



Stability and Churning in Medi-Cal and Healthy Families

Gerry Fairbrother, Ph.D.
Joseph Schuchter, M.P.H.

Child Policy Research Center
Cincinnati Children's Hospital Medical Center

March 2008



**This project was funded by The California Endowment.
Cover California's Kids is a program of The California Endowment.**

Gerry Fairbrother, Ph.D.

Professor, Health Policy and Clinical Effectiveness
Associate Director, Child Policy Research Center
Cincinnati Children's Hospital Medical Center

Gerry Fairbrother, Ph.D., is Professor and Associate Director of the Child Policy Research Center at Cincinnati Children's Hospital Medical Center and the Department of Pediatrics, University of Cincinnati. Dr. Fairbrother has led investigations into child health insurance enrollment patterns, barriers, and costs, the impact of Medicaid managed care on children's preventive health screening, and the effect of financial incentives on physician behavior. She has served as a consultant to the Institute of Medicine on projects dealing with immunization financing and the consequences of uninsurance and has worked with the Centers for Disease Control and Prevention to help states monitor immunization rates for children in Medicaid. Dr. Fairbrother holds a Ph.D. from Johns Hopkins University and is a Fellow of the New York Academy of Medicine and a Fellow of the Ambulatory Pediatric Association. She was awarded the "Best Ohio Health Policy Award for Independent Scholar or Practitioner" from the Health Policy Institute of Ohio in 2006.

Joseph Schuchter, M.P.H.

Epidemiologist
Child Policy Research Center
Cincinnati Children's Hospital Medical Center

Joseph Schuchter, MPH is an Epidemiologist with the Child Policy Research Center. His current work is focused on issues of health care access, specifically, health insurance coverage for children. He has also worked in public health, academic and non-government organizations performing research, surveillance, investigation, and monitoring and evaluation. Joe's interests include identifying and addressing determinants of health in the policy and built environments.

We thank the California Department of Health Services for their assistance and cooperation in this project. The views in this report are those of the authors and not The California Endowment.

Table of Contents

Executive Summary	2
Introduction	2
Medi-Cal and Healthy Families – an Overview	3
Retention in Medi-Cal and Healthy Families	3
Churning in Medi-Cal and Healthy Families	7
Why do Healthy Families Children Drop Off the Rolls?	8
Cost after a Gap	8
What do these findings say about probable effects of the Quarterly Status Report?	11
References	12
Appendix A. Descriptions of Medi-Cal Programs	13
Appendix B. Methodological Notes	14

Executive Summary

This report examines enrollment patterns and gaps overall and for specific groups within Medi-Cal and Healthy Families, as well as medical costs after a gap. We use this information to examine the possible effect of the Governor's plan to reinstate Quarterly Status Reports in Medi-Cal. Highlights include:

- Overall, approximately 50% of newly-enrolled children "survive" after 21 months of enrollment in both Medi-Cal and Healthy Families;
- The sharpest drop in enrollment is seen at the 12-month renewal point, especially for children in Healthy Families and those in the 1931(B) and children's percent programs in Medi-Cal;
- For children in other Medi-Cal – especially those who are also receiving food stamps or cash assistance – the drop is more gradual over time. These families need to renew more frequently to maintain the other social supports and thus, stay in closer touch with county assistance agencies.
- More frequent renewals will hit hardest children in the 1931(b) and percent programs of Medi-Cal. It is likely that *half the children in these programs will be dropped at every renewal period.*
- These families are teetering on the brink of poverty, are likely to be affected by an economic downturn, and may need the support health coverage offers for their children.
- Costs of medical care are substantially higher immediately after a gap. The longer the gap, the higher the cost afterwards.
- In Medi-Cal, it is likely that costs saved in the short-term by reducing enrollment using Quarterly Status Reports will be offset by pent up needs later on (or transferred to the safety net in the shorter term).

Introduction

Children need to have not only health insurance, but stable, continuous health insurance to get the full benefit of health care. Study after study has shown that children with stable coverage (usually defined as continuous coverage for a year or more) are more likely to have a usual source of care and less likely to have unmet medical needs than either children with unstable, on-and-off coverage or uninsured children.^{1,2} Stable coverage allows children to regularly access preventive care and protects families from catastrophic costs. Conversely, unstable coverage – coverage with gaps - leads to interruption of care, in the form of unfilled prescriptions and delayed or missed appointments. Importantly, children with unstable coverage are similar to children with no coverage at all in the benefits they receive from health care.

Stable coverage helps the family as well as the child. Parents say that knowing that their child has access to care when they need it relieves family stress associated with worry around health care and increases peace of mind; conversely, when children do not have coverage, parents are reluctant to permit them to play vigorously, for fear of an injury they cannot afford.^{3,4}

Public insurance programs have built-in challenges to stability, namely their requirement for periodic renewal. Children in Medi-Cal and Healthy Families are required to show that they continue to meet the income, residence and other requirements every 12 months and sometimes more frequently.

Under current California regulations, once enrolled, health insurance coverage continues for 12 months, regardless of changes in income or other eligibility requirements.⁵ The 12-month continuous eligibility requirement has been in place since 2001, with California being one of the first states to institute this reform.⁶ However, in the face of budget shortfalls, the Governor has proposed to have Medi-Cal children renew coverage every three months

(Quarterly Status Report), rather than the current once-a-year. This change could dramatically affect stability, causing eligible children to lose coverage. This report examines current enrollment patterns – gaps and stability – for Medi-Cal and Healthy Families overall and goes into detail for some of the sub-programs within each. Information in this report will shed light on what we might expect from requirements to shorten renewal periods for California’s children.

Section 1: Medi-Cal and Healthy Families – an Overview

In California, Medi-Cal is the Medicaid program for the lowest income and highest need children, generally those in families earning less than 100% of the federal poverty level (FPL). Healthy Families is the name in California for the State Children’s Health Insurance Program (SCHIP). Healthy Families covers children up to 250% FPL. Although there is some overlap in the poverty level of beneficiaries in the programs, and there is shared application and administration, Medi-Cal and Healthy Families are separate programs aimed at different income levels, and thus, at different children. Children with Medi-Cal insurance may be in families receiving other public assistance, such as cash assistance and food stamps. Healthy Families, on the other hand, reaches children of the “working poor,” who are not likely to be in families receiving public assistance. Overall, by August 2006, Medi-Cal reached about 3.1 million children,⁷ while Healthy Families reached about 750,000.⁸

Medi-Cal is not just one program, but rather an amalgam of many different subcategories, each representing an eligibility grouping with requirements that make children in that group eligible. Fitting children in the proper eligibility subcategory is complex and depends on age, family income, disabilities, demonstrated need and other factors. (Table 1 in Appendix A shows the major eligibility subcategories, and a prior report described these in more detail.⁹)

Healthy Families does not have the multiplicity

of eligibility categories that Medi-Cal does, but does cover a range of family incomes, from roughly 100% FPL to 250% FPL. There is cost sharing for these higher-income families in the form of monthly premiums, which are charged on a sliding scale based on family income, and range from \$4 to \$45. Thus, Healthy Families also covers a range of incomes and needs, although without the many eligibility categories.

Section 2: Retention in Medi-Cal and Healthy Families

This section compares retention and retention patterns in Medi-Cal and Healthy Families overall, and for subcategories of children in both programs. The analyses in this section follow a cohort of children from the time they first enroll and for 21 subsequent months. Details of the methods are in Appendix B.

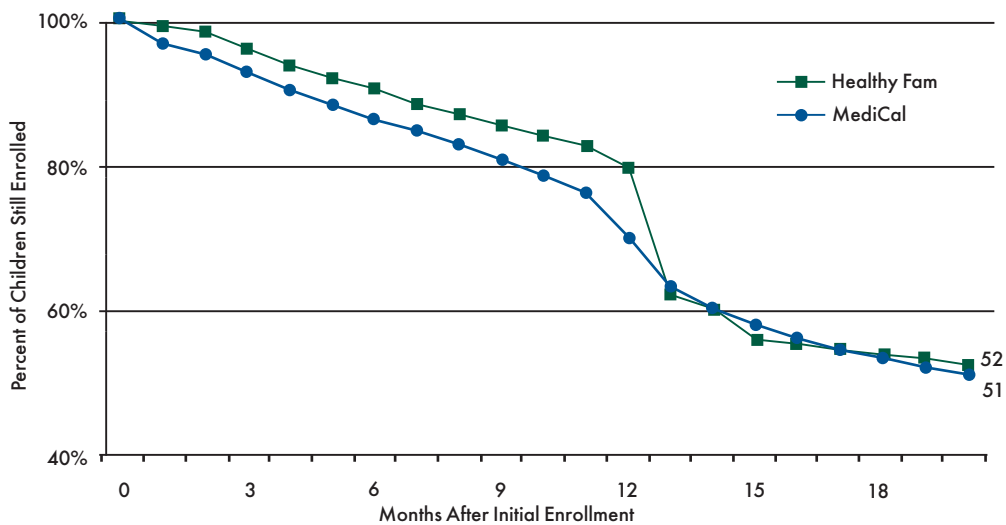
Retention is poor in both Medi-Cal and Healthy Families

Overall, retention is poor in both Medi-Cal and Healthy Families. After the first renewal period – at the 13-month point – the same proportion of children, roughly 62%, remain continuously enrolled in Medi-Cal and Healthy Families and by 21 months only approximately 50% remained (Figure 1).

Despite the common end-point, there is an important difference in the enrollment patterns in Medi-Cal and Healthy Families. Healthy Families children show a sharp drop-off in enrollment at the 12-month renewal period, whereas for Medi-Cal children, the drop-off is more gradual and takes place fairly evenly over all months. Still, despite different patterns, by the end of 21 months retention is similar in both programs, with only half of the children originally enrolled still continuously enrolled in the respective programs.

The sharp decline for Healthy Families at the 12-month mark is clearly a function of the renewal process. The reasons for the more gradual decline for Medi-Cal bear upon the Governor’s proposal for quarterly status reporting and are explored in greater detail in the next section.

FIGURE 1: HEALTHY FAMILIES CHILDREN SHOW A SHARP DROP-OFF AFTER 12 MONTHS, BUT RETENTION IS POOR IN BOTH PROGRAMS



In Medi-Cal, children in SSI and CalWORKs have greatest stability

As indicated in Section 1, Medi-Cal is not just one program, but many sub-programs. Some of the children in Medi-Cal are also in families receiving other social services, such as cash assistance and food stamps. This additional connection to the social services may be the reason for the patterns in Medi-Cal enrollment we saw. Children in Healthy Families, on the other hand, are in families with incomes above the eligibility threshold for these other social services, and their only public assistance may be Healthy Families. Still, Healthy Families covers a range of incomes; needs and retention may not be the same for various income groupings. The next sections look at the differences in enrollment continuity for children in various sub-programs.

We use four of the eligibility categories from Medi-Cal – SSI, CalWORKs, 1931(B), and the “percent programs” – to illustrate the difference in enrollment patterns. We describe the eligibility requirements for each below:

- **SSI** (Supplemental Security Income) is a cash payment for elderly, blind, disabled. Those who receive SSI checks automatically receive Medi-Cal. Approximately 3% of Medi-Cal children were in SSI.⁹

- **CalWORKs** is a welfare program that provides cash assistance to needy families in California; it is California’s implementation of the national TANF program. Families eligible for CalWORKs are automatically eligible for full-scope Medi-Cal without having to apply separately for it. This category accounts for the second largest share of children, after 1931(B), with 29% of Medi-Cal children.

- **Section 1931(B) Program** is for families who are poor enough to qualify for cash assistance, either under the current Cal WORKs (TANF) program or the former AFDC (Aid for Dependent Children) program, but have not chosen to enroll (usually because the eligibility period for cash assistance is limited by the federal welfare reform provisions to 5 years). Because these families are poor, many of them qualify for food stamps and sometimes public coverage for the parents. The category accounts for the largest share of children in the Medi-Cal program – 45%.

- **Percent Programs for Children (133% and 100% of the Federal Poverty Level).**

Children enrolled in these programs are at the highest income levels permissible under Medi-Cal and are likely to have one or more parent working. The “percent programs” specify increasing generous income eligibility thresholds for increasingly younger children. Because children in these eligibility categories are not below the poverty line, they may not be receiving public benefits other than Medi-Cal. We have removed the infants in the 200% program because they automatically age out when they turn one. The 100 and 133 percentage programs together account for 6% of children in Medi-Cal.

Figure 2 looks more closely at enrollment stability for children in four of the sub-programs in Medi-Cal. Stability is greatest for children in the SSI program. At the end of 21 months, 82% of SSI children were still enrolled. It makes sense for this program to be the most stable for several reasons. Children qualify based on disability, which is not expected to change over time. In addition, SSI recipients receive cash supplements - a powerful incentive to renew on time.

Enrollment patterns in the other three programs are identical up to the 12-month renewal point, with approximately 82% of all children retained until that point. The patterns after the 12-month renewal point are dramatically different for the three programs. Children in Medi-Cal by virtue of their being in families eligible for CalWORKs show a gradual decline in enrollment, with 61% still enrolled at 21 months after the time they enrolled. Loss of Medi-Cal coverage for these children would also indicate that they had lost cash assistance, and because families need that money for food, rent and other necessities, they are likely to renew on time for CalWORKs. Furthermore, families are required to renew eligibility for CalWORKs quarterly, which currently is much more frequently than for Medi-Cal. Families may renew Medi-Cal coverage for their children at the same time as they renew coverage in CalWORKs. Because both the frequency of renewal and

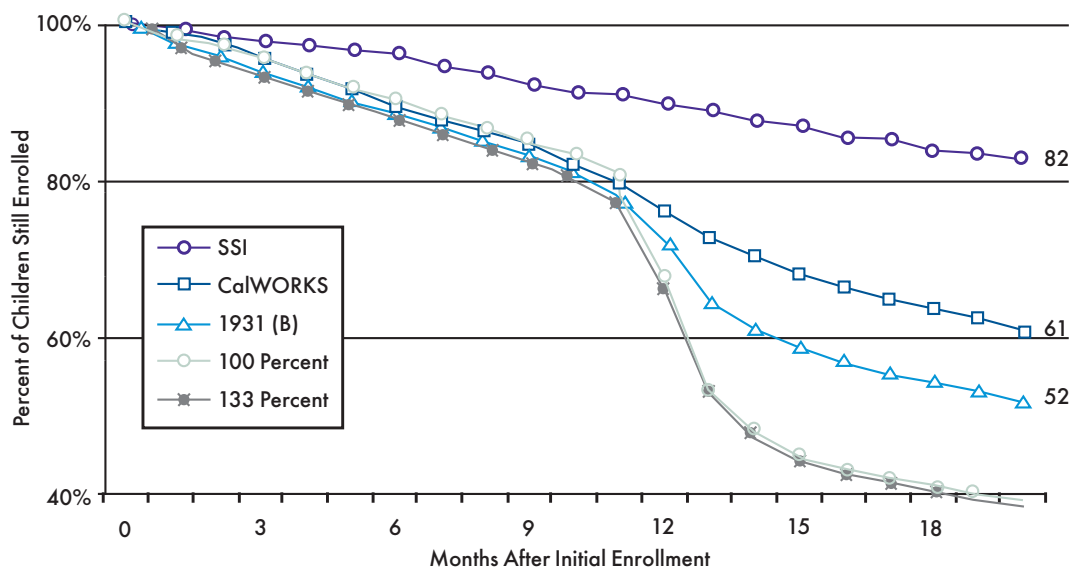
the requirements for family enrollment in CalWORKs are far more stringent than for children’s enrollment in Medi-Cal, children in families bringing in documentation for CalWORKs eligibility would clearly be eligible for Medi-Cal.

Children in the Section 1931(B) program have the next greatest stability after the 12-month renewal point. Families in this eligibility category are poor enough to have food stamps and possibly to qualify for coverage for parents. Thus, loss of coverage for these children would indicate that the family had lost these other supports. As with CalWORKs, family eligibility for food stamps needs to be renewed more frequently than eligibility for Medi-Cal. And, as in the case for CalWORKs, children may renew Medi-Cal coverage at these more frequent intervals when the family renews for food stamps. Not all children in 1931(B) are in families with these other supports, and these children would need to renew at 12 months, but the families may not need to come in more frequently for other renewals. This may account for the sharper drop at 12 months for children in the 1931(B) program, compared with CalWORKs children.

Children in the 100% and 133% children’s programs – that is those whose eligibility is determined by income and the relatively higher incomes (within a Medi-Cal population) have enrollment patterns more like Healthy Families children, with a steep drop-off in enrollment at the 12-month renewal time. (Infants in the 200% program were removed from this analysis, since they would age out during 21 months). About half the children in these programs fall off the rolls at the 12-month renewal (80% enrolled going into the 12-month renewal point; 40% remain afterwards).

Family incomes for these children are too high to qualify for cash assistance, food stamps or parental coverage, and thus, renewal affects the children’s coverage only and not a variety of social support programs for the family. The incomes for these families are consistent with parents having a job, albeit a low-wage job. These families are teetering on the brink of

FIGURE 2: IN MEDI-CAL, PROGRAMS RELATED TO CASH ASSISTANCE OR FOOD STAMPS HAVE GREATEST STABILITY



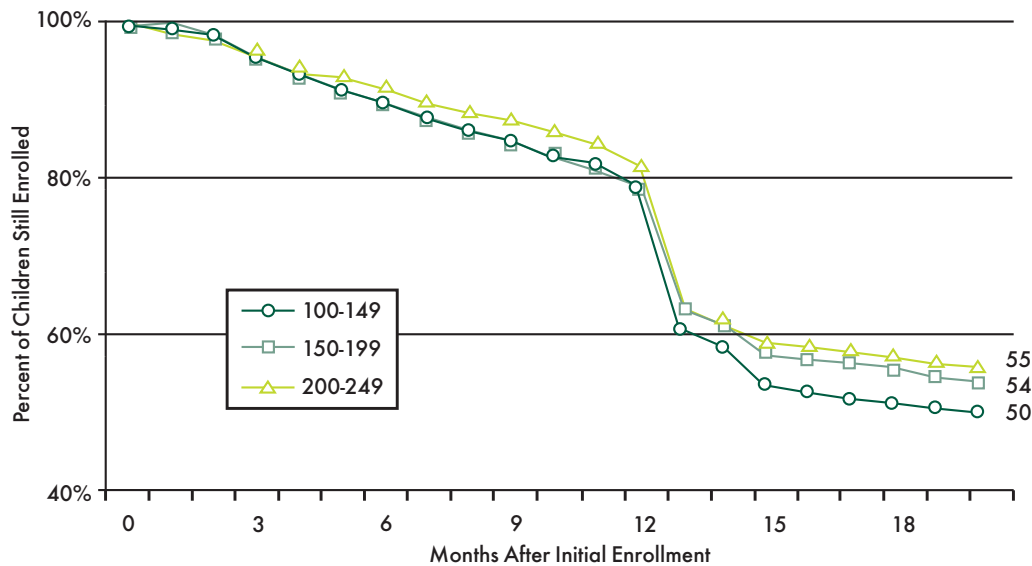
poverty, are generally struggling to maintain a job and take care of children and generally have stressful lives.¹⁰ The economic downturn that is affecting the state budget is also likely affecting these families. Making it more difficult for these families to maintain coverage for their children may be adding another burden to these “on the brink” families. Indeed, research shows that 88% of uninsured children have at least one working parent.¹¹

In Healthy Families, all groups show a drop at 12 months

Patterns of enrollment for Healthy Family children are similar for all income categories. All show a dramatic drop in enrollment at the 12-month renewal point. Enrollment stabilizes after the drop at the 12-month renewal period, and by 21 months only 50% to 55% of children remain continuously enrolled in the programs. This figure is consistent with the drop described in the previous section for children in the Medi-Cal percentage programs and is consistent with other research showing a 50% drop at every renewal period for SCHIP children.¹² Like children in the percentage programs, these are children of the “working poor,” who are struggling to stay out of poverty and almost certainly not able to afford private coverage.

This figure shows dramatically that children in Healthy Families are having difficulty at the point of renewal. A major question is whether the drop-off is due to trouble navigating the renewal process, or due to children becoming ineligible either through families earning more or less the prior year. This issue is explored more in the next section, but the enrollment pattern of the middle group sheds light on this issue as well. The fact that children in the middle-income group (150% - 200% FPL) have the same pattern as those in the lower and higher group argues for problems navigating the renewal process as the main culprit. If families in the upper grouping earn more or families in the lower grouping earn less, the children may not be eligible for Healthy Families. On the other hand, families in the middle grouping could remain eligible for Healthy Families with income loss or gain (depending on the amount). The fact that their enrollment patterns are the same as those of children in the upper and lower groupings adds weight to the argument that the drop-off has to do with problems with the retention process rather than eligibility.

FIGURE 3: CONTINUOUS ENROLLMENT IN HEALTHY FAMILIES



Section 3: Churning in Medi-Cal and Healthy Families

Data in the preceding section make clear that there is a steady drop in continuous enrollment over time, and while the drop may be steeper for some subcategories within Medi-Cal and Healthy Families, it occurs in all of them. There are many legitimate reasons for children dropping off the program rolls, including moves to another state or family income changes so that the child no longer meets income eligibility thresholds. However, another important reason is that the family does not traverse the administrative process for renewal quickly enough and the child is dropped – involuntarily – from the program. These children are still eligible, and as studies in California and elsewhere have shown, most return to the program after only a few months.^{13, 14} This moving on and off the insurance programs is called “churning”.

A major question is whether the children who are dropped at the 12-month renewal period are still eligible when dropped from the program. A second question is how many return to the program and how soon. This section examines these questions, with an emphasis on Medi-Cal children, because these are the children targeted by the proposed Quarterly Status Report.

Approximately one Medi-Cal child in three is back on the program within one year

For this analysis, we followed Medi-Cal children who were dropped from the program at the 12-month renewal point (dropped at 12 to 14 months) and followed them for one year after the point of being dropped. (Our dataset does not permit this analysis for Healthy Families). As shown in Table 1, one child in three (35%) in these four programs is back on the program within a year after being dropped. As might be expected, higher proportions of children return to CalWORKs and 1931(B) – up to 40% within the year – because of the additional benefits, whereas fewer children are back on the percentage programs. Children who are back on the program within a year of being dropped are likely to have been eligible when they were dropped. Furthermore, gaps in enrollment are associated with changes in eligibility codes and county, indicating that children who fall off the rolls may be experiencing life changes at the time of renewal, possibly making renewal more challenging.

Other studies have underscored the fact that sizeable portions of the children or families dropped from the rolls at renewal come back on soon thereafter. One Medi-Cal study found that two-thirds of beneficiaries who were

TABLE 1: OVER ONE-THIRD OF CHILDREN DROPPED AT ANNUAL ELIGIBILITY RENEWAL RETURN WITHIN A YEAR

	Back on the program within 6 months after being dropped	Back on the program within 12 months after being dropped
100 Percent	20	28
133 Percent	20	30
1931 (B)	26	37
CalWORKs	29	40
Total	25	35

dropped for reasons related to mid-year reports being missing or incomplete were back on the program within eight months.¹⁵ Because eligibility for adults is less generous than for children, it is likely that these adults are more impoverished than the population of children in the present study and more in need of the supports.

Our study showed that children continued to come back on the program after two and three years. By three-years after being dropped, half to two-thirds of the children are back in Medi-Cal. It is not clear why the children waited so long or what their coverage status was during the time off Medi-Cal.

It is not possible to discern from enrollment data alone what happened to children who were dropped from the program and did not come back. They may be uninsured, may have private coverage or may have moved between Medi-Cal and Healthy Families. National data show, however, that many children dropped from public programs become uninsured.^{16, 17}

Section 4: Why do Healthy Families Children Drop Off the Rolls?

In Healthy Families, the program for which we have information about reasons for dropping from the program, the loss of coverage may be avoidable for a large proportion of children, up to 74%, as shown in Table 2. It is not possible to know for certain which of the reasons are avoidable. For example, the largest reason for non-renewal (for 34% of children) was that information was not received (or not

received on time) by the county assistance workers. This could be because families were not able to assemble the documents on time, which would lead to a potentially avoidable dropping from the rolls. However, it could also be because some of these families believed that they were not eligible and for that reason did not turn in the renewal information. Likewise, families may not have paid the premium because they had other alternatives for coverage or because they could not afford them. Still, even if a portion of the children in these ambiguous categories were dropped for potentially avoidable reasons, this suggests an important avenue for retention efforts and a mechanism to reduce the number of eligible, uninsured children.

The smaller proportion of children (27%) were dropped for clearly unavoidable reasons, such as family income decreasing (and was eligible for Medi-Cal) (8%) or increasing (4%) out of the Healthy Families range, or the child aged out of the program (7%).

Section 5: Cost after a Gap

We compared Medi-Cal costs during the six months before and six months after a gap, using Medi-Cal claims (medical claims, institutional claims, and pharmacy claims) for children. We compared costs in the six months before and after the gap for children with gaps of three or more months, six or more months, and 12 or more months (see the Methodology Notes).

For each of these three analyses, we then summed the cost for hospitalizations, health care providers, prescriptions, laboratory tests,

TABLE 2: MOST CHILDREN WERE DROPPED FROM HEALTHY FAMILIES FOR POTENTIALLY AVOIDABLE REASONS

	#	%
Possibly avoidable		
Renewal information not received	177,119	34
Non-Payment of Premium	126,586	24
Renewal Info Incomplete. Req info not rcvd.	75,341	14
Citizenship/Immigration Doc. not provided in 2 months	8,747	2
Other	1,309	0
Subtotal	389,102	74
Unavoidable		
Income qualifies for No-Cost Medi-Cal / Income too low	39,845	8
Subscriber reached 19 years of age	34,130	7
Applicant requested termination	28,220	5
Income too high	19,232	4
Currently in No-Cost Medi-Cal	13,533	3
Subtotal	134,960	27
Total	524,062	100

medical equipment, psychiatric services and other costs for each of the six months prior to the gap and each of the six months following the gap. In all cases, we followed the same children before and after the gap, and reported on the costs for the entire population of children.

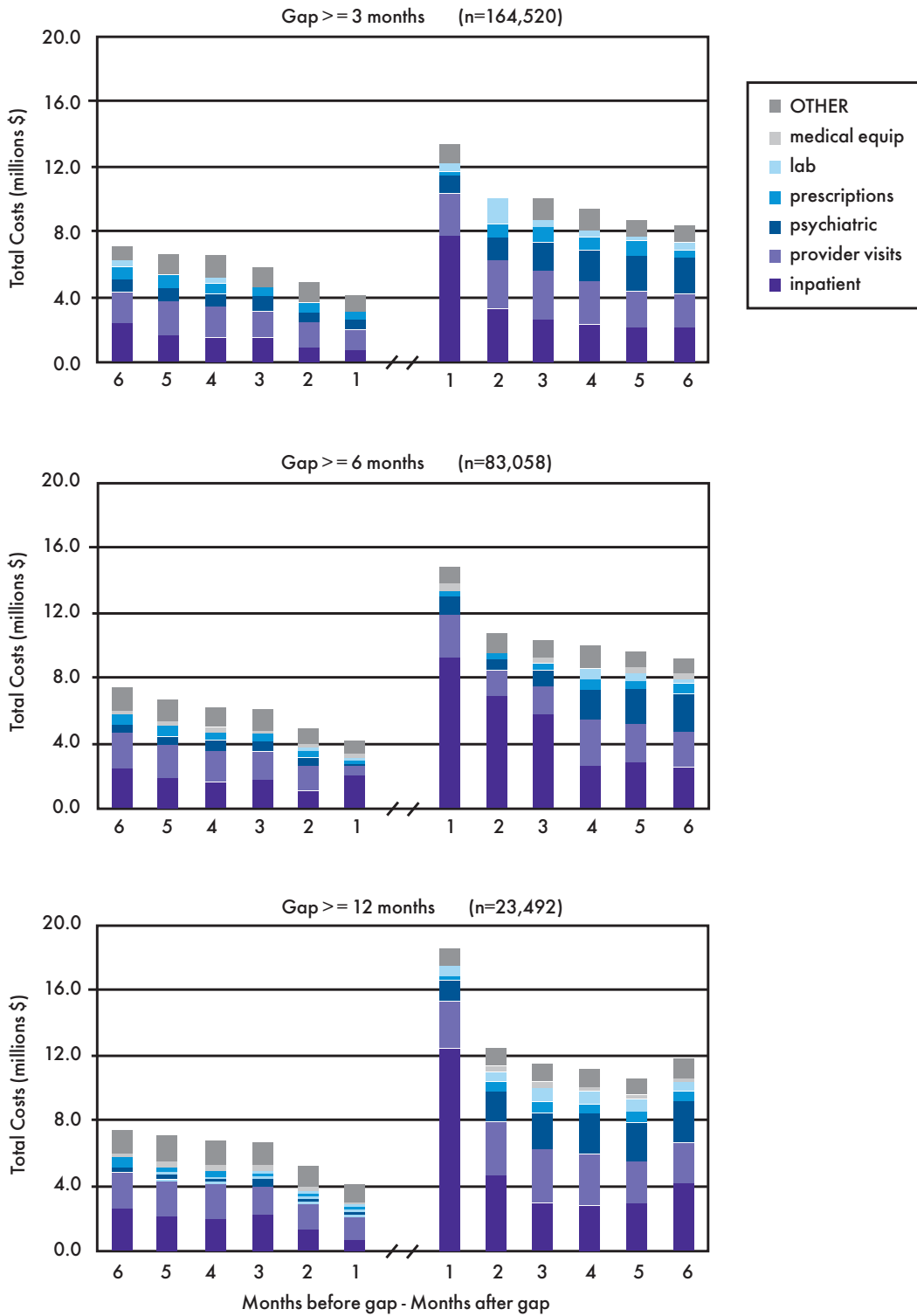
As shown in Figure 4, the costs in the six months prior to a gap are relatively low and actually decline before the gap. However, costs are dramatically higher in the first months after the gap, especially for hospitalizations. In the first graphic, showing costs for children with at least a three-month gap, total costs averaged \$5.9 million in the six months before the gap, but rose to approximately \$13.5 million in the first month after the gap and averaged \$10.1 million for the whole six months after. Costs for in-patient hospitalizations were responsible for much of the increase, however, costs for health care provider also rose.

The second and third graphics in Figure 4 show that the longer the gaps the higher the cost following the gap. Costs before the gap look similar in all three graphics, but the longer the gap the higher the cost. After gaps of three, six and 12 months, we see total cost increases of 1.7, 1.9 and 2.1 times amounts prior to the gap. In addition to these direct medical costs, there are administrative costs of additional processing, which have been estimated to cost \$140 - \$160 per person on average.¹⁵

A close examination of the hospital diagnoses after the gap for children whose first service was a hospitalization show a mixture of acute and chronic conditions. Several of the common acute conditions – such as appendicitis, bone fracture, or pneumonia – may have occurred even if the child had not had the gap. However, asthma, depression/bipolar disorder and diabetes were in the top 20 most frequent reasons for hospitalizations. These conditions are treatable and represent potentially avoidable hospitalizations. Thus, the conditions represent a mixture of both the reason for return to Medicaid and indication of suboptimal care and pent-up demand during the gap.

It is important to note that today, as a result of litigation (*Conlan v Bonta*), costs after a gap may include the full market rate for services paid out-of-pocket during the 3-month retroactive eligibility period. Payments for this retroactive period are expected to be substantially higher than the Medicaid rate, generally double this amount.¹⁸

FIGURE 4: COSTS ARE HIGHER AFTER A GAP. THE LONGER THE GAP, THE HIGHER THE COSTS



Section 6: What do these findings say about probable effects of the Quarterly Status Report?

Our data suggest that children in the CalWORKs and SSI programs drop off gradually throughout the year and show a less dramatic drop-off at the 12-month renewal point. Families in these programs are the most impoverished or have the most disabled children. They are also receiving cash assistance and/or food stamps, and in some case parents may also have public insurance coverage. Eligibility requirements for cash assistance and food stamp participation are much more stringent than for children's coverage, and renewal periods are more frequent (quarterly).

The effects of the proposed quarterly reporting for Medi-Cal may be more detrimental to other children not already in regular contact with the social services system. Specifically, children in the percentage programs, who interact with the social services system once every 12 months, are likely to be affected. Families of these children earn too much to qualify for cash assistance or food stamps and thus, their primary contact with the county assistance office is for health insurance for their children. As our data (and that of others) shows, children in these programs show a sharp drop-off at renewal.

The more frequent the renewal period, the more frequent the drop off is likely to be. A much earlier study of SCHIP compared retention for children in states with 12-month and 6-month renewal, and found roughly twice the drop-off for children in the state with a 6-month renewal requirement.¹² Our study showed about half of the children in the percentage programs were dropped at the 12-month renewal point (drop from 80% to 40%). It is likely that half of the children in these programs would be dropped at each renewal or quarterly status reporting point. Our data also show that of those Medi-Cal children dropped from the program at the annual renewal, one in three returns within the year, indicating that these children remain eligible.

Reinstating Quarterly Status Reports is counter to reform efforts for simplification. This additional requirement is likely to have a negative impact on children's enrollment. In Florida, after certification requirements were added with the implementation of active renewal, the probability of being dropped at renewal was approximately 10 times the probability than during passive renewal.¹⁹ Similar differences in retention at renewal points have been seen in comparisons of passive and active renewal in other states.¹²

Furthermore, the temporary, short-term reduction in the Medi-Cal budget realized by dropping children may be off-set by medical costs for these children when they return with pent-up needs. Our data show substantial increases in cost of medical care after the gap. Finally, savings to Medi-Cal may be further offset by use of care in community health centers, emergency rooms and other safety-net facilities.

References

1. Olson LM, Tang SF, Newacheck PW. Children in the United States with discontinuous health insurance coverage. *N Engl J Med*. Jul 28 2005;353(4):382-391.
2. Federico SG, Steiner JF, Beaty B, Crane L, Kempe A. Disruptions in insurance coverage: patterns and relationship to health care access, unmet need, and utilization before enrollment in the State Children's Health Insurance Program. *Pediatrics*. Oct 2007;120(4):e1009-1016.
3. Lave JR, Keane CR, Lin CJ, Ricci EM, Amersbach G, LaVallee CP. Impact of a children's health insurance program on newly enrolled children. *Jama*. Jun 10 1998;279(22):1820-1825.
4. Kenney G. The impacts of the State Children's Health Insurance Program on children who enroll: findings from ten states. *Health Serv Res*. Aug 2007;42(4):1520-1543.
5. Cohen Ross D, Marks C. *Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006*. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured; 2007.
6. Quacinella L. 2001 Policy Changes: Medi-Cal and Healthy Families Coverage for Low-Income Children, Youth and Parents and "Medically Indigent Adults": UCLA Center for Healthy Policy Research; 2001.
7. California DHS Medical Care Statistics Section. Medi-Cal Beneficiary Counts. http://www.dhs.ca.gov/ffdbm/mcss/RequestedData/Special_Family/spec_fam.htm.
8. California Managed Risk Medical Insurance Board. Healthy Families Program August 2006 Summary. <http://www.mrmib.ca.gov/MRMIB/HFP/HFPRptSum.pdf>.
9. Fairbrother G, Cassidy A. *Churning and Racial Disparities in Medi-Cal: Effect of Churning on Eligible Uninsured*. Los Angeles, CA: The California Endowment; October 2006.
10. Fairbrother G, Kenney G, Hanson K, Dubay L. How do stressful family environments relate to reported access and use of health care by low-income children? *Med Care Res Rev*. Apr 2005;62(2):205-230.
11. Families USA for the Campaign for Children's Health Care. *No Shelter From the Storm: America's Uninsured Children* Sept. 28, 2006.
12. Dick AW, Allison RA, Haber SG, Brach C, Shenkman E. Consequences of states' policies for SCHIP disenrollment. *Health Care Financ Rev*. Spring 2002;23(3):65-88.
13. Sommers BD. Why millions of children eligible for Medicaid and SCHIP are uninsured: poor retention versus poor take-up. *Health Aff (Millwood)*. Sep-Oct 2007;26(5):w560-567.
14. Fairbrother GL, Emerson HP, Partridge L. How stable is Medicaid coverage for children? *Health Aff (Millwood)*. Mar-Apr 2007;26(2):520-528.
15. Personal communication. Cathy Senderling, County Welfare Directors Association. March 13, 2008.
16. Mitchell JB, Haber SG, Hoover S. What happens to children who lose public health insurance coverage? *Med Care Res Rev*. Oct 2006;63(5):623-635.
17. Sommers BD. From Medicaid to uninsured: drop-out among children in public insurance programs. *Health Serv Res*. Feb 2005;40(1):59-78.
18. California Department of Health Care Services. May 2007 Medi-Cal Local Assistance Estimate for Fiscal Years 2006-07 and 2007-08. <http://www.dhs.ca.gov/ffdbm/estimates/2007may/default.htm#FFS>.
19. Herndon J, Shenkman E, Vogel B. *The Impact of Renewal Policy Changes in the Florida Healthy Kids Program*: Institute for Child Health Policy; January 2007.

Appendix A. Descriptions of Medi-Cal Programs

Medi-Cal Program	Program Description
Cash-Related Programs	
CalWORKs	California Work Opportunity and Responsibility to Kids is California's cash aid, welfare-to-work program for families. California established CalWORKs to conform to the federal requirements that eliminated Aide to Families with Dependent Children (AFDC) and established Temporary Assistance to Needy Families (TANF). Families receiving CalWORKs checks are automatically eligible for Medi-Cal.
Supplemental Security Income (SSI)	SSI is a cash payment program for elderly, blind and disabled. Those who receive SSI checks automatically receive Medi-Cal.
Foster Care and Adoption Assistance	Children who receive foster care checks are also eligible to receive Medi-Cal.
Refugee Medical Assistance (RMA)/ Refugee Cash Assistance	Some immigrants fleeing persecution from their homelands are classified by the U.S. Citizenship and Immigration Service as refugees. Needy refugees who meet the eligibility requirements for CalWORKs, or who meet the income and resource eligibility standards may receive special Refugee Cash Assistance and Refugee Medical Assistance during their eight months in the U.S. These individuals are automatically eligible for Medi-Cal.
Section 1931(B) for Families	
Section 1931(B)	This program provides coverage for families who do not receive cash assistance, but would have been eligible for the former AFDC program. This program covers families who decide not to enroll in CalWORKs (i.e., not to receive cash assistance), even though they may be eligible.
Children's Programs	
133% Program	This program provides Medi-Cal coverage for all children from age 1 up to age 6 whose family income is at or below 133% of the Federal Poverty Level.
100% Program	This program provides Medi-Cal coverage for all children age 6 to 19 whose family income is at or below 100% of the Federal Poverty Level.
Medically Needy	
	Medically needy individuals are those who meet the SSI requirements for aged, blind or disabled (aged would not apply for children) or the former AFDC requirements of deprivation, but do not receive cash assistance, usually because their incomes are too high. Over 10% of adults are Medically Needy, but only few children (approximately 2%).
Other Programs (excluded from this study)	
	Other programs include pregnancy-related programs, programs for Medically Indigent and transitional/continuing coverage for people who have lost cash assistance.
Other Children's Programs	There are several programs offering limited services to children, such as Minor Consent Services, Accelerated Enrollment, and National School Lunch Express Enrollment.
200% Program	This program provides Medi-Cal coverage for infants up to age 1 whose family income is at or below 200% of the Federal Poverty Level. Infants born to a mother on Medi-Cal are automatically eligible for Medi-Cal for their first year.

Appendix B. Methodological Notes

Enrollment/Eligibility Analyses

Our analytic dataset consists of 24 months of enrollment eligibility data from both Medi-Cal (the Medicaid Eligibility Dataset – MEDS) and Healthy Families (the Managed Risk Medical Insurance Board –MRMIB dataset). Medi-Cal data is from July 2003 to June 2005; Healthy Families data is from January 2004 through December 2005.

We began by constructing a cohort of new enrollees. Those who were enrolled in the first month of the dataset may have already been enrolled. Therefore, we selected only those who were not enrolled in the first month, but were enrolled in the second, third and fourth months in each dataset. We then followed these children for 21 months (For example, a child in Medi-Cal enrolled in July 2003, was removed from the analysis, because they were probably already enrolled. Children who were not enrolled in July, but were enrolled in August, September or October were included in the cohort and were considered new enrollees. This cohort was then followed, for 21 months (children newly enrolled in August 2003 followed until April 2005; children newly enrolled in September 2003 followed until May 2005 and children enrolled in October 2003 followed until June 2005.) These cohorts were checked for seasonal variation.

Children in the dataset are those in the specific aid categories listed in Appendix A. We removed several categories, which offered only limited or temporary services. These include the pregnancy-related and transitional programs, as well as “limited aid” categories for beneficiaries with inadequate documentation. All tables and figures in this report reflect this dataset described here. We also removed the infants in the 200% program because they “age out” after 12 months.

Cost Analyses

The cost analysis used Medi-Cal claims covering the period January 1, 1999 through December 31, 2001. We used reimbursement of Medi-Cal claims as the measure of cost. We use the term “cost” rather than “reimbursement” in the text for simplicity. Because we wanted to follow cost trends six months before and after a gap, we restricted the analysis to children who had been enrolled that length of time or longer on both sides of the gap. We also restricted the analysis to children with gaps of at least three months to allow the effect of a gap to manifest.

Approximately 4.4 million children 0-18 years had been enrolled in Medi-Cal at any point in the three-year period. Of those, 164,520 met the criteria for inclusion in this dataset—enrolled for six months or more before the gap, had a gap of three months or more, and enrolled for six months or more after the gap.

The California Endowment

1000 North Alameda
Los Angeles, CA 90012
800.449.4149
213.928.8801 (fax)
www.calendow.org

For more information about Cover California's Kids, please visit www.covercaliforniakids.org