Healthy Families:

Family Health Insurance Through One Door

March 2001

Recommendations for Creating a Unified Health Insurance Program for California's Children and Their Parents

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

Insure the Uninsured Project

With Funding from The California Endowment and The California Wellness Foundation

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Background and Executive Summary

On December 19, 2000 Governor Gray Davis, Health and Human Services Agency Secretary Grantland Johnson and legislators initiated a very important effort to improve health care for California families.[1] By submitting a "waiver request" to federal officials, California became one of the first states to develop a plan for using available federal State Children's Health Insurance Program (SCHIP) funds to provide health coverage for working parents who lack health insurance but whose children qualify for publicly-funded health insurance.[2]

The governor, legislators and state health officials have exercised extremely valuable leadership on an issue that is ripe for attention and reform. Their actions continue a tradition of leadership on health reform in which California has historically been a leader in providing for the health needs of its residents. Having been the first to initiate a number of reforms—like its California Children's Services (CCS) program to care for children with disabilities—California has frequently pioneered health initiatives that were later picked up across the country.

California's residents now face a daunting add-on collection of programs and policies built over many decades.

But one consequence of this proactive approach is that California's residents now face a daunting add-on collection of programs and policies built over many decades. And while each piece has valuable objectives, the cumulative effect is a maze of inconsistent, redundant, and inconvenient rules that discourage parents and their children who want and need health care. In addition, the fragmented approach to health coverage has continued to leave many working parents uninsured. While programs exist to cover a large number of California's uninsured children, their parents have not been eligible for the same coverage.

Simply put, there are two critical challenges that must be addressed to make health care a reality for all families in our state: first, eligibility for publicly subsidized health insurance needs to be extended to targeted groups of working poor who cannot afford to buy insurance in the private market and who lack coverage through their jobs; second, the inefficient, wasteful, and confusing features of existing programs need to be "modernized" so that eligible, working families will be able to actually use them and benefit from them.

The Opportunity

The federal SCHIP waiver option provides California a timely and very important opportunity to address both challenges, and in the process, position California as a leader in creating a unified, convenient, and sensible health care program for children and their working parents.

However, the limited success of existing public health insurance programs makes crystal clear that there is a right way and a wrong way to move forward. An estimated 68 percent of all uninsured children in the state are eligible but not enrolled in California's public health programs (Medi-Cal or Healthy Families) despite considerable resources and energy directed at finding and enrolling them.[3] One extremely valuable lesson emerges: no matter how well-targeted the eligibility rules are and no matter how much money is spent on outreach, working parents and their children will not use health care unless it is convenient and simple to do so. Today, California's system is not simple, nor will it be if we make more people eligible under a federal SCHIP waiver without first addressing "what's broken."

Where Things Stand Today

The elements proposed in California's SCHIP waiver request offer a valuable place to begin. The plan's principal focus is on the first challenge—providing eligibility to more uninsured parents. In addition, the plan includes some important streamlining measures for these parents, including a year of continuing service and eligibility without having to complete duplicative forms

every few months. However, a number of other crucial steps to cut red tape, keep siblings together and with their parents, reach all parents of children currently eligible for coverage, make the simplification elements uniform across the programs, and assure the system is convenient for working parents are not addressed. Until these features that are "broken" get fixed, policymakers can expect the same failures to occur that have been experienced through existing insurance efforts.

About This Report

This report is for policymakers and staff in the executive branch and legislature, interest groups, and others at work to improve health care for California's children and families. We hope it will help inform efforts to refine and implement California's SCHIP waiver request and make necessary reforms that extend beyond the parameters of the waiver. The report attempts to answer the following inter-connected questions:

- How can we "modernize" the largest health insurance programs for low-income working families in California to eliminate unnecessary bureaucracy, cut the duplicative red tape that families encounter, and make the various funding sources operate as one simple-to-use program?

- How can we remove the perceived barriers associated with California's two largest public health insurance programs so they "look and feel" as much as possible like the private sector care that Californians value?

- How can we best leverage available state and federal dollars to cover the greatest number of uninsured Californians?

- How can we most effectively target eligibility to low-income working uninsured parents and children who are not eligible today?

There is now a wealth of information from families and local communities to guide decisions about unifying and simplifying existing arrangements. The recommendations presented in this report are based on extensive knowledge of California's attempts to date to insure children, with special focus on the state's experience during the past two years to enroll eligible children into its Healthy Families and Medi-Cal programs. In particular, the proposals rely on feedback we have received from communities across California as to what is and is not working for families, along with an analysis of what is possible under federal and state law and the policies and procedures used in California's existing programs.

Many recommendations contained here have been proposed by others and are widely supported. We have attempted to bring the various recommendations together in an achievable, comprehensive plan for how California's family health system should be designed. Above all, we believe that the single guiding principle governing California's health system should be making it work for California families.

The report contains three core parts:

- The Current Landscape: Brief background on the problem of California's uninsured and the principal programs in place to help them;

- The One Door Plan: A detailed plan for creating a unified family health program out of today's puzzle of existing programs and policies; and

- Chart Summary: A chart comparing the new program to what exists today. (See Appendix A.)

Moving Forward to Implement the One Door Plan

The One Door Plan outlined in this report attempts to take California's disparate and fragmented approach to health coverage and replace it with a coordinated system of care that makes sense to California's working families. It recommends:

- Developing a simple administrative structure for California's largest publicly funded health insurance programs (Medi-Cal and Healthy Families) so that families can apply through one application to one program, called Healthy Families.

- Streamlining the eligibility rules and enrollment procedures so that families can more easily apply for and use their health insurance.

- Extending coverage to parents so that an entire family with an income up to 250 percent of the federal poverty level (FPL; $36,575 for a family of three in 2001)[4] can be insured.

The plan focuses on Medi-Cal and Healthy Families because almost three-fourths of California's uninsured children are eligible for these two programs. However, we recognize that children and families in California receive their health care from a variety of sources, including county hospitals, community clinics, and other state-based health programs such as Access for Infants and Mothers (AIM). Coordinating these health systems with Medi-Cal and Healthy Families and ensuring that a strong public health network continues is extremely important if we are ever to achieve a viable and accessible health system for all Californians. We present this plan as a powerful building block in this effort.

We also recognize that it will take several years to fully implement the One Door Plan. But we believe it is achievable if its implementation is undertaken in a smart and strategic manner. To achieve this success, we recommend two phases for implementation.

Phase 1: Implementation with the SCHIP Waiver—July 1, 2001

The recently submitted SCHIP waiver proposal can represent the first significant step toward full implementation of the One Door Plan. To make the waiver plan truly workable for families, we recommend three changes to the SCHIP waiver request and several companion changes that do not require a waiver. Since the proposed start date for program implementation in the waiver is July 1, 2001, we recommend that these additions be implemented by that same date.

- Children are more likely to enroll in health insurance if their parents are also eligible. Since children with family incomes up to 250 percent of the FPL are currently eligible for Healthy Families, their parents should be too. Stopping at 200 percent of the FPL, as the current waiver proposes, would complicate an already tangled system of eligibility rules.

- Children should be placed in the same health plan as their parents to ensure coordination of care and to alleviate unnecessary burdens placed on families. To help get to this point, there should be a "line in the sand." All children ages 1 to 18 and their parents with incomes at or below 133 percent of the FPL should have their care financed through Medicaid (Medi-Cal in California) and all those with incomes above should receive it through SCHIP (Healthy Families in California).

- To assure that health care is not "priced out of reach" for working poor parents, the family premiums and co-payments proposed in the waiver should be adjusted slightly. On top of the current child premiums, families with incomes of 134 to 150 percent of the FPL should pay $10 per month per adult and those with incomes above 150 percent of the FPL should pay $13 per month per adult. Families should pay no co-payments for preventive or pregnancy-related services.

Moreover, the following complementary steps that do not require a waiver should be implemented on July 1, 2001 along with waiver provisions:

- Red tape should be cut in Medi-Cal's program for parents to make the policies consistent with how their children are treated and how Healthy Families works (offering one year of service and elimi-

nating the unnecessary paperwork to document assets in order to determine eligibility).

- Parents who are legal immigrants should have the same coverage available to them as their children do, with eligibility not tied to their date of entry. The state should provide the necessary funds until federal dollars are available.

- There should be one comprehensive outreach plan, one mail-in application form, and one central processing unit for children and their parents, regardless of which program pays for their care.

- Children eligible for and enrolled in other public programs should be targeted for outreach and "express laned" into health insurance.

Phase 2: Implementation—2001 to 2003

The measures tied to July 1 implementation would create a very substantial building block for reform. The additional good government recommendations made in our report can be implemented through budget and legislative cycles over the next 24 months, to take effect by 2003.[5] They include:

- Institute consistent ways of counting income, along with the use of a standard income deduction.

- Make policy uniform for children and their parents on other key features such as start date for coverage, retroactive coverage, and health plan and provider choice.

- Use the name Healthy Families for the unified "one-door" program, regardless of which program pays for care.

- Eliminate unnecessary application steps, such as having families submit documentation that is not required under federal law.

- Strengthen the tie-in with employer-based coverage by allowing the use of payroll deductions for premiums and employer purchasing credits.

- Dedicate funds for important public health functions, including transportation, translation and culturally appropriate outreach.

All of these reforms and how they interconnect are described in greater detail in this report. In addition, Appendix A provides an easy-to-read summary chart on the One Door Plan.

A Word About Cost

The One Door Plan does not expand coverage significantly beyond what has already been recommended by the state and thus is quite affordable. Children eligible for the One Door Plan are already eligible for health coverage. The only new cost would be the addition of an estimated 518,000 parents with incomes between 100 and 250 percent of the FPL. Governor Davis has already proposed covering roughly 80 percent of these parents. Thus, the only additional parents covered by our proposal are parents with incomes between 200 and 250 percent of the FPL.[6] Because the One Door Plan recommends some key cost-cutting administrative measures that over the long term should make California's health programs truly cost-efficient, some of the cost for the additional parents would be offset by administrative savings.

The One Door Plan does not expand coverage significantly beyond what has already been recommended by the state and thus is quite affordable.

In addition, this plan can be implemented with the amount of SCHIP funds already allocated to the state. Even with the expansion to parents as proposed in the SCHIP waiver, state officials expect to return at least $750 million in unspent federal SCHIP funds over the next three years.[7] Instead of losing this money, California can put a program in place that will ensure good health for working families for years to come. We look forward to further analysis on this issue.

California's Current Health Landscape

The Uninsured

California has a unique opportunity to begin to reverse the state's legacy of having one of the lowest health insurance coverage rates in the nation. Compared to other states, California ranks fourth worst in the percent of people without health insurance coverage, ahead of only Texas, Arizona, and New Mexico.[8] In fact, one in six of the nation's uninsured resides in California.[9] The status of California's uninsured is:

- One in five (approximately 6.8 million) Californians are uninsured.[10]
- Of these, almost half are children and parents: 1,849,000 children and 1,247,000 parents.[11]
- 54 percent of these uninsured children and parents are already eligible for health insurance coverage through Medi-Cal and Healthy Families: 1,261,000 children and 400,000 parents.[12]

Our proposal, which creates a unified, simplified, and streamlined program, seeks to make it easier for those children who are already eligible for coverage to enroll, and to provide coverage to their uninsured parents. Under our proposal 70 percent of all children and parents who are uninsured in California (1,261,000 children and 918,000 parents) would be eligible for health insurance.[13] This includes the addition of 518,000 parents with incomes between 100 and 250 percent of the FPL who are currently not eligible for coverage.[14]

The Programs

California provides health insurance coverage for its low income and uninsured children and parents through a number of different state programs. This report focuses on California's two largest health insurance programs: Medi-Cal and Healthy Families.[15]

- Medi-Cal. California's Medicaid program pays for comprehensive benefits for approximately 2.5 million children and 2.5 million adults.[16] Medi-Cal is funded with state and federal funds. Eligibility for participation for children and parents is divided into several categories. Those related to the family's annual income are in the chart on this page.

Other persons eligible for Medi-Cal include the aged, blind, and disabled, and individuals with certain specific health needs.[18]

- Healthy Families. California utilizes federal funding provided under the State Children's Health

Category	Family Income Level
Pregnant women and infants	Up to 200 percent of the FPL (29,260 for a family of 3 in 2001)
Children ages 1 to 5	Up to 133 percent of the FPL ($19,458 for a family of 3 in 2001)
Children ages 6 to 18	Up to 100 percent of the FPL ($14,630 for a family of 3 in 2001)
Parents[17]	Up to 100 percent of the FPL ($14,630 for a family of 3 in 2001), as applicants. Up to about 150 percent of the FPL once they become recipients.

Insurance Program (SCHIP) to provide health care insurance to uninsured children who are not eligible for Medi-Cal without a share of cost (see above) but who have family incomes up to 250 percent of the FPL. As of January 8, 2001, 362,373 infants and children were enrolled in Healthy Families.[19] California receives a 66 percent federal match to cover the cost of coverage for children enrolled in Healthy Families.

The variability and differences among these two programs make it extremely difficult for eligible families to access and navigate the system, not to mention the difficulty facing counties, health plans, and providers that are charged with constructing a sensible delivery system for uninsured families. It is not uncommon for a family's eligibility for either program to continually shift with changes in the child's age and the family's income. For example, many families applying to Medi-Cal or Healthy Families for their children find that one child is eligible for care in one program, while a second child is eligible for the other.

These issues are addressed in the following recommendations and outlined in Appendix A in chart form.

The One Door Plan: A Strengthened Healthy Families Program

GUIDING FRAMEWORK

The main goal of these recommendations is to make it easy for families to enroll in and maintain health coverage. These suggestions would also simplify the administration of the programs and increase efficiency and effectiveness for both administering agencies and those assisting applicants. The intent of this proposal is to create a system that not only works for families but, by eliminating administrative roadblocks and unnecessary red tape, will be cost-efficient for the state to run.

One challenge of such a proposal is how to maintain certain features of the programs that are important to participants while creating a unified system that is straightforward for families to use. For this reason, we propose that some of the core features of Medi-Cal and Healthy Families be maintained, but that a simple administrative structure be created that allows families to apply to one program, with one application, through uniform and simplified eligibility and redetermination rules.

The intent of this proposal is to create a system that not only works for families but, by eliminating administrative roadblocks and unnecessary red tape, will be cost-efficient for the state to run.

In particular, the specific features that we recommend maintaining within each program include:

- No Waiting List: Under federal law, persons eligible for Medi-Cal are guaranteed to receive services under the program. We feel this guarantee is essential to maintain, especially for lower income families who would be hardest hit during an economic downturn.

- Benefits: Since Medi-Cal's benefits are more comprehensive than Healthy Families', especially concerning children, it is important to maintain the crucial health, dental, and vision benefits provided under Medi-Cal to those who are currently eligible for the program.

- Federal Matching Rate: The federal government provides different matching funds for Medi-Cal and Healthy Families. Federal cost sharing would be maintained, ensuring that California would not lose the more attractive SCHIP federal match funds for which it is eligible.

A UNIFIED PROGRAM

Eligibility Guidelines

As much as possible, eligibility levels would be streamlined so that all family members will have the same financing source for their coverage.

Children and their parents,[20] including pregnant women, with incomes up to 250 percent of the FPL (annual incomes of $36,575 for a family of 3) would be eligible for the new One Door Plan. Health, dental, and vision coverage would be provided under one program named Healthy Families, and the state would determine on the back-end which funding stream pays for the insurance and what health benefits the family receives.

Legal immigrant children and legal immigrant parents meeting these income rules would be eligible for the program regardless of their date of entry into the country. Their coverage, however, would be covered by state funds since a Medicaid or SCHIP match is not currently allowed under federal law.

Once a family applies, the state would use the eligibility guidelines following to determine which financing source to use for their care and which benefits to provide: Medi-Cal or SCHIP (California's current Healthy Families program).

One Door Plan Eligibility Guidelines			
Income Level	Pregnant Women and Infants	Age 1 to 18	Parents
201% to 250% FPL	SCHIP	SCHIP	SCHIP
134% to 200% FPL	Medi-Cal	SCHIP	SCHIP
0% to 133% FPL	Medi-Cal	Medi-Cal	Medi-Cal

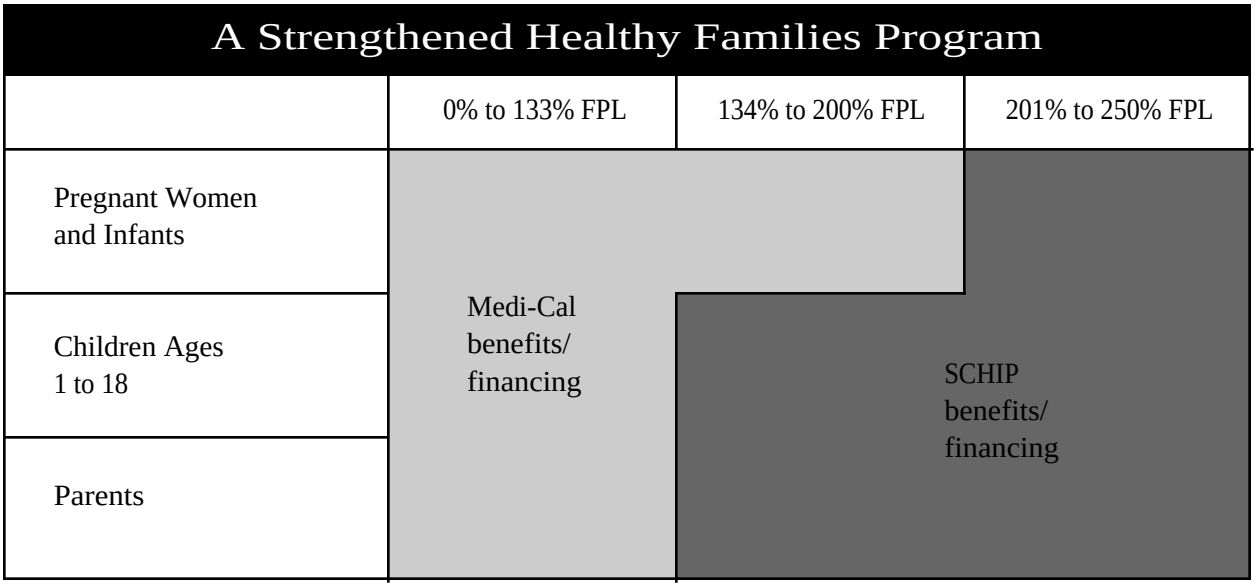
The intent of this proposal is, as much as possible, to allow family members to have the same financing source for their coverage and thus receive the same benefits. Under the current system, because of the age and income guidelines, siblings within the same family many times end up in different programs with different benefits. If parents were added to this already complex situation, it would result in a system in which parents and any of their children could be in separate programs. To help achieve consistency within families, under this proposal a small number of children (roughly 68,000) ages 6 to 19 who are currently uninsured and eligible for Healthy Families (those with incomes between 100 and 133 percent of the FPL) would receive their financing and benefits through Medi-Cal.[21]

We recommend maintaining one exception to the basic approach of keeping all children and parents in the same family together. We suggest keeping pregnant women and infants with incomes up to 200 percent of the FPL in Medi-Cal. Medi-Cal offers a comprehensive benefits package, which is particularly important to infants who may be born with health problems. In addition, federal law currently prohibits shifting individuals eligible for Medicaid into SCHIP, in part because of the significant difference in matching rates. Given the federal fiscal interest and "cost neutrality" requirements in waivers, it is unlikely that federal authorities would permit children or pregnant women to be shifted out of Medi-Cal.

If health plans and providers participate uniformly across programs (as we recommend below), maintaining this group of children and parents in Medi-Cal would not impact how individual family members access their care. Medi-Cal would function purely as a funding source that is invisible to the families. However, while we seek this as the ultimate goal, we believe it is important in the interim to institute some flexible schemes that allow family members to stay in the same health plans. We propose:

- Women receiving SCHIP benefits with incomes from 134 to 200 percent of the FPL who become pregnant and their newborns could, instead of switching back and forth between Medi-Cal and SCHIP health plans, stay with their current SCHIP health plan. The mother through 60 days post-partum and the child up to age one would technically be covered by Medi-Cal, with the additional benefits SCHIP does not cover provided through a wrap-around fee-for-service program. During the mother and child's period of Medi-Cal eligibility, the state would receive the federal Medi-Cal matching rate versus the SCHIP rate.

- Newly enrolling pregnant women and their newborns with incomes from 134 to 200 percent of the FPL would be placed in a SCHIP health plan. The mother through 60 days post-partum and the child up to age one would technically be covered by Medi-Cal, with the additional benefits SCHIP does not cover provided through a wrap-around fee-for-service program. During the mother and



child's period of Medi-Cal eligibility, the state would receive the federal Medi-Cal matching rate.

Length of Eligibility

All family members will be eligible for coverage starting the first day of the month in which the application is received, along with three months of retroactive coverage, and coverage will continue for a continuous 12 months.

Under the current system, eligibility for service starts at a different time for each program. Healthy Families offers coverage beginning 10 days after the date in which the application is approved. Medi-Cal, on the other hand, starts coverage the first day of the month in which the application is received.

We recommend that eligibility begin on the same date across the two programs, beginning the first day of the month in which the application is received. We believe that with the assurance that the services will be covered for the entire month, parents will be less likely to delay seeking treatment for their uninsured children who are ill or injured while they await the start of coverage.

Medi-Cal also offers families the option of applying for three months of retroactive coverage. Because of the important financial protection retroactive coverage provides for low-income families, we recommend preserving a three-month retroactive coverage option for all families under the new program. Since the goal of this new program is to provide continuing health coverage to all eligible families, we believe that the need for retroactive coverage will dissipate over time.

Once the applicant's coverage begins, we recommend that he or she remain eligible for a continuous 12 months. Children eligible for Medi-Cal or Healthy Families already have a full year of continuous eligibility.[22] However, parents do not have continuous eligibility and must submit documentation if circumstances change in a way that might affect eligibility, causing an undue burden on families. Just like individuals signing up for coverage through their employer, applicants in the new Healthy Families program should have to renew only once a year.

SIMPLIFIED ELIGIBILITY RULES

Income Counting Rules

Income will be defined and counted in the same way, including common definitions for family members, rules for inclusion in the household budget unit, and countable income, regardless of which federal or state funding stream finances the coverage.

To better coordinate Medi-Cal and Healthy Families, the state should use the same rules across programs for determining family size, the household budget unit, and countable income. Currently, the Medi-Cal household budget unit is defined as related persons living in the same home who have financial responsibility for health care for the applicant. Step-parents and ineligible family members without a duty to support can be excluded. Healthy Families usually includes the income of a step-parent living in the home and, in some cases, counts the income of responsible adults living outside the home.

To better coordinate Medi-Cal and Healthy Families, the state should use the same rules across programs for determining family size, the household budget unit, and countable income.

These differences can be eliminated and still maintain each program's integrity by adopting the Medi-Cal rules. As a general rule, only income from legally responsible relatives living in the home should be counted. Step-parents and ineligible family members without a duty to support should be excluded. Minor siblings' income should not be counted.[23]

Family Assets

A family's assets will not be counted.

In addition to the above income counting rules, currently parents applying for Medi-Cal are not eligible if they possess assets, such as a car or bank account, valued at more than the allowable limit, varied by family size. Although most families at this income level rarely accumulate assets over the Medi-Cal limits, families are still required to provide detailed information on all of their assets. This unnecessary administrative obstacle should be eliminated, as it already has been in Medi-Cal for children and pregnant women and in Healthy Families. Because of the amount of paperwork and staff resources devoted to obtaining this information, administrative savings would also be achieved through this streamlining measure.

Income Deductions and Exclusions

Income deductions and exclusions will be based on a very simple calculation (details to be determined based on further analysis).

Currently, families applying for coverage in Medi-Cal or Healthy Families can subtract a range of income deductions, such as child care and child support expenses, in determining their countable income. In addition, these programs exempt a confusing array of income, including foster care benefits, certain grants and scholarships, and some types of benefits for crime victims. These varying deductions and exclusions significantly complicate the application and enrollment process.

To simplify the process for families and those assisting them, we recommend that the state move towards the use of a standard income deduction that is used for all families. This would mean that families or application assistors would no longer have to undertake complicated, time-consuming calculations to determine a family's eligibility for the program. However, further research and analysis is needed to ensure that this strategy is executed correctly and in a way that is beneficial to families. We recommend that a workgroup of knowledgeable parties be formed to determine which deductions and exclusions it makes sense to include, how to set a standard deduction that is comparable in value to the current deductions and/or exclusions, how to differentiate between work and non-work income, and implementation requirements, including the potential need for federal waivers.

Documentation Requirements

Information on the application will be verified through existing computer systems, appropriate databases, and/or sampling. The only items for which documentation will be required are those required by federal law (i.e., verification of immigration status for non-citizens). Social Security Number of each applicant is optional, but follow-up to obtain Social Security Number may be required for persons receiving Medi-Cal benefits.

Currently, Medi-Cal and Healthy Families require applicants to submit documents to verify their income, residency, and identity, among other things. Community groups persistently identify documentation as one of the most significant barriers families face in completing the joint application form.

Not only are the documentation requirements burdensome, but they are inconsistent across programs. For example, Healthy Families requires a copy of the child's birth certificate, while Medi-Cal does not. These differences make it difficult to create a uniform program for families, with only one application.

In fact, federal rules do not require families seeking coverage under Medicaid or SCHIP to provide verifying documentation unless the person seeking coverage is not a citizen, in which case documentation of the non-citizen's currently legal immigration status is required.[24]

By eliminating these unnecessary documentation requirements, families would simply self-declare information provided in the application under penalty of perjury. The state could verify such information through its current income and eligibility verification system (IEVS), other appropriate databases or through post-eligibility random sampling or audits. Thirteen states including Florida, Michigan and Texas have already successfully eliminated unnecessary documentation requirements for either their Medicaid for children or SCHIP programs.[25]

Since it may assist the verification process, the One Door Plan would make it optional for families to provide applicant's Social Security Numbers (SSN). However, since federal Medicaid law requires SSNs for each applicant, the state may have to follow-up with persons found eligible for Medi-Cal benefits if they did not provide their SSN. SCHIP law does not require SSNs and states cannot require persons to provide them.[26]

Cost Sharing

Family cost sharing will be made consistent across funding sources, with premiums being tied to a family's ability to pay.

Under the current health system, out-of-pocket patient spending requirements vary widely. The Medi-Cal program has no premiums and only nominal co-payments. The Healthy Families program has monthly premiums ranging from $4 to $9 per child and $5 co-payments for non-preventive services. In order to create consistency across the programs, we propose that cost-sharing requirements be based on a sliding income scale. Our recommendations are as follows.

Premiums

Families receiving their benefits and financing through Medi-Cal would utilize the Medi-Cal premium structure, as required under federal law. For parents and children ages 1 to 18 above the Medi-Cal eligibility level we recommend that a family's premiums be based solely on income on a graduated scale. The premium levels we suggest were determined by combining the current child premiums for Healthy Families with a slightly higher adult premium, since coverage for adults is more costly.

The recommended premium levels were derived by taking into consideration current health insurance market rates and average employee cost-sharing levels.[27] In addition, based on empirical research on the appropriate cost-sharing levels for low-income and working families, we structured the premiums so that families will generally pay no more in premiums than roughly 2 percent of their income.[28]

Building on the principle of Healthy Families' current $3 community provider discount, a community provider discount would also be available for all persons. However, if health plans and providers become uniform across the programs (discussed later), this may need to be reevaluated.

The rates are as follows:

One Door Plan Premium Levels			
	Pregnant Women and Infants	Age 1 to 18	Parents
201% to 250% of the FPL	\$9 per child, \$13 per adult, per month; \$44 maximum per family, per month[29]		
151% to 200% of the FPL	None		
134% to 150% of the FPL	None	\$7 per child, \$10 per adult, per month; \$34 maximum per family, per month[30]	
0% to 133% of the FPL	None		

Co-Payments

In addition to premiums, families would be responsible for certain co-payments. Per federal Medicaid rules, pregnant women and infants with incomes up to 200 percent of the FPL and parents and children ages 1 to 18 with incomes up to 133 percent of the FPL would have nominal co-payments.

All other parents and children with incomes above 133 percent of the FPL would pay no co-payments for preventive and pregnancy-related services. For other health services, a \$5 per visit co-payment would be required. Prescription drugs, except those provided in an inpatient setting where no co-payment is charged, would be available to children and their parents at a \$5 co-payment.

To ensure that these co-payments do not deter families from seeking services, a cap would be placed on how much an individual child or family eligible for SCHIP benefits would have to pay in health co-payments per year.[31] Currently, the co-payment annual maximum under Healthy Families for a child is \$250 per family, no matter how many children are enrolled. This would remain the case under the One Door Plan if only the children in the family were enrolled in coverage. If a child and at least one parent were enrolled in coverage, the co-payment annual maximum would be \$500 per family each benefit year, no matter the number of enrollees.[32]

A person with a chronic illness requiring many doctor visits and/or prescriptions could quickly see their co-payment costs soar. We believe that caps above the limits proposed would cause undue hardships on low-income families and could be counterproductive to the very goal of California's health insurance effort, which is to increase health access.

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EASY ACCESS FOR FAMILIES

Application Process

One application form will be used, regardless of the financing source, which can be mailed to a single entry point for processing within 10 days.

Only one application will be used under our proposal. Families wishing to enroll all eligible family members would complete one application, saving time and confusion. The current joint Medi-Cal for children and Healthy Families mail-in application has been effective and user-friendly in this sense. However, community groups also report that parents are confused about why they cannot use this same application to sign them-

selves up for coverage and have to go to a local welfare office to apply separately. While the state is currently developing an application for Medi-Cal parents and their children that can be mailed in, this does not accomplish the goal of only one form.

An administrative agency, referred to as a Single Point of Entry (SPE), should process the applications. Not only would this assist families when trying to figure out where to mail the application; one common entity would also be able to immediately screen the applications for any missing information.

A SPE is currently used to process the joint Medi-Cal for children and pregnant women and Healthy Families applications. However, under that system the Medi-Cal applications are separated out and forwarded to the appropriate county for the final eligibility determination. The Healthy Families applications are processed at the SPE. The system of forwarding Medi-Cal applications to the counties has created tremendous difficulties, including excessive time to forward the applications, difficulties tracking applications at the county level, insufficient training of county eligibility workers, missing applications, and applications bouncing back and forth between Medi-Cal and Healthy Families.[33]

We recommend that the primary avenue for eligibility determinations under the One Door Plan be the SPE. Since federal law requires that Medicaid eligibility determinations be made by public employees, this would require the co-location of Medi-Cal staff at the SPE to process the Medi-Cal applications. Once an eligibility determination is made, the Medi-Cal case file can be forwarded to the appropriate county for assignment to an ongoing caseworker so that the applicant has ongoing local assistance. Healthy Families applicants would have their eligibility determination made by either personnel of the administrative entity or the public employees. Since the SPE would be handling a significant number of applications, adequate funding and training must be provided to the SPE to ensure the applications are processed correctly and in a timely manner. We also recommend that a bar code system be implemented to track the applications throughout the process, and that there be a toll-free number to call for location and status of applications, as was recently implemented for Healthy Families.

To ensure applications are processed in a timely manner, we recommend that all applications be processed within 10 days of receipt. This is the time frame used by Healthy Families and it stands in stark contrast to Medi-Cal's processing time of 45 days. This standard will make the processing time uniform for the programs and, most importantly, will help ensure that children receive care promptly. This will also instill, if not magnify, the efficiencies in an improved system as we propose here.

While processing all the applications within 10 days would be an enormous shift, we believe it is achievable if the streamlining recommendations we propose are implemented. Eliminating unnecessary documentation requirements, using a standard income deduction, and applying uniform income counting rules should greatly shorten the time necessary to make an eligibility determination.

Community Outreach

Families will have assistance from a range of trusted sources, including community groups, clinics, county hospitals and county eligibility workers, to help them complete the application.

Since our proposal attempts to enroll and cover over 2 million uninsured children and parents in health insurance, outreach mechanisms rooted in the community will be vital in finding and enrolling them. As is currently provided with the Medi-Cal for Children/Healthy Families application, we propose the continued use of trained individuals, called Certified Application Assistors (CAAs), to assist families in completing the application. The CAAs would be stationed at such places as clinics, county hospitals, community service centers, and schools. These CAAs would receive $50 per successful application completed. Medi-Cal eligibility work-

ers at the county would also be fully trained in completing the new application and would be available to assist any family wishing to sign up for coverage.

In addition, government and philanthropic grants provided to community groups to conduct aggressive outreach and enrollment activities should be continued, and expanded appropriately, to ensure effective, community-driven efforts are undertaken. These grants are particularly crucial for reaching immigrant populations that might be afraid to sign up for public programs.

Certified Application Assistors and community-based organizations receiving state grants have become increasingly important not only in completing initial applications, but in providing new enrollees with follow-up assistance in order to keep them enrolled and help them access health care once they are insured. These broader responsibilities should be reflected through additional funding.

Lastly, with the implementation of a new application, initial training for the CAAs, eligibility workers, and community groups should be provided, along with continued training thereafter.

Express Lane Eligibility

Families already enrolled in public programs that use comparable income rules (like school lunch, Food Stamps, WIC) will be "express laned" into health coverage.

Through Express Lane Eligibility, California can expedite eligibility for health insurance for eligible families whose members already receive public services through programs with similar income eligibility rules. These include free and reduced price school meals, WIC, and Food Stamps. Since this proposal will increase the number of parents eligible for health coverage, we recommend implementing Express Lane Eligibility to make it easier to find and enroll these families.[34]

Health Plan and Provider Choice

Families will have uniform access to health plans, regardless of which funding stream is financing the coverage.

Currently, Healthy Families and Medi-Cal managed care each contract with different health plans (using different rate schedules) to provide health, dental, mental health, and vision services to families. The perceived difference of providers who participate in Healthy Families compared to those who participate in Medi-Cal exacerbates the stigma sometimes associated with Medi-Cal. And in some cases, this perception has discouraged eligible families from applying for Medi-Cal. In practice, some plans contract with both Medi-Cal and Healthy Families. However, as long as differences between the plan choices remain, many potential enrollees will perceive a "two-tiered" system that favors those higher income families receiving benefits from Healthy Families. Under the current system:

- Healthy Families typically offers choice among 3 to 10 plans, depending on the county. In some counties, Healthy Families enrollment is concentrated with one plan (often the "Community Provider Plan"), while in others the enrollment is more broadly distributed among three or four competitors. The extent of family choice is the result of negotiations between the Managed Risk Medical Insurance Board (MRMIB) and the health plans. In small and rural counties, there is typically only a single plan choice.

- Depending on the county, Medi-Cal offers families a single choice (a County Organized Health System "COHS"), dual choice (Two-Plan model), or multiple choice of plans (Geographic Managed Care). The extent of family choice is the result of: 1) negotiations between the state Department of Health Services (DHS) and county government as to which managed care arrangement the county prefers; and 2) market share restrictions established by DHS for the Two Plan model counties. In small or rural counties, there is typically only Medi-Cal

Fee-for-Service or a single choice COHS plan. Certain Medi-Cal children, such as foster children and those with CCS designated conditions or Medi-Cal share of cost, are normally exempt from enrollment in managed care.

Ultimately, we recommend that families have uniform access to health plans, regardless of what funding stream is financing their coverage. To get to this point, we recommend that a workgroup of the various stakeholders be established to examine the possibility of creating a single entity to negotiate and contract with health plans to provide benefits under the unified program.

This workgroup would evaluate how a single contracting/negotiating entity could ensure: access to the same plans for families currently receiving financing and benefits under Medi-Cal and Healthy Families; choice among plans for families; consistent rate structures among plans and providers; maintenance of services for children in foster care, the CCS program, and Medi-Cal Fee-For-Service; and protections for the safety net.

MAKING OTHER IMPORTANT CONNECTIONS

Employer Linkages

The consolidated program should tie into employment-based coverage, the dominant form of coverage for Californians. This could be done by implementing payroll deductions for the public program's premiums, and allowing working uninsured families the option of premium subsidies for health care coverage available through their employer.

Especially given California's low rate of employment-based coverage compared to the rest of the country, these measures are an opportunity to make employment-based coverage more affordable for low wage working families and to increase voluntary employer financing of health benefits. Five states including Massachusetts and Maryland have already made a commitment to increasing employment-based coverage through tie-ins with their publicly funded insurance programs. If properly designed and targeted, this option could decrease "crowd out" incentives.

Public Health and Enabling Elements

The consolidated program should include dedicated funds for important public health functions that are not easily supported through capitated payments or fee-for-service—including, for example, services for highly mobile migrant families. In addition, low-income populations often require services that are not usually provided under a direct delivery model in order to access care. Such enabling services that should be covered under this proposal include transportation, translation, public health education, outreach, and mobile services for difficult to reach groups.

Conclusion

This proposal attempts to provide a roadmap for how to make California's health care system truly accessible to the families it serves. Its implementation will require a combination of strategies, including changes in federal law through waivers and state legislative changes, but we believe all are achievable. While decisionmakers may be tempted to carve out and implement only certain of the recommendations presented here, we urge that an attempt be made to look at these recommendations as a whole. These reforms interconnect and will be effective in breaking down the barriers to enrollment only if each is put in place. We have outlined a plan of action for accomplishing these reforms in this manner in the Introduction and Executive Summary.

The overriding goal of this proposal is to make California's public health programs actually work for families. We look forward to joining with state officials, policymakers, advocates, and community groups to make this happen.

Appendix A: Chart Summary of California's Current Medi-Cal and Healthy Families Programs versus the One Door Plan

	Current Programs		The One Door Plan: A Strengthened Healthy Families Program
	Medi-Cal for Children & Parents (Poverty Level Program)	State Children's Health Insurance Program (Healthy Families)	
Number of Eligible but Not Enrolled Children and Parents	An estimated 1,661,000 uninsured children and parents are currently eligible.		An estimated 2,179,000 children and parents would be eligible. This includes the addition of roughly 518,000 uninsured parents to the already 1,661,000 eligible children and parents.
Guiding Framework			
Waiting Lists	No waiting lists.	Waiting lists can be used.	No waiting lists for persons having care financed through Medi-Cal.
Benefits	Benefits vary among the two programs, with Medi-Cal providing the most comprehensive package.		Benefits maintained within Medi-Cal and Healthy Families and determined by how coverage is financed.
Federal Matching Rate	50% federal match.	66% federal match.	Federal matching rate maintained within Medi-Cal and Healthy Families.
A Unified Program			
Income Eligibility Guidelines	• Pregnant women and infants up to 200% FPL; • Children ages 1-5 up to 133% FPL; • Children ages 6-18 up to 100% FPL; • Parents up to 100% FPL, as applicants; about 150% after become recipients.	• Infants, 201% to 250% FPL; • Children ages 1-5, 134% to 250% FPL; • Children ages 6-18, 101% to 250% FPL.	Children and parents with incomes up to 250% FPL. Care financed and benefits provided are determined by income level: • Pregnant women/infants up to 200% FPL = Medi-Cal; • Children ages 1-18 and parents up to 133% FPL = Medi-Cal; • Children ages 1-18 and parents 134-250% FPL = SCHIP; and • Pregnant women and infants 201-250% FPL = SCHIP.
Immigration Requirements	State funds provide Medi-Cal eligibility to legal immigrants no matter when they entered the US.	State funds provide Healthy Families eligibility to legal immigrant children no matter when they entered the US.	All legal immigrant parents and legal immigrant children meeting income rules are eligible no matter when they entered the U.S. Financing provided through state funds, unless Congress allows usage of federal funds at a later date

	Current Programs		The One Door Plan: A Strengthened Healthy Families Program
	Medi-Cal for Children & Parents (Poverty Level Program)	State Children's Health Insurance Program (Healthy Families)	
Start Date	First day of month in which application is received.	10 days after the date the application is approved.	All family members eligible for coverage starting the first day of the month in which the application is received.
Retroactive Coverage	Three months of retroactive coverage.	None.	All family members eligible for three months of retroactive coverage.
Continuous Eligibility	Children have 12 months continuous eligibility. Parents are required to report any income changes during year.	12 months continuous coverage.	All family members eligible for 12 months continuous coverage.
Simplified Eligibility Rules			
Income Counting Rules	The definition of family member and rules for inclusion in household budget unit and counting income differ between the two programs.		Income defined and counted in the same way regardless of which federal or state funding stream finances the care.
Family Assets	Not counted for children and pregnant women; counted for parents.	Not counted.	Not counted.
Income Deductions and Exclusions	Applicants can subtract a number of income deductions and exclusions from their gross income to determine eligibility.		Income deductions implemented using a standard deduction. A workgroup would be formed to provide further analysis and recommendations for implementing a standard income deduction.
Documentation Requirements	Pregnancy,[35] income, deductions, CA residency, citizenship, and immigration status. Social Security Number (SSN) required for each applicant.	Income, deductions, birth certificate for citizenship status, and immigration status of non-citizens. SSN not required.	Information on the application verified through existing computer systems, appropriate databases and/or sampling. The only documentation required is that required by federal law (i.e., verification of immigration status for non-citizens). SSN optional; state follows up with families determined eligible for Medi-Cal benefits to obtain applicant SSNs if not already provided.

	Current Programs		The One Door Plan: A Strengthened Healthy Families Program
	Medi-Cal for Children & Parents (Poverty Level Program)	State Children's Health Insurance Program (Healthy Families)	
Cost sharing	No premiums, nominal co-payments.	$4-$9/month per child premiums. $3 community provider discount. $5 co-payments for non-preventive services; none for preventive services. $250 annual co-payment maximum per family.	• Pregnant women/infants up to 200% FPL & children ages 1-18 and parents up to 133% FPL = No premiums and nominal co-payments. • Children ages 1-18 and parents 134-150% FPL = $7/month per child, $10/month per adult ($34 maximum per family, per month), and $5 co-payment for non-preventive services. • Children ages 1-18 and parents 151-250% FPL & pregnant women/infants 201-250% FPL = $9/month per child, $13/month per adult ($44 maximum per family, per month), and $5 co-payment for non-preventive services. • $3 community provider discount. $250 annual co-payment maximum per family if only child(ren) enrolled; $500 annual co-payment maximum per family if child(ren) and at least one parent enrolled.
Application Process	• Mail-in application for Medi-Cal for children and pregnant women and HealthyFamilies. • Application sent to single point of entry (EDS); counties make final eligibility determination. • Separate adult/children application (mail-in being developed).	• Mail-in application for Medi-Cal for Children and HealthyFamilies. • Application sent to single point of entry (EDS) for eligibility determination.	One application used, regardless of financing source, which is mailed to single point of entry (SPE) for processing within 10 days. Families with coverage financed through Medi-Cal have eligibility determination made at the SPE by Medi-Cal staff or other public employee; those through HealthyFamilies have determination made at SPE by public employee or other personnel. Once a determination is made, the Medi-Cal file is forwarded to county for assignment to a caseworker.

	Current Programs		The One Door Plan: A Strengthened Healthy Families Program
	Medi-Cal for Children & Parents (Poverty Level Program)	State Children's Health Insurance Program (Healthy Families)	
Community Outreach	Children Only: Contracts with CBOS; Certified Application Assistors (CAAs) receive $50 per successful application.	Contracts with CBOS; CAAs receive $50 per successful application.	Families have the assistance of community groups, clinics, county hospitals, and county Medi-Cal eligibility workers through CAA fees and increased CBO contracts. Initial and ongoing training provided to all assistors.
Express Lane Eligibility	Options for implementation being developed by Health and Human Services Agency.		Families already enrolled in public programs that use comparable income rules (like school lunch, Food Stamps, WIC) are "express laned" in.
Health Plan and Provider Choice	Medi-Cal offers families a single choice, dual choice or multiple choice of plans, depending on county. Pregnant women, some children and individuals with chronic medical conditions may be exempt from managed care. Rural counties mostly have fee-for-service.	Offers choice among 3-10 plans, depending on county.	Families have uniform access to health plans, regardless of what funding stream is financing the coverage. A workgroup would be formed to analyze and make recommendations for developing this system.
Making Other Important Connections			
Employer Linkages	Not Applicable.		The program ties into employment-based coverage, for example, by allowing the use of payroll deductions and purchasing credits.
Public Health and Enabling Elements	Not Applicable.		Dedicated funds provided for important public health functions not easily supported through the program, including transportation, translation, and culturally appropriate outreach.

Appendix B: Endnotes

1 State of California Health and Human Services Agency, California's Healthy Families SCHIP 1115 Demonstration Project, December 20, 2000, www.mrmib.ca.gov/MRMIB/HFP/HFPParent Proposal.html.

2 On July 31, 2000 the Health Care Financing Administration (HCFA) issued guidance permitting states for the first time to submit waivers for State Children's Health Insurance Program (SCHIP) demonstration projects under section 1115 of the Social Security Act. Under the rules, states can now submit proposals to HCFA to undertake strategies that are not otherwise permitted under the SCHIP law, including covering parents. To be eligible for the waiver a state must demonstrate that it is successfully reaching and enrolling eligible children into Medicaid and SCHIP (Medi-Cal and Healthy Families in California). HCFA must approve the waiver request prior to any implementation by the state. See Health Care Financing Administration, Letter to State Medicaid Officials, July 31, 2000, www.hcfa.gov/init/ch73100.htm.

3 Brown, E.R., J. Kincheloe and H. Yu. Health Insurance Coverage of Californians Improved in 1999—But 6.8 Million Remained Uninsured. Los Angeles, CA: UCLA Center for Health Policy Research, February 2001. Estimates derived from the March 2000 Current Population Survey and reflect health insurance status during 1999.

4 Federal Register, Vol. 66, No. 33, February 16, 2001, pp. 10695-10697. The Department of Health and Human Services issues federal poverty guidelines in April each year, which are used for administrative purposes to determine financial eligibility for certain federally funded programs. In 2001, the federal poverty level in the 48 contiguous states and D.C. (except Alaska and Hawaii) was $8,590 for a family of one; $11,610 for a family of two; $14,630 for a family of three; and $17,650 for a family of four.

5 Unless noted, most of the proposals in this report can be implemented at the state level without prior federal approval. As part of the 1996 welfare reform, Congress gave states broad flexibility to redesign their Medicaid program for families with children, since the goals of welfare reform are promoted by supporting families with health insurance when they work. In addition, the SCHIP law gives states a great deal of flexibility in setting eligibility rules.

6 Brown, E.R., J. Kincheloe and H. Yu. Health Insurance Coverage of Californians Improved in 1999. ibid. This report bases its data on calculations by the UCLA Center for Health Policy Research of 2000 Current Population Survey data, which estimates that expanding coverage to parents with incomes up to 200% of the FPL would make 412,000 new parents eligible, and coverage to parents with incomes up to 250% of the FPL would make 518,000 new parents eligible.

7 State of California Health and Human Services Agency, California's Healthy Families SCHIP 1115 Demonstration Project, Attachment A, ibid. This figure represents the state's projections on the amount of its unspent federal SCHIP allotment for the Federal Fiscal Years (FFY) 2001, 2002, and 2003. This does not include California's $590 million unspent federal SCHIP allotment in FFY 2000. In the recently passed federal budget, Congress dictated that states with unspent SCHIP funds in FFY 2000 are allowed to retain a percentage of these funds, estimated to be about 60%.

8 Mills, R. Current Population Reports: Health Insurance Coverage, 1999. U.S. Department of Commerce, Economics Administrat ion, U.S. Census

Bureau, September 2000. Based on a three-year average, 1997-1999.

9 Brown, E.R., N. Ponce and S. Teleki. "Health Insurance Coverage of Californians," in Schauffler, H. and E.R. Brown. The State of Health Insurance in California, 1999. Berkeley, CA: Regents of the University of California, January 2000.

10 Brown, E.R., J. Kincheloe and H. Yu. Health Insurance Coverage of Californians Improved in 1999. ibid.

11 Ibid.

12 Ibid.

13 Ibid. This figure is derived from the addition of 518,000 newly eligible parents, if income is raised to 250% of the FPL, to the 400,000 uninsured parents already eligible for Medi-Cal but not enrolled, resulting in roughly 918,000 eligible uninsured parents. The number of uninsured but eligible children would remain at the current level of 1,261,000 because our proposal does not increase the income eligibility levels for this group.

14 Ibid.

15 This proposal focuses on the two primary health insurance programs for children and their parents: Medi-Cal and Healthy Families. There are a variety of additional ways that health care is provided to Californians such as through federally qualified health centers (FQHC), rural health clinics, community safety nets, county health systems, and the Indian Health Service. There are also other statewide programs specifically for children, such as Access for Infants and Mothers (AIM), California Children's Services (CCS), and Child Health and Disability Prevention (CHDP), which provide unique, specialty services to a specific population.

16 California Department of Health Services, unpublished data, March 2000.

17 Parents and children in families with "deprivation" may be eligible for no share of cost or share of cost Medi-Cal under section 1931(b) family coverage provisions or under the Medically Needy family coverage provisions. Created by Congress under Section 1931 of the Social Security Act, 1931(b) is a Medi-Cal category that combines AFDC and CalWORKS eligibility criteria. Section 1931(b) coverage is available to otherwise eligible parents and children regardless of whether they receive cash assistance under CalWORKS. As of March 1999, the 1931(b) program covers families with incomes up to 100% of the FPL at the time of application, about 150% of the FPL as "recipients." If income is over that amount, parents and children may qualify for Medi-Cal under the Medically Needy provision. Share of cost for persons who are not aged, blind or disabled starts at 70% of the FPL, making the program unavailable as a practical matter to many families for anything other than catastrophic coverage. However, as of January 1, 2001, share of cost for the aged, blind, and disabled will not begin until 133% of the FPL.

The Medically Indigent (MI) program used to cover significant numbers of children in two-parent families with income over the FPL limits for the child's age group. With the relaxing of the 100-hour rule in 1999 under Medi-Cal, the MI program now covers many fewer children.

As of July 1, 2000, former foster youth who "aged out" of foster care at 18 became eligible for no share of cost Medi-Cal until they turn 21. There is neither an income nor an asset test for those 19- and 20-year-olds.

18 In order to qualify for Medi-Cal this way, the individual must be aged, blind or disabled according to Social Security rules. In addition, individu-

als with specific health care needs such as dialysis, tuberculosis services, intravenous nutrition, and certain services for minor or short-term nursing home stays may also qualify for Medi-Cal under special programs. See Page C. and S. Ruiz. The Guide to Medi-Cal Programs. Oakland, CA: Medi-Cal Policy Institute, 1999.

19 See Managed Risk Medical Insurance Board, "Healthy Families Subscribers Enrolled by Age; by Gender," www.mrmib.ca.gov/MRMIB/HFP/HFPRpt2.htm.

20 Under this proposal parents eligible for coverage include pregnant women, responsible adult caretakers in the home, including a natural or adoptive parent, a step-parent and any relative who provides care and supervision to a child if there is no natural or adoptive parent in the home.

21 March 1999 Current Population Survey (CPS), analyses by UCLA Center for Health Policy Research. According to MRMIB, as of October 30, 2000 there are 68,731 children in this income and age group who are enrolled in Healthy Families. Since the CPS data reflect status for children in 1998, many of these uninsured but eligible children could already be enrolled in Healthy Families. In this case, these children would remain in that program until their yearly renewal, at which time they would be shifted into Medi-Cal.

22 Children eligible for Healthy Families have had 12 months of continuous eligibility since the implementation of the program in 1997. Continuous eligibility became available for children under Medi-Cal on January 1, 2001.

23 For Medi-Cal rules regarding responsible relatives and unit determination, see Barclay's California Code of Regulations, Title 22, Social Security, Division 3, Health Care Services, Article 8. Medi-Cal rules can be somewhat administratively complex because of Sneede/Gamma. However, these rules are a result of federal law and are intended to provide protections to potentially eligible families.

24 Health Care Financing Administration, Letters to State Health Directors, January 23, 1998 and September 10, 1998. Also see footnote 1.

25 See www.cbpp.org/shsh/stateverify.htm for a list of states that allow self-declaration of income.

26 Health Care Financing Administration, Letter to State Health Officials, September 10, 1998.

27 Data derived from a review of premium levels for various health plans, including the Health Insurance Plan of California (HIPC), Kaiser Permanente, and Blue Cross; and Employer Health Benefits 2000 Annual Survey, Kaiser Family Foundation and Health Research and Education Trust, 2000.

28 Ku, L. and T. Coughlin. The Use of Sliding Scale Premiums in Subsidized Insurance Programs, The Urban Institute, Washington, DC, March 1997. This study examined the relationship between the premium scales and participation rates in four state health insurance programs for low-income residents: Hawaii's QUEST, Minnesota's MinnesotaCARE, Tennessee's TennCare, and Washington's Basic Health Plan. It found that when premiums are 1% of income, 57 percent of the uninsured would participate, but at 3% of income only a third would do so and at 5% of income only a sixth would participate. Our proposal suggests premium levels of no greater than 2% of income.

29 Families will pay premiums for a maximum of two children and two adults.

30 Ibid.

31 The co-payment caps would apply to health services only. Dental and vision services would have

no co-payment caps, as is currently the case for Healthy Families.

32 Derived from conversations with Leighton Ku, Center on Budget and Policy Priorities, February 2001.

33 See Barillas, R. and D. Horner. *Community Voices: Findings from the Children's Health Insurance Feedback Loop on Efforts to Enroll Children in Medi-Cal and Healthy Families*. Oakland, CA: The 100% Campaign, May 2000 and Horner, D., L. Mohamadi and M. Leung. *Community Voices: Findings from the Children's Health Insurance Feedback Loop on Efforts to Enroll Children in Medi-Cal and Healthy Families*. Oakland, CA: The 100% Campaign, October 2000, www.100percentcampaign.org.

34 For additional information on Express Lane Eligibility see The 100% Campaign's *Express Lane Eligibility: How California Can Enroll Large Numbers of Uninsured Children in Medi-Cal & Healthy Families*, February 2000, www.100percentcampaign.org and The Children's Partnership's *Putting Express Lane Eligibility Into Practice*, December 2000, www.childrenspartnership.org/express_lane/index.html.

35 State law has permitted self-declaration of pregnancy since July 1, 2000 but implementation was delayed. The Department of Health Services recently instructed counties to allow self-declaration of pregnancy in the federal poverty level program and 1931(b) program but has not decided whether a provider post-eligibility verification will be required.

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