

LOSING GROUND: DECLINING MEDI-CAL ENROLLMENT AFTER WELFARE REFORM



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EXECUTIVE SUMMARY

The 1996 federal welfare law delinked eligibility for Medicaid (Medi-Cal in California) from the receipt of cash assistance. In an effort to ensure continued eligibility for low income families, Congress required states to provide Medicaid coverage to recipients of state programs funded under the Temporary Assistance for Needy Families (TANF) block grant, as well as any individuals who would have been eligible for AFDC, the former cash assistance program. As a result of this change, individuals no longer need to receive cash assistance in order to qualify for Medi-Cal. Despite attempts to maintain health coverage, studies suggest that large numbers of families have lost Medicaid since the enactment of welfare reform.

This paper examines Medi-Cal enrollment trends in light of the substantial drop in welfare caseloads in recent years. Our findings show that while the number of persons receiving non-cash-related Medi-Cal has increased substantially, the gain is less than the number of persons who lost Medi-Cal coverage when they left cash assistance. Most of the decline in family-based coverage occurred before California's implementation of welfare reform in January 1998. Since January 1998, enrollment in non-cash-related Medi-Cal has exceeded the decline in cash-related Medi-Cal. However, enrollment trends have varied substantially between counties, and the drop in cash-related coverage exceeded the rise in non-cash-related enrollment in a majority of the state's counties in the most recent period studied (April 1999 through December 2000). This report concludes with an analysis of some of the factors that are and are not associated with Medi-Cal enrollment gains, and case studies of counties with significant gains or losses of family-based Medi-Cal enrollment.

MAJOR FINDINGS

- Family-based Medi-Cal enrollment declined by 194,029 between March 1995 and December 2000. Most of the drop occurred between the middle of 1996 and the beginning of 1998, with a partial recovery in 1999 and 2000.
- The decrease in coverage reflects fewer people enrolling in Medi-Cal as a result of receiving cash assistance through the CalWORKs program. Between March 1995 and December 2000, the number of persons receiving cash-related Medi-Cal fell by 1,268,050, while the number of persons enrolled in family-based Medi-Cal categories that are not linked to cash assistance rose by 1,074,021.
- Over the period studied, family-based enrollment shifted from being predominantly linked to cash assistance to predominantly non-cash related. In March 1995, three quarters (76.0 percent) of family-based Medi-Cal enrollment was cash-related, while in December 2000 less than half (42.8 percent) of family-based coverage was linked to cash assistance. Non-cash-related enrollment first surpassed cash-related enrollment in March 2000.
- Between March 1995 and December 2000, 84.7 percent of the decline in cash-related Medi-Cal enrollment was offset by an increase in non-cash Medi-Cal enrollment. We call this percentage offset a "replacement rate."
- Replacement rates varied significantly during the three phases studied in this analysis (March 1995 to January 1998, January 1998 to April 1999, and April 1999 to December 2000). The three phases correspond to different policy frameworks for family-based Medi-Cal. The replacement rate for the period

March 1995 to January 1998 was 6.8 percent. This is the period between the peak of welfare (then AFDC, now CalWORKs) caseloads and the implementation of welfare reform in California. In other words, only seven persons enrolled in non-cash-related Medi-Cal for every 100 persons who left cash-related Medi-Cal during this period. The replacement rate for January 1998 to April 1999 was 116.9 percent. This period covers the time from the “delinking” of Medi-Cal eligibility and cash assistance to the issuance of the final rules for the new 1931(b) category of Medi-Cal eligibility. The replacement rate for the final period was 163.0 percent. This period begins with the issuance of the final 1931(b) rules and ends in the final month for which data were available at the time of this analysis.

- The increase in family-based coverage after the implementation of the policy changes related to the 1996 federal welfare law suggests that the “delinkage” of Medi-Cal and cash assistance, as well as measures taken to encourage Medi-Cal enrollment among individuals who are not receiving cash assistance, have helped to improve health coverage, particularly among children. However, the effectiveness of these policies varies substantially among counties.
- Medi-Cal enrollment trends varied substantially among counties. Replacement rates for the March 1995 to December 2000 period ranged from a high of 134.1 percent in Los Angeles County to a low of 5.8 percent in Plumas County (a replacement rate of more than 100 percent means that the increase in non-cash enrollment was larger than the decline in cash enrollment).
- The magnitude of Los Angeles County’s enrollment gain significantly affects the replacement rate for the state as a whole. If Los Angeles County is excluded, the overall replacement rate for the state is 66.9 percent (as compared to 84.7 percent); the replacement rate for Phase One excluding Los Angeles County was 21.3 percent (as compared to 6.8 percent); the replacement rate for Phase Two excluding Los Angeles County was 81.3 percent (as compared to 116.9 percent); and the replacement rate for Phase Three was 127.7 percent (as compared to 163.0 percent).
- Counties with high poverty rates tend to have higher replacement rates, while low replacement rates are associated with larger decreases in unemployment rates. The share of children enrolled in the Healthy Families Program is not statistically related to county replacement rates. The percentage of uninsured county residents was positively associated with replacement rates. In other words, counties with higher rates of uninsurance tend to have higher replacement rates. County policies and practices appear to be the most significant factor influencing family-based Medi-Cal enrollment trends.

Strategies for Boosting Coverage

The case studies described in this report, as well as other research, identify a number of strategies that can be used to boost enrollment in the Medi-Cal and Healthy Families Programs:

- *Counties with high replacement rates made maintaining and increasing coverage a major priority.* Strong leadership can help ensure that eligible families receive the Medi-Cal coverage they are entitled to. In counties with high replacement rates, this message often originated with the key department heads and/or elected officials. In particular, counties with strong cooperation between county health and social services departments tended to have higher replacement rates.
- *Counties should use every available opportunity to encourage families leaving welfare to maintain health coverage.* Counties should aggressively seek to ensure that families have health coverage when they leave welfare for work. Studies suggest that many “welfare leavers” obtain jobs without employer provided coverage. The new 1931(b) and Transitional Medi-Cal programs are designed to ensure that families do not lose coverage when they leave welfare for work. Enrollment remains particularly low in Transitional Medi-Cal, which provides health coverage to individuals whose in-

come rises above the eligibility limit for other programs. Further research is needed to determine why utilization of this program remains low.

- ***Increase outreach efforts.*** A large number of California's uninsured are eligible for, but not enrolled in Medi-Cal or the Healthy Families Programs, including families that lost coverage when they left the welfare rolls. Promising outreach strategies include the use of bilingual staff and programs that collaborate with schools and community clinics.
- ***Foster simplicity.*** Many observers cite the complexity of the Medi-Cal application form and the burden of the previously required quarterly reports as barriers to enrollment. The state should continue efforts aimed at simplifying application forms and procedures, including "express lane" eligibility, which links health coverage to participation in other programs such as the school lunch program, and streamlined income verification procedures.
- ***Improve computer support for county caseworkers.*** County officials identify inadequate computer support systems as a barrier to encouraging enrollment. Automated redetermination systems could expedite enrollment and help caseworkers catch errors that may delay coverage. Improved systems could also help identify families that are eligible for, but not enrolled in, Medi-Cal who are receiving other county services.
- ***Remove barriers to coverage.*** Currently, adults applying for Medi-Cal are subject to assets limits, while children applying for Medi-Cal or the Healthy Families Program are not. The assets test prevents families with very low incomes from obtaining coverage if they have even minimal savings, and adds complexity to the application process.

LOSING GROUND: DECLINING MEDI-CAL ENROLLMENT AFTER WELFARE REFORM

The 1996 federal welfare law delinked eligibility for Medicaid (Medi-Cal in California) from the receipt of cash assistance.¹ In an effort to ensure continued eligibility for low income families, Congress required states to provide Medicaid coverage to recipients of state programs funded under the Temporary Assistance for Needy Families (TANF) block grant, as well as any individuals who would have been eligible for Aid to Families with Dependent Children (AFDC), the former cash assistance program.² As a result of this change, individuals no longer need to receive cash assistance in order to qualify for Medi-Cal. Despite attempts to maintain health coverage, studies suggest that large numbers of families have lost Medicaid since the enactment of welfare reform.³ Moreover, Census data show that the share of non-elderly Californians receiving health coverage through Medi-Cal declined by 27 percent between 1994 and 1999.⁴

This paper examines Medi-Cal enrollment trends in light of the substantial drop in welfare caseloads in recent years.⁵ Specifically, this analysis explores the extent to which the decline in the number of persons enrolled in Medi-Cal and receiving cash assistance has been replaced by persons receiving Medi-Cal, but not cash assistance. The drop in cash-related Medi-Cal is not surprising given the drop in welfare caseloads, but the critical question is whether policies enacted to ensure coverage of low income families have succeeded in boosting non-cash-related enrollment.

Family-Based Medi-Cal enrollment includes parents and children enrolled in Medi-Cal and does not include persons who are eligible based on age or disability. It is made up of **cash-related enrollment** categories linked to receipt of cash assistance through the CalWORKs (formerly AFDC) program and **non-cash-related enrollment**, including children and parents who no longer receive, or have never received, cash assistance, but are eligible for Medi-Cal by virtue of fulfilling income and other requirements.

Our findings show that while the number of persons receiving non-cash-related Medi-Cal has increased substantially, the gain is less than the number of persons who lost Medi-Cal coverage when they left cash assistance. Most of the decline in family-based coverage occurred before California's implementation of welfare reform in January 1998. Since January 1998, enrollment in non-cash-related Medi-Cal has exceeded the decline in cash-related Medi-Cal. However, enrollment trends have varied substantially between counties and the drop in cash-related coverage exceeded the rise in non-cash-related enrollment in a majority of the state's counties in the most recent period studied (April 1999 through December 2000). This report concludes with an analysis of some of the factors that are and are not associated with Medi-Cal enrollment gains, and case studies of counties with significant gains or losses of family-based Medi-Cal enrollment.

METHODOLOGY AND "REPLACEMENT RATES"

This report uses data from the California Department of Health Services (DHS) to examine trends in family-based Medi-Cal enrollment from early 1995, when welfare enrollment peaked in California, through December 2000, the most recent month for which reliable data are available. The analysis excludes the elderly and individuals who receive Medi-Cal due to disability in order to focus on the impact of welfare reform on Medi-Cal coverage of low income families.⁶ Appendix I describes the methodology used to categorize specific enrollment codes.

The Replacement Rate Concept

This paper uses the concept of “replacement rates” to examine to what extent a decline in cash-related enrollment over a period of time is offset by an increase in non-cash-related enrollment over the same period. A replacement rate of 63 percent, for example, means that for every 100 people who left cash-related Medi-Cal, 63 people enrolled in non-cash-related Medi-Cal. The enrollment information used does not tell us whether the *same* 100 people who left cash assistance enrolled in non-cash Medi-Cal, only that during the period when 100 people left cash-based Medi-Cal, 63 enrolled in non-cash Medi-Cal. This report calculates replacement rates for all 58 counties for the period March 1995 to December 2000 and examines county-level differences in replacement rates for three interim phases.

The replacement rates used in this report are based on point-in-time measures of the change in enrollment between selected months. They do not provide longitudinal information on individuals’ Medi-Cal enrollment over time and do not measure the proportion of eligible individuals who are enrolled. Many factors in addition to county policies and practices can affect Medi-Cal enrollment, including local labor market conditions and the share of jobs within the county that provide employment-based health coverage.

An Overview of Medi-Cal Policy Changes in the Context of Welfare Reform

March 1995: California’s cash assistance (Aid to Families with Dependent Children, or AFDC) caseload peaks; cash-related Medi-Cal enrollment peaks in April 1995 at 2,723,484.

August 1996: The Personal Responsibility and Work Opportunity Reconciliation Act, restructuring the nation’s welfare programs, is enacted. The new welfare law includes a provision delinking cash assistance and Medicaid, and creates Section 1931(b) Medicaid aimed at ensuring that provisions of the new welfare law do not cause families to lose health coverage.

January 1998: CalWORKs, California’s Temporary Assistance for Needy Families (TANF) program, is implemented. The state is unprepared to implement the new 1931(b) category. Counties are directed not to terminate families leaving cash assistance from Medi-Cal until the state issues rules for 1931(b) eligibility. Families leaving cash assistance are supposed to retain Medi-Cal eligibility through the Edwards category. By the end of the year, enrollment in the Edwards category increases 164 percent from 152,537 to 402,658. This is referred to as the “Edwards backlog,” as these cases would need to be reviewed for 1931(b) eligibility once the state issued the rules (see below).

March 1998: A new state law extends eligibility for Medi-Cal eligibility to children ages 14 to 18 in families with incomes of up to 100 percent of the federal poverty level and eliminated the limitation on assets for children.^a By March 2000, enrollment in these programs has increased by 125,200.

April 1999: Counties reach a state deadline to review all cases in the Edwards backlog for 1931(b) eligibility. Many counties do not complete processing the backlog by this time.

March 2000: A new state law extends eligibility under the 1931(b) category to include certain individuals in families with incomes up to 100 percent of the federal poverty level. This change primarily affects parents, because children at this income level were previously eligible for other Medi-Cal programs.

December 2000: Enrollment in cash-related Medi-Cal has declined by 1,268,050 – down 47 percent from March 1995.

^a US Department of Health and Human Services, Health Care Financing Administration, *Medicaid Welfare Reform Implementation Review: California* (January 2001), p.3.

Despite these limitations, replacement rates provide a useful tool for examining the impact of welfare reform on Medi-Cal enrollment. They can help identify counties that have successfully maintained Medi-Cal coverage and strategies that can be useful for boosting enrollment in other counties. Replacement rates can also point to counties where improvement is needed.

The “Edwards” Category

Individuals leaving cash assistance are reclassified as “Edwards” or Aid Code 38 Medi-Cal cases.^a Counties use the Edwards category to continue Medi-Cal coverage for individuals leaving cash assistance until the county determines whether they are eligible for 1931(b) or some other Medi-Cal category. The Edwards category was established pursuant to a 1985 state appellate court decision in *Edwards v. Kizer*, which required the state to evaluate whether families leaving cash assistance are eligible under any of the non-cash-related Medi-Cal eligibility categories.^b Individuals typically receive Medi-Cal coverage in the Edwards category for one to two months until the county determines whether they are eligible under any other category.

Because California was slow to implement the new federal 1931(b) eligibility category after welfare reform, the Edwards category took on an important role in the transition to the new program. Starting in January 1998, the DHS instructed counties to leave parents and children in the Edwards category until final 1931(b) eligibility rules were released.^c

Enrollment in the Edwards category increased dramatically during 1998, from 152,537 in January to 402,658 in December. However, less than half of California’s counties are responsible for the increase; it appears that the rest did not provide families leaving cash assistance with coverage in the Edwards category. A number of families either lost their Medi-Cal coverage upon leaving cash assistance or were improperly placed in an aid category requiring them to pay a share of medical costs.^d In 1998 and 1999, counties struggled to process the enormous backlog of cases that had accumulated in the Edwards category. In order to move to 1931(b), families needed to complete and submit redetermination forms. However, many were unaware of their continuing eligibility or had lost contact with the county welfare office. In December 2000, enrollment in the Edwards category was 237,424, well above pre-welfare reform levels.

^a Up to three counties may have used Aid Code 3C instead.

^b *Edwards v. Kizer*, 167 Cal. App. 3d 1071 (1985). See Western Center on Law and Poverty, “Keeping Medi-Cal After Leaving Welfare: The Right to a Redetermination of Medi-Cal Eligibility Before Medi-Cal Ends,” *CalWORKs: A Comprehensive Guide to Welfare and Related Medi-Cal Issues for California Families*, Chapter VIII, Section C, downloaded from <http://www.wclp.org/advocates/library/calworks/ch8c.html> on September 6, 2001.

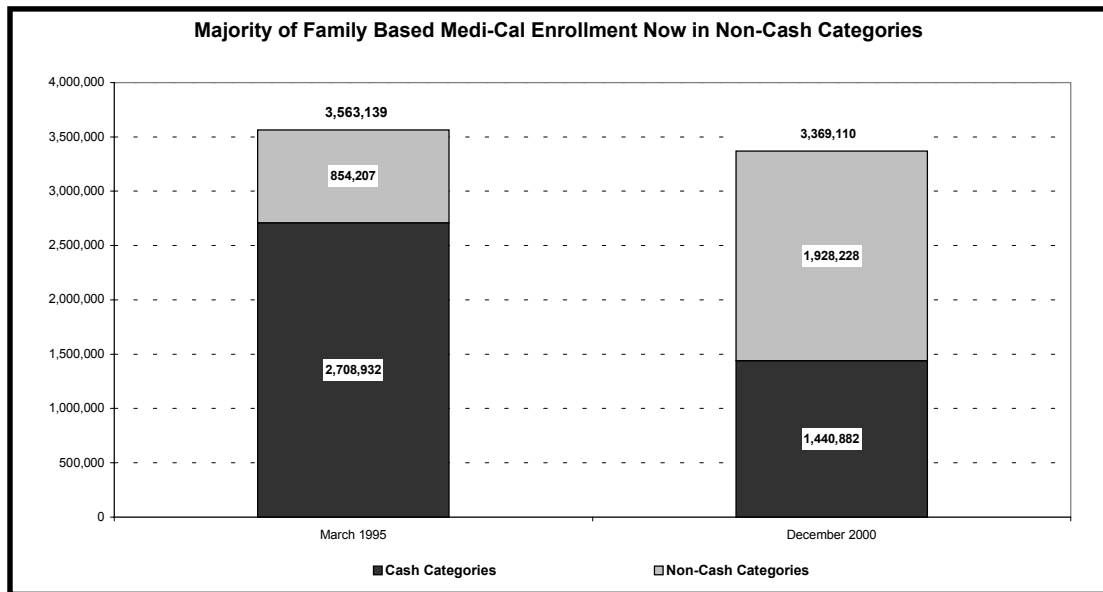
^c California Department of Health Services, *All County Welfare Directors Letter 98-43* (September 30, 1998).

^d Western Center on Law and Poverty, “Section 1931(b) Medi-Cal for Certain Low Income Families,” *CalWORKs: A Comprehensive Guide to Welfare and Related Medi-Cal Issues for California Families*, Chapter VIII, Section D, downloaded from www.wclp.org.

STATEWIDE TRENDS IN MEDI-CAL ENROLLMENT

Family-based Medi-Cal enrollment declined between 1995 and 2000, despite program and eligibility expansions, increases in the number of uninsured persons in the state, and population growth. While the number of parents and children enrolled in non-cash Medi-Cal has increased, the increase has not fully offset the decline in cash-related Medi-Cal enrollment.

Statewide, total family-based Medi-Cal enrollment fell by 194,029 between March 1995 and December 2000 (5.4 percent). During this period, cash-related enrollment declined dramatically, while non-cash-related enrollment increased. As families left cash assistance, enrollment in cash-related Medi-Cal fell by 1.27 million, from 2,708,932 to 1,440,882. Enrollment in non-cash-related Medi-Cal increased by 1.07 million from 854,207 to 1,928,228. This translates into a statewide replacement rate of 84.7 percent. In other words, for every 100 people who left cash assistance linked Medi-Cal, approximately 85 people enrolled in non-cash-related Medi-Cal.



Among the non-cash-related eligibility categories, the most dramatic shifts occurred in the 1931(b)-Only and Edwards categories.⁷ Enrollment in 1931(b)-Only Medi-Cal began in January 1998, and by December 2000 there were over 1.1 million persons receiving coverage. Enrollment in the Edwards category peaked in December 1998. Edwards enrollment increased by over 250,000 during 1998, after the state ordered counties to enroll persons leaving cash assistance in the Edwards category until the 1931(b) rules were finalized.

REPLACEMENT RATES BEFORE, DURING, AND AFTER IMPLEMENTATION OF CALWORKS AND 1931(b)

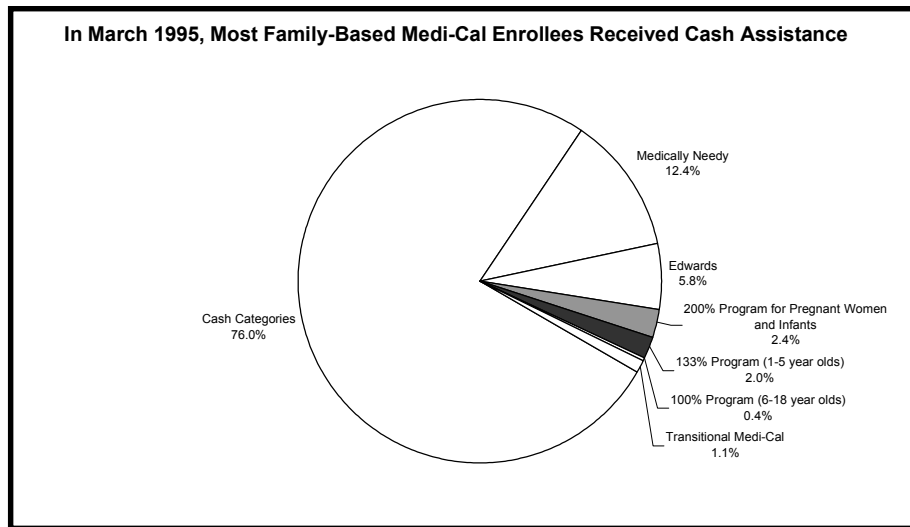
In an effort to examine the impact of changing state and federal policies, this report analyzes changes in Medi-Cal enrollment during three different phases. The periods correspond to major changes in Medi-Cal and welfare policies:

- Phase One, from March 1995 to January 1998, covers the period after the peak in welfare caseloads and prior to the implementation of welfare reform in California;
- Phase Two, from January 1998 to April 1999, represents a period of transition during California's implementation of welfare reform and associated Medi-Cal policies; and
- Phase Three, from April 1999 to December 2000, represents the period when the new 1931(b) Medi-Cal program was fully implemented.

California			
	March 1995	December 2000	Change March 1995 to December 2000
Total Family-Based Enrollment	3,563,139	3,369,110	-194,029
Cash Categories	2,708,932	1,440,882	-1,268,050
Non-Cash Categories	854,207	1,928,228	1,074,021
Medically Needy	441,037	241,619	-199,418
Edwards	205,703	237,424	31,721
200% Program for Pregnant Women and Infants	86,130	113,287	27,157
133% Program (1-5 year olds)	69,570	88,346	18,776
100% Program (6-18 year olds)	12,652	74,477	61,825
1931(b)-Only	0	1,130,986	1,130,986
Transitional Medi-Cal	39,115	42,089	2,974
March 1995 - December 2000 Replacement Rate			84.7%

Phase One – March 1995 to January 1998: Before CalWORKs Implementation

March 1995 was selected as the starting date for this analysis because cash assistance caseloads peaked in California that month and declined afterward. January 1998 marks the end of Phase One with the implementation of California's new welfare law. Prior to January 1998, Medi-Cal eligibility for families was closely linked to receipt of cash assistance. In March of 1995, people in families receiving cash assistance comprised just over three-quarters (76.0 percent) of family-based Medi-Cal enrollment.



Between March 1995 and January 1998, family-based Medi-Cal enrollment in California declined by 493,313 (13.8 percent). Enrollment in cash-related Medi-Cal fell sharply in tandem with cash assistance caseloads, while non-cash-related Medi-Cal enrollment increased only slightly. The slight increase in non-cash coverage offset only a small fraction of the declining cash-related enrollment, translating into a statewide replacement rate of 6.8 percent.

Replacement rates for Phase One varied among counties from 184.8 percent in Madera County to -61.8 percent in Modoc County.⁸ Los Angeles County had one of the lowest replacement rates at -49.1 percent and the statewide replacement rate excluding Los Angeles County was 21.3 percent.⁹ Counties with higher replacement rates tended to have larger enrollment increases in the Medically Needy and Transitional Medi-Cal categories during Phase One. Rural counties and rural counties with a major city tended to have higher Phase One replacement rates than urban and suburban counties.

Phase Two – January 1998 to April 1999: Edwards Enrollment Doubles

In January 1998, the first month of Phase Two, the state began to implement the new CalWORKs welfare program, and the state ordered counties to provide coverage to individuals leaving cash assistance in the Edwards category until the final rules for 1931(b) Medi-Cal eligibility could be completed. Phase Two ended in April 1999 with release of the state's final rules for 1931(b) Medi-Cal and a state directive for counties to review all cases on hold for 1931(b) eligibility. During this phase, enrollment in the Edwards category should have increased substantially, as counties maintained coverage in this category rather than transferring cases to other aid categories after one or two months.

Family-based Medi-Cal enrollment increased by 60,900 (2.0 percent) during Phase Two. Enrollment in cash-related Medi-Cal continued to decline, while non-cash-related Medi-Cal enrollment increased sharply. During this period, the non-cash-related enrollment increase more than offset the decline in cash-related enrollment, and the statewide replacement rate was 116.9 percent. Enrollment in the

Edwards category more than doubled during this period after the state instructed counties to use the category to provide coverage to individuals leaving welfare pending a determination of eligibility in other categories. In addition, enrollment in the new 1931(b)-Only category climbed to almost 216,609, with nearly 80 percent of the increase occurring in Los Angeles County.

Replacement rates for this period ranged from 213.2 percent in Sutter County to -500.0 percent in Alpine County. Despite the state's instructions to hold welfare leavers in the Edwards category, enrollment in this category declined in 33 counties during this period and increased by less than 25.0 percent in an additional five counties.

Phase Three – April 1999 to December 2000: Final 1931(b) Rules Available

Phase Three begins in April 1999, the month the state released the final 1931(b) rules and ordered counties to review all Edwards cases for eligibility in 1931(b)-Only or other Medi-Cal categories. December 2000, the most recent month for which reliable Medi-Cal enrollment data is available, is the final month of this analysis.

Enrollment in family-based Medi-Cal increased by 238,384 (7.6 percent) between April 1999 and December 2000. Enrollment in cash-related Medi-Cal continued to decline, while non-cash-related Medi-Cal enrollment again increased sharply. During this period, the non-cash-related increases more than offset the declines in cash-related enrollment, and the statewide replacement rate was 163.0 percent. Edwards enrollment declined as counties began to process the backlog of cases, but remained above the January 1998 level. Enrollment in the 1931(b)-Only category more than quintupled during this period.

Replacement rates for this period ranged from 404.8 percent in Orange County to -92.2 percent in San Benito County. At the end of Phase Three, Mariposa, Mendocino, and Yuba Counties still had no parents or children enrolled in 1931(b)-Only Medi-Cal. Statewide, over one-third (33.6 percent) of all individuals enrolled in family-based Medi-Cal were in the 1931(b)-Only category, but in 15 counties, less than 16 percent of the caseload was enrolled in 1931(b)-Only Medi-Cal.

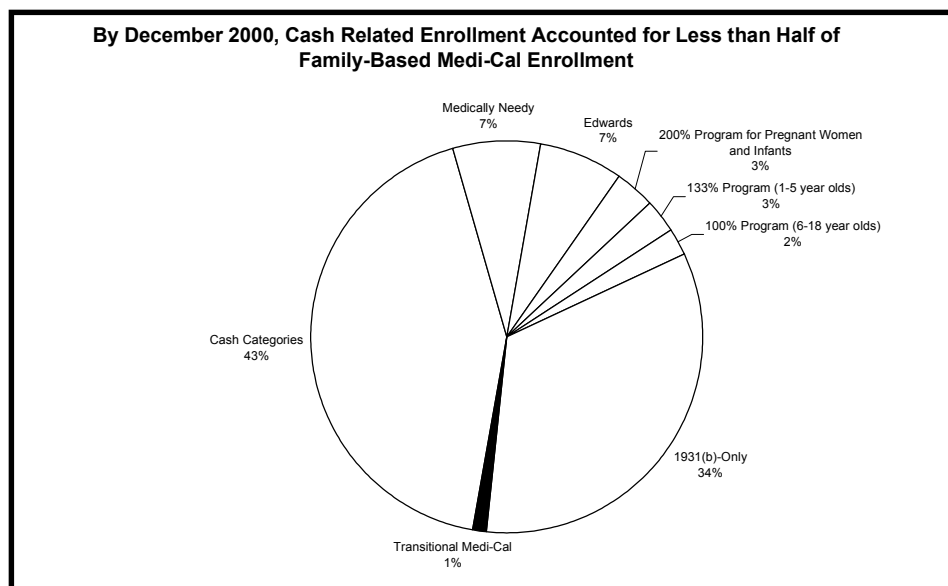
While the statewide replacement rate for Phase Three shows a substantial jump in non-cash-related enrollment, eight counties had negative replacement rates during the period and an additional 13 counties had replacement rates of less than 50 percent. Twenty-one counties had replacement rates above 100 percent, indicating a net gain of family-based enrollment during Phase Three.

ENROLLMENT TRENDS VARY WIDELY AMONG COUNTIES

Replacement rates between March 1995 and December 2000 varied widely among counties, from a high of 134.1 percent in Los Angeles County to a low of 5.8 percent in Plumas County. The differences in replacement rates appear to be driven by variations in non-cash enrollment increases across counties, rather than the size of the drop on the welfare-linked population, since cash-related enrollment declined relatively uniformly across counties. The wide variation among counties suggests that factors other than state law had a substantial impact on the degree to which low income families retained health coverage.

In January 1998, the state instructed counties to provide Medi-Cal coverage to families leaving cash assistance using the Edwards category until the final eligibility rules for 1931(b) Medi-Cal were available. Despite the state's instructions, Edwards enrollment increased in only 19 counties during 1998. Thirteen of these were urban or suburban counties, and several are among those with high overall replacement rates.

Of the five counties with the highest replacement rates, three – Los Angeles, Fresno, and Tulare – show similar trends in family-based Medi-Cal enrollment during the period studied. Edwards enrollment increased significantly in these three counties during 1998, and 1931(b)-Only enrollment increased sharply in the same counties from early 1999 through 2000. Edwards enrollment declined during 1998 in three of the five counties with the lowest replacement rates – Yuba, Sierra, and Nevada Counties.



DID WELFARE LEAVERS INAPPROPRIATELY LOSE MEDI-CAL COVERAGE?

Welfare reform added a new layer of complexity to the Medi-Cal program, albeit with the important goal of maintaining health coverage for those who left, or chose not to receive, cash assistance. Changes to Medi-Cal associated with the new welfare law include the addition of new eligibility categories (aid codes), new sets of rules and regulations, and the need for caseworkers to manually determine income eligibility for coverage. These changes occurred at the same time that counties were required to substantially restructure their welfare programs, taxing staff and administrative resources.

An analysis of enrollment trends and replacement rates cannot demonstrate directly whether individuals inappropriately lost Medi-Cal, since publicly available data does not permit tracking individuals. Moreover, counties do not collect or report data on terminated cases, and non-cash enrollment data includes new applicants, as well as those leaving cash assistance.

Publicly available enrollment data suggest that the expectation that families would maintain coverage has not been fulfilled in many California counties. Policy changes implemented during the period covered by this study extended Medi-Cal eligibility to more than 250,000 Californians.¹⁰ Despite these changes, family-based enrollment increased by only 9.7 percent between January 1998 and December 2000. Family-based enrollment excluding Los Angeles County increased by only 1.1 percent between January 1998 and December 2000. Family-based Medi-Cal enrollment declined in 41 counties between January 1998 and December 2000. In many cases, the drop in enrollment was significant, with family-based enrollment down by more than 10 percent in 28 counties during the same period.

The drop in family-based enrollment that occurred in numerous counties across the state strongly suggests that many families that left cash assistance also lost Medi-Cal coverage. This may have happened because they were not aware of their continuing eligibility, were deterred by the cumbersome

process of eligibility redetermination, because county workers did not completely understand the new program, or the county failed to make serious efforts to maintain enrollment. Others who left cash assistance may not have lost Medi-Cal eligibility, but may have been improperly placed into an aid category which required them to pay a share of their medical costs.¹¹

Recent Efforts Aimed at Boosting Enrollment

Since 1998, the state has taken a number of steps to simplify the process of applying for Medi-Cal and to promote the availability of health coverage, particularly for children. Between 1998-99 and 2000-01, the state allocated \$77.7 million for outreach and education efforts aimed at boosting children's enrollment in Medi-Cal and the Healthy Families Programs. Specific efforts include media campaigns, support for community-based outreach programs, and payment of applicant assistance fees to individuals who help children and pregnant women complete Medi-Cal or Healthy Families Program application forms. Special programs target non-English speaking, immigrant, and other underserved populations. A number of persons interviewed for this report cited the availability of state outreach funds as an important factor in successful local enrollment efforts.

Changes made to expand eligibility, simplify the Medi-Cal eligibility process, and remove barriers to enrollment include:

- Extending Medi-Cal coverage to children up to age 18 in families with incomes of up to 100 percent of the federal poverty level (FPL), beginning in March 1998.
- Expanding eligibility for 1931(b)-Only Medi-Cal to parents in families with incomes of up to 100 percent of the FPL, effective in March 2000.
- Eliminating the assets test for children applying for Medi-Cal, effective January 2001.
- Removing the requirement for a face-to-face interview, beginning in July 2000. This allows applicants to obtain health coverage without having to visit the county welfare department.
- Providing 12 months of continuous eligibility for coverage of children, beginning in January 2001.
- Eliminating quarterly status reporting. Prior to January 2001, families were required to file a quarterly report documenting their earnings even if no change in status occurred since their last report.
- Establishing criteria that counties must follow before terminating the Medi-Cal coverage of a former CalWORKs recipient, effective January 2001.
- Successive attempts to streamline the application form for Medi-Cal and the Healthy Families Program and to create a "single point of entry" to process applications for both programs.

The focus on outreach and making coverage more accessible has also changed attitudes at the local level. In the words of one county administrator, "We now have a different mindset and view our role as health promoters." However, most of the increased enrollment efforts did not begin until 1998, and several key changes, such as the elimination of quarterly status reports, were not implemented until after the period covered by this analysis. This report's findings suggest that outreach efforts helped boost enrollment in Phase Three, but by this time many families who left cash assistance had lost coverage and, in many cases, were no longer in contact with county welfare departments.

LOOKING AT COUNTIES WITH LOW REPLACEMENT RATES: WHAT ARE SOME POSSIBLE EXPLANATIONS FOR VARIATION IN REPLACEMENT RATES?

A comparison of replacement rates across counties allows exploration of why replacement rates might be low overall or lower in some counties than in others.¹² For example, if large numbers of families leaving cash assistance found jobs that provide family health insurance coverage or if families enrolled their children in the Healthy Families Program (HFP), which began in 1998, then low replacement rates might make sense. If this were true, we would expect counties with higher rates of job-based insurance or larger HFP enrollment to have lower replacement rates. In order to explore these possibilities, this analysis statistically analyzed the relationship between replacement rates and a number of social and economic variables and found that:

- ***Healthy Families Program Enrollment Does Not Appear to Affect Medi-Cal Enrollment.*** The Healthy Families Program (HFP) provides low-cost health coverage for children in families with incomes above the Medi-Cal eligibility limit and below 250 percent of the federal poverty level.¹³ In December 2000, the final month included in this analysis, statewide HFP enrollment reached 362,634, significantly greater than the 194,029 net decline in family-based Medi-Cal enrollment between March 1995 and December 2000. It is possible that some people left cash assistance and their incomes increased to the point where their children were eligible for the HFP rather than Medi-Cal. If families leaving cash assistance were enrolling their children in the HFP, we might expect lower Medi-Cal replacement rates in counties with larger enrollment in HFP. However, this was not the case. In fact, there is no statistically significant relationship between replacement rates and HFP enrollment as a share of a county's population aged 0 to 17.
- ***Economic Growth May Affect Enrollment.*** Replacement rates in counties with higher than average rates of unemployment did not differ significantly from counties with lower unemployment. However, the change in a county's unemployment rate between 1995 and 2000 was positively correlated with its replacement rate. In other words, a larger drop in a county's unemployment rate was associated with a lower replacement rate. This could suggest that more families leaving cash assistance found jobs with health insurance in counties with tighter labor markets.
- ***Only a Modest Relationship Exists Between Rates of Uninsurance and Replacement Rates.*** This analysis found a modest positive relationship between county rates of uninsurance and replacement rates, and no significant relationship between replacement rates and rates of job-based insurance.¹⁴ In other words, higher replacement rates are associated with a larger share of county residents lacking health coverage.
- ***Rural Counties Have Lower Replacement Rates.*** This analysis classified counties as urban, suburban, rural with a major city, and rural (See Appendix II). The overall replacement rate was low for rural counties in all three phases. The average urban county replacement rate was very low (6.8 percent) in Phase One, but over 100 percent in Phases Two and Three. Overall, rural counties' replacement rates averaged 48 percent compared to 60 percent for suburban counties, 72 percent for urban counties, and 75 percent for rural counties with major cities.
- ***High Poverty Counties Have Higher Replacement Rates.*** Poverty rates vary widely among counties, ranging from a low of 6.6 percent in San Mateo County to a high of 30.3 percent in Imperial County in 1997. Higher 1995 and 1997 poverty rates correlate with higher overall replacement rates. Similarly, the change in poverty rates between 1995 and 1997, the most recent year for which data are available, is negatively associated with a county's replacement rate, meaning that a drop in poverty is associated with a lower replacement rate.

RESEARCH SUGGESTS THAT MOST LEAVERS DO NOT RECEIVE JOB-BASED COVERAGE

Another possible explanation for low replacement rates is that some welfare leavers may have acquired job-based insurance coverage after they left welfare. If this were affecting replacement rates, we would expect counties with greater job growth or higher rates of job-based insurance to have lower replacement rates. An examination of individuals who left welfare in San Mateo, Santa Clara, and Santa Cruz Counties, all counties with replacement rates lower than the statewide rate, indicates that a majority (60.0 percent) of leavers who had jobs were not offered health insurance through their employer.¹⁵ Similarly, a survey of individuals leaving cash assistance in Napa County, which also had a below average replacement rate, found that only two-thirds were receiving Medi-Cal and 13 percent had neither Medi-Cal or job-based coverage.¹⁶ Nationally, a 1997 survey found that 41 percent of women

and 25 percent of children who left welfare were uninsured, and that both women and children were more likely to be uninsured the longer they have been off cash assistance.¹⁷

COUNTY ENROLLMENT PROCEDURES APPEAR TO AFFECT ENROLLMENT

California's 58 counties face many obstacles to maintaining and increasing Medi-Cal enrollment. Medi-Cal eligibility rules are complex, requiring eligibility workers to have detailed knowledge of an array of different eligibility programs. The application process is cumbersome, often requiring applicants to come in person to a county welfare office and produce multiple forms of documentation to prove income and assets. Since the implementation of welfare reform, some of these barriers have become even more difficult to surmount.¹⁸

The state's instructions for implementing the new, complex rules were transmitted to counties in dozens of sometimes contradictory All County Letters between 1998 and 2000.¹⁹ None of the counties have computerized eligibility systems capable of handling 1931(b) eligibility determinations, so workers must complete several pages of worksheets manually in order to enroll a family in Medi-Cal. Observers also cite a fundamental conflict between the goals of welfare reform and Medi-Cal. The new welfare law attempts to quickly move families off assistance, while the goal of the Medi-Cal program is to provide health coverage to all eligible families.²⁰

County policies and practices also affect Medi-Cal enrollment. For example, counties that appeared to follow state instructions for holding welfare leavers in the Edwards category until 1931(b) rules were released had higher replacement rates. Counties where Edwards enrollment increased in 1998 had replacement rates averaging 67.4 percent, compared to 55.4 percent for counties where Edwards enrollment decreased. Similarly, county efforts to fully implement 1931(b)-Only Medi-Cal also appear to affect replacement rates. Statewide, 1931(b)-Only enrollment made up about one-third of family-based Medi-Cal enrollment in December 2000. Counties with higher than average 1931(b)-Only enrollment rates have replacement rates averaging 72.9 percent. This compares to an average replacement rate of 48.3 percent for counties with lower than average 1931(b)-Only enrollment rates. These findings suggest that county efforts to maintain and increase enrollment can improve coverage.

EXAMINING COUNTY-LEVEL VARIATION: FOUR COUNTY CASE STUDIES

While the policy framework and eligibility rules for Medi-Cal are established by the state, there is substantial variation in counties' approach to Medi-Cal outreach and enrollment practices. Some counties aggressively sought to maintain coverage by keeping families enrolled under the Edwards category. Others, citing the lack of clear state authority to maintain coverage, allowed families to fall off the rolls. Some counties devoted substantial resources to outreach, while others waited until enrollment levels plummeted to establish outreach efforts, allowing many families to fall through the cracks. The following profiles examine four counties, two with high replacement rates and two with low rates.

San Mateo County

In San Mateo County, total family-based Medi-Cal enrollment dropped by a third (from 28,472 to 18,993) between March 1995 and December 2000. Cash-related Medi-Cal enrollment fell by 77.8 percent in San Mateo County, more sharply than the 46.8 percent decline for the state as a whole. Non-cash-related enrollment increased by only 40.1 percent, compared to 125.7 percent statewide. San Mateo County's replacement rate was 31.3 percent, ranking 49th among all counties and 13th out of the 15 suburban counties.

Contrary to the state's instructions, San Mateo County did not hold welfare leavers in the Edwards category until the final 1931(b) rules were issued. One county official attributed this to general confusion about the state's instructions and the state's failure to issue a formal All County Letter telling counties to maintain coverage. Enrollment in 1931(b)-Only began to increase in early 1999, and rose to nearly 8,000 by December 2000.

San Mateo County							
	March 1995	January 1996	January 1997	January 1998	January 1999	January 2000	December 2000
Total Family-Based Enrollment	28,472	27,379	24,778	20,702	17,760	16,989	18,993
Cash Categories	17,723	16,550	13,188	9,389	6,105	5,011	3,933
Non-Cash Categories	10,749	10,829	11,590	11,313	11,655	11,978	15,060
Medically Needy	5,346	5,098	5,166	5,008	5,089	3,208	1,738
Edwards	1,553	1,696	1,803	1,444	916	780	682
200% Program for Pregnant Women and Infants	1,619	1,551	1,851	2,001	2,208	2,472	2,410
133% Program (1-5 year olds)	1,366	1,579	1,575	1,676	1,796	1,808	1,331
100% Program (6-18 year olds)	233	303	424	526	840	1,001	576
1931(b)-Only	0	0	0	0	92	2,381	7,982
Transitional Medi-Cal	632	602	771	658	714	328	341
March 1995 - December 2000 Replacement Rate 31.3%							

More recently, county officials have begun taking steps to boost coverage. A state outreach grant was used to outstation county staff in clinics and to promote coverage at community events. Staff of the county-run health plan for Medi-Cal recipients began to contact families who had left cash assistance that were not enrolled in Medi-Cal to encourage them to re-enroll. While many could not be reached, county staff report that a substantial fraction did receive renewed coverage through this effort.

Staff also note that the complexity of Medi-Cal application procedures and quarterly income and status reports discourage participation.²¹ The state's confusing and often contradictory instructions for implementing 1931(b) Medi-Cal as well as the manual processing required for determining 1931(b) eligibility were also cited as obstacles to the county's efforts.

Santa Clara County

Santa Clara County's replacement rate was 36.8 percent, ranking 44th overall and last among urban counties. In Santa Clara County, total family-based Medi-Cal enrollment declined by a third, from 119,289 to 79,513, between March 1995 and December 2000. Cash-related Medi-Cal enrollment declined by over two-thirds (69.0 percent), a much sharper drop than the 46.8 percent decline statewide. Non-cash enrollment increased by 83.0 percent, as compared to a 125.7 percent rise statewide, but the increase was not nearly enough to offset the decline in cash-related enrollment.

Unlike many counties, Santa Clara County followed the state's instructions to hold welfare leavers in the Edwards category, and the county's Edwards enrollment increased more than four-fold in 1998. Enrollment in 1931(b)-Only Medi-Cal began in November 1998, and increased to 35,707 by December 2000. The county completed processing its Edwards backlog in early 2000.

Santa Clara County							
	March 1995	January 1996	January 1997	January 1998	January 1999	January 2000	December 2000
Total Family-Based Enrollment	119,289	113,222	100,731	84,376	82,541	80,234	79,513
Cash Categories	91,315	85,154	72,677	54,609	43,278	36,390	28,333
Non-Cash Categories	27,974	28,068	28,054	29,767	39,263	43,844	51,180
Medically Needy	17,964	16,177	15,738	15,198	14,787	8,643	4,778
Edwards	2,557	2,918	2,595	3,197	16,002	6,249	2,008
200% Program for Pregnant Women and Infants	2,450	2,528	2,532	2,682	2,861	3,298	2,731
133% Program (1-5 year olds)	2,226	2,714	2,738	2,873	3,175	3,169	1,653
100% Program (6-18 year olds)	368	599	838	1,042	1,946	2,130	921
1931(b)-Only	0	0	0	0	232	18,367	35,707
Transitional Medi-Cal	2,409	3,132	3,613	4,775	260	1,988	3,382
March 1995 - December 2000 Replacement Rate				36.8%			

Santa Clara County employees cite many of the same difficulties as other counties in adjusting to the new 1931(b) program. Implementation of the new, complex program coincided with implementation of CalWORKs and increasing specialization by CalWORKs and Medi-Cal eligibility workers. The eligibility process for 1931(b) Medi-Cal is not automated, so workers must complete several manual budgets as part of each application. In addition, when the county began to process its Edwards backlog by mailing out redetermination packets, early response rates were only 15 or 20 percent. In response, the county created a special temporary unit for outreach and retention, contacted clients in the Edwards caseload by telephone, and offered after hours appointments with eligibility workers. Response rates rose to 40 or 45 percent. This year, the county is in the process of restructuring the duties and responsibilities of Medi-Cal and CalWORKs workers to include greater attention to Medi-Cal enrollment and retention.²² The county also implemented a significant child health coverage initiative in 2001.

Los Angeles County

Los Angeles County's replacement rate, 134.1 percent, was the highest of all counties and much higher than the statewide rate of 84.7 percent. In Los Angeles County, total family-based Medi-Cal enrollment increased by over 114,429 between March 1995 and December 2000. Cash-related Medi-Cal enrollment declined by over 335,707, or 39.0 percent compared to 46.8 percent statewide. This decline was more than offset by an increase in non-cash-related enrollment of about 450,136, or 142.0 percent, compared to 125.7 percent statewide. A spike in Edwards enrollment occurred during 1998 and early 1999 as the county placed welfare leavers in Edwards before implementing 1931(b) Medi-Cal. The county had 441,518 persons enrolled in 1931(b) Medi-Cal in December 2000.

Los Angeles County responded to declining Medi-Cal enrollment earlier than did many other counties, largely in response to pressure from local health advocates and the County Board of Supervisors. In response to a 1997 mandate from the County Board of Supervisors to enroll 100,000 children in Medi-Cal in two years, the county sent eligibility workers out to churches, schools, and community events and met the target ahead of schedule. When welfare reform was implemented, the county formed a Medical Care Access Work Group involving social services, health, and mental health department staff; school districts; managed care plans; and community organizations to investigate barriers to access and plan enrollment and retention efforts. County staff joined with community organizations to seek state

Los Angeles County							
	March 1995	January 1996	January 1997	January 1998	January 1999	January 2000	December 2000
Total Family-Based Enrollment	1,178,156	1,114,639	1,105,397	1,015,009	1,084,565	1,200,770	1,292,585
Cash Categories	861,261	860,873	827,892	751,815	676,617	593,074	525,554
Non-Cash Categories	316,895	253,766	277,505	263,194	407,948	607,696	767,031
Medically Needy	142,211	128,698	131,969	121,194	122,974	127,422	116,118
Edwards	112,483	54,023	64,092	51,209	163,770	58,743	82,656
200% Program for Pregnant Women and Infants	32,184	31,763	32,627	32,629	38,564	46,820	45,207
133% Program (1-5 year olds)	22,755	28,499	31,523	33,679	42,709	52,382	41,110
100% Program (6-18 year olds)	2,910	5,093	8,137	11,643	26,831	42,957	37,700
1931(b)-Only	0	0	0	0	371	277,422	441,518
Transitional Medi-Cal	4,352	5,690	9,157	12,840	12,729	1,950	2,722
March 1995 - December 2000 Replacement Rate				134.1%			

outreach contracts for 1931(b) Medi-Cal and for Healthy Families. Continued community outreach efforts targeted various ethnic communities, as well as CalWORKs and food stamps clients. Outreach to non-English speaking individuals included distribution of a brochure on health coverage options that was translated into 11 languages. Local advocates cite the creativity and commitment of county Department of Public Social Services' staff as factors that led to the county's successful enrollment efforts.

In order to process the backlog of Edwards cases that built up after the implementation of CalWORKs, the county set up a new processing center and hired as many as 100 new eligibility workers. In addition to mailing redetermination packets, staff made after hours phone calls, compared records with managed care plans to get more recent contact information, and coordinated efforts with the state-funded outreach programs. County officials estimate that over two-thirds of Edwards clients completed the redetermination process and were placed into 1931(b)-Only Medi-Cal.

The county also made procedural accommodations intended to maximize enrollment and retention, such as requiring second reviews of all terminated cases and determining eligibility using information from other available sources, including the food stamp system, before requesting additional documentation from clients. In 2001, the county is piloting a "paperless" redetermination system, in which clients' income will be verified using electronic data available to the state, eliminating burdensome documentation requirements.²³

Los Angeles County's Medicaid Waiver

Los Angeles County's Section 1115 Medicaid waiver, approved in 1996, expanded the types of expenditures that qualified for federal matching funds and changed the county's system of delivering care to Medi-Cal eligible populations. The first waiver expired in June 2000 and was amended and renewed for an additional five years.

Although the first waiver changed how the county was reimbursed for providing Medi-Cal services, its impact on Medi-Cal enrollment was limited. The waiver's intent was to assist the county's fiscally distressed health system, not to alter county policies for Medi-Cal outreach, enrollment, or retention.

The second waiver, approved in 2000, includes specific Medi-Cal enrollment targets and financial sanctions if the county fails to meet them. It also requires the state to conduct studies of individuals who lose Medi-Cal to identify barriers to participation and develop procedures to address these barriers.

Tulare County

Tulare County's replacement rate, 112.5 percent, was the fourth highest in the state and much higher than the statewide rate of 84.7 percent. In Tulare County, total family-based Medi-Cal enrollment increased by 2,992 between March 1995 and December 2000. Cash-related Medi-Cal enrollment declined by 23,929, or 41.8 percent compared to 46.8 percent statewide. This decline was more than offset by an increase in non cash-related enrollment of 26,921, or 176.3 percent, compared to 125.7 percent statewide. Edwards enrollment increased significantly during 1998, as the county maintained enrollment of individuals leaving welfare in Edwards prior to implementing 1931(b) Medi-Cal. By December 2000, 1931(b) enrollment reached nearly 31,731, posting large gains in 1999 and 2000.

Tulare County							
	March 1995	January 1996	January 1997	January 1998	January 1999	January 2000	December 2000
Total Family-Based Enrollment	72,571	71,665	71,500	65,713	68,684	67,942	75,563
Cash Categories	57,302	55,087	53,068	46,529	41,289	36,518	33,373
Non-Cash Categories	15,269	16,578	18,432	19,184	27,395	31,424	42,190
Medically Needy	9,508	9,584	10,293	9,906	11,078	5,463	2,308
Edwards	2,146	2,525	2,541	2,851	8,696	3,972	2,224
200% Program for Pregnant Women and Infants	1,366	1,343	1,429	1,606	1,696	1,925	1,687
133% Program (1-5 year olds)	1,191	1,450	1,553	1,764	2,189	2,294	1,188
100% Program (6-18 year olds)	260	444	620	847	1,764	2,311	1,183
1931(b)-Only	0	0	0	0	338	14,711	31,731
Transitional Medi-Cal	798	1,232	1,996	2,210	1,634	748	1,869
March 1995 - December 2000 Replacement Rate				112.5%			

Tulare County's relatively high replacement rates appear to be due to a variety of factors, including a strong commitment among county offices to ensuring continued coverage. County staff attempted to call every person who left cash assistance to determine their Medi-Cal eligibility. The county has also outstationed Medi-Cal eligibility workers in community clinics and contracted with private organizations to extend education and outreach efforts to schools and rural areas. In addition, the county made a commitment to ensure that workers outstationed in clinics or engaged in outreach in rural areas were bilingual in Spanish and English.

ROOM FOR IMPROVEMENT: OVER ONE MILLION UNINSURED CALIFORNIANS ARE ELIGIBLE FOR MEDI-CAL

More than six million Californians lacked health coverage in 2000, nearly one out of five of the state's residents.²⁴ Rates of uninsurance are much higher among those with incomes at or near the poverty line. More than one in four children (27 percent) and half of adults (51 percent) living below the poverty line are uninsured; 24 percent of children and 39 percent of adults between 100 and 249 percent of the federal poverty level are uninsured.²⁵

Much more remains to be done. Many of California's uninsured are eligible for, but not enrolled in, public programs providing coverage. An estimated 726,000 uninsured children and 685,000 uninsured

adults are eligible for Medi-Cal, with another 535,000 uninsured children eligible for the Healthy Families program.²⁶ The recent Medi-Cal enrollment trends documented in this report, as well as the state's increase in job-based coverage, are promising. Since the implementation of the state's new welfare program in January 1998, enrollment gains in non-cash-related Medi-Cal categories have exceeded the drop in cash-related coverage. However, these gains are not uniform, and in many counties the drop in cash-related enrollment significantly exceeds the gain in non-cash coverage. There is tremendous variation among California's 58 counties in eligibility procedures and enrollment trends. This variation lends credence to claims that the state could improve monitoring of county practices and outcomes. Our analysis suggests that county policies and attitudes toward enrollment can play a significant role in determining whether families obtain and maintain Medi-Cal coverage. State policy changes can make it easier for counties to boost enrollment and maximize the use of federal matching funds to reduce the number of California's uninsured.

STRATEGIES FOR BOOSTING COVERAGE

The case studies described above, as well as other research, identify a number of strategies that can be used to boost enrollment in the Medi-Cal and Healthy Families Programs:²⁷

Counties with high replacement rates made maintaining and increasing coverage a major priority.

Strong leadership can help ensure that eligible families receive the Medi-Cal coverage they are entitled to. In counties with high replacement rates, this message often originated with the key department heads and/or elected officials. In particular, counties with strong cooperation between county health and social services departments tended to have higher replacement rates.

- Counties should encourage communication and cooperation between health and social service departments.
- Strong leadership, at both the state and local levels, can convey the message that Medi-Cal can be an essential support for low income working families. The goal of maintaining health coverage should not be viewed as conflicting with welfare reform's goal of transitioning families to employment.

Counties should use every available opportunity to encourage families leaving welfare to maintain health coverage. Counties should aggressively seek to ensure that families have health coverage when they leave welfare for work. Studies suggest that many "welfare leavers" obtain jobs without employer provided coverage. The new 1931(b) and Transitional Medi-Cal programs are designed to ensure that families do not lose coverage when they leave welfare for work. Enrollment remains particularly low in Transitional Medi-Cal, which provides health coverage to individuals whose income rises above the eligibility limit for other programs. Further research is needed to determine why utilization of this program remains low.

- Additional research is needed to determine the extent to which individuals leaving welfare for work obtain job-based health coverage, whether job-based benefits include dependents, and whether the cost of job-based coverage presents a financial barrier to enrollment or utilization.
- Counties should consider reviewing the cases of all families leaving welfare and Medi-Cal to ensure that all possible categories of continued coverage have been considered. Washington State, for example, conducts a daily audit of closed cases to determine whether Medicaid eligibility was appropriately considered.
- Counties should use income reporting and eligibility data from other programs, such as Food Stamps and the National School Lunch Program, to identify individuals who may qualify for, but who are not currently enrolled in, Medi-Cal.

Increase outreach efforts. A large number of California's uninsured are eligible for, but not enrolled in, Medi-Cal or the Healthy Families Programs, including families that lost coverage when they left the welfare rolls. Promising outreach strategies include the use of bilingual staff and programs that collaborate with schools and community clinics.

- Additional work is needed to reassure immigrants and immigrant communities that they are eligible for Medi-Cal, and that Medi-Cal enrollment will not jeopardize their immigration status. Outreach efforts on the so-called "public charge" issue should be conducted in languages other than English.

Foster simplicity. Many observers cite the complexity of the Medi-Cal application form and the burden of the previously required quarterly reports as barriers to enrollment. The state should continue efforts aimed at simplifying application forms and procedures, including "express lane" eligibility, which links health coverage to participation in other programs such as the school lunch program, and streamlined income verification procedures.

Improve computer support for county caseworkers. County officials identify inadequate computer support systems as a barrier to encouraging enrollment. Automated redetermination systems could expedite enrollment and help caseworkers catch errors that may delay coverage. Improved systems could also help identify families that are eligible for, but not enrolled in, Medi-Cal who are receiving other county services.

- The state should build on the promising Health-e-App model, a web based Medi-Cal and Healthy Families Program application, to improve automation of the Medi-Cal application and redetermination processes. Preliminary research suggests that automated systems can reduce error rates and expedite enrollment.²⁸

Remove barriers to coverage. Currently, adults applying for Medi-Cal are subject to assets limits, while children applying for Medi-Cal or the Healthy Families Program are not. The assets test prevents families with very low incomes from obtaining coverage if they have even minimal savings, and adds complexity to the application process.

- At least 17 states have eliminated resource limitations on families applying for Medicaid. Research suggests that eliminating the assets test creates administrative savings and greatly simplifies the application process.²⁹ While California has eliminated the assets test for children, it remains a barrier to enrolling low income adults in Medi-Cal. The current test imposes strict limits on the resources, such as automobiles or savings for a child's education, that families can have and still qualify for coverage.

APPENDIX I: CONSTRUCTING “CASH-RELATED” AND “NON-CASH-RELATED” CATEGORIES

This paper categorizes California Department of Health Services’ (DHS) enrollment data into two primary categories: cash-related and non-cash-related. The analysis excludes individuals who were not enrolled in family-based Medi-Cal categories, including individuals receiving coverage in aged and disabled eligibility categories, in order to focus on caseload changes associated with the implementation of welfare reform.

Cash-related eligibility categories: In California, individuals who receive cash assistance and are found eligible are enrolled in the Medi-Cal program under a specific set of eligibility categories. As cash assistance caseloads drop in California, we would expect enrollment numbers in these Medi-Cal categories to drop, as well. (Aid codes included: 30, 32, 33, 35, 3E, 3G, 3H, 3L, 3M, 3P, 3R, 3U.)

Non-cash-related eligibility categories: Adults and children in low income families in California who do not receive cash assistance may be eligible for Medi-Cal under any one of the following categories:

- **1931(b)-Only Medi-Cal:** Section 1931(b) Medi-Cal was created in the 1996 federal welfare reform law and intended to ensure that new restrictions on cash assistance would not cause families to lose their health coverage. The 1931(b)-Only Medi-Cal category covers families who meet the eligibility requirements for cash assistance, but choose not to apply; families who have reached the time limits for cash assistance; and families who are not eligible for CalWORKs but would have been eligible for AFDC.³⁰ California began to enroll families in 1931(b)-Only Medi-Cal in early 1999. Beginning in March 2000, eligibility for 1931(b)-Only Medi-Cal was expanded to include all families with incomes up to 100 percent of the federal poverty level (FPL). As a result, this category expanded to include newly eligible parents and their children, who were shifted into 1931(b)-Only from other programs. (Aid codes included: 3N, 3V.)
- **Edwards:** When families leave cash assistance, they continue to receive coverage in a temporary holding category called “Edwards,” usually for one to two months, until the county evaluates whether they are eligible for Medi-Cal under any other category. Starting in January 1998, the DHS instructed counties to leave parents and children in the Edwards category until final 1931(b) eligibility rules were released. Enrollment in the Edwards category increased dramatically in 1998 and early 1999. (Aid code included: 38.)³¹
- **Transitional Medi-Cal:** Families leaving cash assistance for work generally remain eligible for Medi-Cal at least for a limited period under Transitional Medi-Cal (TMC).³² TMC provides up to 24 months of coverage to families who lose their eligibility for regular Medi-Cal due to increased earnings. (Aid codes included: 39, 3T, 54, 59, 5T, 5X, 5Y.)
- **Federal Poverty Level Programs:** Even when TMC is not available, many of the children in low income families remain eligible for Medi-Cal simply by meeting an income test. The “100 percent” category covers children ages 6 through 18 with a family income up to 100 percent of the FPL, while the “133 percent” category covers children ages 1 through 5 with a family income up to 133 percent of the FPL. Pregnant women and infants are eligible for Medi-Cal under the “200 percent” program if they have a family income up to 200 percent of the FPL. (Aid codes included: 100 percent: 7A, 7C, 8R, 8T; 133 percent: 72, 74, 8N, 8P; 200 percent: 44, 47, 48, 69, 76, 7F, 7G.)
- **Medically Needy:** California has a “medically needy” eligibility category for families with children. The Medically Needy category generally covers families whose income is too high to

qualify for cash assistance. A share of cost requirement applies to some families qualifying as Medically Needy based on family income. To qualify as Medically Needy, families must meet the AFDC deprivation requirements, which primarily limit coverage to single parent families or families with an incapacitated spouse, and income and resource tests.³³ Beginning in March 2000, many families that formerly qualified for coverage as Medically Needy became eligible for 1931(b) Medi-Cal-Only coverage under the expanded income eligibility standard. Coverage under the 1931(b) category is advantageous to families, since it requires no share of cost and provides eligibility for Transitional Medi-Cal for families whose incomes rise. Thus, enrollment in the Medically Needy category would be expected to decline. (Aid code included: 34.)

APPENDIX II:

Family-Based Medi-Cal Replacement Rates					
County	Type	Overall: 3/95-9/00	Phase I: 3/95-1/98	Phase II: 1/98-4/99	Phase III: 4/99 - 12/00
State		84.7%	6.8%	116.9%	163.0%
State w/o LA		66.9%	21.3%	81.3%	127.7%
Alameda	Urban	64.0%	6.0%	154.5%	69.9%
Alpine	Rural	74.1%	120.8%	-500.0%	n/a
Amador	Rural	77.0%	92.2%	136.0%	39.6%
Butte	Rural/City	54.7%	66.4%	63.0%	34.7%
Calaveras	Rural	74.9%	81.2%	49.0%	90.9%
Colusa	Rural	58.7%	46.7%	25.5%	198.3%
Contra Costa	Suburban	68.1%	23.8%	124.2%	81.7%
Del Norte	Rural	62.8%	109.8%	13.1%	62.8%
El Dorado	Suburban	35.7%	21.4%	22.0%	92.0%
Fresno	Rural/City	111.7%	30.1%	134.6%	223.0%
Glenn	Rural	27.8%	39.5%	21.1%	9.8%
Humboldt	Rural/City	55.3%	62.3%	41.1%	56.0%
Imperial	Rural	80.0%	59.6%	73.6%	104.5%
Inyo	Rural	57.9%	110.8%	9.5%	73.7%
Kern	Rural/City	108.8%	111.0%	34.1%	169.1%
Kings	Rural	94.7%	54.0%	59.0%	221.9%
Lake	Rural	44.5%	21.6%	85.8%	36.2%
Lassen	Rural	35.7%	30.1%	56.1%	31.8%
Los Angeles	Urban	134.1%	-49.1%	208.3%	234.3%
Madera	Rural/City	57.6%	184.8%	59.7%	-37.7%
Marin	Suburban	29.0%	31.5%	-21.4%	72.0%
Mariposa	Rural	34.6%	76.1%	11.3%	-3.7%
Mendocino	Rural	45.0%	70.8%	42.8%	4.2%
Merced	Rural/City	77.8%	16.6%	28.9%	235.0%
Modoc	Rural	26.2%	-61.8%	100.0%	-38.4%
Mono	Rural	43.5%	77.6%	37.1%	6.8%
Monterey	Rural/City	72.8%	-1.9%	201.9%	116.6%
Napa	Suburban	44.1%	35.5%	53.8%	51.1%
Nevada	Rural	25.0%	20.0%	57.4%	-11.9%
Orange	Suburban	87.0%	-4.0%	68.7%	404.8%
Placer	Suburban	25.0%	1.7%	144.6%	-67.5%
Plumas	Rural	5.8%	-54.4%	56.7%	23.1%
Riverside	Suburban	74.6%	15.0%	101.5%	120.6%
Sacramento	Urban	81.8%	34.3%	97.7%	108.5%
San Benito	Rural	30.0%	58.7%	72.9%	-92.2%
San Bernardino	Suburban	49.7%	12.5%	30.7%	193.8%
San Diego	Urban	48.5%	5.8%	107.8%	51.5%
San Francisco	Urban	69.4%	-6.5%	92.0%	167.5%
San Joaquin	Rural/City	44.8%	52.7%	42.6%	36.4%
San Luis Obispo	Rural/City	80.9%	18.0%	23.8%	260.5%
San Mateo	Suburban	31.3%	6.8%	12.1%	174.1%
Santa Barbara	Suburban	115.6%	13.2%	106.9%	347.4%
Santa Clara	Urban	36.8%	4.9%	89.3%	74.1%
Santa Cruz	Suburban	59.8%	-4.4%	50.7%	206.5%
Shasta	Rural/City	54.6%	123.3%	42.0%	13.7%
Sierra	Rural	19.5%	-16.7%	176.0%	-76.5%
Siskiyou	Rural	46.4%	28.4%	50.4%	74.4%
Solano	Suburban	63.3%	64.3%	44.6%	73.9%
Sonoma	Suburban	37.8%	6.7%	95.1%	16.8%
Stanislaus	Rural/City	72.0%	45.8%	38.9%	173.5%
Sutter	Rural	82.5%	36.6%	213.2%	83.5%
Tehama	Rural	42.1%	52.8%	43.6%	14.8%
Trinity	Rural	33.9%	53.0%	84.0%	-15.7%
Tulare	Rural/City	112.5%	36.3%	170.7%	177.6%
Tuolumne	Rural	56.2%	65.5%	44.6%	50.1%
Ventura	Suburban	115.5%	28.5%	45.7%	378.2%
Yolo	Suburban	64.2%	26.0%	33.5%	131.1%
Yuba	Rural	24.4%	43.4%	-34.7%	12.6%

ENDNOTES

¹ Medi-Cal provides health coverage to low income individuals and persons with limited ability to pay for health coverage, including the aged, blind, disabled, families, children, pregnant women, and individuals with specific health care needs. The federal and state governments jointly fund Medicaid. Individuals receiving federally-funded cash assistance automatically receive Medi-Cal. Federally-funded cash assistance includes CalWORKs (formerly AFDC), Supplemental Security Income (SSI/SSP), foster care, adoption assistance, and certain refugee assistance programs. This report looks only at family-based coverage and excludes individuals receiving coverage in categories linked to age, disability, foster care, adoptions assistance, or refugee status. For a full review of Medi-Cal eligibility, see Claudia Page and Susan Ruiz, *The Guide to Medi-Cal Programs: A Description of Medi-Cal Programs, Aid Codes, and Eligibility Groups* (Medi-Cal Policy Institute, 1999).

² Medi-Cal Policy Institute, "Section 1931(b) Medi-Cal," *Medi-Cal Facts*, Number 7 (January 1999).

³ See Leighton Ku and Bowen Garrett, *How Welfare Reform and Economic Factors Affected Medicaid Participation* (Urban Institute, February 2000); Families USA, *Go Directly to Work, Do Not Collect Health Insurance: Low-Income Parents Lose Medicaid* (June 2000); and Jocelyn Guyer, *Uninsured Rate of Poor Children Declines, But Remains Above Pre-Welfare Reform Levels* (Center on Budget and Policy Priorities, September 29, 2000).

⁴ E. Richard Brown, et al., *The State of Health Insurance in California: Recent Trends, Future Prospects* (UCLA Center for Health Policy Research, 2001), p. 4.

⁵ California's welfare (AFDC and CalWORKs) caseloads fell by 44.8 percent between March 1995 and December 2000.

⁶ This report uses the Department of Health Services' data set "Counts of Medi-Cal Beneficiaries by County, Aid Code, and Month," updated May 2001. Retroactive enrollment procedures alter several months of DHS beneficiary counts when the data is updated each month. To limit, but not eliminate, the distortions caused by this retroactive adjustment, the CBP only analyzed data through December 2000. Appendix I describes how data were combined into cash-related and non-cash-related categories.

⁷ The 1931(b)-Only category was created as part of the 1996 federal welfare reform law, the Personal Responsibility and Work Opportunity Reconciliation Act, as a means of providing Medicaid coverage to individuals who would have qualified for welfare under the old system, but who are not receiving cash assistance. The Edwards category is used to provide temporary coverage to individuals while their eligibility for other Medi-Cal categories is determined.

⁸ A replacement rate of greater than 100 percent indicates that the gain in the number of eligible families enrolled in Medi-Cal exceeded the drop in cash-based enrollment, and reflects the fact that many individuals are eligible for, but not enrolled in, Medi-Cal. A negative replacement rate indicates that non-cash enrollment declined over the period examined, as did cash-related enrollment.

⁹ From March 1995 to December 2000, Los Angeles County's overall replacement rate was the highest in the state and the county accounted for 38.4 percent of the state's family-based Medi-Cal enrollment in December 2000. In order to illustrate trends in the 57 smaller counties, as well as those for the state as a whole, this report includes data for the state, for the state excluding Los Angeles County, and for individual counties.

¹⁰ Significant policy changes include extending eligibility to parents in families with incomes of up to 100 percent of the federal poverty level and eliminating the assets test for children.

¹¹ Western Center on Law and Poverty, "Section 1931(b) Medi-Cal for Certain Low Income Families," *CalWORKs: A Comprehensive Guide to Welfare and Related Medi-Cal Issues for California Families*, Chapter VIII, Section D, downloaded from www.wclp.org. Some Medi-Cal enrollees are required to pay a share of cost. Individuals leaving cash assistance should generally be placed into the 1931(b)-Only category, then the Transitional Medi-Cal program, neither of which require payment of a share of cost.

¹² The relationship between replacement rates and other factors was explored using the statistical technique known as regression analysis. Regression analysis is used to assess the strength and nature of the relationship between the values of different variables. The results of the regression analysis are significant with $p \leq .05$. This means that the likelihood of the associations occurring by chance is less than or equal to 5 percent. Relationships cited below were significant at the .05 level.

¹³ The Healthy Families Program was established as California's version of the federal State Children's Health Insurance Program (SCHIP).

¹⁴ Rates of job-based insurance by county were obtained from E. Richard Brown, PhD, et al., *The State of Health Insurance in California: Recent Trends, Future Prospects* (UCLA Center for Health Policy Research, March 2001). The rate of uninsurance and job-based coverage was available for 30 counties. Due to the method used to derive the estimates of job-based coverage and uninsurance, the margin of error in these estimates is relatively large.

¹⁵ Anne Moses, David C. Mancuso, and Charles Lieberman, *Examining Circumstances of Individuals and Families Who Leave TANF: Assessing the Validity of Administrative Data, 12-Month Report*, Burlingame, CA: Sphere Institute (December 2000).

¹⁶ Deana Goldsmith and Lisa Evans, *Evaluation of the Napa County CalWORKs Program: Participant Outcomes and Post Program Experiences*, (Berkeley Planning Associates, October 15, 1999).

¹⁷ Bowen Garrett and John Holahan, *Welfare Leavers, Medicaid Coverage, and Private Health Insurance* (Urban Institute, March 2000).

¹⁸ More recently, the state has taken a number of steps to simplify the application process.

¹⁹ All County Letters are directives issued by the state to counties to provide official notification of changes in policies and procedures.

²⁰ The CalWORKs program includes a diversion component that provides families with one-time assistance in order to keep

families from going on cash assistance. Families that opt for diversion assistance can receive Medi-Cal coverage if they are eligible.

²¹ AB 2877 of 2000 eliminated quarterly status reporting effective January 1, 2001.

²² Conversation with Santa Clara County staff (April 2001).

²³ Conversation with Los Angeles County staff (April 2001).

²⁴ US Bureau of the Census, *Table HI-4 Health Insurance Coverage Status and Type of Coverage by State All People 1987 to 2000* (September 28, 2001).

²⁵ E. Richard Brown, PhD, et al., *The State of Health Insurance in California: Recent Trends, Future Prospects* (UCLA Center for Health Policy Research, March 2001), p. 4.

²⁶ E. Richard Brown, PhD, et al., *The State of Health Insurance in California: Recent Trends, Future Prospects* (UCLA Center for Health Policy Research, March 2001).

²⁷ While eligibility for Healthy Families is currently limited to children, the state has requested a waiver to extend eligibility to parents of eligible children in families with incomes of up to 200 percent of the FPL, and recent legislation would extend eligibility to parents in families with incomes of up to 250 percent of the FPL.

²⁸ Bob Atlas, et al., *Business Case Analysis of health-e-app* (The Lewin Group, June 2001).

²⁹ Vernon K. Smith, et al., *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences* (Kaiser Commission on Medicaid and the Uninsured, April 2001).

³⁰ All families with children who receive CalWORKs receive their Medi-Cal under cash-based Section 1931(b) and are included in the cash-related categories for purposes of this analysis. For a description of Medi-Cal aid categories and eligibility, see the Medi-Cal Policy Institute's *The Guide to Medi-Cal Programs* (1999).

³¹ Medi-Cal Policy Institute, "Section 1931(b) Medi-Cal," *Medi-Cal Facts*, Number 7 (January 1999).

³² Families technically now qualify for TMC when they otherwise would lose their eligibility for Medicaid under Section 1931 due to earnings. However, the Section 1931 and TANF eligibility rules in California are sufficiently similar that most families leaving welfare for work will also simultaneously leave regular Medi-Cal for TMC.

³³ As of March 1, 2000, two-parent families meet the deprivation test if the combined family income is at or below 100 percent of poverty.