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Medi-Cal Enrollment Among Former Cash Welfare Recipients

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PREFACE

This RAND report contains results of a study of Medi-Cal coverage for former cash welfare recipients in California. In particular, it presents analyses of the Medi-Cal participation rates of former cash aid recipients to determine precisely their levels of coverage and to identify how these levels have varied by calendar time, time since leaving cash aid, recipient characteristics, Medi-Cal program, and county. It uses individual-level, administrative data from the Medi-Cal Eligibility Data System (MEDS) and information from interviews with welfare department and Medi-Cal officials in five selected counties: Alameda, Butte, Fresno, Sacramento, and San Diego.

This report should be of interest to policymakers, program officials, and general readers interested in Medi-Cal and CalWORKs policy. It is intended to inform decision makers at the state and county level, in the California Legislature, the California Department of Health Services (CDHS), and the California Department of Social Services (CDSS), and the county welfare departments (CWDs).

This research was made possible through the financial assistance of the California Program on Access to Care (CPAC), of the California Policy Research Center (CPRC) at the University of California. The research took place within the Center of the Study of Social Welfare Policy (under the directorship of Jacob Klerman), which is, in turn, within the Labor and Population (L&P) Program, under the directorship of Lynn Karoly.

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SUMMARY

INTRODUCTION

In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which eliminated Aid to Families with Dependent Children (AFDC) and replaced it with Temporary Assistance to Needy Families (TANF). In contrast to the limitations placed on cash assistance, PRWORA encouraged broader and greater use of Medicaid. Except for eligibility for immigrants, PRWORA expanded Medicaid eligibility and allowed states to expand it even further.

The national expansions to Medicaid came primarily in two areas. First, the new rules did not require people to sign up for cash assistance to receive Medicaid. The new Section 1931(b) made people eligible for Medicaid if they met the eligibility criteria for either AFDC or its replacement, TANF. Second, Transitional Medical Assistance (TMA), which provides temporary short-term coverage to people leaving AFDC/TANF, became available to more persons.

As noted above, PRWORA allowed the states to expand Medicaid even further. This was the case in California, where Medi-Cal (the state's Medicaid program) combines funds and policy at the federal, state, and county levels and extends eligibility and services to more people and for longer periods than the federal Medicaid program. The extensions are particularly evident in California's TANF program, California Work Opportunity and Responsibility to Kids (CalWORKs). Most notably, these include defining 1931(b) eligibility broadly, to combine the lowest bounds of AFDC and CalWORKs criteria, and extending Transitional Medi-Cal (California's TMA) from 12 to 24 months for adults.

Despite this enlargement of programs, concern is high that former cash recipients are not enrolled in, are not "taking up," Medicaid/Medi-Cal after they leave TANF/CalWORKs. Nationally, both administrative and survey data suggest that Medicaid take-up rates are low among former

cash aid recipients.[1] In California, the situation is similar; declining overall Medi-Cal rates for the past several years have led to concern that enrollment among former cash recipients had declined as well (Western Center on Law and Poverty, 2001, Ellis and Smith, 2000).

While these studies have established that total Medi-Cal enrollment has fallen, they are unable to answer whether this general trend is true for the subset of Medi-Cal enrollees who are former cash aid recipients. Medi-Cal is an extensive program that serves many people, only a fraction of whom are former cash welfare recipients. Studies that use aggregate Medi-Cal figures conflate the enrollment of former welfare recipients with the enrollment of other Medi-Cal clients. The others, such as elder and disabled people and current welfare recipients, can have very different rates of enrollment than former cash recipients.

In addition, many studies have been necessarily limited to pre-CalWORKs data (Garrett and Holahan 1999, Ku and Bruen 1999). At best, the early post-PRWORA data came from too soon after PRWORA programs were instituted to be able to assess their impacts on Medi-Cal participation. Given the major policy change that CalWORKs represents, generalizing current enrollment levels from earlier data is at best difficult and at worst inaccurate. These limitations of earlier studies--both in terms of approach and the data sets used--underscore the need for additional research.

This study seeks to overcome these limitations by examining former cash welfare recipients' Medi-Cal participation to determine precisely *their* enrollment and how their enrollment varies by calendar time, time since leaving cash aid, Medi-Cal program, recipient characteristics, and county. Specifically, we ask about the degree to which people who move off cash assistance continue to receive Medi-Cal and the policy and program reasons behind these trends. We answer these questions with quantitative tabulations of recent administrative data and qualitative analyses of open-ended interviews. Using Medi-Cal administrative records, we identify persons who have left AFDC/CalWORKs and trace their Medi-Cal coverage across the dimensions noted above. We then combine

[1]For a more complete discussion of this literature, see Dion and Pavetti (1999) and Guyer (2001).

these quantitative analyses with information from interviews with county welfare department (CWD) and Medi-Cal officials in six selected counties: Alameda, Butte, Fresno, Kern, Sacramento, and San Diego. These counties were chosen to reflect the diversity in California's communities. We use these data sources to illustrate the past and present state of Medi-Cal coverage among former cash recipients and to assess the policy and program reasons behind these levels.

While this approach and data help overcome the limitations discussed above, the approach does have limitations of its own. The most important of these is that the data do not include other forms of health care coverage (in particular, private health insurance and the Healthy Families program, California's Child Health Insurance Program, or CHIP). Examining these forms of health insurance would require additional data sources and strategies other than the ones used here.

We present our findings in four sections that correspond to four questions, the first three of which refer to state-level trends while the fourth refers to county-level variations:

- What has happened to Medi-Cal coverage among former recipients since CalWORKs?
- Which programs contribute to the changes in coverage?
- Are former recipients following the expected path among programs?
- How do counties vary on these changes in coverage?

The final section summarizes these main findings and examines their implications for Medi-Cal policy. We also include two appendices, which provide more detail on the racial-ethnic and age analyses discussed in Sections 2 and 3 and the county analysis discussed in Section 5.

WHAT HAS HAPPENED TO MEDI-CAL COVERAGE AMONG FORMER RECIPIENTS SINCE CalWORKs?

In answering this question, we started from previous research findings that show, using aggregate data, that Medi-Cal rates began to fall in 1996 (Ku and Bruen 1999). Because the aggregate data do not separate former welfare recipients from other enrollees, we then

examined enrollment among those who had recently left AFDC/CalWORKs. With our individual-level data, we found instead that Medi-Cal participation among former cash recipients has risen sharply over the past three years (1998-2000), since the CalWORKs program was instituted in January 1998. In 1997, 27.6 percent of former recipients in their first three years away from cash aid received Medi-Cal, on average. In 1998, the percentage had risen to 32.6 percent; in 1999, it was 42.8 percent; and by 2000, the rate had risen to 45.1 percent--substantially higher than the percentage enrolled in 1997. The increase in Medi-Cal enrollment rates among former welfare recipients is evident for both adults and children and for all racial-ethnic groups.

WHICH PROGRAMS CONTRIBUTE TO THE CHANGES IN COVERAGE?

The answer to our first question was that Medi-Cal take-up rates for former welfare recipients have increased since AFDC/CalWORKs was implemented. The obvious next question concerns which of the many programs that California has in place to provide Medi-Cal services are responsible for this increase. We found that increased enrollment in the Edwards and 1931(b) categories are responsible for most of the rise in participation. In 1998 and 1999, sharp increases in Edwards enrollment drove the trend, supplemented by rising Medically Needy rates in 1998. In 1999 and 2000, steep increases in the new 1931(b) program--which began implementation in 1999--led to the overall rise.

Unlike the Edwards and 1931(b) categories, which rose after CalWORKs, Transitional Medi-Cal participation declined gradually between 1997 and 1999 and leveled off in 2000. Medically Needy rates began to decline in 1999 as the 1931(b) program was instituted.

ARE FORMER RECIPIENTS FOLLOWING THE EXPECTED PATH IN USING PROGRAMS?

The policy changes behind these programs indicate a particular set of transitions that maximizes coverage among former welfare recipients. The simplest version of this path rests on the assumption that people's earnings rise the longer they are away from cash aid. After leaving CalWORKs, we expect people would be enrolled in the Edwards program with its automatic rollover from cash aid. Once redetermination were complete, people would then move either into Transitional Medi-Cal, if

their financial resources were too high for 1931(b), or into Section 1931(b) with Transitional Medi-Cal to follow when their earnings rose further. This would offer the broadest coverage for the longest time. Assuming that their earnings continue to rise, they would eventually move off Transitional Medi-Cal and into private health insurance or, among children, into one of the Percent Programs or the Healthy Families Program. Because people's earnings do not always steadily rise, we would also expect to see some former cash aid recipients cycling back onto 1931(b) and perhaps into the Medically Needy program.

When we examine the enrollment data, we find that former cash aid recipients' Medi-Cal coverage follows some of these transitions but not others. More specifically, we found some evidence that former cash aid recipients follow the path through Edwards to 1931(b), but we also found evidence that some of the transitions are less common than we might expect, especially those involving Transitional Medi-Cal. A number of former welfare recipients move directly from the Edwards category into the Medically Needy program or from Section 1931(b) directly into the Medically Needy program, both of which bypass Transitional Medi-Cal. The concern is that some people who would be eligible for Transitional Medi-Cal, with its higher income ceiling, are not receiving it.

HOW DO COUNTIES VARY ON THESE CHANGES IN COVERAGE?

While the first three questions focus on state-level issues related to Medi-Cal enrollment, we also want to know how the individual counties --where the various policies and programs are implemented--vary in terms of the increase in coverage we have seen. We used both the MEDS data and conducted interviews with the six selected counties to provide a context of the *process* of implementation that enables an understanding of the trends in enrollment observed in the tabulations of enrollment.

We found that the state-level trends are both reflected and contradicted across California's counties. The increase since CalWORKs is nearly universal, a wide range of Medi-Cal rates exists across counties. In addition, some counties held people in the Edwards category after they left CalWORKs, until the 1931(b) guidelines became stable. Although directed by the state to do so, this created a backlog

of cases that was extremely difficult and time consuming to process. Other counties did not develop a backlog of Edwards cases but continued to determine Medi-Cal eligibility for people leaving CalWORKs after January 1998 according to the pre-CalWORKs rules. Both sets of counties began to roll out the new 1931(b) program after its regulations stabilized in 1999. This implementation was complicated by a series of factors, including the timing and clarity of the new Medi-Cal guidelines, the lack of automation in processing cases, the increasing complexity of Medi-Cal, and the increased workload and staffing needs.

CONCLUSIONS

Our findings should be of interest to former cash aid recipients, county welfare departments and staff, and the state of California. The rise in Medi-Cal enrollment that we found shows that even though former recipients still do not retain Medi-Cal for most of their first three years off aid, increasing numbers of them do, and this reverses a long-term trend. This increase provides some indication that county welfare departments are implementing the new programs as intended and that the state's new programs are helping people to retain Medi-Cal after leaving CalWORKs. At a different level, the findings also indicate the importance of using individual-level, as opposed to aggregate, data, despite the far greater access and ease of aggregate tabulations.

However, the findings also raise some concerns. First, the increasingly complex nature of Medi-Cal has dramatically changed Medi-Cal caseworkers' jobs over the past several years, and even with the best of caseworkers, recipients have a higher chance of being enrolled in a program that may not offer them the best coverage, or of being erroneously dropped from Medi-Cal entirely. The ambiguity that can surround the state's directives is evident in the different interpretations made by counties about processing Medi-Cal eligibility for people who left cash aid at the beginning of CalWORKs. In addition, because not all the transitions through the Medi-Cal programs were as common as expected, some former recipients may not be receiving all possible benefits, or they may be incurring a share of cost that is not necessary. The growing complexity, combined with the difficulty that

county staff have had understanding the new regulations, suggests that CDHS needs to provide additional support to counties for clarifying the array of current programs and how they relate to each other.

ACKNOWLEDGMENTS

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ACRONYMS

ACL	All County Letter
AFDC	Aid to Families with Dependent Children
CalWORKs	California Work Opportunity and Responsibility to Kids Act of 1997
CDHS	California Department of Health Services
CDSS	California Department of Social Services
CHIP	California's Child Health Insurance Program
C-IV	Consortium IV
CPAC	California Program on Access to Care
CPRC	California Policy Research Center
CWD	County Welfare Department
LAO	Legislative Analyst's Office
LEADER	Los Angeles Eligibility Automated Determination, Evaluation, and Reporting System
MEDS	Medi-Cal Eligibility Determination System
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
SAWS	Statewide Automated Welfare System
TANF	Temporary Assistance to Needy Families
WCDS	Welfare Client Data System

1. INTRODUCTION

BACKGROUND

In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which eliminated Aid to Families with Dependent Children (AFDC) and replaced it with Temporary Assistance to Needy Families (TANF). In contrast to the limitations placed on cash assistance, PRWORA actually encouraged broader and greater use of Medicaid. Except for eligibility for immigrants, PRWORA expanded eligibility for Medicaid and allowed states to expand it even further.

The national expansions to Medicaid came primarily in two areas. First, the new rules did not require people to sign up for cash assistance to receive Medicaid. The new Section 1931(b) made people eligible for Medicaid if they met the eligibility criteria for either AFDC or its replacement, TANF. Second, Transitional Medical Assistance (TMA), which provides temporary short-term coverage to people leaving AFDC/TANF, became available to more persons.

As noted above, PRWORA allowed the states to expand Medicaid even further. This was the case in California, where Medi-Cal (the state's Medicaid program) combines funds and policy at the federal, state, and county levels and extends eligibility and services to more people and for longer periods than the federal Medicaid program. The extensions are particularly evident in California's TANF program, California Work Opportunity and Responsibility to Kids (CalWORKs). Most notably, these include defining 1931(b) eligibility broadly, to combine the lowest bounds of AFDC and CalWORKs criteria, and extending Transitional Medi-Cal (California's TMA) from 12 to 24 months for adults.

Despite this enlargement of programs, concern is high that former cash recipients are not enrolled in, are not "taking up," Medicaid/Medi-Cal after they leave TANF/CalWORKs. Nationally, both administrative and survey data suggest that Medicaid take-up rates are low among former

cash aid recipients.[2] Garrett and Holahan (1999) report that nearly half of women and almost a third of children had no insurance (including Medicaid) by one year after they left welfare, using data from the 1997 National Survey of America's Families. Moreover, rates appear to have fallen recently; Davidoff et al (2001) report a decline in Medicaid enrollment between 1994 and 1997, using data from the National Health Interview Survey. In California, the situation is similar; declining overall Medi-Cal rates for the past several years have led to concern that enrollment among former cash aid recipients had declined as well (Western Center on Law and Poverty, 2001, Ellis and Smith, 2000).

While many of these studies have established that total Medi-Cal enrollment has fallen recently, they are unable to answer whether this general trend is true for the subset of Medi-Cal enrollees who are former cash aid recipients. Medi-Cal is an extensive program that serves many people, only a fraction of whom are former cash welfare recipients. Studies that use aggregate Medi-Cal figures conflate the enrollment of former welfare recipients with the enrollment of other Medi-Cal clients. The others, such as elder and disabled people and current welfare recipients, can have very different rates of enrollment than former cash recipients.

Other studies, particularly those that use survey data, are able to distinguish between former welfare recipients and other Medi-Cal enrollees but have been necessarily limited to pre-CalWORKs data (Garrett and Holahan 1999, Ku and Bruen 1999). At best, the early post-PRWORA survey data came from too soon after PRWORA programs were instituted to be able to assess their impacts on Medi-Cal participation. Given the major policy change that CalWORKs represents, generalizing current enrollment levels from earlier data is at best difficult and at worst inaccurate.

Both sets of earlier studies--those based on aggregate administrative data and those based on individual survey data--provide important insight into the issue of Medi-Cal enrollment after welfare. However, their limitations--both in terms of the approach they have

[2]For a more complete discussion of this literature, see Dion and Pavetti (1999) and Guyer (2001).

taken and the data they have used--underscore the need for additional research.

OBJECTIVE AND APPROACH

This study seeks to overcome these limitations by examining former cash welfare recipients' Medi-Cal participation to determine precisely *their* enrollment and how their enrollment varies by calendar time, time since leaving cash aid, Medi-Cal program, recipient characteristics, and county. Specifically, we ask about the degree to which people who move off cash assistance continue to receive Medi-Cal and the policy and program reasons behind these trends. We answer these questions with quantitative tabulations of recent administrative data and qualitative analyses of open-ended interviews. Using Medi-Cal administrative records, we identify persons who have left AFDC/CalWORKs and trace their Medi-Cal coverage across the dimensions noted above. We then combine these quantitative analyses with information from interviews with county welfare department (CWD) and Medi-Cal officials in six selected counties: Alameda, Butte, Fresno, Kern, Sacramento, and San Diego. We use these data sources to illustrate the past and present state of Medi-Cal coverage among former cash recipients and to assess the policy and program reasons behind these levels.

While this approach and data help overcome the limitations discussed above, the approach does have limitations of its own. The most important of these is that the data do not include other forms of health care coverage (in particular, private health insurance and the Healthy Families program, California's Child Health Insurance Program, or CHIP). In addition, administrative records lack information on enrollees' awareness of their own coverage status; after leaving welfare, some people may assume that they were no longer enrolled in Medi-Cal as well, and the MEDS data allow us to assess enrollment but not knowledge or use. Examining these forms of health insurance would require additional data sources and strategies than the ones used here.

ORGANIZATION OF THIS DOCUMENT

We present our findings in terms of four sections that correspond to the answers to four questions, the first three of which refer to state-level trends while the fourth refers to county-level variations:

- What has happened to Medi-Cal coverage among former recipients since CalWORKs?
- Which programs contribute to the changes in coverage?
- Are former recipients following the expected path among programs?
- How do counties vary on these changes in coverage?

The final section summarizes these main findings and then examines their implications for Medi-Cal policy. We also include one appendix, which provides more detail on the county analysis discussed in Section 5.

2. WHAT HAS HAPPENED TO MEDI-CAL COVERAGE AMONG FORMER RECIPIENTS SINCE CalWORKs?

Our main question is what has happened to Medi-Cal coverage among former cash recipients since they left AFDC/CalWORKs. As noted in Section 1, previous research in this area has established the recent decline in total Medi-Cal enrollment--the typical way trends in Medi-Cal are analyzed--but it has been unable to illustrate precisely what has happened to former recipients, one of the categories that make up total enrollment. Using our approach and data, we can inform understanding of aggregated Medi-Cal enrollment as well as look at those rates disaggregated into specific groups.

In this section, we report on both the aggregate and disaggregate analyses and demonstrate the importance of analyzing former recipients separately from other Medi-Cal participants. Our analyses of the aggregate data tend to confirm what previous researchers have shown--a downward trend in total Medi-Cal enrollment from around 1996 on. That is, the number of *all* persons with an active Medi-Cal card (not just former welfare recipients) began to fall in 1996.

Previous research suggests that this decline applied to former welfare recipients as well (Ellis and Smith 2000, Ku and Bruen 1999). However, by examining the Medi-Cal participation rates of former AFDC/CalWORKs recipients directly, we find the opposite of what earlier literature, based on less current and precise data, had indicated. In contrast to the decline in total Medi-Cal enrollment, we see instead a sharp increase in Medi-Cal enrollment among former cash aid recipients since CalWORKs. Although many former welfare recipients do not retain Medi-Cal after leaving cash aid, more have done so since CalWORKs, especially in the first several months after leaving. Moreover, the rise in coverage occurs across all months since leaving cash aid, and it is sharpest among those who have remained off cash welfare. Finally, we note that the sharp increase in enrollment is shared across ages and race-ethnicities of recipients. Below, we discuss these findings in more detail.

TOTAL MEDI-CAL ENROLLMENT HAS DECLINED SINCE 1996

Studies show that Medi-Cal rates in general began to fall in 1996 (Ellis and Smith 2000, Ku and Bruen, 1999). These studies use the aggregate enrollments that are available to address the question of former cash aid recipients' Medi-Cal enrollment. Figure 2.1 updates these general results using the same data that underlie our later results, the January 1987 through December 2000 Medi-Cal Eligibility Data System (MEDS) files. These administrative data are the computer records of Medi-Cal enrollment that are recorded on a monthly basis for each Medi-Cal recipient and kept by CDHS. These are the records from which aggregate enrollment reports are derived. Figure 2.1 shows Medi-Cal enrollment for all persons from 1990 through 2000 (the black line), or the number of persons with Medi-Cal at any given point in each year. In the years preceding welfare reform, 1990-1994, this number, total Medi-Cal enrollment, had been rising. It leveled off in 1995 and declined by 8.4 percent between 1996 and 1998. Participation rose slightly again in 1999 but resumed its decline in 2000. Even with the 1999 rise, overall enrollment was lower in 2000 than it had been since 1992. This decline, particularly through 1998, sounded the initial alarm that many former cash aid recipients, who were likely eligible for Medi-Cal, were not receiving or not retaining their Medi-Cal benefits.

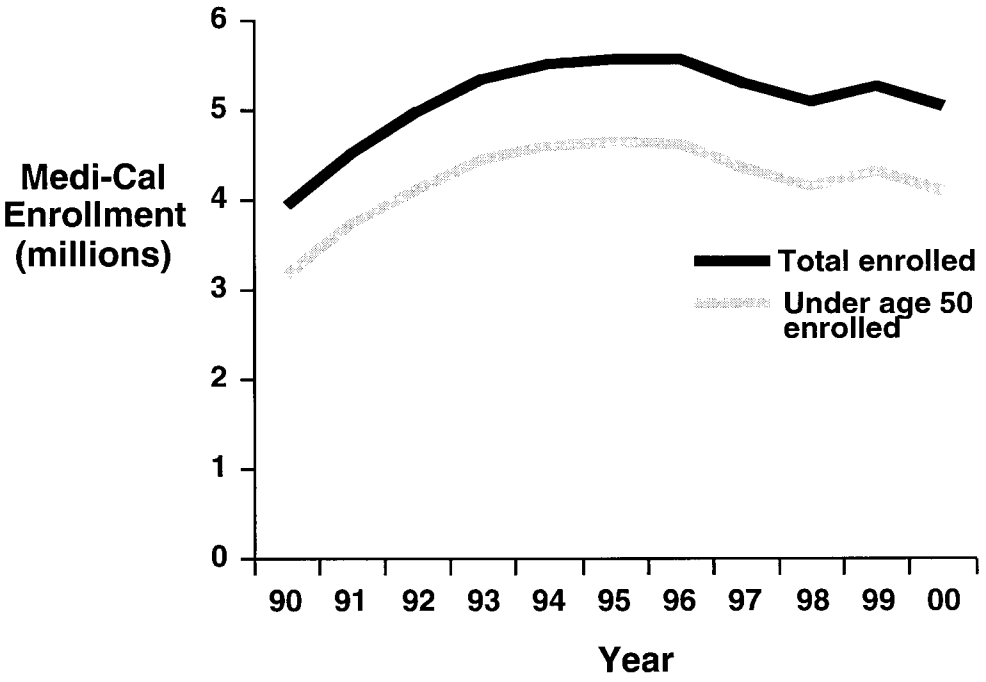

Figure 2.1--Total Medi-Cal Enrollment by Year

However, despite the clear decline in total enrollment, these data do not tell us whether particular subgroups (i.e., former welfare recipients) were continuing to receive Medi-Cal benefits. This is because the overall enrollment conflates the participation of former cash recipients with that of all other Medi-Cal enrollees. Thus, it is unclear whether the general decline accurately represents trends for the subgroup of enrollees who left welfare.

The enrollment of the nonelderly population more closely approximates the enrollment of former cash aid recipients, since the vast majority of nonelderly enrollees are current and former welfare recipients (LAO, 2000). When we consider only those under age 50, the enrollment pattern does not change, as earlier research also found (Ku and Bruen, 1999). Again, however, the extent to which this decline precisely reflects the trend for former cash recipients is not clear. It may simply reflect a decline in the number of nonelderly receiving Medi-Cal through AFDC/CalWORKs.

In fact, the welfare caseload itself was dropping sharply during this period, and the results in Figure 2.2 are consistent with that

possibility. The figure shows the number of people under age 50 enrolled in Medi-Cal each year from 1990 through 2000 through two sets of programs: AFDC/CalWORKs and those related to former recipients--the Edwards, Transitional Medi-Cal, and 1931(b) programs. The Edwards and Transitional Medi-Cal programs are designed mainly for former welfare recipients, and many former recipients are likely eligible for the new 1931(b) category as well.

Consistent with the findings of Ku and Bruen, more recent aggregate data show that Medi-Cal coverage as part of AFDC/CalWORKs rose quickly from 1990 through 1994 and then fell even more quickly from 1996 through 2000. Enrollment in the corresponding post-welfare programs rose between 1997 and 1998, but the increase is much smaller than one might expect, given the decline among AFDC/CalWORKs enrollees. Nor does the more recent data suggest a 1999-2000 increase that would match the 1996 to 2000 drop in AFDC/CalWORKs-related Medi-Cal. This continues to suggest a downward trend in former recipients' enrollment. However, it is unrealistic to expect Medi-Cal among former recipients to rise as much as the decline resulting from the falling AFDC/CalWORKs caseload. This is because former cash recipients will have lower Medi-Cal participation than current recipients, even under ideal circumstances.

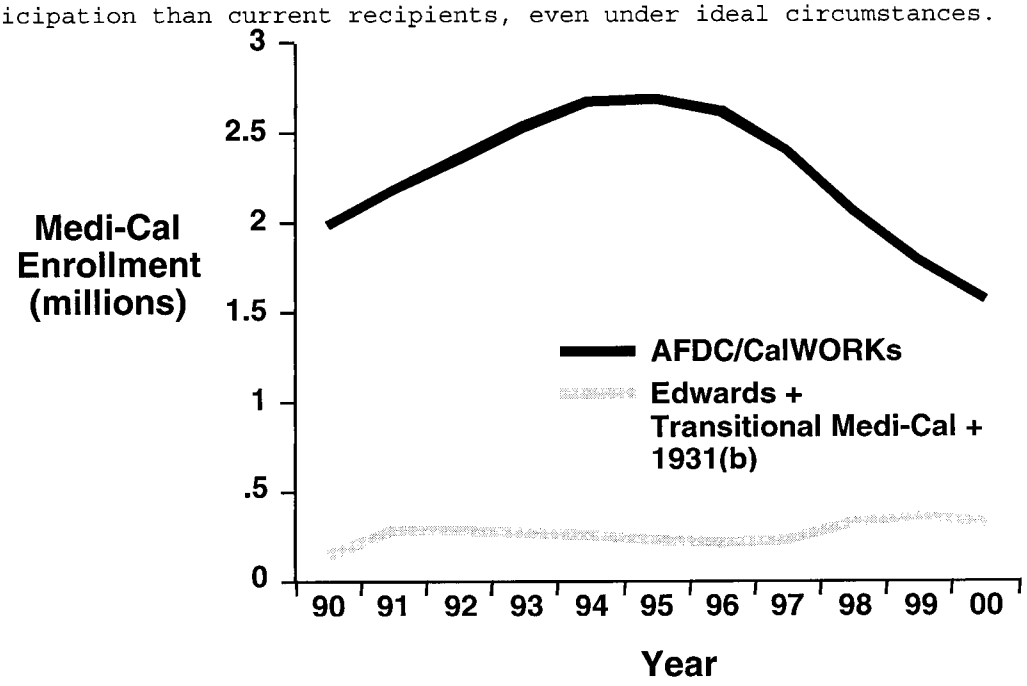

Figure 2.2--Medi-Cal Enrollment for Those Under Age 50 by Program

Current recipients receive Medi-Cal automatically, while some former recipients receive health insurance through California's CHIP program (Healthy Families) or through an employer. Nevertheless, the rise in Edwards, Transitional Medi-Cal, and 1931(b) enrollment appears to be sluggish at best. Just as important is our uncertainty about whether the slight increase in the Edwards, Transitional Medi-Cal, and 1931(b) programs accurately reflects the trend for former cash aid recipients. This is because the 1931(b) category covers people other than former cash aid recipients, and former recipients may also have been, and may continue to be, enrolled in other Medi-Cal programs.

Taken together, Figures 2.1 and 2.2 illustrate the difficulty of estimating Medi-Cal enrollment for one subgroup--former cash recipients --with aggregate data. The closer we get to specifying Medi-Cal use among former cash recipients, the more varied the different trends look. What we need is enrollment data specifically for those people who recently left AFDC/CalWORKs. For this, we need the individual MEDS data from which the aggregate numbers are derived and that identify when people leave cash aid.

MEDI-CAL ENROLLMENT AMONG FORMER AFDC/CalWORKs RECIPIENTS RISES SHARPLY SINCE 1998

When we examine former AFDC/CalWORKs recipients using individual-level data that specifically identify them, the findings are striking. Medi-Cal enrollment has increased among former cash recipients since CalWORKs was implemented in 1998. We examine this finding over calendar time and by time since leaving aid.

Medi-Cal Eligibility Data System (MEDS) Data

A more precise analysis requires individual level data. Data at the individual level enables us to compute the fraction of former recipients who take up Medi-Cal, consider how enrollment varies with time since leaving cash aid, and examine the Medi-Cal programs through which former recipients are enrolled.

Our main source of data is the Medi-Cal Eligibility Data System (MEDS). The MEDS data enable us to answer the research question directly, rather than having to generalize from pre-CalWORKs data, from survey data, or from overall Medi-Cal enrollments. The MEDS records we use are at the individual level, like survey data, but administrative, like aggregate enrollment data. Compared to survey data, they have a high degree of accuracy, cover the entire population of interest (all former cash aid recipients), are not missing data, and are current. Compared to aggregate Medi-Cal enrollment data, the individual records enable us to identify former cash recipients because they contain information on AFDC/CalWORKs receipt as well as on Medi-Cal enrollment, and they specify enrollment in every Medi-Cal program, rather than only in certain programs. As noted previously, the MEDS is limited in that it lacks data on other forms of health insurance coverage and on participants' knowledge and use of their Medi-Cal.

The data are recorded on a monthly basis for each Medi-Cal participant back to 1987. We report results for data from January 1990 through December 2000. From the universe of all Medi-Cal enrollees, we first selected persons who had received AFDC/CalWORKs at some point. We then identified the month and year when each of these persons stopped receiving AFDC/CalWORKs. We are interested in their Medi-Cal history after that point, we then selected three subsequent years of data.[3] Our analysis file for the graphs that follow thus contains monthly Medi-Cal enrollment records for the first 36 months after an individual stopped receiving AFDC/CalWORKs. Because the number of former welfare recipients during this period is still too large to analyze (36 months of data for nearly eight million persons), we analyzed a stratified random sample of 17 percent of the cases. The sample is stratified by county to ensure that all counties are represented and then weighted to California population size.

[3] We treat one month gaps in aid receipt as administrative errors, since they are often the result of late filing of monthly status reports. We thus treat those away from AFDC/CalWORKs at least two consecutive months as having left cash aid.

General Pattern Over Calendar Time

Figure 2.3 presents both the number and percentage of people who were enrolled in Medi-Cal in the first three years after they left AFDC/CalWORKs. The figure excludes returns to cash aid, meaning that former recipients remain in the analysis for 36 months or until they start to receive AFDC/CalWORKs again, whichever comes first. The figure shows enrollment trends between 1990 and 2000 and can be interpreted as the number and percentage of former AFDC/CalWORKs recipients who have Medi-Cal, among former recipients who left AFDC/CalWORKs within the past three years.

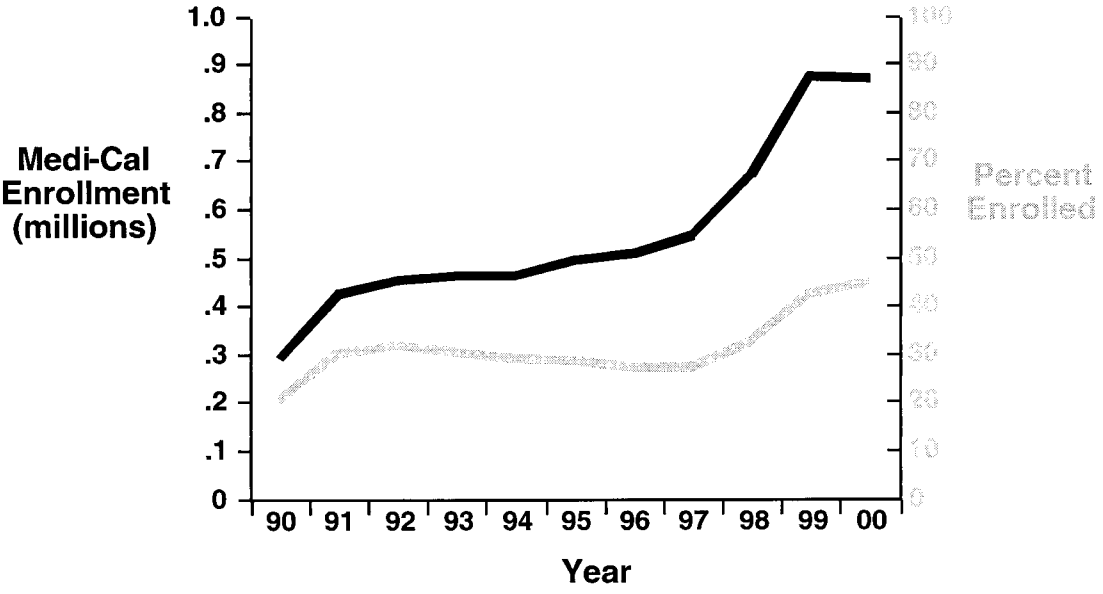

Figure 2.3--Medi-Cal Enrollment Among Former AFDC/CalWORKs Recipients, by Year

We focus first on the *number* of former cash aid recipients enrolled (the black line), since this corresponds with the approach in Figures 2.1 and 2.2. We see that the number of persons who had left cash aid and were enrolled in Medi-Cal rose steadily since 1990, leveling off only in 2000. Moreover, this number of persons increased especially sharply from 1997 through 1999. This is in stark contrast to the results indicated by the aggregate data, that enrollment among former recipients had at most increased slightly in 1997 and 1998. This is our first evidence that former recipients' recent enrollment may be very

different from their earlier trends and very different from what was previously thought. Although the number of former cash recipients fell slightly in 2000, this is likely the result of the declining welfare caseload--there are simply fewer current CalWORKs recipients in the pool to leave cash aid. This idea is strengthened by the increasing *rate* of participation among former recipients (the gray line).

Since the number of recent former recipients varies so much over this period, the *percentage* of former cash aid recipients enrolled in Medi-Cal provides a better assessment of Medi-Cal take-up than the number. The Medi-Cal enrollment rate between 1990 and 2000 roughly mirrors the trend for the number of former recipients with Medi-Cal. The fact that the *number* of former recipients with Medi-Cal rose between 1993 and 1996 while the *rate* of enrollment declined is a simple function of the increase in the welfare caseload and its corresponding decline. Examining only the number thus disguises the fact that the take-up *rate* among former recipients fell over the same period. Beginning in 1997, the rate of Medi-Cal take-up among former cash recipients began to increase rapidly. During this post-CalWORKs reversal, 27.6 percent of former recipients had Medi-Cal during their first three years away from cash aid in 1997, compared to 45.1 percent in 2000--an increase of more than half.

This dramatic increase in enrollment among former recipients is an important result given what we know from earlier studies. It represents a reversal of earlier trends and a contradiction of the implications of the aggregate data. The increase in enrollment began clearly in 1998, the year that CalWORKs came into being, and gained momentum in 1999.

By Time Since Leaving Cash Aid

The percentage of former cash aid recipients enrolled in Medi-Cal changes not only over calendar time but also over the time that has elapsed since people left cash aid. Figure 2.4 depicts enrollment rates over the first 36 months after leaving AFDC/CalWORKs. For example, the solid black line shows that among those who left cash aid in 2000, almost 90 percent were enrolled in Medi-Cal their first month after leaving aid. Twelve months after leaving aid, only 45 percent were

enrolled in Medi-Cal. The lines are shorter for those who left cash aid in 1999 and 2000 because there were fewer months of post-welfare data for them.

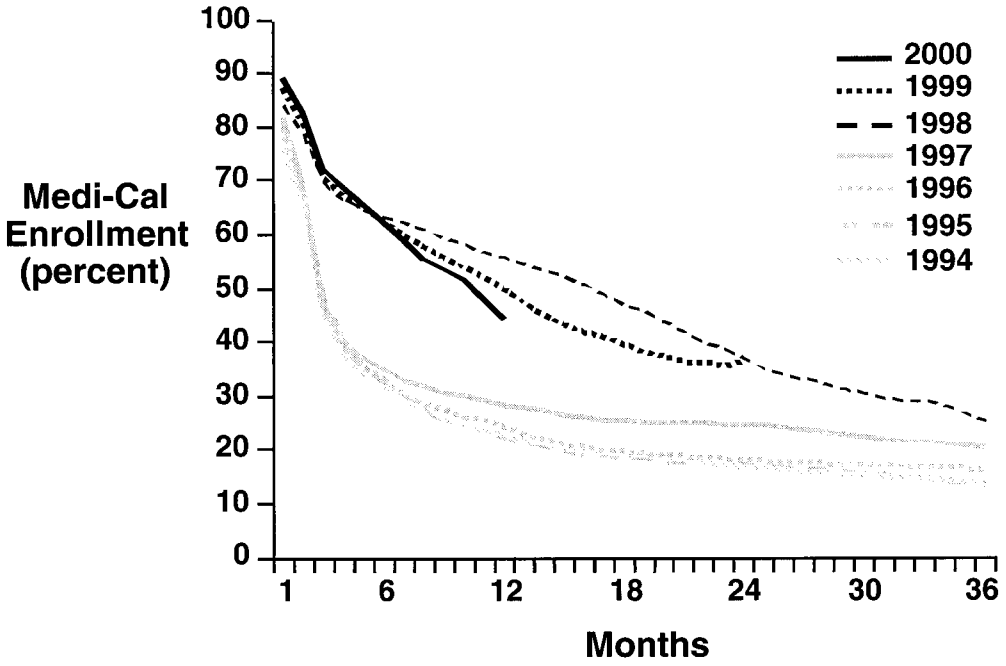

Figure 2.4—Percent with Medi-Cal by Calendar Year and Months Since Left Cash Aid

Figure 2.4 has four implications. First, enrollment declines with time away from welfare. For reasons we discuss in detail in the next section, the fraction of former recipients enrolled in Medi-Cal is very high in the first few months after leaving cash aid but declines thereafter.

Second, the pattern of decline shifted sharply with welfare reform. For 1994 through 1997--approximately the pre-welfare reform period (the bottom group of gray lines)--enrollment declined very rapidly thereafter. Since CalWORKs (the top group of black lines), the decline with time off cash aid is much less rapid. For example, in 1997 (the solid gray line), 81.9 percent of former recipients were enrolled in Medi-Cal in the first month after they left AFDC. Six months after leaving, only 35.2 percent were enrolled; by twelve months, only 28.7 percent were enrolled, and by twenty-four months, only 24.9 percent were

enrolled. In 2000 (the solid black line), 89.2 percent of former cash recipients had Medi-Cal coverage one month after they left CalWORKs, and by six months, 62.3 percent remained enrolled. This level fell to 44.3 percent by twelve months after leaving, far higher than the rate in 1997. Thus, we see a definite decline in former recipients' Medi-Cal enrollment the farther away they are from cash aid, but this decline has become less severe since CalWORKs was instituted.

Third, the figure illustrates a cohort phenomenon. Events occurring in a particular calendar period, e.g., the inception of CalWORKs in January 1998, are likely to affect Medi-Cal rates in a cohort pattern--altering former recipients' enrollment throughout the time we follow them, not just at the time of the event. However, rather than affecting all enrollees evenly from the time of the event forward, events are likely to affect Medi-Cal rates primarily for those who leave welfare *after* the event. This is because of the importance for Medi-Cal of continuous enrollment. For CWDs, Medi-Cal take-up is primarily a matter of maintaining the continuous enrollment of former welfare recipients. The alternative is reenrolling those who are not connected to Medi-Cal for a period and involves the low probability of linking up with persons who have little to no contact with a welfare office. Given the importance of continuous enrollment, then, we would expect to see the rise in Medi-Cal enrollment follow a cohort pattern primarily for those who left cash aid in or after 1998, and this is what we observe in Figure 2.4. Following this cohort pattern, there is little increase in enrollment over time off welfare among those leaving welfare through 1997 (the gray lines), but there is a sharp increase among the cohorts leaving in 1998 and later (the black lines). That is, after CalWORKs was instituted, more people remained connected to Medi-Cal and did so for a longer time. Among those who had been away from cash aid for twelve months, 28.7 percent were enrolled in Medi-Cal if they left in 1997 (the solid gray line), compared to 55.9 percent of those who left one year later in 1998 (the dashed black line).

Fourth, the recent rise in enrollment has been strongest among those in the middle range, who left cash aid 6-21 months previously. Although the increase is evident at all times since leaving cash aid, it

is largest after the first few months and before the end of the three years. Between the beginning of 1997 and the end of 2000, enrollment grew by 7 percentage points for those one month away from cash aid, and it grew by 25 percentage points for those three months away from cash aid. For those 9, 15, and 21 months away from cash aid, enrollment rates of coverage rose the most, roughly doubling between 1997 and 2000. Those 30 months away from cash aid also had large gains, at about 8 percentage points.[4] The rates after nine months are slightly lower for those who left CalWORKs in 1999 and 2000 than for those who left in 1998. This results from shifts in enrollment across specific Medi-Cal programs, which we discuss in the next section, along with the possibility that enrollment may continue to decline.

By Race/Ethnicity and Age

We have seen how Medi-Cal enrollment for former AFDC/CalWORKs recipients rose after CalWORKs and that it varies by time since leaving cash aid. We also analyzed whether this increase was similar across various groups of recipients or was concentrated among particular socio-demographic groups. We tabulated these same results separately for adults and children and for (non-Hispanic) whites, Hispanics, (non-Hispanic) African Americans, and other racial-ethnic groups. The results suggest few differences in enrollment trends across these groups. Adults' and children's rates are quite similar and follow the same pattern over calendar time as that of all former recipients. Racial-ethnic groups' rates also followed the same general pattern, rising sharply after CalWORKs. Racial-ethnic groups' rates were more disparate before CalWORKs and converged with the increase in 1998 and

[4] The above discussion has focused on Medi-Cal take-up among people who left cash aid for as long as they remained off of cash aid. This is the most conservative definition in terms of enrollment after cash aid, since Medi-Cal enrollment automatically accompanies a return to AFDC/CalWORKs. By excluding periods where people have returned to cash aid, we calculated Medi-Cal enrollment not associated with AFDC/CalWORKs. When we include these returns to cash aid and examine any form of Medi-Cal enrollment after people leave welfare (including through AFDC/CalWORKs), we find the same general pattern. The only difference is that enrollment is higher at later months and the increase over calendar time is not as high.

1999. In 2000, the enrollment rate for whites leveled off while the rates for the other three groups continued to rise. Appendix A presents these results in more detail.

3. WHICH PROGRAMS CONTRIBUTE TO THESE CHANGES IN COVERAGE?

In Section 2, we found that when we examined the disaggregated data, the percentage of former cash aid recipients enrolled in Medi-Cal increased sharply with the inception of CalWORKs in 1998. In this section, we explore which specific Medi-Cal programs contributed to the observed changes. We find that the initial increase is largely due to a temporary administrative phenomenon involving the Edwards program and that the later increase is largely due to the emergence of the 1931b program, which is likely to endure. We also find that several programs that might have been expected to contribute to Medi-Cal coverage among former cash aid recipients do not do so. In the next section, we return to why this is so.

MEDI-CAL IS COMPRISED OF A NUMBER OF PROGRAMS

Medi-Cal is a conglomeration of many programs, only some of which are frequently used by former AFDC/CalWORKs recipients. The most important programs, with regard to former cash welfare recipients, and the recent changes accompanying them, are as follows:

- **Edwards Category**--The Edwards Category (named after a court case, Edwards vs. Kizer) extends Medi-Cal eligibility to anyone leaving AFDC/CalWORKs while their eligibility for continued Medi-Cal coverage is determined. It is designed to provide coverage for approximately one to two months during this redetermination. This purpose shifted and broadened dramatically in the immediate post-CalWORKs period.
- **1931(b) Category**-- In California, the Section 1931(b) category provides Medi-Cal coverage to those who are currently eligible for CalWORKs or who would have been eligible for AFDC, using its July 16, 1996, rules, regardless of whether they receive such cash assistance. Because it is responsive to the eligibility criteria for both programs, more people qualify for Medi-Cal under Section 1931(b) than would under AFDC or

CalWORKs criteria alone. Section 1931(b) designates Medi-Cal coverage to persons who stopped receiving AFDC or CalWORKs cash aid but had financial resources still within the AFDC or CalWORKs eligibility limits.

- **Transitional Medi-Cal**--Transitional Medi-Cal is California's Transitional Medical Assistance program, providing temporary coverage to persons who leave AFDC/CalWORKs because of increased earnings. As with the federal Transitional Medical Assistance, Transitional Medi-Cal is now available to those leaving 1931(b) coverage, as well as to those leaving AFDC/CalWORKs. Transitional Medi-Cal provides coverage for up to 12 months for children and was expanded for adults in 1998, increasing benefits from a maximum of 12 to a maximum of 24 months after leaving AFDC/CalWORKs or 1931(b) coverage.
- **Medically Needy**--The Medically Needy program has historically been the route to Medi-Cal for families with children who do not qualify for AFDC, since its eligibility criteria are only slightly less strict than those for AFDC. Since the addition of the 1931(b) category and the extension of coverage to others without welfare, its role is less unique. More important, however, direct and indirect benefits can be lower from the Medically Needy program than from 1931(b). This is because as people's earnings rise, they remain eligible longer through 1931(b) and subsequent Transitional Medi-Cal than through Medically Needy. In addition, the Medically Needy program can carry a share of cost for recipients, which Section 1931(b) and Transitional Medi-Cal do not.
- **Percent Programs**--Although not intended specifically for former cash aid recipients, another set of programs deserves mention--the Percent Programs. The Percent Programs are a series of Medi-Cal programs that began in the early 1990s and extend coverage to children in low-income families. These programs expand eligibility to children with family incomes 100 percent to 200 percent of the federal poverty line, depending on their age.

MOST OF THE RISE IN PARTICIPATION RESULTS FROM EDWARDS AND 1931(B) ENROLLMENT

With this brief introduction to the major Medi-Cal programs for former welfare recipients, we can disaggregate Medi-Cal enrollment by program. Figure 3.1 indicates that most of the recent rise (after 1997) in former recipients' Medi-Cal enrollment occurs because of rising enrollments in the Edwards and the 1931(b) categories. The thick black line represents total Medi-Cal enrollment among former recipients and duplicates the gray line shown earlier in Figure 2.3.

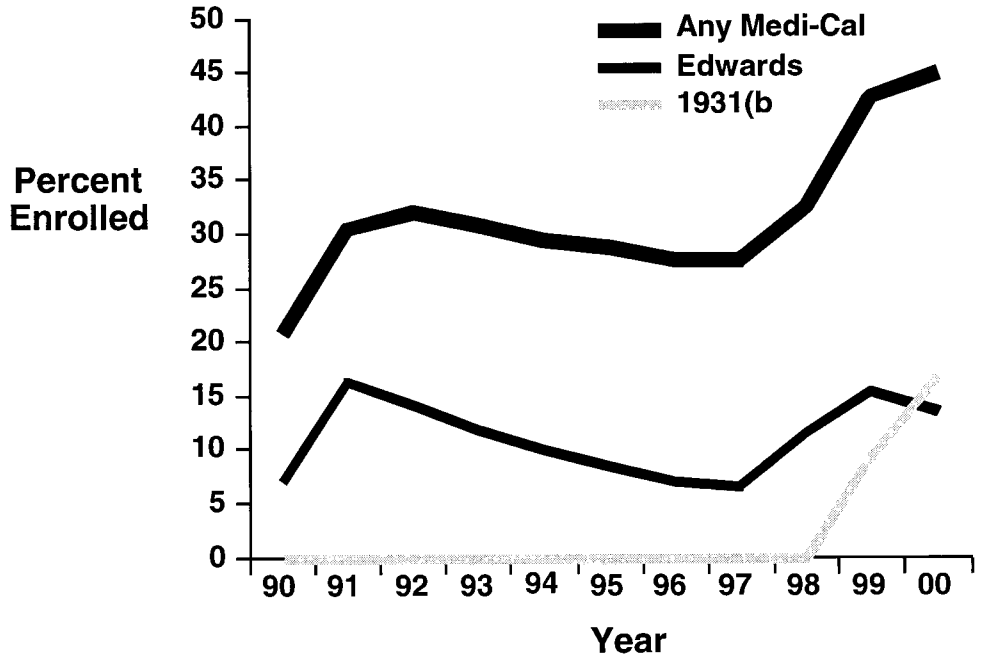

Figure 3.1--Contributions of Edwards and 1931(b) by Year

Most of the initial rise in Medi-Cal enrollment among former cash aid recipients occurred in the Edwards category (the thinner black line). Enrollment in Edwards doubled between 1997 (6.6 percent), before CalWORKs, and 2000 (13.5 percent). Edwards enrollment rose dramatically because CDHS instructed counties to hold new cases that were moving off of welfare in the Edwards category until 1931(b) regulations were established. The process of developing those regulations took many

months, however, and it was not until 1999 that counties began to roll out 1931(b). As a result, an enormous backlog of Edwards cases developed, raising both the Edwards and overall enrollments. As counties began to catch up with the backlog of cases, Edwards enrollment began to decline in 2000, a trend which we expect will continue while counties finish processing the backlogged cases. In terms of former welfare recipients' Medi-Cal enrollment, this Edwards backlog means that much of the initial rise in enrollment is the result of an administrative phenomenon that is temporary.

At the same time, the second part of the increase in former recipients' Medi-Cal take-up results from the implementation of the 1931(b) program (the gray line). With its broader eligibility criteria and indefinite time period, 1931(b) covered a growing number of persons moving off of AFDC/TANF in 1999 and 2000. Enrollment rose from zero percent in 1998 to 16.8 percent in 2000. It compensated for falling Edwards enrollment in 2000 and falling enrollment in other programs in 1999 and 2000 to yield an overall increase in former recipients' Medi-Cal take-up. More than any other single program, Section 1931(b) caused former welfare recipients to continue being enrolled in Medi-Cal.

TRANSITIONAL MEDI-CAL DOES NOT CONTRIBUTE TO THE INCREASE IN ENROLLMENT, BUT MEDICALLY NEEDY DOES CONTRIBUTE

The Edwards and 1931(b) categories are not the only programs affecting recent welfare recipients. Figure 3.2 adds the contribution of the other two programs that have been key to former recipients' Medi-Cal--Transitional Medi-Cal and Medically Needy. Despite the expansion of Transitional Medi-Cal in 1998, its enrollment actually fell after CalWORKs was instituted, from 3.7 percent in 1997 to 1.7 percent in 1999. By 2000, enrollment in Transitional Medi-Cal leveled off, remaining at 1.7 percent.

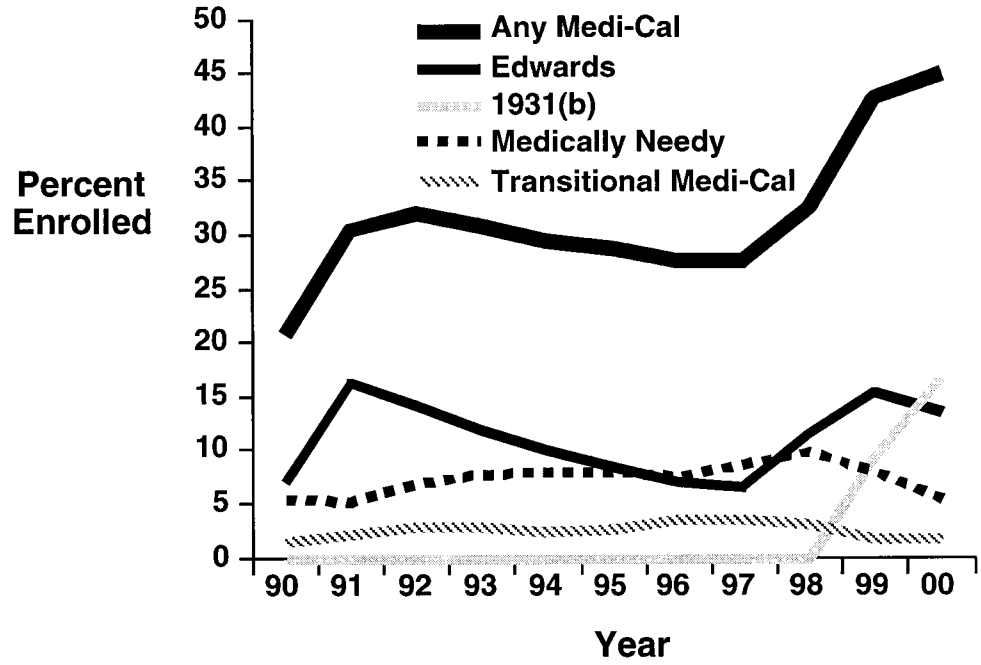

Figure 3.2--Contributions of Medically Needy and Transitional Medi-Cal by Year

The initial decline in Transitional Medi-Cal likely reflects two related issues. First, the timing of the processing of the Edwards backlog meant that former recipients continued their Medi-Cal coverage with Edwards until at least 1999 when the 1931(b) program began to be rolled out. The continued Edwards coverage thus temporarily eliminated the need for Transitional Medi-Cal in the first year of CalWORKs. Second, by 1999, the wider coverage available under 1931(b) meant that fewer families might need Transitional Medi-Cal coverage than needed it before CalWORKs, when 1931(b) was not available. This is especially true in the first several months after leaving cash aid when people's incomes may be lower. Eligibility for the 1931(b) program is not time-limited, and people can reserve their limited Transitional Medi-Cal coverage for a time when their earnings rise. The 1931(b) program thus both lowers and delays the need for Transitional Medi-Cal. This delay becomes evident by the third year after CalWORKs. With the Edwards backlog further diminished and people in 1931(b) having been there for several months, Transitional Medi-Cal enrollment ceased declining and stabilized, presumably as people moved from 1931(b) to Transitional

Medi-Cal. Thus, Transitional Medi-Cal enrollment remains low and did not contribute to the overall rise in Medi-Cal participation. At the same time, its decline may be temporary and reverse in the near future.

Unlike the Edwards, 1931(b), and Transitional Medi-Cal categories, the Medically Needy program was not designed specifically for those leaving cash assistance, nor was it part of the Medi-Cal expansions of the late 1990s. However, as the figure shows, until 1999, the Medically Needy program had been at least the second largest source of Medi-Cal for former recipients (after the Edwards category). Medically Needy rates rose further in the first year after CalWORKs, combining with the steep rise in Edwards coverage to drive the 1998 increase in former recipients' Medi-Cal take-up. More recently, though, while the 1931(b) program has exploded, the Medically Needy program has waned and contributed little to the most recent rise in former recipients' Medi-Cal enrollment. Beginning in 1999, however, Medically Needy enrollment fell and ceased to contribute to the overall rise. The need for it had fallen with the emergence of 1931(b), with its broader coverage options.

FEW DIFFERENCES IN PROGRAM-SPECIFIC RATES BY AGE AND RACE-ETHNICITY

When we examine the take-up rates in these programs separately for adults and children and for different racial-ethnic groups, we find similar results. Despite expanded eligibility in Transitional Medi-Cal for adults and the Percent Programs for children, these two programs are not the driving forces behind the increase in adult's and children's Medi-Cal take-up. Instead, the Edwards and 1931(b) categories are responsible for the increase in enrollment for both groups, explaining all of adults' and most of children's rise in Medi-Cal take-up.

By race-ethnicity, the increase in enrollment was also driven by rates in the Edwards and 1931(b) programs, which grew quickly after CalWORKs was instituted. These two programs also explain the divergence between whites' enrollment rates and those for Latinos/-as, African Americans, and other racial-ethnic groups in 2000. Although the rates for all four groups were quite similar at the start of CalWORKs, enrollment among whites leveled off in these programs in 2000 while that for the other three groups continued to rise.

4. ARE FORMER RECIPIENTS FOLLOWING THE EXPECTED PATH IN USING PROGRAMS?

In Section 3, we discussed which programs contributed to the increase in former recipients' Medi-Cal enrollment that we saw in Section 2. Beyond gross enrollments, we are also interested in how former recipients are moving through the various programs, whether they are transitioning among the programs in a way that maximizes their coverage. The design of the programs implies that recipients would take a specific path through the programs over time. If they are not taking this path, then former recipients may not be getting the full benefits laid out in the policies.

When we conduct the analysis, we find that recipients are not following all transitions indicated in the policies. Here, we discuss this finding in more detail, starting first with a discussion of what path through the different programs is expected.

GIVEN THE ESTABLISHED POLICY, FORMER RECIPIENTS WERE EXPECTED TO TAKE SPECIFIC PATHS IN USING PROGRAMS

The many changes to Medi-Cal policy during the late 1990s suggest a particular path, or set of paths, through the various Medi-Cal programs that we would expect most people to follow after they leave AFDC/CalWORKs. The simplest version of this path rests on the assumption that the earnings of those leaving welfare rise through time. This path is illustrated with the bold boxes in Figure 4.1. After leaving CalWORKs, we would expect people to move into the Edwards program with its automatic rollover from cash aid. Once redetermination was complete, people would then move either into Section 1931(b) with Transitional Medi-Cal to follow when their earnings rose, or directly into Transitional Medi-Cal, if their earnings and assets were too high for 1931(b). Assuming these people's earnings continue to rise, they would eventually move off Transitional Medi-Cal and into private health insurance or, among children, into one of the Percent Programs or the Healthy Families program.

Because people's earnings do not always steadily rise, there are additions to this path, illustrated in Figure 4.1 with dotted lines.

For people who move from Edwards to 1931(b) to Transitional Medi-Cal and then experience a drop in income, we would expect a return to 1931(b) if the decline qualified them for that program again. If they are ineligible for 1931(b) or if they have been unable to obtain private health insurance before their Transitional Medi-Cal benefits end (12 months for children and 24 months for adults), they may qualify for the more traditional Medically Needy coverage. Similarly, if they move directly from Edwards into Transitional Medi-Cal and their incomes fall or simply fail to keep rising, they may re-qualify for Section 1931(b) or, alternatively, for the Medically Needy program. Children, of course, can move into the Percent Programs at any time that they qualify. Finally, left off this figure for the sake of simplicity are other possible transitions: leaving Medi-Cal entirely (whether for another source of health insurance or for no insurance) and returning to CalWORKs.

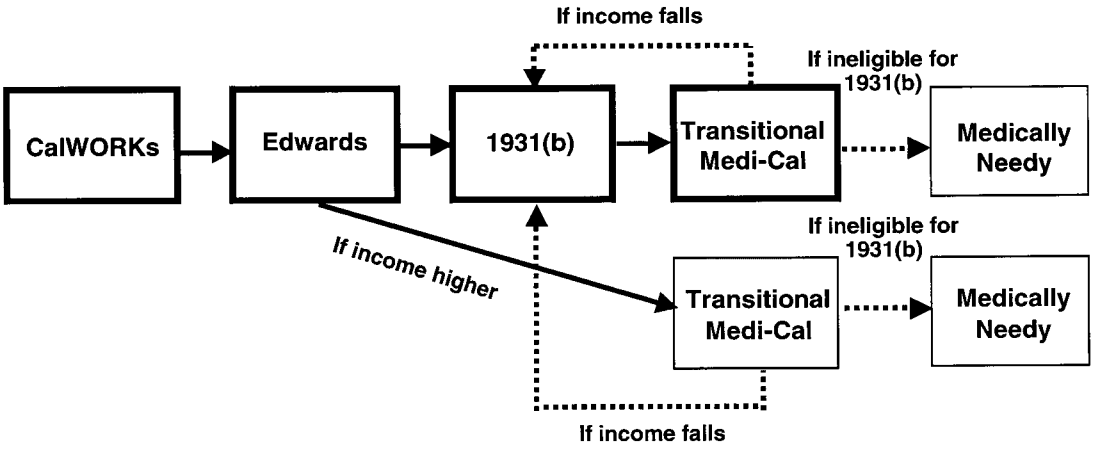

Figure 4.1--Expected Paths for Former Recipients

We note that the more traditional Medically Needy program does not clearly or easily compare to 1931(b) in terms of eligibility requirements, which are similar but not identical between the two programs. However, with regard to benefits, the Medically Needy program is less desirable than the 1931(b) and Transitional Medi-Cal programs. Section 1931(b) is preferable as a potential first stage in the path because it is not time-limited and because, unlike the Medically Needy

program, it provides eligibility for Transitional Medi-Cal's benefits. Transitional Medi-Cal is important because it has a higher income ceiling than either the 1931(b) or Medically Needy programs. People receiving Transitional Medi-Cal may gain earnings without penalty that are higher than is possible for people receiving Medically Needy coverage. Transitional Medi-Cal is the only program geared toward former recipients that has as high of an income threshold. Its eligibility is restricted to those coming directly from CalWORKs or 1931(b); people cannot move into it from the Medically Needy program. In addition, persons enrolled in the Medically Needy program can carry a share of cost, as noted earlier, and this reinforces its lesser desirability compared to the 1931(b) or Transitional Medi-Cal programs. Thus, Medically Needy becomes the last stage of our transition chart.

Based on these program specifications, we would expect to see people leaving CalWORKs move into the Edwards category, those leaving Edwards move into 1931(b) or Transitional Medi-Cal, and those leaving 1931(b) move into Transitional Medi-Cal. To a lesser degree, we would also expect to see former cash aid recipients cycling back onto 1931(b) as well as moving into the Medically Needy program.

FORMER RECIPIENTS ARE NOT TAKING ALL THE EXPECTED TRANSITIONS

When we examine the enrollment data, we find that former cash aid recipients' Medi-Cal enrollment follows some of these transitions but not others. Table 4.1 contains the frequency of all possible transitions from one of these programs to another. The left-most column in the table refers to the type of Medi-Cal in the last month; the top row refers to the type in the current month; and the cells refer to the frequency of transitions between the two. The frequencies should be read horizontally; for example, 43.1 percent of those who left a status of no Medi-Cal returned to CalWORKs. In most months, former recipients retain the same kind of Medi-Cal that they had in the previous month; indeed, only 3.0 percent of recipients in this group moved from any one of these categories to another. Because of this relative infrequency, we restrict this table to those months where people actually make a transition from one type of Medi-Cal to another. (This is why the

diagonals are all zero.) The table thus shows the probability of moving from one program to another, conditional on a transition having occurred that month. It represents all possible transitions. Those below and to the right of the internal lines (between Edwards and Other) are transitions from one Medi-Cal program to another. Finally, we use data from only the most recent recipients, those who left cash aid in 1999 or 2000, and we limit it to the first 24 months after leaving cash aid because of the low enrollment in the third year after leaving.

Table 4.1--Month-to-Month Transitions by Program Type: Probability of Transitions, Conditional on Transition Occurring That Month

Current month / Last month	No Medi-Cal	Return to CalWORKs	Edwards	1931(b)	TMC*	Med. Needy	Other	Total
No Medi-Cal	0.0	43.1	1.9	22.0	0.2	18.1	14.8	100
CalWORKs	11.8	0.0	59.7	11.2	3.2	9.4	4.6	100
Edwards	42.5	21.8	0.0	24.5	2.1	5.8	3.3	100
1931(b)	67.1	15.5	0.5	0.0	3.6	10.4	2.9	100
TMC*	18.1	10.3	47.8	10.8	0.0	7.7	5.3	100
Medically Needy	45.0	19.0	1.0	19.3	2.2	0.0	13.6	100
Other	16.1	1.9	52.0	19.0	3.6	7.5	0.0	100

Note: First 2 years off CalWORKs, January 1999 to December 2000.
*TMC = Transitional Medi-Cal.

We note that the most common transition out of most types of Medi-Cal (outside of CalWORKs participation) is to leave Medi-Cal entirely. Former recipients who are enrolled in Edwards, 1931(b), or Medically Needy are more likely to have no Medi-Cal after these programs than to enroll in another Medi-Cal program. Roughly two-thirds of those in Section 1931(b) and over two-fifths of those in the Edwards and Medically Needy programs leave Medi-Cal when they leave those categories. Recall, however, that our data do not allow us to determine eligibility and that persons leaving Medi-Cal may or may not have other forms of health insurance.

The transitions reported in Table 4.2 follow some of the expected paths but not others. Figure 4.2 summarizes how the expected path shown earlier is supplemented by the additional program transitions observed in the data (shown in bolded arrows). These additional transitions include moving directly from the Edwards category into the Medically Needy program or from 1931(b) directly into the Medically Needy program. Both of these transitions bypass Transitional Medi-Cal. However, once recipients are enrolled in the Medically Needy program, they cannot move from there back into Transitional Medi-Cal.

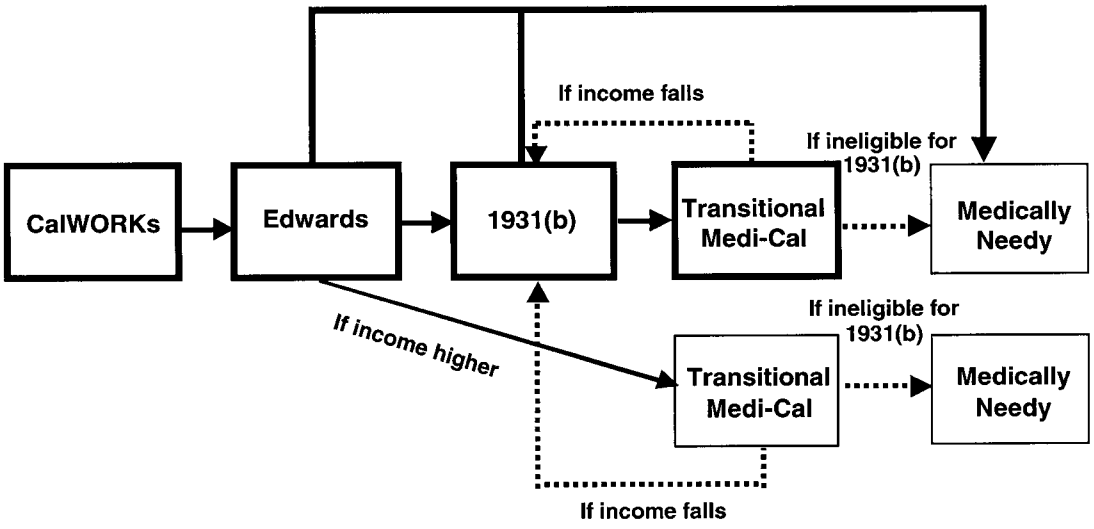

Figure 4.2--Actual Paths for Former Recipients

Our interviews with CWD staff help explain these additional transitions. Moving from Edwards directly into the Medically Needy program may occur partly because some counties continued to process former recipients with Medically Needy and Transitional Medi-Cal while they waited for the 1931(b) regulations to be completed. Moving from 1931(b) directly into the Medically Needy program is curious and suggests that the order of programs that maximizes clients' coverage has not been clearly understood. In fact, CWD staff reported a great deal of confusion about the relationships among these various programs. While their goal was clearly to obtain the most and best Medi-Cal coverage for their clients, they also described the task of establishing a priority order among the programs as arduous and unclear.

When we follow the path that we expect former cash aid recipients to take through these different Medi-Cal programs, we find, as shown in Figure 4.2, that some of the expected transitions are supported by the data more than others. We begin by examining recipients' first transition, out of CalWORKs. The data do support this first transition in the expected path, since the Edwards category is the most common form of when people leave CalWORKs. Over one-half of the people leaving CalWORKs (either after their first cash aid spell or after a return to cash aid) move into Edwards, 59.7 percent. What is surprising is that nearly half the people leaving CalWORKs do not move into Edwards. Some people do not retain Medi-Cal, 11.8 percent, and the remainder move directly into another Medi-Cal program, usually 1931(b) or Medically Needy. 1931(b) enrolls 11.2 percent of those leaving CalWORKs, and 9.4 percent move directly into the Medically Needy program; 3.2 percent move into Transitional Medi-Cal, and 4.6 percent move into other programs.

Looking at the next expected stage, out of Edwards, we see that people leaving the Edwards category are most likely to leave Medi-Cal altogether, as noted above. An additional one-fourth (24.5 percent) move into 1931(b), the transition expected under the new policy. However, nearly as many return to CalWORKs, 21.8 percent. Others leaving Edwards enter the Medically Needy, Transitional Medi-Cal, and other programs.

When people stop being enrolled in 1931(b), they are by far most likely to leave Medi-Cal entirely, compared to continuing with another program. Moreover, the second most likely transition is returning to CalWORKs, which 15.5 percent of those leaving 1931(b) do. Beyond these two possibilities, the most common form of Medi-Cal after 1931(b) is the Medically Needy program, enrolling 10.4 percent of former recipients. Only 3.6 percent of people leaving 1931(b) move into Transitional Medi-Cal, the transition we would expect under the new policy. Finally, less than one percent return to the Edwards category (0.5 percent), and 2.9 percent move into other forms of Medi-Cal.

Unlike the other programs, people who leave Transitional Medi-Cal are most likely to move into the Edwards category. Nearly one half of those exiting Transitional Medi-Cal are enrolled in Edwards, 47.8

percent. This may be a temporary phenomenon resulting from the necessary re-evaluation of every person's eligibility under the new 1931(b) rules; counties may be temporarily placing Transitional Medi-Cal cases into Edwards to avoid using up people's limited Transitional Medi-Cal time while they await redetermination. We note, however, that the total number of people leaving Transitional Medi-Cal is relatively small, as it enrolls only 2.0 percent of former recipients in these transition months (data not shown). After Edwards, leaving Medi-Cal altogether is the next most likely transition for people who stop getting Transitional Medi-Cal, with 18.1 percent leaving Medi-Cal. Another sizeable minority either enter Section 1931(b) or return to CalWORKs, 10.8 percent and 10.3 percent, respectively. Finally, nearly as many move into the Medically Needy program, 7.7 percent, or into other programs, 5.3 percent. Thus, in contrast to what the policy indicates, many former recipients do not leave Medi-Cal when they move out of Transitional Medi-Cal. They are actually more likely than people leaving the Edwards, 1931(b), or Medically Needy categories to retain Medi-Cal through another program.

Finally, we note the transitions among former recipients leaving the Medically Needy program, since it is also relatively common. Nearly half of those who stop getting Medically Needy leave Medi-Cal entirely, as noted. The next most common transition is a return to CalWORKs, done by about one-fifth (19.0 percent) of those in Medically Needy. About as many people move into Section 1931(b) (19.3 percent), which again likely reflects the redetermination process of the new policy. A small percentage move into Transitional Medi-Cal (2.2 percent) and the Edwards category (1.0 percent), while 13.6 percent of those in the Medically Needy program retain their Medi-Cal by moving into other programs.

Taken together, these transitions suggest three points about the role that the Medi-Cal programs play in former recipients' continued enrollment. First, the 1931(b) program appears to be taking hold. It plays a consistent part at each of the transition points, indicating that it is being considered for people newly off cash aid and for redetermination among people already enrolled in another program.

Second, Transitional Medi-Cal may be being overlooked. People leaving CalWORKs or Edwards are less likely to be enrolled in Transitional Medi-Cal than in any other single program, and for those leaving 1931(b), Transitional Medi-Cal is the second least likely destination.

Finally, the relatively high frequency of Medically Needy enrollment is surprising. Its eligibility requirements can be stricter (although this is not always the case), and it can include a share of cost, the requirement that recipients contribute financially to their health care costs. Despite these characteristics, people are more likely to move into the Medically Needy program than into Transitional Medi-Cal from any other program shown. Thus, the presence of 1931(b), with 16.1 percent of all transitions, the relative absence of Transitional Medi-Cal, with 1.7 percent of all transitions, and the presence of Medically Needy, with 10.3 percent of all transitions (data not shown) suggest that both understanding and confusion about the different programs and the relationships among them exist in county welfare departments.

5. HOW DO COUNTIES VARY ON THESE CHANGES IN COVERAGE?

The previous three sections examined state-level issues related to the Medi-Cal enrollment of former welfare recipients. However, we also want to know how the individual counties--which implement the various policies and programs--vary in terms of the increase in enrollment we have seen. To illustrate the state-level patterns in greater detail, we examine how these patterns vary across counties, both across all counties and in greater depth in six selected counties where we also conducted qualitative field work: Alameda, Butte, Fresno, Kern, Sacramento, and San Diego. These counties were chosen because they represent a range of regions, geographic sizes, population sizes, and political climates. These county analyses provide an important context about the *process* of implementation that help us understand the trends in enrollment produced by the MEDS data.

We find that there is substantial variation by county in the amount of increase in Medi-Cal take-up and in the use of different Medi-Cal programs. We relate this variation to differences in how counties addressed the Edwards hold and in their subsequent implementation of 1931(b).

THE 58 COUNTIES SHOW WIDE VARIATION IN ENROLLMENT BUT A SIMILAR OVERALL PATTERN

Medi-Cal enrollment among former cash recipients varies widely between 1990 and 2000. Table 5.1 illustrates this variation by showing the enrollment rate among former cash recipients who had been away from CalWORKs for exactly twelve months in 2000. The graph shows the percent enrolled at month twelve. The statewide average enrollment rate for this group is 48.5 percent, but the averages by county span a much broader range: between 31.3 percent (San Bernardino County) and 87.8 percent (San Francisco County) of former recipients in their twelfth month after leaving CalWORKs had Medi-Cal, depending on the county. (See Table A.1 in Appendix A for the enrollment rates by year.) This wide range appears to reflect differences across the counties in their use of the key programs.

Table 5.1--Percent of Former CalWORKs Recipients Enrolled in Medi-Cal in 2000, by County

County	Enrollment	County	Enrollment
Alameda	73.6	Orange	41.0
Alpine	32.6	Placer	35.6
Amador	45.6	Plumas	50.7
Butte	41.9	Riverside	47.3
Calaveras	64.5	Sacramento	48.5
Colusa	49.6	San Benito	35.9
Contra Costa	43.0	San Bernardino	29.9
Del Norte	43.3	San Diego	46.6
El Dorado	29.8	San Francisco	78.2
Fresno	57.6	San Joaquin	37.8
Glenn	47.5	San Luis Obispo	47.8
Humboldt	39.4	San Mateo	36.3
Imperial	44.9	Santa Barbara	47.9
Inyo	35.3	Santa Clara	38.2
Kern	34.8	Santa Cruz	35.9
Kings	39.4	Shasta	40.8
Lake	37.6	Sierra	17.7
Lassen	33.5	Siskiyou	41.4
Los Angeles	61.2	Solano	34.6
Madera	37.3	Sonoma	39.7
Marin	38.0	Stanislaus	38.6
Mariposa	35.1	Sutter	45.2
Mendocino	41.4	Tehama	41.4
Merced	49.3	Trinity	36.9
Modoc	32.3	Tulare	40.6
Mono	20.0	Tuolumne	43.5
Monterey	37.0	Ventura	39.3
Napa	41.5	Yolo	40.7
Nevada	41.4	Yuba	37.7

Figure 5.1 offers an example of the variation in program enrollments using eight counties: the six counties we interviewed plus the extremes. The figure illustrates how counties vary not only in overall Medi-Cal rates (Table 5.1) but in program-specific rates as well. Counties that developed Edwards backlogs were still processing them in 2000 (the black part of the bars), with Edwards enrollment ranging from 0 percent to 62.0 percent. Other counties continued to have higher than expected Medically Needy enrollment (the white part of the bars); it ranged from 0.7 percent to 23.3 percent (data not shown). Most counties had begun to engage the new 1931(b) program (the light gray part of the bars), but the degree of enrollment ranged from 0 percent up to 37.5 percent (data not shown). Finally, Transitional Medi-Cal enrollment (the dark gray part of the bars) also ranged widely, from 0 percent to 11.9 percent (data not shown).

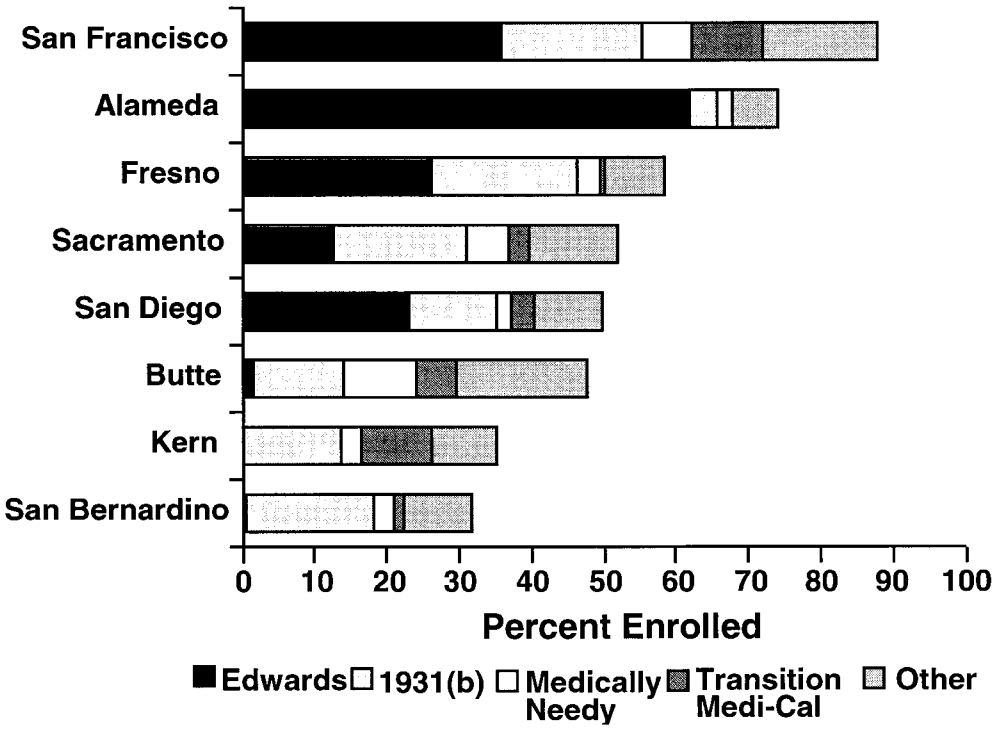

Figure 5.1--Variation Among Selected Counties

These variations are the result of several factors involved in implementing the many changes to Medi-Cal that accompanied CalWORKs,

including the Edwards backlog and 1931(b) addition. This variation may diminish as counties process remaining Edwards backlogs and continue to shift away from traditional use of the Medically Needy program. Whether or not county enrollment patterns become more similar will depend on their continued implementation of Section 1931(b), their rates of Transitional Medi-Cal enrollment, and their outreach efforts to persons moving off of CalWORKs. We describe the factors that have led to this variation in greater detail below.

IN IMPLEMENTING THE NEW PROGRAMS, THERE WERE SOME COMMON THEMES ACROSS THE COUNTIES

Our visits to the six counties revealed that while the counties are implementing the changes to Medi-Cal that accompanied CalWORKs, this process has involved a number of difficulties. We describe the process of implementation and the recurring issues faced by counties, since these issues likely affect both the process for these counties and implementation statewide. The common themes include the timing and clarity of the recent Medi-Cal guidelines, the role of data systems, the increasing complexity of Medi-Cal programs, and the need for more staff to handle the workload that increased with these changes.

Timing and Clarity of the Post-CalWORKs Medi-Cal Guidelines

With the start of CalWORKs in January 1998, CDHS directed counties to provide all persons leaving cash aid with temporary Edwards enrollment, until the accompanying Medi-Cal regulations were developed. The first preliminary version of the 1931(b) guidelines came in September 1998, and additional All County Letters (ACLs) followed that refined its specifications. Counties reported that these follow-up guidelines stabilized around April 1999 with more detail about 1931(b). Officially, however, the regulations are not yet finalized, and counties continue to receive occasional clarifications and changes to the existing guidelines.

The amount of time that elapsed before counties had working 1931(b) guidelines--combined with record increasing numbers of people leaving cash aid as welfare rolls fell--meant that Edwards cases piled up rapidly in many counties. Although the direction to hold people in

Edwards came from CDHS, pressure to eliminate these backlogs grew in other corners of the state. By 1998, most former cash aid recipients were enrolled in health maintenance organizations (HMOs), which, in contrast to the old fee-for-service (FFS) programs, charge the state a capitation fee for each enrollee every month. The state incurs these charges whether or not Medi-Cal clients use their benefits or even know they are still enrolled. Because the backlogged Edwards cases undoubtedly included some persons who would not remain eligible for Medi-Cal under the new regulations and some who were not aware they were still enrolled, these excess capitation charges came to be viewed as a drain on the state's budget (LAO 1999, 2000). CDHS therefore received direction--which it in turn passed on to counties--to eliminate the backlog of Edwards cases as quickly as possible. Eliminating the backlogs would reduce the state's Medi-Cal costs, which had overrun their estimate budgets (LAO 1999, 2000).

However, such rapid elimination was complicated and delayed by six factors. First, the time involved in finalizing the new regulations meant that counties had to wait before they could finalize their implementation plans. Second, and relatedly, the delay in implementation meant that eligibility and even contact information for many of the backlogged cases were out of date by the time counties were ready to implement the new program. Locating people added to processing time. Third, the new regulations increased the number of Medi-Cal programs, and this meant that determining eligibility simply took more time because each program has unique requirements. Fourth, this labor-intensive process was exacerbated by the lack of automation in determining eligibility. Fifth, the high volume of backlogged cases and increased workload meant that counties had staffing shortages that they had to solve before they could process much of the backlog or apply the new programs.

Finally, counties' particular strategies for implementation often required additional time to develop. Whether counties had Edwards backlogs or not, they had to interpret the new 1931(b) regulations and develop plans to implement them. These processes were complicated by the fact that CDHS was adjusting the guidelines at the same time that

counties were developing plans. Many counties simply waited until the guidelines seemed relatively stable--April 1999--before devising their strategies for interpreting and implementing the new program. Interpreting the guidelines meant, first, understanding the policy and, second, translating it into actual procedures for staff to use.

Especially while the guidelines were incomplete, counties reported substantial difficulty in understanding them and, specifically, in how they applied under different circumstances. This meant further communication with the state and with other counties (e.g., at welfare directors meetings) to clarify the policy's intent and to determine how the 1931(b) program related to other Medi-Cal programs to maximize former recipients' enrollment. All the counties we interviewed did have a clear knowledge of the program, but *when* that knowledge was clear for them varied tremendously, from late summer 1999 to early spring 2001. Once understood, translating the guidelines into actual procedures required staff training and a fair amount of trial and error as caseworkers determined how 1931(b) affected different household types and related to other programs. Thus, working through the Edwards backlog required an enormous effort that continued well into 1999 and 2000 as counties processed both the volume of backlogged cases and the continuing stream of new welfare leavers.

The Role of Data Systems

Our interviewees consistently stressed the importance of computer systems for implementation. The procedures for redetermining Medi-Cal eligibility are not automated. The task includes calculating a new family budget for each program tested for eligibility and often for different household members as well. Staff reported that the lack of automation alone has added significant time to processing backlogged Edwards cases and implementing 1931(b). Moreover, it requires a thorough understanding of the regulations of each program, how they interrelate, and how they apply to complex family structures. As of spring 2001, the newest Medi-Cal programs, including 1931(b), were not yet in the computer systems that counties use to process public assistance programs. Rather, county staff must determine eligibility

manually for 1931(b), as well as for any other program when 1931(b) requirements are not met.

Combining staff reports of the specific tasks involved in processing Medi-Cal with further analysis of our administrative data suggests additional insights. California's 58 counties use four different computer systems to operate their public assistance programs, including Medi-Cal. Table 5.2 lists the counties by system.

Table 5.2--Which of California's Welfare Processing Data Systems the Counties Use

Data System	County
SAWS	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Monterey, Napa, Nevada, Plumas, San Benito, San Joaquin, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba
WCDS	Alameda, Contra Costa, Fresno, Orange, Placer, Sacramento, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Tulare, Ventura, Yolo
C-IV	Merced, Riverside, San Bernardino, Stanislaus
LEADER	Los Angeles

Caseworkers in Butte County, running the Statewide Automated Welfare System (SAWS), reported that a backlog of Edwards cases was not a problem. Similarly, in discussions with Kern County staff, we learned that in SAWS, it was almost impossible to keep former recipients in the Edwards category indefinitely, despite the fact that CDHS requested them to do so. Consistent with this perspective, we found that 37 of California's 58 counties did not have notable increases in Edwards enrollment and that 29 of these counties used the SAWS. Only six of the 35 SAWS counties appeared to have even slight increases in Edwards enrollment. Thus, most of the counties using SAWS do not appear to have preserved former recipients' Medi-Cal after CalWORKs until their eligibility could be redetermined with 1931(b). Rather, they appear to have continued processing them with the programs available before CalWORKs began.

In contrast, most counties using the other large consortium, the Welfare Client Data System (WCDS), appear to have had large Edwards

backlogs. Indeed, the enrollment data show remarkable rises in Edwards enrollment in 13 of the 18 counties using the WCDS. Many of these counties have large populations, which is why Edwards enrollment rose statewide. Administrative and eligibility staff in four of these counties--Alameda, Fresno, Sacramento, and San Diego--described the Edwards backlogs they developed and the procedures they later used to process them.

Only five counties use either of the other two systems, and the situation there appears intermediate. Los Angeles, using the Los Angeles Eligibility Automated Determination, Evaluation, and Reporting System (LEADER), showed a sizeable increase in Edwards enrollment, as did one of the Consortium IV (C-IV) counties. The other three C-IV counties did not have notable increases in the Edwards category.

These variations by computer system suggest that even to the degree that redetermination is automated, it may not be done so accurately. That is, counties' implementation of the new programs may be stunted not only by the lack of inclusion of new programs and new requirements into their data systems, but also by an inability to overcome that exclusion.

Increasing Complexity of the Medi-Cal Programs

Related to the difficulties involved in incorporating the new 1931(b) program is the fact that the number and complexity of Medi-Cal programs is growing. There are currently over 25 Medi-Cal programs in existence, most with multiple subcategories (over 120 across all the programs) that have separate requirements and benefits (Page and Ruiz 1999). Although former cash recipients tend to be concentrated in a small number of programs, caseworkers have to work with the whole series to ensure enrollment for those who are eligible. The growing number has added to the workload and time needed for redetermining former recipients' eligibility and for implementing the recent changes in two ways. First, the volume of regulations has grown along with the number of programs. Each program has unique eligibility requirements, with which caseworkers need to be familiar. Moreover, because the guidelines changed so frequently, CDHS stopped printing the manual that lists them. As a result, departments and caseworkers do not have an up-to-date

reference of eligibility criteria.[5] Second, the number of budgets that caseworkers have to calculate for eligibility has also grown along with the number of programs. Each time a caseworker determines if a person is eligible for a certain program, a family budget based on that person's family income and assets must be calculated. These budgets need to be prepared anew for each program tested, because they all have unique criteria, and sometimes they must be calculated separately for each person. Thus, the recent explosion of new Medi-Cal programs has meant that processing cases requires more knowledge and more time and is more complex than it used to be.

The difficulty of working with this complexity appears to be a broader issue than staff training alone can address. In all of the counties we visited, Medi-Cal staff had undergone specialized training for the Medi-Cal programs and regulations that were new with CalWORKs. Some counties waited to hold training until after the 1931(b) regulations stabilized, while other counties conducted earlier training, which they later supplemented as regulations changed. Whatever the approach, caseworkers reported that training alone was insufficient for using the new programs. Only by repeated experience working with the regulations did they become familiar with how eligibility criteria and benefits overlap and how to make decisions among the many possible outcomes for any one person.

In addition to the complexity of Medi-Cal, family and household structures have become increasingly complex over the last couple decades, complicating redetermination further (McLanahan and Casper 1995). Multiple family relationships may exist in the same household, and when combined with the different qualifications of Medi-Cal programs, this means that providing the most possible benefits to one household can involve the use of many Medi-Cal programs. Caseworkers often have to evaluate individual members of a family separately, and, as noted, recalculate family budget units for each one. Staff members

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[5]Counties can purchase a privately published version of this manual, *Barclay's*, but it does not include finalized 1931(b) regulations, since they do not yet exist, and counties usually choose not to pay the expense.

reported that on occasion, the same case may be covered by as many as six different programs.

Need to Increase Staffing to Deal with Changes

The greater number and complexity of Medi-Cal programs, the greater complexity of family structure, and the lack of automation combine to create a higher Medi-Cal workload and a need for more staff. This is in addition to extra staff needed to process the Edwards backlog. CalWORKs required more staff than the old AFDC program needed (Klerman et al., 2001), and the Medi-Cal programs accompanying the policy have increased departments' staffing needs further. All the counties we visited hired at least some new Medi-Cal workers, a process that took additional time and meant further delay for the Edwards processing and 1931(b) implementation in most counties.

Counties that had Edwards backlogs experienced an ever greater increase in the Medi-Cal workload, in order to process the backlogged cases. They dealt with staffing the backlog in a variety of ways, including hiring new workers, shifting existing workers from other tasks to the backlog, and authorizing overtime work and pay, with some counties using a combination of these strategies. Even with the staffing increases in place, the backlog was large enough that it required extensive time to complete, at least a year in most of the counties we visited. Once the Edwards backlog is eliminated, however, these counties will continue to have a higher Medi-Cal workload than they had prior to CalWORKs because of the reasons noted above and because many have begun outreach efforts to raise enrollment further.

The general result of these various obstacles was a lengthening of the time it took to process the Edwards backlog and implement Section 1931(b). The consequences in particular counties depended on how counties interpreted the guidelines and how quickly they were able to make sense of them, how quickly counties were able to staff their programs, and what particular issues were operating in counties that affected these timelines. Faster processing of the Edwards backlog in some counties was primarily the result of staffing differences and the different allocation of resources to the backlog.

6. CONCLUSIONS

The findings presented in this document give rise to conclusions for former cash aid recipients, CWDs and their staff, and the state of California. These conclusions fall into two areas, and we discuss these two areas in this section.

MEDI-CAL COVERAGE OF FORMER CASH AID RECIPIENTS HAS RISEN SINCE CalWORKs, REVERSING AN EARLIER TREND

The recent increase in Medi-Cal enrollment among former cash aid recipients is the most significant finding of this research, and it carries important conclusions. First, the rise in enrollment has meaning for those leaving welfare. Even though not every former recipient retains Medi-Cal for most of these first three years, increasing numbers of them do, and this is a reversal of a long-term trend. In addition, the likely corollary of this growing coverage is that former recipients are undoubtedly less likely to be uninsured or underinsured than they were before CalWORKs. Finally, to the degree that former recipients in past years were obligated to rely on cash assistance to obtain health care coverage, they are less likely to do so today, since they are more likely to retain it without cash aid today. This trend is in direct accord with the Medi-Cal policies of expansion of access and eligibility that accompanied welfare reform. At the same time, the fact that some of the increase in enrollment was due to a temporary phenomenon, the Edwards hold, means that we need to temper our enthusiasm. As the Edwards backlog is eliminated, the increase in enrollment is likely to slow and may even reverse. Whether the increase will continue will likely depend on the continued implementation of 1931(b) and Transitional Medi-Cal and on county outreach efforts to retain former recipients in the Medi-Cal program.

The increase in Medi-Cal coverage among former cash recipients also indicates that CWD staff are implementing the new programs with some accuracy. We would expect an increase in Medi-Cal enrollments to accompany the roll out of 1931(b), given the new program's eligibility rules. Thus, the relatively high and increasing participation in

1931(b) suggests that once staff began to apply the new program, they have been doing so as the policy intended. Moreover, that enrollment continued to increase even after the Edwards backlog was being processed strengthens the idea that staff are enrolling former recipients in 1931(b) as directed. It also supports the idea that outreach efforts beginning to be made by CWDs to continue former cash recipients' Medi-Cal are succeeding. At the same time, the fact that former recipients are not moving through all the expected transitions between programs indicates that CWDs are not implementing the changes with complete accuracy. CWDs have further to go to ensure coverage to all eligible persons leaving CalWORKs, particularly in terms of Transitional Medi-Cal and Percent Program enrollment.

For CDHS and the state of California, the rise in coverage indicates that the programs that the Department has put into place over the last several years are in fact helping people to retain Medi-Cal after they leave CalWORKs. Although many former recipients do not continue their Medi-Cal, the trend in enrollment has reversed, and this suggests that the current programs are having an impact. Encouraging more thorough application of these new programs, including outreach efforts and especially among those with low enrollments (Transitional Medi-Cal and the Percent Programs), appears to be indicated next.

Finally, the rise in Medi-Cal take-up is in contrast to previous research and is a direct result of examining individual-level data on former AFDC/CalWORKs recipients rather than aggregate-level data on a broader group. This draws attention to the importance of using such individual-level data, despite the far greater access and ease of aggregate tabulations. Relatedly, when only less precise data are available, the results here point to the critical need to interpret findings based on them with caution.

IMPLEMENTATION OF RECENT MEDI-CAL POLICY HAS BEEN DIFFICULT, AND FURTHER ASSISTANCE FROM THE STATE IS NEEDED

The findings raise some additional concerns. Medi-Cal has become increasingly complex, and this affects caseworkers' efforts to give recipients the best possible coverage. In addition, counties have been

unclear about CDHS guidelines, and this affects how and how well they interpret and implement Medi-Cal policies.

One of the clear findings from the qualitative interviews was the increasingly complex nature of Medi-Cal. The number of programs is growing, but even more, new programs develop independently of each other, with each bringing slightly different eligibility rules. The trend in Medi-Cal policy--toward greater access and eligibility--has been enacted largely one program at a time. Consequently, the growing breadth of coverage has been accompanied by more and more regulations and by more and more interactions among programs.

The most direct consequences of this trend are experienced by caseworkers, whose jobs have changed dramatically over the past several years. Medi-Cal caseworkers today have a greater number of steps to take and greater confusion about those steps to get to their goal of identifying the best Medi-Cal coverage for a recipient. Staff members' workload has increased, and with it, the chance of error has increased as well. This, in turn, means that recipients have a higher chance of being enrolled in a program that may not offer them the best coverage, or of being erroneously dropped from Medi-Cal entirely. These chances are made even greater by the fact that automation has not kept pace with the program changes. Even if caseworkers were perfectly accurate, the changes necessitate spending more time interpreting and evaluating programs, which makes it harder to work with clients individually. Thus, the movement toward greater access and eligibility for recipients is accompanied by a danger that they may actually be worse served.

The extreme variation across counties in overall enrollment and in the use of specific programs provides some evidence of this danger. Different interpretation of new regulations and different strategies for implementation and outreach have meant that the chance of retaining low or no cost health care after one leaves CalWORKs depends in part on the county where one lives. This is the case in terms of many Medi-Cal programs but it is particularly evident with regard to implementing 1931(b). How counties interpreted the state's directives for determining Medi-Cal eligibility in 1998 and 1999 demonstrates how this confusion can contribute to inadequate or inaccurate enrollment. That

half of California's counties evaluated former recipients' eligibility for programs such as Transitional Medi-Cal and Medically Needy as they had before CalWORKs while the other half retained their Medi-Cal coverage by holding them in the Edwards category is striking, and both of these approaches have important consequences.

Processing cases without the 1931(b) regulations means that some people undoubtedly received less coverage than they would have received with 1931(b), while the extended use of Edwards undoubtedly meant that some people received more coverage than they would have received with earlier redetermination. Those enrolled in Transitional Medi-Cal faced time limits that they would not have faced in Section 1931(b), while those enrolled in Medically Needy programs may have had to pay a share of cost that is not required by 1931(b). In contrast, former recipients in counties that placed people in the Edwards hold kept their coverage, but staff shortages and confusion about the timing of the 1931(b) regulations meant that recipients did not always know they still had coverage. In addition, counties that did not develop an Edwards backlog had a much lower staff burden than counties that did develop a backlog that subsequently had to be processed. Finally, the Legislative Analyst's Office (LAO) has made clear the negative impact that the Edwards backlog had on the state's budget.

Finally, the post-CalWORKs changes to Medi-Cal policy, including the 1931(b) program, indicate a particular order of Medi-Cal programs that former recipients would follow to have the greatest chance of continuing coverage. The fact that not all transitions in this path were as common as expected provides additional empirical support for the implication that some people may not be receiving all possible benefits or may be incurring an unnecessary share of cost. It also supports the idea that the counties and possibly the state are still unclear about the relationship among some of these programs.

The growing complexity of Medi-Cal, combined with the difficulty that county staff have had in understanding the new regulations and the evidence that some former recipients are not getting the full possible benefits, suggests that CDHS needs to provide additional support to counties. Such support needs to clarify the requirements of the current

programs and how they relate to each other. By assisting the counties to enact the policies more fully and accurately, the positive direction in which enrollment has moved in the past three years will be more likely to continue.

A. MEDI-CAL ENROLLMENT BY AGE AND RACE-ETHNICITY

AGE

Medi-Cal enrollment can differ for adults and children because certain programs are aimed at specific age groups. Figure A.1 shows enrollment rates for adults and children between 1990 and 2000. Children in this analysis are defined as persons age 0-18.

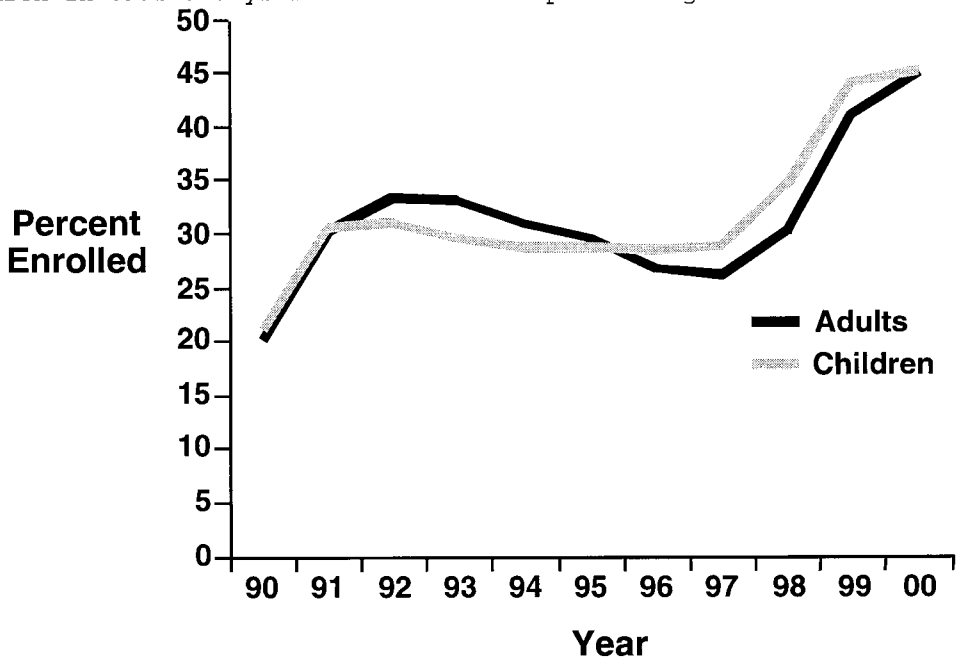

Figure A.1--Medi-Cal Enrollment Rates by Age and Year

The figure indicates, first, that adults and children follow a similar pattern to what we have seen earlier, with a rise in the early 1990s, a gradual decline in the mid 1990s, and steep increases in enrollment after 1997. Second, we see that adults and children have basically the same enrollment pattern over the decade. The trend for children is slightly smoother, as adults' enrollment rose higher in the early 1990s and fell lower in the middle of the decade. When CalWORKs began, enrollment for both groups increased sharply. The two rates converged after CalWORKs and were virtually identical in 2000.

We can also compare age-specific enrollments in different Medi-Cal programs to better understand the contributions of specific programs to adults' and children's rise in take-up since CalWORKs. Some Medi-Cal programs are designed for particular groups, which may leave their impact underrepresented in an analysis of their frequency in the population as a whole. The most important of these programs are Transitional Medi-Cal, which expanded to a total of 24 months for adults, and the Percent Programs, which extended coverage to low-income children. Given the post-CalWORKs rise in Medi-Cal enrollment among former recipients and the fact that Transitional Medi-Cal expanded at the same time and the Percent Programs developed only a few years earlier, we might expect that a sizable part of the overall increase is due to these programs.

Figure A.2 presents enrollment by program and age for 1997 and 2000 and shows that this is not the case. First, with regard to Transitional Medi-Cal, we find that both adults' and children's rates fell after CalWORKs and that in 2000, adults actually have slightly lower rates than children. The sharp rise after CalWORKs in adults' overall Medi-Cal rates is thus not driven by the expansion of Transitional Medi-Cal. With regard to the Percent Programs, 2.1 percent of children were covered by a Percent Program in 2000. (The first measurable enrollment only occurs in 1999.) This explains only a fraction of the 16.5 percentage point increase in Medi-Cal enrollment among former recipients under age 18 between 1997 and 2000. As with Transitional Medi-Cal among adults, the expanded eligibility brought about by the Percent Programs does not drive most of the recent rise in children's Medi-Cal enrollment. The Edwards and 1931(b) categories are instead the programs behind the post-CalWORKs increase in enrollment for both groups. These two programs explain all of adults' and most of children's rise in Medi-Cal take-up. Even though enrollment in Transitional Medi-Cal declined for both groups over the period, the 1931(b) increases were large enough to compensate for that decline.

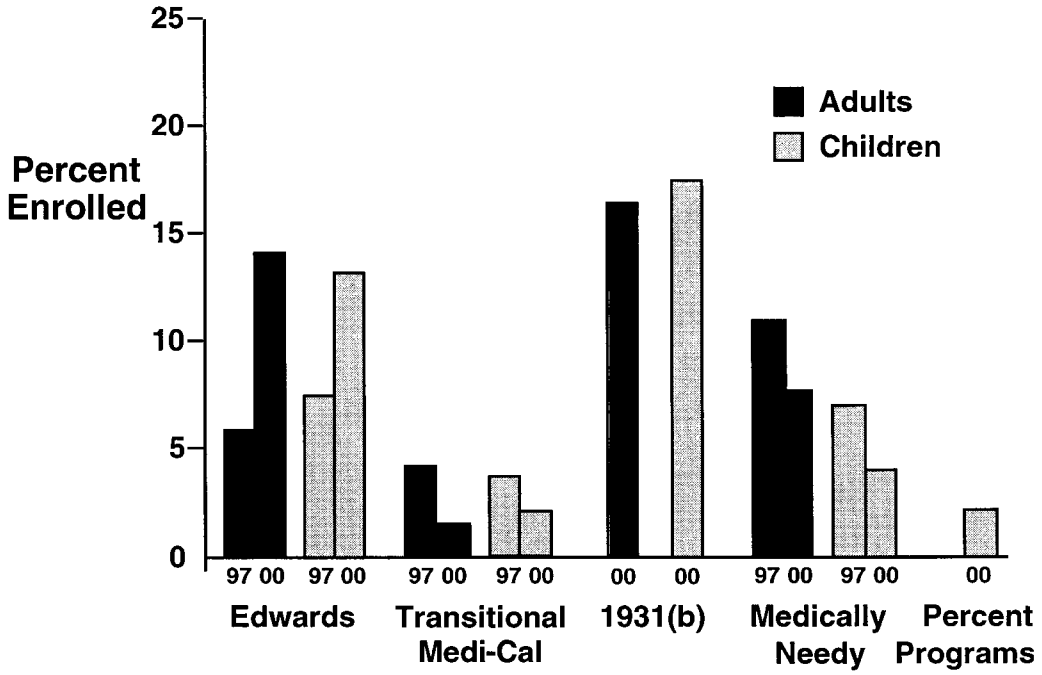

Figure A.2--Percent Enrollment by Age by Program by Time Since Leaving Aid, 1997 and 2000

Finally, we noted a convergence between adults' and children's Medi-Cal rates in Chapter 2, as adults' enrollment rose slightly faster than children's after 1998. Figure A.2 shows this is because adults gained more in the Edwards and Medically Needy programs. Edwards' enrollment rose more for adults than for children between 1997 and 2000. For children, enrollment in 1931(b) grew slightly more them than for adults by 2000. Both groups saw declines in Transitional Medi-Cal and Medically Needy rates, but adults' higher rates of Medically Needy continued through 2000 and helped to close the age difference in rates.

RACE-ETHNICITY

We also examined Medi-Cal enrollment by race-ethnicity to see if the recent rise in enrollment is evident across different racial-ethnic groups. Figure A.3 shows Medi-Cal take-up from 1990 through 2000 for four racial-ethnic groups: (non-Hispanic) whites, Hispanics, (non-Hispanic) African Americans, and other groups.

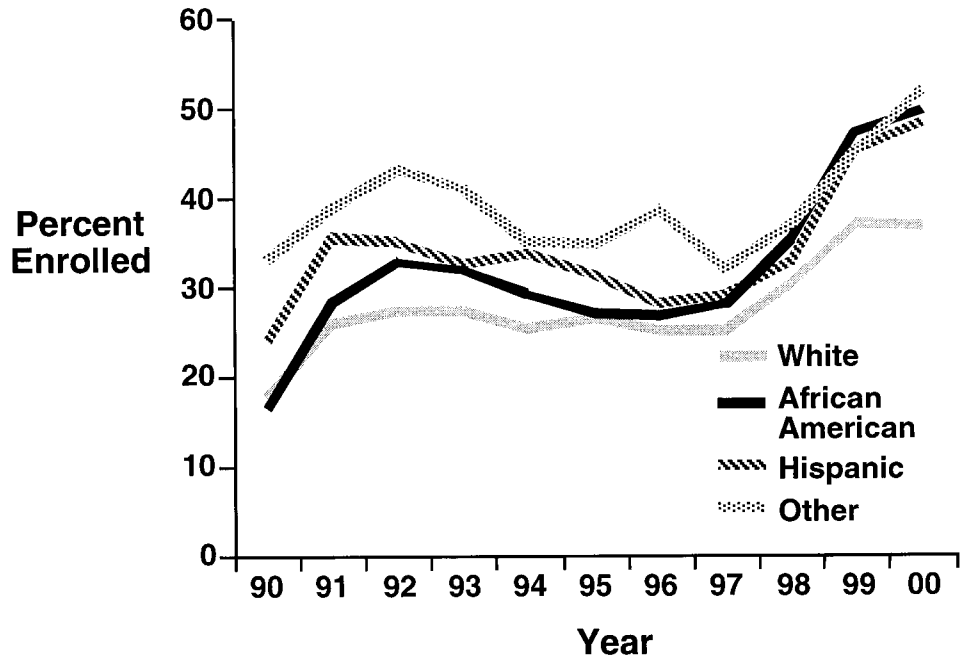

Figure A.3--Medi-Cal Enrollment Rates by Race-Ethnicity and Year

For most of the 1990s, enrollment rates for the four groups were rather different, the lowest rate ranging 9 to 16 percentage points below the highest in any given year before 1997. In 1998, racial-ethnic differences in enrollment began to converge, and for all groups but whites, they continued to converge through 2000. Whites' participation rose in 1998 and 1999, as it did for all groups, but leveled off in 2000 at around 36 percent. In contrast, the enrollment of Hispanics, African Americans, and other racial-ethnic groups continued to rise sharply in 2000, ending with approximately half of these former recipients enrolled in Medi-Cal in 2000. Despite this difference in the past year, the pattern for each group generally reflects the pattern for the population as a whole over the course of the decade: rising in the early 1990s, stabilizing for much of the mid-1990s, and finally increasing sharply since CalWORKs began.

Finally, we examine program enrollment by race-ethnicity. Figure A.4 presents 1997 and 2000 Medi-Cal rates by program for whites, Latinos, African Americans, and other racial-ethnic groups.

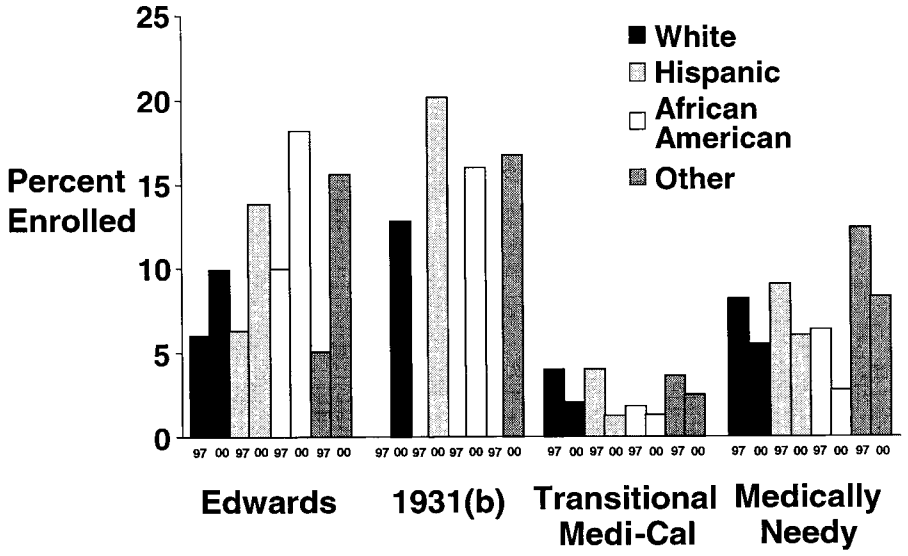

Figure A.4--Percent Enrollment by Race-Ethnicity by Program by Time Since Leaving Aid, 1997 and 2000

Between 1997 and 2000, Edwards coverage rose less for whites than for the three other groups. Among whites, enrollment in the Edwards category rose from 6.0 percent in 1997 to 9.9 percent in 2000, but among the other three groups, it roughly doubled during this time. Similarly, Medi-Cal enrollment expanded into the new 1931(b) category more for African Americans, other racial-ethnic groups, and, especially, Hispanics than it did for whites. The result is that even though the rates for all four groups were quite similar at the start of CalWORKs, the take-up rate for whites leveled off in 2000 while the rates for the other three groups continued to rise, as shown in Figure A.3.

B. COUNTY VARIATIONS IN MEDI-CAL TAKE-UP RATES FOR FORMER RECIPIENTS BY YEAR

Table B.1 provides the Medi-Cal take-up rates for former recipients for all 58 counties from 1990 to 2000.

Table B.1--Percent of Former Cash Aid Recipients with Medi-Cal by County and Year

	90	91	92	93	94	95	96	97	98	99	00
California	**20.9**	**30.5**	**31.5**	**30.9**	**28.5**	**27.2**	**27.3**	**27.3**	**32.9**	**43.3**	**45.3**
Alameda	21.6	27.6	29.3	31.5	31.0	30.2	30.7	27.9	37.1	56.7	64.4
Alpine	22.3	24.4	15.1	12.8	10.4	13.6	26.3	34.3	35.9	49.0	42.7
Amador	18.4	18.2	25.4	25.6	25.3	23.2	22.5	22.9	33.4	38.0	40.4
Butte	27.4	46.4	45.4	30.6	30.0	28.8	35.0	37.0	40.2	45.4	44.8
Calaveras	22.5	21.2	27.6	24.4	22.1	26.1	28.9	34.3	41.8	52.5	56.3
Colusa	25.5	35.9	39.0	43.1	44.3	48.9	48.5	44.8	48.4	45.9	49.2
Contra Costa	23.1	27.5	30.3	29.4	27.5	27.5	28.3	27.6	34.7	43.0	41.5
Del Norte	20.9	23.9	25.0	25.6	23.7	25.4	25.8	30.2	32.4	33.3	38.1
El Dorado	14.5	19.9	26.3	23.6	20.8	22.8	23.1	24.0	29.0	29.2	28.8
Fresno	27.5	41.2	34.5	34.0	31.4	30.7	33.0	29.5	34.7	45.0	50.9
Glenn	28.8	33.6	36.1	36.6	28.8	34.0	36.1	36.8	36.5	39.1	42.9
Humboldt	22.5	26.7	30.3	29.6	28.8	28.9	30.5	34.1	38.4	39.2	38.0
Imperial	26.4	35.5	38.2	33.7	29.2	27.8	25.8	27.5	37.1	44.2	45.0
Inyo	25.4	23.1	25.3	24.8	24.3	24.0	24.5	39.6	37.5	41.1	37.5
Kern	23.0	25.8	28.9	32.3	27.5	27.6	32.9	32.4	34.4	35.9	37.5
Kings	26.2	29.1	30.1	33.0	32.3	35.9	39.2	38.3	38.9	40.2	40.2
Lake	21.9	26.1	26.8	28.2	26.2	25.6	26.4	27.4	31.8	35.6	36.4
Lassen	23.3	37.6	31.4	29.5	28.0	26.5	25.9	26.7	29.0	34.5	36.3
Los Angeles	20.3	36.4	38.7	37.0	32.4	28.2	26.1	26.4	34.3	54.8	56.0
Madera	27.4	32.5	31.5	32.2	32.9	36.7	40.0	39.1	38.9	38.7	37.1
Marin	21.9	27.9	30.6	31.1	31.0	32.4	35.6	35.0	36.2	35.1	34.3
Mariposa	23.2	28.5	28.1	28.2	31.3	29.4	25.0	31.3	39.9	40.5	39.0
Mateo	20.5	26.1	26.5	28.4	28.9	30.6	30.1	28.6	28.2	31.5	33.2
Mendocino	24.3	25.9	27.2	28.6	25.8	33.5	36.9	37.7	39.4	40.7	40.7
Merced	23.7	27.3	32.9	42.0	35.1	33.5	31.8	31.0	30.5	35.1	44.3
Modoc	19.6	23.4	30.5	25.3	25.8	27.4	27.6	22.9	26.3	33.3	36.7
Mono	17.7	17.3	21.7	25.3	26.5	27.4	25.6	22.5	28.4	30.9	32.0
Monterey	25.6	38.1	27.5	26.5	26.5	25.7	25.6	24.5	29.9	34.3	35.1
Napa	21.0	24.7	28.8	30.3	29.1	29.1	30.5	33.6	34.6	38.0	37.0
Nevada	17.9	24.1	30.0	28.5	27.3	28.7	27.7	29.5	31.2	36.2	35.4
Orange	19.7	28.4	30.9	29.8	28.3	27.1	27.3	27.7	33.3	35.7	38.4
Placer	19.1	24.2	29.1	30.7	27.6	27.9	26.6	27.6	33.8	41.6	33.1
Plumas	23.1	25.5	31.9	32.3	34.6	45.5	36.1	30.6	38.5	47.4	53.7
Riverside	15.7	25.3	26.7	24.9	23.7	23.4	22.6	23.0	30.6	40.9	40.0
Sacramento	20.0	29.9	29.8	29.4	27.1	26.5	26.3	27.5	33.9	39.2	45.0
San Benito	20.5	25.3	27.1	26.0	25.9	24.2	25.2	26.8	34.9	38.1	32.1
San Bernardino	16.3	23.6	24.9	24.1	21.6	20.4	19.8	20.7	23.3	26.5	29.1
San Diego	18.2	24.6	23.3	22.7	21.4	21.2	21.5	21.6	29.5	43.9	42.6
San Francisco	25.9	38.1	39.3	39.4	39.0	36.8	35.4	34.9	39.9	52.4	64.0
San Joaquin	25.8	28.1	30.9	31.9	31.1	33.0	36.5	33.1	33.2	35.7	36.2
San Luis Obispo	22.5	32.4	33.7	33.7	31.8	30.6	31.3	31.8	34.8	40.5	43.0
Santa Barbara	25.6	32.7	33.0	33.8	33.5	31.2	30.3	31.1	35.8	39.7	44.6
Santa Clara	20.6	23.9	26.8	28.9	29.2	28.3	27.6	27.2	32.4	41.2	36.7

	90	91	92	93	94	95	96	97	98	99	00
Santa Cruz	20.4	27.8	27.8	29.4	29.7	29.8	29.7	30.0	29.2	30.7	33.7
Shasta	22.6	27.0	28.6	27.9	26.7	28.2	37.1	34.3	37.0	41.1	41.3
Sierra	14.5	20.1	23.6	21.4	19.6	20.2	31.3	28.8	23.2	25.6	31.1
Siskiyou	23.0	25.0	27.0	26.3	27.1	27.3	25.9	27.2	29.9	34.2	38.4
Solano	18.1	21.4	24.6	26.2	25.2	25.1	27.4	30.3	31.7	33.1	36.1
Sonoma	21.8	26.1	26.9	28.7	28.5	28.8	28.4	27.6	34.6	40.9	34.2
Stanislaus	23.1	31.5	32.0	32.1	31.6	31.6	32.3	32.9	32.9	35.0	37.2
Sutter	25.7	31.0	36.5	34.3	31.0	32.9	34.6	37.2	42.3	47.4	42.8
Tehama	26.7	31.5	32.9	30.5	28.4	29.5	32.5	32.6	34.7	35.6	36.7
Trinity	26.7	28.3	30.3	27.4	26.3	27.3	27.6	33.6	38.5	38.0	38.8
Tulare	26.3	32.7	27.7	28.2	28.0	28.2	31.0	32.5	36.8	42.6	40.9
Tuolumne	20.4	28.8	30.9	29.4	29.8	30.0	26.5	30.8	36.0	37.7	37.1
Ventura	20.2	24.9	28.1	28.6	26.8	27.3	28.7	28.8	32.0	34.4	37.9
Yolo	21.0	26.1	26.0	26.1	26.7	28.0	28.4	29.7	32.8	36.1	37.5
Yuba	25.3	26.6	28.5	29.3	27.5	30.0	37.7	35.6	35.3	35.8	37.5

Source: January 1987 through December 2000 MEDS

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