

# Closing Health Insurance Gaps for Families: WIC Can Help Make It Happen



**Findings**

**May 2003**

**from a**

**Southern**

**California**

**Pilot Project**



**The Children's  
Partnership**



**CALIFORNIA WIC ASSOCIATION**

Funded by **The California Endowment**

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The Children's Partnership (TCP) is a national nonprofit organization founded to put the unique needs of children front and center in a changing economy, culture and policy world. TCP brings to this project a strong history in health research and policy analysis including the development of Express Lane Eligibility, a policy to increase health insurance enrollment among uninsured children already enrolled in other public programs. In California, TCP's work has also included the formation of the 100% Campaign, a partnership with the Children's Defense Fund and Children Now to ensure that all of California's uninsured children receive health coverage.

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California WIC Association (CWA) is a nonprofit organization that was formed by directors of local WIC agencies in 1992. CWA activities include: training and staff development; public education and advocacy; and participation in maternal and child health, public health, and nutrition education coalitions. CWA members and staff provide leadership by acting as a resource for organizations dedicated to the promotion of maternal and child health, and by participating on Department of Health Services Advisory Boards and Task Forces. CWA seeks inclusion and partnership beyond the traditional WIC network, including other service providers, businesses and corporations, vendors, and the general public.

We would like to extend our thanks to the *Closing Health Care Gaps for WIC Families* Project staff who provided invaluable time and support to this report:

**Harbor-UCLA REI:** Heidi Kent, Terry Silberman, Rosa Gonzales, Mary Jane Olivas, Everardo Sandoval, Steve Baranov  
**Public Health Foundation Enterprises:** Judy Gomez, Thelma Artiga, Eloise Jenks  
**Northeast Valley Health Corporation:** Annette Besnilian, Jerry Villela, Irma Aguayo, Gayle Schachne  
**Riverside County Community Health Agency:** Gayle Hoxter, Carela Perez, Margarita Mendez, Perveen Ali  
**Watts Health Foundation:** Debra Keyes, Mary Ramirez  
**San Diego State University Foundation:** Sarah Larson, Carol Morales, Veronica Lopez  
**State WIC Branch:** Diane Phillips, Jennie Yamaguchi, Kathy Benabides, Linnea Sallack

We also send our thanks to the individuals who provided technical assistance and comments on the report.

Jenny Haley, The Urban Institute  
Dana Hughes, University of California, San Francisco  
Donna Cohen Ross and Leighton Ku, Center on Budget and Policy Priorities  
Lucien Wulsin, Insure the Uninsured Project



## **Closing Health Insurance Gaps for Families: WIC Can Help Make It Happen**

**Findings from a Southern California Pilot Project**

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As hard economic times and rising health care costs converge, the need for effective methods of bringing the eligible uninsured into California's health insurance programs grows increasingly acute. Almost 5 million Californians are uninsured – nearly 1 million of these are children. Especially troubling is the fact that most of these uninsured children are eligible for existing state health insurance programs (such as Medi-Cal or Healthy Families), but are not enrolled. However, many of these uninsured children do participate in other public programs that have eligibility standards similar to those for Medi-Cal and Healthy Families. In The Children's Partnership and California WIC Association's previous report, *WIC: A Door to Health Care for California's Children*, we showed how one such program — the Supplemental Nutrition Program for Women, Infants, and Children (WIC) — can be an important entryway to health coverage for these families. WIC appeared to be a promising link to health insurance that is both effective and efficient: WIC serves a large volume of the children and families who qualify for Medi-Cal and Healthy Families and bringing outreach to WIC agencies brings enrollment efforts to where the children are.

Since that report, the California WIC Association has tested this notion through a pilot project (funded by The California Endowment) called Closing Health Care Gaps for WIC Families. The pilot devised and implemented strategies for identifying WIC participants (and their family members) likely to be eligible for health insurance coverage, and helping them to enroll. In this report, The Children's Partnership has once again joined with The California WIC Association to analyze the work undertaken by the pilot sites: to quantify and understand the impact WIC can have on enrollment, and glean key lessons for future work. Using the findings from the pilot project and new data on the insurance status of WIC families, we conclude the report with a blueprint for how WIC can most effectively be utilized as an entryway to health insurance – and how WIC can play a key role in a next generation of Express Lane Eligibility efforts.

### Health Insurance Enrollment Efforts Today

Misunderstandings about eligibility and the length and complexity of the application process are among the most commonly identified barriers to enrollment in Medicaid (called "Medi-Cal" in California) and the State Children's Health Insurance Program, or SCHIP (called "Healthy Families" in California). Effective efforts to overcome these barriers generally include: providing public education, simplifying the application process, and supplying families with ongoing assistance (mainly through paid Certified Application Assistors) in navigating the enrollment system.

In California, efforts have been made in all three areas, including two new and related fronts. The first is the development of an online, potentially paperless application called Health-E-App. The second is the establishment of avenues for enrolling uninsured children into Medi-Cal or Healthy Families through other public benefit programs. This is called Express Lane Eligibility. Both of these new strategies lay the groundwork for WIC (and other public programs) to be effective gateways to health insurance coverage.

Unfortunately, several of the important gains made in California to increase enrollment are in jeopardy at the writing of this report (February 2003). The governor's proposed fiscal year 2003-04 budget eliminates the enrollment assistance system provided through the Certified Application Assistants (CAAs). This proposal would significantly undermine families' ability to successfully complete complex applications and enroll in health coverage.

## Linking to Health Insurance Coverage: Elements for a WIC Gateway

One of the most compelling reasons to use WIC as an express lane to health insurance coverage is that it serves the target population in great numbers. Each year, California WIC serves nearly 1.3 million people whom likely qualify for Medi-Cal or Healthy Families. More specifically:

- Eligibility thresholds for WIC, Medi-Cal and Healthy Families are so similar that most WIC participants (and their family members) are income-eligible for one of these health insurance programs. WIC serves pregnant women, infants and children ages 1 to 5 with incomes up to 185% of the federal poverty level (FPL); Medi-Cal serves pregnant women with incomes up to 200% of the FPL; and Medi-Cal/Healthy Families combined serve children up to 250% of the FPL.
- Newly available data from the California WIC program (a direct result of efforts undertaken during the Closing Health Care Gaps for WIC Families Project) confirm that more than 180,000 of WIC participants (80% of whom are infants and young children) are uninsured.

In short, because WIC serves many low-income families who are uninsured (including 145,000 uninsured children), it alone has the potential to provide health insurance outreach and enrollment assistance to almost one-fourth of California's 655,000 eligible but uninsured children. Yet in addition to serving the target population in great numbers, there are a number of other reasons why it makes particular sense to use WIC as a priority gateway to health insurance enrollment.

- **WIC is about health and well-being.** One of WIC's principal goals is encouraging health care. As a result, WIC staff have always informally helped families navigate the health care maze. In fact, federal regulations require WIC agencies to inform their clients about health insurance options and refer them to application assistance.
- **WIC is a trusted resource.** Because WIC does not ask intrusive enrollment questions (about immigration status, for example) or require extensive income or asset documentation, it is perceived as a "user-friendly" and supportive resource in the community.
- **WIC already has an established link with Medicaid.** Recognizing the important connection between WIC and Medicaid, in 1989 Congress authorized WIC agencies to accept a family's Medicaid enrollment as proof of income eligibility for WIC.
- **WIC has the technological capacity.** WIC has a common statewide, automated system (called ISIS) that could be linked to other programs. In addition, WIC is currently converting to an Internet-based telecommunications system, which could help connect it to other systems. Finally, WIC agencies already can link to MEDS (the Medi-Cal Eligibility Data System) to confirm family information and Medi-Cal enrollment.
- **Health insurance coverage for participants helps WIC.** Health insurance coverage and use of the health care system maximize the positive health impacts of the nutritional benefits offered by WIC. In addition, it is easier and faster for WIC workers to get required medical information (e.g. blood work that assesses the risk of anemia) if a participant has insurance and a medical home.

## Closing Health Care Gaps for WIC Families Pilot Project: Overview and Results

In March 2000, with funding from The California Endowment, the California WIC Association launched Closing Health Care Gaps for WIC Families in six WIC agencies in mostly urban, high immigrant communities in Los Angeles, Riverside and San Diego counties. These pilot sites serve half of all WIC participants in California. The Project had three goals: 1) to increase public awareness about the importance of health care and the availability of insurance coverage; 2) to facilitate actual enrollment in Medi-Cal and Healthy Families; and 3) to track participants' progress through the enrollment system.

While specific activities varied in each site, project efforts generally included: staff training, participant education, application assistance provided by WIC staff or outside enrollment partners, tracking participants' progress through the enrollment system, and providing assistance until enrollment is finalized. The Project also played a key role in the development and testing of a now permanent change to WIC's data collection system, so that it captures the most useful information about participants' health insurance status.

### Project Results: Improvements in Health Insurance Coverage

Findings from the Closing Health Care Gaps for WIC Families Project clearly demonstrate that with appropriate levels of financial support, WIC programs are ideal partners in outreach and enrollment for Medi-Cal and Healthy Families:

- **More WIC participants were covered by Medi-Cal or Healthy Families.** Coverage rates for Medi-Cal and Healthy Families increased by 29% for the prenatal women, infants and children who were served at the pilot sites: While only 45% of WIC participants seen at the pilot sites had Medi-Cal/Healthy Families at the beginning of the Project, 58% of WIC participants did at the end of the Project.
- **A greater share of WIC participants was in the "pipeline" to health insurance.** WIC participants in the enrollment "pipeline" (meaning they applied for coverage and were awaiting approval) tripled at the pilot sites from 3% to 9%.
- **Fewer WIC participants reported having no insurance.** The pilot sites experienced a 53% decrease in the share of uninsured participants (those with no insurance and not in the pipeline).

### Coverage Status for WIC Participants in the Pilot Sites

COVERAGE STATUS	INFANTS		CHILDREN		WOMEN		Total	
	Before	After	Before	After	Before	After	Before	After
Healthy Families/Medi-Cal	23%	37%	55%	67%	39%	55%	45%	58%
Applied and Awaiting Decision	6%	17%	1%	4%	8%	20%	3%	9%
No Health Insurance*	55%	30%	27%	12%	35%	6%	34%	16%
Private Insurance*	16%	16%	17%	17%	18%	18%	17%	17%

Note: "Before" refers to data from the beginning of the pilot project, starting in June 2000 for pregnant women and in July 2001 for infants and children. "After" refers to data from the end of the project (June 2002).

\* Because questions about private insurance status were not asked until approximately one year into the pilot project, we used the highest rate of private insurance as a constant, and adjusted "no health insurance" in the "before" data to reflect that constant (for more details on this calculation, see Appendix E).

- **The Project also found that infant coverage rates were comparatively low.** Despite notable increases over the course of the Project in the percentage of infants who had health insurance or were awaiting approval, infants were still more than twice as likely to be uninsured than children (30% of infants at the end of the Project were uninsured as compared to 12% of children), and infants were more than four times as likely to be awaiting an eligibility determination from Medi-Cal/Healthy Families than older children (17% of infants awaiting compared to 4% of children). This is despite the fact that infants are automatically eligible for coverage based on their mother’s enrollment in Medi-Cal at the time of delivery.

### **Closing Health Care Gaps for WIC Families Pilot Project: Lessons Learned**

In addition to yielding encouraging data on improvements in health insurance coverage, the Closing Health Care Gaps for WIC Families Project provides some important lessons for both WIC sites and policymakers on the ingredients for a successful enrollment project. The Project demonstrates how WIC can be effectively engaged in the application process and reveals some of the principal challenges in the Medi-Cal and Healthy Families enrollment system.

#### **Ingredients for a Successful Enrollment Project**

WIC pilot sites chose a variety of intervention strategies (i.e. training existing staff, hiring new staff, or contracting out the work) depending on their capacity and preferences as well as the “personality” of the local Medi-Cal agency. For all the strategies employed, however, effective WIC-based enrollment assistance required:

- Hands-on assistance – even with a seemingly user-friendly enrollment system;
- Designated experts in every WIC site, with reduced workload for in-house staff taking on this role;
- All staff having basic knowledge of health insurance issues and program eligibility requirements, in addition to motivation to help people in this arena;
- An ongoing commitment to training and quality assurance as staff turn over and the health insurance rules change; and
- Additional office space and supplies as well as phone and computer access.

#### **Challenges in the Enrollment Process**

The Closing Health Care Gaps Project demonstrated that collaboration with county Medi-Cal agencies helped WIC staff better navigate the enrollment process. Positive working relationships led to joint problem-solving and system modifications. However, the Project also revealed insights to the challenges in offering health insurance enrollment assistance, highlighting persistent barriers in the Medi-Cal application process that were beyond the control of WIC staff. These barriers included a complex application process, inconsistencies in how rules were applied and applications processed, and delays in agency responsiveness. In addition, the Project found that fears about the impact of state health insurance enrollment on immigration status persist and deter enrollment.

In the end, the large increase in WIC participants in the health insurance “pipeline” suggests that hands-on assistance could only move an application so far. Significant improvements to the design and operation of the enrollment process itself would be required to expedite enrollments on a large scale.



### Next Steps: A Blueprint for Action

This report shows that WIC provides the state with a highly efficient avenue for reaching large numbers of uninsured families eligible for its health insurance programs, Medi-Cal and Healthy Families. WIC has the potential to enroll a total of 145,000 of its uninsured children participants— over 20% of California’s target population of uninsured but eligible children.

In fact, because the six pilot sites serve half of all WIC families in California, the Closing Health Care Gaps for WIC Families Project has already provided significant help toward getting the job done — with a 29% increase in the Medi-Cal/Healthy Families coverage rate and 53% drop in the uninsured rate for the prenatal women, infants and children seen at those pilot sites. At the very least, financing from various sources should be secured to continue this Project.

Following is a blueprint for increasing health insurance enrollment in California through the WIC program, building on Express Lane Eligibility efforts already underway. Most of these steps will require only administrative action, however some legislative authority may be required for the larger system changes, such as creating a full Express Lane process.

#### First Steps

- Continue the investment in the existing community enrollment system (CAA fees).
- Invest in WIC linkages to insurance enrollment through financing from various state, federal and private sources to continue enrollment activities like those undertaken by the Closing Health Care Gaps for WIC Families Project.
- Enforce current regulations mandating basic health insurance education and referral for WIC participants.
- Coordinate currently disparate state efforts to improve information and enrollment systems among programs, so that current changes being made to WIC’s eligibility system will not have to be redone in order to implement Express Lane Eligibility.
- Prioritize addressing low rates of WIC infant coverage. For example, automatically enroll newborns by implementing online in-hospital health insurance enrollment for newborns immediately after birth and by automatically enrolling infants from the Child Health and Disability Prevention (CHDP) Gateway.
- Build a true CHDP Gateway that allows an initial screening for services to provide a foundation for a Medi-Cal/Healthy Families health care application. The Gateway can serve as a model for other program linkages, including WIC.
- Improve the Medi-Cal enrollment system by enhancing responsiveness, further simplifying the application process, reducing inconsistencies in applying program rules and ensuring that rules and procedures make the system work well. To avoid undermining progress already made, state budget proposals should not force counties to become “gatekeepers” to insurance enrollment.

#### Steps for the Next Generation of Health Insurance Enrollment Work: Express Lane Eligibility

Build a true Express Lane Enrollment System by simplifying the health insurance application for WIC applicants and/or streamlining the enrollment process for eligible WIC applicants into Medi-Cal/Healthy Families. To begin the process, the state should bring together interested stakeholders to explore the best options for implementing Express Lane through WIC.

Seek permanent financing from various sources to institutionalize the infrastructure necessary for local WIC staff to do Express Lane Eligibility in health insurance.

**Conclusion**

As we had anticipated, WIC agencies are poised to be effective gateways to health insurance coverage, if appropriately utilized and supported. The Closing Health Care Gaps for WIC Families Project demonstrates that a well-planned strategy for WIC staff to provide intensive, one-on-one application assistance can help increase health insurance enrollments. The results of such “stepped-up” efforts far surpass what has resulted from the regular education and referral activities WIC sites have routinely performed.

Yet the complexity of insurance program rules and enrollment processes continue to deter families in their intention to seek coverage. The state should maximize the potential of WIC as a health insurance gateway by implementing Express Lane Eligibility at WIC agencies. California has begun to implement “express enrollment” through other programs (e.g. the School Lunch program). The time is ripe to implement express enrollment through WIC.

# introduction

As hard economic times and rising health care costs converge, the need for effective methods of bringing the eligible uninsured into California's health insurance programs grows increasingly acute. The most recent data show that 4.5 million Californians – nearly 1 million of whom are children – are uninsured.<sup>1</sup> Being uninsured not only puts the health and future well-being of these Californians at significant risk, but it drains state and county tax dollars that subsidize care for the uninsured.<sup>2</sup> Many of these uninsured Californians qualify for either Medi-Cal (the state's Medicaid program) or Healthy Families (California's "State Children's Health Insurance Program") – they are simply not enrolled. In fact, more than 1.1 million uninsured children and adults (most of whom are parents) are eligible for this coverage.<sup>3</sup> Something is standing in the way of health insurance enrollment. Although California offers a range of preventive and ongoing health insurance options for uninsured families, these data suggest that the entryways to this coverage are not working the way they should.

By contrast, many of California's uninsured (but eligible) children successfully find their way through the doors of other public programs. The National School Lunch Program, Food Stamps and the Supplemental Nutrition Program for Women, Infants, and Children (WIC) are among the many public programs that serve large numbers of children who do not have health insurance but are eligible for it.

In a July 2000 report called *WIC: A Door to Health Care for California's Children*, The Children's Partnership and the California WIC Association described how the WIC program can be such a gateway to health insurance coverage. The report showed that WIC not only serves large numbers of infants, young children and pregnant women who are in the same income group as the health insurance programs, but also has a strong community presence, a "user-friendly" reputation, and the technological capacity to link to the health insurance enrollment system.<sup>4</sup> As a result of these features, the WIC program is an ideal vehicle for "Express Lane Eligibility," meaning the strategic coordination of application procedures between public programs so that enrolling in one provides easy entry — or an "express lane" — into another.

Since that report, two important developments have enabled us to get a better picture of how WIC can be an effective door to health care coverage. First, in October 2001 the WIC program began using a new data collection screen as part of the application process that has yielded much more accurate information on the health insurance status of WIC families. Second, the California WIC Association (CWA) undertook an innovative two-year pilot project (funded by The California Endowment) to test whether and how WIC can serve as an effective link to health insurance enrollment.

A "before-and-after" comparison of the health insurance status of WIC participants in CWA's six pilot sites demonstrates concretely that WIC can use its assets to help families access health coverage with remarkable success. Medi-Cal and Healthy Families coverage rates increased by a full 29% for the prenatal women, infants and children served. The share of WIC participants "in the pipeline" for coverage (meaning they applied and were awaiting a final eligibility determination) tripled at these pilot sites. And, the pilot sites experienced a 53% decrease in the portion of uninsured participants (with no insurance and not awaiting an eligibility determination). In short, the Closing Health Care Gaps for WIC Families Project provides solid new data on the positive impact WIC can have on health insurance coverage. In addition, the experiences of the participating WIC sites offer important "real-world"

lessons as we seek the most effective strategies for identifying and enrolling eligible families into health insurance programs at WIC sites.

### **About This Report**

For this report, The Children’s Partnership once again joined with the California WIC Association to determine the extent to which WIC sites can increase health insurance for their participants, and the most effective strategies for doing so.

The report begins with an update on California’s efforts to enroll eligible families into health insurance coverage, including recent “Express Lane Eligibility” efforts. We then offer new information that confirms WIC’s value as a health insurance enrollment vehicle. The report presents health coverage results from the Closing Health Care Gaps for WIC Families Project and an analysis of the continuing challenges and opportunities WIC agencies face in providing Medi-Cal and Healthy Families enrollment assistance. We conclude with a compelling blueprint for action that can help California’s next generation of Express Lane Eligibility efforts move forward through the WIC program.

California has a tradition of leadership and creativity on health care reform, often pioneering health initiatives that are then replicated across the country.<sup>5</sup> Low-income children and pregnant women in California can get health care coverage and services through several state programs: Medi-Cal, Healthy Families, Access for Infants and Mothers, California Children's Services, and the Child Health and Disability Prevention Program. (See *Appendix A for additional information on California's programs.*) In addition, a growing number of counties provide their own insurance programs for children and families who are not eligible for the state insurance programs. Finally, in certain areas of the state there are private insurance programs for low-income children, such as California Kids and Kaiser Permanente Cares for Kids.

Yet despite this panoply of options, California has one of the lowest health insurance coverage rates in the nation, behind every state except Texas and New Mexico.<sup>6</sup> As mentioned, there are almost 5 million Californians who are uninsured, 1 million of whom are children.<sup>7</sup> Without insurance, these Californians are significantly less likely to get the preventive care they need, and are more likely to use emergency health services when the problem has become more severe. This results in the problem becoming significantly more expensive to treat.<sup>8</sup> For children in particular, living without health insurance means facing health problems that could put their future growth and development at serious risk. One recent study found that people who did not get (or delayed getting) medical care had significant increases in stress, lost time at work or school, and/or experienced temporary or long-term disabilities.<sup>9</sup>

Among the uninsured children in the state, nearly 2 out of 3 (655,000) could get coverage immediately through Medi-Cal or Healthy Families. In addition, 465,000 uninsured adults in California, the majority of whom are parents, are eligible for Medi-Cal.<sup>10</sup> To help the large numbers of people who are eligible for public health insurance coverage get enrolled, advocates, policymakers, practitioners and communities across the country have been working to identify the barriers to getting coverage, and testing different strategies to overcome them.

*"We have had a lot of problems with [immigration issues] in San Diego. At one point, the county offices had signs actually discouraging immigrants from using public programs. It is routine practice here for a welfare investigator to be sent unannounced to people's homes when an application for any kind of service is submitted."*

- Sarah Larson,  
Executive Director,  
San Diego State University  
Foundation WIC.

### Understanding the Barriers to State Health Insurance Coverage

Studies have found that misunderstandings about eligibility and the length and complexity of the application process are among the most commonly identified barriers to enrollment in Medicaid and SCHIP. One recent study further characterized the principal barriers in terms of the concerns or perceptions of applicants: 1) they will be made to answer unfair personal questions; 2) they will face a long and complicated application process; 3) they are not eligible or have to be on welfare to get Medicaid; and 4) they will not be treated with respect by caseworkers and/or physicians.<sup>11</sup>

A recent study of barriers experienced by California's ethnic minority communities expands this list of obstacles to include disparities in coverage availability within families and a lack of accessible and culturally appropriate information.<sup>12</sup> Fear and confusion about enrollment is intensified among the large numbers of eligible but uninsured families in California who are immigrants or the U.S.-born children of immigrant parents. Despite federal guidance indicating otherwise, many immigrants fear that receiving public benefits (such as health insurance) will negatively affect their immigration status, their ability to naturalize, or their capacity to sponsor an immediate relative.<sup>13</sup>

While these barriers and concerns are real, research also reveals that families with eligible children consider Medicaid to be a good program and would like to enroll their children.<sup>14</sup> This was found to be true for 70% of English-speaking Latino parents and 63% of Spanish-speaking Latino parents in California.<sup>15</sup>

### Finding Solutions: What California Has Tried

Over the last several years, California has taken a number of steps to address the barriers to health insurance enrollment. The state has made changes to its enrollment process: shortened the application form to four pages, permitted it to be returned by mailed, and created a joint Medi-Cal/Healthy Families application so that if a child is ineligible for one program, the application can be sent to, and considered by, the other one. Most recently, the state implemented “accelerated enrollment,” which temporarily enrolls a child into Medi-Cal based on a preliminary screen of the joint application, while it is forwarded to the county for a final determination.

Yet even with a simpler application, many families need substantial assistance to navigate the enrollment system. Recognizing this, the state funded the training of nearly 2,000 Certified Application Assistors (CAAs) who help families complete the joint Medi-Cal/Healthy Families application in a range of community-based settings for a small stipend per successful application. In fact, 61% of joint applications submitted to the state were completed with the assistance of CAAs. California data show that families receiving assistance filling out the joint Medi-Cal/Healthy Families application have higher enrollment rates for their children than those who do not get help (79% enrolled as opposed to 63% enrolled).<sup>16</sup> The state also gave grants to community groups to provide intensive outreach, enrollment and retention services.

Unfortunately, this essential community enrollment system is at risk of being dismantled. As part of the reductions made to fill the states’ budget deficit, the community grants were eliminated in the state’s fiscal year 2002-03 budget. In addition, at the writing of this report (February 2003), the governor’s proposed fiscal year 2003-04 budget eliminated the CAA. If this proposal is approved, fewer families would be likely to successfully complete applications and a significant number of children would be less likely to enroll.

Policymakers, advocates, foundations and service providers in California have moved forward on other important efficiencies in the enrollment infrastructure. In particular, efforts are underway to: 1) develop an online, potentially paperless, application; and 2) establish avenues for Express Lane Eligibility in Medi-Cal or Healthy Families through other public benefit programs.

- **Online Enrollment.** The California HealthCare Foundation and the State Department of Health Services have developed the country’s first fully automated Web-based application for enrolling low-income children in Medi-Cal and Healthy Families — called Health-e-App. Using this system, CAAs with Internet access can complete the joint application in 20-30 minutes. Health-e-App allows for: quick error-checking and accurate computing of income and deductions; a preliminary eligibility determination in a few seconds; confirmation that an application has been submitted and the ability to track its status; as well as electronic payment of premiums and other innovations. After a period of pilot-testing, Health-e-App is currently being rolled-out across the state.<sup>17</sup> A Web-based application system will enable programs like WIC to use technology to facilitate health insurance enrollments.

- **Express Lane Eligibility.** In June 2001, by statutory mandate, the California Health and Human Services Agency provided Governor Davis with specific recommendations for “streamlining application and enrollment” for Medi-Cal and Healthy Families. The report identified five options for coordinating with 14 public programs (including WIC): establish and enhance referral processes with follow-up capacity, provide education and on-site application assistance, develop common applications, share eligibility information and grant presumptive eligibility.<sup>18</sup>

Building on these recommendations, California is implementing Express Lane Eligibility for health insurance enrollment in three program areas.<sup>19</sup> In October 2001, two new laws (AB 59-Cedillo and SB 493-Sher) authorized improved information-sharing and coordination of eligibility processes between Medi-Cal and the National School Lunch and Food Stamp programs. Under both bills, information families submit to enroll in School Lunch or Food Stamps would be used to enroll the children into Medi-Cal, without the family having to complete a Medi-Cal application. Both will be implemented in July 2003.

In addition, the state is developing an Internet-based system to allow a child who is income-eligible for Medi-Cal or Healthy Families and applying for services through the Child Health and Disability Prevention Program (CHDP) to receive temporary Medi-Cal/Healthy Families coverage. To receive ongoing coverage, the families would be required to complete a full application. This “CHDP Gateway” will be implemented in July 2003. (See *Appendix A for a description of CHDP.*) As a result of these efforts, Medi-Cal and Healthy Families enrollment should be significantly easier for participants in these three programs.

In this environment of hard economic times and rising health care costs, maximum efficiency in bringing eligible but uninsured families into California’s health insurance system is particularly critical. These Internet enrollment and program linkage infrastructures are good news in that respect. However, these strategies will be impacted by any potential loss in the existing community enrollment infrastructure provided through CAAs. Maintaining the existing investment in the enrollment systems while building its commitment to harnessing technology and streamlining enrollment between public programs offers great promise for moving enrollment efficiencies forward. This report suggests a logical strategy for building on these efforts. The following chapters present how using one specific entry point – WIC – can make a real dent in the number of uninsured people.

# wic gateway

There are a number of reasons why using WIC as an “Express Lane” to health insurance coverage makes great sense. Perhaps most compelling is the fact that WIC serves essentially the same population as Medi-Cal and Healthy Families, serves this group in great numbers, and a significant number of WIC participants are uninsured.

**WIC serves the target population in great numbers.** WIC agencies in California provide food and nutrition education to on average 1.24 million pregnant, breast-feeding and post-partum women, infants and young children (ages 1-5). Of all California WIC participants (1.4 million people)<sup>20</sup>, there are about 338,000 women, 322,000 infants and 753,000 children. Over half of the infants born in California are enrolled in WIC.<sup>21</sup> In large urban areas, WIC clinics may enroll as many as 200 new prenatal women and their families each month. In Los Angeles County alone, 93% of all low-income infants are born to WIC moms.<sup>22</sup> (See Appendix B for additional information on the WIC Program.)

**Many WIC participants are uninsured.** Newly available data collected by the California WIC Branch (a direct result of efforts undertaken during the Closing Health Care Gaps for WIC Families Project) confirm that, as of September 2002, more than 181,000 WIC participants are uninsured: about 36,000 women, 84,000 children and more than 62,000 infants. (See Table 1). With 655,000 children in California uninsured but eligible for Medi-Cal or Healthy Families, WIC alone is able to reach almost one-fourth of the state’s target population of uninsured children.<sup>23</sup>

**Table 1 - Insurance Status of WIC Participants\***

	Women	%	Children	%	Infants	%	Total	%
Medi-Cal	202,348	60%	471,904	63%	116,109	36%	790,361	56%
Healthy Families (HF)	729	0%	36,468	5%	2,014	1%	39,211	3%
Medi-Cal “Pipeline”**	32,670	10%	24,523	3%	76,877	24%	134,070	9%
HF “Pipeline”**	130	0%	3,360	0%	1,040	0%	4,530	0%
Private Insurance	65,634	19%	130,520	17%	62,683	19%	258,837	18%
No Insurance	35,552	11%	83,718	11%	62,158	19%	181,428	13%
Other	858	0%	2,461	0%	1,201	0%	4,520	0%
<b>Total</b>	<b>337,921</b>		<b>752,954</b>		<b>322,082</b>		<b>1,412,957</b>	

Source: California Department of Health Services, WIC Supplemental Nutrition Branch, September 2002 data. Numbers may not add to 100% due to rounding.

\*Represents all individuals participating in WIC, not just those served in the month.

\*\*These WIC participants are in the “pipeline” to Medi-Cal/Healthy Families enrollment because they have applied to be enrolled and are awaiting final approval from the insurance programs.

**The programs have similar income-eligibility thresholds.** Because the income-eligibility thresholds for WIC, Medi-Cal and Healthy Families are very similar, most WIC participants (and their family members) are income-eligible for one of the two health insurance programs.

- WIC serves pregnant women, infants and children ages 1 to 5 with incomes up to 185% of the federal poverty level (FPL).
- Medi-Cal serves pregnant women with incomes up to 200% of the FPL.
- Medi-Cal/Healthy Families combined serves children up to 250% of the FPL.



Fortunately, differences in the additional eligibility requirements for WIC and Medi-Cal/Healthy Families do not diminish the likelihood that WIC participants will be eligible for one health insurance program or the other:

- While household size is counted differently in these programs, the high eligibility ceiling for pregnant women under Medi-Cal, and for children under Medi-Cal and Healthy Families, ensures that most — if not all — WIC women and children are income-eligible for at least one of the health insurance programs.
- While full-scope Medi-Cal and Healthy Families require applicants to be U.S. citizens, Legal Permanent Residents or to meet certain other immigration criteria, WIC does not have citizenship or permanent residency requirements. However, since children eligible for WIC are 5 years of age or younger, they are most likely U.S.-born. In addition, undocumented pregnant women and children are eligible for restricted Medi-Cal, which covers emergency and pregnancy-related services.

*(See Appendix C for a more complete comparison of eligibility guidelines for Medi-Cal, Healthy Families and WIC).*

In addition to the fact that WIC serves the health insurance outreach target population in great numbers, there are several other important reasons why WIC (among many public benefit programs) should be viewed as a priority Express Lane vehicle.

**WIC and health care go hand in hand.** One of the principal goals of the WIC program is to encourage and facilitate access to maternal, prenatal and pediatric health care. In keeping with this goal, WIC staff have been informally helping people navigate the health care maze for decades. In fact, current federal regulations require WIC agencies to inform their clients about health insurance options and refer them to application assistance.<sup>24</sup> In addition, over the years individual WIC programs have taken on a range of extra activities to improve the health and well-being of their participants, such as immunization drives and oral health education. The combination of WIC's standard program and these "extra" efforts has made WIC highly cost-effective in improving health outcomes (such as birth weight, infant mortality, and childhood anemia). Recently, a four-year strategic plan for the California WIC program developed by a broad spectrum of public and private sector experts prioritized financing these "extra" activities (specifically including health insurance outreach).

**WIC is a trusted resource.** Because health insurance enrollment can be a complicated process that requires families to provide personal information, securing families' trust is a critical ingredient of successful application assistance. The WIC program holds a unique position in this regard. Because the program does not require citizenship documentation, ask intrusive enrollment questions, or require extensive income and asset certification, it is generally perceived as a "user-friendly" and supportive resource in the community. In short, people like, trust and use WIC.

**WIC already has an established link with Medi-Cal.** Federal officials have already recognized the important connection between WIC and Medicaid. In 1989, Congress authorized WIC agencies to accept a families' documented participation in Medicaid as proof of income-eligibility for WIC.<sup>25</sup> Although a family is still required to meet WIC's additional eligibility requirements — such as being nutritionally at-risk and a state resident — this "adjunctive eligibility" process substantially streamlines WIC enrollment.

**WIC has the technological capacity.** In its report to Governor Davis, the California Health and Human Services Agency found WIC to be “the only program that has a common statewide, automated system (called ISIS) that could be linked to other programs.”<sup>26</sup> In addition, the report confirmed that WIC agencies can link to MEDS (the Medi-Cal Eligibility Data System) to confirm participant information and check for enrollment. Finally, the state WIC branch is currently converting its telecommunications infrastructure to an Internet-based system to enhance internal program efficiency. This conversion will be pilot tested this summer (2003) and rolled out statewide contingent on the results of the pilot. Bridging the technology gap between hands-on community-based programs and the Medi-Cal/Healthy Families systems is key to streamlining enrollment, and WIC has the infrastructure in place to do so.

**WIC benefits from providing enrollment assistance.** Using WIC as a vehicle for health insurance enrollment also benefits WIC. For example, it is easier and faster for WIC workers to get required medical information (e.g. blood work that assesses the risk of anemia) if a participant has insurance and a medical home. In addition, health insurance coverage and use of the health care system maximize the positive health impacts of the nutritional benefits offered by WIC. (Additional benefits that accrued to the WIC programs through the Closing Health Care Gaps for WIC Families Project are discussed in more detail in later sections).

Given the obvious linkages, the state has made some efforts over the last few years to reach and enroll women and children through the WIC program. It has: provided promotional material and mail-in applications to all WIC agencies; encouraged WIC staff to attend application assistant training sessions; sent a letter to WIC participants encouraging them to enroll in Medi-Cal; and occasionally made funding for WIC outreach activities available, which “gets the word out” in low-income neighborhoods.

#### Facts about California WIC

- 100% federally funded, locally administered.
- Provides nutrition vouchers to pregnant women, infants and children ages 1-5.
- 1.24 million participants are served by 81 local agencies at 650 clinic sites.
- 52% are preschool children up to age 5, 23% are infants and 25% are women.
- Most participants (72%) are Latino/a, followed by 13% white, 8% African American, 6% Asian.
- No written application. No paper verification required. Eligibility determined on-site by staff.

*Source: California Department of Health Services, WIC Supplemental Nutrition Branch.*

While some success has come of these efforts, our earlier work with WIC agencies suggested that with a modest investment of resources, more intensive activities would yield a real improvement in the number of WIC participants with health insurance coverage.<sup>27</sup> The California WIC Association undertook the Closing Health Care Gaps for WIC Families Project to test these assumptions. The following two sections describe data findings and lessons learned from the Project, which provide valuable insights into WIC’s effectiveness as a door to health coverage.

# overview & results

*“We applied for this grant to use the comfort we have established in the community to take families one important step further. And it really worked.”*

*- Annette Besnilian,  
Director of Special  
Projects and Programs,  
Northeast Valley Health  
Corporation*

In March 2000, with funding from The California Endowment, the California WIC Association launched a two-year demonstration project in six Southern California WIC programs to substantially increase access to health care among WIC participants. The Project set out to show that: 1) WIC programs are ideal partners in outreach and enrollment for Medi-Cal and Healthy Families; and 2) with financial support WIC can help increase the percentage of its participants that have health insurance coverage or that have begun the enrollment process and are awaiting a final decision.

The Closing Health Care Gaps for WIC Families Project took place in six WIC agencies in mostly urban, high immigrant communities in Los Angeles, Riverside and San Diego counties. The participating WIC agencies included both large and small agencies, county-based systems, and community-based nonprofit clinic systems. They were: Northeast Valley Health Corporation, REI-Harbor UCLA, Riverside County Community Health Agency, San Diego State University Foundation, Watts Health Foundation and Public Health Foundation Enterprises. Together, the six participating sites serve as many as 600,000 women, infants and children each month, almost half of the state’s WIC population. Each site received a grant ranging from \$200,000 to \$310,000 over a two-year period. *(For a summary of the individual pilot project programs and activities, see Appendix D.)*

With the infusion of additional funds, the Closing Health Care Gaps for WIC Families pilot sites were able to undertake a range of activities in three critical areas: 1) increasing public awareness about the importance of health care and the availability of insurance coverage; 2) facilitating actual enrollment in Medi-Cal and Healthy Families; and 3) tracking participants’ progress through the enrollment system. In its first year, the Project targeted prenatal women, expanding efforts to infants and children in the second year. Specific activities varied in each site, but taken together, Project efforts included the following:

- **Staff training.** WIC staff at all levels received ongoing training on: the value of early and comprehensive prenatal care; the importance of health insurance coverage for all family members; the rights of all low-income pregnant women in California to receive prenatal Medi-Cal; public charge<sup>28</sup> and other immigration issues as they relate to the use of public programs; effective referral-making; and successful enrollment assistance. Training sessions were conducted by the California WIC Association, representatives from the different counties’ Departments of Public Social Services (DPSS), the Public Health Foundation Enterprises (PHFE) WIC program and other local groups. Training was aimed at educating staff as well as motivating them to get involved in the work. A special training workshop was developed for the initiative. In addition, a number of sites held regular meetings with DPSS staff to review cases, go over rule changes, and trouble-shoot specific problems. These meetings served a training function as well.
- **Participant education.** The pilot sites employed a combination of group and individual education strategies for WIC participants on the relevant topics listed above. A new class on family health and accessing health insurance coverage was developed by PHFE WIC and launched in each site for new entrants and returning prenatal women. In addition, individual sites developed a range of educational materials for their participants, including fliers, dry-erase boards to announce when application assistance was available, brochures and videos. The material was aimed at encouraging families to obtain coverage, explaining the health insurance enrollment process, distinguishing the myriad health insurance programs, and calming fears and providing facts about public charge and other immigration issues.

- **Application assistance by WIC staff.** Several of the pilot sites chose to designate specific staff as application assistants. These staff were thoroughly trained, relieved of some or all of their previous duties, and made responsible for providing application assistance as well as follow-up case management and “system navigation” to all participants reporting they (or a family member) had no (or pending) health insurance coverage. The shift in staff role was generally viewed as a promotion within the agency.
- **Application assistance by outside enrollment partners.** Several of the pilot sites brought in CAAs or actual county eligibility workers to provide application assistance and follow-up on site. In addition, some clinics contracted with CAAs in other community-based organizations to provide assistance in off-site locations, including in participants’ homes. In some sites, information and assistance was also made available through toll-free phone numbers..
- **“Tagging and tracking” participants.** All six pilot sites implemented strategies to identify or “tag” participants in need of health insurance coverage and track their progress through the enrollment process. Specifically, this entailed: developing a new screen for WIC’s data system which would elicit more accurate information about health insurance status; gathering information about health insurance status at all points of interaction with participants (intake, follow-up appointments, group sessions), placing administrative “holds” in participant files so that staff would not overlook a participant in need of follow-up assistance; manually reviewing logs of participant status; and following up with individual phone calls.

For this report, we reviewed the six pilot sites’ proposals and interviewed the staff at the six WIC sites about their activities, experience and perspectives. In addition, the California WIC Association and the State WIC Branch collaborated to compile the pilot sites’ data on health insurance status:<sup>29</sup> the portion of women, infants and children covered by Medi-Cal/Healthy Families; the portion who applied for coverage but were awaiting an eligibility determination; and the remaining portion of participants without any insurance (and not awaiting approval). Our analysis compared the health insurance status of WIC participants seen at the beginning of the Project period to the insurance status of participants at WIC sites at the end of the Project period. The results follow.

### **Project Results: Improvements in Health Insurance Coverage**

During the course of the Closing Health Care Gaps for WIC Families Project, Medi-Cal and Healthy Families enrollment increased for all population groups. In the six pilot sites — serving as many as 600,000 participants — Medi-Cal and Healthy Families coverage increased by 29% for prenatal women, infants and children (from 45% of participants covered to 58% covered).

The Project appears to have been even more successful in helping get WIC participants into the Medi-Cal/Healthy Families “pipeline” — meaning an application has been submitted but not yet approved. By the end of the project, three times as many WIC participants were in the health insurance “pipeline” (an increase from 3% to 9% of participants).

We distinguish the “pipeline coverage” status separately because, although we assume they will eventually receive coverage, actual enrollment was not yet finalized, and they are, in the meantime, uninsured.<sup>30</sup> The increase in those in the enrollment “pipeline” shows the pilot sites’ progress toward enrolling those who are eligible to the extent the sites could affect their

enrollment. While actual enrollment is clearly preferable to awaiting coverage, even intensive, hands-on-assistance can only bring an application so far. Ultimately, only the state insurance programs are responsible for the timeliness of enrollment decisions.

In short, a smaller portion of the WIC participants was uninsured after the Project (16%) compared to before the Project (34%) — a 53% drop.

Below, we present the Project results by population group. *(For notes on data methodology, see Appendix E. For a program-by-program breakdown of data, see Appendix F).*

**More WIC participants had Medi-Cal or Healthy Families coverage (Chart 1).**

- **Infants.** Over the course of the Project, the percentage WIC infants covered by Medi-Cal or Healthy Families increased by 61% (from 23% covered to 37%).

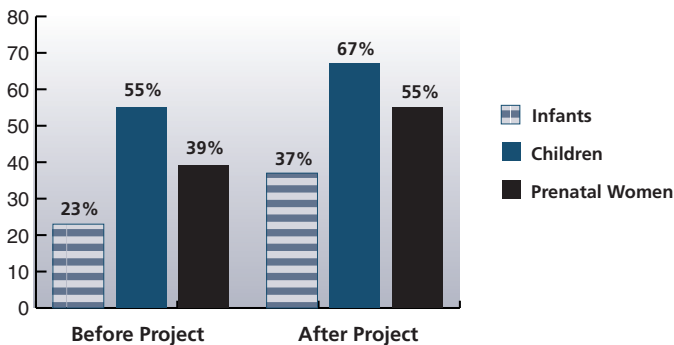
The enrollment increases ranged across the pilot sites from 68% at Public Health Foundation Enterprises (from 25% covered to 42%), to 21% at San Diego State University Foundation (from 29% covered to 35%). Since almost all WIC infants qualify for Medi-Cal, the percent of publicly insured infants who were enrolled in Healthy Families remained extremely low throughout the Project (at or below 2%).

- **Children.** Over the course of the Project, the percentage of WIC children covered by Medi-Cal or Healthy Families increased by 22% (from 55% covered to 67%).

The enrollment increases ranged across the pilot sites from 30% growth at San Diego State University Foundation (from 43% covered to 56%) to 16% growth at Watts Health Foundation (from 63% covered to 73%). Because children are eligible either for Medi-Cal or Healthy Families, the WIC-based application assistants had to navigate complex eligibility criteria to make sure that participants enrolled in the appropriate program. They succeeded: While about 2% of children enrolled in one of the two programs had Healthy Families coverage when the Project began, 8% were enrolled in Healthy Families at the end of the Project.



**Chart 1. Medi-Cal/Healthy Families Coverage**



- **Prenatal women.** Over the course of the Project, the percentage of WIC prenatal women with Medi-Cal or Healthy Families<sup>31</sup> increased by 41% (from 39% covered to 55%).

The enrollment increases ranged across the pilot sites from 53% growth at Riverside County Community Health Agency (from 36% covered to 55%) to 20% growth at Northeast Valley Health Corporation (from 44% enrollment to 53%). *(See Appendix E, for clarification on the data concerning prenatal women).*

**More WIC participants made it into the enrollment “pipeline”  
 (Chart 2).**

- **Infants.** Over the course of the Project, WIC infants who were in the enrollment “pipeline” for Medi-Cal/Healthy Families almost tripled (from 6% in the pipeline to 17%).

This increase ranged across the pilot sites from sixfold growth in Northeast Valley Health Corporation (from 3% in the pipeline to 18%) to more than a doubling at Watts Health Foundation (from 10% in the pipeline to 23%).

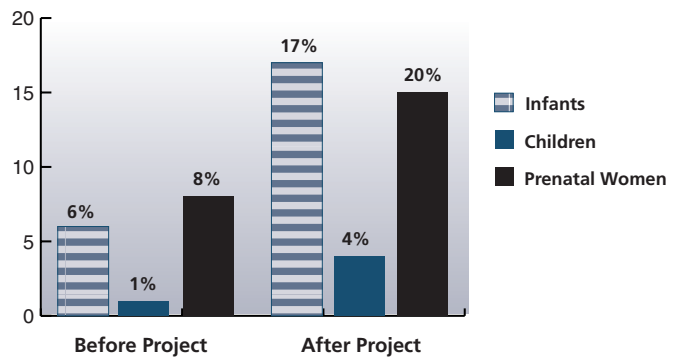
- **Children.** Over the course of the Project, WIC children who were in the enrollment pipeline for Medi-Cal/Healthy Families increased fourfold (from 1% in the pipeline to 4%).

Most of the pilot sites experienced a fourfold increase with Riverside having a sixfold increase (from 1% children in the pipeline to coverage to 6%).

- **Prenatal Women.** Over the course of the Project, WIC prenatal women who were in the enrollment pipeline for Medi-Cal/Healthy Families increased two and a half times (from 8% in the pipeline to 20%).

Northeast Valley Health Corporation experienced the most dramatic increase, from 1% of prenatal women in the enrollment pipeline to a full 24% by the end of the project. Even Public Health Foundation Enterprises with the slowest growth almost doubled the percent of women in the pipeline, from 10% to 17%.

**Chart 2. Participants in the Enrollment “Pipeline”**



**Fewer WIC participants reported having no health insurance  
 (Chart 3).**

- **Infants.** Over the course of the Project, WIC infants without health insurance (and not in the pipeline) decreased by 45% (from 55% of infants uninsured to 30%).

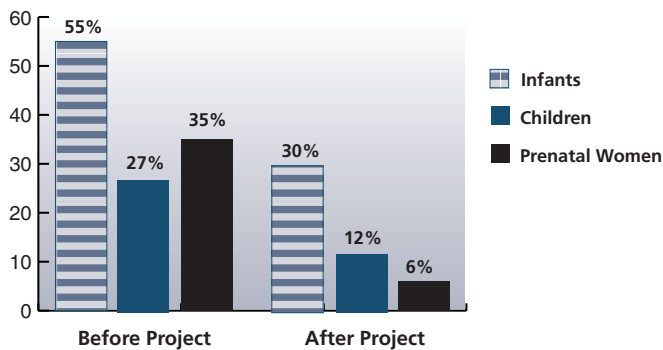
The decreases in uninsured infants range across the pilot sites from 49% drops at Riverside County Community Health Agency and Public Health Foundation Enterprises (from 51% to 26% uninsured at each site) to a 31% drop at Northeast Valley Health Corporation (from 67% to 46% uninsured).

- **Children.** Over the course of the Project, WIC children without health insurance (and not in the pipeline) decreased by 56% (from 27% of children uninsured to 12%).

The decreases in uninsured children range across the pilot sites from a 59% drop at Riverside County Community Health Agency (from 27% uninsured to 11%) to a 44% drop at San Diego State University Foundation (from 34% uninsured to 19%).



**Chart 3. WIC Participants with No Health Coverage**



- **Prenatal women.** Over the course of the Project, WIC prenatal women without health insurance (and not in the pipeline) decreased by 83% (from 35% of women uninsured to 6%).

The decreases in uninsured women range across the pilot sites from an 88% drop at Riverside County Community Health Agency (from 40% uninsured to 5%) to a 67% drop at San Diego State University Foundation (from 36% uninsured to 12%).

**Infant coverage rates were particularly low.**

Despite notable increases in the percent of infants who had health insurance or were in the enrollment pipeline, data from the Project revealed that infants were still significantly more likely to be uninsured than children (30% of infants at the end of the Project were uninsured as compared to 12% of children). In addition, infants were likely to have higher Medi-Cal/Healthy Families pending levels than children (37% of uninsured infants had pending status, as compared to 24% of children). In fact, more than 62,000 infants, or 19% of infants, served by all California WIC agencies were uninsured, compared to 11% of all WIC children.<sup>32</sup>

This is particularly troubling because newborns are supposed to be automatically enrolled: through a phone call or a referral form. Infants are “‘deemed eligible’ for Medi-Cal continuously from birth until the first birthday if the mother was eligible for [Medi-Cal] and receiving coverage...at the time of the delivery.”<sup>33</sup> In other words, if the mother is enrolled or was eligible at delivery, a newborn must be automatically enrolled without an additional application. Because virtually all pregnant women who are eligible for WIC services are also eligible for Medi-Cal, their infants should all be eligible for automatic enrollment.

While the state has not yet sufficiently clarified how counties are to implement automatic newborn enrollment, the state Medi-Cal office is preparing to release guidelines on the automatic and continuous enrollment for newborns. Of particular interest to WIC agencies will be clarification that allows (and promotes) WIC agencies to submit referral forms to counties to initiate infants’ automatic enrollment. Two of the Project pilot sites have already developed educational material aimed at reminding pregnant women of how to automatically enroll their newborns in Medi-Cal.

Advocates and stakeholders are working to further facilitate the automatic enrollment process for newborns by calling for greater flexibility in current infant referral requirements and using technology to streamline newborn “enrollment at delivery.” This would include electronic enrollment from hospitals to trigger real-time enrollment so the newborn leaves with an insurance card.<sup>34</sup> In addition, the CHDP Gateway discussed previously could serve as another real-time link to infant enrollment where infants receiving services at a CHDP provider office could be automatically and immediately enrolled in ongoing Medi-Cal.

**The Project was a success.**

Data from the Closing Health Care Gaps for WIC Families Project suggest that with a modest investment in the pilot sites’ activities, WIC programs can efficiently increase the portion of participants who have health insurance coverage or are “in the pipeline” for coverage. In short, the Project shows that WIC programs are ideal partners in enrolling families in Medi-Cal and Healthy Families. The Project also provides new and valuable information about how WIC can most effectively be used in this role.

# Lessons Learned

In addition to the data yielded by Closing Health Care Gaps for WIC Families, the Project produced some important lessons for WIC sites and policymakers on the challenges the Medi-Cal/Healthy Families enrollment process presents for application assistance efforts. These lessons will help us identify the most effective strategies for using WIC as a door to health insurance enrollment.

## Ingredients for a Successful Enrollment Project

Providing enrollment assistance at WIC sites makes sense on many levels. Yet there are some legitimate concerns that linking WIC to programs with stricter immigration requirements and a less “user-friendly” culture might have a negative effect on WIC’s own integrity and popularity. The Closing Health Care Gaps for WIC Families Project provides a better understanding of some of the issues WIC programs face in undertaking health enrollment activities — and some of the key ingredients for success.

***With a modest investment of resources, undertaking health insurance outreach and assistance can be positive for both families and the clinics themselves . . .***

**Public relations benefits.** Many of the pilot sites found that word spread quickly in their communities about WIC’s ability to help people get health insurance coverage: no waiting in long lines, no being passed back and forth between social workers, one-on-one help following up with the county Medi-Cal eligibility department. Sites found their efforts made participants happy and increased their willingness to come to the clinic and take part in WIC’s other activities. The success also extended beyond WIC participants. The Project work helped staff build relationships with doctors’ offices and other social services providers, which resulted in additional referrals back to WIC.

**Staff development benefits.** Project staff indicated that it was personally and professionally rewarding to be selected for the new work, to master a different substantive area, and to be able to help their participants on the critical matter of securing health insurance coverage. In their own words:

“It is very rewarding...it makes me feel good. People say ‘thank you... I didn’t know that,’ and I didn’t get so many ‘thank yous’ before.”

- Rosa Gonzales, Nutrition Assistant, REI-Harbor UCLA WIC

“Doing this makes me feel more powerful, more helpful. People are very grateful. It helps me build a more personal relationship with the participant. Helping them talk to DPSS is a huge relief.”

- Mary Jane Olivos, Nutrition Assistant, REI-Harbor UCLA WIC

“With this work we’re a different person to the participant. They open up about their families and their situation.”

- Jerry Villela, Grant Coordinator for Health Care Access Programs, Northeast Valley Health Corporation

*“Time for follow-up is so important – people know that at this clinic we take the time to go all the way...”*

- Everardo Sandoval,  
Certified Application  
Assistant, Crystal  
Stairs/REI-Harbor  
UCLA pilot site



••• ***but specific capacity issues underlie the ability of WIC sites to succeed at enrollment efforts.***

- **Health care enrollment cannot be an add-on activity.** All six pilot sites agreed that it was impossible to have the time and skills needed to take families successfully through the health insurance enrollment process and provide required WIC services. Moreover, the training and practice required for successful application assistance meant it was not efficient to have many staff helping smaller numbers of families with enrollment. Rather, it was best to designate one lead application assistant and one back-up.
- **All staff should have a basic competence on the issue.** Staff report that in order to do effective health care enrollment, everyone in the WIC system had to do his or her part. Participants had to be flagged and helped at many different contact points (at the front desk, at intake, during class, during recertification, while picking up coupons, etc.), or they would likely fall through the cracks. As a result, all staff needed a minimal knowledge set (e.g. the basic differences between Medi-Cal and Healthy Families, general eligibility and public charge rules, what kind of application assistance the clinic provides).
- **Ongoing training and quality assurance is key.** The complexity and ever-changing nature of the health insurance system necessitated an ongoing commitment to training. Expert staff as well as general line staff all needed regular updating as the rules changed.
- **Patience and flexibility are required.** Staff reported that it took time to get up to speed on health insurance enrollment. In some cases, it took the full two years of the Project for all staff to reach the desired level of competence. In addition, short staffing, appointment no-shows and walk-ins were a reality of clinic life that sometimes made it difficult to meet education curriculum requirements as well as do successful application follow-up. Maintaining flexibility in staffing was key.
- **A variation in staff reaction should be expected.** Most lead staff in the Project found it was not hard to “get people on board” conceptually, and that designated staff were enthusiastic about the work. However, some staff indicated the new responsibilities made them feel like social workers (not a compliment in many WIC communities), and were concerned that participants would seek to get an even broader range of help from them as a result.
- **Toll-free numbers are important resources.** Pilot site staff found the county Medi-Cal and Healthy Families hotlines to be useful resources – at times even more useful than speaking directly to a participant’s assigned eligibility worker. In addition, some of the sites established or tapped into other health insurance outreach resource lines. Staff found it particularly helpful to use these lines on a speakerphone with the participant.
- **In-person interaction should be a focus.** Sites found that the more disconnected education and application assistance were from human contact, the less likely participants would be to access the service. For example, one clinic made an un-staffed telephone and resource table available to participants, but it was rarely used. In the same vein, sites generally agreed that running educational videos in the waiting room or classroom setting had limited value without someone being available to answer follow-up questions. That said, one site developed its own video, called “HELP!” and found it a good educational resource when used in combination with in-person assistance.

- **An infrastructure must be established.** Pilot sites found that the more infrastructure that was available (space, staff, administrative support, resources), the easier the work was. Smaller clinics may have difficulty producing and disseminating educational material, scheduling additional classes, maintaining flexibility in staffing, and supporting technological innovations. However, the WIC community is just that: a community in which resource-sharing and cross-clinic technical assistance are routinely practiced.
- **An investment in resources is critical.** Very little of the project activity could have been undertaken without private financial support from The California Endowment. Dedicating staff time to a different set of activities and developing new infrastructure to support the work would not have been possible within the existing WIC budget.

In sum, the Closing Health Care Gaps for WIC Families Project demonstrated that the intervention strategies at WIC sites made a difference in linking families with coverage. The specific activity (i.e. training existing staff, hiring new staff or contracting out the work) varied depending on local WIC capacity and preferences as well as the “personality” of the local Medi-Cal agency. No matter which strategy was employed, however, effective WIC-based enrollment assistance required the following ingredients:

- Hands-on assistance — no matter how user-friendly the system.
- Designated experts on staff in every WIC site (either by training existing staff, hiring and training new staff or contracting with Certified Application Assistors).
- Reduced workload for in-house staff.
- All staff having basic knowledge of health insurance issues and program eligibility requirements, in addition to motivation to help people in this arena.
- Flexibility in staffing that takes into account the realities of clinic life.
- An ongoing commitment to training and quality assurance as staff turn over and the health insurance rules change.
- Adequate time for staff to get up to speed on complex programs.
- Additional office space and supplies as well as phone and computer access.

### Pros and Cons of Different Staffing Strategies

WIC sites can either use current staff or outside workers to conduct health enrollment efforts. The following describes the experiences of the pilot sites in using the two options. In either scenario, outside financial resources were critical. It is extremely unlikely that a WIC agency would have the extra funds needed to support effective application assistance work.

#### Using your own staff:

The pilot sites found that new and challenging job responsibilities could serve as a reward or promotion for staff. However, short staffing on WIC’s front lines (due to erosions in federal funding) is common. As a result, designated health insurance enrollment staff often were pulled into other work, and non-health insurance enrollment staff were called upon to take on some of those responsibilities (e.g. teaching a class or following up with a DPSS worker). Being able to juggle schedules and priorities was critical.

#### Bringing in outside workers:

The pilot sites found that a Medi-Cal eligibility worker on site brought participants as close as possible to the application process, particularly if the worker was able to access the eligibility review and determination system. However, bringing in outside Certified Application Assistors (CAAs) required having extra space and resources to finance their use of utilities and office supplies. In addition, some sites found out-sourced CAAs to be less reliable or less committed to the clinic’s schedule and culture than on-staff assistants. Others felt these problems were offset by knowing that participants would actually be seen on-site (as opposed to sending them out into the community with an appointment card). Sites found advantages and disadvantages to setting these staff up in the lobby of the clinic — i.e. greater exposure for the work and the chance to “catch” participants spontaneously, but a lack of privacy for discussing personal issues with participants.

*“The barriers that we’ve known about continue to be the barriers.”*

*- Judy Gomez, Special Projects Coordinator, Public Health Foundation Enterprises, WIC*

## Challenges In The Enrollment Process

Increases in health insurance coverage during this Project demonstrate that WIC staff can indeed master the enrollment maze. However, the Project also uncovered a crucial finding: no matter how much assistance and trouble-shooting WIC staff provided, in many instances complicated rules and requirements for Medi-Cal and Healthy Families made it impossible to finalize enrollments in a timely manner, or sometimes at all. The specific findings are as follows:

### **Collaboration can go a long way toward facilitating enrollment . . .**

During the course of the Project, some constructive collaborations with local Medi-Cal eligibility determination agencies emerged. For example:

- **Positive working relationships developed.** According to Project staff, some local Medi-Cal eligibility determination agency workers came, over time, to view the WIC-based CAAs or designated WIC staff as an extension of themselves, became used to the calls, and were better able to help.
- **Joint problem-solving took place.** The shared trainings and case briefings undertaken in some sites were viewed as a positive opportunity to get clarification where needed, and jointly trouble-shoot problems in the enrollment system.
- **Useful modifications to the system were made.** In some instances, work with local Medi-Cal eligibility determination agencies actually stimulated refinement of procedures so they were more participant-friendly. One pilot site worked with its Medi-Cal agency counterparts to develop a mail-in packet that included applications and a range of relevant information. The joint effort resulted in the Medi-Cal eligibility agency re-thinking and streamlining some of its paperwork requirements.

### **. . . but strict requirements and a complicated program design still create formidable barriers to enrollment.**

Despite this positive work, Project staff in all six sites experienced significant frustrations trying to navigate the Medi-Cal eligibility system. They encountered barriers that were not resolvable simply by having a firm understanding of the program requirements, but that could be overcome only by tremendous perseverance. The WIC experience showed once again that until real changes are made to the Medi-Cal enrollment systems, intensive hands-on enrollment assistance will continue to be necessary for families to have a chance of making it through the complex maze. Pilot sites identified these specific problems:

- **Complexity of the application process.** Pilot staff found it challenging to stay current with constant changes in the program rules and requirements. They reported that sometimes even the Medi-Cal workers themselves were not up to date on what was required to apply or stay enrolled. Because the process is so complex, misunderstandings and misinterpretations between local Medi-Cal workers, CAAs and participants were common, and often resulted in breaks in health insurance coverage.

- **Inconsistent enrollment patterns across population groups.** Staff across sites reported that when a woman completed an application for herself and her child at the same time, the child's approval would routinely come through first. At the same time, sites that anecdotally monitored the number of contacts needed to get a participant successfully enrolled in Medi-Cal or Healthy Families reported that more contacts were needed for infants and children than for prenatal women. Unfortunately, when there are differences in coverage within a family, the entire family uses health services less.<sup>35</sup>
- **Client wariness about immigration issues.** Fears about the perceived impact of state program enrollment on immigration status still persist. Many Project staff reported that participants were reluctant to enroll in health insurance programs based on incorrect information about public charge?. Informal "legal" advice given in immigrant communities may send cautionary signals to families about how their involvement in public programs can impact their immigration status. Family members themselves may also discourage women from pursuing health insurance enrollment, principally because they are concerned about public charge issues. Staff indicate that this misinformation can be quite challenging to overcome.
- **Discontinued coverage and inconsistency in program rules.** The pilot sites' staff reported their participants were sometimes taken off coverage without notice and for unclear reasons, and the process of getting someone "back on their coverage" was long and difficult. In addition, staff reported inconsistencies in the way county Medi-Cal offices and local medical providers applied the rules of presumptive eligibility for pregnant women.
- **Insurance program staff unresponsive.** The pilot sites' staff reported it took many contacts to correct even small errors (such as a misspelled name) or to make other changes in a participant's file, such as selecting a new primary care provider. Staff also reported that participants often did not receive their Medi-Cal cards until long after coverage had been authorized, so they continued to pay out of pocket, to avoid needed care, or to utilize emergency services. At a more basic level, WIC staff indicated that their phone calls to local eligibility offices often were not returned and they frequently were unable to access bilingual staff.

California faces some critical challenges. We must develop strategies to reach the million uninsured children and parents who are eligible for health insurance coverage. In particular, we must reduce the high rates of the uninsured among the most vulnerable group – our infants. In these tight financial times, WIC can be a particularly efficient partner for enrolling eligible families because:

- WIC serves essentially the same population as Medi-Cal and Healthy Families — low-income pregnant women, infants and children. As a result, the majority of WIC participants are very likely eligible for Medi-Cal or Healthy Families;
- WIC serves a particularly vulnerable population. Rates of private insurance are low and many WIC participants – particularly infants — lack health insurance altogether.
- WIC serves this target population in great numbers; over half of the infants born in California are served at WIC sites.
- WIC and Medicaid are already linked administratively – use of Medicaid is proof of eligibility for WIC.
- WIC has a sophisticated eligibility system that can link to the health insurance programs.

In short, WIC is the right place to focus. Since over 181,000 WIC participants (of whom 145,000 are infants and young children) have no insurance, WIC has the potential to affect a significant percentage of California’s low-income uninsured population. In fact, with 655,000 uninsured children in California who are eligible for Medi-Cal or Healthy Families, WIC can effectively reach almost one-fourth of the state’s target population of uninsured children. The Closing Health Care Gaps for WIC Families Project alone has already exemplified how efficient a one-stop shop WIC can be: In the short period of the Project, tens of thousands of women, infants and children enrolled in Medi-Cal or Healthy Families. The energy from this Project should be harnessed to make WIC a priority health insurance gateway.

The following blueprint shows how policymakers can make it happen. The blueprint begins with some common sense first steps most critical to keeping the momentum going. Most of these steps can be undertaken administratively, although some of the larger reforms might require legislative action. The blueprint then offers a detailed strategy for building upon the first set of recommendations by launching the next generation of work: deliberately building on the state’s online application submission and existing Express Lane Eligibility efforts to systematically and permanently connect WIC to health insurance enrollment.

### First Steps

- **Continue to invest in the existing community enrollment system.** Limiting the ability of WIC to partner with CAAs would significantly decrease the capacity of WIC to serve as a health insurance entryway. The state should maintain the current enrollment assistance infrastructure by continuing to provide modest enrollment fees to Certified Application Assistors (CAAs). CAAs are responsible for 61% of the joint Medi-Cal/Healthy Families applications submitted to the state. Their elimination, as proposed by the governor at the writing of this report, would dismantle the state’s existing community enrollment system and severely limit the number of children who successfully enroll into, and maintain, Medi-Cal and Healthy Families coverage. As documented by the Closing Health Care Gaps for WIC Families Project, CAAs are also the primary avenue in which WIC sites can provide Medi-Cal and Healthy Families enrollment assistance.

- **Invest in continued WIC enrollment activities.** The momentum generated by the work of the Closing Health Care Gaps for WIC Families Project should not be allowed to dissipate and the proven effectiveness of WIC as an enrollment gateway should be supported. As described earlier, what it takes is clear: people, resources and time. State and federal financing, in addition to leveraging private foundation funding, is needed to support WIC agencies in continuing to provide intensive, one-on-one health insurance enrollment assistance. For example, Congress and the president, as they reauthorize the national WIC program this year, should include adequate administrative funds to support health coverage information and referral activities. At a minimum, the state should establish a work group to review existing sources of support for ongoing health insurance enrollment assistance and offer findings in three months.
- **Enforce current WIC health referral regulations.** The state WIC Branch and Department of Health Services (DHS) should jointly lead an effort to ensure that, at a minimum, all WIC agencies are meeting requirements to inform participants about health insurance options (including providing factual information about public charge) and refer them to application assistance. The two state agencies should make sure these activities are undertaken in a culturally competent manner.
- **Coordinate disparate state efforts to improve information and enrollment systems.** Integrating different program systems is smart government. As mentioned, in July 2003, the state plans to launch the “CHDP Gateway” — an Internet-based system that will enable eligible children served by CHDP health care providers to be immediately (but only temporarily) enrolled in health care coverage. The state WIC branch is, at the same time, converting WIC’s telecommunications infrastructure to an Internet-based system to enhance internal program efficiency. These efforts are currently proceeding on separate tracks, bypassing an important opportunity to incorporate into WIC some of the technology interfaces the CHDP Gateway will establish with Medi-Cal’s eligibility system. If the efforts are not coordinated now, future work to link WIC and health care enrollment likely will require revising WIC’s information system again, wasting valuable state funds. This coordination will also greatly facilitate WIC’s ability to undertake the next generation of Express Lane Eligibility work which is laid out in the section below.
- **Address low rates of infant enrollment.** The Closing Health Care Gaps for WIC Families Project revealed something we did not expect: that, contrary to federal law, many eligible newborns are not automatically enrolled into Medi-Cal at the time of delivery. Instead, a significant portion of infants receiving WIC services were found to be uninsured. State and county Medi-Cal agencies must make it a priority to identify what barriers currently exist to automatically enrolling eligible newborns. The state must strengthen the current systems, releasing clear guidance that would allow and encourage WIC agencies to identify uninsured infants and send automatic enrollment referral forms to counties. In addition, the state should use technological pathways to facilitate automatic and immediate enrollment, particularly for infants, at different service access points, such as at the hospital or at the provider’s office through the CHDP Gateway. As a program that serves this population and has the necessary technological capacity, the state should also consider building WIC agencies into an electronic infant automatic enrollment process.



- **Build a true CHDP Gateway as a model for other program linkages such as WIC.** For CHDP and other programs like WIC to be true links to full ongoing coverage, the CHDP Gateway should be designed so that the information a family provides at the CHDP provider office to obtain care can also serve as their formal application for Medi-Cal. Instead, current state efforts would require these families to submit another full application to begin the enrollment process and receive ongoing Medi-Cal. Building a true and effective CHDP Gateway will put important building blocks in place for future gateways, including through WIC.
- **Keep improvements to county Medi-Cal service systems moving forward.** State and county Medi-Cal agencies must continue to re-examine their service systems to improve responsiveness, further simplify the application process, reduce inconsistencies in coverage and ensure that rules and procedures make the system work well.<sup>36</sup> Some counties are already examining procedures and practices to identify areas for improvement. The privately funded CORE Project (County Outreach Retention and Enrollment) is a two-year effort to identify improvement opportunities and redesign procedures in the Healthy Families and Medi-Cal enrollment and renewal systems in six counties.<sup>37</sup> Lessons from this work should be broadly applied.

At the very least, the state should not take system improvement efforts several steps back by establishing policies that force counties to become “gatekeepers” to Medi-Cal insurance. For example, imposing funding penalties on counties based on caseload growth and requiring counties to impose additional hurdles to keeping coverage will undermine counties’ progress to facilitate the enrollment process for families.

### **Steps For The Next Generation of Health Insurance Enrollment Work: Express Lane Eligibility**

This report makes it clear that stepped-up enrollment activities at WIC sites will bring more California families into the health insurance system. However, the Closing Health Care Gaps for WIC Families pilot also shows that under the current system, administrative barriers often stymie even this level of intervention. In addition, the project shows that to effectively enroll participants requires time — and resource-intensive assistance. Instead, California must make significant, long-term system changes that streamline the application process and maximize the help that staff from other public programs (like WIC) can provide.

The most effective way to use WIC to enroll eligible children in Medi-Cal or Healthy Families would be to allow WIC applicants to automatically apply for health coverage at the same time that they apply for WIC, using the information provided to WIC as the foundation for the health care application. This would be Express Lane Eligibility.

As discussed, WIC is a logical avenue for building such an Express Lane Enrollment system. All of the infants and children enrolled in WIC are most likely income-eligible for Medi-Cal or Healthy Families, and WIC is the only public program in California with a common statewide, automated system that could be linked to Medi-Cal and Healthy Families.<sup>38</sup> As mentioned, WIC currently operates its own Express Lane system (called “adjunctive eligibility”) whereby Medicaid eligibility serves as proof of income eligibility for WIC. The doors have already been opened to collaboration between these programs. *(See Appendix C for a side-by-side comparison of eligibility guidelines for Medi-Cal, Healthy Families and WIC.)*

An Express Lane system could be structured in many ways. We present two options here; the availability of staff, resources and technology will help determine which option to pursue. As such, the state should begin the process of building a WIC Express Lane by bringing together stakeholders to explore the most promising options and to determine what action is required to make them happen, including possible legislation. We hope the following provides a beginning roadmap for that work.

### **Option 1: Simplify the health insurance application for WIC applicants.**

WIC applicants could generate a complete Medi-Cal/Healthy Families application with a little assistance from WIC staff. A promising model for this process is used by Florida's subsidized child care program. There, a family can opt to use the information provided for a subsidized child care eligibility interview to complete a Medicaid/SCHIP application and submit it before they leave the child care office.

In California the process could work as follows: A WIC application is currently completed in person at the WIC office where WIC staff enter enrollment information directly into the computer. With an Express Enrollment option in place, the WIC applicant could elect to have the information from the WIC application automatically entered into a Medi-Cal/Healthy Families application. For these families, a drop-down screen would appear on the computer asking a few additional questions needed to complete the health insurance application. WIC staff would complete the additional screen with the family and print out the finished application. The family would sign the document and append necessary documentation before sending it to Medi-Cal for processing.

### **Option 2: "Express" enroll eligible WIC applicants.**

The model currently used by California's Breast and Cervical Cancer Treatment Program (BCCTP) could be used for WIC. Under BCCTP, providers can screen and enroll applicants using an Internet-based application and receive immediate approval for services. A follow-up process obtains any missing data or forms needed to grant ongoing eligibility.

Following this strategy, applicants at a WIC site could be preliminarily enrolled in health insurance coverage based solely on WIC's standard screen of income and documentation. The family could receive a real-time designation as temporarily eligible for coverage, and get the information necessary to access health care. The WIC office would then forward (preferably through the Internet) the applicant's information to the Medi-Cal/Healthy Families programs. A simple follow-up process would be established by Medi-Cal/Healthy Families to make a final eligibility determination, seeking only information not already provided through WIC, such as documentation of immigration status.

Putting Express Lane Eligibility into place requires: 1) strategic planning to ensure that the process is effective and efficient; 2) sustained collaboration between WIC and the insurance programs; and 3) adequate investment of time and resources to design the process, develop the necessary technology, and staff the effort. While private foundations can provide some financial support, policymakers, WIC and insurance program administrators must identify permanent funding sources to institutionalize the infrastructure necessary for Express Lane Eligibility.



# conclusion

WIC agencies have the potential to be highly effective gateways to health insurance with a modest investment of resources from various sources. The Closing Health Care Gaps for WIC Families Project demonstrates that a smart investment and careful plan for WIC staff to provide intensive, one-on-one application assistance can significantly increase health insurance enrollments. The results of such “stepped-up” efforts far surpass what has resulted from the regular education and referral activities WIC sites have routinely performed.

Yet despite these improvements, the complexity of insurance program rules and procedures continues to deter families in their intention to seek coverage, and too often thwarts even the most intensive assistance efforts. Ultimately, people cannot be enrolled if the system is broken.

With all of this in mind, California has begun to implement “express enrollment” through other income-comparable public programs such as School Lunch. The results of this pilot project show that WIC should be a high priority gateway. The time is ripe to implement express enrollment through WIC. Over the long term, this investment in smart government will help make sure California can honor its commitment to keep families healthy, strong and productive.

# endnotes

<sup>1</sup> This estimate reflects how many were uninsured when asked in the survey. About 6.3 million—or 1.3 million children—were uninsured some point during the year. Brown, E.R., Ponce, N., Rice, T., & Lavarreda, S.A. (2002). *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey*. Los Angeles CA: UCLA Center for Health Policy Research.

<sup>2</sup> *Ibid.*

<sup>3</sup> *Ibid.*

<sup>4</sup> Barillas, R & Horner, D. (2000). *WIC: A Door to Health Care for California's Children*. Santa Monica, CA: The Children's Partnership with The California WIC Association. Available at: [www.childrenspartnership.org/expresslane/other-careport.html](http://www.childrenspartnership.org/expresslane/other-careport.html)

<sup>5</sup> Horner, D. & Lazarus, W. (2001). *Healthy Families: Family Health Insurance Through One Door: Recommendations for Creating a Unified Health Insurance Program for California's Children and Their Parents*. Oakland, CA: The 100% Campaign.

<sup>6</sup> *Health Insurance Coverage 2001*. (2002). Washington, D.C.: U.S. Census Bureau, Current Population Survey.

<sup>7</sup> *op. cit.* (1)

<sup>8</sup> Coleman, M.S. et al. (2002). *Care Without Coverage: Too Little, Too Late*. Washington, D.C.: Institute of Medicine of the National Academy of Sciences; Kogan, M.D., Alexander, G.R., Teitelbaum, M.A., Jack, B.W., Kotelchuck, M., and Pappas, G. *The Effects of Gaps in Health Insurance on Continuity of Care Among Preschool-aged Children in the United States*. (1995). *JAMA* 274(18): 1472-1473; *No Health Insurance? It's Enough to Make You Sick: Scientific Research Linking the Lack of Health Coverage to Poor Health* (1999). Washington, D.C.: American College of Physicians-American Society of Internal Medicine.

<sup>9</sup> National Public Radio/Kaiser Family Foundation/Harvard University Kennedy School of Government (2002). *Survey on Health Care.*, Menlo Park, CA: Kaiser Family Foundation.

<sup>10</sup> *op. cit.* (1)

<sup>11</sup> Stuber, Maloy, Rosenbaum & Jones July, 2000: *"Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid*. Washington, DC: George Washington University Center for Health Services Research and Policy.

<sup>12</sup> *Insuring California's Healthy future: Use of Medi-Cal and Healthy families Public Insurance Programs by California's Ethnic Minority Communities*, (2002). Claremont, CA: Tomas Rivera Policy Institute.

<sup>13</sup> *Ibid.*

<sup>14</sup> Perry, M., Kannel, S., Burciaga Valdez, R. & Chang, C., (2000). *Medicaid and Children: Overcoming Barriers to Enrollment Findings from a National Survey* Menlo Park, CA: The Kaiser Commission on Medicaid and the Uninsured.

<sup>15</sup> *Barriers to Enrollment in Healthy Families and Medi-Cal: Differences by Language and Ethnicity, Findings from a California Survey*, (rev. 2001). San Francisco, CA: University of California, Institute for Health Policy Studies.

<sup>16</sup> *Healthy Families/Medi-Cal for Families Application Assistance Factbook*, (2002). Managed Risk Medical Insurance Board.

<sup>17</sup> See [www.healthapp.org](http://www.healthapp.org)

<sup>18</sup> *Streamlining Application and Enrollment for the Healthy Families Program and Medi-Cal for Children*. California Health and Human Services Agency, Department of Health Services, Managed Risk Medical Insurance Board (2001).

<sup>19</sup> Express Lane Eligibility is a term coined by The Children's Partnership. See Horner, D., Morrow, B., Lazarus, W., (2000). *Putting Express Lane Eligibility Into Practice*. Washington, DC: The Children's Partnership and Kaiser Commission on Medicaid and the Uninsured.

<sup>20</sup> 1.4 million represents the total number of participants in September 2002. The 1.24 million estimate is the subset of those participants who are served by WIC agencies on average in a month.

<sup>21</sup> Whaley, S. & True, L., (2000). *California WIC and Proposition 10: Made for Each Other*. Los Angeles, CA: UCLA Center for Healthier Children, Families and Communities.

<sup>22</sup> *Ibid.*

<sup>23</sup> *op. cit.* (1)

<sup>24</sup> 50 CFR 246.7(1) and (2).

<sup>25</sup> 50 CFR 246.7(12)(vi). This rule also applies to WIC applicants who are enrolled in Food Stamps and the Temporary Assistance to Needy Families (TANF) program.

<sup>26</sup> *op. cit.* (18) p. 5

<sup>27</sup> *op. cit.* (4)

<sup>28</sup> Public Charge is a determination made by immigration authorities to determine whether immigrants seeking to become legal permanent residents are likely to rely on government assistance as their primary source of support. By law, receiving health care benefits does not create public charge problems or affect immigration status in any other way.

<sup>29</sup> Information on the health insurance status of WIC participants was entered into WIC's ISIS computer system by project staff and then aggregated by WIC Branch data managers.

<sup>30</sup> Those who are eventually enrolled in Medi-Cal will have retro-active coverage (reimbursement) back to three months prior to when the individual applied.

<sup>31</sup> Adult women are not eligible for Healthy Families. However, pregnant teenagers can be eligible for Healthy Families (depending on age and family income), but may be categorized by WIC as "prenatal women." The numbers in this category are very small (.02% of all prenatal women).

<sup>32</sup> California Department of Health Services, WIC Supplemental Nutrition Branch, September 2002.

<sup>33</sup> Title 42 of the United States Code, Section 1396e(a) (4),

<sup>34</sup> *A Framework for Newborn Enrollment and Coverage Issues in Medi-Cal* (2002). Los Altos, CA: The David and Lucile Packard Foundation, Newborn Enrollment Project of Maternal and Child Health Access

<sup>35</sup> Hanson, K.L., (1998). *Is Insurance for Children Enough? The Link Between Parents' and Children's Health Care Use Revisited*. Inquiry, vol. 35:294-302. Rochester, NY: Blue Cross and Blue Shield Association.

<sup>36</sup> For more detailed recommendations see "Healthy Families/Medi-Cal for Children Administrative Outreach Recommendations" (February, 2002), a publication of The 100% Campaign. Available at [www.100percentcampaign.org](http://www.100percentcampaign.org). Also see the work of the CORE Project (County Outreach, Enrollment and Retention), a two-year effort to identify improvement opportunities and redesign procedures in the Healthy Families and Medi-Cal enrollment and renewal systems in six California counties. Information available at [www.coreproject.org](http://www.coreproject.org)

<sup>37</sup> Conversation with Dana Hughes, Institute for Health Policy Studies, University of California San Francisco, March 2002, San Francisco, CA: IHPS.

<sup>38</sup> *op. cit.* (18)

PROGRAMS	DESCRIPTION
<p><b>Medi-Cal for Children</b></p> <p>Call local Medi-Cal agency or call 1-888-747-1222 for applications and the names of neighborhood organizations that can assist families.</p>	<p>A free health insurance program covering medical, dental and vision services. Eligibility: under age 1 at or below 200% of the FPL; ages 1-5 at or below 133% of the FPL; ages 6-18 at or below 100% of the FPL; ages 19-21 at or below 100% of the FPL for certain children such as those leaving foster care, medically needy or medically indigent; covers pregnant women with income up to 200% of the FPL for pregnancy-related and emergency care without a “share of cost.” Certain income deductions may apply. Children pay no premiums or copayments. Citizens, legal permanent residents and certain other immigrants may receive full-scope Medi-Cal. Undocumented and certain other immigrants qualify for restricted Medi-Cal for pregnancy-related services and emergency conditions.</p>
<p><b>Healthy Families</b></p> <p>Call 1-888-747-1222 for applications and the names of neighborhood organizations that can assist families.</p>	<p>A low-cost health insurance program for uninsured children from birth up to age 18 that provides medical, dental and vision care to children with family incomes at or below 250% of the FPL who are not eligible for Medi-Cal. Certain income deductions may apply. Families pay a monthly premium of \$4 to \$9 per child (not to exceed \$27 per family) depending on family income, size and insurance plan. Co-payments of \$5 are paid for certain services, not to exceed \$250 per year. No co-payments for preventive care. Citizens, legal permanent residents and certain other immigrants are eligible.</p>
<p><b>Access for Infants and Mothers (AIM)</b></p> <p>Call 1-800-433-2611 for applications and the names of neighborhood organizations that can assist families.</p>	<p>Subsidized health insurance for uninsured pregnant women who are less than 30 weeks pregnant and their children up to age 2 with family incomes of 200% to 300% of the FPL. Coverage is provided to the woman throughout pregnancy and 60 days after the child is born. The family premium is 2% of total family income per year for the pregnant woman and for the baby up to its first year; for the child’s second year (with proof of immunization), the premium is \$50.</p>
<p><b>California Children’s Services (CCS)</b></p> <p>Contact local county health department. For a list of county CCS offices: <a href="http://www.dhs.cahwnet.gov/pcf/cms/HTML/CCS/directory.htm">http://www.dhs.cahwnet.gov/pcf/cms/HTML/CCS/directory.htm</a></p> <p>1-800-288-4584 in Los Angeles County</p>	<p>A state program that pays for medical care for children up to age 21 with certain chronic or serious medical problems, whose families have annual incomes below \$40,000 or out-of-pocket health care expenses of 20% of family income or more. Depending on income, the child may be eligible for complete coverage or share of cost. Medi-Cal and Healthy Families children receive these specialized services through the CCS program.</p>

PROGRAMS	DESCRIPTION
<p><b>Family PACT (Planning, Access, Care, and Treatment) Program</b></p> <p>1-800-942-1054</p>	<p>Comprehensive family planning services to low-income men and women with no other source of family planning services or reproductive health care insurance coverage. The program provides education; counseling; contraceptive methods; emergency contraception; pregnancy tests and counseling; sexually transmitted disease testing, counseling, and treatment; breast and cervical cancer screening; sterilization; Hepatitis B immunization; and education, testing, and counseling for HIV. California residents with a family income at or below 200% FPL and no other source of reproductive health care insurance coverage are eligible for the program. Medi-Cal clients with an unmet share of cost may also qualify. Eligibility determination and enrollment are conducted at provider's office with a point of service activation of the client membership card.</p>
<p><b>Presumptive Eligibility for Pregnant Women (in Medi-Cal)</b></p> <p>1-800-824-0088</p>	<p>Immediate and temporary pregnancy-related Medi-Cal services for pregnant women before they are approved for Medi-Cal coverage. Qualified local providers presumptively enroll women based on income, pregnancy and residency status. The pregnant woman may immediately access health services with the agreement that she will later apply for ongoing Medi-Cal coverage (by the end of the next month). If she applies for ongoing Medi-Cal, she continues to be "presumptively enrolled" until her Medi-Cal eligibility is determined. If she does not apply in time or is determined ineligible, she will lose coverage at the end of the month following the month she was presumptively enrolled. Presumptive eligibility is limited to once per pregnancy. This program does not cover for labor and delivery.</p>
<p><b>Child Health and Disability Prevention Program (CHDP)</b></p> <p>1-916-654-0364 1-800-993-CHDP in Los Angeles County</p>	<p>For more information, contact a county/city health department's CHDP program. Free preventive health care, assessments, including checkups, immunizations, and vision and hearing testing for children from birth to age 19 who are not already covered by full-scope Medi-Cal/Healthy Families and are in families with incomes up to 200% of the FPL. Children in Head Start are also covered. Applicants are not required to provide Social Security numbers or immigration status information. California is currently developing a "CHDP Gateway" to Healthy Families/Medi-Cal to begin July 2003. The current proposal intends to provide two months of "pre-enrollment" coverage for uninsured children served under the CHDP program. Families must then submit a full application to enroll in ongoing Medi-Cal/Healthy Families coverage to continue coverage beyond the two-month period.</p>

The Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a federally funded, locally administered program that provides pregnant women and children with a check or voucher for nutritiously defined food items, such as milk and eggs, that can be obtained at local grocery stores. The value of the vouchers depends on the participant but averages nationally \$32 per person per month. Families also receive nutritional education counseling and breastfeeding support.

In California, the nation's largest WIC Program, 81 local agencies serve nearly 1.24 million participants at 650 clinic sites, with an annual food budget of \$580 million and a nutrition services and administration budget of \$200 million. WIC, administered by the Department of Health Services WIC Supplemental Nutrition Branch, employs 3,000 local and state staff, and uses over 4,000 local grocery stores as redemption sites for WIC checks. The WIC caseload reflects California's diversity. The majority of participants are Latinos (72%), followed by white (13%), African American (8%), Asian (6%), and Native American (1%). Over 52% (650,000) of WIC participants are preschool children up to age 5, followed by pregnant or postpartum women (25%) and infants (23%).

A local WIC site — whether a permanent clinic, a small storefront, or a folding table in a firehouse or church basement — is a fixture of nearly every small town, low-income neighborhood, and reservation in California. Local WIC agencies in the state are evenly divided between those based in 48 county public health programs and 52 nonprofit providers, some of which operate programs in more than one county. However, nonprofit contractors now serve the majority of WIC participants. Local programs range in size from small rural or neighborhood sites serving less than 1,000, to large urban programs, such as one with a caseload of 316,000 participants, dwarfing most state WIC programs.

WIC has no written application. Eligibility questions are asked of the family on-site and documented directly into a state-run mainframe-based system, called the Integrated Statewide Information System (ISIS).

For more information, please see [www.wicworks.ca.gov](http://www.wicworks.ca.gov).



	<b>No Cost Medi-Cal for Children/Pregnant Women</b>	<b>Healthy Families</b>	<b>California WIC</b>
<b>Income/ Eligibility Standards</b>	<p>Households with the following incomes, by age, are eligible:</p> <ul style="list-style-type: none"> <li>• Pregnant women at or below 200% of the federal poverty level (FPL)</li> <li>• Infants at or below 200% of the FPL</li> <li>• 1 through 5, at or below 133% of the FPL</li> <li>• 6 through 18, at or below 100% of the FPL</li> </ul> <p>Recipients must cooperate with the state in pursuing third-party liability unless good cause prohibits pursuit.</p>	<p>Households with the following incomes, by age, are eligible:</p> <ul style="list-style-type: none"> <li>• Infants, 201% to 250% of the FPL</li> <li>• 1 through 5, 134% to 250% of the FPL</li> <li>• 6 through 18, 101% to 250% of the FPL</li> </ul> <p>Child cannot be Medi-Cal eligible nor have had employer coverage in the last 90 days (with some exceptions).</p>	<p>Infants and children up to age 5; Pregnant, postpartum and breastfeeding women.</p> <p>Gross income up to 185% of the FPL.</p> <p>Must be nutritionally at-risk.</p> <p>Recipients certified eligible for CalWorks, Food Stamps or Medi-Cal are automatically income-eligible</p>
<b>Income Deductions, Disregards &amp; Exclusions</b>	<p>Deductions are allowed as follows:</p> <ul style="list-style-type: none"> <li>• \$90 per month for each working household member</li> <li>• monthly child care expenses (max. of \$200/month for children under 2; \$175/month for ages 2 and older)</li> <li>• monthly court-ordered alimony payments</li> <li>• monthly court-ordered child support payments</li> <li>• \$50 per month for receipt of alimony and/or child support</li> </ul> <p>Excluded from income: Supplemental Security Income/State Supplemental Payment (SSI/SSP), CalWORKS (CA's Temporary Assistance to Needy Families program), General Relief (CA's General Assistance program), grants or scholarships for college, earnings of a child under age 14 or in school and some government benefits payments.</p>	<p>Deductions are allowed as follows:</p> <ul style="list-style-type: none"> <li>• \$90 per month for each working household member</li> <li>• monthly child care expenses (max. of \$200/month for children under 2; \$175/month for ages 2 and older)</li> <li>• monthly court-ordered alimony payments</li> <li>• monthly court-ordered child support payments</li> <li>• \$50 per month for receipt of alimony and/or child support.</li> </ul> <p>Excluded from income: SSI/SSP, CalWORKS, general relief, grants or scholarships for college, earnings of a child under age 14 or in school and some government benefits payments.</p>	<p>No deductions.</p> <p>Numerous income exclusions — e.g., in-kind housing benefits, student financial aid, energy assistance, Food Stamps, School Lunch, Child Care Development Block Grant (CDBG), Job Training Partnership Act (JTPA), and assistance from some smaller programs.</p>



	<b>No Cost Medi-Cal for Children/Pregnant Women</b>	<b>Healthy Families</b>	<b>California WIC</b>
<b>Allowable Resources/ Assets</b>	No assets test is required for pregnant women/children in percent poverty programs but required for families and parents.	No assets test is required.	Not applicable.
<b>Unit for Determining Income Eligibility</b>	Related persons living in the same home who have financial responsibility for health care for the applicant (spouse for spouse, parent for child). A pregnant woman is counted as two.	Related persons living in the same home who have some financial responsibility for health care for the applicant. Some exceptions include responsible adults live separately.	Related and non-related persons living together as one economic unit. A pregnant woman is counted as two.
<b>Documentation Requirements</b>	Social security number of applicant and proof of: <ul style="list-style-type: none"> <li>• Identity and CA residency</li> <li>• Income and deductions</li> <li>• Pregnancy</li> <li>• Immigration status</li> </ul>	Birth certificate and proof of: <ul style="list-style-type: none"> <li>• Income and deductions</li> <li>• Immigration status</li> </ul>	<ul style="list-style-type: none"> <li>• Proof of income for all members of family/economic unit (self-declaration of income is permitted for homeless persons, migrant workers, and cash employees);</li> <li>• Proof of identity and CA residency; and</li> <li>• Proof of pregnancy, if applicable.</li> <li>• Proof of enrollment in CalWorks, Food Stamps or Medicaid, if applicable.</li> </ul> <p>For Nutritional Status: Height and weight are measured and a hematological test is administered. Blood work is either done on-site or client is referred to a nearby health facility. Will also accept a medical exam with this information from the last 60 days.</p>
<b>Verification Rules</b>	Utilize Income No-Eligibility Verification System (IEVS) and Statewide Alien Verification Eligibility (SAVE) to perform post-eligibility review.	Utilize IEVS and SAVE to perform post-eligibility review.	None.





	<b>No Cost Medi-Cal for Children/Pregnant Women</b>	<b>Healthy Families</b>	<b>California WIC</b>
<b>Citizenship Limitations</b>	Federal law allows only citizens and qualified immigrants who entered the U.S. before August 22, 1996, to be eligible for Medicaid, with some exemptions. Qualified immigrants entering after that date become eligible after five years. State funds provide Medi-Cal eligibility to legal immigrant children no matter when they entered the U.S.	Federal law allows only citizens and qualified immigrants who entered the U.S. before August 22, 1996, to be eligible for Healthy Families, with some exemptions. Qualified immigrants entering after that date become eligible after five years. State funds currently provide Healthy Families eligibility to legal immigrant children no matter when they entered the U.S.	None.
<b>Redetermination Periods</b>	Every 12 months. Enrolled families required to report any change in circumstances that might affect eligibility. Pregnant women remain covered for two months after the month of delivery.	Every 12 months.	Every six months. Infants under 6 months of age may be certified for a period extending up to their first birthday. Pregnant women are certified for the duration of their pregnancy or for up to six weeks postpartum.

Program Name (County)	Program Description	Pilot Project Interventions
<p><b>Northeast Valley Health Corporation (NEVHC) (Los Angeles)</b></p> <p>Contacts: Gayle Schachne, Annette Besnilian, Jerry Villela (818) 898-1388 or AnnetteB-WIC@nevhc.org</p>	<ul style="list-style-type: none"> <li>• 67,000 participants, monthly</li> <li>• 150 staff</li> <li>• 14 clinics, with nine participating in the pilot.</li> </ul> <p>Pilot Project funds: \$260,000/2 years</p>	<ul style="list-style-type: none"> <li>• WIC staff assist families with enrollment and follow-up (@ 50% time).</li> <li>• Completed applications go to one staff member who sends to dedicated county Medi-Cal eligibility unit.</li> <li>• Monthly meetings with DPSS to trouble-shoot.</li> <li>• Health access info presented in orientation.</li> <li>• All staff trained to check participants' status.</li> </ul>
<p><b>REI-Harbor UCLA (Los Angeles)</b></p> <p>Contact: Heidi Kent (323) 757-7244 x 229 or hkent@slahp.org</p>	<ul style="list-style-type: none"> <li>• 100,000 participants, monthly</li> <li>• 200 staff</li> <li>• 10 sites, with two participating in pilot.</li> </ul> <p>Pilot Project funds: \$200,000/2 years</p>	<ul style="list-style-type: none"> <li>• All WIC staff refer women and children to onsite CAAs who assist with Medi-Cal/Healthy Families enrollment.</li> <li>• At pilot sites, Project staff conduct intensive follow-up to uninsured women and children to ensure timely enrollment in Medi-Cal/Healthy Families.</li> <li>• Revised orientation materials to include health care access information.</li> <li>• All prenatal women get health care education class at second WIC visit.</li> </ul>
<p><b>Riverside County Community Health Agency, Nutrition Services Branch (Riverside)</b></p> <p>Contacts: Gayle Hoxter, Perveen Ali (909) 358-5311</p>	<ul style="list-style-type: none"> <li>• 56,600 participants, monthly</li> <li>• 120 staff</li> <li>• 16 clinics participating in pilot county-wide.</li> </ul> <p>Pilot Project funds: \$260,000/2 years</p>	<ul style="list-style-type: none"> <li>• Provided education classes and application assistance at all 16 WIC sites.</li> <li>• Referral to the County Perinatal Outreach and Education Program and the Healthy Beginning Program (East County) for case management and follow-up.</li> <li>• Tracked participants for outcomes at follow-up appointments.</li> <li>• Collaborated with: Adolescent Family Services, Black Infant Health, Comprehensive Perinatal Services Program, Perinatal Care Guidance, Child Health and Disability Program, Family Planning Program, and Perinatal Outreach and Education.</li> </ul>

Program Name (County)	Program Description	Pilot Project Interventions
<p><b>San Diego State University Foundation (San Diego)</b></p> <p>Contact: Veronica Lopez (858) 505-3074</p>	<ul style="list-style-type: none"> <li>• 37,000 participants, monthly</li> <li>• 92 staff</li> <li>• 4 sites</li> </ul> <p>Pilot Project funds: \$224,758/2 years</p>	<ul style="list-style-type: none"> <li>• Pilot Project funds: \$224,758/2 years.</li> <li>• Developed health insurance questionnaire to identify those interested.</li> <li>• Partnered with community-based organization for 6 CAAs.</li> <li>• CAAs report to dedicated staff member who monitors progress.</li> <li>• Developed flier for prenatal women about infant enrollment.</li> </ul>
<p><b>Watts Health Foundation (Los Angeles)</b></p> <p>Contact: Mary Ramirez (323) 587-3474</p>	<ul style="list-style-type: none"> <li>• 22,125 participants, monthly</li> <li>• 50 staff</li> <li>• 5 sites</li> </ul> <p>Pilot Project funds: \$215,000/2 years</p>	<ul style="list-style-type: none"> <li>• Hired dedicated CAA to rotate between three clinics and case manager who was a WIC worker. Outside CAAs also stationed at all five WIC sites.</li> <li>• Use DPSS/Healthy Families toll-free line.</li> <li>• Health education class in all sites.</li> <li>• Used incentives (aprons, T-shirts) to increase participation.</li> <li>• Developed flier for prenatal women about infant enrollment.</li> <li>• Held two educational health fairs.</li> </ul>
<p><b>Public Health Foundation Enterprises (Los Angeles)</b></p> <p>Contact: Judy Gomez (626) 856-6650</p>	<ul style="list-style-type: none"> <li>• 316,825 participants, monthly</li> <li>• 650 staff</li> <li>• 50 sites, with 40 participating in pilot.</li> </ul> <p>Pilot Project funds: \$310,000/2 years</p>	<ul style="list-style-type: none"> <li>• DPSS eligibility workers outstationed in 22 WIC centers and one Medi-Cal Eligibility Worker (EW) housed in administrative offices to process mail-in applications (designed with DPSS).</li> <li>• Healthy Families Assistors outstationed in 40 WIC Centers.</li> <li>• First year operated dedicated phone bank to assist WIC participants with navigating health care system.</li> <li>• Second year, two clinics dedicated staff to make follow-up calls to all participants indicating no insurance.</li> <li>• Developed health care education class used by other pilot sites.</li> <li>• Developed numerous handouts, mail-in application packet, and put health insurance question on dietary recall and other clinic paperwork.</li> </ul>

We examined the change in health insurance status for WIC participants served at the WIC pilot sites, broken out by pregnant women, infants, and children. In order to measure changes in health insurance status over the course of the Closing Health Care Gaps for WIC Families Project period, we compared health insurance status of pilot site participants “after” the Project to the insurance status of participants “before” the Project began. Due to limitations in the WIC ISIS data system, the Project was not able to track and report, in an aggregate manner, individual enrollment changes over the course of the Project. As a result, we could not track the individual enrollment outcomes of the WIC participants for whom the pilots assisted with insurance applications during the Project. This analysis instead compares two groups — the health insurance status of WIC participants seen at the six pilot sites “before” the Project and the health insurance status of those seen “after” the Project period. In other words, we compared the portion or percentage of “before” and “after” WIC participants who are, for example, uninsured or covered by Medi-Cal/Healthy Families. We did not compare the “before” and “after” numbers of WIC participants based on health status because the overall number of WIC participants seen at WIC sites may vary over time independent of the effects of this Project.

We recognize that WIC participants counted in the study may have enrolled on their own or benefited from enrollment assistance outside of this Project. However, such “outside” effects would most likely contribute to enrollment in both the “before” group and the “after” group data.

Also, during the course of the Closing Health Care Gaps for WIC Families Project, two significant developments occurred that impacted the way data are presented.

First, a second year of work (with an expanded focus) became available to grantees midway through the first year. As a result, while “phase one” of the Project (June 2000 – June 2001) was limited to activities with (and data collection on) prenatal women, “phase two” (July 2001 – June 2002) expanded the target population to include infants and children. As a result, the “before” data on prenatal women are available from June 2000, and on infants and children from July 2001.

Second, the development of a new screening mechanism that would capture more useful data evolved over the first 16 months of the Project. Early on, staff realized that the existing ISIS query “Are you on Medi-Cal?” would not yield full and accurate information about the health insurance status of WIC participants. Prompted by pressure generated by this Project, and with input from the California WIC Association staff and the Project grantees, the state WIC branch developed, tested and made permanent changes to the ISIS data collection system. The new screen — which asks more detailed questions about health insurance status — came online officially in October 2001—16 months after the Project began.

As a result of this development, the entire WIC program now has the capacity to gather detailed information on health care coverage for all California WIC participants. However, the advent of this new screen during the course of the Project meant that baseline data had to be reassessed mid-course (new data management training was also required mid-course). Data on whether or not a woman had Medi-Cal (or was pending for Medi-Cal) are available from June 2000, but data on whether the remainder had private insurance or no coverage are only available from October 2001. Similarly, data on infants and children are available beginning in July 2001, but they only capture the full picture beginning in October 2001. To accommodate these developments, we elected to do the following:

1. Compare data on prenatal women over the complete time span of the Project (June 2000 – June 2002). The “before” data (June 2000) derived the percent of prenatal women without any coverage (“uninsured”) using a fixed percentage for private insurance (see below for a detailed explanation of this adjustment) to adjust for the absence of this specificity in data collection at that period. By making these conservative adjustments, 16 months of data on prenatal women are not lost.
2. Compare data for infants and children from when the new screen was launched (October 2001) to June 2002. A similar adjustment was also made to the “before” data (October 2001) because not all data were being collected using the new questions at that time.

**Distinguishing among the uninsured — those in the “pipeline” to coverage and those who are not.** Data for this Project were collected in six categories: “has Medi-Cal;” “has Healthy Families;” “has private insurance;” “is pending for Medi-Cal (referred to in the report as being in the “pipeline” or those who have submitted an Medi-Cal/Healthy Families application and were awaiting final approval);” “is pending (or “in the pipeline”) for Healthy Families;” and “has no health coverage.” While, those in the “pipeline” were likely uninsured while they awaited enrollment, we distinguish them from the “uninsured” in order to underscore this part of the enrollment process that WIC can affect. WIC staff, despite intensive hands-on assistance can only bring a family so far toward enrollment — the state insurance programs themselves are ultimately responsible for final enrollment decisions.

**Holding private insurance rates constant and decreasing rates in the “no health insurance” category.** The percent of WIC participants reporting no health insurance coverage at the beginning of the project has been modified to take into account improvements in data collection capacity over time. Specifically, over the first five months of the Project, the percentage of WIC participants reporting they had private insurance increased steadily for all population groups. For example, 6% of prenatal women reported having private insurance coverage in October 2001, 14% reported having it in December, and 17% reported having it in February 2002. After that point, the rates of private insurance were relatively stable for the remaining months of the Project. At the same time, the percent of WIC participants who reported having no health insurance made a rapid decline in the first few months, suggesting that many of those who were initially categorized as having no health insurance, in actuality had some form of private insurance instead. Given steady improvements in data collection capacity over the life of the Project, and the socioeconomic status of the population group, it is likely that the trajectory of these data is more the result of improved data collection than a dramatic increase in the percent of WIC participants acquiring private insurance.

To take this assumption into account and improve the accuracy of the findings, the following calculations were made: The highest percentage of participants “having private insurance” is used as a constant across all data points for that population group, and the number and percent of participants reporting no health insurance coverage is adjusted downward based on those revised percentages. All relevant data in the report reflect this formula.

A final note: The health insurance status data for WIC participants (statewide and in the six pilot sites) may differ slightly from a seemingly comparable statewide population — low-income children statewide. Any differences in uninsured rates, Medi-Cal/Healthy Families coverage and private coverage could reflect actual differences in populations. WIC participants are probably a poorer and more vulnerable population even compared to a statewide population of low-income families.

**COMPARISON OF HEALTH INSURANCE COVERAGE OF  
WIC INFANTS**

*Changes from the beginning of the project to the present*

WIC INFANTS' HEALTH INSURANCE STATUS	WIC PILOT SITE - OCTOBER 2001													
	NEVHC		SLAHC-REI		PHFE		RIVERSIDE		SDSUF		WATTS		Grand Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Receiving Medi-Cal	2,936	17%	3,751	19%	17,648	25%	3,413	22%	2,434	29%	694	14%	30,876	23%
Medi-Cal "Pipeline"	555	3%	1,031	5%	4,266	6%	1,282	8%	299	4%	504	10%	7,937	6%
Receiving Healthy Families	8	0%	25	0%	98	0%	16	0%	17	0%	1	0%	165	0%
Healthy Families "Pipeline"	6	0%	19	0%	61	0%	15	0%	8	0%	1	0%	110	0%
Receiving Private Insurance	327	2%	464	2%	2,288	3%	386	3%	277	3%	52	1%	3,794	3%
No Health Insurance	13,237	78%	14,148	73%	46,556	66%	10,133	66%	5,258	63%	3,574	74%	92,906	68%
Totals	17,069	100%	19,438	100%	70,917	100%	15,245	100%	8,293	100%	4,826	100%	135,788	100%
Adjusted No Insurance**	11,450	67%	11,933	61%	36,381	51%	7,732	51%	3,788	46%	3,251	67%	74,536	55%

WIC INFANTS' HEALTH INSURANCE STATUS	WIC PILOT SITE - JUNE 2002													
	NEVHC		SLAHC-REI		PHFE		RIVERSIDE		SDSUF		WATTS		Grand Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Receiving Medi-Cal	3,989	24%	6,543	33%	28,521	41%	5,031	32%	2,922	34%	1,469	31%	48,475	36%
Medi-Cal "Pipeline"	3,015	18%	3,754	19%	10,502	15%	3,526	23%	1,336	16%	1,083	23%	23,216	17%
Receiving Healthy Families	79	0%	149	1%	598	1%	149	1%	74	1%	19	0%	1,068	1%
Healthy Families "Pipeline"	26	0%	63	0%	278	0%	85	1%	33	0%	6	0%	491	0%
Receiving Private Insurance	2,098	12%	2,771	14%	12,346	18%	2,860	18%	1,793	21%	368	8%	22,236	16%
No Health Insurance	7,736	46%	6,825	34%	18,008	26%	3,996	26%	2,351	28%	1,796	38%	40,712	30%
Totals	16,943	100%	20,105	100%	70,253	100%	15,647	100%	8,509	100%	4,741	100%	136,198	100%
No Insurance**	no adj.		no adj.		no adj.		no adj.		no adj.		no adj.		no adj.	

Source: California Department of Health Services, WIC Supplemental Nutrition Branch.

\* Medi-Cal or Healthy Families "Pipeline" are those participants who have applied for Medi-Cal/Healthy Families and are awaiting final approval.

\*\*WIC agencies had changed how they asked about health insurance status in October 2001, during the Project. As a result, we adjusted the "pre-project" figures (October 2001) for "No Health Insurance" participants to more realistically reflect changes in the percent of uninsured participants (rather than the effect caused by the change in data collection). To adjust the "No health care" (Oct 2001) numbers, we held the percentage of those "receiving private insurance" constant during the Project--fixing the percentage at the highest percentage. Then, we adjusted the "No health insurance" figures downward by the difference of the fixed private insurance percent and the reported private insurance percent (if collected). The "Adjusted no insurance" number reflects the adjusted amount. "No adjustment" indicates that the figures for that month reflect the highest percentage of private insurance.

Pilot sites: NEVHC - Northeast Valley Health Corporation; UCLA-REI - REI UCLA-Harbor; PHFE - Public Health Foundation Enterprises; Riverside - Riverside County Community Health Agency, Nutrition Services Branch; SDSUF - San Diego State University Foundation; and Watts - Watts Health Foundation

**COMPARISON OF HEALTH INSURANCE COVERAGE OF  
WIC CHILDREN**

*Changes from the beginning of the project to the present*

WIC CHILDREN'S HEALTH INSURANCE STATUS	WIC PILOT SITE - OCTOBER 2001													
	NEVHC		LAHC-REI		PHFE		RIVERSIDE		SDSUF		WATTS		Grand Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Receiving Medi-Cal	22,190	56%	33,384	56%	104,036	55%	15,862	51%	9,394	42%	8,723	63%	193,589	54%
Medi-Cal "Pipeline"	386	1%	881	1%	1,669	1%	327	1%	177	1%	191	1%	3,631	1%
Receiving Healthy Families	295	1%	395	1%	1,793	1%	341	1%	181	1%	48	0%	3,053	1%
Healthy Families "Pipeline"	21	0%	85	0%	258	0%	57	0%	58	0%	11	0%	490	0%
Receiving Private Insurance	1,013	3%	1,796	3%	6,017	3%	1,077	3%	744	3%	258	2%	10,905	3%
No Health Insurance	15,877	40%	23,042	39%	76,113	40%	13,357	43%	11,527	52%	4,665	34%	144,581	41%
Totals	39,782	100%	59,583	100%	189,886	100%	31,021	100%	22,081	100%	13,896	100%	356,249	100%
Adjusted No Insurance**	10,990	28%	15,338	26%	48,717	26%	8,437	27%	7,504	34%	3,690	27%	94,675	27%

WIC CHILDREN'S HEALTH INSURANCE STATUS	WIC PILOT SITE - JUNE 2002													
	NEVHC		LAHC-REI		PHFE		RIVERSIDE		SDSUF		WATTS		Grand Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Receiving Medi-Cal	24,373	63%	37,826	64%	115,786	63%	17,850	57%	10,566	49%	9,267	70%	215,668	62%
Medi-Cal "Pipeline"	1,420	4%	2,404	4%	4,585	2%	1,536	5%	609	3%	540	4%	11,094	3%
Receiving Healthy Families	1,757	5%	2,295	4%	10,510	6%	2,126	7%	1,448	7%	354	3%	18,490	5%
Healthy Families "Pipeline"	121	0%	299	1%	1,205	1%	292	1%	170	1%	45	0%	2,132	1%
Receiving Private Insurance	5,763	15%	9,438	16%	31,930	17%	6,041	19%	4,626	22%	1,169	9%	58,967	17%
No Health Insurance	5,466	14%	6,505	11%	19,788	11%	3,433	11%	4,054	19%	1,760	13%	41,006	12%
Totals	38,900	100%	58,767	99%	183,804	100%	31,278	100%	21,473	100%	13,135	99%	347,357	100%
No Insurance**	no adj.		no adj.		19,317	11%	no adj.		no adj.		no adj.		no adj.	

Source: California Department of Health Services, WIC Supplemental Nutrition Branch.

\* Medi-Cal or Healthy Families "Pipeline" are those participants who have applied for Medi-Cal/Healthy Families and are awaiting final approval.

\*\*WIC agencies had changed how they asked about health insurance status in October 2001, during the Project. As a result, we adjusted the "pre-project" figures (October 2001) for "No Health Insurance" participants to more realistically reflect changes in the percent of uninsured participants (rather than the effect caused by the change in data collection). To adjust the "No health care" (Oct 2001) numbers, we held the percentage of those "receiving private insurance" constant during the Project--fixing the percentage at the highest percentage. Then, we adjusted the "No health insurance" figures downward by the difference of the fixed private insurance percent and the reported private insurance percent (if collected). The "Adjusted no insurance" number reflects the adjusted amount. "No adjustment" indicates that the figures for that month reflect the highest percentage of private insurance.

Pilot sites: NEVHC - Northeast Valley Health Corporation; UCLA-REI - REI UCLA-Harbor; PHFE - Public Health Foundation Enterprises; Riverside - Riverside County Community Health Agency, Nutrition Services Branch; SDSUF - San Diego State University Foundation; and Watts - Watts Health Foundation



**COMPARISON OF HEALTH INSURANCE COVERAGE OF  
WIC WOMEN**

*Changes from the beginning of the project to the present*

WIC WOMEN'S HEALTH INSURANCE STATUS	WIC PILOT SITE - JULY 2000													
	NEVHC		UCLA-REI		PHFE		RIVERSIDE		SDSUF		WATTS		Grand Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Receiving Medi-Cal	3,417	44%	3,514	37%	14,970	38%	2,214	36%	1,291	34%	1,256	49%	26,662	39%
Medi-Cal "Pipeline"	93	1%	848	9%	3,909	10%	253	4%	258	7%	108	4%	5,469	8%
Not Receiving Medi-Cal**	4,235	55%	5,235	55%	20,174	52%	3,759	60%	2,211	59%	1,218	47%	36,832	53%
Totals	7,745	100%	9,597	100%	39,053	100%	6,226	100%	3,760	100%	2,582	100%	68,963	100%
Receiving Private Insurance**	1,160	15%	1,525	16%	7,665	20%	1,261	20%	869	23%	249	10%	12,730	18%
Adjusted No Insurance**	3,075	40%	3,710	39%	12,509	32%	2,498	40%	1,342	36%	969	38%	24,102	35%

WIC WOMEN'S HEALTH INSURANCE STATUS	WIC PILOT SITE - JUNE 2002													
	NEVHC		LAHC-REI		PHFE		RIVERSIDE		SDSUF		WATTS		Grand Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Receiving Medi-Cal	3,749	53%	5,101	53%	21,484	57%	3,403	55%	1,590	42%	1,783	68%	37,110	55%
Medi-Cal "Pipeline"	1,689	24%	2,512	26%	6,451	17%	1,285	21%	879	23%	420	16%	13,236	20%
Receiving Private Insurance	1,067	15%	1,533	16%	7,362	20%	1,262	20%	877	23%	252	10%	12,353	18%
No Health Insurance	620	9%	499	5%	2,210	6%	283	5%	448	12%	154	6%	4,214	6%
Totals	7,125	100%	9,645	100%	37,507	100%	6,233	100%	3,794	100%	2,609	100%	66,913	100%
Adjusted No Insurance**	no adj.		no adj.		no adj.		no adj.		no adj.		no adj.		no adj.	

Source: California Department of Health Services, WIC Supplemental Nutrition Branch.

\* Medi-Cal or Healthy Families "Pipeline" are those participants who have applied for Medi-Cal/Healthy Families and are awaiting final approval.

\*\*WIC agencies had changed how they asked about health insurance status in July 2000, during the Project. As a result, we adjusted the "pre-project" figures (July 2000) for "No Health Insurance" participants to more realistically reflect changes in the percent of uninsured participants (rather than the effect caused by the change in data collection). To adjust the "No health care" (July 2000) numbers, we held the percentage of those "receiving private insurance" constant during the Project—fixing the percentage at the highest percentage. Then, we adjusted the "No health insurance" figures downward by the difference of the fixed private insurance percent and the reported private insurance percent (if collected). The "Adjusted no insurance" number reflects the adjusted amount. "No adjustment" indicates that the figures for that month reflect the highest percentage of private insurance.

Pilot sites: NEVHC - Northeast Valley Health Corporation; UCLA-REI - REI UCLA-Harbor; PHFE - Public Health Foundation Enterprises; Riverside - Riverside County Community Health Agency, Nutrition Services Branch; SDSUF - San Diego State University Foundation; and Watts - Watts Health Foundation



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