The Problem

The recent implementation of the Healthy Families Program for low-income children in California has made even more visible those features of the Medi-Cal program that continue to create barriers to enrollment, continuity of care, access to needed care, and provision of high-quality medical care.

♦ Nearly 30% of the children in the state who are eligible for Medi-Cal are not enrolled in the program and remain uninsured.

♦ 21% of Medi-Cal recipients experienced a period without health insurance coverage in the last 12 months, compared to only 9% of Californians insured through other sources.

♦ 61% of Medi-Cal recipients who experienced such a gap in their coverage also reported that they had not sought needed medical care in the last year because of cost.

♦ Only 31% of Medi-Cal managed care plans were able to report if their members received a health assessment within their first 120 days of enrollment during 1997.

Policy Options

❖ Improve the outreach and application process for uninsured children to increase enrollment of all eligible children in either Medi-Cal or the Healthy Families Program.

❖ Adopt presumptive eligibility for children applying for Medi-Cal, as the state has done for pregnant women.

❖ Provide continuous eligibility for all Medi-Cal recipients for 12 months, eliminating requirements for recertification every three months.

❖ Change the enrollment procedures in Medi-Cal managed care plans so that recipients are locked in to one health plan for one full year from their date of enrollment.

The Evidence

Children’s Access

One of the major barriers to increasing enrollment of eligible children in the Medi-Cal program is the cumbersome application process. Nearly 30% of all the children in the state who are eligible for Medi-Cal are not enrolled in the program and remain uninsured (Exhibit 1). (No comparable data for adults are available.) Three strategies would help to maximize coverage of Californians eligible for Medi-Cal:

1) Adopt policies of presumptive eligibility;

2) Streamline the application so that all individuals who apply are automatically considered for any program for which they are eligible; and

3) Increase outreach activities.

Gaps in Continuity

During 1998, more than one in five Medi-Cal recipients experienced a period without health insurance coverage (Exhibit 2). The Medi-Cal program presently requires all recipients to re-certify their eligibility every three months (90 days). As a result, many Californians cycle on and off Medi-Cal coverage, which has serious implications for the ability of health care providers to deliver continuous care. Such frequent recertification leaves Medi-Cal recipients periodically without coverage or financial access to needed care. Approximately 22% of Medi-Cal recipients did not seek medical care when they needed it in the last year.
Financial Barriers to Care

Among adult Medi-Cal recipients who have experienced a gap in their coverage, the problem of securing access to needed care is severe, with more than 60% reporting cost as a barrier to seeking needed care in the last year (Exhibit 3). For Medi-Cal recipients who had continuous coverage over the last year, only 12% reported financial access barriers to receiving needed care.

Health Insurance Policy Program (HIPP)

Addressing these barriers to access and continuous enrollment in the Medi-Cal program would greatly contribute to the evolution of the program to provide continuity of care and access to comprehensive coverage and high-quality care for California’s most vulnerable populations.

Healthy Assessments

Medi-Cal managed care plans in two-plan counties are required to provide each enrollee with a comprehensive health assessment within 120 days of enrollment. However, under current recertification and enrollment requirements, enrollees can lose their eligibility for coverage or switch plans before 120 days have passed.

A survey of Medi-Cal managed care plans found that in 1997 less than one-third were able to track and report if their members had received their required 120-day health assessment (Exhibit 4). Many plans pointed to the lack of continuous eligibility and lack of plan lock-in requirements as major barriers for ensuring the proper provision of care. Medi-Cal managed care recipients in two-plan counties can switch plans every 30 days.