Children's Advocacy Institute

CHILDREN'S HEALTHCARE PROPOSAL:
TRUE PRESUMPTIVE ELIGIBILITY

SUMMARY

- **Two-thirds of uninsured children are currently eligible for public coverage. The implications of that void are momentous for them and their families. Ironically, in denying them coverage the state also inflicts upon itself gratuitous and substantial harm.**

- **To prevent about 6,600 ineligible children per year from receiving public payment for medical treatment, California will:**

    - **Block access to needed and cost-effective care for 500,000 children**

    - **Leave on the table about $500 million dollars of federal money.**

    - **Incur ongoing annual administrative expenses of about $450 million.**

- **Each of these costs is avoidable by shifting from the current mindset of exclusion for children who are not individually enrolled to "true presumptive eligibility," where children are covered as a matter of state policy. Under such a system, federal funds are received based on statistical evidence of qualified spending, and the families of the now miniscule percentage of families whose children are not qualified for public coverage are billed post-treatment on a sliding scale.**

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Questions Examined

- **How many children lack medical coverage in California?**
- **How many of these children are eligible for public coverage?**
- **How many are not eligible and hence are properly barred?**
- **How much does it cost to maintain the current system of child-by-child pre-coverage qualification and enrollment to prevent the unqualified from getting enrolled?**
- **What would be the savings if such preliminary filtering were replaced by post-treatment billing (assessment on a sliding scale where the child is not qualified for public coverage)?**
- **Quite apart from the recent research documenting substantial long-term savings from child coverage (through enhanced public health and lower future medical costs), what are the benefits from "true presumptive eligibility" over the current system of exclusion unless specifically enrolled?**

Background Facts and Figures

As of 2005, 763,000 California children were medically uncovered at a given point in time; 1.1 million are uncovered at some point over a given 12-month period. About two-thirds of these children are legally entitled to and eligible for health insurance from the Medi-Cal or Healthy Families programs under existing law.[1] They just aren't enrolled. Not being enrolled means that their parents face a Hobson's choice when deciding whether to take them to the Emergency Room for an illness or injury, for those parents will be billed at four to five times the rate paid by public programs or private insurers. Even a short hospital stay will jeopardize the college fund, pension, or possibly the home of the family. Medical billings are the leading cause of personal bankruptcies in the state.

To complicate matters, some of those children who are insured have been enrolled in a kind of conditional/uncertain coverage over the last three years.[2] That is, some 30 counties are insuring an undetermined number of the otherwise uncovered children (including both those eligible under Medi-Cal or Healthy Families ***and*** others who are not). These counties vary in their coverage; for example, some counties include the undocumented, and some include families up to 300% of the poverty line. This charitable coverage is being accomplished with private foundation, special fund, and county money. The result is an inconsistent, fragmented and ephemeral system — dependent upon uncertain funding — and still not reaching 763,000 children, about 500,000 of whom are eligible for at least one of the two main public programs. The future viability of this patchwork coverage is in doubt given growing pressure on its financial sources.

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[1] UCLA Center for Health Policy Research, *Findings from the 2005 California Health Interview Survey* (Los Angeles, CA: July, 2007) at 62, 65, available at www.healthpolicy.ucla.edu/pubs/files/SHIC_RT_072807.pdf.

[2] In 2003, California began the Child Health and Disability Prevention (CHDP) "gateway" program, also called presumptive eligibility. Under this program, children who see a CHDP provider and appear to meet eligibility requirements are enrolled in Medi-Cal or Healthy Families for two months. Approximately 7.2% of federal State Children's Health Insurance Program (SCHIP) dollars spent in FFY 2007 will support enrollment of these children in Healthy Families. See California Budget Project, *SCHIP Reauthorization: Congress Can Help California Provide Health Coverage to More Children*, Budget Brief (June 2007), available at www.cbp.org/pdfs/2007/0706_bb_SCHIP_update2.pdf. Note that the bridge program is (as of 2007) no longer eligible for federal funding (see http://2007-08.archives.ebudget.ca.gov/pdf/Revised/BudgetSummary/FullBudgetSummary.pdf).

Of the state's 11 million residents ages 0–19, only 2% (219,000) are uninsured *and* ineligible for public coverage (*e.g.*, they are either undocumented or they are uncovered and living in homes over 250% of the poverty line). Of this 2% who are properly filtered out, only a very small percentage will actually incur substantial medical expense in any given year (defined as over $2,000). Assume that 3% of children incur a medical expense of over $2,000 annually. Applied to the unqualified group, our current prior restraint system of enrollment-or-no coverage prevents the undeserved payment of incurred medical costs for 6,600 children a year. The actual number is likely to be lower. These particular expense payments are not likely to lead to manifest abuse — unlike welfare, SSI, or other benefits, the monies here pay the actual billed costs of medical treatment diagnosed as necessary.

In order to avoid this relatively minor expenditure, California seeks to prequalify each child patient prior to public coverage. The Children's Advocacy Institute (CAI) proposes an alternative reverse-English approach that does not require an affirmative opt in. Rather, CAI calls upon the state to enact "true presumptive eligibility," where children not privately covered are deemed to be publicly covered by operation of law, subject to *post hoc* billing of parents where warranted. The current approach saves the treatment cost of under 6,600 ineligible children a year. The proposed approach offers four kinds of advantages:

- Over 500,000 children not covered but eligible would now be covered. Moreover, the 900,000 who are uncovered at some point each year would enjoy continuous and stable coverage.

- The inconsistency, uncertainty, and strained local resources from the county patchwork of varied policies is rationalized with a statewide, consistent floor not dependent on ephemeral funding.

- About $500 million in available (or likely available) federal funding is collected for child health coverage rather than sent back to Washington for possible distribution to other states.

- The state saves hundreds of millions of dollars in reduced administrative costs. Instead of qualification, enrollment, incentive payments to enroll, premium collection and verification of millions of children, we have perhaps higher co-pays and *post hoc* paperwork to accomplish the billing of the 6,600 children who are uninsured, ineligible, and incur a high medical cost in a given year.

California currently foregoes these four categories of advantage and savings for the avowed purpose of keeping an estimated 6,600 children a year from undeserved payment of a substantial medical bill. Such a cumbersome system of pre-qualification may be justified where 50%, or 30%, or perhaps 15% of the state's children might enjoy unwarranted public subsidy otherwise — but as that proportion falls to 10%, then 5%, and now to 2%, such an approach lacks rational support. The cost of *post hoc* verification and billing for the small percentage of this small percentage (3% of 2% of the state's children) needing significant treatment in a given year commends the elimination of the current presumptive bar. At this point, the savings from our current "opt in" system are substantially less than either the administrative cost of the prior restraint system imposed on millions of children as a precondition to public coverage, and are also less than the federal money left on the table because of the inevitable failure of an "affirmatively enrolled only" system to actually cover all who are eligible.

These financial and coverage advantages exclude the more indirect and long-term benefits of child medical coverage increasingly documented. They exclude the economies of scale available with universal coverage for purposes of general public health administration. They also exclude the benefit of certain and predictable coverage that does not depend upon location, or temporary private foundation or county funding. And they do not include a critical factor of human equity: The prevention of high billings from ER treatment translated into family bankruptcy — just to provide needed medical care for a child.

Federal Monies Foregone

California has historically left over $300 million in federal SCHIP (Healthy Families) money on the table at a 2–1 federal match. Over the last four years, the state has been using its allocation of these capped SCHIP funds (which have not increased with population). But the SCHIP program will be reauthorized at a higher level within the next year. Even if its income eligibility is not increased to 300% or 400% of the poverty line as the Democratic version of the bill would provide, either the House or Senate versions for reauthorization will provide federal funding at a 2–1 match for those who are presently eligible.[3] Hence, under the current arrangement and without presumptive eligibility, the state will lose at least $160 million annually in otherwise available SCHIP funding.[4] If the caps are increased to 300% or more of the federal poverty line — as is likely — the amount will exceed $250 million per year. In addition to this sum, the state loses the 1–1 federal match for Medi-Cal for the 247,000 children here uncovered, adding another $250 million in federal funds left on the table,[5] and bringing the likely total to $500 million as a conservative projection.

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[3] California Budget Project, *SCHIP Reauthorization: Congress Can Help California Provide Health Coverage to More Children*, Budget Brief (June 2007), available at www.cbp.org/pdfs/2007/0706_bb_SCHIP_update2.pdf.

[4] The unenrolled Healthy Families child population more recently stands at 228,000. California HealthCare Foundation, *Funding California's SCHIP Coverage: What Will it Cost?* (May 2007) at 10, available at www.chcf.org/documents/policy/FundingCaliforniaSCHIPCoverage.pdf. According to a recent study of enrollment projection, under its current format of signing up children one at a time, the state will reduce the current unenrolled Healthy Families eligible children by 53% over 5 years, or 10% per annum. These figures may be optimistic given the recent record of enrollment — which, as noted above, reflects an affirmative increase over the last several years. The projections of 10% annual diminution may also not fully account for the increased difficulty of enrolling those who have heretofore not been reached or have declined. As the number shrinks, the difficulty of enrolling the remaining pool increases. Most families cannot enroll in Healthy Families without paying premiums required in advance and usually in a setting where their children are not then ill. Some of those in the remaining uncovered pool have declined for economic reasons that may account for their refusal and may make enrollment problematical under the current system. Our estimate of $160 million in foregone revenues assumes that just over 20,000 of the current 228,000 uncovered will be enrolled and produce an uncovered population of just over 200,000 for 2009–10. It also assumes that federal SCHIP legislation will be enacted as is expected. Bills approved by the Congress and vetoed by the President are likely to enjoy re-enactment in early 2009. That legislation would increase payments to accommodate a 50% increase in the numbers now covered. This amount would easily subsume all of the 219,000 currently uncovered and Healthy Families eligible kids. Importantly, monies will be foregone without true presumptive eligibility well beyond this conservative estimate for Healthy Families child coverage. We estimate that such additional foregone revenue will exceed $100 million annually. This additional help would come from (a) the expansion of eligibility to higher income families relieving state and federal funding for the "Healthy Kids" program, and (b) increased compensation per child to correct the currently below-market payments to doctors, hospitals and other providers. This last source of funding is likely to be dramatic in amount. In sum, the current $5 billion per annum, now temporarily expanded to $6.1 billion for 2008, would be increased to above $12 billion per year in the Senate version, and higher in the House proposal for SCHIP. Hence, California's continued reliance on individual enrollment is reasonably projected to leave from $160 million to $260 million "on the table" and unspent in 2009–10 and annually thereafter.

[5] See ER Brown, SA Lavarreda, N Ponce, J Yoon, J Cummings, T Rice, *The State of Health Insurance in California: Findings from the 2005 California Health Interview Survey*, UCLA Center for Health Policy Research (Los Angeles, CA; 2007) Exhibit 43 at 65. The UCLA report identifies 200,000 Healthy Families children eligible for SCHIP monies. The federal contribution is

Administrative Savings

California spends about $732 million on just the Medi-Cal bureaucracy each year[6] (not including Healthy Families). And Healthy Families spends $49.20 per person per year just to maintain enrollment operations for the 750,000 children in the program[7] (amounting to $36.9 million per year). In addition, we have 13 some odd programs that cover groups of children at various younger ages, depending upon varying family incomes and special circumstances. All of these administrative costs would be subject to substantial reduction, allowing these resources to be redirected to back-fill cuts in other areas if such cuts are made.[8]

Assuming conservatively that just one-fourth of the overhead of Medi-Cal is fairly attributable to administering the one-half of its enrollees who are children, administrative savings from enrollment cost elimination would amount to $400 million from that existing source. Total savings are prudently projected at $450 million per year. This total would be offset by the costs of *post hoc* billing for those who incur substantial medical expense in a given year. However, that cost would be imposed only for the small percentage receiving expensive medical treatment, could be streamlined, and would also yield revenue from that assessment possibly offsetting its administrative cost. Because the proposal necessarily foregoes advance premiums imposed upon parents (another source of administrative cost and gratuitous barrier to basic enrollment) some increase in co-pays may be warranted. However, the social cost of a $50 co-pay instead of $10 pales in comparison to the implications of premium charges for working families, which requires parents to pay sums otherwise allocated for rent or food to cover their children who are not ill when payment is due. This current policy helps to stymie the enrollment of hundreds of thousands of children.

The cited administrative savings do not count additional cost savings, including the monies now spent as "incentive payments" to enroll children into Healthy Families (or Medi-Cal). And it does not count the considerable paperwork burden now imposed on the private sector. Hospitals and physicians and clinics are charged with Medi-Cal and Healthy Families paperwork which would be much streamlined where eligibility and enrollment are not at issue except for those incurring substantial expense — and then in a streamlined format. Cost savings in this sector could contribute to the needed diminution of medical inflation rates.

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approximately $800 per child per year. The study found 97,000 unenrolled kids eligible for the varying county programs which often increase eligibility up to 300% of the poverty line. The Medi-Cal contribution from Medicaid would reach 247,000 uncovered children. Although the federal contribution is only 50%, the total expenditure per child is higher and the federal contribution is here about $1,000 per child. Specifically, Medi-Cal costs about $2,100 per child per year, with California paying about $1,050. Federal contribution is approximately $800 for each Healthy Families child (two-thirds /3 of the $1,186 average annual cost per child). See California Healthcare Foundation, *Funding California's SCHIP Coverage: What Will it Cost?* (May 2007) at 8, available at www.chcf.org/documents/policy/FundingCaliforniasSCHIPCoverage.pdf.

[6] This number comes from the LAO analysis of the 2007–08 budget ($763 million in County administration/eligibility 48% of enrollees are children = $366 million x2 (federal match) = $732 million). The LAO Analysis is available at www.lao.ca.gov/analysis_2007/health_ss/healthss_anl07.pdf at C-36.

[7] California Budget Project, *SCHIP Reauthorization: Healthy Families Needs Sufficient Federal Funding*, Budget Brief (December 2006), available at www.cbp.org/pdfs/2006/0612_bb_SCHIP.pdf.

[8] California HealthCare Foundation, *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*, (May 2007), available at www.chcf.org/documents/policy/MediCalFactsAndFigures2007.pdf at 33.

Benefits from Coverage

The same state and local bureaucracy erected to bar the projected 6,600 children from significant medical expense also prevents over 500,000 eligible California children from obtaining health insurance for which they are eligible. And the total is over 750,000 children when adding in those with episodic coverage. This coverage is funded by programs California taxpayers have statutorily committed themselves to, and cause the net loss of the $450 million in available federal contribution annually, as discussed above. These calculations do not include the recent studies finding substantial long term benefits to children and society from stable medical coverage.

Cost – Benefit

Thus, using conservative numbers, the net cost to the State of lost federal revenue of $500 million plus the avoidable bureaucracy costs of Medi-Cal and Healthy Families paperwork qualification of $450 million totals **$950 million**. That amount exceeds the state cost of: (a) insuring Medi-Cal uncovered kids ($250 million), plus (b) the state cost of the 200,000 Healthy Families kids uncovered ($70 million), plus (c) the 100,000 "Healthy Kids" qualified uncovered children likely to be within the new SCHIP federal statute ($35 million), plus (d) the total cost of the 219,000 uncovered and ineligible children at the higher Medi-Cal rate of $2,000 per year per child ($438 million). These costs amount to a **grand total of $800 million** — and effectuate the coverage of all of the 763,000 children not now covered. As indicated above, that amount is $150 million less than the $950 million in gain from the two relatively quantifiable sources of savings and foregone outside revenues.

Assume a budgeted target of $200 million in revenue from the true presumptive eligibility alternative of *post hoc* assessments and from enhanced co-pays.[9] These charges amounts should be keyed to compensating the state for lost premiums no longer charged to enroll, and to finance the *post hoc* billing system for the relatively small percentage of the small proportion of children who require substantial medical treatment and incur concomitant bills. However, note that without any revenue from such billing, the two cited sources of savings provide the state with $150 million in otherwise unobtained net revenue gain for public child-health expenditure — some of which could be dedicated to offset premium monies losses and for the more limited administrative regime of the proposal.

Mechanics

California cannot spend federal money on children who are not eligible for federal programs (without the permission of the federal government). But the proposed "true presumptive eligibility" system is the type of state experiment appropriate for federal section 1115 waiver.[10] It involves substituting

[9] Note that such increased revenue may include some increases in co-pays to compensate for premium losses. In addition, we assess *post hoc* those in wealthier families who are ineligible and whose children incur substantial medical cost in a year. This revenue would substantially exceed the relatively minor paperwork cost applicable to those among the 2% of the state's children who are not qualified, some of whom are ineligible because of citizenship status, and others because of family income.

[10] Section 1115 waivers have been abused historically (see *Beno v. Shalala* 30 F3d 1057 (9th Cir., 1994)). But here is the paradigm application of the concept of state waiver. A state wants to engage in a *bona fide* experiment consistent with federal SCHIP intent to provide efficient and widespread coverage of qualified children. It involves reduction in transaction costs and maximum application of public funds for intended end result use. Given the fact that California and the United States have executive branches controlled by the same party, quick approval of a shift for sake of efficiency

verifiable statistical sampling for allocation of federal funds in lieu of individual paperwork expense. Verification may be as assiduously achieved through sampling of population incomes, and medical billing — without requiring individualized documentation. Federal latitude for allocation of its funding is not uncommon.[11]

The steps to implement the streamlined presumptive eligibility system include the federal waiver noted above, the consolidation of all existing programs into a borderless and inclusive structure, the planned reduction of the "barrier bureaucracy" (probably by attrition of social worker positions over several years), the adjustment of co-pays, the creation of a limited *post hoc* billing system, determination of provider compensation, and monitoring for compliance.

Under the proposed system, if a child shows up at a doctor's office and has no private insurance, her doctor can fill out the Health–E–App on the spot and submit it. We will assume the child is eligible for either Medi-Cal or Healthy Families and the doctor will be paid accordingly. And if the expenditure is substantial, an "under penalty of perjury" statement will be required of parents as to income level for billing on a sliding scale.[12] This after-the-fact approach recognizes that the vast majority of children do not incur any substantial medical service expense in a given year. Paperwork is only triggered for the few who do, and who are facially not within an impoverished or otherwise eligible group for public subsidy.[13]

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from advance screening one by one for federal fund qualification, to one involving legitimate statistical sampling, is rational and within the intended parameters of federal waiver allowance.

[11] For example, Los Angeles has now obtained a substantial waiver in the spending of many millions of federal Social Security Act Title IV-E child welfare funding. Instead of requiring removal of individual children and the allocation of funds to foster care providers child by child, monies may be used up-front to provide services to families pre-removal. The money is not allocated according to the longstanding system of individual child documented care needs by licensed foster care providers, but more amorphously to families to prevent the need to remove children by providing services in-home. The paperwork qualification is simplified, generalized, and radically different. But the purpose of prevention and overall cost savings warranted the state application, and federal approval.

[12] There may be some upper middle class or wealthy parents who lie on the forms noted above. For this reason, it is important to establish a highly visible anti-fraud presence, including, perhaps, higher civil and criminal penalties.

[13] Some will argue that the removal of barriers may provide an inducement for foreign nationals who are not living and working within the United States to cross the border specifically for the treatment of their children. Where such visits do not represent an emergency, but are strictly an attempt to free ride the American system of free health care, either assessment of costs or criminal prosecution should be authorized. Such enforcement should not be allowed as to any child who is in U.S. territory prior to the illness or injury occurring, or where it is a non-elective matter or an emergency. At present, most offices of district attorney have specialized insurance and public welfare fraud units. Special funding is already provided to sustain these teams of prosecutors all over the state. The additional cost of adding these cases should not be prohibitive.