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ENSURING SEAMLESS INSURANCE COVERAGE FOR CALIFORNIA'S CHILDREN

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Recent national research has shown that 85 million people lacked health insurance at some point over a four-year period.¹ While some Americans are consistently uninsured, substantial numbers have intermittent coverage. Consider, for example, a family that is currently covered through a parent's employment-based health insurance. A subsequent job loss could leave that family uninsured until another job with health insurance is secured, the family purchases a non-group health insurance policy, or the family is determined to be eligible for and enrolls in public coverage. Another family with low to moderate income may have children enrolled in the State Children's Health Insurance Program (SCHIP), and an increase in family income could result in these children losing eligibility for public coverage. There may then be a period of uninsurance before affordable new private coverage can be secured. Because health insurance is often tied to factors such as employment status or family income, changes in these areas can affect the continuity of health insurance coverage and, consequently, the quality of care received.²

The New America Foundation has proposed an approach to comprehensive health reform in California that would build on the system that is already in place, relying upon the concept of shared responsibility among households, employers, and taxpayers.³ Because this proposal features a requirement that parents secure health insurance for their children, it is imperative that families losing health insurance coverage due to life circumstances such as a job loss or a change in family income can immediately enroll

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their children in health insurance through another source. This paper addresses the challenges that California families face with respect to health insurance continuity and describes an approach to facilitate seamless health insurance coverage for children.

OVERVIEW

Why is it important that health insurance coverage be seamless?

Health insurance is a central component of child health, and gaps in insurance are associated with decreased access to the health system. Children with recent gaps in health insurance are more likely to lack a usual source of care, more likely to delay seeking needed care, and less likely to have prescriptions filled.^{4,5,6} To minimize such adverse outcomes, continuity of health insurance coverage should be a key policy goal.

What are examples of situations where children may be vulnerable to a gap in health insurance?

Because family circumstances frequently change, there are a number of scenarios that could render children vulnerable to a loss of health insurance. These scenarios include job loss of a parent, job change of a parent, birth of a child, divorce, and changes in family income, including families whose income increases, rendering them ineligible for public insurance.

How can California policymakers ensure that health insurance coverage is seamless?

To ensure seamless coverage, policymakers must take a series of related steps. First, the most critical step is improved outreach. Enrolling in public and private health insurance can be complex. As this paper later discusses, there are a number of improvements that California can make. Second, as is discussed in The New America Foundation's "Shared Responsibility" paper on covering California children, health insurance must be

affordable. And finally, in an environment featuring guaranteed access to affordable health insurance, we would expect that compliance with a requirement for parents to purchase health insurance for their children would become the norm. However, for those who do not comply, a “catch-all” system to achieve 100% enrollment of children in health insurance could be implemented. Essentially, children without insurance would be enrolled by default into back-up health insurance. Today, it is legally required, and has become expected, that parents will send their children to school. We expect that, under New America’s approach, the system will be the same for health insurance.

What is the “catch-all” system?

A buy-in pool, administered by the same agency that administers California’s Healthy Families program, would be available to children in families without access to other health insurance. If parents fail to enroll their child in health insurance, the child would be covered automatically through this buy-in pool and coverage would be retroactively applied to the entire period during which the child was uninsured. Children’s coverage would never be held hostage to any parent’s failure to meet their responsibility.

When a child is automatically enrolled in the catch-all system, parents would be charged the buy-in premium rate for coverage, as well as the appropriate payments for the previous period of uninsurance. A substantial but income-related penalty would be assessed as well. This would occur whenever a child is found to be uninsured during routine compliance checks.

What is the buy-in pool?

The buy-in pool is the insurance option for children who have no other health coverage options or who are found to be uninsured. The buy-in pool could be operated by California’s Managed Risk Medical Insurance Board (MRMIB) and offer the Healthy

Families benefit package. To comply with Federal law, the buy-in pool would be actuarially separate from Healthy Families.

Before families could enroll their children, they would be screened to ensure that they are not eligible for employer-based insurance, Medi-Cal, or Healthy Families. Assistance would be provided to enroll children in these other programs if they were found eligible.

Eligible families could buy into the catch-all pool, with guaranteed issue and an actuarially fair community rate. While families at any income could purchase through the pool, only those below a certain income level and without other insurance options would be subsidized.

How would a buy-in pool facilitate seamless coverage?

The buy-in pool gives children a place to access insurance when all other options have failed. Health insurance is the preferred entry point for the American health care system. Absent insurance, every other aspect of accessing health care becomes much more difficult. This difficulty can translate into negative health consequences, as documented by the Institute of Medicine.⁷

How would automatic enrollment take place in a catch-all system?

At various points in time, the insurance status of children would be reviewed by various entities including schools and providers. If a child is found to be uncovered, he would be referred to MRMIB for automatic enrollment into a health insurance product. This child would be covered by the buy-in pool for the entire previous period of uninsurance. Back premium charges and penalties would then be assessed against the parents (Please see the Mandate Compliance section below for more detail).

The child would be screened for eligibility in other insurance programs and referred to the appropriate program for enrollment. The family would have 60 days to enroll the child in the new program. If proof of enrollment of the child is not provided, then the child would continue to be enrolled in the catch-all pool, and the parents would be assessed penalties in addition to the premium for the enrollment pool.

Given the automatic enrollment system, why should any family bother to seek out insurance for a child?

Families would seek out health insurance, either through the employer-based system, public programs such as Healthy Families and Medi-Cal, or through the buy-in pool to avoid the penalties associated with failing to enroll. Families not offered employer-sponsored health insurance could purchase insurance for their children through the buy-in pool. Families below 250% of the poverty level would have access to the Healthy Families and Medi-Cal programs.

The compliance and penalty section of this paper explains the proposed steps to ensure voluntary compliance with the law.

SIMPLIFYING ENROLLMENT AND PROMOTING OUTREACH

How can participation in the health insurance system be encouraged?

Certainly, an important step is the creation of the catch-all system itself. But that effort alone will not be enough. Any health insurance expansion for children needs to focus on outreach and enrollment simplification. As part of the simplification effort, the buy-in pool will help parents identify their coverage options and make insurance easily accessible.

This should be done by tying the buy-in coverage pool to a statewide system of Children's Health Initiatives (CHIs). Today, CHIs operate in eleven California counties, with more expected to come on-line.⁸ The CHIs function as flexible "one-stop-shops" for parents trying to enroll all their children into health insurance. The expansion of this approach statewide would help get more children enrolled in health insurance.

Incentives to promote monthly electronic premium payment for those in public programs would help ensure that premiums are paid in a timely and efficient way. In addition, the state could work with employers to encourage employees to enroll children in insurance plans. For example, employers who verify that all of their workers' children have health insurance could be eligible for a modest tax credit.

What enrollment simplification measures should be taken?

New America supports the outreach and enrollment measures in the California Healthy Kids bill (SB 437 (Escutia/Alquist) and the now-vetoed AB 772 (Chan/Frommer)), sponsored by the 100% Campaign, PICO California Project, and others during the 2005 Legislative session. The legislation would significantly streamline enrollment in public health insurance. Outreach and enrollment strategies specified in the bill include:

- "Express Lane" simplifications and use of technology to expedite enrollment of children in programs that use similar income rules such as Reduced Price Lunch and WIC. Express Lane is a pilot program in California that uses the school lunch program as a preliminary application for Medi-Cal.
- A simplification of the existing Child Health and Disability Prevention (CHDP) Gateway application program. The Gateway program allows children receiving care through CHDP to become presumptively eligible for Medi-Cal, giving the child two months of temporary eligibility in which to submit a follow-up application.

- Accelerated enrollment in Healthy Families for eligible children who apply at county Medi-Cal offices.
- An on-line Medi-Cal health plan/health care arrangement selection system coordinated with the existing Healthy Families plan selection system.
- Reduced paperwork for children and families to apply for and renew insurance by requesting only as much paperwork as federal law requires.

What outreach options exist to help promote coverage of children in undocumented families?

The primary challenge for immigrants is accessing the public health insurance system. Even among documented families, there are still concerns about accessing government services. New America's proposal would expand use of Local Initiatives as a safe haven for persons to seek public insurance without fear of immigration enforcement. Many immigrant families may have some citizen and some non-citizen children. New America's proposal would treat the siblings of U.S. citizen and non-U.S. citizen children the same.

BASIS FOR MANDATE COMPLIANCE

What is the precedent for mandating parental actions?

There is a long history of mandates on parents designed to promote the welfare of children. Examples include:

- *Mandatory School Attendance* – A California compulsory school attendance law was first passed in 1874 and has been expanded since. The courts can assess fines

of up to \$500 and mandate parenting classes for failure to comply. Extreme cases can result in charges of contributing to the delinquency of a minor, a misdemeanor punishable by a fine of up to \$2500 and up to one year in jail.

- *Vaccines for School Children* – Before a child can enroll in either public or private school, an immunization record must be submitted to the school showing compliance with age appropriate vaccinations.
- *Child Safety Seats* – Persons convicted of failing to have their children secured in a safety seat can be required to attend a safety education program and pay fines of up to \$250.

COMPLIANCE ASSURANCE AND PENALTIES

Briefly, how does the compliance process work?

As explained above, if parents fail to keep their children enrolled in health insurance for any reason, the children will automatically be enrolled in the buy-in pool for the entire period of uninsurance. The parents will be charged the buy-in premium rate for the whole period, as well as substantial income-related penalty fees.

When would a child's insurance status be reviewed?

The first step for a compliance system is creating a structure for periodic review of the insurance status of California's children. This will avoid situations where parents leave children uncovered for years.

New America envisions an overlapping system to review insurance status that requires little new infrastructure, but ensures that status will be reviewed at least once a year.

- *Beginning of the School Year:* At the beginning of the school year, the family would be required to present proof of insurance to the school along with other beginning of the year paperwork. The school could provide a list of students without insurance proof to the buy-in pool. Schools would need fair reimbursement for the additional administrative burden.
- *Tax Check:* For persons filing with the Franchise Tax Board and claiming a child exemption or seeking a refundable, advanceable credit to purchase private health insurance for their child, proof of child health insurance will be required.
- *Accessing Health Provider Services:* Providers seeking payment for health services for children would check health insurance status. If parents cannot demonstrate proof of insurance, the child is presumed to be in the buy-in pool and the pool will be billed for services provided.
- *Insurer Notification:* Families will be required to provide proof of new insurance to their previous coverage provider when changing coverage.

How would privacy restrictions impact the implementation of these reporting requirements?

Within the compliance effort, it will be important to balance privacy rights with the need to ensure that children have health insurance. The following is a brief discussion of some of the privacy issues.

- *Beginning of the School Year:* State law would need to be modified to require that schools request insurance information from parents. Schools would request a copy of the insurance certificate from parents.

- *Tax Check:* State law could be changed to require proof of insurance for children in order for parents to claim the child deduction when they file a tax return. The Franchise Tax Board would report uninsured children to MRMIB.
- *Accessing Health Provider Services:* Today, providers share medical information for billing. For a provider to be paid for services provided for an uninsured child, they would charge information to MRMIB's buy-in pool if no other insurance is offered by a parent. The buy-in pool would pay the claim and seek to determine the insurance status of the child. In addition, state law could be changed to require parents to give proof of insurance to hospital administration prior to discharge of a newborn.
- *Insurer Notification:* To enroll in health insurance, state law could require that persons give permission to their carrier to report the insurance status of a child to MRMIB. That way, insurers can report identifying information about a child who has been disenrolled and for whom no proof of new insurance has been provided.

What are the penalties?

An effective enforcement system for children should promote compliance while avoiding punitive punishments for parents. Traditional mandates use mechanisms like denying services, such as denying education to those who fail to obtain appropriate vaccinations. In many cases, there are criminal penalties associated with existing mandates.

The New America Foundation proposes that parents who fail to insure their children pay the buy-in premiums owed for the uninsured period, as well as an additional penalty. For those under 250% of the poverty line, the penalty should be 5% of the cost for the unsubsidized insurance premium. For those between 250% and 400% of poverty, the penalty should be 15% of that cost in addition to back payments for months in which

premiums were not made. For those over 400% of the poverty line, the penalty should be 25% of the unsubsidized premium cost in addition to back payments for months in which premiums were not made. The unsubsidized insurance premium is used as the base because, for many, the premium will be fully or partly subsidized under the New America proposal. This approach provides the motivation to ensure that insurance is purchased.

Examples:

- *Low-Income Family:* A family at 150% of poverty stops purchasing insurance for a 13 year-old child through an employer and fails to purchase insurance for two months. Since the family did not provide proof of new insurance to their previous carrier, that carrier refers the child to MRMIB and the buy-in pool. At this income level, the insurance premium would have been equal to the Healthy Families charge, assuming the child is eligible. This cost would be \$30 total (\$15 per month as a maximum premium charge under Healthy Families). The child will be covered under the catch-all pool for the previous two months. However, the penalty incurred by this family would be 5% of the \$120 unsubsidized insurance monthly payment for 2 months, for a total of \$12.⁹ Therefore, the total cost is \$42 for the two missed months. The catch-all pool will likely find the child eligible for Healthy Families. If the child is enrolled promptly, then no further penalties would apply.
- *High Income Family:* Now take the same family at 450% of the poverty level. At this income level, insurance costs would be unsubsidized. If the child is found to be uninsured after two months, then he is covered under the catch-all pool. The missed payment amount is \$120 per month for a total of \$240. The 25% penalty is \$60, for a total cost of \$300 for the two missed months.

How will the program collect missed payments and penalties?

Collections of any late payments will be handled in the same manner that any private firm would deal with missed penalties. There would be notifications and opportunities to make partial payments over time at a nominal interest fee.

Those who simply refuse to pay will be reported to credit reporting agencies, which is existing policy in the Access for Infants and Mothers program. The result is that it is difficult, if not impossible, for persons with such debts to get new credit to purchase a car or house. MRMIB already uses this approach effectively for collecting missed payments.

Will the collection process be 100% effective?

No system is going to be perfectly effective. It is reasonable to assume that some families, particularly those at very low income levels and those lacking documentation, will be a challenge to track and collect money from. But the larger goal of any collection process is to ensure compliance by the vast majority of parents. The incentives and penalties may need to be adjusted over time to reach that goal, but the ones we propose are credible enough to merit going forward.

How will those checking proof of insurance know if the coverage meets minimum benefit and cost-sharing standards?

Under ERISA, a state cannot require employers to offer a specific package of benefits. As a result, health insurance purchased by employers would not be subject to certain benefit and cost-sharing standards set by the state. However, the state's Insurance Commissioner could require insurers and self-insured employers in the state to report the actuarial deviation between the benefit packages they offer and the Healthy Families benefit package. In addition, the Insurance Commissioner should make readily accessible a list of companies approved to sell insurance to prevent fraud.

Should there be a religious exemption the mandate requirements?

Any mandate program will need to permit exemptions for those who do not believe in health insurance for religious reasons.

Endnotes

¹ Short, Pamela Farley, Deborah R. Graefe and Cathy Schoen, “Churn, Churn, Churn: How Instability of Health Insurance Shapes America’s Uninsured Problem,” The Commonwealth Fund, November 2003.

² Fairbrother, Gerry and Arfana Haidery, “How Health Insurance Stability Impacts the Quality of Care,” New America Foundation, July 2005.

³ Nichols, Len et. al, “Shared Responsibility to Cover California’s Children: A Key Step on the Road to Universal Health Insurance,” November 2005.

⁴ See Fairbrother, Gerry and Arfana Haidery, How Health Insurance Stability Impacts the Quality of Care, New America Foundation, July 2005, for an explication of the impact of health insurance gaps on care.

⁵ Kogan, M.D., et al. The Effect of Gaps in Health Insurance on Continuity of a Regular Source of Care Among Preschool-Aged Children in the United States, *Journal of the American Medical Association*, 1995. 274(18): 1429-1435.

⁶ Aiken, K.D., G.L. Freed and M.M. Davis, “When Insurance Status is Not Static: Insurance Transitions of Low-Income Children and Implications for Health and Health Care,” *Ambulatory Pediatrics*, 2004. 4(3): 237-243.

⁷ See the series of six reports by the Institute of Medicine’s Committee on the Consequences of Uninsurance. In particular, see Institute of Medicine, “Care Without Coverage: Too Little, Too Late,” National Academy of Sciences, 2002.

⁸ Please see, the Institute for Health Policy Solutions for the most recent information on CHIs at http://www.ihps-ca.org/localcovsol/cov_initiatives.html#map.

⁹ For purposes of this example, \$120 per month is the assumed cost of the buy-in pool premium. This number may be higher or lower in practice.