistant (CAA) enrollment fees, these are not sufficient to support the ongoing efforts that community groups must undertake to help children keep their coverage throughout the year, including education about how to stay covered, and how to seek services, follow-up and troubleshooting for families, and tracking families' renewal. In addition, the community- and school-based outreach contractors are essential for providing the type of specialized assistance needed to serve particularly vulnerable families with special needs like transportation, language translation, or fears about medical care.

Strategy 2 Reimburse CAAs $50 for renewals. The state already reimburses CAAs $50 for initial enrollments. However, CAAs are only paid $25 per renewal for Healthy Families and nothing for Medi-Cal. CAAs provide significant follow-up and reminders to families before even assisting a family with the renewal application in order to ensure that the child's coverage is in fact renewed. These efforts should be considered in the reimbursement amount for both Medi-Cal and Healthy Families.

Strategy 3 Take better advantage of partners' unique relationships with families. The state should encourage health plans to further promote preventive care for children and to educate families on how to use services through their network. In addition, the state should involve schools and community organizations that families have turned to, or have an ongoing relationship with, to better assist them in navigating the critical junctures in the programs' processes (e.g. the renewal process) so that children will not be dropped unnecessarily from coverage.

Moreover, there are many promising activities being conducted by California's community-based organizations, health plans, and counties. These allies can learn from each other's strategies. To this end, The 100% Campaign will soon release a supplement, "Helping Children Keep Health Insurance Coverage: The Important Role of Local Partners," which highlights promising strategies pursued by these partners. The state should also share best practices by identifying other promising strategies in the field and providing its partners with examples and guidance.

Strategy 4 Incentivize county efforts to help families maintain Medi-Cal coverage. Adequate state funding for county Medi-Cal administration should be provided to support the counties' core functions of enrolling families. Additional reimbursements should be earmarked to promote the additional efforts needed to proactively help families keep their coverage. For example, state funding for county Medi-Cal administration should include incentive payments for counties that engage in strong retention strategies.

Strategy 5 Coordinate Medi-Cal and Healthy Families with county health insurance programs. The state should develop links with the county insurance programs to create, to the extent possible, seamless and coordinated coverage for children who must transfer between insurance programs and for children in split families. At the very least, state insurance programs should inform and assist families in enrolling in county

insurance when their children are no longer eligible for state insurance. In addition, the collaboration created from implementing county insurance programs can be invaluable in assisting families with state insurance coverage so families can access the right program through one door.

SEALING UP THE CRACKS: THE FIVE CRITICAL JUNCTURES IN PROGRAM PROCESS

Based on what our research has revealed about the five critical places in the process where families must pay special attention in order to keep their children covered, it is much clearer now which measures can seal up the cracks through which children fall. Notably, many of the recommendations will require investments in planning and infrastructure, particularly in data systems. Such investments will result in a program that functions more like private insurance, by simplifying and expediting family participation.

1 COORDINATING AMONG INSURANCE PROGRAMS

Strategy 1 Synchronize Medi-Cal and Healthy Families renewals.

At a minimum, Medi-Cal and Healthy Families should use the same renewal forms. In addition, there are some important ways in which California can synchronize the renewal dates for families. While it may be difficult to do so for all families, each insurance program should at least allow children in split families to renew coverage together at one time, applying a "rolling renewal" model. For example, when a family renews one child in Healthy Families, they should be given the opportunity to also renew coverage for their Medi-Cal child. The Medi-Cal renewal anniversary would be reset for a year later, which in effect synchronizes renewal dates. As with all rolling renewal approaches, it is important to ensure that children do not lose their guaranteed 12 months of continuous coverage.

Strategy 2 Coordinate Medi-Cal/Healthy Families renewal with other public programs by allowing "express," or "rolling," renewals. Some states coordinate the renewal for insurance programs with *other* public programs to increase the likelihood that families will successfully renew coverage — a one-stop shopping approach. These express, or rolling, renewals are designed to give families a convenient way to renew their insurance at locations where they receive other services, even before their next regularly scheduled renewal period. In select offices in New York City, when families re-enroll with the Food Stamp Program, their health coverage is also renewed, and their next renewal is rescheduled a year in advance.[90] When California's Express Lane Eligibility through Food Stamps and School Lunch programs are fully implemented, the state should allow these programs to also provide express health insurance renewals.

Strategy 3 Automatically enroll children transferring between Medi-Cal and Healthy Families to create a truly seamless bridge. A child no longer eligible for Medi-Cal should be automatically enrolled into Healthy Families by the county. The automatic enrollment would improve upon the bridge program by avoiding any administrative glitches that may occur as eligibility information is transferred from one program to the next. Counties are willing and able (with resources) to enroll children in Healthy Families. Because only public workers can officially enroll children in Medi-Cal, either public workers could be placed where Healthy Families eligibility determinations are made, or Healthy Families could provide "accelerated" enrollment for children transferring to Medi-Cal, similar to initial enrollment.

Strategy 4 Create a bridge for Medi-Cal and Healthy Families children transferring to county insurance programs. Some county initiatives have created bridge coverage for children leaving county insurance for state insurance coverage. For example, Santa Clara's Healthy Kids program provides a two-month bridge — or continued Healthy Kids coverage — while the family fills out the state insurance application.

Healthy Families and Medi-Cal do not offer a similar transition for children who may be eligible for a county initiative insurance. When children lose state insurance program coverage but become eligible for a county insurance program, the state insurance programs should coordinate with the county initiatives to ensure that children can move successfully into their new coverage. For example, Healthy Families should provide two months of bridge coverage for children who are no longer eligible for Healthy Families but may be eligible for a county initiative (e.g. family income has increased above Healthy Families eligibility levels). Healthy Families, in turn, could transfer the child's renewal information to the county initiative for enrollment in the county insurance program. In addition, Healthy Families should accept county insurance applications forwarded by the county initiatives and process them for Healthy Families enrollment.

Strategy 5 Streamline Medi-Cal and Healthy Families Eligibility Rules. Optimally, all children in a single family should be enrolled in the same program. Eighteen states' Medicaid programs have a uniform income-eligibility standard for all children in a family, removing the "age-based" income standard that California still uses.[91] For example, Medicaid provides coverage for all children with family incomes below 133 percent of federal poverty level (FPL) (not just for those below age 6). California should make this commonsense change so that all children in a family whose income is below 133 percent of FPL are eligible for Medi-Cal.

2 SIMPLIFYING THE RENEWAL PROCESS

Strategy 1 Adopt "fast track" or "accelerated" renewal for children. Under the most effective fast-track approach, the state would conduct *ex parte* reviews prior to sending pre-printed renewal forms to families, requesting only their self-declaration of changes to the information provided. If there are no changes, the family submits nothing. Such an approach shifts much of the burdensome legwork from the family to the program that can determine continued eligibility far more efficiently.

There are varying degrees to which California could shift the burden from families to behind-the-scenes administration, such as implementing the SB 87 rules in both Medi-Cal and Healthy Families to conduct *ex parte* reviews prior to requesting eligibility information from families. If the state requires some acknowledgement from families, family members can either sign a pre-printed postcard confirming the eligibility information or phone in their confirmation. In doing so, California would be maximizing the federal flexibility while still upholding program integrity through sample post- renewal eligibility audits.

Strategy 2 Allow families to self-declare income at annual renewals with sample audits. At a very minimum (if California does not adopt fast track), the state should not require families to submit additional documentation at renewal. Both programs would benefit from allowing families to self-declare, avoiding extensive resources

invested in tracking down missing documentation. It would also make it easier for California to obtain the necessary information over the phone. This self-declaration policy can be adequately monitored for any misinformation by checking, after renewal, a statistically significant sample of cases for eligibility — similar to the random sample of checks on tax returns. Again, several states now use this streamlined approach with sufficient safeguards and those that have analyzed their policy have reported no change in eligibility error rates or abuse.

Strategy 3 Eliminate the assets test for Medi-Cal families. The documentation of assets required for parents creates a significant hurdle for children who are eligible. An incomplete renewal form could jeopardize a child's coverage even though children are eligible regardless of assets. In addition, a parent's savings for, say, a child's education or a rainy day fund should not jeopardize the child's eligibility for health insurance.

3 MAKING PREMIUMS EASIER TO PAY

Strategy 1 Rectify the apparent Healthy Families administrative errors in lost payments. While lost payments may occur only occasionally, the program should ensure that its administration is operating effectively. Not only are children needlessly losing insurance, administrative problems also blemish the reputation of the program.

Strategy 2 Offer some leniency when families in Healthy Families face short periods of financial difficulty. The program should offer one-time hardship relief or create a payment plan for families to pay back missed payments.

Strategy 3 Notify families about possible lower premiums and no-cost Medi-Cal when families fail to pay Healthy Families premiums. Some families may not be paying premiums because their income has dropped and they can no longer afford them. Healthy Families offers a lower premium for those with income below 150 of FPL, and Medi-Cal offers coverage without imposing premiums because even modest premiums are difficult to pay with very low incomes. California can be more proactive in ensuring that families are aware and avail themselves of these lower premiums and no-cost Medi-Cal when they cannot pay Healthy Families premiums.

Strategy 4 Simplify and incentivize the payment option to deduct premiums from paychecks. Healthy Families should send participating employers a consolidated invoice for all workers with Healthy Families children. In addition, Healthy Families should encourage the paycheck deduction option by offering families discounted premiums, similar to those offered to families who pay in advance or through electronic funds transfer.

4 COMMUNICATING EFFECTIVELY WITH FAMILIES

Strategy 1 Educate families up front and often that they must renew their children's coverage every year. An emphasis at enrollment (e.g. welcome calls) and reminders through regular correspondence, in addition to a specific renewal outreach campaign, could increase the likelihood that parents know they must renew.

Strategy 2 Color-code the important notices that require families' immediate response. A yellow renewal form within a renewal packet would highlight which paper requires parents' response. Also, yellow, orange, then red bands across the top of notices for late premium payments would identify the level of urgency.

Strategy 3 Keep addresses up to date and ensure notices are in the appropriate language. The programs could institute a regular process of asking if a family's address has changed whenever a parent contacts the program. This approach is standard practice for some health plans when members call in for any reason. Healthy Families should accept updated addresses from health plans, with families' consent, in a similar manner to which Medi-Cal intends to accept updated addresses.

5 ENCOURAGING THE USE OF SERVICES ONCE INSURED

Strategy 1 Ensure utilization standards for children's care. Healthy Families' contracts with health plans should require plans to deliver at least the recommended periodicity for children's well-child care, similar to the standards in Medi-Cal plan contracts. Most importantly, the programs should enforce these standards.

Strategy 2 Monitor and report children's use of health services when covered. The insurance programs should require health plans to report utilization data, at the very least on key indicators such as use of recommended preventive care visits and immunizations. The programs should regularly report whether children in the various health plans are receiving needed care.

Strategy 3 Promote preventive care. The programs should encourage health plans to more regularly educate families on how to use services through a health plan and on the benefits of preventive care. Healthy Families and Medi-Cal should promote preventive care by offering incentives. For example, families could receive a discount on Healthy Families premiums — one free month for every recommended checkup or immunization the child receives.

Strategy 4 Develop a coordinated listing of health plans that are available to split families. One system for choosing health plans under Medi-Cal and Healthy Families would allow families to identify which plans in both programs provide coverage for their family doctor. For example, the Healthy Families provider locator system could be modified to provide the list of Medi-Cal plans in the area covering particular providers.

MOVING FORWARD ON THESE POLICY RECOMMENDATIONS

As the state begins to adopt these recommendations, counties will need appropriate training as well as funding and the time to implement the changes well. In certain cases, like eliminating income documentation, counties will have freed-up resources they can use to promote continued coverage rather than to chase down families' pay stubs.

In undertaking these recommendations, consideration should be given to trying out certain ideas through pilots that can be evaluated either on a local or statewide basis to quantify their impact on children's continued coverage. Targeted demonstrations and their evaluation results can show policymakers whether the tested approaches are accurately targeting eligible children. (See highlight box for possible pilot projects).

Recommendations That Could Be Tested As Pilots

- *Elimination of documentation requirements at renewal;*
- *Leniency or hardship relief for families not paying premiums;*
- *Premium deductions from workers' paychecks;*
- *Premium discounts for using preventive care;*
- *Leveraging community partners in keeping children covered; and*
- *Best practices for community-based retention plans.*

CONCLUSION

Medi-Cal and Healthy Families continues to make progress in improving children's chances of keeping their health insurance coverage. This report documents areas in both programs that could be further improved — families still face onerous requirements that can jeopardize coverage. To succeed at keeping eligible children covered, policymakers must not only remove the administrative hurdles families face, but also shift their mindset that has valued many of these requirements as gatekeepers to the system. We believe strongly in the need for program integrity and effective safeguards against abuse. But these goals must be *balanced* with the measures needed to keep eligible children covered. Experiences from other states have shown that streamlined and family-friendly insurance programs can *both* accurately target eligible children and make it easier for those eligible children to continue their coverage.

With the establishment of Medi-Cal and Healthy Families, the state has made an important commitment to provide its uninsured children with health insurance. These state insurance programs had considerable success at enrollment, and state and local program administrators show a clear commitment to taking enrollment efforts to the next level. Continued coverage is the ultimate measure of the value insurance can provide, particularly for children. It is our vision that insurance program coverage will be as ongoing, reliable, and successful as school attendance. Because health and learning are inextricably linked, both are essential for the healthy development of children.

We look forward to vigorous public debate about our findings and recommendations. We are eager to work with all interested parties to build strong and effective health insurance programs for California's children in which existing cracks are carefully sealed up.

Appendix A: Endnotes

[1] Calculated using data from the U.S. Census Bureau. Bureau of the Census, *Current Population Survey - March 1998*, Bureau of the Census (Washington, D.C., 1998).

[2] Ages 0 – 20 as of January 2002. Department of Health Services, Medical Care Statistics Branch, *Medi-Cal Eligibility Profiles by County, January 2002* (Sacramento, CA, 2002).

[3] Total current enrollment in Healthy Families was 562,614 as of June 7, 2002. Managed Risk Medical Insurance Board, *Healthy Families Program Summary - June 2002* (Sacramento, CA, 2002) http://www.mrmib.ca.gov/MRMIB/HFP/HFPRptSum.html

[4] Children Now, *California Report Card 2000: How Young People are Faring Today* (Oakland, CA: Children Now, 2000); R. Rothstein, "Rx for Good Health and Grades," *New York Times*, September 11, 2002.

[5] P.W. Newacheck, J.J. Stoddard, D.C. Hughes and M. Pearl, "Health insurance and access to primary care for children," N*ew England Journal of Medicine* 338 (8): 513 – 519 (1998); M.D. Kogan, G.R. Alexander, M.A. Teitelbaum, B.W. Jack, M. Kotelchuck and G. Pappas. "The effects of gaps in health insurance on continuity of care among preschool-aged children in the United States," *JAMA* 274(18): 1472-1473 (1995). Also, a 1997 health survey in Los Angeles County found that that the uninsured were almost three times as likely to not have a regular source of care (37%) compared to those enrolled in Medi-Cal insurance (12%). Los Angeles County Department of Health Services, Public Health Office Health Assessment and Epidemiology, *1997 Los Angeles County Health Survey* (Los Angeles, 1997).

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[9] G. Melnick et al., Center for Health Financing, Policy and Management, School of Policy, Planning and Development, University of Southern California, Evaluation of the *Los Angeles CalKids Program: Full Report* (Los Angeles: University of Southern California, 2002).

[10] C. Irvin, P. Peikes, C. Trenholm, N. Khan and Mathematica Policy Research, Inc, *Discontinuous Coverage in Medicaid and the Implications of 12-Month Continuous Coverage for Children* (Cambridge, MA: Mathematica Policy Research Inc, 2001).

[11] Personal communication with Cathy Senderling, County Welfare Directors Association, May 2002.

[12] E.R. Brown, N. Ponce, T. Rice and S.A. Lavarreda, *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey* (Los Angeles: UCLA Center for Health Policy Research, 2002).

[13] Effective July 2002.

[14] S. Soto-Taylor, S. Kolla and W. Sanchez, Managed Risk Medical Insurance Board, *Healthy Families/Medi-Cal for Families Application Assistance Fact Book* (Sacramento, CA, 2002). http://www.mrmib.ca.gov/MRMIB/HFP/CAAFactBk.pdf

[15] Medi-Cal/Healthy Families health plans that are certified to assist families with enrollment may not: conduct door-to-door marketing, or telephone or in-person soliciting; sponsor a families' HF premiums; offer gift or monetary inducements to apply; and, as with CAAs, may not influence a family's choice of health plans. They may participate and assist at public awareness events with all plans present and they may assist families that contact them or those who are current subscribers.

[16] E.R. Brown, N. Ponce, T. Rice and S.A. Lavarreda, *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey* (Los Angeles: UCLA Center for Health Policy Research, 2002).

[17] Lake, Snell, Perry, & Associates, *How and Why Eligible Children Lose or Leave SCHIP/Healthy Families: California Graphic Report* (Washington, D.C., 2002). Released at MRMIB Board Meeting, Agenda Item 5.g. on June 26, 2002.

[18] C.R. Gresenz and J.A. Klerman, *Beyond Medi-Cal: Health Insurance Coverage Among Former Welfare Recipients* (Oakland, CA: Medi-Cal Policy Institute, 2002).

[19] Managed Risk Medical Insurance Board, *Healthy Families Program Children Disenrollment Statistics, HFP Report 9* (Sacramento, CA, 2002). Data available between February 2001 and May 2002 (Sacramento, CA: MRMIB, June 2002). To calculate this estimate, we used data from June 2001 through May 2002. http://www.mrmib.ca.gov/MRMIB/HFP/HFPRpt9.pdf

[20] Total current enrollment in Healthy Families was 562,614 as of June 7, 2002. Managed Risk Medical Insurance Board, *Healthy Families Program Summary - June 2002* (Sacramento, CA, 2002). http://www.mrmib.ca.gov/MRMIB/HFP/HFPRptSum.html

[21] Managed Risk Medical Insurance Board, *Retention and Disenrollment, June 1998 to December 2000* (Sacramento, CA, 2002). (Released at MRMIB Board Meeting, Agenda Item 5 g, 5/26/02.) The MRMIB analysis examined a 13-month period in order to capture the effect of the annual renewal process. In addition, the analysis found that 6% of children re-enrolled after 16 months from initial enrollment.

[22] A.W. Dick, R.A. Allison, S. Haber, C. Brach and E. Shenkman. "Consequences of States' Policies for SCHIP Disenrollment," *Health Care Financing Review* 22 (3): 65-88 (2002). (Florida: 61%; Kansas: 32%; New York: 48% adjusted for presumptive eligibility enrollment; and Oregon: 12%).

[23] California Department of Health Services, Fiscal Forecasting and Data Management Branch, *Analyses Relating to Use of Aid Code '7X'* (Bridge to Healthy Families) and Continuing Eligibility for Children, September 2002. This estimate is based on the cohort of Medi-Cal children enrolled in August 2000. The retention rate reflects 13 months of coverage to include the effects of the annual redetermination.

[24] A. Cox, J.A. Klerman, The RAND Corporation, I. Aguirre Happolt and Medi-Cal Policy Institute, *Medi-Cal After Welfare Reform: Enrollment Among Former Welfare Recipients* (Oakland, CA: Medi-Cal Policy Institute, 2001).

[25] Managed Risk Medical Insurance Board, *Healthy Families Program Children Disenrollment Statistics, HFP Report 9*, Data available between February 2001 and June 2002 (Sacramento, CA: MRMIB, June 2002). To calculate data for this report, we used available disenrollment statistics from February 2001 through June 2002. http://www.mrmib.ca.gov/MRMIB/HFP/HFPRpt9.pdf

[26] Lake, Snell, Perry, & Associates, *How and Why Eligible Children, California Graphic Report*, 2002.

[27] Medi-Cal Policy Institute, Lake Snell Perry & Associates and Dr. Robert Valdez, *Speaking Out...What Beneficiaries Say about the Medi-Cal Program* (Oakland, CA: Medi-Cal Policy Institute, 2000); E.R. Brown, N. Ponce, R. Rice and S.A. Lavarreda. *The State of Health Insurance in California: 2001 California Health Interview Survey* (Los Angeles: UCLA Institute for Health Policy Studies, 2002); L. Wong, T.G. Winterbauer. *Barriers to Re-enrollment in Medi-Cal and Strategies for Retaining Eligible Children: Parents and County Workers Speak Out in Santa Clara County* (Washington, D.C.: Institute for Health Policy Solutions, July 2001).

[28] Managed Risk Medical Insurance Board, *Retention and Disenrollment, June 1998 to December 2000*, (Sacramento, CA, 2002). (Released at MRMIB Board Meeting, Agenda Item 5 g, 5/26/02.) According to MRMIB analysis, 6% of children re-enrolled within four months of disenrollment.

[29] C.R. Gresenze, J.A. Klerman and The RAND Corporation for Medi-Cal Policy Institute, *Beyond Medi-Cal: Health Insurance Coverage among Former Welfare Recipients* (Oakland, CA: Medi-Cal Policy Institute, 2002). The sampling frame includes families who received cash aid some period between January and December 1999. Survey data was collected between August 2000 and March 2001.

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[32] Medi-Cal Policy Institute, *Speaking Out*, 2000

[33] Ibid.

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[34] A.W. Dick, "Consequences of States' Policies for SCHIP Disenrollment," *Health Care Financing Review*, 2000; R. Riley, C. Pernice, National Academy of State Health Policy; M. Perry, S. Kannel, Lake, Snell, Perry & Associates. Why Eligible Children Lose or Leave SCHIP. Findings from a comprehensive study of retention and disenrollment (Portland, ME, 2002).

[35] Lake, Snell, Perry & Associates, *How and Why Eligible Children, California Graphic Report*, 2002.

[36] C.R. Gresenze, *Beyond Medi-Cal*, 2002. The sampling frame includes families who received cash aid some period between January and December 1999. Survey data was collected between August 2000 and March 2001.

[37] The Agency for Healthcare Research and Quality (AHRQ), the Health Resources and Services Administration (HRSA) and the David and Lucile Packard Foundation have funded research tracking retention data in New York, Florida, Kansas, and Oregon. NASHP commissioned a survey of families losing their children's SCHIP coverage in seven states (AL, AZ, CA, GA, IA, NJ, and UT).

[38] I. Hill and A. Lutzky Westpfahl, *Is There a Hole in the Bucket…Understanding SCHIP Retention*, (Washington, D.C.: The Urban Institute, Forthcoming).

[39] Federal rules require families to provide documentation to verify immigration status, not citizenship.

[40] A.W. Dick, "Consequences of States' Policies," *Health Care Financing Review* (2002).

[41] Implemented July 2002.

[42] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage - CMS Publication Number 11000* (Washington, D.C., 2001).

[43] Personal communication with Coleen French, Michigan Department of Community Health, July 16, 2002.

[44] C. Mann, D. Rousseau, R. Garfield and M. O'Malley, *Reaching Uninsured Children Through Medicaid: If You Build It Right, They Will Come* (Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured, 2002).

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[46] California Department of Health Services, Fiscal Forecasting and Data Management Branch, *Analyses Relating to Use of Aid Code '7X' (Bridge to Healthy Families) and Continuing Eligibility for Children*, September 2002. These estimates are based on a 10% sample for the months July 1999 through July 2002.

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[50] Lake, Snell, Perry, & Associates, *How and Why Eligible Children, California Graphic Report*, 2002;

Managed Risk Medical Insurance Board, *Annual Eligibility Review courtesy call*, 2001.

[51] S. Kannel, M. Perry, T. Riley and C. Pernice, *What Parents Say: Why Eligible Children Lose SCHIP: Findings From the Focus Groups for the SCHIP Retention and Disenrollment SWOT Team Study* (Washington, D.C.: National Academy for State Health Policy, 2001) and Lake, Snell, Perry & Associates, *How and Why Eligible Children, California Graphic Report*, 2002.

[52] Lake, Snell, Perry & Associates, *How and Why Eligible Children, California Graphic Report*, 2002.

[53] Managed Risk Medical Insurance Board, *Annual Eligibility Review courtesy call*, 2001.

[54] Lake, Snell, Perry & Associates, *How and Why Eligible Children, California Graphic Report*, 2002.

[55] A.W. Dick, "Consequences of States'," *Health Care Financing Review*, 2002.

[56] C. Irvin, P. Peikes, C. Trenholm, N. Khan and Mathematica Policy Research, Inc. for The Health Resources and Services Administration, *Discontinuous Coverage in Medicaid and the Implications of 12-Month Continuous Coverage for Children* (Washington, D.C.: Mathematica Policy Research, Inc, 2001).

[57] D. Ross, L. Cox, *Enrolling Children and Families in Health Coverage: The Promise of Doing More* (Menlo Park, CA: Kaiser Family Foundation, 2002).

[58] California Department of Health Services, Fiscal Forecasting and Data Management Branch, *Analyses Relating to Use of Aid Code '7X' (Bridge to Healthy Families) and Continuing Eligibility for Children*, September 2002.

[59] The Centers for Medicare and Medicaid Services (CMS) recommends that states should verify income via computer matches and ex parte review. For income that cannot be verified through Income Eligibility Verification System (IEVS), CMS encourages audits or other procedures to ensure integrity. T. Westmoreland, Health Care Financing Administration, *State Medicaid Director Letter, "Efforts to Improve Families' Ability to Enroll in Medicaid,"* (Washington, D.C., April 7, 2000). (http://www.hcfa.gov/medicaid/letters/smd40700.htm); T Westmoreland, Health Care Financing Administration, *Letter to State Quality Control Directors, "MEQC and other Monitoring Activities,"* (Washington, D.C., September 12, 2000); U.S. Department of Health and Human Services, *Continuing the Progress*, 2001.

[60] The Southern Institute on Children and Families, *The Burden of Proof: How Much is too Much for Child Health Coverage*, September 1998. (Columbia, S.C.: Southern Institute on Children and Families, 1998).

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[64] Note: Both programs allow families to submit affidavits if they have jobs that do not provide regular income documentation.

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[66] D. Ross, L. Cox, *Enrolling Children and Families in Health Coverage: The Promise of Doing More* (Menlo Park, CA: Kaiser Family Foundation, 2002).

[67] D. Holmes, Michigan Department of Community Health, "Using Data to Focus Outreach, and Improve Enrollment and Retention in Michigan's SCHIP Program–MICHild." Slides presented at the National Academy of Sciences, Washington, D.C., June 19, 2001.

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[69] D. Ross, *Enrolling Children and Families in Health Coverage*, 2002.

[70] County of Los Angeles, Department of Public Social Services, *Medi-Cal Program Interpretation Handbook, Article 4: Application Process, Redetermination Process*, August 28, 2001. (Los Angeles: L.A.D.P.S.S., 2001).

[71] A.W. Dick, "Consequences of States'," *Health Care Financing Review*, 2002.

[72] Personal communication with Irma Michel, Deputy Director, Eligibility, Outreach, and Marketing, Managed Risk Medical Insurance Board, July 22, 2002.

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[73] Ibid

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[75] California State Budget 2002-2003 Trailer Bill, AB 442 (Chapter 1161, Statutes of 2002, SEC. 22).

[76] Lake, Snell, Perry & Associates, *How and Why Eligible Children, California Graphic Report*, 2002.

[77] Billing statements are available in five languages: English, Spanish, Chinese, Korean, and Vietnamese.

[78] Managed Risk Medical Insurance Board. *Disenrollment Analysis, Summary of Non-payment/10-Day Telephone Calls* (Sacramento, CA, 2001).

[79] Lake, Snell, Perry & Associates, *How and Why Eligible Children, California Graphic Report*, 2002. Other supporting evidence for Medi-Cal communications: L. Wong, T.G. Winterbauer. *Barriers to Re-enrollment in Medi-Cal and Strategies for Retaining Eligible Children: Parents and County Workers Speak Out in Santa Clara County* (Washington, D.C.: Institute for Health Policy Solutions, July 2001) and Managed Risk Medical Insurance Board. *Annual Eligibility Review courtesy call analysis June 2001-October 2001* (Sacramento, CA, 2001).

[80] L .Wong, T.G. Winterbauer. *Barriers to Re-enrollment in Medi-Cal and Strategies for Retaining Eligible Children: Parents and County Workers Speak Out in Santa Clara County* (Washington, D.C.: Institute for Health Policy Solutions, July 2001).

[81] Lake, Snell, Perry & Associates, *How and Why Eligible Children, California Graphic Report*, 2002.

[82] L .Wong, *Barriers to Re-enrollment*, 2001.

[83] Lake, Snell, Perry, & Associates, *How and Why Eligible Children, California Graphic Report*, 2002.

[84] R Riley, *Why Eligible Children Lose or Leave SCHIP*, 2002); E. Shenkman and C. Bono, *The Florida Healthy Kids Program: Participant Retention Project: Preliminary Report* (Gainesville, FL: Institute for Child Health Policy, 2001).

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[86] E. Shenkman and C. Bono, *The Florida Healthy Kids Program: Participant Retention Project: Preliminary Report* (Gainesville, FL: Institute for Child Health Policy, 2001).

[87] Managed Risk Medical Insurance Board, *Healthy Families 2002 Dental Report* (Sacramento, CA, 2002).

[88] Information provided to Managed Risk Medical Insurance Board by Milliman USA, Consultants, and Actuaries, April 22, 2002, as cited in Managed Risk Medical Insurance Board, *Healthy Families 2002 Dental Report* (Sacramento, CA, 2002).

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

[90] These renewals require careful monitoring to ensure that a child does not inadvertently *lose* insurance when renewing coverage in coordination with another program. In states with 12 months of continuous eligibility, it is important that systems are adjusted and staff are trained to guarantee coverage for at least a year even if income changes indicate the child is not eligible.

[91] D. Ross, *Enrolling Children and Families in Health Coverage*, 2002.

Appendix B: Methodology

The findings and recommendations contained in this report were derived from the following sources:
1) A detailed examination of the Medi-Cal and Healthy Families programs;
2) A compilation and review of existing national and state research about retention of children in state health insurance programs;
3) Interviews with officials, advocates, and researchers in nine states about their insurance program designs and strategies for keeping children covered;
4) Interviews with California health plans about their experience with Healthy Families and Medi-Cal and their strategies for keeping children covered; and
5) Group interviews with Certified Application Assistants (CAAs) throughout California that assist families in enrolling in state and local insurance programs.
Appendix E lists those individuals interviewed for this report.

We also examined policies and practices from a sample of other states in an attempt to identify promising ideas and lessons relevant to California. States examined include: Connecticut, Florida, Kansas, Massachusetts, Michigan, New Jersey, New York, Oregon, and Rhode Island. Most of the states we selected are currently implementing strategies to keep children covered through their insurance programs; others were selected based on their inclusion in a national research project conducted by the Child Health Insurance Research Initiative (CHIRI), a collaborative effort between researchers and funders to supply information for improving access and quality health care for children. The CHIRI project is funded by the Federal Agency for Healthcare Research and Quality (AHRQ), The David and Lucile Packard Foundation, and The Health Resources and Services Administration (HRSA). For more information visit www.ahcpr.gov/about/cods/chiri.htm#chiri.

We solicited observations from 42 California Certified Application Assistants (CAAs) whose organizations assist families to enroll in state and local insurance programs. The CAAs were selected to ensure diversity in terms of geographic location, ethnicity and socio-economic background of their clientele, and the type of organizational base (e.g. faith-based, community-based, or school-based). Interviews facilitated by Julie M. Brown and Associates explored their perceptions of the Medi-Cal and Healthy Families program rules and operations, factors affecting whether a child keeps or loses coverage, and suggestions for strategies to keep children enrolled.

Finally, The 100% Campaign interviewed seven California health plans (Alameda Alliance for Health, Blue Cross of California, CalOptima, Community Health Group, Health Plan of San Mateo, Health Net, and L.A. Care) about their coverage strategies for both commercial and public insurance plans, and their experience with Medi-Cal and Healthy Families in particular. The health plans were selected to represent different geographic regions of the state, and we included plans serving large numbers of Medi-Cal and Healthy Families beneficiaries.

Appendix C: Flowchart – Healthy Families Process for Continuing Coverage

The following narrative describes each step a child must go through to enroll and stay enrolled in Healthy Families. It was developed by The 100% Campaign based on a review of program policy and guidance. We highlight particular junctures in the process that can affect a child's continued coverage:

⚠ marks those specific steps in the process in which a child is at risk of losing coverage; ✋ marks when in the process a child is disenrolled from the program because she/he is no longer eligible; and ↻ marks when in the process a child is disenrolled but may still be eligible. In some cases, the child may reapply if the rules and requirements are met. ⬆ marks when a previous process step is repeated.

I) Child is enrolled in Healthy Families.[1] The child is guaranteed eligibility for 12 continuous months.[2] If other siblings are on Healthy Families, their redetermination date now becomes the latest sibling's redetermination date. Each child is assigned a Client Index Number (CIN) and all children in the family enrolled in Healthy Families share the same Healthy Families family member number.

II) At the point of application or eligibility determination, the family chooses a health plan, dental plan, and primary care provider.

III) A welcome letter, an immunization schedule, and the Healthy Families Program (HFP) guide are sent by first-class mail, postmarked within two business days of the eligibility determination.[3]

IV) The family receives welcome packets from the chosen health, dental, and vision plans, including member identification cards.[4]

V) The family receives a "welcome" call[5] from the Healthy Families program between 10 and 20 days after the effective date of coverage.[6] The call provides information about the Healthy Families program and is made in the applicants' chosen language.

⚠ VI) If the family does not submit citizenship or immigration documentation within two months of applying to Healthy Families, the child is **disenrolled**.[7] ↻

⚠ VII) The premium payment process is initiated:

A) A monthly Healthy Families premium bill is sent to family (the family has already paid the first-month's premium at the point of application).[8]

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[1] The child's effective enrollment date is 10 days after the eligibility determination date. Healthy Families notifies the health plan electronically of the eligibility determination and effective date.

[2] Exceptions to 12 months' continuous eligibility include non-payment of premium, not submitting documentation, leaving the state, or becoming ineligible due to age (turning age 19).

[3] Contract between Managed Risk Medical Insurance Board (MRMIB) and Electronic Data Systems, Agreement #97MHF043 A.6. Section IV.F5.

[4] The health, vision, and dental plans have 10 days after the eligibility determination date (before the effective date of enrollment) to send out the identification card and health plan packets.

[5] Healthy Families leaves voice messages with families.

[6] Contract between MRMIB and Electronic Data Systems, Agreement #97MHF043 A.6. Section IV.F.6.

[7] Title 10 California Code of Regulations, chapter 5.8, MRMIB, Healthy Families Program 2699.6611(a)(3) (Emergency Regulations, effective 4/29/02). Previously, families were required to submit immigration documentation within 30 days and citizenship documentation within 60 days of applying to Healthy Families otherwise the child was disenrolled. Approximately 1.2% of all disenrollments are due to not submitting citizenship or immigration documentation within 30 days or 60 days (respectively) of applying for Healthy Families. Managed Risk Medical Insurance Board, Healthy Families Program Children Disenrollment Statistics, HFP Report 9 (Sacramento, CA, 2002). (Sacramento, CA: MRMIB, June 2002). http://www.mrmib.ca.gov/MRMIB/HFP/HFPRpt9.pdf The 100% Campaign calculation is based on data over a 16-month period, from February 2001 to May 2002. It excludes children disenrolled because they were ineligible (at annual renewal or reached age 19).

[8] At the point of application, the family pays the first month only or pays three months of premiums up front to receive the fourth free. Effective July 1, 2002, Healthy Families discontinued pro-rating the first month's premium.

1) Languages: The premium bill is available in English, Spanish, Korean, Vietnamese, and Chinese.

2) Amount: The premium ranges from $4-$9 per month depending on the family income at enrollment. A family is charged for a maximum of three children ($27 maximum premium).

3) Frequency: The family has the option of paying monthly, or paying up front for three months every four months, (receiving the fourth month free).

4) Due date: The premium is due on the 20th of the month.

5) Payment options: The family has four payment options, some with discount incentives:[9]

(a) pay by check, cashier's check or money order with the payment stub and enclosed envelope;

(b) pay by credit card through a toll-free number;

(c) pay by cash at a local Rite Aid store; or

(d) pay through the electronic fund transfer method.[10]

B) If a premium payment is not received by Healthy Families,[11] a warning is included in the next month's invoice.

1) If the family has made the payment but Healthy Families does not have a record of the payment, the program will attempt to track down the payment and credit the account. If the family has been disenrolled and the program finds the payment, the family will be reinstated.

C) If the premium has not been received for 45 days, another warning is sent to the family via mail.

D) If the premium has not been received by the 20th of the second month, HFP contacts the family by phone to remind the family to pay the premium, as well as payment options.[12] A survey is also conducted to determine why families did not make payments and if the family intends to send in the premium.[13]

E) If the family does not make the premium payment by the last day of the second month, the child will be **disenrolled**.[14] A disenrollment letter is sent to the family. The child will be able to reapply using a one-page application and paying any unpaid premiums.[15]

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[9] Healthy Families offers a fifth payment option, payment through wage withholding, but the program has not yet publicized this option. The Healthy Families wage withholding method allows an employer to deduct an employee's Healthy Families premium from her paycheck every month. The employer either has payments directly deducted from their bank accounts or sends in each family's statement on their behalf. Currently, less than 0.5% of Healthy Families subscribers are using the wage withholding method.

[10] As of July 2002, a 25% discount will be provided to all premium payments made by electronic transfer.

[11] For example, a family does not submit a premium payment or the program does not record a submitted payment.

[12] Unfortunately, the Healthy Families Program does not remind families that if their income has changed, they may be eligible for a lower premium or no-cost Medi-Cal.

[13] Managed Risk Medical Insurance Board. Disenrollment Analysis, Summary of Non-payment/10-Day Telephone Calls (Sacramento, CA, 2001).

[14] Currently, a family is disenrolled retroactively to the last full month that a premium was paid. Approximately 35.2% of all disenrollments are due to non-payment of premium. Managed Risk Medical Insurance Board, Healthy Families Program Children Disenrollment Statistics, HFP Report 9 (Sacramento, CA, 2002). (Sacramento, CA: MRMIB, June 2002). http://www.mrmib.ca.gov/MRMIB/HFP/HFPRpt9.pdf The 100% Campaign calculation is based on data over a 16-month period, from February 2001 to May 2002. It excludes children disenrolled because they were ineligible (at annual renewal or reached age 19).

[15] Previously, there was a six-month penalty with certain exceptions, however this policy was eliminated as part of the 2002-2003 State Budget Trailer Bill language, AB 442 (Chapter 1161, Statutes of 2002, SEC. 22).

F) Within 30 days of disenrollment, the family is contacted by phone (three times on different days and times, including the evening and Saturday) to determine the reason for disenrollment. If the family cannot be reached after three attempts, a written postage-paid disenrollment survey is sent to the family. The survey is coded to link back to the family member number.

VIII) Child utilizes services. The family may make the first appointment due to a pressing medical concern, or for preventive measures such as a physical or vaccination.

IX) If the child reaches age 19 before the anniversary date, the child is **disenrolled** at the end of the month of his or her birthday.[16]

X) If the child leaves the state, the child is **disenrolled**.

XI) Two months prior to the child's anniversary date, the Annual Eligibility Review (AER) Process is initiated.

A) The AER packet is sent to the HFP applicant 60 days prior to the anniversary date.

1) Content: Renewal form which already includes child/children's names, date of birth, address, and family member number.

2) Languages: English, Spanish, Vietnamese, Khmer, Hmong, Armenian, Chinese, Korean, Russian, and Farsi.

3) Requirements: Complete and submit partially pre-printed renewal form with eligibility information about family members' health insurance status, relationship to child, birth date, monthly income, including updated income documentation before the end of their anniversary month.[17]

B) Sixty days prior to the anniversary date, the health plan and authorized Certified Application Assistants (CAAs) are notified about the member's renewal date, enabling them to remind the family to submit the AER packet.[18]

C) If the family responds before the end of their anniversary month:

1) If the family sends a complete AER packet:

(a) If the child is Healthy Families eligible, a congratulations letter is sent which lists the children covered and notifies the family which children are eligible for Healthy Families for another 12 months of coverage. The anniversary date is based on the anniversary date of the last member of the family to be added.

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[16] Title 10 California Code of Regulations, chapter 5.8, Managed Risk Medical Insurance Board, Healthy Families Program 2699.6611(a)(2). (Emergency Regulations, effective 4/29/02.) Approximately 6% of all disenrollments are due to the child reaching age 19. Managed Risk Medical Insurance Board, Healthy Families Program Children Disenrollment Statistics, HFP Report 9 (Sacramento, CA, 2002). (Sacramento, CA: MRMIB, June 2002). http://www.mrmib.ca.gov/MRMIB/HFP/HFPRpt9.pdf The 100% Campaign calculation is based on data over a 16-month period, from February 2001 to May 2002.

[17] If the family has no other means of providing income documentation, the family can submit a written affidavit of income. Title 10 California Code of Regulations, chapter 5.8, Managed Risk Medical Insurance Board, Healthy Families Program 2699.6600(c)(1)(J)(3). (Emergency Regulations, effective 4/29/02.) Providing income documentation is difficult for some families, especially cash-based workers. Income documentation (a pay stub or federal personal income tax return) is not a state or federal law but required through the state Healthy Families regulations. The federal guidelines, in fact encourage states not to require income documentation.

[18] Implemented April 2001 for health plans. When the new joint application is released, families can authorize the Healthy Families Program to notify the enrollment entity (or CAA), which assisted them in applying, of children's anniversary renewal date. The date for the new application release is to be determined.

(b) If the child is determined ineligible due to low income:

(i) If the family has authorized the transmittal of information, the AER packet will be forwarded to the family's local county welfare office for no-cost Medi-Cal determination and a letter indicating the transfer of information is sent to the family.[19] If the family is indeed determined to be eligible for no-cost Medi-Cal by the county eligibility worker, the child is enrolled in Medi-Cal. (See Appendix D for Medi-Cal for Children flowchart.)

(a) While the information is being transmitted and the county is making an eligibility determination, Healthy Families will provide two months of coverage in what is called the "bridge program." Families must continue to pay the Healthy Families premiums in order to maintain coverage during this bridge program.[20]

(b) Healthy Families has the ability to track the application to the county and report how many applications were successful and pending (by county); however, Healthy Families has the ability to track denials only for cases which receive accelerated enrollment in Medi-Cal.

(c) The Single Point of Entry (SPE) liaisons will troubleshoot any applications bounced back between Healthy Families and the county.[21]

(ii) If the family has not authorized the forwarding of the AER form for consideration as a Medi-Cal application, then the Healthy Families program sends a letter asking the family to reconsider Medi-Cal screening as an option. The child is placed on the Healthy Families "bridge program" to Medi-Cal.

(c) If the child is determined to be ineligible for Healthy Families, then the child is **disenrolled**. A denial letter explaining the reason for denial (including information about appeal rights and a program review form) is sent to the family.[22]

2) If the family submits an incomplete AER packet:

(a)The Healthy Families Program sends an "Incomplete Packet" letter, which describes the reasons, why the packet is incomplete and the date at which the child will be disenrolled. The letter is available in English, Spanish, Chinese, Vietnamese, and Korean.

[19] Effective July 1, 2002. The transmittal of information also includes an income computation, the CIN, and the reason why the application is being transferred to the county. Contract between MRMIB and Electronic Data Systems, Agreement #97MHF043 A.6. Section IV.B.5 (b).

[20] Title 10 California Code of Regulations, chapter 5.8, Managed Risk Medical Insurance Board, Healthy Families Program 2699.6611(g). (Emergency Regulations, effective 4/29/02).

[21] Three SPE liaisons are employed at single point of entry to troubleshoot any applications that are returned from the county to single point of entry. Contract between MRMIB and Electronic Data Systems, Agreement #97MHF043 A.6. Section IV.B.6 (a).

[22] For example, the applicant requests disenrollment, the family's income is too high or too low, the subscriber reaches age 19, or the applicant is covered by no-cost Medi-Cal. Approximately 21% of all disenrollments from Healthy Families Program are due to child's ineligibility at the annual renewal due to income being too high, too low, currently enrolled in no-cost Medi-Cal, or currently enrolled in employer-sponsored coverage. Managed Risk Medical Insurance Board, Healthy Families Program Children Disenrollment Statistics, HFP Report 9 (Sacramento, CA, 2002). (Sacramento, CA: MRMIB, June 2002). http://www.mrmib.ca.gov/MRMIB/HFP/HFPRpt9.pdf The 100% Campaign calculation is based on data over a 16-month period, from February 2001 to May 2002.

(b)The Healthy Families Program makes three attempts to contact the family by phone[23] for missing information. Attempts to contact the family are made on different days and times, including a Saturday.

(c) If the information is received by the end of the anniversary month, eligibility is determined. (Follow steps XI. C. 1)

(d) If the missing information is not received by the end of the anniversary month, the subscriber is **disenrolled**.[24]

(i) A disenrollment letter with appeal rights and a "Still Not Too Late to Return the AER package" letter is sent to the family.[25]

(ii) The family has 60 days from the disenrollment date to return the complete AER package with a break in coverage.

(iii) After 60 days from the disenrollment date have passed, the family must reapply to Healthy Families using the standard joint Healthy Families/Medi-Cal for Children (HF/MCC) application.[26]

D) If the family does not respond before the anniversary date:

1) Approximately 30 days after sending the renewal packet, HFP sends a reminder postcard, which requests a response within 30 days and provides contact information for the AER Unit at HFP. The post-card is available in five languages: English, Spanish, Chinese, Vietnamese, and Korean.

2) During the second 30-day period, HFP attempts to contact the family via phone[27] three times on different days and times, including a Saturday. HFP conducts a survey during the call to determine if the family received AER package, if the package is in the proper language, if the family needs assistance, and reasons for not returning AER package. HFP then tracks the return rates of the families who planned or did not plan to return the AER package.[28]

3) If the family does not submit the AER packet before the end of the month of their anniversary date, the subscriber is **disenrolled**. Steps (XI)(C)(2)(d)(i-iii) apply.

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[23] Healthy Families may leave voice messages but does not currently describe the reason for the call.

[24] Approximately 23.0% of all disenrollments from Healthy Families are due to incomplete AER submissions. Managed Risk Medical Insurance Board, Healthy Families Program Children Disenrollment Statistics, HFP Report 9 (Sacramento, CA, 2002). (Sacramento, CA: MRMIB, June 2002). http://www.mrmib.ca.gov/MRMIB/HFP/HFPRpt9.pdf The 100% Campaign calculation is based on data over a 16-month period, from February 2001 to May 2002. It excludes children disenrolled because they were ineligible (at annual renewal or reached age 19).

[25] Approximately 31.2% of all disenrollments from Healthy Families Program are due to AER information not received by the due date. Managed Risk Medical Insurance Board, Healthy Families Program Children Disenrollment Statistics, HFP Report 9 (Sacramento, CA, 2002). (Sacramento, CA: MRMIB, June 2002). http://www.mrmib.ca.gov/MRMIB/HFP/HFPRpt9.pdf The 100% Campaign calculation is based on data over a 16-month period, from February 2001 to May 2002. It excludes children disenrolled because they were ineligible (at annual renewal or reached age 19).

[26] Contract between MRMIB and Electronic Data Systems, Agreement #97MHF043 A.6. Section IV.L.11.

[27] Healthy Families may leave voice messages, but does not currently describe the reason for the call.

[28] Managed Risk Medical Insurance Board. Annual Eligibility Review courtesy call analysis June 2001-October 2001 (Sacramento, CA, 2001).

Appendix D: Flowchart – Medi-Cal for Children[1] Process for Continuing Coverage

The following narrative describes each step a child must go through to enroll and stay enrolled in Healthy Families. It was developed by The 100% Campaign based on a review of program policy and guidance. We highlight particular junctures in the process that can affect a child's continued coverage:

⚠ marks those specific steps in the process in which a child is at risk of losing coverage; ✋ marks when in the process a child is disenrolled from the no-cost program because she/he is no longer eligible; and ↻ marks when in the process a child is disenrolled but may still be eligible. A child may reapply if the rules and requirements are met. ⬆ marks when a previous process step is repeated.

I) Child is enrolled in no-cost Medi-Cal. The child is guaranteed 11 months of continuous eligibility following at least one month of no-cost Medi-Cal, regardless of changes in income or family size.[3] The child is assigned a Medi-Cal identification number and a Client Index Number (CIN).

II) The family chooses a health plan and primary care provider within 30 days of enrollment. If the family does not choose a health plan or primary care provider, a health plan is assigned for them.

III) The family receives an approval Notice of Action (NOA)[4] within 10 days of enrollment from the county Medi-Cal office informing them of their child's eligibility and enrollment, the effective date, and share of cost Medi-Cal coverage (if any).

IV) The family receives a welcome packet from the chosen health plan, including a member identification card, within 15 to 45 days of enrollment.

V) Child utilizes services. The family may make the first appointment due to a pressing medical concern or for preventive measures such as a physical or vaccination.

✋ VI) If the child moves out of state, the child will be **disenrolled**.

VII) If the child remains in the state but moves out of the county, the child's coverage will be transferred to the new county without a redetermination.[5]

⚠ VIII) If the child's eligibility conditions changes, the family must report the changes to the county eligibility worker within 10 days. The county may also independently become aware of changes in the family's circumstances that could affect Medi-Cal eligibility. Because children receiving no-cost Medi-Cal coverage are guaranteed 11 months of continuous coverage (following one month of no-cost Medi-Cal), family changes within the year will not affect a child's eligibility.[6]

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[1] The flowchart primarily focuses on the process as it applies only to children enrolled in the Medi-Cal for Children program, which includes the following eligibility aid categories: 100% program (7A, 7C, 8R, 8T) and 133% program (aid codes 72, 74, 8N, 8P). This flowchart does not apply to families in the CalWORKs or 1931 (b) categories, unless noted.

[2] As of September 2002, the state is in the process of clarifying its guidance on the Medi-Cal annual redetermination process. This flowchart provides the process based on current guidance and practice. The process may change as the state finalizes guidance for counties on how to conduct annual re-determinations.

[3] Exceptions to the guarantee of 12 months continuous eligibility is if a child ages out of the program or moves out of state. If the child remains in the state but moves out of the county, the child will be able to transfer coverage to the new county.

[4] All notices and letters have the eligibility worker's name and phone number to call for information and assistance.

[5] The child's Medi-Cal coverage must not be terminated merely because the family moves to another county. The state is in the process of finalizing county guidance on transferring files between counties. The family is not required to re-apply for coverage or apply for re-determination in the new county solely due to a change in county residence.

[6] If the family's eligibility status has changed, the family members, aside from the children, will lose their Medi-Cal coverage after the county has found, through a full eligibility redetermination, including an ex parte review (see procedures in (Step IX) above), that family members are ineligible for all Medi-Cal programs.

Appendix D: Flowchart – Medi-Cal for Children[1] Process for Continuing Coverage

IX) If Step VIII triggers a Medi-Cal eligibility redetermination, a county makes the determination (with respect to the change that has occurred) without the involvement of the beneficiary through the use of the *ex parte*[7] process.

A) An *ex parte* review of all available county resources (including all family members' Medi-Cal, CalWORKS, and Food Stamp files) is conducted to obtain information or verification needed to complete the eligibility redetermination due to the change in circumstances that has occurred.

B) If the ex parte process is unsuccessful, the county Medi-Cal eligibility worker must attempt to contact the family by phone[8] for missing information or verification.[9]

C) If eligibility or ineligibility is not established in Steps (IX)(A) or (IX)(B) then the eligibility worker must forward the MC 355 (Request for Information) form by mail to the beneficiary, indicating what is incomplete or missing. The form is available in English and Spanish. Twenty (20) days must be allowed for return of the verifications requested through the MC 355 before any discontinuance action can be initiated.[10]

D) If the family's eligibility status has changed, family members may be disenrolled only after this redetermination process proves they are ineligible for all Medi-Cal programs. However, even if family members lose eligibility after a full redetermination, the child will not be disenrolled until the annual redetermination date because children are guaranteed 11 months of continuous coverage following one month of no-cost Medi-Cal.

X) Approximately one month prior to the child's anniversary date, the Renewal Process is initiated.[11]

A) The county sends the renewal packet to the MCC applicant.[12]

1) Content:

(a) Renewal Form:

(i) If the family receiving Medi-Cal benefits includes adults and children, the renewal form (MC 210 RV) is used as the Medi-Cal renewal application for the entire family.[13] (Three pages plus a cover letter.[14])

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[7] ACWDL 01-36 and 01-39 instruct counties to conduct ex parte review at redetermination. The Department of Health Services is continuing to discuss the ex parte process while counties await further instructions. (Lee Macias, DHS, Medi-Cal Eligibility Branch, May 22, 2002.)

[8] Phone calls are made during business hours (most counties work Monday-Friday 8 a.m.-5 p.m.).

[9] As part of SB 87, an eligibility worker may collaborate with a community-based organization to contact the family, as long as confidentiality is protected.

[10] In assessing eligibility, the county may not request information or documentation that has been previously provided, is not subject to change, or is not absolutely necessary to the eligibility determination.

[11] The state is currently reviewing their guidance to counties on the renewal process and the renewal form.

[12] The renewal application is due in the anniversary month not on a specific date. (Lee Macias, DHS, 5/3/02)

[13] The MC 210 RV form is currently being revised (as a result of SB 87) to ask the family to provide only the information subject to change. The renewal application is not currently pre-printed or customized. If the family loses the renewal application, they can request another one.

[14] A cover letter is included which says that it is time for redetermination and to send in the information requested for verification.

(ii) If the child originally used the simplified mail-in joint application (MC 321 HFP) and is enrolled in Medi-Cal for Children, some counties may send to the family another MC 321 HFP,[15] which acts as the renewal application.[16]

(b) Additional Program Materials:

(i) Declaration of Citizenship

(ii) MC 219,[17] known as the Rights and Responsibilities (1 page)

(iii) Motor Vehicles Form (1 page)

(iv) Information on Child Health and Disability Prevention Program (CHDP) and Early and Periodic Screening, Detection, and Treatment Program (EPSDT) (1 page)

(v) MC Notice 007 dated January 1998 (4 pages), which provides the general limits of MC benefits and gives the income limits and rules of the 1931 b program.

(vi) Other materials.[18]

(c) Health Plan information is sent separately by the health plan.

2) Languages:

(a) The MC 210 RV is available in English and Spanish.

(b) The MC 321 HFP is available in English, Spanish, Khmer, Hmong, Armenian, Chinese, Korean, Russian, Farsi, Vietnamese, and Lao.

3) Requirements.[19] The family is required to complete the renewal form, providing changes in information, including family's health insurance status, family size, value of assets,[20] and updated income with documentation.[21] The family is not required to resubmit information that is not subject to change, such as immigration status.

B) If the child is enrolled in a Medi-Cal managed care plan, the department transmits monthly beneficiary eligibility information to the plan that includes the beneficiary's annual redetermination month and year. However, the annual redetermination information does not contain the date by which any forms must be submitted to the county.

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[15] The MC 321 HFP is not a renewal form but the joint HF/MCC application. Children enrolled in Medicaid through the "percentage of poverty" programs are not subject to an assets test. The MC 321 HFP form does not include an assets test. However, if the family is sent the MC 210 RV, they are required to complete an assets test. This allows for uninsured adult family members to also be considered for Medi-Cal.

[16] Angeline Mrva, Chief of Medi-Cal Eligibility Branch. ACWDL 99-36. July 16, 1999.

[17] The MC 219 informs families of their rights and responsibilities and, as federally required, notifies them that the county will verify information available on other state data systems with all confidentiality rules applying.

[18] For example, in San Diego County, the packet also includes information about public charge (1 page).

[19] Medi-Cal Regulations. Title 22, Division 3, Subdivision 1, Chapter 2, Article 4, Section 50189. "Redetermination-Frequency and Process."

[20] Children's eligibility does not require an assets test; however, if the family is sent the MC 210 RV form to renew the child, an assets test is included on the form.

[21] Providing income documentation is difficult for some families, especially cash-based workers. Requiring income documentation (a paystub, 1040, or a W-2) is required by state law not federal law. The federal government (Center for Medicare and Medicaid Services) in fact encourages states not to require income documentation.

Appendix D: Flowchart – Medi-Cal for Children[1] Process for Continuing Coverage

C) If the family responds before the anniversary date:

1) If the family sends a complete application:

(a) If the child is eligible for no-cost Medi-Cal, the child receives Medi-Cal for another 11 months of coverage.[22]

(b) If the child is determined to be ineligible for no-cost Medi-Cal due to income changes or aging out of the program,[23] the family is informed that the child qualifies for Medi-Cal with a share of cost and is mailed a HFP application.

(c) If the child is determined ineligible for no-cost Medi-Cal due to high income or age **and the individual appears to be eligible for HFP**, the following steps in bridging Medi-Cal and Healthy Families occurs:

(i) A copy of the renewal application, a transmittal form, (NOA, budget worksheets, and a photocopy of the birth certificate (if available) will be forwarded to Healthy Families single point of entry (SPE) if the family has authorized the forwarding of information.[24]

(ii) The family is sent a notice of action[25] (NOA) that the child is now eligible for Share of Cost (SOC) Medi-Cal and may be eligible for Healthy Families.

(iii) The child will receive one month of no share of cost Medi-Cal during the bridging between programs.[26] The child does not need to complete a new application. Healthy Families will accept the notice of action.[27]

(iv) Healthy Families will track and monitor the applications that are bridged over by tracking through MEDS. The county does not track denials in bridging system.

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[22] No letter is sent to the family (as in Healthy Families) that coverage is continuing. The family receives written notification only if eligibility status or share of cost changes.

[23] Generally, a child is eligible for Medi-Cal if the child is under 1 year old with a family income up to 200% FPL; or is between 1-5 years old, with a family income up to 133% FPL, or is between 6-18 years old up to 100% FPL. A child with incomes above these levels can be eligible for Healthy Families. At the age of 19, a child is no longer eligible for Healthy Families. Some children up to age 21 may still be eligible for Medi-Cal such as those who were in foster care, medically indigent, medically needy or those receiving minor consent services. .

[24] Effective with the implementation of the expansion of HFP for parents. ACWDL 02-23, April 18, 2002. However, the state 2002-2003 budget trailer bill provides for the process to move forward without the implementation of parental coverage

[25] California Code of Regulations. Title 22 Social Security, Division 3, Subdivision 1, Chapter 2, Article 4, Section 50179.

[26] The state had planned to implement two months of no-share-of-cost Medi-Cal in the bridging program as of 7/1/02. However, the Governor in the 2002-2003 State Budget limited the bridging between programs to one month of no share of cost Medi-Cal. Previously, children received one month of SOC Medi-Cal during the bridging between programs.

[27] As of 7/1/02, Medi-Cal automatically tracks applications between counties and Healthy Families.

(v) If the family is indeed determined to be eligible for Healthy Families, the child is enrolled in Healthy Families. (See Appendix B for Healthy Families flowchart.)

(vi) If the family chooses not to participate in share of cost Medi-Cal, The child is **disenrolled** and a discontinuance letter is sent to the family.[28]

2) If the family submits an incomplete renewal packet:

(a) The deadline for renewal submission is held while the county follows up with the family.

(b) If the family does not provide information such as the pay stub, the county Medi-Cal eligibility worker conducts the *ex parte*[29] process outlined in Step (IX).

(c) If the family responds to the request for additional information, steps in (X)(C) (when a family completes a renewal form) apply.

(d) If the family does not respond to the request for more information:

(i) A reminder notice[30] is generated by the automated computer system 20 days after the renewal packet is sent to the family.

(ii) If the family does not respond to the reminder notice and has not submitted the renewal packet before the anniversary date,

(a) The child is **disenrolled** and the family receives a discontinuance letter that states the date of discontinuance, the reason for discontinuance, how to file an appeal, and information on aid pending the appeal.

(b) To reinstate coverage, the family has 30 days from the anniversary date to return the complete renewal package but the child will experience a break in coverage.

(c) If the family wishes to reinstate coverage after the 30 days from the anniversary date have passed, the family must reapply using the MC 321 HFP or MC 210.

D) If the family does not respond before the anniversary date:

(i) A reminder notice[31] is generated by the automated computer system 20 days after the renewal packet is sent to the family.

(a) If the family does not respond to the reminder notice and has not submitted the renewal packet before the anniversary date, the steps in (X)(C)(2)(d)(ii) apply.

[28] The county records the reason for disenrollment. Discontinuance is tracked, if it is known.

[29] ACWDL 01-36 and 01-39 instruct counties to conduct ex parte review at redetermination. The Department of Health Services is continuing to discuss the ex parte process while counties await further instructions. (Lee Macias, DHS, Medi-Cal Eligibility Branch, May 22, 2002.)

[30] Available in English and Spanish.

[31] Available in English and Spanish.

Appendix E: Acknowledgements

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