



The Affordable Care Act and Children's Coverage in California

OUR PROGRESS AND OUR FUTURE

The Children’s Partnership is a California-based nonprofit children’s advocacy organization committed to improving the lives of children where they live, learn, and play. Our mission is to better the health and well-being of underserved children through strong community partnerships, forward-looking research, and informed policy. We build meaningful partnerships with communities and decision-makers to provide a powerful voice for children and champion programs and policies that break down barriers to advancement. Since 1993, TCP has been a leading voice for children and a critical resource for communities across California, working every day to provide all children with the resources and opportunities they need to thrive.

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Foreword

Over the past six years, the Affordable Care Act (ACA) and subsequent efforts to build on its impact have made incredible improvements in the lives of tens of millions of Americans. As a result, health insurance is fairer, more affordable, and more accessible across the country. In California, one of the greatest success stories for health reform, the law has opened doors to coverage for over six million consumers. California was the first state in the nation to enact legislation creating a health insurance marketplace, Covered California, and an early adopter of the Medicaid expansion to ensure more low-income Californians enrolled in coverage. In taking a lead on implementation, California has put the needs of consumers first and provided greater security for children and families.

Providing quality health insurance and care is an investment in the future of our children and provides a foundation for children to succeed in school and life. Before the passage of the ACA, uninsured rates had been falling for children nationwide. Between 1997 and 2015, the national rate of uninsured children fell more than 65 percent from 14.9 percent to 4.8 percent. Increases in public coverage through both Medicaid and the Children's Health Insurance Program (CHIP) placed a national focus on children's coverage and yielded tremendous success that created a foundation for the ACA. While the ACA created new coverage opportunities for the majority of the uninsured—primarily adults—these previous children's coverage successes should not be undermined but, instead, furthered.

Today, over 5.6 million children, more than half of California's children, are enrolled in Medi-Cal. Medi-Cal provides affordable health care to children who need it most—especially millions of children of color

who have historically faced disproportionately poorer health outcomes. A strong future for health care in America will build on the progress of the Affordable Care Act, but it also requires us to defend and enhance Medicaid and CHIP programs at the federal and state levels, given their historic success in providing child-specific health benefits to the nation's most vulnerable children.

At The Children's Partnership, we have proudly joined national and statewide partners to advocate critical health care reforms impacting millions of children and families, before and as part of the Affordable Care Act. As we reflect on these past six years and celebrate the incredible accomplishments to advance the health of American families, we will continue to serve as a voice for children and work to improve a system of coverage and care that serves our children and their specific needs. The pages that follow offer a look into the incredible progress California has made in health care reform and the future actions we must take to continue to support a healthy future for all California children. We look forward to continuing the work with our partners to make this a reality.



Mayra E Alvarez, MHA



Introduction

The Patient Protection and Affordable Care Act (ACA), enacted in March 2010, has powerful implications for the health and well-being of children and their families in California and across the country. In the past six years, the ACA has taken important steps toward providing Americans with quality, affordable health care, improving consumer protections, slowing health care cost growth, expanding covered benefits, and improving health care quality and delivery. Specifically, the ACA has increased the number of individuals who have access to health insurance, simplified enrollment, required that benefits include core essential health services, and has promoted innovations to help coordinate the fragmented delivery of care. Without a doubt, the law's enactment forever reshaped the nature of coverage and health care delivery for families and their children in the United States, including millions of children in California.

Six years after the ACA set into motion a series of game-changing reforms for health care, California's leadership in implementation has helped provide health

coverage to more families and children than ever before. California was the first state in the nation to enact legislation creating a health insurance marketplace,* an opportunity provided to states by the ACA. The creation of Covered California, the state-based marketplace, provided a place for Californians to shop for and buy affordable health coverage and has allowed California to lead the way in state efforts to implement the ACA. The State also chose early adoption of the Medicaid expansion under the ACA in order to ensure more low-income Californians were able to enroll in coverage while also claiming its share of federal health care dollars made available to states through the ACA.

While much attention has been paid to the enrollment and experience of adults under the ACA, the law has also had tremendous impact on children's health coverage and opportunities to improve the overall health of children in California. Children have reaped the benefits of enrollment simplifications, free preventive services, mandated essential pediatric health benefits (including pediatric oral and vision services), outreach and enrollment activities, and other provisions of the ACA. As a result of the State's leadership and commitment to expanding health coverage to its residents, 5.6 million children are currently covered through Medi-Cal, California's Medicaid program, and just over 70,000 children are covered through Covered California. This amounts to well over half of all California children.¹ Overall, the rate of uninsured Californians dropped from nearly 15 percent in 2009 to just under 12 percent in 2014.² For children, the uninsured rate dropped from 5.7 percent to 4.5 percent during the same period.³

Further, the expansion of Medi-Cal to low-income adults earning up to 138 percent of the federal poverty level (FPL) created a pathway for enrolling already eligible uninsured children into coverage. The ACA requires, as a condition to covering eligible parents in Medicaid, that those parents must also enroll their eli-

5.7 million
children in California
are enrolled in
either Medi-Cal or
Covered California—
more than half of all
children in the state.



*This document uses the term "marketplace" to refer to what are also known as the "Health Insurance Marketplace," "Health Benefit Exchange," or "Exchange." In some states, the marketplace is run by the state, such as Covered California in California. In others, the marketplace is run by the federal government (HealthCare.gov).

Major Children's Coverage Milestones: 2010–2016

POST-AFFORDABLE CARE ACT HEALTH CARE REFORMS

2010

MARCH 23, 2010

President Barack Obama signs the **Patient Protection and Affordable Care Act** into law.

SEPTEMBER 23, 2010

Significant reforms take effect, including:

- Children cannot be denied coverage for **pre-existing conditions**.
- Those under the **age of 26** can stay on their parents' insurance.
- **Lifetime limits** on coverage eliminated so those with chronic conditions or in need of costly treatment will be able to count on health coverage no matter the cost.
- Most health plans must cover a set of **preventive health services** for children at no cost.

SEPTEMBER 30, 2010

California passes legislation creating a **health insurance marketplace**—the first state in the country to do so.

NOVEMBER 12, 2010

California's **Bridge to Reform Medi-Cal Waiver** is approved to start local coverage for adults in advance of the ACA Medicaid expansion.

2012

OCTOBER 30, 2012

The newly established **DACA program** offers deportation relief and work authorization to certain undocumented immigrants. In California, approximately 125,000 young Californians with DACA are estimated to be eligible for Medi-Cal.

2013

JANUARY 1, 2013

California began consolidation of its stand-alone CHIP program, the Healthy Families Program, into **Medi-Cal**.

OCTOBER 1, 2013

Open enrollment for the California marketplace begins through **Covered California**.

2014

JANUARY 1, 2014

- **Covered California** insurance coverage begins.
- **Expanded Medi-Cal coverage** for adults with incomes up to 138% FPL takes effect.
- Beginning this year, all individuals must have health insurance or face a **tax penalty**.

FEBRUARY 2014

California offers **Express Lane Enrollment** for CalFresh enrollees to enroll in Medi-Cal.

2015

JANUARY 1, 2015

All children enrolled in Covered California plans are automatically enrolled in **dental coverage**.

APRIL 16, 2015

CHIP funding is extended through 2017 with an enhanced federal match.

JUNE 24, 2015

California expands Medi-Cal to **all children**, regardless of immigration status, to begin in May 2016.

DECEMBER 30, 2015

California's 1115 waiver renewal, "**Medi-Cal 2020**," is approved with provisions to help improve children's access to quality health and dental care.

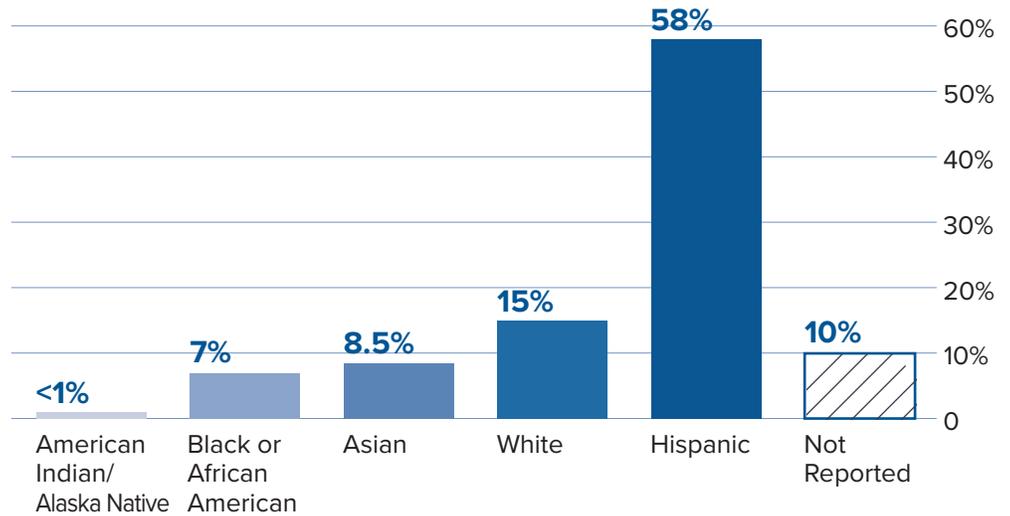
2016

MAY 16, 2016

Medi-Cal expands to **all children**, regardless of immigration status.

Racial Demographics of Children Enrolled in Medi-Cal

Note: Data compiled based on eligibility and enrollment data in Medi-Cal as of June 1, 2015, and includes children ages 0–20. N = 5,609,192. Source: California Department of Health Care Services, “Medi-Cal Children’s Health Dashboard,” March 2016, accessed April 12, 2016, www.dhcs.ca.gov/services/Documents/March_2016_Pediatric_Dashboard.pdf.



gible children.⁴ Studies show that increasing coverage for parents also increases the number of children with health coverage, creating what’s known as a “welcome mat” effect for children.⁵ This proved particularly true in California’s expansion of Medi-Cal to low-income adults. In the first year of open enrollment, nearly 80,000 children enrolled in Covered California, while about 500,000 children enrolled in Medi-Cal (October 2013 to September 2014), demonstrating the critical role Medi-Cal plays in the health care system for California’s children.⁶

There is no better population to examine than children when considering the promise of the ACA, for the changes to health coverage and delivery will have an impact on their health for a lifetime. This report provides a review of the major impacts ACA reforms have had on California children’s coverage through Medi-Cal and Covered California* since the passage of the ACA in 2010, as well as additional coverage reforms that the State chose to implement independent of the ACA during the same time period. Specifically, this

report highlights what the progress made possible by the ACA has meant for the health of children as well as policy solutions to make further progress. The report also provides actionable recommendations for the future related to: eligibility for coverage, health care benefits for children, the affordability of coverage, how families enroll in and renew coverage, and how families are using their coverage and getting care for their children. In some cases, the major impacts affect children and adults similarly. In other cases, there are impacts specific to children and their unique health care needs. Recommendations are primarily California focused, but some federal recommendations are also included to underscore the nationwide impact of those issues. As we look forward, these findings help illustrate where we can help build consensus and public will to further the success of the ACA and continue to do what is best for the health and well-being of California’s children.

*This report does not examine the effects of reforms on children’s insurance in the individual and employer markets.

The Affordable Care Act: Improvements for Children’s Health Coverage

Prior to the ACA, most uninsured children were already eligible for coverage through existing programs but were not enrolled. However, major ACA policy changes to increase access to preventive services and improve care have broadly benefited children and their families in California. Across the nation, these improvements include:

- ▶ A comprehensive package of benefits, known as Essential Health Benefits (EHB), is the minimum that the ACA requires to be offered by non-grandfathered health plans in the individual and small group markets, both within and outside of the marketplaces. The ACA lists ten categories of benefits that must be part of the EHB package, among them “Pediatric services, including oral and vision care.” In 2015, California began requiring all health plans sold through Covered California to include pediatric dental benefits, meaning every child who enrolls in coverage through Covered California also has dental benefits.
- ▶ Free preventive services, such as well-child visits, immunizations, and developmental screenings for children, are required in most health plans.⁷ An estimated 2.2 million children in California gained preventive services coverage with zero cost sharing due to the ACA.⁸
- ▶ Young adults can stay on their parents’ health insurance plans until the age of 26. The ACA recognizes that young adults newly entering the work environment may have difficulty obtaining affordable, comprehensive coverage on their own, and that the cost of coverage can interfere with plans for college or embarking on a career.⁹ In 2011, over 435,000 California young adults under age 26 gained coverage as a result of this provision of the ACA.¹⁰
- ▶ States must provide Medicaid coverage to youth under age 26 if they were in foster care at age 18. This ensures that former foster youth can access the health care services they need, just as non-foster youth who can stay on their parents’ health insurance until age 26 are able to do. In California, about 12,000 youth formerly in foster care now have coverage through Medi-Cal as a result of this provision.¹¹
- ▶ Children and adults can no longer be denied coverage by health insurance companies for pre-existing health conditions, such as asthma and diabetes. Nearly 600,000 California children had pre-existing health conditions in 2010.¹² Families no longer have to worry about being denied coverage for those conditions.¹³
- ▶ Eligible low- and middle-income families have access to financial assistance when purchasing private insurance through federal and state marketplaces, such as Covered California, making coverage more affordable for more Californians. In June 2015, 90 percent of members in Covered California were eligible for subsidies.¹⁴
- ▶ The ACA maintained the Children’s Health Insurance Program (CHIP) through 2019. Maintaining CHIP’s comprehensive, child-specific benefits package and low to no cost sharing has been critical for children nationwide. Without the ACA’s commitment to CHIP, California children and all other CHIP children across the nation may have been the only population to have lost benefits.* CHIP, like Medicaid, is a proven success in providing child-specific coverage for millions of low- to moderate-income working families.

*In California, CHIP children are covered under Medi-Cal. Without a federal CHIP program and CHIP enhanced match, California would have to pay a greater share of the cost of the Medi-Cal coverage. If the State reversed course and moved back to a separate CHIP program, and if federal CHIP was not continued, California CHIP children would be moved into Covered California with lower benefits and greater cost sharing.

Coverage—Expand Eligibility & Cover Child-Focused Benefits

The first step to ensuring children can benefit from health reform is to ensure children are eligible for health coverage and that such coverage includes comprehensive and child-specific benefits. Widespread political support for the ACA in California gave the State early momentum to seize on opportunities to expand coverage provided by the law and use this momentum as an impetus for additional expansions in eligibility for coverage and creation of robust benefits. As a result of the culmination of coverage expansions during this period, all low- to moderate-income children* in California now have an affordable coverage option.

Eligibility

California was one of the initial states to take advantage of federal incentives to expand its Medicaid program to low-income adults. Under the ACA, states can expand Medicaid to adults with incomes at or below 138 percent of the federal poverty level (FPL). Coverage for these newly eligible adults is fully federally funded (100 percent federal match) for three years, phasing down to 90 percent by 2020. California's Medi-Cal expansion for adults began in January 2014. As of September 2015, about 3.2 million California adults were enrolled in Medi-Cal as a result of this

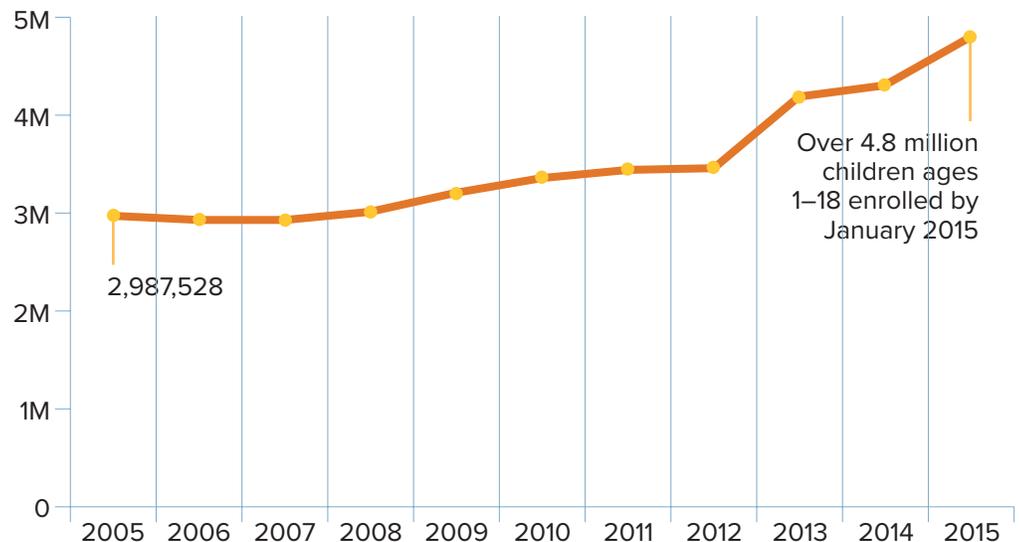
expansion.¹⁵ Not only are these adults finally able to get affordable health coverage, but many of their children were also enrolled, illustrating the “welcome mat” effect (described above).¹⁶

Like Medi-Cal, the federal Children's Health Insurance Program (CHIP) is a critical source of coverage for children. In 2015, CHIP was funded for an additional two years (through 2017). CHIP provides states with a set amount of funding that must be matched with state dollars to provide coverage to uninsured children and pregnant women who earn too much to qualify for traditional Medicaid. CHIP's federal match rate was enhanced as part of the ACA, bringing California's federal match rate up to 88 percent from 66 percent. In 2013, California consolidated its stand-alone CHIP program, known as the Healthy Families Program, into Medi-Cal, which brought over 750,000 Healthy Families children into Medi-Cal.¹⁷ Overall, federal CHIP funding covered over 1.2 million California children and pregnant women in 2015 and will remain a critical source of affordable and child-specific comprehensive benefits for children.¹⁸

*Certain California children still do not have affordable insurance options, namely undocumented immigrant children with incomes above the Medi-Cal income eligibility level and those offered parents' employer-based coverage that is not affordable and yet disqualifies them from getting Covered California coverage.

Trend in Medi-Cal's Child Population from 2005–2015, Ages 1–18

Source: California Department of Health Care Services, “Understanding Medi-Cal's Child Population,” October 2015, accessed April 12, 2016, www.dhcs.ca.gov/Documents/Medi-Cal_Utilization_Data_for_Children.pdf.



In addition to the expansion of Medi-Cal, California was the first state in the nation to enact legislation creating a health insurance marketplace—Covered California—offering affordable private insurance options to Californians. Federal tax credits are offered to help offset premium costs for qualified individuals with incomes up to 400 percent of the FPL. Additional assistance to reduce cost sharing is available for those with incomes between 100 and 150 percent of the FPL, which lowers the amount of out-of-pocket costs for deductibles, coinsurance, and copayments. Both children and adults are eligible for subsidies through Covered California if they meet the income guidelines, are US citizens or lawfully present, do not qualify for Medi-Cal, and are not offered what the ACA deems as “affordable” employer-sponsored insurance. Over 70,000 children were enrolled in Covered California as of June 2015, of which approximately 50,000 were receiving financial assistance.¹⁹

The creation of the marketplace has also had implications for existing California coverage options for pregnant women and their newborns. As with other adults in California, the State raised the Medi-Cal income eligibility level for pregnant women to get full-scope Medi-Cal benefits during their pregnancy from 60 percent of the FPL to 138 percent of the FPL.²⁰ This change in eligibility gave these women the option to stay on pregnancy-related Medi-Cal or to switch to the regular Medi-Cal program. While pregnancy-related Medi-Cal provides full health coverage benefits—not just a narrow set of prenatal and hospital labor and delivery services—it is delivered through a fee-for-service system, while regular Medi-Cal is predominantly delivered through managed care organizations. Pregnant women with incomes above 138 percent and below 213 percent of the FPL are eligible for pregnancy-related Medi-Cal. Previously, these pregnant women were eligible to enroll in both pregnancy-related Medi-Cal and Covered California during pregnancy, enabling them to receive both services related to their pregnancy and comprehensive health benefits. Now, eligible women enrolled in Covered California who become pregnant are informed of their eligibility for Medi-Cal but have the choice to remain in Covered California.²¹ Generally, if a person is eligible for Medi-Cal, they are not eligible for Covered California. The above scenario is an exception.

Beyond Medi-Cal expansion for childless adults and the availability of private coverage through Covered California, the State also provided youth under age 26 who were in foster care at age 18 an opportunity for coverage through Medi-Cal. This coverage opportunity ensures former foster youth can access the health

care services they need, just as non-foster youth who can stay on their parents’ health plans until age 26 are able to do. In California, about 12,000 youth formerly in foster care now have coverage through Medi-Cal as a result of this provision.²²

As coverage opportunities for the majority of Americans expanded under the ACA, California continued its coverage opportunities for those left out of the ACA, namely members of the immigrant community. With the creation of the federal Deferred Action for Childhood Arrivals (DACA) program, a new group of immigrant children qualified for Medi-Cal coverage in California. Beginning in 2012, the DACA program began offering deportation relief and work authorization to certain undocumented immigrants who arrived in the US as children and meet several other requirements relating to age, education, and residency.²³ Individuals with DACA are granted what is called Permanently Residing in the United States Under Color of Law (PRUCOL). In California, individuals with PRUCOL, who meet income and other qualifications, are eligible for Medi-Cal, which California pays for with state-only funds.²⁴ Approximately 125,000 young Californians with DACA are estimated to be eligible for Medi-Cal, but approximately 11,000* have enrolled as of 2014.²⁵

Furthering its commitment to Californians not covered by the ACA, the State went further in its efforts to cover immigrant children. Historically, many undocumented immigrant children received coverage through local county health insurance programs and Kaiser Permanente’s Child Health Program because these children were locked out of full-scope Medi-Cal. Over time, several local county programs have restricted their coverage population or shut down, due to funding challenges. To ensure all children have access to health coverage, Senate Bill (SB) 75 was signed into law as part of the 2015–2016 state budget. Beginning in May 2016, SB 75 expanded the Medi-Cal program to allow an estimated 170,000 to 250,000 income-eligible children,** regardless of immigration status, to qualify for full-scope Medi-Cal coverage (certain undocumented immigrants are currently eligible for restricted-scope Medi-Cal benefits). In providing health coverage for California’s undocumented immigrant children, the State cements its commitment to a statewide system of coverage for all low-income children in California.

*The UC Berkeley Labor Center assumes the 11,000 estimated enrollees based on increases in PRUCOL enrollment in 2014.

**UC Berkeley-UCLA CalSIM 1.91 estimates that 250,000 undocumented immigrant children will be newly eligible for full-scope Medi-Cal once the law is implemented. State budget estimates for FY16–17 assumed 170,000 children would enroll.

Benefits

Children enrolled in Medi-Cal receive comprehensive health care benefits tailored to children’s specific needs. Specifically, children enrolled in Medi-Cal receive Early Periodic Screening, Diagnosis, and Treatment (EPSDT), which is a federally mandated comprehensive set of health services designed to ensure that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services, as well as meet the special physical, emotional, and developmental needs of low-income children.²⁶ The Medi-Cal program provides child-specific benefits with no cost sharing for low-income children and very modest premiums for slightly higher-income children (above 150 percent of the FPL). As such, Medi-Cal is a model of affordable, child-appropriate insurance for California children, even in comparison to the benefits packages offered in Covered California.²⁷ Similar to the EPSDT package provided through Medi-Cal, the federal CHIP program supports a comprehensive level of benefits more specific to children’s needs. In fact, the federal Centers for Medicare and Medicaid Services recently certified that the current marketplace qualified health plans (QHP) do not provide the same level of benefits provided through CHIP.²⁸

The ACA bolstered the package of products and services offered by health plans in the individual and small group markets, both inside and outside of the marketplace. Now, most health plans must provide

a comprehensive package of ten categories of products and services, known as Essential Health Benefits (EHB). A critical component of the EHB is free preventive services, which means that enrolled children receive vaccinations and annual well-child visits in addition to other recommended preventive services, without cost sharing.²⁹ The package of preventive services for children is outlined in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*.³⁰ Supported by the Health Resources and Services Administration, *Bright Futures* is the definitive standard of pediatric well-child and preventive care developed by an evidence-informed, active collaboration led by the American Academy of Pediatrics (AAP).³¹

The EHB package also includes “pediatric services, including pediatric oral and vision care.” However, federal regulations to date have not clarified what benefits should be included in the pediatric services EHB category, other than the general pediatric dental and vision care. In the absence of specific guidance, state marketplaces are given minimal information from the federal government as to what benefits should supplement their benchmark plan in order to fulfill the pediatric services EHB. States’ benchmark plan options (except for the pediatric dental benchmark plan options) are essentially employer-based coverage plans, which are generally concerned with the coverage needs of adults. As such, relevant mandates for coverage of child-specific services may not be included in benchmark plans,

What are Essential Health Benefits?

The ACA bolstered the package of covered benefits and services offered by health plans in the individual and small group markets, both inside and outside the health insurance marketplace. Most health plans must provide a comprehensive package of products and services, known as Essential Health Benefits (EHB), within at least the following 10 categories:

* The pediatric services EHB requires further refinement and clarification.

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care*

preventing children from accessing services necessary for their healthy development. The current California benchmark plan (Kaiser Small Group HMO 30), recently reauthorized until 2017, does provide more generous preventive care services than what is currently available in most plans sold to individuals or small businesses.³² However, despite the broad range of covered benefits, there are still some services particularly important for children’s development that are not covered under this benchmark plan, such as hearing aids.³³

In addition, while children’s dental coverage is part of the pediatric services EHB, the way states offer dental coverage for children varies. In fact, in many states and on the federal marketplace, children’s dental coverage is sold separately from medical coverage, subjecting families to additional costs and bureaucracy to enroll in dental coverage. Initially, California was one of these states, selling only “stand-alone” pediatric dental benefits to families. Using this approach, only 30 percent of children enrolled in medical coverage through Covered California were also enrolled in dental coverage.³⁴ Advocates spent the first year of open enrollment making the case for integrating pediatric dental plans into health plans offered by Covered California. By the second open enrollment period, all children who received their health coverage through Covered California automatically received dental benefits, without an additional cost or extra enrollment step. California is one of three states and the District of Columbia that offers embedded dental plans.³⁵ As a result, all children enrolled in Medi-Cal and Covered California have affordable, comprehensive dental care. In fact, for 2017, California chose its CHIP/Medi-Cal dental benefits as the pediatric dental benefit benchmark, which includes EPSDT dental coverage.



Coverage—where we need to go

While there have been tremendous strides in improving and expanding coverage options and benefits for children and families, there are gaps to fill and benefits to improve. Many recommendations for future advancements may require federal policy changes, but there are several steps California policymakers can take to ensure the state’s children receive the most affordable, comprehensive health coverage.

Fix the “family glitch” so more families can access affordable coverage. The “family glitch” refers to how some moderate-income families may be locked out of access to financial assistance for marketplace health plan coverage. In order to be eligible for premium tax

credits or cost-sharing reductions, families must have incomes below 400 percent of the FPL and not have access to what the ACA deems as affordable employer-sponsored insurance.³⁶ But the federal government defines “affordable” based only on the cost of individual coverage offered by an employer and not the significantly higher cost of a family plan. Thus, if a family’s income would otherwise make family members eligible for subsidized coverage through Covered California, those dependent family members are ineligible for Covered California subsidies because they have access to employer-sponsored coverage, even if the family cannot afford such coverage. It is estimated that an additional 144,000 Californians* would qualify for and use premium subsidies in California, half of whom are children, if the family glitch was resolved by calculating affordability using the cost of the full family coverage plan and not just the employee-only coverage.³⁷ To make good on the promise of affordable health coverage for all and to accurately reflect Congress’s intent, the federal Administration should correctly interpret the eligibility provision defining “affordable” to include the true cost of family coverage. In the absence of a reinterpretation, Congress must clarify the provision as such, so these working families and their children are not unfairly denied affordable coverage.

In the absence of federal action, the State could address the family glitch through a federal Section 1332 waiver proposal. Section 1332 of the ACA

*This number is based on a specific scenario: If the cost of self-only coverage is less than 9.5 percent of household income, but the cost of family coverage is greater than 9.5 percent of household income, then family members—but not the employees themselves—would be eligible for subsidized coverage in the marketplace.

permits states to apply for a waiver to pursue innovative strategies for providing their residents with access to high-quality, affordable health insurance, while retaining the basic protections of the ACA.³⁸ While the current deficit neutrality guardrails of the 1332 waiver guidelines make this difficult to achieve, guidance under future Administrations might offer enough flexibility to allow a state 1332 waiver remedy for the family glitch.

Expand Medi-Cal to low-income undocumented immigrant adults and allow undocumented immigrants to purchase coverage through Covered California. There are 1.5 million Californians who will remain ineligible for full-scope coverage through Medi-Cal or Covered California due to their immigration status.³⁹ To ensure access to coverage for all Californians, the State should expand Medi-Cal coverage to low-income adults, regardless of immigration status, and seek permission from the federal government via a Section 1332 waiver to allow undocumented Californians to purchase coverage (without subsidies) through Covered California. When parents are also eligible for coverage, the whole family is more likely to enroll and more children will be able to get the health care they need.

Provide child-specific, comprehensive coverage for children enrolled in health plans through Covered California. In considering an appropriate definition of pediatric services, Medicaid's EPSDT benefit offers the gold standard because it provides all the medically necessary health services that children need. Until there is a federal definition of the pediatric services EHB category, offering at least a CHIP-comparable benefits package, California should pursue a Section 1332 waiver through the federal government to offer Covered California children Medi-Cal-contracted health plans (as non-QHPs), as a means of providing a comprehensive pediatric services benefits package.

Provide the "Pediatric Services" Essential Health Benefit to youth up to age 21. Despite federal regulations stating that states have the flexibility to extend pediatric services coverage beyond the age of 19 and receive federal financial assistance for doing so, California policymakers have yet to exercise this option.⁴⁰ Extending eligibility for pediatric benefits to age 21 in Covered California would align with existing standards in Medi-Cal and ensure that children receive critical, comprehensive services, including oral and vision care, until age 21, regardless of which coverage option they are in. This is particularly important as many families experience fluctuating incomes that cause their eligibility to teeter back and forth between Covered California and Medi-Cal.

Fund the Children's Health Insurance Program (CHIP) in 2017. CHIP has demonstrated unequivocal success at reducing the number of uninsured children and providing affordable, comprehensive, and high-quality child-specific health benefits for children whose family incomes are above the Medicaid eligibility level but not high enough to afford private coverage. Until an alternative means of child-centered coverage exists and can demonstrate the same cost-sharing protections and child-specific benefits, CHIP will need to be funded beyond 2017. CHIP was reauthorized by Congress through 2019, yet fully appropriated only through 2017. Not only should CHIP be fully funded throughout its authorization period, but it should also be reauthorized beyond 2019. If CHIP is not funded and reauthorized and marketplace coverage continues to pale in comparison, the CHIP children may be the first group to dramatically lose benefits under health care reform.

Affordability—Ensure Families Can Afford Coverage & Care

Eligibility for health coverage only goes as far as families' ability to afford it. California has been largely successful in containing costs in the marketplace for the 1.3 million people currently enrolled through Covered California.⁴¹ Covered California has been explicit in its effort to put consumers first and, as a result, is a leader in efforts to control costs and keep coverage within financial reach for consumers while giving them additional coverage options.

Through the operation of its marketplace, California is using all the tools provided by the ACA to ensure that consumers get the most affordable coverage. Unlike most state marketplaces and the federal marketplace, Covered California does not allow all health insurance companies to participate in the marketplace. Instead, Covered California is an “active purchaser,” which means it selects insurers to participate in the marketplace, designs the products it wants those insurers to offer, and negotiates premiums on consumers' behalf.⁴² In its role as an “active purchaser,” Covered California negotiated lower rate increases on average than the increases experienced by other states or by individual consumers prior to enactment of the ACA.⁴³

Another tool Covered California used to focus competition based on premiums, networks, and quality (and not benefits) was to create a standard benefits design, which establishes the services that all qualified health plans must offer. With standardized benefits, Covered California consumers can more accurately compare health insurance plans. Without a standard benefits design, there are often too many product options that are confusing and can lead to poor choices by consumers, either by picking a plan that is too expensive or picking one that has more out-of-pocket cost sharing than expected.⁴⁴

As a result of the provisions in the ACA and cost containment tools Covered California has chosen to utilize, Californians are benefiting from multiple efforts to keep coverage affordable. In 2015, 90 percent of members in Covered California benefited from financial assistance made possible by the availability of subsidies through the ACA. In addition, over 670,000 Covered California enrollees (of which nearly 50,000 are children) benefit from cost-sharing subsidies that help reduce out-of-pocket health care costs in the form of reduced copayments for office visits, lab tests, and more.⁴⁵ State efforts furthered this work to help

make coverage more affordable. For example, Covered California provides a cost estimator tool on its website to help consumers calculate their potential out-of-pocket costs under various plans.⁴⁶ In addition, California was the first marketplace in the country to impose a cap on out-of-pocket costs for specialty prescription drugs, beginning this year, ranging from \$150 to \$500 per month.⁴⁷ The vast

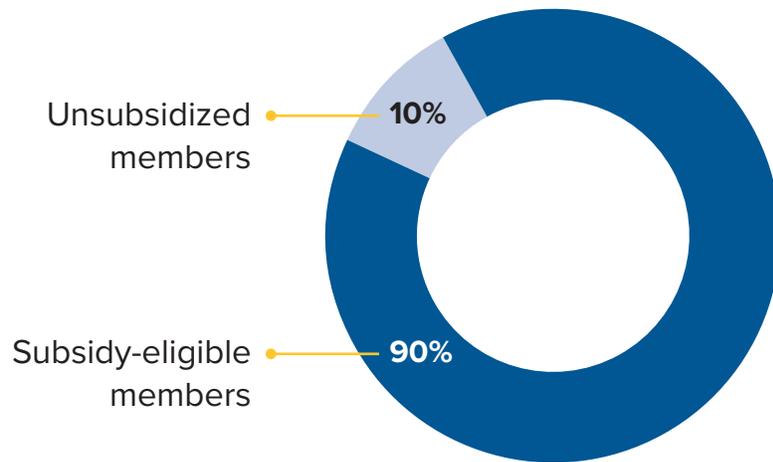
majority of consumers will see their specialty drugs capped at \$250 per month, per prescription.⁴⁸

Medi-Cal clearly offers the most affordable insurance options, as it is serving those families with the lowest incomes. Children particularly benefit from Medi-Cal's very low costs: low-income children enrolled in Medi-Cal have no cost sharing, such as copayments, deductibles, or coinsurance. For those children with family incomes between 160 and 266 percent of the FPL, only a very modest premium of \$13 per child, per month is imposed, with a maximum of \$39 per family, per month.⁴⁹ Nationally, Medicaid's affordability, coupled with the comprehensive child-specific benefits, is highly valued by parents and outweighs other family coverage considerations, such as parents being in separate plans than their children. Parents far prefer affordable, quality coverage for their children over having the same plan as their children.⁵⁰

Lack of affordability remains the most common reason cited for going without health insurance in California.

Percentage of Individuals Receiving Financial Help in Covered California

Note: N = 1,306,520 which includes both children and adults. Source: California Health Benefit Exchange, “Covered California Active Member June 2015 Profile,” accessed February 18, 2016, http://hbex.coveredca.com/data-research/Active%20Member%20Profile/CC_Active_Member_Profile_2015_06_June_rev_2015_10_08.xlsx.



Affordability—where we need to go

While the proportion of uninsured Californians reporting cost as the reason for lacking coverage fell from 53 percent to 43 percent in 2014, lack of affordability remains the most common reason cited for going without insurance in California.⁵¹ Among people with health insurance, one in five working-age Americans reports having problems paying medical bills in the past year that often cause serious financial challenges and changes in employment and lifestyle.⁵² When insured individuals received medical bills, three-quarters said that the amount they had to pay for their insurance copayments, deductibles, or coinsurance was more than they could afford. As the ACA implementation moves forward, ensuring coverage is affordable for children and their families remains critical.

Support families and individuals’ ability to afford health coverage and care by lowering the cap on Covered California plans’ overall out-of-pocket costs. A recent national analysis from the Medicaid and CHIP Payment and Access Commission (MACPAC), as required by the ACA, found that out-of-pocket spending (premiums and cost sharing) in the second lowest cost silver marketplace plans was an average of \$1,073 versus \$148 in average separate CHIP plans—almost seven times as much.⁵³ The Commonwealth Fund

found that, nationally, for those without cost-sharing reductions, average copayments, deductibles, and out-of-pocket limits under catastrophic, bronze, and silver plans are considerably higher than those under employer-based plans on average.⁵⁴ Marketplace plans are also far more likely than employer-based plans to require enrollees to meet deductibles before they receive coverage for prescription drugs.⁵⁵ While many enrollees are benefiting from financial assistance in Covered California, lowering the current cap on overall out-of-pocket costs to make affordable coverage a reality for children and families who do not qualify for Medi-Cal or have employer-based coverage should be a policy priority.

Provide subsidies for adults to purchase dental coverage through marketplaces, including Covered California. Currently, dental benefits are offered to adults for purchase through Covered California, but with no subsidy. Making dental benefits more affordable for adults—and, thus, the whole family—will likely lead to more children using the dental benefits they have, based on evidence that when parents have health coverage and care, all family members, including children, are more likely to use their benefits.⁵⁶ The federal government should include dental coverage as an Essential Health Benefit. Alternatively, the State could offer adult dental benefits and pay for the subsidy using state-only funds.

Enrollment—Streamline Health Coverage Enrollment & Renewal

Once families are aware of their coverage opportunities, enrollment and renewal in health coverage should be an easy process. Now that California has a system of coverage for all low-income children, enrollment need not be a matter of whether or not they qualify, but instead a matter of for which insurance options children are eligible. The ACA created an enormous opportunity to revamp health coverage enrollment processes to be more efficient and easier for families. All states are required to have electronic enrollment systems, which offered California the opportunity to create a user-friendly interface to shop for coverage through Covered California or enroll in Medi-Cal, but it also offered an opening to explore other ways to simplify enrollment and renewal.

Enrollment

After the passage of the ACA, California immediately began work to develop the software backbone for California’s online eligibility, enrollment, and renewal system, known as the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). CalHEERS serves an array of functions, including application processing, plan comparisons and selection (Covered California only), renewals, appeals, notices,* and calculations for financial assistance. It also houses the eligibility business rules used to determine eligibility for Medi-Cal categories and Covered California. Families can now apply for coverage online (in English and Spanish), in addition to the option to apply in person, by phone, fax, or mail. One of the ACA’s stated goals was to enable individuals and families to apply for coverage using a single application and have their eligibility determined for all insurance affordability programs through one simple process.⁵⁷

While CalHEERS houses the business rules for eligibility for both Medi-Cal and Covered California, this system only processes and determines enrollment for Covered California. Individuals eligible for Medi-Cal who apply for coverage through CalHEERS have their application transferred to their local county for a final Medi-Cal eligibility determination and management of Medi-Cal cases.

County Medi-Cal workers have the expertise and experience in Medi-Cal eligibility and enrollment procedures, as well as existing systems, as compared with the more recent CalHEERS system and service center representatives. Nonetheless, as with bifurcated enrollment assistance, having two enrollment systems carries with it the risk of coordination glitches, particularly for families with parents enrolled in Covered California and children enrolled in Medi-Cal.

Getting the new enrollment system operational in time for open enrollment in 2013 resulted in several application and enrollment glitches affecting both Covered California and Medi-Cal enrollment. These system glitches and the tremendous volume of Medi-Cal applications overall led to an unprecedented backlog of unprocessed Medi-Cal applications. During the backlog period, the State estimated that 195,000 children had pending Medi-Cal applications and were not receiving coverage while waiting.⁵⁸ While the backlog has vastly improved, in 2015 there was still a small backlog and California is only processing 25 to 50 percent of Medi-Cal applications in “real time.”⁵⁹ Medi-Cal-eligible

California is only processing 25 to 50 percent of Medi-Cal applications in “real time.”

children applying online are afforded an important expedited policy, called Accelerated Enrollment, which allows them to receive immediate coverage while their application is processed. Unfortunately, the State rejected providing Accelerated Enrollment to Medi-Cal-eligible children who applied via the county or over the phone, on the assumption that enrollment through these direct pathways would be virtually immediate. However, the 2014 backlog and less than “real time” enrollment disproves that assumption.

With regard to encouraging enrollment, the State took advantage of early implementation opportunities to

*Under AB 1341 (2014), counties are to send out Medi-Cal notices.

efficiently enroll or renew children and adults into coverage in other innovative ways. California chose the federal option to offer “facilitated” enrollment for individuals who were currently enrolled in the Supplemental Nutrition Assistance Program (SNAP), or CalFresh in California, through its “Express Lane Enrollment (ELE)” Project. ELE allows the State to use eligibility information from CalFresh to determine CalFresh beneficiaries as eligible for Medi-Cal and enroll them into coverage with no additional application and only enrollee consent. Because California adopted the ACA Medicaid expansion, the State wanted to use this strategy. California identified and enrolled about 197,000 adults and 37,000 children who received CalFresh in 2014 into Medi-Cal.⁶⁰ ELE is a tremendously efficient strategy for identifying, reaching, and enrolling many uninsured children.

In 2014, California enrolled approximately 197,000 adults and 37,000 children who received CalFresh into Medi-Cal through Express Lane Enrollment.

At the inception of CalHEERS, the Medi-Cal Access Program (MCAP)* eligibility screening was not provided to pregnant women applying online through CalHEERS, leaving many pregnant women unaware of their eligibility for the more affordable coverage provided by MCAP and instead were notified that they qualified for Covered California. As of October 2015, a year and a half after CalHEERS went live, pregnant applicants eligible for MCAP are now being identified when they apply online through CalHEERS or at the county level.⁶¹

A more recent enrollment issue involves new documentation requirements for families intending to apply for Covered California coverage during the Special Enrollment Period (SEP), which allows eligible individuals to enroll in coverage if they experience a qualifying life event, such as having a baby, losing a job, or otherwise losing their health coverage.⁶² Nationally, CMS issued its own documentation requirements for the SEP in the federal marketplace in response to assertions by health plans that families are erroneously enrolling in coverage during the SEP. CMS

is now requiring applicants to provide documentation demonstrating their eligibility to use the SEP to enroll in the federal marketplace. For example, in order for a baby born outside of the open enrollment period to qualify to be enrolled through an SEP, the parent(s) must provide documentation, such as a birth certificate. This could delay coverage and thus critical health care for uninsured individuals, particularly newborns receiving critical care in their first few months of life, prior to receiving an official birth certificate. Covered California is developing a post-enrollment sampling process for verification documentation for SEP eligibility for 2016.⁶³

Renewal

The ACA also includes provisions to help individuals keep their health coverage once enrolled by requiring streamlined renewal processes. Now, when possible, all states must use available data to renew Medicaid eligibility (called *ex parte* renewal), instead of requiring families to provide paper proof of their continued eligibility for coverage. Initially, Medi-Cal was slow to comply with the new ACA renewal requirements. But in 2014, California adopted a temporary federal renewal strategy—a type of “express” renewal, in which counties could renew coverage for Medi-Cal beneficiaries for those also enrolled in CalFresh, based on their recent CalFresh eligibility determination. Beginning in 2015, California counties were able to renew coverage for most Medi-Cal members automatically, based on existing eligibility information via CalWORKs (the state’s welfare program), CalFresh, or Covered California, as well as other state and federal data records. If eligibility cannot be determined, the county now sends a renewal application to individuals with as much pre-populated information as possible for the beneficiary to confirm.⁶⁴ In 2015, California was one of 10 states that was able to renew 50 to 75 percent of Medi-Cal beneficiaries via *ex parte* renewals.⁶⁵ For Covered California members who want to stay with the same health care plan, renewal is essentially automatic, with some verifications—either online or by phone—in order to continue receiving tax credits.⁶⁶ These new renewal processes reduce the burden on families, save unnecessary administrative costs to the State, and, most importantly, help to eliminate lapses in coverage.

*Medi-Cal Access Program (formerly known as Access for Infants and Mothers) is a long-standing program that covers pregnant women with annual incomes between 213 and 322 percent of the FPL. Women can stay on MCAP until the second month after delivery, and their child can stay on MCAP for up to two years.

Enrollment— where we need to go

While progress has been made, efforts to ensure enrollment and renewal for coverage is as simple and streamlined for children and families as possible must continue. This means families, particularly those in families with members in multiple coverage options (e.g. Medi-Cal and Covered California), can easily apply for and enroll in coverage in real time through all entry points; receive the application assistance they need; compare and enroll in a plan; retain coverage easily; and transfer smoothly between insurance programs when circumstances change.

Ensure a smooth enrollment process for all undocumented immigrant children into full-scope Medi-Cal. As noted in the Coverage section of this report, low-income undocumented immigrant children are newly eligible for full-scope Medi-Cal benefits. For all newly eligible children, the enrollment process should be clear, understandable, and trusted for immigrant families. There are several core implementation elements necessary to ensure a smooth and seamless enrollment of undocumented immigrant children, including 1) monitoring the transition of restricted-scope enrollees to full-scope Medi-Cal; 2)

understandable information for families in all threshold languages; 3) clear communications to families with official clarification of privacy protections and public charge rules; and 4) culturally competent outreach and enrollment assistance.

Provide Accelerated Enrollment for children regardless of where they enter the system. Medi-Cal-eligible children should be granted Accelerated Enrollment for Medi-Cal through all points of entry, whether a family applies for their coverage in person, via phone, online, or through a mailed paper application. No child should experience delays in receiving care because their parents chose to enroll them over the phone or in person. Until all entry points can provide real-time enrollment, Accelerated Enrollment will be the best alternative to ensuring children receive immediate coverage and can seek care.

Implement Express Enrollment strategies through CalFresh, WIC, and CHDP. The previously mentioned expedited enrollment approach, called SNAP-facilitated enrollment, became a permanent option for targeted enrollment strategies offered by CMS in 2015.⁶⁷ Given its success in using this facilitated enrollment strategy, called Express Lane Enrollment in California, the State should seek federal authority to formally adopt and continue Express Lane Enrollment for CalFresh as a permanent option in California.*

There is also a separate federal Express Lane Eligibility (ELE) option, which allows states to use data and eligibility findings from other public benefits programs to determine if children are also eligible for Medicaid and CHIP. ELE offers a particularly effective strategy for maximizing children's enrollment under California's new system of coverage for all low-income children. For example, now that all low-income children, regardless of immigration status, are eligible for Medi-Cal, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)—which provides nutrition and health education and financial assistance to buy healthy foods to women and children with family incomes at or below 185 percent of the FPL—would serve as an effective and efficient pathway to Medi-Cal enrollment for pregnant women, parents, and children.

In addition, the Children's Health Disability Prevention (CHDP) program—a well-child and development screening program for all low-income California

*DHCS indicated that it intends to pursue a waiver to continue its Express Lane Enrollment project. Announced at the March 4, 2016, meeting of the Medi-Cal Consumer Focused Stakeholder Working Group.



children—has a gateway to Medi-Cal enrollment. CHDP application information can serve as an initial screen for Medi-Cal eligibility and provides temporary coverage while families complete a Medi-Cal application. The CHDP Gateway could be further improved to offer Express Eligibility, in which the CHDP application can serve as the beginning of a Medi-Cal application, not just a screen, and provide ongoing coverage while any follow-up information is obtained.

Improve the online application experience through regular consumer testing to identify what causes delays and confusion. Consumers are still experiencing technical difficulties with both Medi-Cal and Covered California online enrollment and renewals through the Covered California website. A recent report found that unclear guidance and questions related to income and household size resulted in errors in critical sections of the application used for Medi-Cal eligibility and Covered California subsidy eligibility calculations.⁶⁸ In addition, poorly designed online renewal forms frustrated users.⁶⁹ Given that over half of consumers are applying for coverage online, Covered California should monitor the online enrollment experience with actual consumers as well as test for quality improvements to identify where in the online enrollment process applicants experience delays or confusion and implement solutions to address identified problems.⁷⁰

Monitor enrollment experiences of families with members in different coverage programs to identify what is working and areas for further or improved coordination. Covered California and DHCS are required to report application, enrollment, and renewal data on a regular basis.⁷¹ It would be of great value for these enrollment and retention reports to include data on families in which some members are enrolled in Medi-Cal and others through Covered California, in order to identify challenges facing these families and pursue solutions. While little is known about these families' specific enrollment and renewal experiences, given their complicated circumstances, these families are most likely at particular risk of losing coverage or being confused about which communications from which agency require a response. With a few years of experience having two insurance options implemented in tandem under the State's belt, it is time to critically examine how families with members in both coverage options are faring and whether more coordination is needed to facilitate enrollment and renewal.

Streamline health coverage enrollment and renewal processes for families transitioning from Medi-Cal to Covered California. Many Californians transition between Covered California and Medi-Cal health coverage as their incomes change. In fact, it is estimated that 16.5 percent of all Medi-Cal enrollees will become eligible for health coverage through Covered California during the course of a year because of income increases.⁷² Conversely, about one in five people with subsidized Covered California plans will become eligible for Medi-Cal.⁷³ These transitions intrinsically leave families at risk for having gaps in coverage. Thus, particularly tight coordination between Covered California and Medi-Cal related to requests for family information is essential. For example, families leaving Medi-Cal and transitioning to Covered California need to be informed as soon as possible about their Medi-Cal termination. They also need to be given information about the critical timelines and actions needed to complete their Covered California enrollment, such as the need to sign up for a Covered California plan before the end of the month in order to be enrolled by the time their Medi-Cal coverage terminates. Given the difficulties with seamless, uninterrupted coverage between two programs, families would benefit from "bridge" coverage, in which transitioning families continue receiving Medi-Cal coverage until their Covered California enrollment is complete. The bridge Medi-Cal coverage would, in essence, be temporary Covered California coverage, paid with federal tax credit subsidies if the family was determined eligible for Covered California tax credit subsidies. The State could submit a federal Section 1332 waiver proposal to create such a bridge, maintaining coverage levels and deficit neutrality.

Implement a flexible standard for accepting eligibility information for enrollment and renewal of coverage in Medi-Cal. California could adopt other eligibility and enrollment simplifications, such as a "reasonable compatibility" standard for income, as done in 34 other states.⁷⁴ Such a standard allows a discrepancy between certain reported eligibility information on an application or renewal that comes up in the verification process to be accepted if it is a relatively small discrepancy, without further paper documentation by families. These "reasonable compatibility" standards provide useful enrollment flexibilities to states in determining eligibility efficiently and to families who are otherwise eligible.

Outreach & Enrollment Assistance— Educate & Connect Families to Coverage

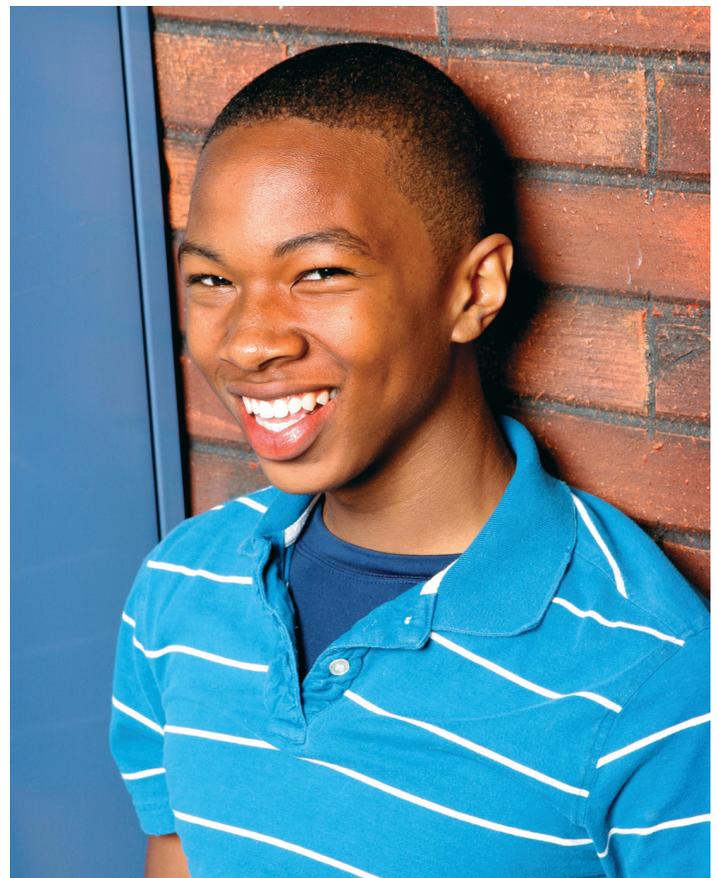
Outreach is key to making sure families are aware of health coverage options and have the assistance they need to enroll—for both themselves and their children. Experience with previous expansions of health coverage and other public benefits has shown that simply offering new coverage options does not ensure people will take advantage of them.⁷⁵ For example, the creation of CHIP in 1997 resulted in the reduction of the child uninsured rate by 36 percent nationally.⁷⁶ However, such coverage gains did not come easily or quickly. It took a significant financial investment by the federal government, states, foundations, and others to educate the millions of eligible but uninsured families about the new program and to connect their children to coverage. As a result of outreach grants and campaigns, enrollment assistance, and simplification of the enrollment process, many states were then able to significantly reduce their rates of uninsured children.⁷⁷

Similarly, outreach related to the new coverage options available through the ACA required a robust, multifaceted effort to reach newly eligible populations. To raise awareness around coverage options available through the ACA and the launch of Covered California in 2013, Covered California invested in community mobilization and grassroots education as essential elements in reaching eligible Californians. Covered California initially established two grant programs. One focused on outreach and education to reach and inform consumers about coverage options and encourage enrollment primarily through community-based organizations. The second focused on enrollment assistance through Certified Enrollment Counselors (CECs) and insurance agents, but also included outreach and education activities. Covered California also invested in robust paid media campaigns, designed to reach both broad and targeted audiences in urban and rural markets across California, including print, radio, social media, and television.

As to be expected in the rollout of a brand new coverage option, there were shortcomings in the outreach programs in the first year of implementation. In the first open enrollment period, for example, there were

too few CECs to help families enroll, and payments to them were not only critically delayed but also insufficient to cover the true costs of enrollment assistance. It also quickly became clear that most customers needed multiple contacts in multiple venues to get enrolled.⁷⁸

As a result of these and other lessons, Covered California has made improvements to its education and enrollment assistance activities. Before the start of the second open enrollment period, Covered California made significant operations and marketing adjustments including: 1) instituting a new navigator model in 2014 and awarding grants to organizations to handle outreach, education, and enrollment; 2) doubling the capacity of the Service Center—where individuals call for information and enrollment assistance—and extending Service Center hours; and



3) redesigning the consumer website to include a full Spanish-language site and more culturally appropriate materials in additional languages than originally offered.⁷⁹ During the second open enrollment period, consumers were also able to access in-person assistance at more than 500 storefront sites statewide.⁸⁰ All of these changes resulted in approximately 70 percent of eligible consumers enrolling or renewing with assistance from certified insurance agents, CECs/navigators, or with the help of Covered California Service Center representatives over the phone, which was up from 58 percent in the first open enrollment period.⁸¹

Building on these enhancements, multiple efforts were implemented for the third open enrollment period to improve outreach and education. A holistic, multicultural marketing campaign was launched to better assist Californians, particularly those still uninsured, in understanding the value of health insurance and being covered.⁸² For consumers requiring in-person assistance, storefronts provided community locations to access free assistance from certified enrollers during a variety of hours. Covered California streamlined eligibility and criteria for storefronts and worked to strengthen this critical piece of community engagement through a cleanup effort of existing storefronts and the creation of support materials, such as a toolkit and Storefront Finder User Manual.⁸⁵

Despite improvements to outreach and enrollment assistance by Covered California, application assistance support is bifurcated. Due to federal requirements, Medi-Cal enrollment cannot be compensated by Covered California.⁸⁴ As a result, CECs and agents were neither trained in Medi-Cal eligibility and enrollment nor could they use Covered California grant funding to support their Medi-Cal application assistance. The lack of coordinated support for application assistance particularly impacted children since far more children are eligible and applied for Medi-Cal, as compared to Covered California. While Covered California outreach served as an effective opening for Medi-Cal children to also apply, the Covered California grantees were less equipped to assist them.

There were, however, some outreach programs specifically targeted to those eligible for Medi-Cal. In 2013, the federal government awarded funding through the Connecting Kids to Coverage Outreach and Enrollment grants* to state agencies, nonprofits, health centers, and school-based organizations to identify and enroll children eligible for Medicaid and CHIP—nine of which were California grantees that received a total of \$5.2 million through July 2015.⁸⁵ The California Department

of Health Care Services (DHCS) also received funds from The California Endowment, matched by the federal government, for local outreach to connect to hard-to-reach populations and enroll them in Medi-Cal. As a result, \$25 million was distributed to the state's 58 counties to cover outreach and enrollment activities conducted between February 2014 and June 2016.

Successful enrollment into health coverage requires a multifaceted approach to outreach and education efforts. Research from Covered California found that consumers require multiple contacts before completing enrollment.⁸⁶ Reaching consumers requires an aggressive media strategy, coupled with on-the-ground, culturally sensitive education by community-based entities, such as schools, and organizations that families trust.⁸⁷ Finally, families need assistance with the application process. Without such help, families either do not submit applications or submit incomplete applications.⁸⁸ In either case, the result is that children and families remain uninsured, defeating the purpose of health reform.

Outreach—where we need to go

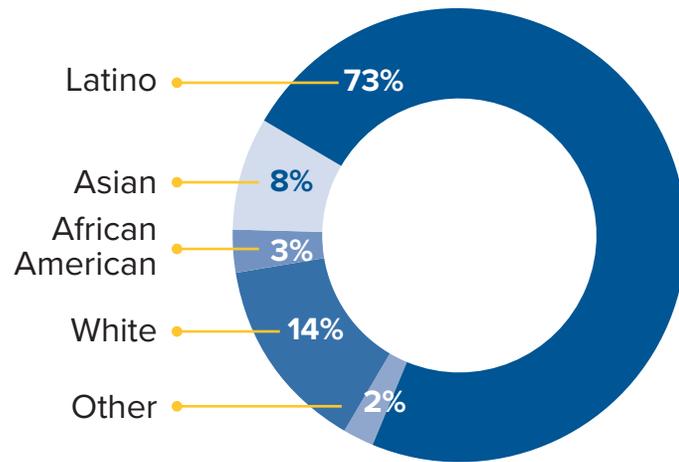
While we have made great strides in reducing the number of uninsured children, there are 437,000 remaining uninsured children** in California, and the majority of them are eligible for Medi-Cal or subsidized coverage in Covered California.⁸⁹ The remaining uninsured population of children is much harder to reach than those who enrolled in the initial years of coverage expansions and outreach campaigns. For example, uninsured children in traditionally hard-to-reach populations include those in very low-income and homeless families, families in which parents do not speak English, and families in rural areas.⁹⁰ Furthermore, the uninsured rate among children varies based on demographic factors, including income, race, ethnicity, age, and geographic location. School-aged children, those of Latino descent, and near-poor children are disproportionately represented among the uninsured.⁹¹ In 2010, almost half (42 percent) of uninsured children nationally lived in an immigrant family.⁹² Two-thirds (69 percent) of these uninsured children are citizens; furthermore 39 percent are Medicaid-

*The Connecting Kids to Coverage Outreach and Enrollment Grant funds are provided through the Affordable Care Act to continue the grant program first funded under the Children's Health Insurance Program Reauthorization Act (CHIPRA). The objective is to reduce the number of children who are eligible for but not enrolled in Medicaid and CHIP and to keep them covered for as long as they qualify.

**With the signing of Senate Bill 75 in 2015, undocumented immigrant children are now eligible for Medi-Cal. The State estimates that 50,000 children who are undocumented and uninsured will enroll in the program and are not reflected in the latest data of uninsured children.

Demographics of Californians Under Age 65 Projected to Remain Uninsured, 2019

Note: Projections are based on a “High Sign-Up Scenario” which takes into account the extent and effectiveness of outreach and enrollment efforts in the state. N = 3,380,000. Source: Laurel Lucia et al., Which Californians will Lack Health Insurance under the Affordable Care Act? (Berkeley, CA: UCLA Center for Health Policy Research and UC Berkeley Labor Center, January 2015)



eligible, 39 percent are not eligible for Medicaid, and eligibility is unknown for the 21 percent that are low-income, non-citizens.⁹⁵ Reaching these families will require an ongoing investment in time-intensive, targeted, culturally competent, innovative outreach and enrollment assistance strategies, including outreach to families through schools, small businesses, religious organizations, and other non-health channels.

Invest in culturally competent, targeted in-person assistance to reach underserved populations. California is a diverse state and the services provided should reflect the needs of the community. Of the 9.6 million kids in California, 51 percent are Latino, 27 percent are white, 11 percent are Asian, 5 percent are African American, almost 5 percent are multiracial, and fewer than 1 percent are American Indian/Alaska Native or Native Hawaiian/Pacific Islander.⁹⁴ As mentioned, Latinos represent the largest group of uninsured Californians; by 2019, it is projected that approximately three-quarters of the remaining uninsured will be Latino.⁹⁵ Research has shown that the availability of culturally and linguistically competent in-person assistance is particularly important for communities of color and those with limited English proficiency.⁹⁶ Reaching consumers through trusted messengers lends legitimacy to outreach and enrollment programs and makes a complex and confusing system less intimidating.⁹⁷ Support for local initiatives, such as community enrollment events, and community-driven programs, such as promotoras or community health workers, can help reach underserved populations in a more effective manner.⁹⁸ Ongoing efforts to provide effective in-person education and assistance

to consumers should focus on funding groups that are trusted community members with experience in providing culturally competent assistance.

Equip community leaders with tools to connect families to health coverage and care. Working with trusted community partners that already interact with children and families is a critical and effective strategy to reach the uninsured. Faith-based organizations have been a tremendous partner in educating certain communities. For example, the Congregations Organized for Prophetic Engagement (COPE) used community meetings held at local churches, where the focus was school engagement and the meetings run by congregants they already trusted as educators, to inform parents about the availability of affordable health care and encourage them to enroll.⁹⁹ Schools are also particularly powerful, trusted messengers.¹⁰⁰ The Children’s Partnership’s ALL IN For Health Campaign works with California’s schools and early learning providers to provide families information about Medi-Cal and Covered California coverage options. In addition, because one-third of uninsured children in California have a parent working for a small business,¹⁰¹ the small business community is another partner to help provide their employees’ families information about coverage options, if they are not providing coverage themselves.* The State and stakeholders should continue to identify partnerships where eligible families and children congregate—at places of worship, school,

*For example, the small business community could be equipped with resources to help small businesses educate employees about coverage options, especially Medi-Cal, for children. For more information, visit <http://www.childrenspartnership.org/our-work/health-care/small-business-for-kids-health>.

and work—as additional avenues to educate families about health coverage options for their children and themselves.

Provide assurances for mixed-status families, including families with undocumented immigrant children, regarding the use of their immigration status information. Many immigrant families that have members who are uninsured but eligible for Medi-Cal or Covered California fear that enrolling in health insurance will draw attention to their own or another family member’s undocumented status.¹⁰² This is particularly relevant given the new Medi-Cal eligibility for undocumented immigrant children. This fear understandably persists, even though there has been clear communication from US Immigration and Customs Enforcement (ICE) that it will not use information from health insurance applications in immigration enforcement.¹⁰³ Fears are particularly pronounced given the recent enforcement actions taking place in many immigrant communities around the country, including at least one site in California, that are separating families. Further, many families fear that receiving public benefits puts at risk their ability to become a permanent resident.

Outreach, as well as official communications to families, will need to include family-friendly and official information that outlines the existing privacy assurances and public charge limitations. Moreover, partnerships with trusted sources of information will help ensure comfort with the application process for immigrant families. Additionally, pending a court decision, immigration relief through the Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA)* program would allow parents to come out of the shadows and allay their fears of deportation, thereby encouraging enrollment of citizen or lawfully residing children in DAPA families.¹⁰⁴

Ensure education to uninsured individuals emphasizes the availability of financial assistance. Research shows that more than one-third of those eligible but uninsured are not aware of financial assistance available to them.¹⁰⁵ Yet, the availability of financial assistance was the most important factor for a majority of those that signed up for coverage.¹⁰⁶ Trusted messengers can relay facts about the financial help available to reduce the cost of insurance through subsidies or that they may be eligible for free or low-cost coverage through Medi-Cal.

Increase and sustain funding for application assisters who are trained and certified in Medi-Cal enrollment assistance. With Covered California unable to fund enrollment assistance for Medi-Cal enrollments and renewals, application assistance for families eligible for Medi-Cal is not widely available. Funding for Medi-Cal application assistance has been piecemeal and inconsistent, primarily reliant on generous private philanthropic support. To ensure the quality of enrollment and renewal assistance families and individual receive, the State should develop a standardized training and certification program for community organizations, CECs, and agents and allow only certified assisters to receive funding for enrollment and renewal assistance. The State can build on the similar Certified Application Assistance program created by the organization that ran California’s now-defunct Healthy Families Program.

*In November 2014, President Obama announced several immigration executive actions that included DAPA. DAPA will allow undocumented parents with US citizen or lawful permanent resident children to apply for work authorization and protection from deportation. As of the writing of this report, no one can apply for the program. It is currently on hold until the Supreme Court rules on the matter where lower courts have put a hold on this executive action.

Care—Ensure Children Get the Care They Need

As more children than ever have access to quality, affordable health coverage, equal attention must be paid to ensuring families are knowledgeable about how to use their coverage and that providers in the coverage network are prepared to meet the needs of those enrolled. Decades of efforts to expand coverage and increase enrollment have culminated in the opening of marketplaces and the expansion of Medicaid across the country. While fine-tuning the enrollment system and outreach will always be important, the next phase of implementation shifts toward making sure children and families receive the care they need. Unmet health, dental, and mental health needs can result in developmental delays in children that affect their health, social, and academic outcomes.¹⁰⁷ Low-income children and children of color, in particular, face greater barriers to getting needed care and exhibit critical health disparities, which may cause them to lag behind their wealthier and healthier white peers.¹⁰⁸ The change in focus from enrollment to care presents an important opportunity to explore how and where the health care system can best meet the needs of children and families in a high-quality, targeted manner.

Families' Understanding of Health Insurance and the Health Care System

As millions more enroll in coverage, informing families of how to use their insurance is necessary to assist families in getting and staying healthy. Children's access to care through their insurance depends on their parents' ability to understand and navigate the coverage system on their behalf. When at least 1 in 3 parents of young children has limited health literacy skills, there is cause for concern regarding the risk children face, as measured by health care utilization, health behaviors, and other health outcomes.¹⁰⁹ More broadly, various studies have demonstrated a lack of health literacy among American families. In 2014, the Kaiser Family Foundation conducted a survey of Americans focused on health insurance literacy. While the general public did fairly well, those who scored lower included people with lower levels of education, younger Americans, and the uninsured.¹¹⁰ Another

report, from 2013, found that 51 percent of Americans did not understand such basic health insurance terms as premium, deductible, and copay.¹¹¹ According to America's Health Insurance Plans, nearly nine out of ten adults have difficulty using health information to make informed decisions about their health.¹¹²

51 percent of Americans did not understand basic health insurance terms such as premium, deductible, and co-pay in 2013.

Greater knowledge of health insurance may also lead to increased utilization of preventive services. Generally, Americans with higher education levels consume more preventive medical care as a result of being better informed or better able to process available information about preventive services.¹¹³ Studies have found that individuals with low levels of health literacy are less likely to receive a flu shot or utilize other forms of preventive care.¹¹⁴ With financial barriers mitigated by the ACA and the requirement of preventive services without cost sharing, utilization of preventive services is increasingly dependent on consumer knowledge and awareness of the importance of such services.

Health insurance policies, terms, and requirements are complex and overwhelming, especially for populations that are newly insured. Gaps remain in the amount of knowledge families have to make informed decisions. Without this knowledge, families may face a loss of coverage, not utilize care, and become further frustrated with the health care system.

Access to Care

In the last 10 years, the number of children enrolled in Medi-Cal has increased by 61 percent.¹¹⁵ Significant growth occurred between 2012 and 2015, as Medi-Cal absorbed the Healthy Families Program population and the ACA was implemented.¹¹⁶ And, with the implementation of SB 75, an additional 170,000 to

250,000 undocumented immigrant children are newly eligible for full-scope Medi-Cal this year. This significant growth calls into question whether Medi-Cal and its contracted managed care plans have enough participating providers in the right places to care for the millions of children and adults in the program and if it can keep pace and provide care as the pool of newly enrolled individuals expands. A recent review of rates for dental providers serving the Medi-Cal population showed a significant reduction in dental providers in the Medi-Cal program since 2008 (12.6 percent decrease in rendering providers and a 14.5 percent decrease in billing providers), demonstrating that, at least in Medi-Cal’s dental program, there are not enough providers to serve the increased number of Medi-Cal enrollees.¹¹⁷

In order to monitor and report on children’s access to care in the Medi-Cal program, several important advances at both the federal and state level have occurred. In 2016, CMS finalized the first major update to Medicaid and CHIP managed care regulations in more than a decade. These regulations prioritize delivery system reform, modernization and transparency of access and performance monitoring as well as quality of care that considers, in part, the specific needs of children and improves accessibility and the quality of information for consumers. For the first time, under these new rules, states must develop specific network adequacy standards for primary pediatric care, specialty pediatric care, pediatric behavioral health, and pediatric dental care. With these distinct child-specific standards, we will be able to discern and ensure children’s access to care.

Additionally, the new federal rules require plans to document their compliance with network adequacy standards and other access to care requirements.

This is particularly welcome in California after a 2015 State Auditor report found that DHCS did not verify the provider network adequacy data it received from Medi-Cal health plans.¹¹⁸ Another advancement is a new state law that puts in place new requirements for health plans to regularly update their provider directories and enhances state oversight of the accuracy of those directories.

The approval of California’s Medicaid Section 1115 waiver renewal, entitled Medi-Cal 2020, provides the State an opportunity to transform the delivery of care for its Medi-Cal population. The waiver provides at least \$6.2 billion in federal funding over the next five years for hospital financing and delivery

innovation, local health care integration innovation through “Whole Person Care” pilots, consolidated care opportunities for California’s remaining uninsured, and a Dental Transformation Initiative (DTI) to improve children’s access to preventive dental care—all of which may have a significant impact on access and the quality of children’s care. Notably, the waiver’s required Medi-Cal managed care access evaluation also offers a valuable opportunity to systematically examine child-specific access issues, which have not yet been examined.

Due to the clear evidence that California children are not getting the dental care they need, the DTI presents a particularly exciting opportunity. Over half of all children in Medi-Cal did not see a dentist in 2013, according to a December 2014 State Auditor report.¹¹⁹ The DTI leverages an unprecedented amount of new federal support to reward dental providers for 1) providing preventive dental care to additional children; 2) assessing children’s risk for dental disease and implementing treatment plans based on that risk; and 3) maintaining continuity of dental care for children enrolled in Medi-Cal.¹²⁰ Critically, the DTI sets aside millions of dollars for local pilot programs. If leveraged well, these pilots can make a huge difference in deploying innovative ways to bring dental care to children in community settings. These are children who would otherwise go without care due to socioeconomic barriers and the lack of dentists that take Medi-Cal in their community. The DTI, coupled with the suggestions below, could make a huge dent in the dental care crisis California’s underserved children currently face.

Over half of all children in Medi-Cal did not see a dentist in 2013.

Quality of Care

DHCS requires Medi-Cal health plans to report on a set of quality indicators, which includes a number of federally recommended quality indicators as well. In Federal Fiscal Year 2014, California reported only 12 out of the 22 child health quality indicators, compared to the median 16 reported nationally by other states.¹²¹ While only two states measure all of the federally recommended child health quality indicators, most other states—but not California—have already adopted the measures for well-child visits in the first 15 months of

life (42 states), adolescent well-care visits (44 states), and follow-up care for children prescribed ADHD medications (34 states).

Although children comprise a small proportion of Covered California enrollees, it is important that Covered California understands the health care experience of this population and ensures that the needs of each child are being met, recognizing that children's unique needs are distinct from those of adults. That means Covered California health and dental plans should include: child-specific monitoring measures for enrollment, plan performance indicators, a thorough analysis of network adequacy, and assessments of timely access and utilization rates. For example, while challenges in network adequacy for Medi-Cal are highlighted above, Covered California has its own. In 2015, California ranked fourth in the nation in the narrowness of the networks offered in marketplace plans. In Covered California, three-quarters of plans only had 25 percent or less of available physicians in their rating region.¹²² Though studies have shown that network narrowness was not associated with hospital quality in California,¹²³ continued surveillance of the impact of such networks on access to care is necessary to ensure children and families are able to seek the services they need, when they need them.

Increasing the availability of providers, the quality of services, and families' knowledge of the health care system will help us realize the promise of health care reform.

Care—where we need to go

Increasing the availability of providers, the quality of services, and families' knowledge of the health care system will help us realize the promise of health care reform. The delivery of health care services and promotion of innovative approaches to improve such delivery will be critical to improving the health and well-being of children.

Explore integration of health care literacy in existing educational venues for children and their families. Awareness campaigns utilizing schools as partners to inform families about health insurance

have demonstrated success in reaching uninsured children.¹²⁴ Medi-Cal, Covered California, philanthropy, health plans, schools, and other stakeholders should use avenues where families are already receiving education about a topic related to improving their families' well-being to educate families about using their children's health coverage and getting needed care. Health plans are a critical source for reaching new enrollees with information regarding how to understand their coverage and be active health care consumers. Financial education seminars and other programs focused on financial literacy for families are an opportune avenue to reach families with insurance-related information and make clear the link between health insurance and a family budget. An examination of model health education and navigation from other states could also prove fruitful in identifying promising opportunities for use in California.

Support community partners to educate families about their children's benefits and how to get care.

Families, especially those who are new to health coverage, may not understand the health insurance system and how to use it to access preventive and treatment-related health care. The best messengers for this education and support are those who know these families best, including schools, community health workers or community-based public health workers who have a close understanding of the community they serve, religious organizations, and others whom families trust. The State should support community-based education and support models, not only because such models improve families' health literacy, but also because such an investment is also an investment in preventive care, which leads to both healthier children and adults and is cost effective in the long run.

Increase the number of providers serving children enrolled in Medi-Cal through targeted innovative payment reforms.

Medi-Cal payments to providers are now among the lowest in the nation: 80 percent of the national average.¹²⁵ This creates a disincentive for providers to treat Medi-Cal-enrolled children. California could incentivize contracted health plans and providers by paying enhanced rates for improved performance on currently reported quality measures, such as increases in timely immunization rates for two year olds, well-child visits, and ambulatory care/reduced emergency room visits. For health plans struggling to retain pediatric providers in designated Health Professional Shortage Areas or Medically Underserved Areas, increased capitation rates could be awarded to plans struggling with network adequacy. Plans would share the increase with newly

empanelled providers. This would build on the Dental Transformation Initiative model, described above.

Conduct an audit of children’s access to care in Medi-Cal to ensure children are getting the care they need. A comprehensive audit of children’s health care access in Medi-Cal should be conducted if the Medi-Cal 2020 waiver access assessment does not sufficiently examine children’s specific access conditions. An access assessment should include direct provider surveys regarding their willingness to accept Medi-Cal children as patients.

Increase child-specific data monitoring, performance indicators, and reporting. More child-specific quality measures are needed to clarify the types of specific and targeted solutions needed to improve access to quality care in Medi-Cal. Covered California should similarly work with stakeholders to create child-specific quality measures to track the health experiences of enrolled children. Additionally, data should be disaggregated by age, race/ethnicity, geographic location, and other factors to identify health care disparities. In Medi-Cal specifically, California should, at a minimum, adopt quality measures for well-child visits in the first 15 months of life, adolescent well-care visits, and follow-up care for children prescribed ADHD medications. Covered California should implement child-specific monitoring measures for enrollment as well as plan performance indicators, a thorough analysis of network adequacy, and assessments of timely access to care and utilization rates. These measures should include children’s experiences in getting needed dental care.

Ensure efforts to reform the delivery of care consider the specific needs of children. As implementation of the ACA demonstrates continued progress in enrollment of uninsured Americans, increased attention is placed on the delivery of health care and how to contain costs and improve quality. Much of the discussion around delivery system reform has moved away from a focus on the quantity of services delivered to ensuring quality care that is safe, timely, effective, equitable, and efficient. However, the focus around care delivery tends to concentrate on care delivered in a medical setting. As we continue to see the progress made possible by the ACA, performance standards and incentives must be established to ensure a comprehensive approach to child health care, linking health and non-health sectors to address critical social, environmental, and developmental factors impacting the

health of children. Discussions should also consider the interconnectedness of the social, economic, and environmental conditions that affect children’s health and, in doing so, more specifically consider the relationship between the health care system, schools, juvenile justice facilities, and child protective services in order to more adequately respond to the needs of children.¹²⁶ The federal Center for Medicare and Medicaid Innovation recently announced an initiative to test whether an Accountable Health Community model that systematically identifies and addresses health-related social needs and connects consumers to services can impact total health care costs, overall health, and quality of care.¹²⁷ Similarly, California has launched an effort to support a model that incorporates health care groups, community initiatives, and public health in improving community health and reducing unnecessary health care utilization and costs.¹²⁸ Creating a more holistic system of care breaks down administrative silos between these sectors and eliminates the isolation in which each is currently operating. In California, where one in two children is enrolled in Medi-Cal, changes to public programs will have a profound effect on the health and well-being of children. Any changes must consider such an effect, prior to implementation. A holistic approach to health care delivery for children can serve to benefit the diverse experiences of California children, meeting families where they are.

Use advances in technology to bring health care to children and families. Low-income children—such as those enrolled in Medi-Cal—living in medically underserved areas, including rural and parts of urban areas, face geographic and economic barriers to getting health care. Telehealth—the use of technology to provide health care from a distance—has proven to be a high-quality and cost-effective solution to bring care to underserved children in their communities, especially children with special health care needs, those who have mental health care needs, and those who live in rural and other medically underserved areas.¹²⁹ In addition, telehealth helps keep children in school and parents at work, while saving families time and money for costs related to transportation, hotel stays, and child care for their other children. The State should facilitate wider adoption of telehealth by providing Medi-Cal reimbursement for all care delivered through telehealth, as clinically appropriate, just as they reimburse care delivered through an in-person visit.

Where We Go From Here

Children in California have seen considerable gains in coverage and benefits as a result of the ACA and other reforms made in the period since the enactment of the ACA. In fact, the ACA bolstered momentum within California to provide coverage to even more children and helped usher in opportunities to finish the job of covering all California children, starting with extending Medi-Cal coverage to all low-income children, regardless of immigration status.

This overview of how the ACA and related reforms have impacted children in California is a review of the effects. With six years of implementation of the major reforms of the ACA, the focus can now shift from establishing and building operations to the more detailed tracking, monitoring, and assessment of how specific populations are faring and what modifications, if any, might make further improvements. Because children are a small portion of the population that gained eligibility under the new ACA coverage expansions, children have not been a particular focus of inquiry when examining how the new system is working. As noted, quality and utilization measures specifically related to children's care, as well as systematic examinations of children's access to care, are critical components of any next steps in advancing health coverage in California.

As children's advocates, we are challenged to examine how children are best served in predominantly adult-focused coverage and care systems when little child-specific care data are available. For example, what modifications to Covered California cost-sharing

design features best serve the affordability of children's care, and are there unique considerations related to delivering care for children as compared to adults? Clearly, in many cases, the experience of children is similar to those of adults, such as in the enrollment process. Nonetheless, without a more fine-tuned lens and child-specific filter, children are more likely to be shoehorned into a system that may or may not fit their specific health care needs.

Further, as we move forward, what becomes clear is that the foundation of coverage for California children is the Medi-Cal program. As such, it's critically important to focus on the child-specific features of Medi-Cal, such as the new statewide system of coverage for all low-income children through the expansion of Medi-Cal, and the Medi-Cal EPSDT benefit for children, a benefit that by definition provides children what they need. With national discussions to dismantle the current Medicaid and CHIP programs heating up, maintaining and increasing investments in these insurance programs that serve half of all California children becomes all the more necessary. Children are a relatively inexpensive population to take care of, but, in doing so, the State makes an investment for their lifetime, supporting their development into healthy, productive adults. While work needs to be done to improve the system of coverage and care for all Californians, we must continue to explore the specific needs of children and ensure their well-being for today and tomorrow.



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