Lasting Returns:

Investing in Health Coverage for California's Children

A Publication of the California Budget Project
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the california budget project

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The California Budget Project (CBP) was founded in 1994 to provide Californians with a source of timely, objective, and accessible expertise on state fiscal and economic policy issues. The CBP engages in independent fiscal and policy analysis and public education with the goal of improving public policies affecting the economic and social well-being of low- and middle-income Californians. Support for the CBP comes from foundation grants, publications, and individual contributions.

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executive summary

Public policies have made significant progress toward ensuring that children have access to affordable, quality health coverage. In 1997, Congress established the State Children's Health Insurance Program (SCHIP) that provides federal dollars to states to expand health coverage for children in low-income families. California used SCHIP funding to create the Healthy Families Program, which provided health coverage for over 664,000 low-income children in June 2004. SCHIP builds on the national commitment to health care that began with the creation of the Medicaid Program in 1965. The Medicaid Program, a partnership of the federal government and the states, provided health coverage for over 25 million children nationally in 2003. Medi-Cal, California's Medicaid program, provided coverage for about 3 million children in the same year.

About 1.1 million California children lacked health coverage during all or part of the year in 2003.

In recent years, California has substantially expanded health coverage for uninsured children. Current policies play an important role in filling the gaps for children whose families do not have access to or cannot afford to purchase health coverage through the private market. Despite these gains, much remains to be done. About 1.1 million California children lacked health coverage during all or part of the year in 2003. Some of these children were eligible for, but not enrolled in, existing programs. Others

failed to qualify for public health coverage programs.

Studies document the importance of health coverage to children's well-being and life outcomes. Children with health coverage are more likely to have better health outcomes than those without. Better health status can improve educational outcomes, thereby resulting in higher wages and improved economic well-being later in life. Health coverage helps ensure that children have a regular source of care and that they receive cost-effective, preventive services, such as immunizations, that lead to better health outcomes. Uninsured children, on the other hand, are more likely to use emergency rooms as a regular source of care and are more likely to have unmet needs for prescription drugs, dental care, and medical care.

Current policies provide a strong foundation for extending health coverage for all California children. Improved outreach and further administrative simplification can boost enrollment among children who are eligible for health coverage through existing programs. Furthermore, federal policies allow California to obtain additional dollars, thereby reducing the state's cost of expanding health coverage for many children who do not qualify under existing rules.

What This Report Does

While support for children's health coverage is strong among both policymakers and the public, cost considerations have limited the pace of progress toward universal health coverage for children. *Lasting Returns: Investing in Health Coverage for California's Children* explores a range of options for increasing enrollment of children in existing programs and expanding health coverage for the state's remaining uninsured children. This report provides a menu of options, rather than a single proposal or blueprint, to inform the work of those seeking to expand children's health coverage at both the state and county levels. Many of the strategies examined in this report are complementary, filling gaps in existing programs and making incremental progress toward the goal of ensuring that all California children have access to quality health care.

Who Are California's Uninsured Children?

Approximately 1.1 million California children, or one out of nine, were uninsured during all or part of the year in 2003. Research finds that:

- Nearly six out of 10 uninsured children may be eligible for, but not enrolled in, existing programs;
- Low-income children are more likely to lack health coverage than higher-income children;
- Adolescents are less likely to have health coverage than younger children;
- Children in immigrant families are less likely to have health coverage than children in US-born families; and
- Most of California's uninsured children are in working families.

Existing Programs That Provide Health Services to Low-Income Children

California offers a number of programs that provide health services to low-income children. Each program has different eligibility requirements and offers different services. The Medi-Cal, Healthy Families, and Access for Infants and Mothers (AIM) programs offer comprehensive health coverage for certain groups of children. Other programs, including Child Health and Disability Prevention (CHDP) and California Children's Services (CCS), provide limited

health services to children. In addition, 10 counties have implemented county programs that provide health coverage for uninsured children who do not qualify for Medi-Cal or Healthy Families.

Many Uninsured Children May Be Eligible for Existing Health Coverage Programs

Barriers to enrollment in Medicaid and SCHIP programs include complex enrollment and renewal processes, lack of knowledge about the programs, and the association of Medicaid with welfare. Immigrant families may face language barriers to enrollment, not understand program rules, or fear repercussions if they use public benefits. In some cases, families may not believe there is a need for health coverage for their children.

Options to Increase Enrollment in Existing Health Coverage Programs

California could take steps to increase enrollment of eligible children in existing health coverage programs, including Medi-Cal and Healthy Families. Promising policy strategies include:

- Expanding and improving express lane eligibility;
- Implementing the Newborn Hospital Gateway;
- Creating a "bridge" program, or a temporary period of eligibility, for children transferring from Medi-Cal and Healthy Families to county health coverage programs;
- Allowing Medi-Cal applicants to self-certify their income;
- Simplifying the renewal process;
- Making Healthy Families premiums easier to pay;
- Maximizing federal funding for local outreach and enrollment assistance; and

Expanding coverage to children through Medi-Cal or Health Families can be cost-effective because federal funds cover a significant share of the costs.

- Restoring state support for certified application assistants (CAAs), who help applicants complete their paperwork.

Options Used by Other States to Expand Children's Health Coverage

California can learn from innovative policy strategies used by a number of states to expand children's health coverage. These include:

- Expanding eligibility for public health coverage programs;
- Allowing higher-income families to purchase health coverage through state "buy-in" programs;
- Helping families cover the cost of employment-based health coverage through premium-assistance programs; and

- Allowing employers and families to purchase health coverage through a state-subsidized program.

State Financing Options to Expand Children's Health Coverage

California could use a number of financing options to expand children's health coverage (Table ES1). Potential financing options include:

- ***Seeking new federal matching funds.*** The federal government contributes to the cost of providing health coverage for children in the state's Medi-Cal and Healthy Families programs who meet income, citizenship or immigration, and other requirements. California could seek additional federal funds to help cover the cost of expanding comprehensive health coverage for children whose family incomes exceed existing program limits. The federal government also allows states to match federal funds to provide limited health services to children, regardless of immigration status. While California is currently matching federal funds for health services provided under this option, additional federal funds are available to expand health services.

- ***Using existing federal and state health services funds***. Some uninsured children who could enroll in expanded health coverage programs may already receive limited health services through existing programs paid for with federal and state funds. California could use funding that currently supports limited health services to reduce the need for new dollars to fund the cost of expanding comprehensive children's health coverage.

- ***Generating and reinvesting state savings.*** The state could implement policies to generate savings in existing health programs, including Medi-Cal, without reducing services or eligibility, and reinvest those savings to expand health coverage for children. The state could, for example, implement Medi-Cal pharmacy

Table ES1: State Financing Options for Expanding Children's Health Coverage

Financing Options	Children Who May Be Covered		Required Actions
	Children with Family Incomes over 250 Percent of the Federal Poverty Level	All Immigrant Children	
Seeking New Federal Matching Funds	✓		Federal Approval
Using Existing Federal and State Health Services Funds	✓	✓	Federal Approval and/ or State Law Changes
Generating and Reinvesting State Savings	✓	✓	Federal Approval and/ or State Law Changes
Raising Additional State Revenues	✓	✓	State Law Changes
Seeking First 5 Funds	✓	✓	State First 5 Commission Approval

cost-containment measures and reinvest the savings to expand coverage.

- ***Raising additional state revenues.*** The state could raise additional revenues to support the expansion of children's health coverage. Covering all California children would require additional funds that, in light of the state's ongoing budget problems, may best be supported through a new source of revenues. Public opinion research suggests that voters understand the importance of health care for children. This strong level of public support for children's health coverage suggests that voters may look favorably on proposals to raise additional revenues.

- ***Seeking First 5 funds.*** California could seek approval from the state First 5 Commission to use First 5 Tobacco Tax Proceeds to help finance expansion of health coverage for children up to age 5. First 5 revenues, however, are declining due to the decrease in tobacco use, and there are often competing demands for the use of these funds.

County Financing Options to Expand Children's Health Coverage

There are a number of options available to counties to finance the expansion of children's health coverage (Table ES2). Potential financing options include:

- ***Seeking new federal matching funds.*** The state could seek federal approval to allow counties to use their local dollars to match new federal funds to provide comprehensive health coverage for children with family incomes above 250 percent of the federal poverty level (FPL) who meet other program requirements. Four counties have already received approval to use federal funds for children with family incomes up to 300 percent of the FPL. The state could also seek federal approval to allow counties to use local dollars to match new federal funds to

Table ES2: County Financing Options for Expanding Children's Health Coverage

Financing Options	Children Who May Be Covered		Required Actions
	Children with Family Incomes over 250 Percent of the Federal Poverty Level	All Immigrant Children	
Seeking New Federal Matching Funds	✓		Federal Approval
Using Existing Federal, State, and County Health Services Funds	✓	✓	Federal, State, and/or County Approval
Raising Additional County Revenues	✓	✓	Voter Approval
Seeking First 5 Funds	✓	✓	County First 5 Commission Approval
Using Funds from the Tobacco Master Settlement Agreement	✓	✓	County Approval

provide limited health services to children, regardless of immigration status.

- ***Using existing federal, state, and county health services funds.*** Some uninsured children who could enroll in county health coverage programs may already receive limited health services through existing programs paid for with federal, state, and county funds. Existing funding for these limited health services could reduce the need for new dollars to fund the cost of expanding comprehensive children's health coverage.

- ***Raising additional county revenues.*** Counties could seek voter approval for revenue increases to finance expanded children's health coverage. Several local governments in California have dedicated new revenues to support health services.

- ***Seeking First 5 funds.*** Counties could seek approval from their county First 5 commission to use local First 5 funds to finance health coverage for children up to age 5. The source of First 5 funds is revenue from a statewide tax on tobacco products.

- ***Using funds from the tobacco Master Settlement Agreement.*** In 1998, California participated in a national settlement of lawsuits against the tobacco industry on behalf of states and localities. These lawsuits sought reimbursement for states' expenses for smoking-related health costs. Under the tobacco Master Settlement Agreement, the tobacco industry makes annual payments to California. Counties can use their share of tobacco settlement funds to finance health coverage for children.

how to use this report

How you use this report will depend on who you are and what you want to know. For example, Chapter 6 provides financing options for those working toward universal health coverage for children at the state level. Chapter 7 provides financing options for policymakers and advocates working to expand health coverage at the county level using local funds.

How to Use This Report	
If you want to know:	**This is where you can find it:**
Who are California's uninsured children?	Chapter 1 provides a profile of California's uninsured children.
What are California's existing programs that provide health services to low-income children?	Chapter 2 describes existing health programs, including eligibility requirements, services, program spending, funding sources, and numbers of children served.
How do children enroll in existing health coverage programs and why are many eligible children not enrolled?	Chapter 3 provides an overview of the enrollment processes for Medi-Cal and Healthy Families, reasons why eligible children may not enroll in these programs, and county efforts to increase enrollment in existing health coverage programs.
What policies could increase enrollment of eligible children in existing health coverage programs?	Chapter 4 discusses policy options to increase enrollment of eligible children in existing health coverage programs.
What policies do other states use to expand children's health coverage?	Chapter 5 discusses policy options used by other states to expand children's health coverage.
What financing options are available to the state to expand children's health coverage?	Chapter 6 examines financing options available to the state to expand children's health coverage.
What financing options are available to counties to expand children's health coverage?	Chapter 7 examines financing options available to counties to expand children's health coverage.

introduction:

opportunities to provide health coverage for california's uninsured children

Public policies have made significant progress toward ensuring that children have access to affordable, quality health coverage. In 1997, Congress established the State Children's Health Insurance Program (SCHIP) that provides federal dollars to states to expand health coverage for children in low-income families. California used SCHIP funding to create the Healthy Families Program, which provided health coverage for over 664,000 low-income children in June 2004. SCHIP builds on the national commitment to health care that began with the creation of the Medicaid Program in 1965. The Medicaid Program, a partnership of the federal government and the states, provided health coverage for over 25 million children nationally in 2003. Medi-Cal, California's Medicaid program, provided coverage for about 3 million children in the same year. In recent years, California has substantially expanded health coverage for uninsured children. California has expanded health coverage for new groups of children and simplified enrollment for health coverage, thereby increasing the number of eligible children enrolled. Current policies play an important role in filling the gaps for children whose families do not have access to or cannot afford to purchase health coverage through the private market. For example:

- In 1998, the state implemented the Healthy Families Program to take advantage of SCHIP funding.

- California also improved the enrollment process for children in Medi-Cal and Healthy Families by reducing unnecessary reporting requirements, simplifying eligibility rules, and streamlining enrollment based on eligibility for other public programs. As a result, more eligible children have obtained health coverage through these programs.

- A number of counties have established initiatives extending health coverage for children, beyond what is available at the state level. These counties have used local funds to implement collaborative and innovative measures to enroll eligible children in existing programs and to expand health coverage for other uninsured children.

Current policies provide a strong foundation for extending health coverage for all California children.

Despite these gains, much remains to be done. About 1.1 million California children lacked health coverage during all or part of the year

in 2003. Some of these children were eligible for, but not enrolled in, existing programs. Others failed to qualify for public health coverage programs.

Current policies provide a strong foundation for extending health coverage for all California children. Improved outreach and further administrative simplification can boost enrollment among children who are eligible for health coverage through existing programs. Furthermore, federal policies allow California to obtain additional dollars, thereby reducing the state's cost of expanding health coverage for many children who do not qualify under existing rules.

What Are the Benefits of Children's Health Coverage?

Studies document the importance of health coverage to children's well-being and life outcomes.[1] Children with health coverage are more likely to have better health outcomes than those without. Better health status can improve educational outcomes, thereby resulting in higher wages and improved economic well-being later in life. Health coverage helps ensure that children have a regular source of care and that they receive cost-effective, preventive services, such as immunizations, that lead to better health outcomes. Uninsured children, on the other hand, are more likely to use emergency rooms as a regular source of care and are more likely to have unmet needs for prescription drugs, dental care, and medical care.

A 2002 state evaluation of the benefits to children of having comprehensive health coverage through the Healthy Families Program found that for children in the poorest health, school attendance and performance improved after enrollment in Healthy Families. In particular, children's ability to pay attention in class and keep up with school activities improved significantly. One year after enrollment in Healthy Families, performance in each of these two areas improved by 68 percent.[2]

What This Report Does

While support for children's health coverage is strong among both policymakers and the public, cost considerations have limited the pace of progress toward universal health coverage for children. This report explores a range of options for increasing enrollment of children in existing programs and expanding health coverage for the state's remaining uninsured children. This report provides a menu of options, rather than a single proposal or blueprint, to inform the work of those seeking to expand children's health coverage at both the state and county levels. Many of the strategies examined in this report are complementary, filling gaps in existing programs and making incremental progress toward the goal of ensuring that all California children have access to quality health care. In this report:

- Chapter 1 provides a profile of California's uninsured children;
- Chapter 2 describes existing health programs for low-income children;
- Chapter 3 provides an overview of the enrollment processes for existing health coverage programs and explains why some eligible children are not enrolled;
- Chapter 4 discusses policy options to increase enrollment in existing health coverage programs;
- Chapter 5 discusses policy options used by other states to expand children's health coverage;
- Chapter 6 examines financing options available to the state to expand children's health coverage; and
- Chapter 7 examines financing options available to counties to expand children's health coverage.

part I:
background

chapter 1:
who are california's uninsured children?

About 1.1 million, or one out of nine, California children were uninsured during all or part of the year in 2003.[3] Much remains to be done to extend health coverage for the state's remaining uninsured children. Many uninsured children, for example, are eligible for health coverage under existing programs. Thus, the state could expand efforts to help families enroll their children in programs for which they already qualify. Research finds that:

- ***Nearly six out of 10 uninsured children may be eligible for, but not enrolled in, existing programs.*** Of the 782,000 California children who were uninsured at the time they were interviewed for the 2003 California Health Interview Survey, 207,000 were eligible for Medi-Cal, 224,000 were eligible for Healthy Families, 44,000 were eligible for county health coverage programs, 159,000 had family incomes that exceeded the eligibility level for Healthy Families and other public health coverage programs, and 148,000 were not eligible for Medi-Cal or Healthy Families due to their immigration status (Figure 1.1).[4]

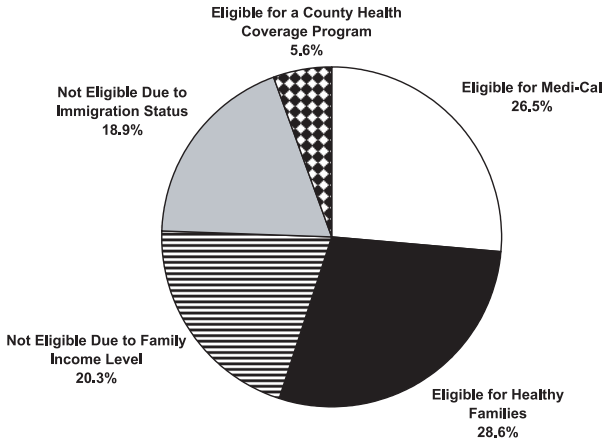
- ***Low-income children are more likely to lack health coverage than higher-income children.*** In 2001, about one-quarter (24.8 percent) of children with family incomes at or below the federal poverty level (FPL) lacked health coverage, but fewer than one out of 20 children with family incomes above 300 percent of the FPL lacked health coverage (Figure 1.2).[5]

- ***Adolescents are less likely to have health coverage than younger children.*** In 2001, approximately one out of 12 (8.6 percent) children ages 11 or under were uninsured, while about one out of nine (11.7 percent) adolescents ages 12 to 17 were uninsured.[6]

Nearly six out of 10 uninsured children may be eligible for, but not enrolled in, existing programs.

- ***Children in immigrant families are less likely to have health coverage than children in US-born families.*** In 2001, slightly less than one out of 22 (4.5 percent) US-citizen children who lived in families in which both parents were US-born citizens were uninsured. On the other hand, about one out of six (16.3 percent) US-citizen children who lived in immigrant families in which at least one parent had a "green card" were uninsured and about four out of 10 (39.9 percent)

Figure 1.1 : Nearly 60 Percent of California's Uninsured Children May Be Eligible for Existing Programs



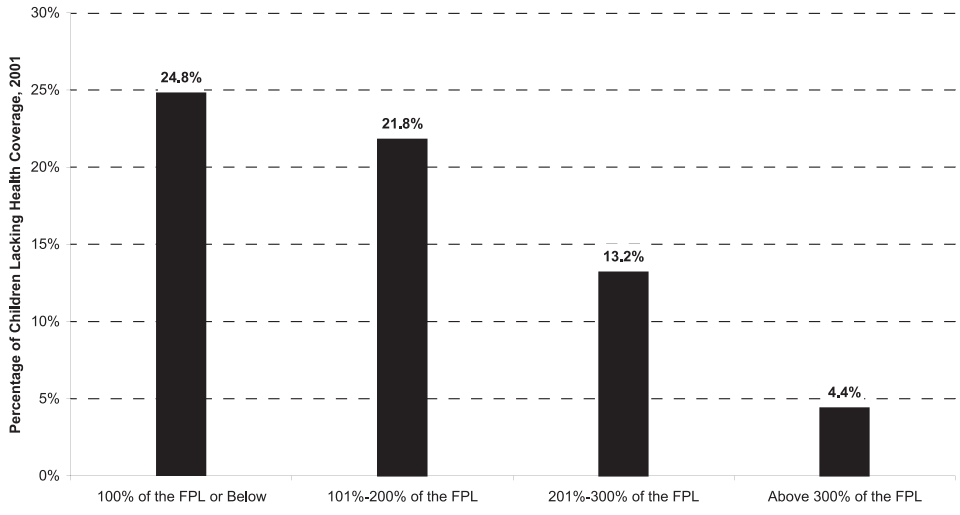
Total Uninsured Children Under Age 19 in California, 2003 = 782,000*

* This estimate reflects the number of children who were uninsured at the time they were interviewed for the 2003 California Health Interview Survey.
Source: UCLA Center for Health Policy Research

children who were not US citizens were uninsured.[7]

- ***Most of California's uninsured children are in working families.*** In 2003, 69.6 percent of California's uninsured children were in families in which the head of the household was working full-time year-round, and 85.2 percent were in families in which the head of the household worked at least part-time or part of the year.[12] Many of the uninsured lack access to

Figure 1.2: Low-Income Children Are More Likely to Lack Health Coverage



Note: Includes children under age 18.
Source: 2001 California Health Interview Survey

employment-based health coverage and report affordability as the primary reason that they are uninsured.

One reason uninsured families may not be able to afford health coverage, even if offered by their employer, is that uninsured Californians tend to have lower incomes than insured Californians and thus spend a greater share of their budgets for basic needs, leaving less for health coverage. An analysis of the spending patterns of insured and uninsured Californians found that the uninsured have much smaller household budgets and spend proportionately more on basic needs such as housing, education, and food in the home. On average, uninsured households had an annual income of $20,600, compared to $45,900 for insured households. While uninsured families spent an average of 54.6 percent of their household budgets on housing, education, and food in the home, insured families spent an average of 47 percent of their budgets on these items.[21]

Health Services for Immigrant Children

State programs have different eligibility requirements for immigrant children. Medi-Cal and Healthy Families provide health coverage for US citizens and some immigrant children.[8] For example, children who do not meet the immigration status requirements may be eligible for emergency and pregnancy-related services through Medi-Cal. Some programs, such as the Child Health and Disability Prevention Program, provide services to children regardless of immigration status.

Siblings in immigrant families may not be eligible for the same programs due to differences in their immigration status. Nationally, about 85 percent of immigrant families with children are of mixed immigration status in which at least one parent is a noncitizen and at least one child is a citizen. Eighty-nine percent of the children in these mixed-status families are US citizens. Mixed-status families can include any combination of immigrants and naturalized citizens.[9] In situations in which one child is a US citizen and another child is a noncitizen, siblings may not be eligible for the same public program solely due to their immigration status. For example, one child may be eligible for comprehensive Medi-Cal coverage, while a sibling may be eligible only for emergency Medi-Cal services. Thus, even siblings in the same family may have different access to services.

Undocumented immigrant children in California use less health care. In 2001, one out of four undocumented immigrant children had no usual source of care, compared to one out of 25 US-citizen children living in families in which both parents were US-born citizens. About one-fifth (22 percent) of undocumented immigrant children up to age 11 had not seen a medical doctor in the past 12 months and about one-fifth (19 percent) of undocumented immigrant children ages 2 to 17 had never visited a dentist. Among US-citizen children in the same age groups living in families in which both parents were US-born citizens, fewer than one out of 10 (8 percent) had not seen a medical doctor in the past 12 months and one out of 10 had never visited a dentist.

However, lack of doctor visits did not result in more visits to emergency rooms or additional hospital stays for undocumented immigrant children.[10] While 12 percent of undocumented immigrant children had visited the emergency room in the past 12 months, a much larger percentage (22 percent) of US-citizen children living in families in which both parents were US-born citizens had visited the emergency room. For both populations, one out of 20 reported a hospital stay in the last year.[11]

Status of Employment-Based Health Coverage in California

In 2003, about half (50.8 percent) of California children had employment-based health coverage through their parents' workplace.[13] However, many children in working families remain uninsured. Working parents may not be able to access health coverage through their employers for several reasons. Among California's uninsured workers in 2001, about six out of 10 (61.6 percent) worked for employers that did not offer health coverage, about one-quarter (24.3 percent) were not eligible for health coverage offered by their employer, and about one out of seven (14.1 percent) chose not to participate in health coverage through their employer.[14]

The most common reason California employers give for not offering health coverage is high premiums.[15] Low-wage workers, workers in agriculture, and workers in small firms are the least likely to work for firms that offer health benefits.[16]

In 2001, about half of California employees who were eligible for health coverage through their employer did not participate because the plan was too expensive.[17] In general, average premiums and employee contributions are higher for smaller firms, compared to larger firms. In 2003, the average annual premium cost for family health coverage in California was $7,481 for health maintenance organization (HMO) health plans and $10,020 for preferred provider organization (PPO) health plans.[18] A worker's average share of the premium for family health coverage was 30 percent.[19]

California law regulates health insurers from whom businesses purchase health coverage for their employees. California law, for example, limits health insurers' ability to raise small employers' premiums due to changes in employees' health status and prohibits health insurers from canceling small employers' group coverage just because an employee requires expensive health services.

In November 2004, California voters rejected Proposition 72, a referendum on SB 2 (Burton, Chapter 673 of 2003).[20] SB 2 required employers with 200 or more employees to pay into a fund to cover at least 80 percent of the cost for health coverage for their employees and dependents. Employees would have contributed up to 20 percent of the cost for health coverage. SB 2 capped employee contributions at 5 percent of wages for employees with incomes up to 200 percent of the FPL. SB 2 required medium-sized employers, with between 50 and 199 employees, to contribute at least 80 percent of the cost of health coverage for workers, but not for dependents. Employers could have also opted to directly provide health coverage rather than pay into a fund. In addition, if employers of Medi-Cal- and/or Healthy Families-eligible employees paid into the fund, the fund would have paid the state's share of cost for any employee or dependent who voluntarily enrolled in Medi-Cal or Healthy Families.

Characteristics of Individual Private Health Coverage

Families may choose to purchase individual health coverage through the private market. In 2001, only 2.9 percent of children had privately-purchased health coverage. Nationally, the average premiums for individual private health coverage are much lower than the average premiums for employment-based health coverage. This could reflect the relatively younger ages of persons who purchase individual private health coverage; less generous individual health plans that may or may not reflect the individual's health care needs; and the choices that people may make when buying health coverage for themselves, paying only for the benefits that they believe they will use.[22] In

addition, health plans generally require individuals to pay higher out-of-pocket costs, compared to employment-based health coverage.

California law provides relatively few consumer protections for individual purchasers of health coverage who have been uninsured. In general, health insurers may deny coverage based on the individual's health status and may charge unlimited premiums. State and federal laws provide better protections for individuals who are switching from employment-based health coverage to individual private health coverage.[23] In addition, benefit packages and out-of-pocket costs vary substantially among health insurers that offer individual private health coverage.

chapter 2:
existing programs that provide health services to low-income children

California offers a number of programs that provide health services to low-income children. Each program has different eligibility requirements and offers different services. The Medi-Cal, Healthy Families, and Access for Infants and Mothers (AIM) programs offer comprehensive health coverage for certain groups of children. Other programs, such as Child Health and Disability Prevention (CHDP) and California Children's Services (CCS), provide limited health services to children (Table 2.2). In addition, 10 counties have implemented county programs that provide health coverage for uninsured children who do not qualify for Medi-Cal or Healthy Families.

A number of programs provide health services to children. Each has different eligibility requirements and offers different services.

Medi-Cal

The Medi-Cal Program is California's Medicaid Program, a federal-state program providing health coverage for low-income individuals. Medi-Cal covers health services for children, parents, the elderly, persons who are blind, and persons with disabilities who receive public assistance or meet income and other eligibility requirements. Under federal law, state Medicaid programs must offer a core set of benefits, including doctor visits, hospital care, and laboratory services. The state and federal governments each pay half of Medi-Cal Program costs for federally-eligible expenditures. The annual federal-state cost for Medi-Cal coverage for a child is $1,307.[24]

Medi-Cal covers nearly one out of four children in California.[25] California children are eligible for Medi-Cal with family incomes up to 200 percent of the FPL depending on the child's age.[26] Medi-Cal covers children who meet the following income eligibility criteria, and does not require such children to share in the cost of services (Table 2.1):

- Infants under age 1 with family incomes up to 200 percent of the FPL;
- Age 1 up to age 5 with family incomes up to 133 percent of the FPL; and
- Age 6 up to age 18 with family incomes up to 100 percent of the FPL.[27]

Children with family incomes too high to qualify for Medi-Cal without a share of cost may receive coverage by paying a share of the cost during the month in which health expenses are incurred.[28]

Some immigrant children are eligible for comprehensive Medi-Cal coverage.[29] Immigrant children who do not meet immigration status requirements may be eligible only for Medi-Cal emergency and pregnancy-related services.

Healthy Families

In 1998, California used SCHIP funding to create the Healthy Families Program. Healthy Families provides low-cost health coverage for children with family incomes too high to qualify for the Medi-Cal Program. The federal government pays 65 percent and the state pays 35 percent of Healthy Families Program costs for federally-eligible expenditures. The annual federal-state cost for Healthy Families coverage for a child is $1,100.[30]

To qualify for Healthy Families, a child must (Table 2.1):

- Have a family income that does not exceed 250 percent of the FPL, but which is higher than the Medi-Cal income eligibility levels for children who do not pay a share of cost;
- Lack health coverage during the previous three months; and
- Be a US citizen, or meet immigration requirements.[31]

Benefits offered by the Healthy Families Program include physician visits, prescription drugs, hospital inpatient care, preventive care, lab tests, X-rays, vision care, and dental care. Families pay monthly premiums of $4 to $9 per child, up to a maximum of $27 per family.[32] Families also pay a $5 copayment for most services, up to maximum of $250 annually per family.

Access for Infants and Mothers

The Access for Infants and Mothers (AIM) Program is a state program that provides health coverage for uninsured pregnant women and their newborns who do not qualify for Medi-Cal. Coverage is also available for mothers and their infants with health coverage, if the deductible or copayment for maternity care is greater than $500. Children under age 2 in families with incomes above 200 percent and up to 300 percent of the FPL are eligible for the AIM Program. Children born to mothers enrolled in the AIM Program on or after July 1, 2004 are eligible for enrollment in the Healthy Families Program. The state plans to shift all children from AIM into the Healthy Families Program by the end of 2006-07.

Child Health and Disability Prevention

The Child Health and Disability Prevention (CHDP) Program is a state program that provides preventive health services for children in families with incomes up to 200 percent of the FPL, regardless of immigration status. In July 2003, California implemented the CHDP Gateway to reduce access barriers

Table 2.1: Medi-Cal and Healthy Families Income Eligibility

Age	Medi-Cal Program	Healthy Families Program
Infants (under 1)	Up to 200 percent of the FPL	Above 200 percent and up to 250 percent of the FPL
Children (1 up to 5)	Up to 133 percent of the FPL	Above 133 percent and up to 250 percent of the FPL
Children (6 up to 18)	Up to 100 percent of the FPL	Above 100 percent and up to 250 percent of the FPL

Health Care for Indigent Persons

California's counties are responsible for providing health care to indigent individuals. Counties use federal, state, and local funds to provide a range of health services including inpatient, outpatient, and emergency care. There is limited statewide data on county expenditures for health care to indigent children. In 1997-98, 24 counties that include about 90 percent of the state's population spent $1.3 billion on health care services for 1.3 million indigent individuals. Almost one-third (29 percent) of these individuals were under age 21.[61]

Under state and federal law, all persons seeking emergency care must receive the care, regardless of their ability to pay. Thus, emergency care is the only source of guaranteed outpatient care for millions of underinsured and uninsured Californians. However, hospitals and physicians who provide emergency care are often not fully compensated for their services.

to health coverage for uninsured children. The CHDP Gateway allows CHDP providers to temporarily enroll children up to age 18 immediately in Medi-Cal. Temporary coverage lasts up to 60 days, but the child may apply for continuing coverage through Medi-Cal or Healthy Families. In June 2004, the CHDP Gateway began to automatically enroll infants under age 1 in Medi-Cal. These infants are eligible if they are born to mothers eligible for Medi-Cal.

California Children's Services

The California Children's Services (CCS) Program is a state program that treats children and young adults under age 21 who have specified physical limitations and chronic health conditions or diseases. Children and young adults must also have annual adjusted gross family incomes of less than $40,000, out-of-pocket medical expenses expected to exceed 20 percent of family income, or Healthy Families coverage to be eligible for CCS.

Family PACT

The Family PACT Program is a state program that provides family planning services to low-income adolescents up to age 18 and certain adults.[33] California residents with family

Privately-Sponsored Health Coverage Programs

In addition to county health coverage programs, there are also privately-sponsored health coverage programs that cover children who do not qualify for Medi-Cal or Healthy Families. These include:

CaliforniaKids. The CaliforniaKids Program provides low-cost primary health coverage for uninsured children ages 2 through 18 with family incomes up to 250 percent of the FPL, regardless of immigration status. The program covers children who are not eligible for the Medi-Cal or Healthy Families programs. Funding for the CaliforniaKids Program comes from corporations, foundations, and individuals.[63]

Kaiser Permanente: Child Health Plan. Kaiser Permanente's Child Health Plan provides health coverage for uninsured children under age 19 who are not eligible for Medi-Cal or Healthy Families.[64] The program provides comprehensive preventive, primary, and specialty health coverage and requires families to pay a monthly premium.

incomes up to 200 percent of the FPL and with no other family planning coverage are eligible for the Family PACT Program.

County Children's Health Coverage Programs

Ten of California's 58 counties offer programs that provide health coverage for uninsured children who do not qualify for Medi-Cal or Healthy Families (Table 2.3). These programs are part of broader county children's health initiatives that aim to provide universal children's health coverage and implement innovative measures to improve the enrollment processes for public health coverage programs.[59] These counties have created nationally recognized models for expanding health coverage. Counties support these efforts with funding from a variety of sources, including county funds, private foundations, health plans, county First 5 funds, United Way, and national tobacco settlement funds.[60] Additional counties are currently planning to adopt their own children's health initiatives.

Similarities and Differences Among County Health Coverage Programs

County health coverage programs provide comprehensive medical, dental, and vision benefits to children. County health coverage benefits are modeled on benefits provided through the Healthy Families Program. All of the existing county health coverage programs

Table 2.2: Statewide Health Services Programs Available to Low-Income Children in California (Dollars in Thousands)

Program	Children Covered	Funding Sources	Total Funds	State General Fund	Number of Children Served per Month
Medi-Cal for Children	Up to age 18; US citizens and children who meet immigration status requirements[34]	State General Fund, federal Title XIX funds	$4,959,070[35]	$2,479,535[36]	3,017,011[37]
Medi-Cal for Children with a Share of Cost	Up to age 18; US citizens and children who meet immigration status requirements	State General Fund, federal Title XIX funds	$29,705[38]	$14,853[39]	4,050[40]
Emergency Medi-Cal Services for Children	Up to age 18, regardless of immigration status[41]	State General Fund, federal Title XIX funds	$28,888[42]	$14,444[43]	68,689[44]
Healthy Families	Up to age 18; US citizens and children who meet immigration status requirements	State General Fund, federal Title XXI funds	$871,500[45]	$318,900	774,100[46]

Program	Children Covered	Funding Sources	Total Funds	State General Fund	Number of Children Served per Month
Access for Infants and Mothers (AIM)	Under age 2[47]	State General Fund, federal Title XXI funds, state Proposition 99 funds	$45,863[48]	$6,436	11,868[49]
Child Health and Disability Prevention (CHDP)	Under age 21, regardless of immigration status	State General Fund, state Childhood Lead Poisoning Prevention funds	$5,932[50]	$5,632	7,500[51]
CHDP Gateway	Up to age 18, regardless of immigration status	State General Fund, state Childhood Lead Poisoning Prevention funds, federal Title XXI funds	$101,372[52]	$42,164	173,033[53]
California Children's Services (CCS)	Under age 21, regardless of immigration status	State General Fund, federal Title V funds, federal Title XXI funds, county funds, and fees	$236,204[54]	$86,807	38,930[55]
Family PACT	Up to age 18, regardless of immigration status	State General Fund, federal Title XIX funds	$30,248[56]	$9,316[57]	11,372[58]

Note: Medi-Cal, AIM, and Family PACT also provide services to certain individuals ages 19 or older.
Source: Department of Health Services, Managed Risk Medical Insurance Board, and Department of Finance

in California provide coverage for children regardless of immigration status. There are, however, some differences among county health coverage programs. For example, counties set different maximum family income levels and have varying policies regarding required premiums and copayments.[62]

Long-Term Funding for County Health Coverage Programs May Be Limited

Many counties may not be able to sustain their health coverage programs without long-term financial support. Local and philanthropic funding sources are often limited and several counties have capped enrollment in their health coverage programs due to budget constraints. First 5 revenues, for example, have declined as tobacco use has decreased. Also, there are often competing demands at the local level for the use of First 5 funds, which can be used to support a variety of programs besides health coverage.

Table 2.3: County Children's Health Coverage Programs Implemented as of November 2004		
County and Program	**Eligibility**	**Funding Sources**
Alameda: Alliance Family Care	Children with family incomes up to 300 percent of the FPL who do not qualify for Medi-Cal or Healthy Families, regardless of immigration status	Alameda Alliance for Health, Blue Shield of California Foundation, National Tobacco Settlement funds, California Endowment, and California HealthCare Foundation
Kern: Healthy Kids	Children up to age 5 with family incomes up to 300 percent of the FPL who do not qualify for Medi-Cal or Healthy Families, regardless of immigration status	First 5 Kern County
Los Angeles: Healthy Kids	Children with family incomes up to 300 percent of the FPL who do not qualify for Medi-Cal or Healthy Families, regardless of immigration status	Blue Shield of California Foundation, California Community Foundation, California Endowment, First 5 Los Angeles County, Kaiser Permanente, LA Care, Parson's Foundation, and UniHealth
Riverside: Healthy Kids	Children with family incomes up to 250 percent of the FPL who do not qualify for Medi-Cal or Healthy Families, regardless of immigration status	First 5 Riverside County, Inland Empire Health Plan, Riverside Community Health Foundation, and Riverside County
San Bernardino: Healthy Kids	Children with family incomes up to 300 percent of the FPL who do not qualify for Medi-Cal or Healthy Families, regardless of immigration status	First 5 San Bernardino County and Inland Empire Health Plan
San Francisco: Healthy Kids	Children with family incomes up to 300 percent of the FPL who do not qualify for Medi-Cal or Healthy Families, regardless of immigration status	City and County of San Francisco and First 5 San Francisco County
San Joaquin: Healthy Kids	Children with family incomes up to 300 percent of the FPL who do not qualify for Medi-Cal or Healthy Families, regardless of immigration status	First 5 San Joaquin County and Health Plan of San Joaquin
San Mateo: Healthy Kids	Children with family incomes up to 400 percent of the FPL who do not qualify for Medi-Cal or Healthy Families, regardless of immigration status	Blue Shield of California Foundation, California HealthCare Foundation, David and Lucile Packard Foundation, First 5 San Mateo County, Kaiser Permanente, Lucile Packard Foundation for Children's Health, Peninsula Community Foundation, Peninsula Health Care District, San Mateo County, San Mateo County Children's Health Fund, and Sequoia Hospital District
Santa Clara: Healthy Kids	Children with family incomes up to 300 percent of the FPL who do not qualify for Medi-Cal or Healthy Families, regardless of immigration status	California Endowment, California HealthCare Foundation, City of San Jose, David and Lucile Packard Foundation, El Camino Hospital, First 5 Santa Clara County, Health Trust, Lucile Packard Children's Hospital, Santa Clara County, and Santa Clara Family Health Plan
Santa Cruz: Healthy Kids	Children with family incomes up to 300 percent of the FPL who do not qualify for Medi-Cal or Healthy Families, regardless of immigration status	California HealthCare Foundation, Children's Miracle Network, Community Foundation of Santa Cruz County, David and Lucile Packard Foundation, Dominican Hospital, First 5 Santa Cruz County, Pajaro Valley Health Trust, Santa Cruz County, Sutter Maternity and Surgery Center, and United Way

Note: Alameda, San Francisco, San Mateo, and Santa Clara Counties received approval to use federal Title XXI funds. Programs cover children up to age 18, except in Kern County.

Source: Child and Family Coverage Technical Assistance Center - Institute for Health Policy Solutions

chapter 3:
many uninsured children may be eligible for existing health coverage programs

Many uninsured children could receive health coverage simply by enrolling in Medi-Cal or Healthy Families since they are currently eligible for these programs. In 2003, nearly six out of 10 uninsured California children were eligible for existing health coverage programs. The 2003 CHIS found that 207,000 uninsured children were eligible for Medi-Cal, 224,000 were eligible for Healthy Families, and another 44,000 were eligible for county health coverage programs.

This pattern suggests that there may be barriers to obtaining health coverage. In the last several years, California has implemented a number of policies aimed at improving the enrollment process for children in Medi-Cal and Healthy Families. Recent policies include:

- Providing 12 months of uninterrupted coverage for children from the date they are determined eligible for Medi-Cal;
- Establishing the CHDP Gateway, which provides temporary Medi-Cal coverage for children who enroll through CHDP while their application for Medi-Cal or Healthy Families is being processed;
- Implementing "express lane eligibility" to facilitate enrollment in Medi-Cal for children already participating in the National School Lunch Program (NSLP) and the Food Stamp Program; and
- Providing temporary coverage for certain children who apply for Medi-Cal while their application is being processed.

Many uninsured children could receive health coverage simply by enrolling in Medi-Cal or Healthy Families

Advocates have identified other changes that could improve statewide outreach and enrollment in existing programs. The county children's health initiatives also offer lessons for improving outreach and enrollment.

How Do Children Enroll in Medi-Cal and Healthy Families?

Families may apply for Medi-Cal or Healthy Families through:

- ***A joint Medi-Cal and Healthy Families***

mail-in application. Families may apply for Medi-Cal or Healthy Families for their children by completing a joint Medi-Cal and Healthy Families mail-in application and sending it to the state's Single Point-of-Entry (SPE), which screens for eligibility for both programs.[65] If the applicant appears to be eligible for Healthy Families, the SPE processes the application. If the applicant appears to be eligible for Medi-Cal, the SPE forwards the application to the appropriate county for processing.[66]

Families may also receive help from certified application assistants (CAAs). CAAs are trained to help families accurately complete the joint Medi-Cal and Healthy Families mail-in application form. CAAs work with local entities such as schools, health clinics, county departments, and other organizations. Before 2003-04, the state paid these entities for each successful application submitted with the assistance of a CAA. The state eliminated CAA payments in 2003-04 due to budget constraints. The percentage of Healthy Families applications submitted without assistance has increased significantly, from 52 percent in July 2003 to 80 percent in June 2004, resulting in more incomplete applications.[67]

- ***A Medi-Cal application.*** Families may also apply for Medi-Cal by mailing a Medi-Cal application to, or completing an application in person at, a county welfare office. County staff may assist families in completing the Medi-Cal application. If a child does not qualify for Medi-Cal due to the family's income level, the county refers the family to the Healthy Families Program.

- ***Other public programs.*** Children can enroll in Medi-Cal or Healthy Families through other public programs. The CHDP Gateway, for example, pre-enrolls children in Medi-Cal for up to 60 days. Meanwhile, these children can apply to Medi-Cal or Healthy Families for ongoing coverage. The CHDP Gateway also automatically enrolls certain infants under age 1 in Medi-Cal. In addition, children in the NSLP can apply for Medi-Cal using information from the NSLP application, without having to submit a separate Medi-Cal application.

Health-e-App and One-e-App

Health-e-App is the first web-based system in the country for enrolling low-income children and pregnant women in public health coverage programs. Health-e-App allows families to apply for Medi-Cal or Healthy Families on the Internet, which simplifies the application process. Applicants for Healthy Families can also select providers and health, dental, and vision plans.

Based on the Health-e-App approach, One-e-App is a new, web-based system that is being implemented on a pilot basis in certain counties. One-e-App will allow families to enroll in multiple public programs using a single, online application. The goal is to prevent families from having to complete multiple applications that request similar information. Programs could include Medi-Cal, Healthy Families, county health coverage programs, food stamps, and the Supplemental Nutrition Program for Women, Infants, and Children (WIC). Alameda, San Mateo, and Santa Clara counties are participating in the One-e-App pilot. Santa Cruz County is using One-e-App for its Healthy Kids Program, Healthy Families, and Medi-Cal for children and pregnant women.

Why Are Eligible Children Not Enrolled?

Nationally, barriers to enrollment in Medicaid and SCHIP programs include complex enrollment and renewal processes, lack of knowledge about the programs, and the association of Medicaid with welfare.[68] Immigrant families may face language barriers to enrollment, not understand program rules, or fear repercussions if they use public benefits.[69] In some cases, families may not believe there is a need for health coverage for their children.

The Enrollment Process May Be Difficult for Families

Research suggests that improving the enrollment process could significantly increase enrollment in both Medi-Cal and Healthy Families.[70] The state receives many incomplete applications, which suggests families may not fully understand the application requirements or that the required documentation is cumbersome.

In November 2003 about 75 percent of Healthy Families applications were incomplete.[71] Furthermore, the state denied about three-fourths (74 percent) of Healthy Families applications forwarded through the CHDP Gateway between July 2003 and October 2003 due to the applications being incomplete.[72] As many as 41 percent of incomplete Healthy Families applications submitted through the CHDP Gateway lacked adequate income documentation.[73]

Cumbersome Renewal Processes May Cause Children to Lose Coverage

In both Medi-Cal and Healthy Families, families maintain coverage by submitting renewal forms, including required documentation. If a family does not submit all of the required information by the time coverage is scheduled to expire, the state terminates coverage for the child.[74]

Some children may lose coverage unnecessarily due to cumbersome renewal processes. For example, while there were over 673,000 children enrolled in Healthy Families in May 2004, between June 2003 and May 2004 the state terminated coverage for over 110,000 children for submitting incomplete information at renewal.[75] In addition, the number of incomplete Healthy Families renewal applications has increased.[76] While it is unclear how many children who lost coverage remained eligible, simplifying the renewal process would likely prevent some children from losing coverage in the first place.

Families Lack Program Information

Lack of information about available programs may also be a reason why families do not enroll eligible children in the state's health coverage programs. In 2001, parents of nearly one-third (32 percent) of the uninsured children eligible for Medi-Cal did not think their children were eligible. Among children who were eligible for the Healthy Families Program, parents of nearly one-quarter (23 percent) did not know of the program's existence, and another one-third (34 percent) did not think or know if their children were eligible.[77]

Families Have Different Perceptions of How Their Children Will Be Treated

Some families have concerns about how their children will be treated in Medi-Cal and Healthy Families that may influence their decision to apply for coverage.[78] One study found that some parents associate Medi-Cal with welfare and that they are concerned that their children will be treated poorly by health providers, compared to patients with private

health coverage. For example, parents felt that children covered by Medi-Cal might have to wait longer to see a health provider. On the other hand, some families had fewer negative perceptions of the Healthy Families Program, compared to Medi-Cal, and felt that their children would be treated more like privately-insured patients.[79]

Immigrant Families Face Barriers

Immigrant families may not enroll in existing programs for fear of jeopardizing their immigration status. Many immigrants in low-income families may believe there will be negative repercussions for family members if their children receive public benefits, such as the inability to get a green card or become a citizen. Families with mixed immigration statuses may have concerns regarding the confidentiality of the application process and how government authorities might use the information.

Immigrant families with limited English proficiency may face language barriers that make it difficult to learn about programs and complete the application process. These families may not understand outreach messages, be aware of public health coverage programs, or be able to complete an application for Medi-Cal or Healthy Families.[80]

Families Believe They Do Not Need Health Coverage

A 2001 survey found that some parents believe their children do not need health coverage. Parents of 3.8 percent of uninsured children eligible for Medi-Cal and 3.7 percent of uninsured children eligible for Healthy Families did not perceive a need for health coverage for their children.[81] One national study found that low-income uninsured children whose parents felt they did not need or want Medicaid or SCHIP coverage were more likely to be in better health compared to other low-income uninsured children. However, the study also suggested that many of these children were not receiving recommended levels of preventive care.[82]

County Children's Health Initiatives Boost Outreach and Enrollment

A number of counties have taken steps to expand children's health coverage. Alameda, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, and Santa Cruz counties have developed health coverage programs for children who do not qualify for Medi-Cal or Healthy Families. As part of their children's health initiatives, counties have developed innovative strategies and partnerships with community-based organizations to enroll children in Medi-Cal, Healthy Families, and county health coverage programs.[83] Alameda, San Mateo, Santa Clara, and Santa Cruz counties, for example, streamlined the application process, held community-wide enrollment events in which staff helped families complete applications, involved community-based organizations in helping to enroll families, and allowed families to apply for multiple programs in one location.[84]

Alameda County

Alameda County has been implementing a "no wrong door" approach to improving the enrollment process for children's health coverage. Alameda County developed a pilot program whereby eligible families can complete one application for health coverage for their children. The county either enrolls the child in Medi-Cal or forwards the application to another health program, such as Healthy Families or the county's Alliance Family Care Program. Without the pilot, the family would have to seek out and apply to another health program if they were not

eligible for Medi-Cal. Alameda County also uses one application for Medi-Cal, Healthy Families, and Alliance Family Care, which simplifies the application process. However, the county currently is not accepting new applications for enrollment in its Alliance Family Care Program due to county budget constraints.

San Mateo County

San Mateo County implemented a "one-stop" model whereby families can go to a single location to apply for a number of programs, including Medi-Cal, food stamps, and CalWORKs.[85] As part of the county's children's health initiative, county staff assess whether children are eligible for Medi-Cal, Healthy Families, or the county's Healthy Kids Program and help families complete the appropriate application. This reduces families' confusion over differing eligibility requirements among programs and helps ensure that applications are accurately completed.

Santa Clara County

Santa Clara County established a "single point-of-entry" in which families can apply for Medi-Cal, Healthy Families, or the county's Healthy Kids Program. Eligibility workers and application assistants located in clinics and county offices help families apply for all three programs.

Santa Clara County created a simple two-page application for its Healthy Kids Program. The county also simplified the Healthy Kids application process so that families only have to provide documentation of their income and county residency.[86] In addition, the county contacts families that miss a premium payment to determine if they still need coverage. The county may cover the premium if the family is experiencing economic hardship.[87]

An evaluation of Santa Clara County's children's health initiative found that Medi-Cal and Healthy Families enrollment increased by 28 percent between 2001 and 2002, compared to what enrollment would have been in the absence of the county children's health initiative. As a result, Santa Clara County increased state and federal spending in these two programs by about $24 million during the first two years of the initiative.[88] Experience in Santa Clara County suggests that expanding health coverage for children not currently eligible for Medi-Cal or Healthy Families could also boost enrollment of eligible children in these programs.

Santa Cruz County

Santa Cruz County recently implemented a county Healthy Kids Program. The county also launched an outreach campaign to help enroll children in Medi-Cal and Healthy Families, as well as the Healthy Kids Program. Outreach includes holding enrollment events throughout the community; using application assistants at local health fairs, clinics, community centers, schools, and medical offices; and using trained, bilingual assistants to help families fill out applications for the appropriate program. The county is using One-e-App to enroll children in Medi-Cal, Healthy Families, and the county's Healthy Kids Program.

part II:
policy options

chapter 4:
options to increase enrollment in existing health coverage programs

California could take steps to increase enrollment of eligible children in existing health coverage programs, including Medi-Cal and Healthy Families. County children's health initiatives and policies in other states offer models for improving outreach and enrollment. In addition, California could build on approaches already adopted by the Legislature. Promising policy strategies include:[89]

- ***Expanding and improving express lane eligibility.*** Express lane eligibility links children who are enrolled in other public programs to Medi-Cal and Healthy Families. This approach seeks to expedite health coverage enrollment for children who have, in many cases, already provided contact, income, and other eligibility information to another public program, particularly those with similar family income requirements. The state could improve the existing express lane eligibility processes in the NSLP and the Food Stamp Program, as well as expand the express lane eligibility concept to other public programs to reach more uninsured children.[90]

- ***Implementing the Newborn Hospital Gateway.*** SB 24 (Figueroa, Chapter 895 of 2003) authorizes the establishment of a Newborn Hospital Gateway that would allow families to electronically enroll newborns in Medi-Cal from hospitals. However, the state has not implemented this gateway due to lack of funding.[91]

County children's health initiatives and policies in other states offer models for improving outreach and enrollment.

- ***Creating a "bridge" program, or a temporary period of eligibility, for children transferring from Medi-Cal and Healthy Families to county health coverage programs.*** The state could establish a "bridge" program for children who are transferring from Medi-Cal or Healthy Families to county health coverage programs to prevent a break in coverage when children change programs due to a change in income or eligibility status.[92] The state already operates "bridge" programs for children moving between Medi-Cal and Healthy Families. A child who is no longer eligible for

Healthy Families receives two months of Healthy Families coverage while enrollment information is sent to Medi-Cal. In addition, a child who is no longer eligible for Medi-Cal receives one month of Medi-Cal coverage while enrollment information is sent to Healthy Families. Santa Clara County provides a two-month Healthy Kids coverage bridge when a child leaves the county health coverage program and applies for Medi-Cal or Healthy Families.

- ***Allowing Medi-Cal applicants to self-certify their income.*** California could allow Medi-Cal applicants to self-certify their income when they apply for or renew their coverage, rather than provide documentation. Currently, California requires Medi-Cal applicants to provide proof of earned income through documents such as pay stubs and tax returns. The state could use other methods of verifying income without requiring documentation.[93] One study suggests that allowing applicants to self-certify income in Medi-Cal could generate administrative savings and allow more people who are eligible to become enrolled.[94] In July 2003, 12 states allowed families to self-certify their income when applying for Medicaid or SCHIP for children.[95]

- ***Simplifying the renewal process.*** The state could simplify the renewal process for Medi-Cal and Healthy Families by minimizing the information that has to be provided, particularly if a family's circumstances have not changed.[97] When families renew their coverage, the state requires families to update information provided at the time of initial enrollment and submit renewal forms. The state could, instead, require families to return renewal forms only if there are changes affecting eligibility. If a family's circumstances have remained the same, the family would not need to return the form. Florida, Georgia, Utah, and South Carolina use this approach.[98]

- ***Making Healthy Families premiums easier to pay.*** Between June 2003 and May 2004, the state terminated Healthy Families coverage for about 74,000 children for failure to pay their premium. Currently, the state terminates coverage if the premium has not been paid by the end of the second month.[99] The state could implement measures to ensure that fewer children lose coverage for this reason by making the premiums easier to pay. The state could, for example, promote the option that allows families to deduct their Healthy Families premiums from parents' paychecks. Fewer than 1 percent of children in Healthy Families have premiums paid through automatic deductions from their parents' paycheck.

Florida Uses Self-Certification of Income and Child Care Settings to Streamline Enrollment for Children's Health Coverage

In Florida, families who apply for child care can also apply for health coverage under the state's Medicaid or SCHIP programs. During the child care application interview, staff asks whether families are interested in health coverage for their children. If so, the child care program takes the additional information needed to complete the heath coverage application. Since Florida allows families to self-certify their income in its children's health coverage programs, the family simply needs to sign the form and mail the application to the health program in a stamped, pre-addressed envelope. Between December 2000 and August 2001, over 1,400 children applied for health coverage through this streamlined process.[96]

The state could also establish a fund to cover premiums on a one-time basis for families that miss their payments due to temporary financial hardship.[100]

- ***Maximizing federal funding for local outreach and enrollment assistance.*** The state could use county funds spent on outreach and enrollment assistance as a match for available federal Medicaid or SCHIP dollars, thereby increasing the total resources available for these activities.[101] The federal government will match local dollars with Medicaid funds on a one-to-one basis. The federal government will also provide about two dollars in SCHIP funds for every local dollar, up to 10 percent of the state's total SCHIP expenditures.[102]

Teachers for Healthy Kids

Teachers for Healthy Kids (THK) is a project developed jointly by the California Teachers Association and the California Association of Health Plans to involve teachers directly in school-based health coverage outreach. Started in 2002, the program encourages teachers to become directly involved in discussions about health coverage as part of their regular teacher-parent communications. The goal is to make health coverage outreach, enrollment, and parent education a school-wide endeavor, coordinating outreach activities with regular school events. Working with parents, school nurses, school support staff, administrators, government agencies, and community groups, the project seeks to help students without health care obtain adequate and affordable health coverage.[103]

- ***Restoring state support for CAAs.*** The state formerly paid $50 when a CAA helped enroll a child in Healthy Families or Medi-Cal and $25 for each successful Healthy Families renewal. Federal funds covered a portion of the cost of the CAA payments. California eliminated CAA payments in 2003-04 due to budget constraints.

  The state could restore funding to support CAAs by reimbursing local entities that offer CAA services. This could help counties maintain or increase the number of CAAs who help families apply or renew coverage for Medi-Cal or Healthy Families.

  Families who apply to Healthy Families with application assistance, for example, are more likely to have their children enrolled, compared to families who do not receive assistance.[104] Moreover, the elimination of support for application assistance may be linked to an increase in calls for assistance. Since the termination of state support for CAAs, calls to the Healthy Families Program toll-free number have increased significantly. The increase in calls has resulted in more callers receiving a busy signal and longer wait times. In addition, there has been an increase in the number of incomplete applications since elimination of state support for CAAs.

chapter 5:
options used by other states to expand children's health coverage

California can learn from innovative policy strategies used by a number of states to expand children's health coverage. Policy strategies used in other states include:

- ***Expanding eligibility for public health coverage programs.*** Some states cover groups of children who are not eligible for California's Medi-Cal or Healthy Families programs, including children with family incomes above 250 percent of the FPL and children with certain immigration status. Vermont and Missouri, for example, provide health coverage for uninsured children with family incomes up to 300 percent of the FPL, while Minnesota provides health coverage for children with family incomes up to 275 percent of the FPL (Table 5.1).[105]

  Massachusetts, New York, Rhode Island, and the District of Columbia use state or local funds to provide some health coverage for certain children, regardless of immigration status, who do not otherwise qualify for federally-funded programs. New York, Rhode Island, and the District of Columbia appropriate these funds through their SCHIP program.

- ***Allowing higher-income families to purchase health coverage through state "buy-in" programs.*** Health care buy-in programs can provide some families a lower-cost health coverage option for their children, compared to what is available in the individual private market.[106] Under a full-cost buy-in program, families purchase health coverage for children through the state at full cost with no state subsidy. These buy-in programs generally target higher-income families who do not have access to employment-based health coverage and who cannot afford health coverage in the individual private market.

California can learn from innovative policy strategies used by a number of states to expand children's health coverage.

Two factors explain why state buy-in programs may be able to offer families a lower-cost health coverage option than the individual private market. First, states can use the purchasing power from covering a large number of enrollees in their existing health coverage programs to negotiate lower premiums than what families would

pay in the private market. Second, states can generate administrative efficiencies using their existing Medicaid or SCHIP enrollment process, which reduces the overall cost of providing coverage through buy-in programs.[107]

States that have implemented buy-in options in their SCHIP program include Connecticut, Florida, New York, and North Carolina. Connecticut's HUSKY Program, for example, includes a buy-in option for families with incomes above 300 percent of the FPL. These families can buy into the plan with no limit on out-of pocket expenses.[108]

Table 5.1: Family Income Limits Above 250 Percent of the Federal Poverty Level for Children's Health Coverage in Other State Medicaid or SCHIP Programs, April 2003

State	Percentage of the Federal Poverty Level
Connecticut	300
Maryland	300
Massachusetts	400+
Minnesota	275
Missouri	300
New Hampshire	300
New Jersey	350
Vermont	300

Source: Kaiser Commission on Medicaid and the Uninsured

- ***Helping families cover the cost of employment-based health coverage through premium-assistance programs.*** Premium-assistance programs help low-income families pay an employee's share of employment-based health coverage premiums, with the state and federal governments sharing the cost. Several states have received a waiver of federal guidelines allowing federal funds to be used to pay a portion of the cost of employment-based health coverage.[109] The number of eligible individuals receiving premium assistance through these programs, however, has been low. Moreover, premium-assistance programs may have high administrative costs and may not be cost-effective for states, compared to providing health coverage through their Medicaid or SCHIP programs.[110]

  However, Rhode Island's premium-assistance program has been relatively successful in enrolling eligible users. The state's premium-assistance program costs the state less than enrolling the family in Rhode Island's Medicaid or SCHIP program. Rhode Island saves an estimated $178 per month for each family enrolled in the premium-assistance program, rather than in the state's Medicaid or SCHIP managed care program.[111]

  It is unclear whether a premium-assistance program would cost less than Medi-Cal coverage, since California's Medi-Cal costs per enrollee are low compared to other states. California could limit the premium-assistance payment so that the state cost of the payment is less than the state cost of coverage under Medi-Cal or Healthy Families.

- ***Allowing employers and families to purchase health coverage through a state-subsidized program.*** Maine developed a new state-administered Dirigo Health Plan, to provide affordable coverage for certain residents. Dirigo Health offers subsidized health coverage for uninsured

persons under age 65 with incomes up to 300 percent of the FPL. Employers may use Dirigo Health to offer health coverage for their employees. Employers that participate pay part of the premium.

Maine is focusing initial enrollment on small businesses, the self-employed, and individuals. The state finances Dirigo Health through employers' contributions, employees' contributions, and Medicaid dollars for eligible individuals. State general revenues will initially help finance Dirigo Health, but the state plans to replace general revenues with revenues generated through assessments on the gross revenues of insurers and third-party administrators.[112]

County "Buy-In" Programs for Medi-Cal and Healthy Families

Currently, 10 counties operate health coverage programs for children who do not qualify for Medi-Cal or Healthy Families. However, the state could allow counties to buy into Medi-Cal or Healthy Families to provide health coverage for children who are not currently eligible for these programs. This could create administrative efficiencies and reduce overall costs, as counties would not need to create their own health coverage programs. Counties potentially could receive federal matching funds to offset the cost of expanding health coverage through a buy-in program. However, the state would need to seek federal approval to use federal funds for children who are not currently eligible for Medi-Cal or Healthy Families.

part III:
financing options

chapter 6:
state financing options to expand children's health coverage

California could use a number of financing options to expand children's health coverage. The state may need additional funds both to cover children who are currently eligible for Medi-Cal or Healthy Families and to expand health coverage for children who are not currently eligible for these programs. The financing options listed below reflect a range of approaches. The state could combine many with each other and/or with other policy and financing options examined in this report. In addition to the strategies discussed in this chapter, other financing options not discussed in this report, including employer and family contributions, may provide additional resources. Potential financing options include (Table 6.1):

- ***Seeking new federal matching funds.*** The federal government contributes to the cost of providing health coverage for children in the state's Medi-Cal and Healthy Families programs who meet income, citizenship or immigration, and other requirements. California could seek additional federal funds to help cover the cost of expanding comprehensive health coverage for children whose family incomes exceed existing program limits. The federal government also allows states to match federal funds to provide limited health services to children, regardless of immigration status. While California is currently matching federal funds for health services provided under this option, additional federal funds are available to expand health services.

California could use a number of financing options to expand children's health coverage.

- ***Using existing federal and state health services funds***. Some uninsured children who could enroll in expanded health coverage programs may already receive limited health services paid for with federal and state funds through existing health programs. California could use funding that currently supports limited health services to reduce the need for new dollars to fund the cost of expanding comprehensive children's health coverage.

- ***Generating and reinvesting state savings.*** The state could implement various policies to generate savings in existing health programs, including Medi-Cal, without

reducing services or eligibility, and reinvest those savings to expand health coverage for children. The state could, for example, implement Medi-Cal pharmacy cost-containment measures to generate savings and reinvest those savings to expand children's health coverage.

- ***Raising additional state revenues.*** The state could raise additional revenues to support the expansion of children's health coverage. Covering all California children would require additional funds that, in light of the state's ongoing budget problems, may best be supported through new sources of revenue. Public opinion research suggests that voters understand the importance of health care for children and may look favorably on proposals to raise additional revenues.

- ***Seeking First 5 funds.*** California could seek approval from the state First 5 commission to use First 5 tobacco tax proceeds to help finance expansion of health coverage for children up to age 5. First 5 revenues, however, are declining due to the decrease in tobacco use, and there are often competing demands for the use of these funds.

Seeking New Federal Matching Funds

The state could take steps to maximize the receipt of federal funds to help cover the cost of expanded children's health coverage. Options include:

- ***Seeking federal funds for expanded health coverage.*** The federal government contributes to the cost of Medi-Cal and Healthy Families coverage for children in low-income families who are US citizens or meet immigration status requirements.[113] California receives one dollar in federal Medicaid funds for every state dollar in Medi-Cal and about two dollars in federal SCHIP funds for every state dollar in Healthy Families for federally-eligible expenditures.

Table 6.1: State Financing Options for Expanding Children's Health Coverage

Financing Options	Children Who May Be Covered		Required Actions
	Children with Family Incomes over 250 Percent of the Federal Poverty Level	All Immigrant Children	
Seeking New Federal Matching Funds	✓		Federal Approval
Using Existing Federal and State Health Services Funds	✓	✓	Federal Approval and/ or State Law Changes
Generating and Reinvesting State Savings	✓	✓	Federal Approval and/ or State Law Changes
Raising Additional State Revenues	✓	✓	State Law Changes
Seeking First 5 Funds	✓	✓	State First 5 Commission Approval

California could seek federal approval to use federal Medicaid or SCHIP funding to cover part of the cost of expanding comprehensive health coverage for children who have family incomes above 250 percent of the FPL and meet federal program requirements. This would bring in additional federal funds to help finance expanded health coverage for children, although the state would have to provide matching state dollars.[114]

By April 2003, eight states had received federal approval to provide health coverage for children with family incomes higher than 250 percent of the FPL through their Medicaid or SCHIP programs. Seven of these states provided health coverage for children with family incomes at or above 300 percent of the FPL.[115]

- ***Seeking federal funds for SCHIP "health services initiatives."*** While federal matching funds are not available to provide comprehensive health coverage for children who do not meet immigration status requirements, the state could use federal funds to provide limited health services to children, regardless of their immigration status. Under the SCHIP law, states may use federal funds to implement health services initiatives that provide health education services, school-based health services, and direct services, including newborn hearing screening. California could match federal SCHIP dollars to support health services initiatives in targeted communities.[116]

  Such initiatives may serve all low-income children, including, but not limited to, children eligible to receive services under the federal SCHIP law. In addition, states may target health services initiatives to low-income, immigrant communities, including migrant and seasonal farm workers. For example, a state could use federal SCHIP funds to provide services to immigrant children who are not eligible for health coverage under SCHIP due to their immigration status, if the initiative promotes child health in a targeted community or school.[117]

  California currently operates a health services initiative, called the Rural Health Demonstration Project (RHDP). The state's 2004-05 Budget includes about $1.8 million in federal SCHIP funds for the RHDP.[118] The RHDP funds projects that address the lack of health services in rural areas and access problems encountered by special populations, including children of migrant and seasonal farmworkers.

Using Existing Federal and State Health Services Funds

Some uninsured children who could enroll in expanded health coverage programs may already receive limited health services paid for with federal and state funds through existing health programs. These programs are part of the health safety net for uninsured children. Uninsured children may, for example, receive emergency services through the Medi-Cal Program or health screening services through the CHDP Program. California could use at least two strategies to reduce the need for new dollars to fund the cost of expanding comprehensive children's health coverage.[119]

Use Existing Funds for Comprehensive Health Coverage

California could use existing funds to offset the cost of providing comprehensive health coverage. The state's 2004-05 Budget, for example, includes $5.6 million from the General Fund for the CHDP. If the state expanded health coverage for uninsured children, this CHDP funding could reduce the

need for new state dollars to finance the cost of health screenings as part of a comprehensive health coverage plan. In addition, the state spent $14.4 million for emergency Medi-Cal services for children ages 1 to 17 in 2002-03.[120] This funding could reduce the need for new state dollars to cover the cost of emergency services under a comprehensive health coverage plan, if the state were to expand health coverage for uninsured children.[121]

Supplement Health Coverage Through Existing Programs

California could also reduce the need for new funding to expand health coverage by supplementing coverage through existing programs. The state could use emergency Medi-Cal services, for example, to supplement a comprehensive health coverage plan. However, there may be limitations on using federal emergency Medi-Cal funds to pay for emergency services if those services are provided through a comprehensive health coverage plan. The state could also explore the possibility of using the CHDP Program to provide health screening services as part of expanded comprehensive health coverage for children.

California currently supplements Medi-Cal and Healthy Families coverage with services provided through the CCS Program.[122] If a child enrolled in Medi-Cal or Healthy Families develops a CCS condition, the child can receive services through the state CCS Program. The state could extend this model to other programs.

Generating and Reinvesting State Savings

The state could adopt various policies to generate savings in health programs without reducing services or eligibility and reinvest the savings toward expansion of health coverage for children.[124] Some opportunities to generate savings without reducing services or eligibility include:

- ***Shifting mothers in the AIM Program to Medi-Cal.*** The state could shift eligible mothers in the AIM Program to Medi-Cal to cover pregnant women up to 300 percent of the FPL.[125] This would bring in a dollar-for-dollar federal match for AIM mothers who meet Medicaid program requirements and who are currently covered primarily with state funds. This option would not require additional state expenditures, since the state could use existing AIM funding as a match for federal funds. California could redirect the resulting state savings to finance expanded health coverage for children.

  The actual level of savings would vary depending on policy decisions, such as the type of benefit package offered to mothers. For example, if the state provided a benefit

How Does New York Finance Children's Health Coverage?

New York covers children up to 250 percent of the FPL and is one of the few states that provides health coverage for children regardless of immigration status. New York finances the state's share of the Child Health Plus Program through the state's Health Care Reform Act (HCRA) fund. The HCRA fund includes tobacco settlement funds, cigarette tax revenues, assessments on health insurers based on the number of persons covered, surcharges on hospital and clinic services, assessments on inpatient hospital revenues, and proceeds from the conversion of Empire Blue Cross Blue Shield to for-profit status.[123] The HCRA funds are not included in the state budget and are not subject to the regular state appropriation process.

package that was similar to coverage available through AIM, the Legislative Analyst's Office (LAO) estimates that this would bring in additional federal funds of approximately $17 million annually, with a commensurate amount of state savings.[126]

- ***Implementing Medi-Cal cost-containment measures.*** California could implement cost-containment measures, without reducing services or eligibility, to generate savings in the Medi-Cal Program and redirect the savings to fund expanded children's health coverage.[127]

  The state could, for example, implement additional pharmacy cost-containment measures. California, like other states, has implemented significant Medi-Cal pharmacy reforms.[128] Nonetheless, there is evidence that state Medicaid programs are overpaying pharmacies for prescription drugs dispensed to Medicaid beneficiaries.[129] States base their pharmacy reimbursement rates on drug prices reported by manufacturers to commercial pricing services. However, such prices may be much higher than the prices pharmacies pay to wholesalers or manufacturers for drugs covered by Medicaid.[130]

  To reign in costs, some states require drug manufacturers to report accurate prices. In Texas, for example, drug manufacturers must submit accurate pricing information to the state's Medicaid program in order for their drugs to be covered by Medicaid.[131] California could use accurate pricing data to set a more cost-effective Medi-Cal pharmacy reimbursement rate.

  Moreover, federal law allows states to set reimbursement limits for certain drugs that have at least two generic competitors. While California has adopted such limits for some drugs, it could expand that list to ensure that it does not overpay pharmacies for generic drugs dispensed to Medi-Cal beneficiaries.[132]

- ***Exploring the feasibility of imposing fees on additional health providers.*** Federal Medicaid law allows states to impose fees on health providers.[133] Some states have imposed fees on health providers and used the revenues to match federal funding in order to increase reimbursements for those same providers.[134]

  California has imposed a fee on intermediate care facilities (ICFs) and on Medi-Cal managed care plans.[135] The state will keep a portion of these fee revenues to fund the Medi-Cal Program, which results in state savings because the revenues are used to offset General Fund spending. The state will use the remaining fee revenues to match new federal Medicaid funds to provide higher reimbursements to these providers. The state estimates annual ongoing General Fund savings of

Provider Taxes

Provider fees fall under the broader category of provider taxes under Medicaid law. Other states have used provider taxes to help directly finance their health coverage programs. Minnesota, for example, imposes taxes on hospitals, surgical centers, and other health providers to help finance health coverage. The proceeds of a 1.5 percent provider tax cover more than half of MinnesotaCare, Minnesota's program serving low-income children with family incomes less than 275 percent of the FPL.[139] New York levies assessments on provider revenues, including general hospitals, some clinical laboratories, and certain diagnostic and treatment centers, to help subsidize health care.

approximately $22.4 million from the ICF fee and approximately $57 million from the Medi-Cal managed care plan fee when fully implemented.[136]

The state could explore the possibility of imposing a similar fee on additional providers.[137] There are a number of factors to consider in assessing fee proposals, including the impact on providers.[138] The actual level of state savings that could be achieved would depend on various factors, such as the fee level and the level of provider reimbursements. The state could redirect General Fund savings to expand children's health coverage.

Raising Additional State Revenues

The state could raise revenues to support the expansion of children's health coverage. The California Constitution requires two-thirds of the Legislature to vote for any measure enacted for the purpose of increasing state tax revenues. The two-thirds vote requirement applies to increases in state tax rates and measures that limit or repeal state tax expenditures, or "loopholes," regardless of whether the proceeds are deposited in the state's General Fund or a special fund. There are a number of options available for increasing state tax revenues (Table 6.2).[140]

A number of states have raised revenues earmarked to finance their children's health coverage programs. Arizona, Massachusetts, Oregon, and Pennsylvania use tobacco tax revenues to partly finance their SCHIP programs.[141] Washington state's SCHIP program uses revenues from taxes on tobacco products and alcoholic beverages to fund the state's share of health coverage.[142]

Seeking First 5 Funds

Proposition 10, passed by California voters in November 1998, raised the tax on tobacco products statewide. The state may use Proposition 10 revenues, also known as First 5 funds, to promote, support, and improve

Constitutional Constraints on the Taxing Authority of State and Local Governments

The state Constitution limits the state and local governments' ability to raise revenues. A number of voter-approved measures have made it more difficult to increase taxes. A majority of statewide voters voting on a constitutional amendment must approve changes to the state's Constitution. Constitutional provisions affecting the state and local governments' taxing authority include:

- Capping local property tax rates at 1 percent, except for voter-approved rates dedicated to repayment of debt for capital investments. Proposition 13 also prohibited the state from imposing a tax on the sale of real property.
- Requiring measures enacted for the purpose of increasing state tax revenues to be passed by a two-thirds vote of the Legislature.
- Requiring a two-thirds vote of local voters to approve any new or increased tax dedicated to a specific purpose and a majority vote of local voters to approve any general-purpose local tax.
- Prohibiting the imposition of a sales or use tax on food products, except those items taxed on or before January 1, 1993. The state Constitution specifically exempts candy, bottled water, and snack foods from the state's sales tax.
- Limiting the ability of local governments to impose fees and the amount that can be raised through a fee.
- Earmarking the proceeds of motor vehicle fuel taxes and the sales tax paid on fuel for transportation.

Table 6.2: Selected State Revenue-Raising Options		
		Revenues (In Millions)
Tax Commercial Property at Market Value*	$	3,350
Restore Top Income-Tax Brackets	$	2,900
Impose a 1 Percent Sales Tax on a Broad Range of Services, Excluding Health Services	$	1,380
Increase the General Fund Sales Tax Rate by 0.25 Percent	$	1,247
Impose the State's Sales Tax on Legal Services	$	1,195
Impose the State's Sales Tax on Engineering, Architectural, and Surveying Services	$	1,030
Impose the State's Sales Tax on Accounting, Auditing, and Bookkeeping Services	$	830
Impose the State's Sales Tax on Computer Systems Design and Related Services	$	724
Impose a $0.05 Tax per Serving of Alcoholic Beverages	$	700
Increase Corporate Tax Rate by 1 Percent to 9.84 Percent	$	680
Increase the Cigarette Tax by $0.50 per Pack	$	583
Restore Net Operating Loss Deductions to 65 Percent	$	525
Impose the State's Sales Tax on Repair Labor	$	550
Impose the State's Sales Tax on Management, Scientific, and Consulting Services	$	671
Cap Mortgage Interest Deductions at Interest on $500,000 of Debt for Married Taxpayers ($250,000 Single)	$	380
Limit Personal and Corporate Income Tax Credit Carryovers to 50 Percent of Liability	$	375
Restore Subchapter S Corporation Tax Rate to 2.5 Percent	$	350
Impose a 1 Percent Surtax on Personal Income Tax Owed After Credits	$	320
Suspend Indexing of the Personal Income Tax Brackets	$	295
Eliminate Enterprise Zone Tax Credits	$	262
Impose the State's Sales Tax on Cable TV and Other Program Distribution	$	282
Eliminate the Child and Dependent Care Tax Credit	$	210
Eliminate Expensing of Exploration, Research, & Development Costs	$	189
Impose the State's Sales Tax on Laundry and Dry Cleaning Services	$	158
Repeal Double Weighted Sales Factor in the Corporate Income Tax	$	100
Limit Mortgage Interest Deductions to a Maximum of $50,000	$	47

*Revenues raised would go to schools, cities, counties, and special districts. The state's school funding obligation would be reduced by approximately 52 percent of the revenues raised, which would allow the state to redirect freed-up General Fund dollars to other services, including expanded children's health coverage.

early childhood development of children up to age 5.[151] The state may only use First 5 funds to supplement existing levels of service and cannot use the funds to supplant existing funding. The law requires that the state allocate 80 percent of Proposition 10 revenues to county First 5 commissions and 20 percent to the state First 5 commission.[152] The state commission must allocate its 20 percent funds as follows:

- 6 percent for mass media communications;
- 5 percent for education of parents, caregivers, and professionals;
- 3 percent for education, training materials, and guidelines for child care providers;
- 3 percent for research and development;
- 1 percent for administrative services; and
- 2 percent for other activities, except administration.

In 2003, the state commission adopted the Health Access for All Children initiative. The initiative will provide $46.5 million over approximately four years. Most of the funds will go to county First 5 commissions to help pay health coverage premiums for children up to age 5 who are ineligible for Medi-Cal or Healthy Families and who have family incomes at or below 300 percent of the FPL. The state commission will provide one state First 5 dollar for every four dollars from local sources used to subsidize health coverage premiums. The state First 5 commission is currently accepting county First 5 commission applications for funding under this initiative.[153]

First 5 revenues, however, are declining due to the decrease in tobacco use. The state First 5 commission projects that revenues for the state commission will decrease from $111.1 million in 2003-04 to $87.6 million in 2009-10, a 21 percent decrease.[154]

Tax Credits May Not Be an Effective Strategy for Expanding Health Coverage

Concern over the rising number of uninsured individuals has prompted interest in whether tax credits and similar subsidies are an efficient and cost-effective strategy for expanding health coverage. Lawmakers at both the state and federal levels have proposed tax credits for employers and/or individuals in order to reduce the cost of purchasing health coverage.

Currently, both state and federal tax law encourage the purchase of job-based health coverage by allowing employers to deduct amounts spent on employees' health coverage from their income taxes, while excluding the value of health coverage from employees' income for tax purposes. The exclusion of the cost of employers' health insurance payments from workers' taxes cost the state $2.5 billion in lost revenues in 2001.[1]

Tax policies for individuals who purchase health coverage out-of-pocket are far less generous. Individuals must purchase health coverage out of their after-tax income and can only deduct medical expenses if they exceed 7.5 percent of adjusted gross income. Two recent changes have modestly increased tax preferences for certain individuals purchasing health coverage. Beginning in 2002, federal law provides a refundable tax credit equal to 65 percent of the premium paid by certain displaced workers for individual and family health coverage.[144] Beginning in 2003, self-employed individuals operating profitable small businesses can deduct 100 percent of the cost of health coverage for the small-business owner's family.[145]

Research suggests that tax credits are a costly and relatively inefficient strategy for increasing health coverage, particularly at the state level. There are a number of reasons why tax credits are a poor choice for reducing the number of the state's uninsured, including:

- ***The size of the subsidy needed to encourage health coverage would be large.*** Research on the relationship between the price of health coverage and an employer's decision to provide health coverage suggests that a tax credit would have to cover over 50 percent of the

employer's cost to have a significant impact on the number of businesses providing health coverage. A 1992 study of 11 state-level projects designed to expand health coverage found that most small employers were unwilling to purchase health coverage for their employees even if offered subsidies of between 25 and 50 percent of the cost of health coverage. Enrollment exceeded 10 percent of eligible businesses in just three of the projects studied.[146] A more recent study concluded that a 10 percent price reduction would induce only about 3 percent of businesses not currently providing health coverage to begin to offer it.[147] The impact on smaller businesses, those with fewer than 100 employees, is somewhat greater at 6 percent, but still relatively small.

- ***A significant fraction of the cost of a tax credit would go to those who are already insured or employers who already offer health coverage.*** Most of the benefits of a tax credit for small businesses will go to employers that already purchase health coverage: 63 percent of employers with three to 19 workers and 84 percent with 20 to 49 workers offered health coverage in 2003.[148] A recent study conducted for the California HealthCare Foundation estimated that over half of the 2 million persons who would use a tax credit for individuals who purchase health coverage already have health coverage, including 350,000 who have employment-based health coverage.[149] The same study estimated that 1.9 million of the 3.1 million persons who would benefit from a tax credit for employers already have job-based health coverage. Finally, tax credits can be costly, in total and on a "per newly insured" basis. The study cited above estimates that a tax credit for individuals would cost $1.6 billion per year and would cost $2,564 for each newly insured individual and the tax credit for employers would cost $1.9 billion per year and $2,448 for each newly insured person – more than one and one-half the cost of providing Medi-Cal coverage for a non-elderly individual.

- ***Most small businesses and low-income individuals pay little or no state income taxes and thus will not have sufficient income to take advantage of a credit.*** In 2001, 69.9 percent of the state's corporations had less than $20,000 in net income. A corporation with taxable net income of $20,000 would owe $1,768 in state corporate income taxes or approximately 20 percent of the cost of health coverage for a single family.[150] In other words, seven out of 10 California corporations do not pay sufficient corporate income taxes to fully utilize a tax credit equal to 25 percent of the cost of family health coverage for just one worker.

  Also, since state corporate income taxes are deductible for federal tax purposes, a significant fraction of the benefits of a state tax credit would shift to the federal government in the form of increased federal income tax payments. Similarly, many of California's uninsured individuals pay little or no state income taxes. A family of four with two children, for example, had no 2003 state income tax liability unless their income exceeded $43,190, more than twice the FPL. increased federal income tax payments.

chapter 7:
county financing options to expand children's health coverage

There are a number of options available to counties to finance the expansion of children's health coverage. The financing options listed below reflect a range of approaches. In addition, other financing approaches not discussed in this report, including health plan and family contributions, may provide additional resources. Potential financing options include (Table 7.1):

- ***Seeking new federal matching funds.*** The state could seek federal approval to allow counties to use their local dollars to match new federal funds to provide comprehensive health coverage for children with family incomes above 250 percent of the FPL who meet other program requirements. Four counties have already received approval to use federal funds for children with family incomes up to 300 percent of the FPL. The state could also seek federal approval to allow counties to use local dollars to match new federal funds to provide limited health services to children, regardless of immigration status.

- ***Using existing federal, state, and county health services funds.*** Some uninsured children who could enroll in county health coverage programs may already receive limited health services paid for with federal, state, and county funds through existing health programs. Existing funding for these limited health services could reduce the need for new dollars to fund the cost of expanding comprehensive children's health coverage.

There are a number of options available to counties to finance the expansion of children's health coverage

- ***Raising additional county revenues.*** Counties could seek voter approval for revenue increases to finance expanded children's health coverage. Several local governments in California have dedicated new revenues to support health services.

- ***Seeking First 5 funds.*** Counties could seek approval from their county First 5 commission to use local First 5 funds to finance health coverage for children up to age 5. The source of First 5 funds is revenue from a statewide tax on tobacco products. First 5 revenues, however, have declined due to the decrease in tobacco use and there are often competing demands at the county level for the use of these funds.

Table 7.1: County Financing Options for Expanding Children's Health Coverage			
	Children Who May Be Covered		
Financing Options	Children with Family Incomes over 250 Percent of the Federal Poverty Level	All Immigrant Children	Required Actions
Seeking New Federal Matching Funds	✓		Federal Approval
Using Existing Federal, State, and County Health Services Funds	✓	✓	Federal, State, and/or County Approval
Raising Additional County Revenues	✓	✓	Voter Approval
Seeking First 5 Funds	✓	✓	County First 5 Commission Approval
Using Funds from the Tobacco Master Settlement Agreement	✓	✓	County Approval

- ***Using funds from the tobacco Master Settlement Agreement.*** In 1998, California participated in a national settlement of lawsuits against the tobacco industry on behalf of states and localities. These lawsuits sought reimbursement for states' expenses for smoking-related health costs. Under the tobacco Master Settlement Agreement, the tobacco industry makes annual payments to California. Counties can use their share of tobacco settlement funds to finance health coverage for children.

Seeking New Federal Matching Funds

The state could take steps to maximize the receipt of federal funds to help counties cover the cost of expanded children's health coverage. Options include:

- ***Expanding AB 495 to additional counties.*** The federal government contributes to the cost of health coverage for children in low-income families who are US citizens or meet immigration status requirements through Medicaid and SCHIP.[155] California currently receives federal funding for eligible children with family incomes up to 250 percent of the FPL, and for infants under age 2 with family incomes up to 300 percent of the FPL.

AB 495 (Diaz, Chapter 648 of 2001) authorized California to seek federal matching funds for county health coverage programs for children. The state submitted a state plan amendment to the federal government to allow four counties to use SCHIP funds for county health coverage programs. In June 2004, California received federal approval for Alameda, San Francisco, San Mateo, and Santa Clara counties to use federal SCHIP funds to finance county health coverage programs for children with family incomes above 250 percent and up to 300 percent of the FPL who meet other program requirements.

These counties will receive an estimated total of about $5 million in federal

SCHIP funds.[156] The federal government will contribute about two dollars in federal SCHIP funds for every county dollar invested in the county health coverage programs for federally-eligible expenditures.[157] California could seek federal approval to allow other counties to use their local dollars to bring in new federal funds to support new or existing county health coverage programs.

- ***Seeking federal funds for SCHIP "health services initiatives."*** While federal matching funds are not available to provide comprehensive health coverage for children who do not meet immigration status requirements, counties could use federal funds to provide limited health services to children, regardless of their immigration status. Under the SCHIP law, state may use federal funds to implement health services initiatives that provide health education services, school-based health services, and direct services, including newborn hearing screening. California could seek federal approval to allow counties to use local funds to match federal SCHIP funds to support health services initiatives in targeted communities.[158]

  Such initiatives may serve all low-income children, including, but not limited to, children eligible to receive services under the federal SCHIP law. In addition, counties may target health services initiatives to low-income, immigrant communities, including migrant and seasonal farm workers. For example, a county could use federal SCHIP funds to provide services to immigrant children who are not eligible for health coverage under SCHIP due to their immigration status, if the initiative promotes child health in a targeted community or school.[159]

Using Existing Federal, State, and County Health Services Funds

Some uninsured children who could enroll in county health coverage programs may already receive limited health services paid for with federal, state, and county funds through existing health programs. These programs are part of the health safety net for uninsured children. Uninsured children may, for example, receive emergency services through the Medi-Cal Program or health screening services through the CHDP. Redirecting existing funding for these limited health services could reduce the need for new dollars to fund the cost of expanding comprehensive children's health coverage.[160]

Options for using existing federal, state, and county health services funds include:

- ***Allowing counties to access existing federal and state health program funding.*** The state could develop mechanisms to allow counties to use existing state and federal health program funds that would otherwise be unavailable to counties to cover part of the cost of county health coverage programs. When uninsured children enroll in county health coverage programs, they lose eligibility for various state- and federally-funded programs, such as CHDP, that provide limited health services to uninsured children. As a result, counties bear the full cost of providing services previously funded with state and federal dollars, while the state and federal governments experience budgetary savings to the extent that children enroll in county health coverage programs.[161]

  The state could seek federal approval and/or change state rules to allow counties to access existing federal and state funds that currently cannot be used by county health coverage programs. Some options that

may be explored include:

- ***Redirecting state savings to counties.*** The state could provide counties with an allocation that represents what the state would have paid for a particular service in the absence of a county health coverage program, such as emergency Medi-Cal services. In addition, the state could seek federal approval to allow counties to use these state dollars to match federal Medicaid funds for emergency services provided through county health coverage programs.

- ***Designating the county as the entity to deliver certain services.*** The state could explore the feasibility of designating the county, rather than the state, as the entity to deliver certain services, such as emergency Medi-Cal services. The state could, for example, pay the county to provide emergency Medi-Cal services to all children in the county. In addition, the state could seek federal approval to use federal matching funds for these county-provided services.

- ***Amending state program statutes or regulations.*** The state could examine whether state law or regulation changes could allow counties to use state funds that are not currently available to counties to pay for limited services for children when they enroll in a county health coverage program.

- ***Allowing children in county health coverage programs to obtain certain services through existing state- and/or federally-funded programs.*** The state could examine whether children enrolled in county health coverage programs could obtain certain services through existing state- and/or federally-funded programs. For example, children enrolled in county health coverage programs may be able to continue to receive health screening services through the CHDP Program, which receives state funds.

- ***Allowing billing for state and federal funds.*** The state and counties could explore the feasibility of allowing the county to bill programs, including CHDP, for certain services. The state could accomplish this by using existing state and federal funds to pay for certain services provided by county health coverage programs.

- ***Using health services funds for indigent children.*** Counties currently use federal, state, and county funds to provide health services to indigent children. This funding could reduce the need for new county dollars to cover the cost of expanded health coverage to the extent that indigent children enroll in expanded health coverage programs.

Raising Additional County Revenues

Some counties may decide to raise additional revenues to support expanded children's health coverage. California's Constitution limits the revenue-raising authority of local governments. The state Constitution requires any new or increased tax imposed by a local government to be approved by local voters. A tax imposed for a general purpose requires approval by a majority of voters, while a tax earmarked for a specific purpose, such as health, requires two-thirds voter approval.[162] Proposition 218 of 1996 also limited the ability of local governments to impose fees.

Since 2002, a number of local governments have obtained voter approval for revenue increases to finance health services:

- In November 2002, Los Angeles County voters approved a measure to support the region's trauma and emergency services and bioterrorism preparedness efforts.[163] The measure imposed a 3-cent per square-foot annual parcel tax on buildings countywide.

- In March 2004, Alameda County voters approved a measure designed to raise $90 million a year through a ½-cent increase in the county's sales tax rate. An estimated three-quarters of the revenue generated will support the Alameda County Medical Center. The county may use the balance to support medical services provided by community-based health providers, to partially offset uncompensated costs for emergency care and related hospital admissions, and to fund other public health, mental health, and substance abuse services.[164]

- In June 2004, voters in the West Contra Costa Healthcare District passed a measure that imposes a $52 per year parcel tax on single-family homeowners.[165] This measure will raise $6 million annually to help fund the Doctors Medical Center San Pablo.[166]

Seeking First 5 Funds

Counties could use local First 5 funds to finance local expansion of health coverage for children up to age 5. Proposition 10, passed by California voters in November 1998, raised the tax on tobacco products statewide. Counties may use Proposition 10 revenues, also known as First 5 funds, to promote, support, and improve early childhood development of children up to age 5.[168] Counties may only use First 5 funds to supplement existing levels of service and cannot use the funds to supplant existing funding. First 5 commissions in Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, and Santa Cruz counties are helping to finance county children's health coverage programs. The First 5 Santa Clara County Commission, for example, has allocated $3 million per year for five years to provide health coverage for children up to age 5 in the county's Healthy Kids program.[169]

Hillsborough County, Florida

Hillsborough County in Florida funds its managed health care program through a special sales tax. This program, Hillsborough HealthCare, serves low-income residents of the county with family incomes up to 100 percent of the FPL who do not have other health coverage. The county originally financed Hillsborough HealthCare with a ½-cent sales tax, along with $26.8 million per year generated through property taxes mandated by the state to fund health care for indigent individuals.[167]

First 5 revenues, however, have declined due to the decrease in tobacco use. First 5 funding for all counties fell from $502.7 million in 2000-01 to $458.5 million in 2003-04, a 9 percent decrease (Appendix B).[170] Also, since First 5 funds can be used to support a variety of programs for young children besides health coverage, there are often competing demands at the county level for the use of these funds.

Using Funds from the Tobacco Master Settlement Agreement

In 1998, California participated in a national settlement of lawsuits against the tobacco industry on behalf of states and localities. Under the settlement agreement, the tobacco industry will make annual payments to states in perpetuity. The LAO estimates

that California's share of the payments over 25 years will be about $21 billion.[171] More recently, the National Association of Attorneys General announced that increased tobacco settlement payments would be available to participating states.[172]

Counties and four cities share 50 percent of California's tobacco settlement payments (Appendix C). Tobacco settlement dollars are general purpose revenues that recipients could use to help finance children's health coverage. For example, Alameda County has used $2 million of its settlement payments to help finance its Alliance Family Care Program for children. However, while the payments are intended to reimburse states for costs incurred in treating smoking-related diseases, the settlement does not require that the monies be used for health-related programs.[173]

conclusion

Public policies have made significant progress toward ensuring that children have access to affordable, quality health coverage. The establishment of the federal Medicaid Program in 1965 and the federal SCHIP in 1997 laid the groundwork for existing state policies that help fill the gaps for children whose families do not have access to or cannot afford to purchase health coverage through the private market. Many states have maintained strong support for children's health coverage programs, even in tight fiscal times.

California has made significant progress toward extending health coverage for uninsured children. However, much remains to be done. About 1.1 million California children lacked health coverage during all or part of the year in 2003. California has the opportunity and the challenge to build on past successes to extend health coverage for all California children.

Studies document the importance of health coverage to children. Children with health coverage are more likely to have better health outcomes than those without. Better health status can improve educational outcomes, thereby resulting in higher wages and improved economic well-being later in life.

Public opinion research suggests there is broad support for children's health coverage.

Public opinion research suggests there is broad support for children's health coverage. This level of public support reflects the value placed on children's health and well-being. Health coverage plays a key role in promoting children's health and enhancing children's ability to reach their full potential in life. By establishing a goal that all children have health coverage, the state may help ensure that all California children can thrive as individuals, today and in the future.

appendix a:
data issues related to estimating the number of uninsured children

Estimates of the number of uninsured children in California differ depending on the data source. Two primary sources of data are the Current Population Survey (CPS), conducted by the US Census Bureau, and the California Health Interview Survey (CHIS), conducted by the UCLA Center for Health Policy Research. The CPS typically provides higher estimates of uninsured children, compared to the CHIS.

The differences in the estimates result from differences in survey methodology. Differences between the 2001 CHIS and the March 2001 CPS include:

- The CHIS included a larger sample size than the CPS.
- The CHIS collected information directly from the respondent, while the CPS also collected information from a respondent about other family members. Research suggests that data based on reporting for another person is not as accurate as reporting for oneself.
- The CHIS conducted the survey by telephone, while the CPS used telephone and in-person surveys. Research finds that telephone surveys result in lower response rates than in-person surveys. The CPS includes households without telephones.
- The CHIS translated the survey into six languages, while the CPS only translated the survey into Spanish.
- The two surveys asked questions about health coverage differently. The CHIS, for example, asked about health coverage at the time of the interview and about changes in and lack of health coverage during the previous 12 months. The CPS asked about health coverage at any time during the preceding calendar year.

The CHIS and CPS both "undercount" the number of individuals enrolled in Medi-Cal, compared to administrative data from the state Department of Health Services. This undercount may occur because the CHIS and CPS rely on survey data rather than actual program enrollment data. In the CHIS, for example, families may have known they had health coverage but not which program was providing it. Thus, the CHIS may have undercounted the number of children with health coverage through Medi-Cal or Healthy Families and overcounted the number of children with other sources of health coverage.[174]

Each survey has different strengths and limitations. Some researchers suggest using the CHIS data as a "lower bound" estimate for the number of uninsured Californians, compared to CPS data. Researchers recommend using CHIS data for estimating the number of uninsured children in different geographic locations within California due to better data availability. However, researchers suggest using CPS data for interstate comparisons, because the CPS uses one national survey for all the states.[175]

appendix b

Appendix B: First 5 Monthly Allocations to Counties, 2003-04 (Dollars in Thousands)			
County	**Monthly Allocations**	**County**	**Monthly Allocations**
Alameda	$19,153	Orange	$39,552
Alpine	$10	Placer	$2,699
Amador	$230	Plumas	$128
Butte	$2,012	Riverside	$22,068
Calaveras	$281	Sacramento	$16,451
Colusa	$311	San Benito	$850
Contra Costa	$11,412	San Bernardino	$25,400
Del Norte	$239	San Diego	$38,044
El Dorado	$1,476	San Francisco	$7,158
Fresno	$12,424	San Joaquin	$8,530
Glenn	$353	San Luis Obispo	$2,118
Humboldt	$1,304	San Mateo	$8,923
Imperial	$2,258	Santa Barbara	$4,879
Inyo	$156	Santa Clara	$23,541
Kern	$10,192	Santa Cruz	$3,017
Kings	$1,855	Shasta	$1,688
Lake	$529	Sierra	$10
Lassen	$211	Siskiyou	$371
Los Angeles	$133,477	Solano	$5,010
Madera	$1,901	Sonoma	$4,961
Marin	$2,491	Stanislaus	$6,595
Mariposa	$133	Sutter	$1,055
Mendocino	$922	Tehama	$553
Merced	$3,436	Trinity	$97
Modoc	$55	Tulare	$6,363
Mono	$147	Tuolumne	$382
Monterey	$6,239	Ventura	$9,850
Napa	$1,361	Yolo	$2,014
Nevada	$720	Yuba	$912
		Total	**$458,507**

Note: Does not include First 5 payments to counties for baseline funding, administration, travel, school readiness initiatives, retention incentives, and Surplus Monetary Investment Funds. Figures are rounded to the nearest thousand.

Source: California Children and Families Commission

appendix c

Appendix C: Projected 2005 Tobacco Settlement Payments to Counties and Cities (Dollars in Thousands)			
County/City	**2005 Payment**	**County/City**	**2005 Payment**
Alameda*	$15,520	Placer*	$2,670
Alpine	$13	Plumas	$224
Amador	$377	Riverside	$16,613
Butte	$2,184	Sacramento*	$13,153
Calaveras	$436	San Benito*	$572
Colusa*	$202	San Bernardino	$18,376
Contra Costa	$10,200	San Diego*	$30,249
Del Norte	$296	City of San Diego	$10,114
El Dorado	$1,680	San Francisco**	$8,350
Fresno	$8,594	City of San Francisco**	$10,114
Glenn	$284	San Joaquin	$6,059
Humboldt	$1,360	City of San Jose	$10,114
Imperial*	$1,530	San Luis Obispo	$2,652
Inyo	$193	San Mateo	$7,602
Kern*	$7,113	Santa Barbara	$4,293
Kings*	$1,392	Santa Clara	$18,088
Lake	$627	Santa Cruz	$2,748
Lassen	$364	Shasta	$1,755
Los Angeles	$102,333	Sierra	$38
City of Los Angeles	$10,114	Siskiyou	$476
Madera*	$1,323	Solano*	$4,241
Marin*	$2,658	Sonoma*	$4,930
Mariposa	$184	Stanislaus*	$4,805
Mendocino	$927	Sutter	$848
Merced*	$2,263	Tehama*	$602
Modoc	$102	Trinity	$140
Mono	$138	Tulare	$3,956
Monterey	$4,319	Tuolumne*	$586
Napa	$1,336	Ventura	$8,097
Nevada	$989	Yolo*	$1,813
Orange	$30,598	Yuba*	$647
		Total	**$404,574**

* County has securitized all or part of its payments.

** Tobacco Master Settlement Agreement includes payments to County of San Francisco and City of San Francisco.

Notes: Based on 2002 data. Figures are rounded to the nearest thousand.

Source: California Department of Justice

endnotes

[1] Kaiser Commission on Medicaid and the Uninsured, *Children's Health – Why Health Insurance Matters* (May 2002); Kaiser Commission on Medicaid and the Uninsured, *Sicker and Poorer: The Consequences of Being Uninsured* (May 2002); American College of Physicians, *No Health Insurance? It's Enough to Make You Sick – Scientific Research Linking the Lack of Health Coverage to Poor Health* (2000); and US Department of Health and Human Services, *Access to Health Care Part 1: Children* (National Center for Health Statistics: Series 10, No. 196: July 1997).
[2] Managed Risk Medical Insurance Board, *Health Status Assessment Project – First Year Results* (November 2002), p. 9.
[3] E. Richard Brown and Shana Alex Lavarreda, *Children's Insurance Coverage Increases as Result of Public Program Expansion* (UCLA Center for Health Policy Research: December 2004). The 1.1 million estimate includes children under age 19 who were uninsured during all or part of the year in 2003. Data are based on the 2003 California Health Interview Survey (CHIS) conducted by the UCLA Center for Health Policy Research. The CHIS provides lower estimates of the number of uninsured children compared to the Current Population Survey conducted by the US Census Bureau. See Appendix A for a discussion of the differences between the two surveys.
[4] E. Richard Brown and Shana Alex Lavarreda, *Children's Insurance Coverage Increases as Result of Public Program Expansion* (UCLA Center for Health Policy Research: December 2004).
[5] E. Richard Brown, et al., *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey* (UCLA Center for Health Policy Research: June 2002). For 2004, the FPL for a family of three is $15,670.
[6] E. Richard Brown, et al., *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey* (UCLA Center for Health Policy Research: June 2002). One national study found that children ages 6 to 17 are less likely to have parents who think their child is eligible for health coverage under Medicaid or SCHIP, compared to children under age 6, even though children ages 6 to 17 are eligible for these programs. See US Department of Health and Human Services, *Interim Evaluation Report: Congressionally Mandated Evaluation of the State Children's Health Insurance Program* (February 26, 2003), pp. 57-58.
[7] E. Richard Brown, et al., *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey* (UCLA Center for Health Policy Research: June 2002).
[8] For a detailed explanation of immigrant eligibility requirements for Medi-Cal and Healthy Families, see California Immigrant Welfare Collaborative, *Major Benefit Programs Available to Immigrants in California* (October 2003), at http://www.nilc.org/ciwc/tbls_othermats/Cal_Bs_Table%20%20%20October%201%202003.pdf.
[9] Michael E. Fix and Wendy Zimmermann, *All Under One Roof: Mixed-Status Families in an Era of Reform* (Urban Institute: October 6, 1999).
[10] This may be partly due to immigrant families fearing repercussions if they use public services.
[11] Nadereh Pourat, et al., *Demographics, Health, and Access to Care of Immigrant Children in California: Identifying Barriers to Staying Healthy* (UCLA Center for Health Policy Research: March 2003).
[12] California HealthCare Foundation, *Snapshot – California's Uninsured* (2004), p. 14.
[13] E. Richard Brown and Shana Alex Lavarreda, *Children's Insurance Coverage Increases as Result of Public Program Expansion* (UCLA Center for Health Policy Research: December 2004).
[14] E. Richard Brown, et al., *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey* (UCLA Center for Health Policy Research: June 2002).
[15] Henry J. Kaiser Family Foundation and Health Research & Educational Trust, *California Employer Health Benefits Survey, 2003* (March 2004).
[16] E. Richard Brown, et al., *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey* (UCLA Center for Health Policy Research: June 2002).
[17] E. Richard Brown, et al., *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey* (UCLA Center for Health Policy Research: June 2002).
[18] HMOs generally provide comprehensive health coverage with limited out-of-pocket costs, but offer a restricted range of providers. PPOs generally require greater out-of-pocket costs but offer more choice of providers and fewer restrictions on access to care.
[19] Henry J. Kaiser Family Foundation and Health Research & Educational Trust, *California Employer Health Benefits Survey, 2003* (March 2004).
[20] Governor Davis signed SB 2 into law in October 2003. Employer-supported groups gathered signatures to require a referendum on whether SB 2 should take effect or be repealed. By rejecting Proposition 72, voters repealed SB 2.
[21] California HealthCare Foundation, *Insurance Markets – What Do Californians Buy if They Don't Buy Health Insurance?* (July 2003).

[22] Henry J. Kaiser Family Foundation and eHealthInsurance, *Update on Individual Health Insurance* (August 2004), p. 5.
[23] California HealthCare Foundation, *Insurance Markets: Rules Governing California's Individual Health Insurance Market* (June 2003).
[24] CBP analysis of data from Department of Health Services, *May 2004 Medi-Cal Estimate* (May 2004). Data based on estimated per capita costs for 2004-05.
[25] California HealthCare Foundation, *Medi-Cal Facts and Figures: A Look at California's Medicaid Program* (January 2004), p. 3.
[26] The reference "up to" throughout this report means "up to and including."
[27] Former foster care children ages 18 to 20 are also eligible for comprehensive Medi-Cal coverage without paying a share of the cost.
[28] The state calculates the share of cost on a monthly basis by deducting an amount called the "maintenance need level" from the family's net income. Federal law requires the state to set maintenance need levels that permit families to meet basic needs for food, clothing, and shelter.
[29] For a detailed explanation of immigrant eligibility requirements under Medi-Cal, see California Immigrant Welfare Collaborative, *Major Benefit Programs Available to Immigrants in California* (October 2003), at http://www.nilc.org/ciwc/tbls_other-mats/Cal_Bs_Table%20-%20%20October%201%202003.pdf.
[30] Annual cost for Healthy Families coverage based on Governor's January 2004-05 Budget data from the Managed Risk Medical Insurance Board. Reflects weighted average costs per child in Healthy Families.
[31] For a family of three in 2004, 250 percent of the FPL is $39,175. For a detailed explanation of immigrant eligibility requirements for Healthy Families, see California Immigrant Welfare Collaborative, *Major Benefit Programs Available to Immigrants in California* (October 2003), at http://www.nilc.org/ciwc/tbls_other-mats/Cal_Bs_Table%20-%20%20October%201%202003.pdf.
[32] The 2004-05 Budget requires families with incomes over 200 percent of the FPL, but less than or equal to 250 percent of the FPL, to contribute $15 per child up to a maximum of $45 per family for Healthy Families services beginning July 1, 2005.
[33] Family PACT provides services to women up to age 55 and men up to age 60.
[34] Medi-Cal for children includes the Minor Consent Program, which provides limited services related to pregnancy, sexually transmitted diseases, family planning, sexual assault, drug and alcohol abuse, and outpatient mental health treatment.
[35] Reflects data for 2002-03. Only includes data for children up to age 17.
[36] CBP analysis of Department of Health Services data. Assumes state share of total cost is 50 percent.
[37] Reflects data for 2002-03. Only includes data for children up to age 17.
[38] Reflects data for 2002-03. Does not include children in long-term care. Funding for Medi-Cal for children with a share of cost is also included in Medi-Cal for children.
[39] CBP analysis of Department of Health Services data. Assumes state share of total cost is 50 percent.
[40] Reflects data for 2002-03. Does not include children in long-term care.
[41] The state requires individuals with higher incomes to pay a share of cost for emergency Medi-Cal services.
[42] Reflects data for 2002-03. Only includes data for children ages 1 to 17. Funding for emergency Medi-Cal services for children is also included in Medi-Cal for children.
[43] CBP analysis of Department of Health Services data. Assumes state share of total cost is 50 percent.
[44] Reflects data for 2002-03. Only includes data for children ages 1 to 17.
[45] Reflects amount included in the 2004-05 Budget.
[46] Reflects projected year-end caseload in 2004-05, as included in the 2004-05 Budget.
[47] All AIM infants are US citizens.
[48] Reflects amount included in the 2004-05 Budget for AIM infants only.
[49] CBP analysis of Managed Risk Medical Insurance Board data. Reflects caseload included in the 2004-05 Budget.
[50] Reflects amount included in the 2004-05 Budget.
[51] CBP analysis of Department of Health Services data. The 2004-05 Budget included funding for 90,000 health screens in 2004-05.
[52] Reflects amount included in the 2004-05 Budget. Reflects cost for temporary coverage in Medi-Cal.
[53] Reflects caseload included in the 2004-05 Budget. Reflects caseload for temporary coverage in Medi-Cal.
[54] Reflects amount included in the 2004-05 Budget. County funds represent about 32 percent of funding for CCS.
[55] Reflects caseload included in the 2004-05 Budget.
[56] Reflects data for 2003-04. Reflects cost for children up to age 17.
[57] CBP analysis of Department of Health Services data. Assumes General Fund share of cost of 30.8 percent based on General Fund share of cost for all program participants, including adults.
[58] CBP analysis of Department of Health Services data. Based on total number of unduplicated users up to age 17 for

2003-04, which is 136,465.
[59] For a detailed description of county children's health initiatives, see Liane Wong, et al., *Pioneers for Coverage: Local Solutions for Insuring All Children in California* (Institute for Health Policy Solutions: October 2004).
[60] The passage of Proposition 10 in 1998 dedicated revenues from taxes on cigarettes and other tobacco products to support early childhood development for children up to age 5. County commissions receive Proposition 10 revenues, known as First 5 funds, to support local programs. In 1998, California participated in a national settlement of lawsuits against the tobacco industry on behalf of states and localities. As part of the settlement, the tobacco industry makes annual payments to California.
[61] Department of Health Services, Medically Indigent Care Reporting System, *County Indigent Health Care Services and Expenditures, Fiscal Year 1997-98* (October 2001).
[62] For a detailed description of county health coverage programs, see Child and Family Coverage Technical Assistance Center, Institute for Health Policy Solutions, at http://www.cfctac.org.
[63] CaliforniaKids closed enrollment for new applicants as of June 2004.
[64] Originally, the Child Health Plan covered children with family incomes between 200 percent and 275 percent of the FPL. In October 1999, Kaiser Permanente changed the plan to cover children with family incomes between 250 percent and 300 percent of the FPL. In 2001, Kaiser Permanente began enrolling children in a new Child Health Plan program for low-income children in certain areas of the state who are ineligible for Medi-Cal and Healthy Families due to their immigration status.
[65] The SPE is a central processing center for all joint Medi-Cal and Healthy Families mail-in applications.
[66] The Healthy Families Program uses a private contractor to perform eligibility functions. The SPE forwards Medi-Cal applications to county welfare departments because federal law requires public employees to process Medi-Cal applications.
[67] Managed Risk Medical Insurance Board, *Healthy Families Program Application Statistics, Monthly* (July 16, 2004) and Managed Risk Medical Insurance Board, *March 24, 2004 Board Meeting Minutes,* downloaded from http://www.mrmib.ca.gov/MRMIB/Minutes/040424min.pdf on June 29, 2004.
[68] Kaiser Commission on Medicaid and the Uninsured, *Enrolling Uninsured Children in Medicaid and CHIP* (January 2000).
[69] Gabrielle Lessard and Leighton Ku, *Gaps in Coverage for Children in Immigrant Families* (The Future of Children: Volume 13, No. 1: Spring 2003), p. 106.
[70] California HealthCare Foundation, *Using Market Research to Improve Enrollment of Families Eligible for Medi-Cal and Healthy Families* (March 2002), pp. 3-4.
[71] Managed Risk Medical Insurance Board, *March 24, 2004 Board Meeting Minutes,* downloaded from http://www.mrmib.ca.gov/MRMIB/Minutes/040424min.pdf on June 29, 2004.
[72] Managed Risk Medical Insurance Board, *May 4, 2004 Healthy Families Program Advisory Panel Draft Meeting Minutes,* downloaded from http://www.mrmib.ca.gov/MRMIB/Minutes/040504min.pdf on September 3, 2004.
[73] Managed Risk Medical Insurance Board, *April 28, 2004 Board Meeting Minutes,* downloaded from http://www.mrmib.ca.gov/MRMIB/Minutes/040428min.pdf on June 29, 2004.
[74] In Medi-Cal, the child has 30 days after losing coverage to provide the missing information to reinstate coverage, but the child will experience a break in coverage. After 30 days, if information is still missing, the family must reapply to Medi-Cal using the standard application process. In Healthy Families, the child has 60 days after losing coverage to provide the missing information to reinstate coverage, but will experience a break in coverage. After 60 days, if information is still missing, the family must reapply to Healthy Families using the standard application process.
[75] Managed Risk Medical Insurance Board, *Healthy Families Disenrollment Statistics, June 22, 2004 (Possibly Avoidable),* downloaded from http://www.mrmib.ca.gov/MRMIB/HFP/HFPRpt14.pdf on June 29, 2004.
[76] Managed Risk Medical Insurance Board, *April 28, 2004 Board Meeting Minutes,* downloaded from http://www.mrmib.ca.gov/MRMIB/Minutes/040428min.pdf on June 29, 2004 and Managed Risk Medical Insurance Board, *Healthy Families Disenrollment Statistics, November 3, 2004 (Possibly Avoidable),* downloaded from http://www.mrmib.ca.gov/MRMIB/HFP/HFPRpt14.pdf on December 13, 2004. The number of children losing Healthy Families coverage due to incomplete renewal applications increased from 9,534 in November 2003 to 15,213 in October 2004.
[77] E. Richard Brown, et al., *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey* (UCLA Center for Health Policy Research: June 2002).
[78] For a discussion about national research regarding stigma-related barriers to enrollment in Medicaid, see Sara Rosenbaum, et al., *Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid?* (Georgetown University, School of Public Health and Health Services, Center for Health Services Research and Policy: July 2000). This study found that stigma-related barriers to Medicaid enrollment are more a function of how people are treated during the application process and by health providers than how people feel about themselves or

what they perceive others will think of them for enrolling in Medicaid.
[79] Henry J. Kaiser Family Foundation, *Medi-Cal and Healthy Families: Focus Groups with California Parents to Evaluate the Medi-Cal and Healthy Families Programs* (January 2001), p. 17.
[80] Gabrielle Lessard and Leighton Ku, *Gaps in Coverage for Children in Immigrant Families* (The Future of Children: Volume 13, No. 1: Spring 2003), p. 106.
[81] E. Richard Brown, et al., *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey* (UCLA Center for Health Policy Research: June 2002).
[82] Genevieve Kenney and Jennifer Haley, *Why Aren't More Uninsured Children Enrolled in Medicaid or SCHIP?* (Urban Institute: Series B, No. B-35: May 2001), p. 4.
[83] California HealthCare Foundation, *How Policy Changes Impact Enrollment: A Look at Three County Efforts* (May 2004) and California HealthCare Foundation, *County Profiles* (May 2004).
[84] Much of the background information for Alameda, San Mateo, and Santa Clara counties comes from California HealthCare Foundation, *How Policy Changes Impact Enrollment: A Look at Three County Efforts* (May 2004) and California HealthCare Foundation, *County Profiles* (May 2004).
[85] The California Work Opportunity and Responsibility to Kids (CalWORKs) Program provides time-limited cash assistance for eligible low-income families, while helping recipients find jobs and overcome barriers to employment.
[86] Medi-Cal and Healthy Families require documentation to verify a number of items in addition to income and residency.
[87] The state does not allow families to miss premium payments in the Healthy Families Program, even in cases in which families experience temporary economic hardship.
[88] Christopher Trenholm, *Expanding Coverage for Children: The Santa Clara County Children's Health Initiative* (Mathematica Policy Research, Inc.: June 2004). As part of the initiative, Santa Clara County developed a simple outreach message which states that children are likely to receive health coverage if they apply. This appears to have reduced families' hesitation to apply by limiting confusion over eligibility requirements. In addition, the county increased outreach by coordinating with many community organizations to maximize its outreach resources and to target communities with large numbers of low-income children.
[89] Health care advocates have recommended adoption of many of the strategies discussed in this chapter.
[90] The NSLP provides reimbursements to schools that serve meals to children. The Food Stamp Program provides nutritional support to low-income individuals and families. Under AB 59 (Cedillo, Chapter 894 of 2001), families can authorize the use of NSLP application information to apply for Medi-Cal for their children. SB 493 (Sher, Chapter 897 of 2001) authorizes counties to use food stamp application information to determine a child's eligibility for Medi-Cal or forward that information to the Healthy Families Program, with the families' consent. SB 1196 (Cedillo, Chapter 729 of 2004) requires counties to forward the NSLP application information to the Healthy Families Program if the child is ineligible for Medi-Cal. Furthermore, counties must forward the NSLP application information to a county health coverage program, as applicable, if the child is ineligible for Healthy Families. For a discussion of express lane eligibility issues, see The Children's Partnership and the Kaiser Commission on Medicaid and the Uninsured, *Building an On-Ramp to Children's Health Coverage: A Report on California's Express Lane Eligibility Program* (September 2004).
[91] Under SB 24, the state may not implement the Newborn Hospital Gateway until there are sufficient funds from private foundations and other nongovernmental sources to defray the cost of developing the gateway and there are sufficient new state staff funded through non-General Fund sources to administer the gateway.
[92] The 100% Campaign, *Children Falling Through the Health Insurance Cracks* (January 2003).
[93] The federal government requires states to have an Income and Eligibility Verification System (IEVS) in place for Medi-Cal. IEVS is a centralized state database of income information that the state uses to verify income. Through IEVS, the state uses information from other federal and state agencies, such as the Social Security Administration and the Internal Revenue Service, to verify an applicant's income and resources. If the state allowed Medi-Cal applicants to self-certify their income, eligibility workers would still verify the applicant's income using the IEVS. Some states that allow applicants to self-certify income have used audits to verify information.
[94] Medi-Cal Policy Institute, *Simplifying Medi-Cal Enrollment: Options for the Income Test* (June 2003).
[95] Kaiser Commission on Medicaid and the Uninsured, *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge* (July 2003), p. 15. In June 2004, the federal government approved New York's SCHIP plan to verify families' incomes with the New York Department of Tax and Finance, rather than require families to submit documentation of income.
[96] Laura Cox, *Allowing Families to Self-Report Income* (Center on Budget Policy and Priorities: December 28, 2001), p. 7.
[97] For a discussion of options, see The 100% Campaign, *Children Falling Through the Health Insurance Cracks* (January 2003).

[98] Kaiser Commission on Medicaid and the Uninsured, *Enrolling Children and Families in Health Coverage: The Promise of Doing More* (June 2002), p. 16.
[99] The child may reapply using a one-page application and paying any unpaid premiums.
[100] The 100% Campaign, *Children Falling Through the Health Insurance Cracks* (January 2003).
[101] This could require state resources and/or staff to assist counties in claiming federal funds.
[102] Federal law allows states to use up to 10 percent of SCHIP expenditures for certain activities, including program administration, "other child health assistance," outreach, and health services initiatives for improving the health of children.
[103] For more information, see http://www.teachersforhealthykids.com/aboutus.htm.
[104] Managed Risk Medical Insurance Board, *Application Assistance Fact Book* (March 2002). According to the report, 63 percent of children who applied to Healthy Families without application assistance successfully enrolled in the program, while 79 percent of children who applied with application assistance successfully enrolled in the program.
[105] Kaiser Commission on Medicaid and the Uninsured, *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge* (July 2003), pp. 30-31. Minnesota also covers infants under age 2 in families with incomes up to 280 percent of the FPL.
[106] Some states, for example, have implemented buy-in programs for families with incomes above 200 percent of the FPL.
[107] Michael Birnbaum, *Full-Cost Buy-Ins: An Overview of State Experience* (State Coverage Initiatives: August 2001).
[108] Out-of pocket expenses for families include premiums and copayments.
[109] In October 2003, states that had implemented premium-assistance programs included Massachusetts, Maryland, New Jersey, Oregon, Rhode Island, Virginia, and Wisconsin. In November 2004, Idaho received federal approval to use federal funds for a premium-assistance program.
[110] Kaiser Commission on Medicaid and the Uninsured, *Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity* (October 2003).
[111] Richard E. Curtis and Edward Neuschler, *Premium Assistance* (The Future of Children: Volume 13, No. 1: Spring 2003).
[112] Larger businesses often hire independent agencies, or third-party administrators, to administer benefits for their employee health plans.
[113] Federal law bars certain lawfully present immigrants from receiving Medicaid or SCHIP benefits for their first five years in the US, if they arrived on or after August 22, 1996. For a detailed explanation regarding immigrant eligibility for Medicaid and SCHIP, see National Immigration Law Center, *Guide to Immigrant Eligibility for Federal Programs, Fourth Edition* (2002). A number of organizations have urged Congress to pass the Immigrant Children's Health Improvement Act to provide Medicaid and SCHIP coverage for lawfully present immigrant children, regardless of when they entered the US.
[114] The federal SCHIP provides a higher matching rate and thus requires lower state contributions. On the other hand, the federal government caps SCHIP dollars to states, whereas federal Medicaid funding is not subject to a cap.
[115] Kaiser Commission on Medicaid and the Uninsured, *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge* (July 2003), p. 30.
[116] Federal law allows states to use up to 10 percent of SCHIP expenditures for certain activities, including program administration, "other child health assistance," outreach, and health services initiatives for improving the health of children. The federal government will contribute about two dollars in federal SCHIP funds for every county dollar invested, subject to the availability of federal funds under the 10 percent cap. In recent years, California has not matched all of the federal SCHIP funding available under the 10 percent cap.
[117] Centers for Medicare & Medicaid Services, *Letter to State Health Official, January 14, 1998,* downloaded from http://www.cms.hhs.gov/schip/chipimms.asp on July 16, 2004.
[118] SB 1113 (Committee on Budget and Fiscal Review, Chapter 208 of 2004).
[119] However, some children might not enroll in expanded health coverage programs for which they become eligible. Therefore, it is possible that funding for safety net programs, such as the CHDP, would not decline significantly even if comprehensive health coverage were expanded. For a discussion of reasons why eligible children might not enroll in existing health coverage programs, see Chapter 3.
[120] CBP analysis of Department of Health Services data. Assumes General Fund share of total cost is 50 percent.
[121] In addition, some existing spending in Family PACT, Medi-Cal for children in which children pay a share of the cost, and CHDP Gateway could partially reduce the need for new funding to expand children's health coverage.
[122] Supplemental CCS services in Medi-Cal apply to managed care plans.
[123] New York anticipates a one-time payment from Empire Blue Cross Blue Shield as a result of Empire Blue Cross Blue Shield converting from nonprofit to for-profit status. However, New York has not yet used these funds due to

litigation.
[124] For example, seven states have received federal approval to use SCHIP funds to provide prenatal health services to pregnant women, regardless of their immigration status. These states are Arkansas, Illinois, Massachusetts, Michigan, Minnesota, Rhode Island, and Washington. This can result in state savings if the federal funds are used to offset state spending.
[125] The AIM Program provides health coverage for women with incomes between 200 and 300 percent of the FPL. The program provides services to women throughout their pregnancy, delivery, and 60 days after delivery. Federal Medicaid law allows states to expand coverage for pregnant women with incomes up to 300 percent of the FPL.
[126] Legislative Analyst's Office, *Analysis of the 2004-05 Budget Bill* (February 2004), p. C-163.
[127] In 2002, for example, the State Auditor recommended a number of cost-containment measures for purchasing Medi-Cal durable medical equipment and medical supplies.
[128] For example, in the 2003-2004 Budget, the state established education programs to encourage physicians to prescribe more cost-effective drugs and implemented "step-therapy" requirements so that beneficiaries use less costly drugs before proceeding to more expensive drugs. Senate Committee on Budget and Fiscal Review, *Final Action Report: A Summary of the 2003 Budget Act* (September 25, 2003).
[129] Office of Inspector General, *Medicaid Pharmacy – Additional Analyses of the Actual Acquisition Cost of Prescription Drug Products* (US Department of Health and Human Services: September 16, 2002).
[130] As part of the 2004-05 Budget, California will reimburse pharmacies at the average wholesale price (AWP) minus 17 percent. The Office of Inspector General found that pharmacies paid on average AWP minus 17.2 percent for single source drugs and AWP minus 72.1 percent for generic drugs with at least three competing manufacturers. Office of Inspector General, *Medicaid Pharmacy – Additional Analyses of the Actual Acquisition Cost of Prescription Drug Products* (US Department of Health and Human Services: September 16, 2002).
[131] See Texas Health and Human Services Commission, *Request for Information for New Drug Product or for Additional Information of Products Currently Included in Texas Medicaid* (Revised May 1, 2002).
[132] Federal law requires "federal upper limits" (FULs) on drugs costs for generic drugs with at least two generic competitors. Federal law permits states to set their own payment limits, known as Maximum Allowable Cost (MAC) limits. California applies such limits to 37 drugs under its Maximum Allowable Ingredient Cost (MAIC) program. Andy Schneider, *Medicaid: Purchasing Prescription Drugs* (Kaiser Commission on Medicaid and the Uninsured: January 2002); National Pharmaceutical Council, *Pharmaceutical Benefits under State Medicaid Programs: 2002* (2003); and Senate Rules Committee, Office of Senate Floor Analyses, *Analysis of SB 1170* (April 22, 2004).
[133] The federal government limits fees to 6 percent of provider revenues. Also, states must impose fees on all members in a class of providers.
[134] For example, Washington state implemented a fee on nursing homes and used the revenues to match additional federal funds and thereby increase reimbursements to nursing homes. Federal law prohibits states from guaranteeing that the providers subject to the fee will receive an increase in reimbursements to entirely offset the fee increase.
[135] ICFs are health facilities that provide inpatient care to patients with recurring need for skilled nursing supervision and supportive care. California is in the process of implementing a quality assurance fee on ICFs and a quality improvement fee on Medi-Cal managed care plans.
[136] Department of Health Services data.
[137] California recently enacted legislation to impose a quality assurance fee on nursing homes to support an increase in reimbursements for nursing homes. Federal law allows states to impose fees on other Medicaid providers, including inpatient hospital services, outpatient hospital services, physicians' services, home health care services, and outpatient prescription drugs.
[138] For example, the state has proposed that Medi-Cal managed care plans move the Medi-Cal portion of their business into a separate entity so that the quality improvement fee would only apply to the Medi-Cal part of their business. The state has had ongoing discussions with managed care plans regarding this and other implementation issues.
[139] Deborah Chollet and Lori Achman, *Approaching Universal Coverage: Minnesota's Health Insurance Programs* (The Commonwealth Fund: February 2003).
[140] Table 6.2 includes a number of options discussed in the past as potential revenue sources, although it is not meant to serve as a comprehensive list. In some years, a portion of the revenues raised by a tax increase would increase the state's Proposition 98 school funding guarantee. The interaction between tax increases and the Proposition 98 guarantee is complex and depends on a number of factors specified in the state Constitution, including the growth in state revenues and the economy. In the near term, a large fraction of any increased revenues would go to education, since the additional revenues would increase the minimum funding requirement for programs under the Proposition 98 guarantee. See Legislative Analyst's Office, *The 2004-05 Budget: Perspectives and Issues* (February 2004), p. 80. The Proposition 98 requirement would have a significant impact on the state's ability to raise new revenues to finance

non-education programs. These provisions would not apply to revenues raised at the local level or potentially to revenues allocated to local governments as part of a broader "realignment" of responsibilities between the state and counties.

[141] National Conference of State Legislatures: State Budget and Tax News, *State Children's Health Insurance Program Efforts Gain Momentum* (December 2000).

[142] Ian Hill, Holly Stockdale, and Bridgette Courtot, *Squeezing SCHIP: States Use Flexibility to Respond to the Ongoing Budget Crisis* (The Urban Institute: June 2004), A-65.

[143] Economic and Statistical Research Bureau, Franchise Tax Board, *California Income Tax Expenditures: Compendium of Individual Provisions* (September 2003), p. 70.

[144] The credit is available to individuals who are Trade Adjustment Assistance (TAA) recipients, alternative TAA recipients, or eligible Pension Board Guaranty Corporation recipients. Individuals may claim the credit for families' contribution toward SCHIP programs for children's health coverage.

[145] This deduction is also available to certain members of partnerships and some shareholders of S corporations.

[146] W. David Helms, Anne K. Gauthier, and Daniel M. Campion, *Mending the Flaws in the Small-Group Market* (Health Affairs: Summer 1992).

[147] Jonathan Gruber and Michael Lettau, *How Elastic Is the Firm's Demand for Health Insurance?* (March 2000).

[148] Henry J. Kaiser Family Foundation, *California Health Care Chartbook: Key Data and Trends* (July 2004).

[149] Karl Polzer and Jonathan Gruber, *Assessing the Impact of State Tax Credits for Health Insurance Coverage* (California HealthCare Foundation: June 2003), p. 5.

[150] Franchise Tax Board, *Annual Report 2002* (September 2003), p. 142. Estimated based on a recent state proposal that would have created a tax credit equal to $75 per month per eligible individual or 25 percent of the total amount paid or incurred each month by employers for health coverage during the taxable year.

[151] The state commission adopted the name "First 5 California" to convey the importance of the first five years and to help the public understand the overall purpose of the commission.

[152] Existing law requires that the revenues must first reimburse the loss of certain Proposition 99 revenues. Proposition 99, passed by the voters in 1988, allocates revenues from an increase in taxes on tobacco products to various health, environmental, and research programs.

[153] First 5 California, *Health Access for All Children, Request for Funds* (April 5, 2004).

[154] First 5 California, *Strategic Plan, 2003-2006* (January 2004).

[155] Federal law bars certain lawfully present immigrants from receiving Medicaid or SCHIP benefits for their first five years in the US, if they arrived on or after August 22, 1996. For a detailed explanation regarding immigrant eligibility for Medicaid and SCHIP, see National Immigration Law Center, *Guide to Immigrant Eligibility for Federal Programs, Fourth Edition* (2002). A number of organizations have urged Congress to pass the Immigrant Children's Health Improvement Act to provide Medicaid and SCHIP coverage for lawfully present immigrant children, regardless of when they entered the US.

[156] Managed Risk Medical Insurance Board, Press Release, *California Announces Federal Approval and Funding for Expansion of Children's Health Coverage Programs* (June 14, 2004).

[157] The state must now complete contracts with the four counties to implement the AB 495 programs. Each county's board of supervisors must approve the contracts before the county can sign the contract.

[158] Federal law allows states to use up to 10 percent of SCHIP expenditures for certain activities, including program administration, "other child health assistance," outreach, and health services initiatives for improving the health of children. The federal government will contribute about two dollars in federal SCHIP funds for every county dollar invested, subject to the availability of federal funds under the 10 percent cap. In recent years, California has not matched all of the federal SCHIP funding available under the 10 percent cap.

[159] Centers for Medicare & Medicaid Services, *Letter to State Health Official, January 14, 1998,* downloaded from http://www.cms.hhs.gov/schip/chipimms.asp on July 16, 2004.

[160] However, some children might not enroll in expanded health coverage programs for which they become eligible. Therefore, it is possible that funding for safety net programs, such as the CHDP, would not decline significantly even if comprehensive health coverage were expanded. For a discussion of reasons why eligible children might not enroll in existing health coverage programs, see Chapter 3.

[161] The state and federal governments, for example, currently pay $35 toward the monthly cost of emergency services for some uninsured children. However, when a child enrolls in a county health coverage program, the state and federal governments save $35 per month, since those dollars are not redirected to counties to cover emergency services for that child as part of the county health coverage program.

[162] See Articles XIIIA and XIIIC of the Constitution of the State of California. Proposition 218 of 1996 imposed the voter-approval requirement for general purpose local taxes, while Proposition 13 of 1978 imposed the two-thirds

vote for "special" local taxes. Proposition 218 further defined the special tax requirement and also requires local tax increase proposals to appear on the same ballot as the election of a jurisdiction's governing body, except in cases of an emergency as declared by a unanimous vote of the governing body.

[163] See Los Angeles County Measure B, which appeared on the November 5, 2002 county ballot.

[164] See Alameda County Measure A, which appeared on the March 2, 2004 county ballot.

[165] The West Contra Costa Healthcare District is a special district in Contra Costa County.

[166] See West Contra Costa Healthcare Distict Measure D, which appeared on the June 8, 2004 county mail-in ballot.

[167] The county later decreased the sales tax after Hillsborough HealthCare had been in operation for four years.

[168] The state allocates approximately 80 percent of the revenues generated from this tax to county First 5 commissions to fund local initiatives. The state commission, created by Proposition 10, adopted the name "First 5 California" to convey the importance of the first five years and to help the public understand the overall purpose of the commission.

[169] Child and Family Coverage Technical Assistance Center, Institute for Health Policy Solutions, C*omparison of Local Children's Coverage Expansions,* downloaded from http://www.cfctac.org/countyinitiatives/ WebsiteTableDocument 9.22.04.pdf on October 26, 2004.

[170] California Children and Families Commission, *County Funds Distributions, Fiscal Year 2000/2001,* downloaded from http://ccfc.ca.gov/PDF/Fiscal/FundDistFY99-00.pdf on November 16, 2004 and California Children and Families Commission, *County Funds Distributions, Fiscal Year 2003/2004,* downloaded from http://ccfc.ca.gov/PDF/Fiscal/June%202004%20disburse.pdf on September 3, 2004. Figures include monthly disbursements to counties and exclude other First 5 payments to counties.

[171] Legislative Analyst's Office, *Analysis of the 2002-03 Budget Bill* (February 2002), p. C-27.

[172] National Association of Attorneys General, *Settlement: Fifty-one Attorneys General Announce Vibo Corporation Joins Tobacco MSA,* downloaded from http://www.naag.org/issues/20040819-settlement-vibo.php on October 6, 2004. In August 2004, the National Association of Attorneys General announced, "this agreement will be worth something in the range of $1.7 billion to the states over the next ten years."

[173] The state and a number of counties have already "securitized" a portion of their tobacco settlement revenues. The state's 2002-03 Budget, for example, authorized the sale of $4.5 billion in bonds. The state will repay the investors, with interest, from the proceeds of future tobacco settlement payments.

[174] Some families may have thought their children were enrolled in private health coverage, especially if children were enrolled in managed care plans through Medi-Cal or Healthy Families.

[175] California HealthCare Foundation, *California's Uninsured and Medi-Cal Populations: A Policy Guide to the Estimates* (January 2004).

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