PPIC PUBLIC POLICY INSTITUTE OF CALIFORNIA

Expanding Medi-Cal

Profiles of Potential New Users

August 2011

Helen Lee and Shannon McConville
with research support from Kristel Acacio and Kimberly Kay Hoang

Supported with funding from the California Program on Access to Care

Summary

One of the objectives of the federal Affordable Care Act (ACA) is to expand insurance coverage to millions of uninsured Americans, with the goal of improving access to health care and, in doing so, to improve the health of those who will become insured. This report focuses on one of the key ways California will meet this challenge—by expanding enrollment in Medi-Cal, the state's primary public insurance program, to historic new levels. Starting in 2014, as required by the ACA, the current Medi-Cal eligibility income threshold will increase from about 100 to 138 percent of the federal poverty level, and eligibility will be expanded to include poor adults without dependent children.

Millions of Californians (estimates range from 1.7 million to more than 3 million) could gain access to coverage through Medi-Cal expansions under the ACA. This will undoubtedly be a diverse group. Yet questions remain as to who the new Medi-Cal-eligible adults will be and how they may differ from adults currently in the program. Understanding the uninsured poor is a fundamental step to informing policy efforts focusing on outreach and enrollment, the scope of basic benefit design, and social marketing of the availability and value of insurance; and it can also provide state program officials with a broad sense of the upcoming demands on an evolving delivery system. In addition to informing the expansions slated for 2014, profiles of poor, uninsured adults in California can also apprise state and local policymakers of the targeted population eligible for new county-based low-income health programs scheduled to begin this year, who constitute part of the larger group that will become eligible for Medi-Cal in 2014.

We take a mixed methods approach in profiling the new potential Medi-Cal population. First, we analyze available population survey data to create broad, sociodemographic portraits of the currently uninsured, poor adult population. Second, we rely on focus group information gathered from both poor, uninsured adults and low-income parents who have experience with public insurance programs for their children.

Our analysis of the survey data indicates that, by and large, the uninsured are a relatively young population (60 percent are under age 40) and are no less healthy than current, non-disabled Medi-Cal enrollees. Assuming that these characteristics remain stable over the next few years, these findings could bode well for Medi-Cal program officials concerned that the newly eligible will be high-cost users. But this also assumes that participation will be widespread among the total eligible population. Ensuring participation among the young and healthy, in particular, will require targeted efforts at the state and local levels to provide information and awareness of coverage options and to ensure that the eligibility and enrollment processes are not onerous.

At the same time, between 15 and 25 percent of potential new enrollees in Medi-Cal currently report fair or poor health status, with one in four reporting a chronic health condition. Also, rates of obesity and smoking are notable. Thus, a segment of the population that will gain access to Medi-Cal could have substantial health care needs that might indeed be more costly than the health care needs of the broader group of potential new enrollees. This has implications for policymakers and health planners who must make decisions concerning benefit-design packages to meet both basic and more-complex coverage needs, and to prepare delivery systems tasked with coordinating care across primary, mental health, and specialist care services.

In order for reform efforts, and Medi-Cal expansions in particular, to make meaningful differences in health care use and population health, a new social norm, referred to by many as a "culture of coverage," must

emerge, a culture in which insurance is expected, maintained, and ultimately valued. It is particularly important to encourage this normative shift among the low-income populations eligible for expansions, many of whom will likely not be subject to the sanctions included in the ACA to encourage participation. Our focus group analysis provides insights into how to accomplish this shift, as well as its potential challenges. For example, some participants noted that insurance coverage has value beyond its relationship to accessing health care—namely, it provides mental well-being and peace of mind, mitigating the state of anxiety that many of our uninsured participants highlighted as endemic to living without coverage. However, others felt that they had learned to successfully self-manage their health over the years without coverage and without frequent access to the formal health care system. Health planners and providers will have to both respect and transform such self-care strategies if they are to enable provider input and encourage the use of preventive health services.

Current Medi-Cal users who participated in our focus groups identified barriers to access within the system that researchers and policymakers have long known exist. These include the limited number of physicians accepting Medi-Cal patients, long wait times to get an appointment, and perceptions of lower quality of care. While most participants were grateful for the coverage they had, some questioned the overall value of coverage in light of these frustrations. Strategies to reduce such barriers should be considered as the Medi-Cal program is expanded. If a new "culture of coverage" is to be realized, participants must come to believe that coverage means consistent, timely access to quality care. Challenges aside, previous negative experiences with overcrowded clinics and emergency departments, as well as anxiety about future health events, might be ample motivation for uninsured Californians likely to gain eligibility for the Medi-Cal program to pursue public coverage in 2014.

Contents

Technical appendices to this paper are available on the PPIC website:
http://www.ppic.org/content/pubs/other/811HLR_appendix.pdf

Figures

Table

Introduction

In March 2010, President Obama signed federal health care reform—the Affordable Care Act (ACA)—into law. The ACA will transform the way health care is provided and paid for in the United States, representing a major undertaking that, if implemented as planned, will be phased in over the next several years. Despite ongoing political debates over various provisions of the new law, California is already preparing for some of the major changes the ACA requires states to undertake as part of health care reform.

One of the goals of the ACA is to narrow longstanding insurance coverage gaps—a perennial concern of policymakers, health advocates, and researchers (Sommers and Epstein, 2010). Health insurance serves as a mediator to accessing timely health care, and lacking insurance has been linked to delayed care (resulting in costly urgent or emergency treatment), unmet health care needs, anxiety and stress, and poorer health status (Bade et al., 2008; Burman, Mawhorter, and Heede, 2006; Institute of Medicine, 2002; McWilliams, 2009). The law contains various provisions to increase coverage, but the two primary components are: 1) insurance reforms and program expansions that provide affordable access to coverage, and 2) the requirement that most U.S. citizens and legal residents have health insurance, referred to as the individual mandate.[1] The main modes of improving affordable coverage options are the expansion of the Medicaid program—the nation's public insurance safety net for low-income families and qualified adults—and the creation of state health insurance exchanges, with federal subsidies available based on income levels (see text box below for additional information on other key ACA provisions).[2] All of the provisions will become effective as of January 2014; and if estimates prove correct, the ACA could reduce the number of uninsured Americans by more than half, with 28 million previously uninsured individuals gaining coverage (Buettgens et al., 2010).

Medicaid expansions will comprise a significant portion of the anticipated increase in coverage. Prior to the ACA, Medicaid eligibility for adults depended on both income level and being a member of a categorically eligible group—typically either parents with dependent children or disability status. Beginning in 2014, all citizens and legally residing noncitizens who have been in the United States for at least five years and have family incomes below 139 percent of the federal poverty level (FPL)—about $31,000 annual income for a family of four—will be eligible for Medicaid.[3] Scholars have estimated that Medicaid enrollment could increase by 17 million people nationwide, as the program opens its doors to a diverse group who have largely been excluded from public insurance coverage, including poor adults without dependent children or who do not have a qualifying disability.[4] The ability of the ACA to substantially reduce the number of uninsured depends on how successfully states implement the Medicaid expansion, because roughly half of the reduction in the uninsured is projected to come from increased Medicaid participation (Sommers

---

[1] At the time of this writing, some states and elected leaders are contesting the individual mandate provision in federal courts, where Congress' constitutional authority to legislate such a provision (primarily, whether requiring private insurance falls under Congress' power to regulate interstate commerce) is being challenged. Some experts believe that the challenge will reach the U.S. Supreme Court.

[2] Other provisions to expand coverage options include tax incentives to encourage small businesses to offer coverage to their employees and allowing young adults to stay on their parent's insurance coverage until age 26.

[3] The new poverty threshold for Medicaid eligibility is 133 percent of the FPL, with a standard income disregard of 5 percent, which makes the effective threshold for eligibility 138 percent of the FPL. In all of our analyses, we use this 138 percent cutoff and designate poor adults as those with household income below 139% FPL.

[4] A few states did offer coverage to some non-disabled childless adults through waivers for their Medicaid programs, but California was not one of them. For more information on other state's Medicaid program waivers for childless adults, see Kaiser Commission on Medicaid and the Uninsured (2010c).

and Epstein, 2010; Buettgens et al., 2010). In fact, some researchers are predicting an estimated addition in California of about 1.7 million individuals by 2016 (Long and Gruber, 2011). California's Medicaid program, Medi-Cal, has laid important groundwork in anticipation of these expansions.

Key provisions of the ACA relevant for Medi-Cal

Health benefit exchanges. New state-based health benefit exchanges represent a new insurance purchasing option for individuals and small businesses, with federal subsidies available to people with family incomes between 133 and 400 percent of FPL who do not have access to employer-based coverage. California was the first state in the nation to create a health benefit exchange. It will be important that Medi-Cal, the Exchange, and the Basic Health Plan (if implemented) interact well with each other, because income fluctuations will result in individuals moving in and out of income eligibility across the programs.

Basic Health Plan option. States can choose to create a Basic Health Plan (BHP) to cover individuals with incomes between 133 and 200 percent of FPL who would otherwise be eligible for premium subsidies through the Exchange. The BHP must provide the same essential health benefits (discussed below) and be no more costly to participants than coverage in the Exchange. Those eligible for the BHP will not be eligible for the Exchange. Pending legislation (SB 703), if passed, would establish a BHP in California.

Essential benefits package. Plans that participate in the Exchange are required to provide 'essential health benefits' that provide a comprehensive set of services, limit cost-sharing, and are not more extensive than the typical employer plan.

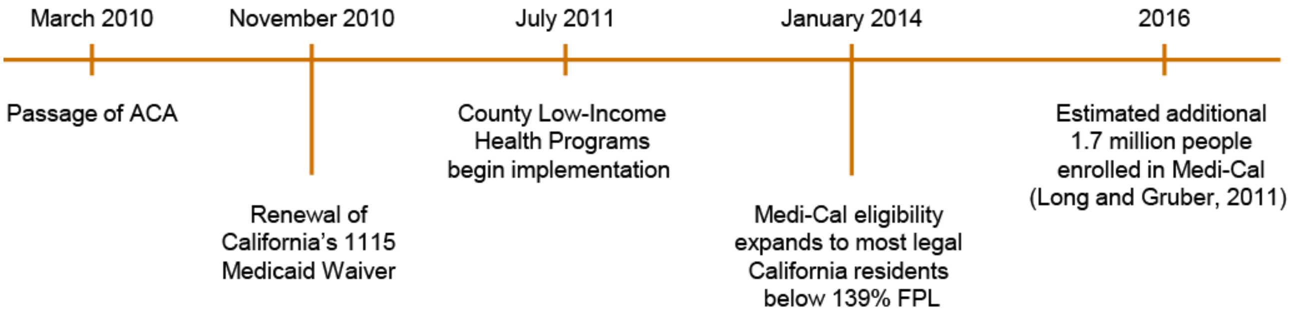
Financing. The federal government will cover 100 percent of the costs of newly eligible Medi-Cal enrollees in the first two years of expansion (2014—2016), gradually dropping to 90 percent in 2019 and beyond. The ACA also increases Medi-Cal reimbursement rates for primary care physicians to the level of Medicare payment rates, with the federal government paying 100 percent of the additional costs for the rate increases, but only for 2013 and 2014. Despite increased federal funding, the state will still incur substantial additional costs to cover expected increases in Medi-Cal enrollment among the previously eligible but unenrolled (the state will need to pay the standard 50 percent of costs), as well as up-front administrative costs to update IT and for enrollment redesign (although the federal government will fund 90 percent of enrollment redesign related to ACA expansions).

California's Medi-Cal Program: Preparing for Reform

California's Medi-Cal program currently serves more than seven million people. Nearly half of its beneficiaries are non-disabled children and another quarter are non-disabled adults; together these two groups account for 38 percent of expenditures. The remaining quarter of Medi-Cal beneficiaries comprises seniors over age 65 (10%) and children and adults with disabilities (16%) who account for the bulk (62%) of spending in the program (California HealthCare Foundation, 2009.) Under Medi-Cal's current delivery and payment structure, half of beneficiaries are covered by managed care plans and half are covered under fee-for-service arrangements where providers are paid for each service delivered.[5] Upcoming changes in the Medi-Cal program, however, are intended to shift more people into managed care arrangements through both the expansion of managed care to additional counties and the transition of seniors and people with disabilities from fee-for-service into managed care in order to better coordinate care, improve outcomes, and control costs.

The primary vehicle to prepare the Medi-Cal program for upcoming expansions is the renewed 1115 Medicaid waiver,[6] which was approved in November 2010 by the federal government (Figure 1) and is intended to serve as California's "Bridge to Reform." There are several important components to the waiver (including shifting seniors and the disabled into managed care arrangements), but the waiver coverage expansions for low-income, uninsured adults through county-based programs offer the most direct means of preparation for reform. Specifically, under the waiver, as many as 500,000 uninsured adults—drawn from the same, broader population that will become eligible for Medi-Cal in 2014—will gain coverage through county-based Low Income Health Programs (LIHP), supported by county funds and up to $3 billion in federal funding (California Department of Health Care Services, 2010). The LIHPs expand on previous county health care coverage initiatives (HCCI), which were part of California's previous 1115 waiver, and are designed to transition enrollees into Medi-Cal once it is expanded. The authorizing legislation for the LIHP projects, AB 342, lays out several requirements for the programs, including assignment of enrollees to medical homes (defined as "a single provider, facility, or health care team that maintains an individual's medical information and coordinates health care services for enrolled individuals") and provider network adequacy requirements, including geographic accessibility and cultural competence. In addition, participating counties must provide a minimum core set of health care and mental health services that are more limited than the state's current Medi-Cal benefits package but that may be more comprehensive than what is available in some county indigent care programs. The level of benefits provided, while defined in LIHPs, is an issue that policymakers need to determine for many of those in the new Medi-Cal eligible population in 2014.

FIGURE 1
Timeline of major milestones for Medi-Cal expansions



In sum, the wavier and LIHPs offer an important opportunity to jump-start the upcoming Medi-Cal expansions, and they could serve as an early avenue to get those who will become newly eligible with

---

[5] Managed care plans primarily serve non-disabled children and adults and pregnant women, all of whom are required to enroll in managed care if they live in one of 25 counties that have one of three types of managed care arrangements in place (i.e., a local health initiative plan, competing commercial health plan, or county-operated health system). The elderly and disabled can voluntarily enroll in managed care in counties where it is available, but few do so (California HealthCare Foundation, 2009).

[6] Section 1115 waivers allow states to alter coverage and delivery options in the Medicaid program outside of existing federal guidelines and still receive federal Medicaid funds. For additional information on California's new 1115 waiver, see Kaiser Commission on Medicaid and the Uninsured (2011).

chronic health conditions into a coordinated care setting before 2014. Several of the previous HCCI programs, which operated in ten counties from September 2007 through August 2010, targeted enrollment to high-needs populations—including those with specific chronic conditions, homeless individuals, and frequent emergency department (ED) users. These programs appear to have been successful in their targeting efforts: Between 40 and 100 percent of enrollees across the 10 counties had at least one chronic disease (Kominski et al., 2010). Although only interim evaluations of the HCCI are available, the preliminary findings suggest that the programs made progress toward all of their goals. For instance, in later years of the program, several counties witnessed changes in utilization patterns that likely signal better management and use of care, such as declines in hospital admissions and ED use (Kominski et al., 2010). Thus, the LIHPs, if building off the HCCI programs, could begin the work of targeting and servicing sicker, higher need populations, who might then have more-established treatment plans in place before transitioning into Medi-Cal.

Thus, despite the challenges inherent in expanding the state's primary public insurance program to incorporate millions more Californians, the state is preparing to take on this challenge, as counties have already developed and experimented with promising program approaches to reach the poor uninsured population. However, questions still remain as to who the currently uninsured, new enrollees may be in California—specifically, what their health care needs will be and how they may differ from those currently enrolled in Medi-Cal. We also know little about how the targeted waiver and Medi-Cal expansion population values health coverage more generally, which will undoubtedly influence their participation in and use of care within these public insurance programs.

Focus of This Report

This report profiles the population that will likely be eligible for Medi-Cal in 2014 and possibly sooner as a result of the county-based LIHPs being created as part of the renewed Medi-Cal waiver. Understanding the characteristics and health status of new enrollees, through both broad and detailed lenses, can provide a sense of the upcoming demands on a system that must now evolve and guide policymakers in many planning and preparation decisions.

We take a multipronged approach to profiling the new potential Medi-Cal population. First, we analyze available population survey data, including the Current Population Survey (CPS), the American Community Survey (ACS), and the California Health Interview Survey (CHIS), to create sociodemographic portraits of the currently uninsured, poor adult population in the state. All three surveys include information on insurance coverage and provide valid state-level estimates of this population, although only the CHIS provides detailed information on health status. These portraits convey the demographic composition and potential underlying health status of the groups targeted by reform, thus offering a critical base of understanding for enrollment planning and outreach efforts. The survey findings can also assist current program officials and providers determine ways in which the composition of the new expansion population differs from those currently served, and thus guide benefit-design decisions and provider-capacity assessments, as well as overall planning for future health care reliance and service provision needs.

Beyond outreach and enrollment, however, several scholars have observed that the success of the ACA in narrowing health insurance gaps fundamentally hinges on the development of a new social norm—a "culture of coverage"—wherein everyone values insurance coverage and accepts the responsibility of having and maintaining it (California Health and Human Services Agency, 2010; Kaiser Commission on Medicaid and the Uninsured, 2010b). Accomplishing this shift will require state and local governments to ensure that the eligibility determination and enrollment process is streamlined, user-friendly, and contains multiple entry points—e.g., schools, providers and clinics, and community-based organizations (California Health and Human Services Agency, 2010). Such a normative shift will also require the creation of a broad-based social marketing campaign that conveys the value of insurance coverage to those who may have been excluded from coverage options in the past, and to those who may be frustrated with the Medi-Cal system as it currently exists. While population surveys are useful for generating broad profiles, they can say little about how the targeted groups of reform may react to new coverage options, which is intertwined with the extent to which these groups trust and interact with the health care system. To shed light on this issue, we also draw upon focus group information gathered from both poor, uninsured adults and low-income parents with experience in public insurance programs for their children. Our focus group respondents provide in-depth insights into questions of and challenges to the value of coverage generally, and the value of Medi-Cal specifically, as the state prepares for the largest expansion of health care insurance since Medicaid's inception.

Who Are the Uninsured Poor?

Although estimates vary based on differing methodologies and timeframes—ranging from 1.7 to 3 million—it is clear that the Medi-Cal program will be tasked with serving additional millions when it is expanded.[7] This will undoubtedly be a diverse group, both in terms of sociodemographic composition and health status. Understanding the characteristics of the new enrollees, including what their health care needs are, is of vital importance to successfully incorporating previously uninsured Californians into the Medi-Cal program. While the efforts under way in counties to establish low-income health programs represent an important first step, reaching and enrolling the broader group gaining eligibility to Medi-Cal is critical to realizing the full success of the ACA expansions.

In this section, we draw from population survey data to present basic demographic and health profiles of poor, uninsured Californians.[8] We examine three different sources—two national in scope and one state-specific. We rely primarily on the Current Population Survey's Annual Social and Economic Supplement (the most commonly used data source to measure the size and characteristics of the uninsured population at the national and state-level) and the California Health Interview Survey, which provides the most detailed information on health status and health conditions available for the state. We also analyzed the American Community Survey, conducted by the Census bureau, which has the largest sample sizes and highest response rate but has only asked about health insurance coverage for the past two years, so there are still some questions concerning the quality of the information. Rather than considering one survey as the definitive source, we examine all three and find largely consistent patterns. In the table and figures below, we present findings primarily from the CPS and CHIS, using the CPS for the sociodemographic profiles and the CHIS for the health status profiles. Results for all of the measures from all three surveys are available in Technical Appendix A, as is a description of each data source and more information on variable construction.

Comparisons of California with Rest of United States

To provide some context for the unique challenges California faces, we first look at how poor, uninsured adults in California compare to those in the rest of the nation. Table 1 provides a quick overview of uninsured, non-elderly adults in California and the rest of the country who have family incomes below the 139 percent poverty threshold, which would make them eligible for Medicaid under the ACA expansions. We present results for two sample groups—one consisting only of citizens and the other consisting of citizens and non-citizens who have lived in the United States for at least five years. We present estimates for both groups because we are unable to ascertain legal status among noncitizens and therefore cannot accurately account for

---

[7] These projections are based on micro-simulation models, which offer the best way to estimate the number of individuals that may actually enroll in the program as compared to the number that may be eligible, and which also take into consideration other shifts in insurance coverage. We are aware of four sets of state-level estimates for the Medi-Cal expansion populations based on micro-simulation models: Auerbach et al. (2011), Long and Gruber (2011), Holahan and Headen (2010), and The Lewin Group (2010). The RAND model (Auerbach et al., 2011) projects over 3.5 million new enrollees but does not account for the unauthorized immigrant population, which is sizable in California. The Urban Institute model (Holahan and Headen, 2010) projects as many as 3 million new enrollees given a high participation assumption.

[8] It is important to note that our analysis of potential new Medi-Cal enrollees is not based on the micro-simulation models noted in the previous footnote, which have been used to predict likely outcomes of reform. Rather, we are examining the population that falls within the very general parameters that would make them eligible for Medi-Cal (namely, income below the 139 percent poverty level and citizenship) but that does not incorporate any simulations or information on personal and firm-level behavior that would more accurately predict actual enrollment.

unauthorized immigrants who are ineligible for the Medi-Cal program.[9] In addition, noncitizens who have been in the United States for less than five years are also ineligible for Medi-Cal under the ACA expansions, regardless of their legal status, and so they are excluded from both groups.[10]

Although little is known about the unauthorized immigrant population, national estimates suggest that they account for about 50 percent of noncitizen adults in California and that they have high poverty and uninsurance rates (Passel and Cohn, 2009). Thus, it is reasonable to assume that many individuals in the larger sample that includes noncitizens may be unauthorized (even after excluding those who recently arrived in California) and thus will not be eligible for the Medi-Cal expansions. It is important to note that about half of adults who are uninsured and income-eligible for the Medi-Cal expansions appear to be noncitizens[11] —some of whom have recently arrived in the state and are not included in the survey samples upon which our profiles are based. While recently arrived legal immigrants who have been in the United States less than five years will be eligible to receive federal subsidies to purchase insurance in the health benefit exchanges and enroll in the Basic Health Plan (if the state chooses that option), the citizenship restrictions included in the ACA and the Medi-Cal program will leave some of California's poor, uninsured adults without full coverage options. In fact, unauthorized immigrants are projected be one of the largest groups remaining uninsured in California post-reform, with an estimated 1.25 million unauthorized immigrants not covered (Long and Gruber, 2011).

TABLE 1
Characteristics of poor, uninsured adults in California and rest of United States

	Citizens only		Citizens and noncitizens in U.S. at least five years	
Characteristics of poor uninsured	**California**	**Rest of U.S.**	**California**	**Rest of U.S.**
Under age 40	60.2%	58.4%	60.1%	59.3%
Single, no minor children	62.6 *	55.3	49.3	50.7
Full-time worker in household	34.2	34.0	44.2 *	38.3
Fair/poor health	16.4 *	20.0	14.3 *	18.0
Any disability-related difficulty	5.2	6.0	3.9 *	5.2
Estimated population size	1,248,000	11,429,000	2,277,000	13,837,000

SOURCE: Current Population Survey, 2008–2010.

NOTE: Sample population includes non-elderly adults, ages 19 to 64, who live in families with incomes below 139 percent of the federal poverty level. The Citizens Only sample includes U.S.-born and naturalized citizens. The Citizens and Noncitizens sample includes only those noncitizens who have resided in the United States for five or more years. The estimated population size is based on the population as of 2009 and does not include projections to later years when ACA will be implemented.

* Indicates difference between California and Rest of U.S at the $p < 0.05$ significance level.

Regardless of whether the sample includes noncitizens, the age profile of poor, uninsured adults in California and the rest of the nation is largely consistent —about six in ten are younger than 40 years old. There are differences in the proportion who are single and have no minor children—although these vary depending on the sample.[12] If only citizens are considered, California's "poor, uninsured adults" category includes a higher proportion of single

---

[9] Unauthorized immigrants are eligible for emergency-only Medi-Cal, which covers pregnancy related services including deliveries and emergency room visits. Under the ACA, it appears that emergency-based Medi-Cal coverage will be extended for unauthorized immigrants up to 138 percent of the FPL, as opposed to 100 percent of the FPL as it currently stands.

[10] Nearly 40 percent of all poor California adults ages 19 to 64 are noncitizens; and of those noncitizens, about 21 percent have been in the United States for less than five years.

[11] This is based on authors' calculations from the CPS.

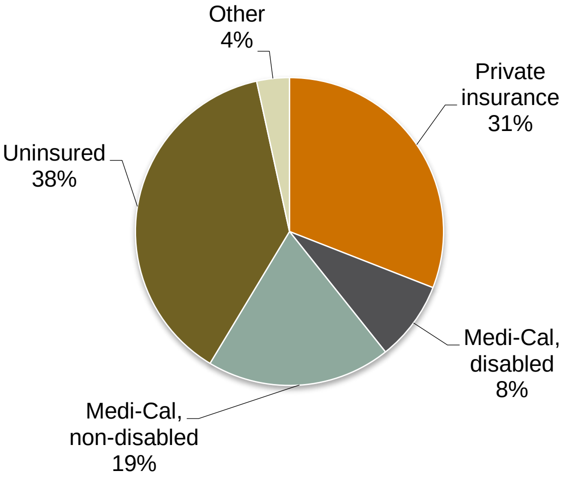
[12] The indicator of minor children in the household indicates that there is a child in the household family unit that is under the age of 18 and also that the adult has at least one of their own children residing in the household.

people with no minor children, compared to the rest of the United States, but if noncitizens are also considered, then California does not look different. California's uninsured poor also look to be slightly healthier, in terms of both self-rated health status and disability-related difficulty, compared to the rest of the nation's uninsured population, regardless of whether noncitizens are included in our sample.

Comparisons of Poor Californians Across Insurance Coverage Groups

We next focus on all poor adults below 139 percent of the poverty level in California and compare characteristics across three insurance groups: (1) privately insured, whether through employment or individually purchased plans; (2) Medi-Cal, non-disabled—defined as those on Medi-Cal who are not also covered by Medicare (dual eligibles) and do not receive Supplemental Security Income (SSI) payments;[13] and (3) uninsured.[14] In all of the following figures, we present results for the sample that contains citizens only to provide the cleanest set of estimates possible. Figure 2 presents the current insurance status of the nearly 3.5 million poor adult citizens in California who would be eligible for Medi-Cal coverage expansions based on income if it occurred today. Specifically, almost 40 percent of these poor adults are uninsured, while 27 percent are covered by Medi-Cal and another 31 percent have private insurance, most often through an employer. When the ACA is implemented, this distribution will undoubtedly change—with a considerable share of the uninsured shifting to Medi-Cal coverage, as well as slightly smaller shares covered by private, employer-based insurance (Long and Gruber, 2011).

FIGURE 2
Current insurance coverage of poor adult citizens in California



SOURCE: Current Population Survey, 2008–2010.

NOTE: Sample population includes non-elderly citizen adults, ages 19 to 64, who live in families with incomes below 139 percent of the federal poverty level.

---

[13] We do not include two insurance coverage groups in these comparative profiles—those categorized as Medi-Cal, disabled (meaning they also reported Medicare coverage and/or received SSI payments) and a catch-all other category (which includes those with Medicare only and also a small group that relies on TRICARE or other VA military health programs). We do not profile these groups because they are very different from the other three groups and tend to be an older, sicker population.

[14] The technical definition of uninsured varies depending on the data source. The CPS reports uninsurance for the entire previous year, although there are questions as to how accurately it captures this full-year construct of uninsurance. In the CHIS and ACS, the insurance categories refer to current insurance status—so uninsurance means the respondent reported being uninsured at the time of the survey. See Technical Appendix A for more information on the differences in insurance coverage measures across the three surveys.

It should be noted that despite the gains in insurance coverage resulting from the ACA, more than three million Californians are projected to remain uninsured. In addition to the sizable unauthorized immigrant population noted earlier, between 20 and 30 percent of the remaining uninsured are estimated to be eligible for the Medi-Cal program but not enrolled (Long and Gruber, 2011; Buettgens and Hall, 2011). The majority of those not enrolled would probably not be subject to the individual mandate provision because of their low incomes (Long and Gruber, 2011); the ACA provides exemptions to the individual mandate for those who do not earn enough income to file a tax return and also includes exemptions based on financial hardship.[15] This relatively large group projected to be uninsured and eligible but not enrolled in Medi-Cal underscores the importance of policy decisions related to the implementation of expansions—including decisions surrounding targeted and tailored outreach, widespread and accessible enrollment processes, and program administration that facilitates easy use and access to adequate care.

At the same time, it is important to recognize that increasing enrollment and utilization may not always be the primary goal of policy, especially during times of budget stress. On the one hand, expansions require increased public investments and new enrollees will incur administrative and utilization costs. On the other hand, scholars have estimated that through increases in coverage, the ACA could reduce the cost of uncompensated care provided to the uninsured by a sizable amount—which is currently funded by a mixture of federal, state and local funds as well as by healthcare providers (Buettgens et al., 2010). At the household and individual level, an Oregon-based study has found that expansion of Medicaid coverage results in decreased medical debt and out-of pocket expenses for low-income enrollees, and results in higher use of preventive services, which can delay costly long-term care situations down the road (Finkelstein et al., 2011).

A detailed understanding of the population gaining eligibility to the program in California will help inform some of the upcoming policy decisions identified above, which in turn, will influence actual enrollment rates and the ultimate size of coverage gaps after 2014.

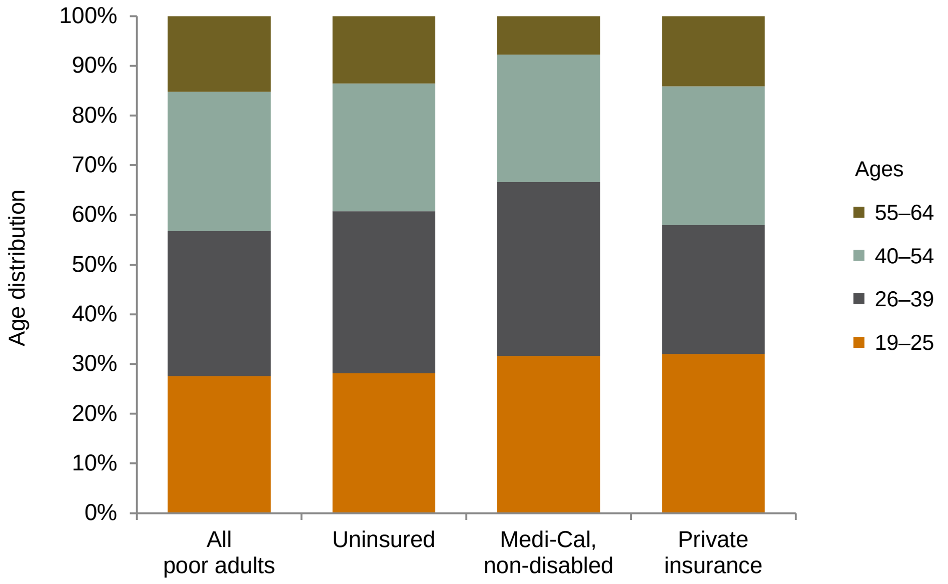
---

[15] Based on 2009 tax rules, single taxpayers who earn less than $9,350 and married couples who earn less than $18,700 would not be subject to the individual mandate because they do not have to file a federal tax return. The mandate would also be waived in "financial hardship" cases where the lowest cost health care plan available would exceed 8 percent of annual income.

Age, Race/Ethnicity, and Family Structure

Regardless of survey source, more than half of the poor adults in California are between the ages of 19 and 40, and fewer than one in six are between the ages of 55 and 64 (Figure 3). The age distribution of the uninsured group is similar to the other two insurance groups, with only a few differences. Fewer Medi-Cal non-disabled recipients fall into the oldest age category, compared to the uninsured, while fewer privately insured are in the 26-to-39 age category. Similar patterns emerge when we include noncitizens who have been in the United States for at least five years, except that there are more age structure differences between the uninsured and privately insured groups.

FIGURE 3
Age distribution by insurance coverage, poor adult citizens in California



SOURCE: Current Population Survey, 2008–2010.

NOTE: Sample population includes non-elderly citizen adults, ages 19 to 64, who live in families with incomes below 139 percent of the federal poverty level.

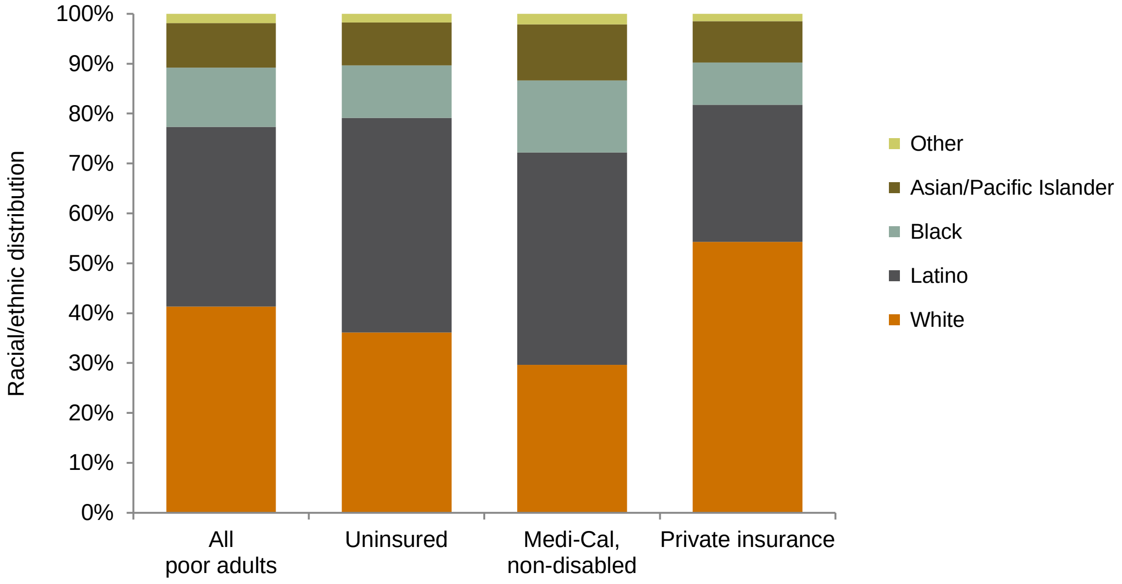
Age, particularly older age, is a broad proxy for the emergence of chronic health conditions, so a younger age distribution should signal a healthier population. From a cost perspective, the fact that such a large proportion of potential new Medi-Cal enrollees are younger than 40 years old is good news. Six in ten poor, uninsured adults are under age 40, and nearly three in ten are under age 25.[16] Health care spending per capita by adults ages 19 to 44 is half that of spending by adults ages 55 to 64 (Hartman et al., 2007). In addition, much of the costs for the younger age group are attributable to maternity care and childbirth, which Medi-Cal already covers in large part for poor adult women (Cylus et al., 2011). Unfortunately, those who are younger may be the least likely to enroll in the program, largely because of better health and lack of health care need or use. This can be seen in Massachusetts, the first state to implement near universal coverage, where the remaining uninsured adults are more likely to be young, single men (Long, Phadera, and Lynch, 2010).

---

[16] Some of the uninsured in the age category of 19 to 25 could gain coverage through the age expansions in dependent coverage mandated in the ACA, although those in poor families likely have less access to family coverage options.

As Figure 4 illustrates, among all poor adult citizens in the state, about 40 percent are non-Hispanic white and 36 percent are Latino. Larger proportions of poor adults with private insurance are non-Hispanic white (54%), while Latinos compose disproportionately smaller shares of those with private insurance (27%). As a result, Latinos make up higher proportions of the Medi-Cal non-disabled and uninsured populations (both 43%). Poor blacks make up higher shares of the Medi-Cal population and lower shares of the privately insured relative to their overall share of poor adults. The racial/ethnic distribution of poor uninsured adults changes considerably if noncitizens are included: The Latino population then comprises more than half of all poor adults and 65 percent of uninsured poor adults (Technical Appendix A, Table A2).

FIGURE 4
Race/ethnicity by insurance coverage, poor adult citizens in California



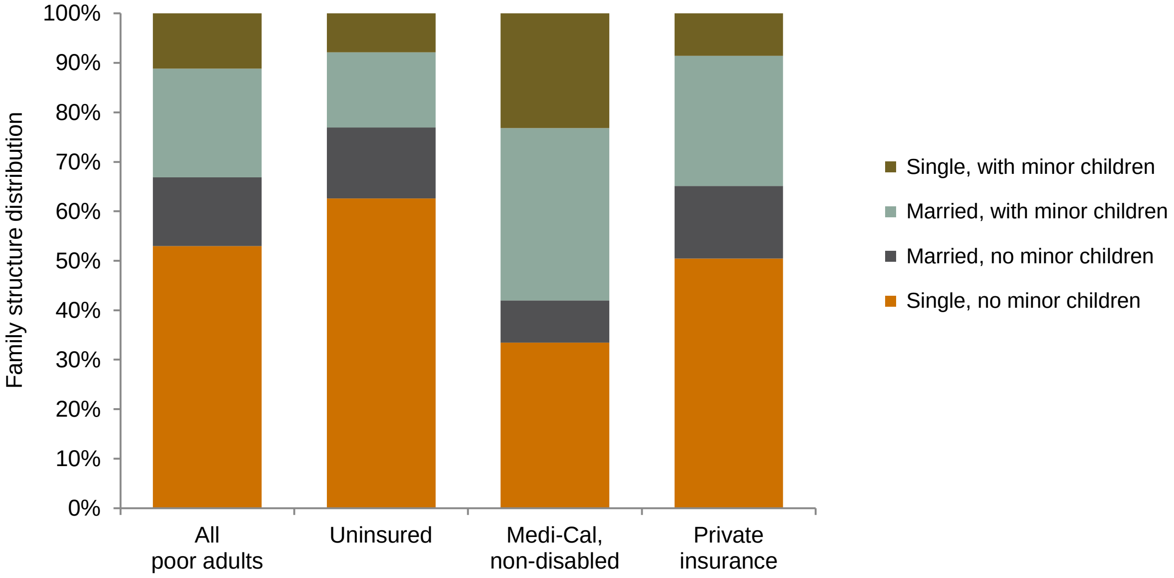
SOURCE: Current Population Survey, 2008–2010.

NOTE: Sample population includes non-elderly citizen adults, ages 19 to 64, who live in families with incomes below 139 percent of the federal poverty level.

Not surprisingly, some of the largest differences between the currently uninsured and insured poor adult populations are reflected in family structure (Figure 5). The Medi-Cal non-disabled population looks quite different from other groups, with considerably larger shares of adults with minor children in the household, both married and unmarried. This is undoubtedly driven by the categorical eligibility requirements of having dependent children in order to qualify for Medi-Cal. Uninsured adults are more similar to the privately insured in terms of family composition, although the uninsured have higher shares of single adults without children, and lower shares of married adults with children compared to the privately insured. Uninsured adults with minor children could include parents whose incomes fall above 100 percent of the FPL (the current income eligibility cut-off for non-disabled adults with dependent children) but below 139 percent of the FPL (the new ACA cut-off), as well as parents who are currently eligible but not participating in the program.

FIGURE 5

Family structure by insurance coverage, poor adult citizens in California



SOURCE: Current Population Survey, 2008–2010

NOTE: Sample population includes non-elderly citizen adults, ages 19 to 64, who live in families with incomes below 139 percent of the federal poverty level. The single definition includes those categorized as divorced, widowed, or never married. The married definition includes those categorized as married - spouse present, married–spouse absent, and separated. The minor children definition indicates that there is a child under 18 in the household family unit and the individual has at least one of their own children in the household.

In addition to age, race/ethnicity, and family structure, we also looked at several other sociodemographic characteristics, including sex, employment, income, and education. There are few differences between the uninsured group and the Medi-Cal non-disabled group, with some exceptions. The most notable exception is in the educational profiles—with the uninsured including more adults with a college degree and significantly fewer adults with less than a high school education, which may result from the higher shares of young mothers and single parents among the Medi-Cal group, who tend to have lower levels of educational attainment. In general, the privately insured have higher education and income levels than the uninsured. The privately insured poor have lower proportions of households with no workers compared to the Medi-Cal (non-disabled) and uninsured populations, although most of the currently uninsured are employed full or part-time.

It is likely that the impact of coverage expansions could vary across the state's regions. Using the ACS, we examined a smaller set of demographic characteristics of the uninsured poor adult population at the county level for the ten largest counties in the state. In this exercise, we used a 200 percent rather than a 138 percent FPL cut-off to increase the sample size (which become small at the local level), but also because the county-based LIHPs created by California's new Medi-Cal waiver include a component that can provide coverage to the uninsured up to 200 percent of the poverty threshold.[17] We find that along most dimensions (including citizenship status, age, and parental status), the counties' uninsured populations appear to be similar (see Technical Appendix A, Table A7). There are a few notable exceptions: The proportion of the county's low-income population who are noncitizens is lower in Alameda and Sacramento Counties and higher in Los Angeles and Orange Counties. Similarly, Alameda and Sacramento Counties have smaller shares of parents, whereas Kern and Riverside Counties have some of the highest shares of parents among their low-income uninsured populations.

Health Status of Potential New Medi-Cal Participants

Beyond understanding the sociodemographic characteristics of the potential new enrollees in Medi-Cal, the most salient questions of interest are probably those relating to their health care needs. The health status of this group will largely determine the resource demands related to the expansion, and understanding the potential needs of this population will help policymakers and program officials prepare for the influx of new participants. Research focused at the national level suggests that poor, uninsured adults may be slightly more healthy than the Medicaid, non-disabled population—but slightly less healthy than privately-insured poor adults (Holahan et al., 2010; Kaiser Commission on Medicaid and the Uninsured, 2010a). Similarly, the poor, uninsured adults in California estimated to be eligible for the Medicaid expansions have comparable health profiles relative to the current Medi-Cal population (Pourat et al., 2011). Based on similar analyses of various survey sources, we discuss a range of general health status markers as well as specific health conditions and behaviors of poor adults in California, comparing health profiles across insurance groups.

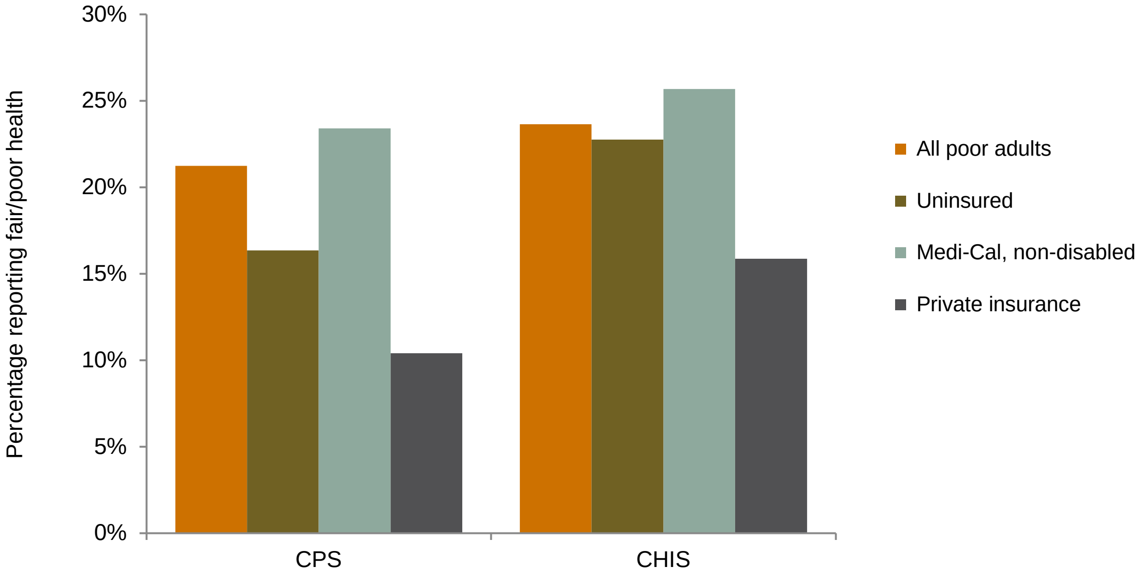
---

[17] In addition, national research shows considerable income fluctuations for people below 200 percent of the FPL, with nearly 50 percent moving between Medicaid eligibility (138%) and exchange eligibility (138% to 200%) over a two-year period (Sommers and Rosenbaum, 2011).

General Markers of Health

We first look at self-reported health status, which is the only health-specific information available in the CPS. Figure 6 displays the percentage reporting fair or poor health status across insurance groups based on both the CPS and CHIS. It is worth noting that the estimates for "all poor adults" in Figures 6 through 9 include those categorized as "Medi-Cal, disabled" and "Other" in addition to the other three insurance groups presented. Although the "Medi-Cal, disabled" and "Other" groups are small (about 12 percent of the poor, citizen, adult population we analyze), they generally have worse health status, which contributes to the estimates of "all poor adults" looking less healthy than an average of the three groups presented would seem to suggest. As shown in Figure 6, while the magnitude of the estimates is different based on the data source (sample respondents in the CHIS are more likely to report fair/poor health across the board), the overall pattern is generally consistent. Specifically, privately-insured poor California adults have the lowest proportion reporting poor health and the Medi-Cal non-disabled have the highest, with the uninsured falling somewhere between. Between 15 and 25 percent of the uninsured group report fair or poor health, which is lower than the Medi-Cal non-disabled group, although the difference is statistically significant only in the CPS data.

FIGURE 6
Self-reported fair/poor health status by insurance coverage, poor adult citizens in California

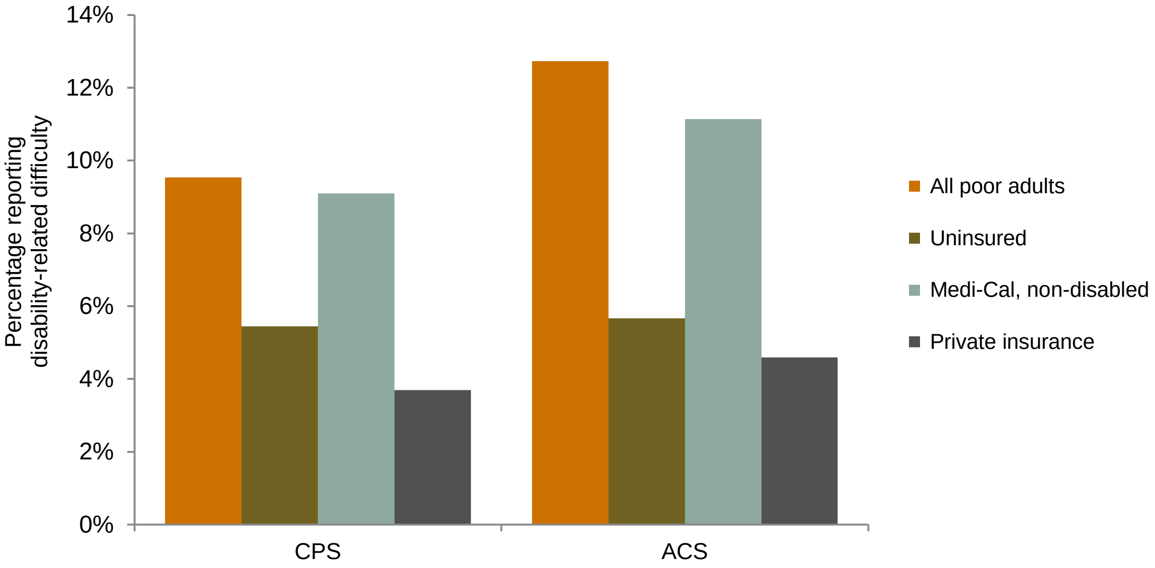


SOURCE: Current Population Survey, 2008–2010; California Health Interview Survey, 2009.

NOTE: Sample population includes non-elderly citizen adults, ages 19 to 64, who live in families with incomes below 139 percent of the federal poverty level.

Next, we look at the presence of any disability-related difficulties[18] reported in the CPS and ACS (Figure 7). These are very broad markers designed to provide an assessment of the level of general disability or potential for disability in the population, but they do not coincide with the actual program definitions for determining disability status to become eligible for Medicare or Supplemental Security Income (SSI). Again, the magnitudes vary slightly but the overall pattern is consistent and suggests that the uninsured are less likely than the Medi-Cal non-disabled population to report any physical, mobility, or self-care difficulties. They are, however, slightly more likely than the privately-insured, poor adult population to report a disability-related difficulty, but the difference is only statistically significant based on the ACS data.

FIGURE 7
Presence of physical, mobility, or self-care difficulties, poor adult citizens in California



SOURCE: Current Population Survey, 2008–2010; American Community Survey, 2009.

NOTE: Sample population includes non-elderly citizen adults, ages 19 to 64, who live in families with incomes below 139 percent of the federal poverty level.

---

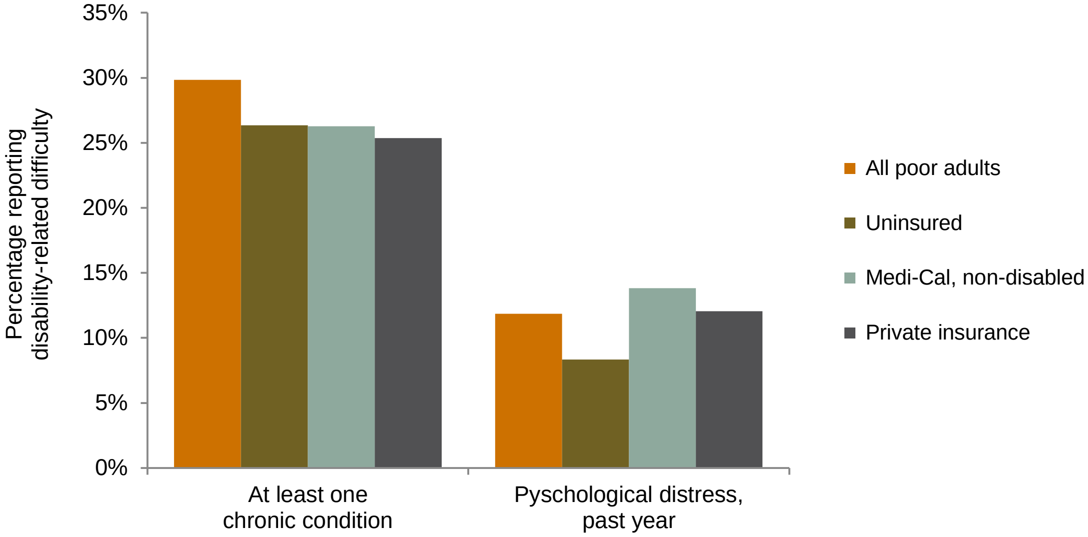
[18] *Physical difficulties* are defined as serious difficulty walking or climbing stairs; *mobility difficulties* are defined as physical, mental or emotional conditions lasting six months or longer that make it difficult or impossible to perform basic activities outside the home; *self-care difficulties* are defined as physical or mental health conditions that have lasted at least six months and that make it difficult to take care of one's own personal needs. All measures exclude temporary health conditions such as broken bones or pregnancy. The series of questions on disability-related difficulties are only included in the CPS in the 2009 and 2010 samples, so estimates for this measure are based on only those two years, rather than on three years, as is the case for all of the other measures.

Chronic Conditions and Health Behaviors

We also examine the presence of a number of self-reported chronic health conditions (diabetes, asthma, hypertension, and heart disease) and psychological distress in the past year,[19] which are only asked in the CHIS (Figure 8). There are no differences across the groups in the presence of at least one serious health condition, although it should be noted that the uninsured, because they do not have insurance coverage, might be less likely to have been diagnosed with a condition due to lower use of health care services. Somewhat surprisingly, the uninsured were less likely than the Medi-Cal non-disabled group to report psychological distress.

FIGURE 8

Presence of chronic health condition or psychological distress, poor adult citizens in California



SOURCE: California Health Interview Survey, 2009.

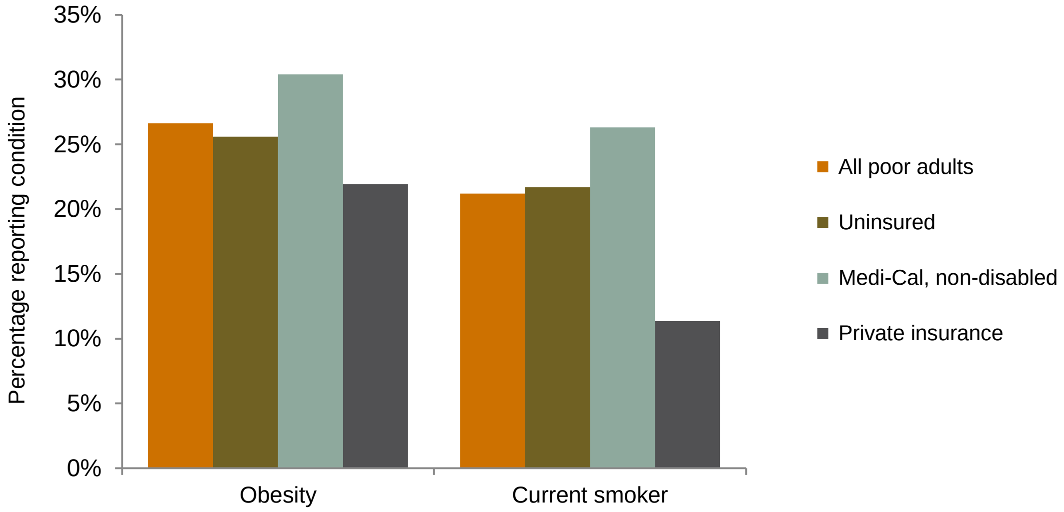
NOTE: Sample population includes non-elderly citizen adults, ages 19 to 64, who live in families with incomes below 139 percent of the federal poverty level.

---

[19] Measure of generalized psychological distress are based on Kessler's six-item distress scale, which is constructed from six questions that asks respondents about anxiety, depression, and hopelessness in the previous year. The maximum score is 24, with a score greater than 13 indicating the presence of psychological distress.

Finally, we examine current smoking patterns and prevalence of obesity, given that these conditions correspond to increased health risks and costs (Figure 9). There are no differences across the groups in prevalence of obesity. Yet prevalence is high, as it is for Californian adults more generally, with about 25 percent falling into the obese category, defined as a body mass index (BMI) of 30 or greater (Lee, 2006). This implies that obesity-related disease prevention is likely to be an important component of health care in the case of both new enrollees and current Medi-Cal patients. In addition, the poor uninsured and current Medi-Cal, non-disabled beneficiaries report higher levels of smoking compared to the privately insured group, suggesting that smoking cessation programs or other interventions to reduce smoking among these groups may be needed.

FIGURE 9
Prevalence of obesity and smoking, poor adult citizens in California



SOURCE: California Health Interview Survey, 2009.

NOTE: Sample population includes non-elderly citizen adults, ages 19 to 64, who live in families with incomes below 139 percent of the federal poverty level.

Taken altogether, the available indicators suggest that the underlying health status of poor, uninsured adults in California is similar to that of poor adults with private insurance and may be slightly better than that of current Medi-Cal beneficiaries—mirroring the patterns at the national level.[20]

This is not to say that serious health conditions are absent in the poor, uninsured adult population—about one in five of these adults report being in fair or poor health, and nearly one in four report at least one chronic condition. In addition, there are specific, noteworthy sub-populations within the larger group of adults likely to gain access to Medi-Cal who have significant health care needs and are probably not captured by the large surveys we use for our analysis. We highlight three of these groups—the parolee or re-entry population, the HIV-positive population, and the chronically homeless population—in the "Special Populations" text box below. The distinctive and multiple health care needs of each of these groups pose serious challenges to their incorporation in existing Medi-Cal managed care systems. Currently, many of these individuals receive care

---

[20] This holds true whether we include only citizens in the sample, as we have with these figures, or include both citizens and noncitizens who have been in the United States for at least five years. Detailed results for the citizen and noncitizen sample populations are included in Technical Appendix A.

through a patchwork of county- and community-based programs, and they will require coordinated management and care, particularly in the case of mental health and substance abuse issues. The incorporation and integration of substance abuse providers, mental health providers, and other specialists who currently work with these groups into the provider networks and medical homes serving Medi-Cal expansion populations will be essential, as will connection to other social services.

Special populations

Re-entry/parolee. According to the most recent statistics from the California Department of Corrections and Rehabilitation, more than 120,000 adults were on parole in California as of December 2010. The overwhelming majority of parolees are male (90%), and while some may qualify for Medi-Cal under current rules, some studies suggest that the majority of parolees are uninsured (Mallik-Kane and Vischer, 2008; Alameda Health Task Force, 2009). Despite being relatively young (the average age of California parolees is 37), the health care needs of the reentry population are substantial, particularly for mental health care and substance abuse services. Nearly two-thirds of California inmates have reported drug abuse or dependence problems, and more than half have reported a recent mental health problem. The re-entry population also has a high prevalence of infectious diseases, including HIV (1%), tuberculosis (13%), and hepatitis B and C (13%), as well as high rates of common chronic conditions such as hypertension (18%) and asthma (14%) (Davis et al., 2009).

HIV-positive. California is home to 40,000 people living with an HIV diagnosis, with Los Angeles and San Francisco Counties accounting for just over half of all HIV cases in the state (California Department of Public Health, Office of AIDS, 2010). Currently, most HIV-positive people must wait until their disease progresses to an AIDS diagnosis before they are classified as disabled and become eligible for Medi-Cal. Many HIV-positive adults receive health services through the federal Ryan White HIV/AIDS program, which 1) funds health services for those with HIV/AIDS who do not have adequate resources, 2) supports reimbursements to a network of providers specializing in HIV/AIDS care, and 3) provides funding for the AIDS Drug Assistance Program (ADAP) that covers prescription drugs for low-income people with HIV/AIDS. As of June 2010, California's ADAP served more than 23,000 clients, 66 percent of whom were uninsured and 42 percent of whom had incomes below 100 percent of the FPL (National Alliance of State and Territorial AIDS Directors, 2011). Many of these individuals will likely become eligible for the Medi-Cal program when it is expanded to include childless adults. Los Angeles County, for example, estimates that 40 percent of clients currently receiving medical outpatient care funded by the Ryan White program would be eligible for coverage under the Medicaid expansions (Los Angeles Department of Public Health, Office of AIDS Programs and Policy, 2011).

Chronically homeless. According to federal statistics, on any given night in California approximately 133,000 people are homeless. Estimates suggest that about one-quarter of the homeless are *chronically* homeless (i.e., they have either been continuously homeless for at least a year and have a disabling condition or have had multiple episodes of homelessness in the past three years). The chronically homeless have high rates of serious mental illness and substance abuse disorders, as well as other serious health issues that make them frequent users of high cost emergency department care and lengthy inpatient visits (Caton et al., 2007).

In addition, there is sound reason to believe that the group that actually enrolls in Medi-Cal, particularly in the initial phases of expansion, will be less healthy than the wider eligible pool—a process often referred to as adverse selection. That is, among the uninsured population, those who need health insurance the most due to health conditions and perceived need will be among the most likely to enroll. Another way of thinking about adverse selection is that the healthier a person is, the less likely he or she may be to enroll in health insurance coverage, particularly if that coverage is costly or not thought to be of value. And, as with any insurance program, it is important to ensure that healthy individuals are included in the program or risk pool to balance the costs and demands of those who are sick. Additionally, health plans and providers may be discouraged from participating if there is a significant degree or potential for adverse selection.

While there is evidence to suggest that adverse selection will occur based on the experiences of other states that have expanded public insurance options to adults, it is neither definitive nor conclusive. Earlier studies examining state-subsidized public insurance programs found little evidence of adverse selection (Long and Marquis, 2002; Kilbreth et al., 1998). However, more recent work examining state Medicaid expansions for childless adults does suggest the potential for adverse selection and higher costs (Allen et al., 2010; Somers et al., 2010; Holahan et al., 2010). For example, a recent report examining ten states with public coverage options for childless adults concludes that the uninsured childless adult group may be more expensive to cover than parents currently enrolled in the program, although less expensive than disabled adults (Somers et al., 2010). In California, the county LIHPs can provide initial insights into the health needs of the larger expansion population, but perhaps more importantly, can enroll those with high medical needs and incorporate them into coordinated care settings where their medical conditions will be better managed prior to entering the Medi-Cal program in 2014.

As others have observed (Holahan et al., 2010), high participation rates among the wider eligible pool will likely mitigate some of the adverse selection concerns about the average costs of new enrollees. In addition, one important component not included in earlier studies of coverage expansions is the presence of an individual mandate. The only evidence we have on the potential effects of the individual mandate comes from Massachusetts and is largely positive. The mandate was found to play a causal role in reducing adverse selection in subsidized coverage among low-income adults and was also associated with an increase in coverage even among those not bound by it (Chandra et al., 2011; Buettgens et al., 2011). In sum, participation in low or no-cost insurance programs is driven by a confluence of factors, including health need, perceived risk, obligations/expectations, and valuations of the importance of coverage.

Perspectives of Current and Potential Medi-Cal Users: Focus Group Insights

How providers and program officials will integrate the diverse group of currently uninsured, potential new enrollees into the Medi-Cal program, while maintaining basic levels of care for those currently enrolled, is a significant unknown. Yet the perspectives of those who will be most directly affected by Medi-Cal expansions are seldom given full voice in discussions of this issue. From a program design and implementation standpoint, the views of both current and potential participants in the Medi-Cal program are relevant to understand for several reasons. First, the currently uninsured may not have any previous experience with enrolling in public programs or very limited knowledge about such programs. In addition, what they do know or believe to be true about Medi-Cal may inhibit participation. Those who are quite familiar with the program, namely parents with publicly insured children, have a wealth of experience to draw from and much to say regarding how to improve the program as expansions get underway. To build a "culture of coverage" among those who have largely been excluded from the Medi-Cal system and among those who might be frustrated with the system in its current state, policymakers would be prudent to first understand how the value of coverage is constructed and situated.

In this section, we present our findings from focus group sessions we led among two target populations that will be very much involved in the Medi-Cal expansions: uninsured, primarily childless, poor adults and low-income parents who are current or recent users of public insurance programs. Researchers have long used focus group methods as an investigative, data-generating technique to explore a specific set of issues related to perceptions and experiences (Kitzinger, 1994)—in our case, people's perceptions of the ACA and Medi-Cal expansions and the value of coverage, and how they access care.[21] While survey data contain large sample sizes, often designed to be representative, the benefit of conducting in-depth discussions with a small group is that salient concerns and viewpoints often emerge, providing insights that cannot be discovered through an examination of numbers. As with most qualitative studies, these groups are not intended to reflect the experiences of an entire target population, but rather to provide some idea of perceptions of, and responses to, a given situation. For example, how are messages regarding ACA and Medi-Cal expansions being received, and what does value of coverage mean to people? Answers to such questions can shed light on how a larger, normative shift may emerge and help identify for policymakers non-quantifiable barriers that may impede such a shift.

In the fall of 2010, we recruited respondents and conducted focus groups in three locations across the state—the greater Los Angeles area, the San Francisco Bay area, and the Fresno metropolitan area in the Central Valley. We selected these locations in order to ensure geographic and racial/ethnic diversity. In each location, we conducted two separate focus groups: one among poor, uninsured, primarily childless adults and one among parents who had experience with public insurance programs covering their children (Medi-Cal and Healthy Families). The typical size for focus groups is 7 to 10 people (Marshall and Rossman, 2010). Each of our groups included an average of about eight participants.

---

[21] The earliest uses of focus group methodology included marketing research in the 1920s (Kitzinger, 1994). Sociologist Robert Merton popularized its use in social science research in the 1950s, examining perceptions of war propaganda. Today, focus groups are used widely in evaluation research (e.g., examining the messaging results of health education campaigns, political polling and opinion research, and film and television reception studies) and in qualitative methods of inquiry in the social sciences (Marshall and Rossman, 2010).

Most of the participants in our focus groups consisting of uninsured adults did not have dependent children, and nearly all had incomes below 139 percent of the poverty threshold, making them likely candidates for Medi-Cal expansions.[22] All participants were currently uninsured, with most reporting that they had lacked coverage from one to four years, although one-quarter reported that they had been uninsured for more than ten years or their whole adult life. The Bay Area and Los Angeles "uninsured" groups were conducted in English, and the Fresno group was conducted with individuals who spoke Spanish as their primary language. Most of the participants in our parent groups were mothers who were intimately familiar with public insurance programs, largely because their children (and sometimes themselves) had coverage through the programs. The majority of our parents had a child in Medi-Cal, although we also included parents who had children in Healthy Families (California's State Children's Health Insurance Program, or SCHIP) to get a sense of their concerns. The Bay Area and Fresno "parent" groups were conducted in English, and the Los Angeles group was conducted in Spanish.

We asked participants a range of questions, from their impressions of health care reform and the Medi-Cal program to their current strategies for navigating the health care system and managing their health. By and large, we covered the same topics in both the uninsured and parent groups, although some distinct perspectives and discussions on Medi-Cal emerged in the parent group, because they were more familiar with Medi-Cal and other public programs. The purpose of the focus groups was not to educate or persuade our informants with regard to the ACA provisions, but rather to hear what they knew about the recent shifts in the policy landscape and to synthesize how their perceptions might feed into the formation of a re-envisioned culture of coverage.[23]

Knowledge about Affordable Care Act Provisions

Although 2014 is still several years off, planning for outreach efforts is already under way. Recent national polls suggest that there is still considerable confusion about key elements of the ACA, and confusion appears to be particularly high among the currently uninsured (Kaiser Family Foundation, 2011). In a recent poll of low-income Californians conducted by the Blue Shield of California Foundation (BSCF, 2011), only 40 percent of respondents felt that the ACA would improve their health care coverage options; nearly 30 percent felt that it would not make a difference, and one in five felt that the ACA would make their options worse. Clearly, there are divided opinions on the new law, which are undoubtedly related to lack of information or clarity with regard to how the ACA will affect personal situations.

Similarly, while all of the participants in our focus groups had heard about federal health care reform, few—and especially among those in the uninsured, childless adult groups—were knowledgeable about the specifics of the law. The overall impression among those who had followed the news or who had conversations within their social networks was that the law was quite confusing—this was true in the case of both the publicly insured and uninsured groups. We discuss below the specific areas in which respondents lacked clarity or knowledge, noting in particular the ways in which ACA implementation might directly address the concerns of respondents about whether they are covered, what would be covered, and how.

---

[22] In the early stages of our recruitment for the Fresno focus group, in which we targeted Hispanic, Spanish-speaking, uninsured, childless adults, it became clear that it would be quite difficult to find adults without dependent children. Thus, while our preference was to include potential respondents who were childless, we relaxed this criteria in Fresno, and five out of eight participants reported having dependent children in their homes.

[23] See Technical Appendix B for more information on the focus groups, including the development of interview guides, recruitment, and coding.

Uncertainty about Medi-Cal Eligibility

In the focus groups comprising the uninsured, a number of respondents in each location voiced confusion over changes in Medi-Cal eligibility based on their prior experiences with unsuccessfully trying to access coverage through such programs. Kelly (in the Bay Area), who had applied for Medi-Cal years before and was denied, was acutely aware that under current program eligibility rules, at least prior to ACA, as a single woman with no children she would not qualify:

> First of all, right now, if you are poor and have kids, you have a better chance of getting some medical attention. With being single, no kids, like myself, the hell that I go through basically any time I want to go anywhere to get help, it's got to be an emergency, like going to County [hospital] or some sort. They don't have different programs for me.

Many of our uninsured childless participants, including Kelly, would benefit from the removal of historic exclusions to Medi-Cal based on dependent children, should their incomes remain below 139 percent of the federal poverty line. Most respondents, though, were unaware that public insurance programs were going to be expanded to a broader group that was previously ineligible even if they had low incomes. If these respondents assume that Medi-Cal eligibility will continue to operate under current guidelines, they might not even attempt to apply for Medi-Cal under ACA, based on their earlier experiences with denials. For respondents like Kelly, the opening of Medi-Cal's eligibility to single, non-disabled, childless adults is a welcome change, and this information should be clearly and vigorously disseminated.

There was also a lack of understanding about the "new," more generous Medi-Cal eligibility thresholds. In particular, uninsured respondents were eager for more specifics about income requirements and whether they would be "over" the Medi-Cal thresholds, which would help determine how truly "affordable" care will be. Many of our parent respondents were also deeply interested in how the ACA would affect their current eligibility for the program: "Are they going to change the requirements [for Medi-Cal] now? I don't think anybody really knows how it is going to unfold…" Several individuals in both the uninsured and publicly insured groups pressed the moderator to help them assess whether they would be income eligible for low or no-cost coverage. Because these were not educational focus groups, our moderator turned the question back around to our respondents, at which point their lack of, and desire for, clear information was reiterated.

Uncertainty about Benefits

Participants also expressed concerns relating to details of coverage plans: What medications would be covered for various conditions? What types of care would they have access to—specialty care? dental care? One uninsured woman from the Bay Area captured these concerns rather succinctly: "The thing is what are they actually going to cover? You see, I had health coverage before. Just because you have health insurance, it doesn't mean they're going to pay for stuff." Currently, the benefits covered through various public programs vary, depending on the type of program (e.g., Medi-Cal, Healthy Families). One Bay Area mother whose children had been in both Medi-Cal and Healthy Families (due to income fluxes) contrasted the two by noting that Medi-Cal was more limited in the medications it would reimburse. Angela, a young mother from Fresno, noticed recent changes in the coverage of medications under Medi-Cal as well: "I think the doctors feel that…. Now they're kind of like, why am I going to prescribe you something? Your insurance is not going to cover it, and if you have Medi-Cal, it's obvious that you can't afford to just go buy it."

In recent years, as observed in both our parent and uninsured groups, Medi-Cal has cut back on the types of services it provides to adults due to budget constraints, especially certain forms of specialist, dental, and vision care. Stories of needing serious dental care to treat an abscess emerged in many of the focus groups, and, not surprisingly, many of these participants felt that such dental issues were medical in nature and should be covered. Parents also reported difficulties accessing certain specialty care for their children (for example, allergists and psychiatrists). Despite these frustrations, other Medi-Cal parents noted that available benefits at least covered basic services. As stated by one uninsured man, "Any coverage is better than no coverage."

The ACA allows states some flexibility in the benefit packages they provide to those who, under the aegis of the act, will now become eligible for Medicaid. Currently, states have the option of providing what are called "benchmark" or "benchmark equivalent" benefit plans to some Medicaid beneficiaries.[24] These benchmark plans tend to be less comprehensive than full-scope Medicaid benefits, more closely resembling typical employer benefit packages. Indeed, the "benchmarks" these plans must adhere to are standard employer plans. California, like most states, does not currently offer benchmark benefits but, instead, provides full Medicaid benefits to all current Medi-Cal beneficiaries eligible for full-scope coverage. State policymakers will need to decide whether to offer benchmark or full Medicaid benefits to newly eligible groups.

It is clear that part of the value placed on coverage is tied to the benefits that the coverage makes available, yet it is unclear how Medi-Cal benefits will change in the future and how Medi-Cal benefits will compare to the benefits and options of other health plans targeted toward those with low incomes (e.g., options provided by the Exchange and, if adopted, the Basic Health Plan). Because cuts to the Medi-Cal program are routinely discussed in the mainstream media and were talked about in both our uninsured and parent focus groups, it may be helpful for policymakers to describe and frame Medi-Cal benefit plans in terms of how they compare to employer sponsored plans, rather than how they compare to previous Medi-Cal plans.

How to Close Insurance Gaps: Thoughts on the Individual Mandate

One of the key, and most contentious, provisions of the ACA is the requirement that most citizens have some form of health insurance or else face a tax penalty, similar to Massachusetts' health reform law. The rationale for the mandate is to help ensure wide participation and broad insurance pools so that costs and risks are spread among the largest possible population, mitigating adverse selection problems. Some focus group participants were clearly unaware that the ACA included an individual mandate. Among those who had heard of the mandate (a little over half of all participants), there was very strong opposition, particularly with regard to the potential fines for noncompliance. This is illustrated in the following excerpt from the Los Angeles group:

> *Ron:* I think it's ridiculous.… We're supposed to vote for what we want, what we don't want, and then if you don't get it, you're going to get a fine or you're taxed?
>
> *Matt:* Pretty much, if you can't afford it…
>
> *Ron:* Yes! I can't afford insurance. What makes you think I can afford this fine you're going to give me?
>
> *Others:* Mmm hmm (affirmative).

---

[24] Certain groups of Medicaid beneficiaries are excluded from such optional plans and must be offered full Medicaid benefits, including people with disabilities, dual-eligibility individuals, certain low-income parents, and other groups with special medical needs.

Mindful of affordability concerns, especially among those with limited financial resources, federal policymakers exempted from the mandate those with incomes below the tax filing threshold and also included financial hardship exemptions in cases where the lowest cost health plan would exceed 8 percent of annual income. Given the low incomes and employment status of our focus group participants (many in the uninsured group worked only part time, and about one in four was unemployed), the penalty would likely not apply for most, if not all, of the members of the groups if the individual mandate were implemented today. Yet most of our uninsured participants were unaware that the mandate provision contained exemptions and that these exemptions would apply to them. Furthermore, most would be income-eligible for Medi-Cal if the ACA were implemented today, providing them with a way to meet the individual mandate provision at little or no personal cost. This is clearly a critical message to communicate in the next few years, as outreach and enrollment efforts gather speed.

Perhaps a more difficult challenge lies in some respondents' strong ideological reservations about "socialized medicine." A number of participants believed the government was overstepping its role in mandating the purchase of insurance, which they felt should be optional. However, an interesting analogy to car insurance emerged in many of the groups, with participants suggesting that this comparison might be useful as state and local governments provide information on the mandate. For example, one participant from Los Angeles noted that in order to drive a car, you must have proof of insurance,; and he then questioned why the same principle shouldn't apply to health care—insurance as a protective measure for yourself and, ultimately, the health of the general public. As Pedro from Fresno summarized:

> I think that it is the best thing that can be done. The government requires things all the time…. I mean you have to have it. Once you have to go to the hospital when something happens to you, or a bad accident, and you don't have insurance because you didn't want to and you didn't want to apply for Medi-Cal…. You will pay for that decision.

Creating a Culture of Coverage

Researchers and policymakers recognize that affordability is a major barrier to obtaining insurance coverage, especially among the low-income population (Blumberg et al., 2007; Bernard and Selden, 2006). For most of the participants in our focus groups, basic affordability barriers should largely be addressed through Medi-Cal expansions and, for the remaining participants, through subsidies to purchase insurance through the state-run health benefit exchange. Aside from affordability concerns, respondents' perceptions of the Medi-Cal expansions (and the importance of coverage more generally) are also shaped by their lived experiences navigating the health care system, both with and without insurance coverage.

Below, we trace how coverage, access, and trust in the health care system intersect to inform perceptions. Understanding these factors is essential to begin building, from the ground up, a normative shift wherein coverage is both expected and valued. To value coverage implies that potential consumers understand how coverage improves their life circumstances. While it may seem that anyone without insurance would obviously value coverage if they had affordable access to it, our focus groups reveal a number of non-financial challenges that affect both health-seeking behavior and participation in the health care system. The challenges identified in our group discussions include limited access to providers, particularly in the Medi-Cal networks, lack of continuity of care, leading to reliance on emergency care and self-treatment strategies rather than preventive care, and perceptions of low-quality care within the safety-net health care system.

Addressing Limited Provider Capacity

Perhaps not surprisingly, the uninsured, childless adult participants in our focus groups reported knowing very little about the Medi-Cal program. However, a handful did express their opinion that Medi-Cal was a low-quality system of care, and their perceptions were shaped by what they understood to be limited access to providers. Indeed, these concerns were echoed and expanded upon in the parent focus groups. While most parents greatly valued the insurance coverage they had through public insurance programs, especially with respect to its affordability, some parents also reported major difficulties in accessing care, including over-crowded providers and long wait times to get an appointment with a primary care provider (PCP). As Michelle, a mother in Fresno noted, these constraints have implications for quality of care:

> They [Medi-Cal providers] tend to schedule five people at one time, so they don't really have time to go over any issues that you have with your children.

Parents in Fresno and Los Angeles complained that Medi-Cal providers were clustered in certain areas of the county and that arranging travel to those areas was quite difficult for those who lived "way on the other side of town."

The greatest barrier to access identified in group discussions was that the list of providers accepting new Medi-Cal patients was both out-of-date and extremely limited. This from Lucy, an incredibly frustrated mother of four in Fresno:

> I swear, they send you this book with the list of providers just to tick you off, just to make you mad.… You'll call every single one of them and "No, not accepting. No, we don't take that anymore.… Nope, we shouldn't even be listed." And you go through the book until you just feel like ripping the book in pieces and throwing it out. I don't even know why they put this stupid book together because most of the doctors don't accept Medi-Cal anymore, or they are full.

Insurance coverage is the primary gateway to accessing health care, but obviously, as demonstrated by the comments above, it is no guarantee of receiving care. Both parents and uninsured childless adults were skeptical about whether health care reform would improve their ability to access *timely* care. In fact, they predicted that because of increased coverage, health care facilities and providers would become even less accessible as the system tries to incorporate a flood of new patients.

Indeed, there appears to be some foundation for such concerns, given California's constraints in provider capacity in certain areas and low physician participation in the Medi-Cal program (Bindman et al., 2010; Grumbach et al., 2009). Until we know how large or geographically concentrated the problem is, it is realistic to assume that the interrelated barriers to accessing care identified by our respondents (particularly parents)—including long wait times, difficulty locating a Medi-Cal provider accepting new patients, and cursory provider-patient interaction time—will remain serious concerns, at least in the early years of implementation. The experience of Massachusetts after the state implemented reforms suggests that we are indeed likely to see initial difficulties in obtaining care due to increased demand on providers from the coverage expansions (Long and Masi, 2009). Expanding access to specialty care and behavioral health services, which are also limited and constrained, will be particularly critical for serving those with more challenging health care needs. The ACA does contain specific initiatives to support the development of primary care networks, including higher Medi-Cal payments for primary care physicians and grants for states to support health care workforce development. These represent important opportunities for California, especially given current budgetary constraints for supporting workforce development and Medi-Cal participation among physicians. The success of these initiatives will be critical in determining how easily new and current consumers navigate care and, ultimately, whether they believe coverage is valuable and worth maintaining. As one father from the Bay Area noted, while it took some time and diligent effort to find a good provider, the system "worked" for his children once he established a PCP.

Promoting Continuity of Care

Several of the participants in our focus groups with Medi-Cal parents reported experiencing income shifts, which resulted in the state unexpectedly dropping their coverage. In the coming years, income fluctuation—which would move people back and forth from the Medi-Cal eligible pool to the exchange pool—is likely to become a major issue under the ACA. Movement in and out of Medi-Cal eligibility as the result of income changes could result in administrative burdens for the state and counties and less continuity and quality of care for patients (Sommers and Rosenbaum, 2011). In fact, transitions between Medi-Cal and exchange eligibility could be quite frequent if the patterns evidenced at the national level hold true for California: National patterns reveal that nearly 50 percent of individuals will experience a change in income over the course of a year that affects their eligibility for Medi-Cal (Sommers and Rosenbaum, 2011). Given these likely fluctuations and their potential effects on continuity of care, it is important for state policymakers and local health agencies to encourage the development of overlapping networks of providers in health plans supported by Medi-Cal and the exchange. Another recommendation from the parents in our focus groups, primarily from those who experienced disenrollment due to income changes, was that there should be year-long continuous eligibility policies in Medi-Cal, similar to food stamps (Cal Fresh), to guard against coverage fluctuations due to both major changes in circumstances (movements in and out of the labor force) and minor income fluctuations.

Reorienting Urgent and Self-Care Strategies

Our discussions of lapses in coverage, even for brief periods, led to many stories of delayed care and unmet needs among our uninsured respondents. When it came to dealing with their health concerns in the absence of insurance, many participants resorted to what might be described as "homemade" medicine, from self-diagnosis of symptoms to employing alternative, non-medical methods (e.g., homeopathic remedies) to treat their self-diagnosed condition. One of our participants perhaps said it best: When asked what living life without insurance means, Karen responded:

> What it does to you is just simple—you end up being your own doctor.

Of course, self-care in the context of limited resources sometimes implies less than optimal treatment regimens. One of our respondents reported that when she's sick with the flu, for example, she seeks out antibiotics (which might be several years old) from friends and family, ingesting only some of the pills and saving others just in case she gets sick again. The consequence of these self-management strategies is that participants are in a constant state of ambiguity about their well-being and may even be compromising their health. For those with a diagnosed chronic condition, the balancing act of managing their health against financial costs is particularly risky, as exemplified in the following remarks by Krista, who is diabetic:

> To be honest, and this is really bad, I have supplies that I need on a daily basis.… I'm at a stand-point now where it's like okay, I have to pay X amount more for my medication.… I'm going to have to pick and choose what's more important, my insulin or testing my blood sugar. I'm taking half care of myself because I can't afford it, which is not good.... It's like, wow, I'm trying to take care of myself but I can't.… It makes me feel bad. It's dangerous.

Self-care strategies challenge the development of a new culture of coverage in two ways. First, if those who have adopted self-care strategies maintain them at the cost of other preventive measures (e.g., engaging in positive health behaviors, receiving regular check-ups, following through on prescribed medication courses), the long-term contribution of insurance coverage to improvements in health status may be minimal. Second, most of our uninsured respondents have adopted an "urgent care" mindset, avoiding the health care system in general but relying on hospital EDs to treat any serious condition or illness that might arise. Fortunately, most participants did recognize that preventive care and routine screenings (e.g., mammography) were an important—and sometimes the most important—benefit of health insurance coverage; and other research has demonstrated that when individuals gain coverage, their use of preventive care increases (Buchmueller et al., 2005).

For individuals with chronic health conditions, such as Krista, maintaining continuous care, behavioral regimens, and follow-through on medications are of vital importance. Conditions, such as diabetes, asthma, and hypertension, are largely manageable but become much more costly when left untreated. As noted previously, California's county coverage initiatives focused on individuals with more serious chronic health conditions, based on the premise that managing their conditions earlier would reduce disease severity and health care spending later. To achieve the state's long-run goal of improving health status while controlling costs, new participants in the Medi-Cal expansions, whether healthy or sick, should be encouraged to reorient their perspective from piecemeal, self-directed strategies of care to a prevention-based model of care.

Addressing Perceptions of Quality

One of the potential barriers to expanding Medi-Cal participation is that those who have not had experience with Medi-Cal may be more sensitive to the potential stigma of enrolling in a public program, especially a program with historic ties to welfare (Sommers and Epstein, 2010). However, when asked about perceptions of Medi-Cal, most respondents in both the uninsured and parent groups felt that Medi-Cal was a "good" program, in spite of their frustrations with access and certain reservations about its quality. When we asked uninsured participants whether they would sign up for low or no-cost health care if offered, all but one raised their hands. When asked whether they would specifically sign up for Medi-Cal if eligible, almost all said they would, in spite of its shortcomings.

But there were also those who voiced strong dissatisfaction with the program. A few Medi-Cal parents felt that the providers who accept Medi-Cal patients are inferior. One frustrated mother from Los Angles noted that doctors misdiagnosed and mistreated her daughter with asthma for years—doctors told her to use saline nose spray for her condition—before it became apparent that she needed inhalers. This mother believed that this experience was typical of the lack of full attention that Medi-Cal doctors give to their low-income patients. And at least one-third of the parents with Medi-Cal coverage believed that medical and administrative staff discriminated against them, as manifested by less than thorough care or not being able to see the doctor in a timely manner. These perceptions of quality clearly influenced the value these particular parents gave to Medi-Cal coverage.

Some of the uninsured adults also felt that they were treated differently by medical staff—in these cases, because they did not have health insurance. About half of the uninsured Spanish-speaking participants in the Fresno group said that they sought medical care in Mexico at times, even though the cost of the trip might be the same as paying for care in Fresno. They believed that Mexico offered two advantages—better treatment from providers and the ability to communicate their health concerns (language differences emerged as one of the barriers to seeking care). A few participants also felt that at times, providers wrongly assumed they were unauthorized immigrants and did not take their health concerns seriously.[25]

In the recent poll of low-income Californians by the Blue Shield of California Foundation (BSCF, 2011), almost 60 percent of those who responded said that if they had more choices and the insurance to cover it, they would be interested in going to a different place for health care than their current source of care. This suggests at least some underlying dissatisfaction with the care these low-income residents receive.

It is revealing that in both of our focus group populations, a number of our respondents reported mistreatment and poor quality of care due to their insurance status, which might reflect common structural dynamics in the health care system, including different levels in the provision of care, based on income and the concomitant factors of 1) low provider reimbursement for the publicly insured and 2) uncompensated care for the uninsured. It is also telling, however, that some of the publicly insured parents in our focus groups reflected that when they accessed care through clinics or EDs as uninsured patients, the quality of care was less satisfactory than when they were insured.

Engaging Healthy People

In addition to these challenges, it is clear that some individuals do not and may not value coverage because they believe they are "healthy" and don't need to worry about health care. While only a handful of participants in our focus groups espoused this point of view, they were adamant in their position, thus underscoring concerns about adverse selection—that healthier individuals will opt out of the system.[26] Of course, most of us who have coverage are particularly grateful for that coverage when we fall ill or are beset by a serious injury, not when we are in good health; but then, such events are unpredictable.

It may thus be important for outreach efforts to highlight the positive psychological benefits of coverage, identified through our focus groups. Several uninsured respondents declared that having insurance coverage would alleviate some of their daily anxieties and bring them peace of mind, as observed by Kelly:

> If it's mandatory for us to have insurance, that's great. Because there are many days I wish I've had insurance…. I think I would sleep better at night, knowing I had it.

Thus, a relevant policy message might be that above and beyond the immediate benefit of access to care, insurance coverage can ease the undercurrent of "what if?" worries, improving psychological well-being.

In addition, as noted earlier, the state will have to make important system-level decisions about how to streamline eligibility determination and enrollment procedures so that it is easier for individuals to maneuver through the bureaucracy and be directed toward appropriate coverage options (Cody et al., 2010). Policymakers and program administrators' ability to do so will speak to the institutional commitment to, and development of, a culture of coverage. While the enrollment process did not emerge as a salient theme in our focus groups, it is likely to be an influential factor in Californians' perception of the state's commitment to affordable, widespread coverage.

---

[25] Although we did not obtain any specific information on citizenship or authorization status, it is likely that, based on their comments, there were one or two unauthorized immigrants in our groups,. Most of our Latino participants were citizens, and several in our uninsured groups had previous public coverage.

[26] It should be noted that most of our uninsured respondents had not seen a primary care provider for basic check-ups or screenings for quite some time. However, while most were probably as healthy as they reported, lack of access to care might have been taking its toll in ways not yet manifested in symptoms.

Conclusion

Despite continuing political and legal challenges to the new federal health care reform law, California is moving forward with implementing some of the major changes required by the ACA. The state, for example, has already begun efforts to increase coverage among low-income populations through the renewal of its Medicaid waiver and the establishment of county-run health coverage programs. The Medi-Cal expansion provisions ushered in by federal health care reform, which will go into full effect in 2014, will build upon and extend these efforts. As illustrated through our profiles of potential new Medi-Cal enrollees, substantial challenges and opportunities lie ahead in incorporating millions of new individuals into the Medi-Cal fold.

Our analyses of three different sources of population survey data consistently revealed that, by and large, poor uninsured adults are no less healthy than the non-disabled population currently enrolled in Medi-Cal, and by some measures are slightly healthier. Our indicators also suggest that the uninsured are a relatively young population, with 60 percent under age 40. Recent UCLA estimates of potential new Medi-Cal enrollees who were uninsured all or part of the year reveal very similar findings (Pourat et al., 2011). Assuming that these characteristics remain stable over the next few years, these findings bode well for Medi-Cal program officials concerned that the new enrollees will be high-cost users, so long as participation is widespread among the total eligible population.

At the same time, depending on the data source, between 15 and 25 percent of potential new enrollees in Medi-Cal currently report only fair or poor health status. In addition, one in four reports a serious chronic health condition and rates of obesity and smoking are high. This suggests that for a segment of the population gaining access to Medi-Cal, health care needs and use might indeed be higher than the larger group of potential new enrollees. In fact, some special sub-populations new to Medi-Cal, including those with high rates of substance abuse and mental health problems, will require a greater level of integration and coordination of services, although the size of these sub-populations is difficult to ascertain with current data sources. As we know from current Medi-Cal spending, a small share of Medi-Cal beneficiaries drive the bulk of spending, and the same may be true for a small proportion of new enrollees who appear to be in poorer physical and psychological health.

These health and sociodemographic profiles should be useful to policymakers preparing for upcoming Medi-Cal expansions. Specifically, those tasked with implementing ACA at the state and local levels must make decisions with regard to the scope of benefit packages (including special services and supports for mental health and substance abuse conditions), the adequacy of current primary and specialist provider care networks, and the ability of delivery systems to provide integrated care through "medical homes" and in cost-sensitive ways. These health profiles should also help inform preparations for serving those who will be covered through the Exchange and the possible Basic Health Plan option, since the populations these plans will potentially draw from will likely overlap. As noted earlier, income transitions that shift people between Medi-Cal and BHP or Exchange eligibility has implications for continuity of coverage across programs. Based on national estimates, these transitions could be sizable. Preliminary work focused on California estimates 1.8 million people could shift from Medi-Cal eligibility (below 139% FPL) to BHP eligibility (139%–200% FPL) based on income changes over the course of one year (Curtis and Neuschler, 2011). Gaining clarity on how often, and by how much, income changes in ways that effect various program eligibility is an important area for further research. If stability of coverage and continuity of care are priorities, policymakers and program planners should examine ways to ensure some degree of overlap in provider networks across programs.

While our survey-based profiles can provide a broad picture of health status, there are limitations in the scope and depth of health markers we were able to examine. Most of our health indicators relied on self-reports, as opposed to clinical assessments, and none indicated the severity of disease or chronic conditions, although our observed patterns are consistent with national work that does contain more detailed health markers. We also cannot assess the extent to which those in poor health have been delaying care over the years, which has implications for pent-up demand and the potential need for more intense treatment interventions. The evaluation of previous county coverage initiatives sheds some light on the extent of pent-up demand, and evaluations of the new county Low Income Health Programs (LIHPs) will offer even greater opportunity to collect more detailed physical and mental health information than the current survey data has been able to capture, and for a much larger group of new enrollees. Because the LIHPs and Medi-Cal expansions will draw from the same population, the state and counties can use this information to inform local program planning and policy development for the 2014 expansions.

In spite of these data limitations, we believe that our profiles offer important insights for future outreach and enrollment efforts. For instance, while a young population pool is promising from an insurer perspective, it is challenging from a participation perspective because those who are younger are less likely to believe they need health care coverage (Holahan and Kenney, 2008). To spread costs and risks, both in Medi-Cal and the exchanges, programs will need to reach out to the large population of young, poor, and currently uninsured. One strategy might be to focus outreach efforts in community colleges or similar settings with high concentrations of racially/ethnically diverse, low-income, and relatively young populations. For example, more than 75 percent of community college students are under age 40 (Sengupta and Jepsen, 2006). Furthermore, about one-quarter of poor, uninsured adults have minor children living in their homes. To the extent that parents value coverage for their children, sometimes more so than for themselves, and given that children are often gateways for entry into public programs among low-income families, promoting the importance of children's coverage alongside parental coverage may be a useful outreach strategy. It is also promising that our focus group participants, although largely unaware of key ACA provisions, were certainly eager for more information on how anticipated changes might personally affect their eligibility for Medi-Cal.

In the end, however, widespread participation and successful incorporation of the targeted Medi-Cal population requires more than education and information about forthcoming policy changes. A number of scholars have argued that in order for reform, and expansions in particular, to make meaningful differences in health care use and the well-being of the general population, a new culture of coverage must emerge in which insurance is expected, maintained, and ultimately valued (Kaiser Commission on Medicaid and the Uninsured 2010b). This normative shift is particularly important among targeted low-income populations, since many will not be subject to the individual mandate and associated tax penalty. Some of our focus group participants thought that expansions in health insurance coverage might be usefully compared to the universal requirement for automobile insurance. Indeed, this could be a convincing way to begin communicating—to both the targeted Medi-Cal population and to Californians more broadly—a new health insurance contract of sorts, with a mutual expectation that citizens will protect their own health and the health of the general public through health insurance and that the government will ensure that all citizens have access to affordable, meaningful coverage.

A related challenge for the culture of coverage was brought to light by the uninsured participants in our focus groups who felt that they had learned to successfully self-manage their health over the years, without coverage and without frequent access to the formal health care system. For these individuals, the value of coverage was trivial. Health plans and providers will have to both respect and alter the regard for self-sufficiency among these individuals if they are to convince them to enroll in the formal health care system. Of course, it is important to note that the uninsured participants who did not value coverage were clearly not thinking about unforeseen illnesses or events. Those who did consider such possibilities argued, quite convincingly, that the importance of coverage extended beyond its ability to provide them with access to care, claiming that one of the primary benefits of coverage was the peace of mind it brought with it, easing the undercurrent of anxiety they had experienced while uninsured of worst-case scenarios.

Finally, while the poor, uninsured participants in our study relied heavily on clinics and emergency departments for urgent care, it is likely that if they had insurance, they would seek continuity of care among less-intensive providers. Indeed, a review of studies examining public insurance expansions found that the expansions were associated with an increase in the use of preventive care among both children and adults (Buchmueller et al., 2005; Finkelstein et al., 2011). Thus, one of the most pressing issues for the planners and practitioners in the expansions of public insurance will be to establish a usual and reliable source of primary care for those who will become new participants in Medi-Cal, thereby mitigating their proclivity to use more costly, urgent-based care. How effectively the Medi-Cal program has addressed this problem among current participants is still open to question, as is evident from our discussions with the Medi-Cal parents in our focus groups and illustrated in studies that indicate high, avoidable ED use among current Medi-Cal beneficiaries (McConville and Lee, 2009).

Concomitant problems which frustrated parents in our focus groups mentioned—and which researchers and state policymakers have long known exist—include the limited number of primary care providers accepting Medi-Cal patients, long wait times to get an appointment, limited geographic access in particular areas, and cursory and, at least perceived, low-quality patient-provider interactions. These access problems beg an important question for policymakers: How can the state create a culture of coverage when public coverage does not consistently ensure consumers timely access to quality care?

Through its Health Care Workforce Development Council, the state is trying to better understand such provider capacity problems and to develop policies that will address them, and the ACA will increase Medi-Cal physician reimbursement rates for primary care providers for two years, which hopefully will increase their participation, at least in the short run. However, without similar increases in reimbursement rates for specialists, access to specialty care is predicted to remain a serious problem.

Most new Medi-Cal enrollees will likely receive care in managed care settings, and unlike fee-for-service patients, Medi-Cal managed care beneficiaries are required to select a primary care provider who serves as their usual source of care and first contact for health care needs. In principle, this should promote better disease management and prevention and help lower rates of preventable hospitalizations down the road due to sub-optimal management (Bindman et al., 2004). However, there is great need for improvement in this process, and new enrollees will certainly need assistance in establishing a viable primary care provider. The medical-home-assignment requirements in low-income county-run health programs could shed some light on how to foster necessary coordination between providers and patients for a larger population, and policymakers should monitor and evaluate relevant process and outcome measures in the LIHP projects.

Despite the access issues related to Medi-Cal, it is worth repeating that many focus group parents were grateful to the program for ensuring some level of care for their children and for easing their own anxieties. This might serve as ample motivation for uninsured, newly eligible Californians to pursue public coverage they might qualify for come 2014, given their previous negative experiences with accessing a limited safety net system and their stated anxiety about potential future health problems. As one uninsured respondent remarked:

> You say 2014? That seems like a long way away. But not when you don't have insurance. 2014 can't come soon enough.

And while policymakers still have a few years to prepare for reform's major provisions, as noted in a recent California Health and Human Services Agency report (2010), "In many respects, 2014 is tomorrow."

References

Alameda County Reentry Health Taskforce. 2008. Reentry Health Care in Alameda County: Initial Assessment and Recommendations of the Alameda County Reentry Health Task Forces. Available at www.urbanstrategies.org/documents/ReentryHealthTaskForceExecutiveSummary_FINAL_001.pdf.

Allen, Heidi, Katherine Baicker, Amy Finkelstein, Sarah Taubman, Bill Wright, and the Oregon Health Study Group. 2010. "What the Oregon Health Study Can Tell Us about Expanding Medicaid." *Health Affairs* 29 (8): 1498–1506.

Auerbach, David, Sarah Nowak, Jeanne S. Ringel, Federico Girosi, Christine Eibner, Elizabeth A. McGlynn, and Jeffrey Wasserman. 2011. *The Impact of the Coverage-Related Provisions of the Patient Protection and Affordable Care Act on Insurance Coverage and State Health Care Expenditures in California*. Santa Monica: RAND Corporation.

Bade, Elizabeth, Jennifer Evertsen, Sabrina Smiley, and Indrani Banerjee. 2008. "Navigating the Health Care System: A View from the Urban Medically Underserved." *Wisconsin Medical Journal* 107 (8): 374–79.

Bernard, Didern M., and Thomas M. Selden. 2006. "Workers Who Decline Employment-related Health Insurance." *Medical Care* 44 (5): 12–18.

Bindman, Andrew, Arpita Chattopadhyay, Dennis Osmond, William Huen, and Peter Bacchetti. 2004. *Preventing Unnecessary Hospitalizations in Medi-Cal: Comparing Fee-for-Service with Managed Care*. Oakland: California HealthCare Foundation.

Bindman, Andrew, Philip Chu, and Kevin Grumbach. 2010. *Physician Participation in Medi-Cal, 2008*. Oakland: California HealthCare Foundation.

Blue Shield of California Foundation. 2011. *On the Cusp of Change: The Healthcare Preferences of Low-Income Californians.* San Francisco: Blue Shield of California Foundation.

Blumberg, Linda, John Holahan, Jack Hadley, and Kather Nordahl. 2007. "Setting a Standard of Affordability for Health Insurance Coverage." *Health Affairs* 26 (4): 463–73.

Buchmueller, Thomas, Kevin Grumbach, Richard Kronick, and James Kahn. 2005. "The Effect of Health Insurance on Medical Care Utilization and Implications for Insurance Expansion: A Review of the Literature." *Medical Care Research and Review* 62 (1): 3–30.

Burman, Mary E., Sydney Mawhorter, and Fred Vanden Heede. 2006. "Multiple Perspectives on Being Uninsured and Barriers to Health Coverage in a Rural Western State." *Journal of Health Care for the Poor and Underserved* 17 (3): 625–40.

Buettgens, Matthew, Garret Bowen, and John Holahan. 2010. *America under the Affordable Care Act*. Washington DC: Urban Institute.

Buettgens, Matthew, and Mark Hall. 2011. *Who Will Be Uninsured after Health Insurance Reform?* Washington DC: Urban Institute.

Buettgens, Matthew, John Holahan, and Caitlin Carrol. 2011. *Health Reform across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid*. Washington DC: Urban Institute.

California Department of Health Care Services. 2010. "California Bridge to Reform: A Section 1115 Waiver Fact Sheet." Available at www.dhcs.ca.gov/Documents/1115%20Waiver%20Fact%20Sheet%2011.2.10.pdf.

California Health and Human Services Agency. 2010. "Implementation of the Affordable Care Act in California: A Window of Opportunity for State Policy Makers." Available at www.healthcare.ca.gov/LinkClick.aspx?fileticket=sGB42p9ZFCk%3D&tabid=414&mid=876.

California HealthCare Foundation. 2009. *Medi-Cal Facts and Figures*. Oakland: California HealthCare Foundation.

Caton, Carol, Carol Wilkins, and Jacquelyn Anderson. 2007. "People Who Experience Long-Term Homelessness: Characteristics and Interventions." National Symposium on Homeless Research Paper. Available at http://aspe.hhs.gov/hsp/homelessness/symposium07/caton/index.htm.

Chandra, Amitabh, Jonathan Gruber, and Robin McKnight. 2011. "The Importance of the Individual Mandate—Evidence from Massachusetts." *New England Journal of Medicine* 364: 293–95.

Cody, Scott, Debbie Reed, Danns Basson, Jordan Pedraza, Emily Sama Martin, Betsy Santos, and Elisha Smith. 2010. *Simplification of Health and Social Services Enrollment and Eligibility: Lessons for California from Interviews in Four States*. Princeton: Mathematica Policy Research.

Curtis, Rick and Ed Neuschler. 2011. *Continuity for (Former) Medi-Cal Enrollees and Affordability for the Low-Income Exchange Population: Background and an Alternative Approach*. Washington DC: Institute for Health Policy Solutions.

Cylus, Jonathan, Micah Hartman, Benjamin Washington, Kimberly Andrews, and Aaron Catlin. 2011. "Pronounced Gender and Age Differences Are Evident in Personal Health Care Spending Per Person." *Health Affairs*, 30(1): 1–8.

Davis, Lois M., Nancy Nicosia, Adrian Overton, Lisa Miyashiro, Kathryn Pitkin Derose, Terry Fain, Susan Turner, Paul Steinberg, and Eugene Williams. 2009. *Understanding the Public Health Implications of Prisoner Reentry in California: Phase I Report*. Santa Monica, California: RAND Corporation.

Finkelstein, Amy, Sarah Taubman, Bill Wright, Mira Bernstein, Jonathan Gruber, Joseph Newhouse, Heidi Allen, Katherine Baicker, and the Oregon Health Study Group. 2011. "The Oregon Health Insurance Experiment: Evidence from the First Year." NBER Working Paper.

Grumbach, Kevin, Arpita Chattopadhyay, and Andrew Bindman. 2009. *Fewer and More Specialized: A New Assessment of Physician Supply in California*. Oakland: California HealthCare Foundation.

Hartman, Micah, Aaron Catlin, David Lassman, Jonathan Cylus, and Stephen Heffler. 2007. "U.S. Health Spending by Age, Selected Years Through 2004."*Health Affairs* 27 (1): w1–w12.

California Department of Public Health, Office of Aids. 2010. "HIV/AIDS Surveillance in California, Quarter 4 2010 Report." Available at www.cdph.ca.gov/programs/aids/Documents/SSQtr4Dec2010.pdf.

Holahan, John, and Genevieve Kenney. 2008. *Health Insurance Coverage of Young Adults: Issues and Broader Considerations.* Washington DC: Urban Institute.

Holahan, John, Genevieve Kenney, and Jennifer Pelletier. 2010. *The Health Status of New Medicaid Enrollees under Health Reform*. Washington DC: Urban Institute.

Holahan, John, and Irene Headen. 2010. *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL.* Washington DC: Kaiser Family Foundation.

Institute of Medicine. 2002. *Care Without Coverage: Too Little, Too Late*. Washington DC: National Academy Press.

Kaiser Commission on Medicaid and the Uninsured. 2010a. *Uninsured and Untreated: A Look at Uninsured Adults Who Received No Medical Care for Two Years*. Issue Paper. Washington DC: Kaiser Family Foundation.

Kaiser Commission on Medicaid and the Uninsured. 2010b. *Optimizing Medicaid Enrollment: Perspectives on Strengthening Medicaid's Reach under Health Care Reform*. Issue Paper. Washington DC: Kaiser Family Foundation

Kaiser Commission on Medicaid and the Uninsured. 2010c. *Expanding Medicaid to Low-Income Childless Adults Under Health Reform: Key Lessons for States Experiences*. Issue Paper. Washington DC: Kaiser Family Foundation

Kaiser Commission on Medicaid and the Uninsured. 2011. *California's "Bridge to Reform" Medicaid Demonstration Waiver*. Policy Brief. Washington DC: Kaiser Family Foundation.

Kaiser Family Foundation. 2011. Kaiser Health Tracking Poll—March 2011. Washington DC: Kaiser Family Foundation.

Kilbreth, Elizabeth, Andrew Coburn, Catherine McGuire, Diane Martin, Paula Diehr, Carolyn Madden, and Susan Skillman. 1998. "State-Sponsored Programs for the Uninsured: Is there Adverse Selection?" *Inquiry* 25 (3): 250–65.

Kitzinger, Jenny. 1994. "The Methodology of Focus Groups: the Importance of Interaction Between Research Participants." *Sociology of Health and Illness* 16 (1): 103–15.

Kominski, Gerald, Nadereh Pourat, Dylan Roby, Allison Diamant, Ying-Ying Meng, Zina Kally and Ann Davis. 2010. *Interim Evaluation Report on California's Health Coverage Initiative*. Los Angeles: UCLA Center for Health Policy Studies.

Lavarreda, Shana Alex, E. Richard Brown, Livier Cabezas, and Dylan Roby. 2010. *Number of Uninsured Jumped to More Than Eight Million from 2007 to 2009*. Los Angeles: UCLA Center for Health Policy Studies.

Lee, Helen. 2006. *Obesity among California Adults: Racial and Ethnic Differences*. San Francisco: Public Policy Institute of California.

Long, Peter, and Jonathan Gruber. 2011. "Projecting the Impact of the Affordable Care Act on California." *Health Affairs* 30 (1): 63–70.

Long, Sharon, and M. Susan Marquis. 2002. "Participation in a Public Insurance Program: Subsidies, Crowd-out, and Adverse Selection." *Inquiry* 39 (3): 243–77.

Long, Sharon, and Paul Masi. 2009. "Access and Affordability: An Update on Health Reform in Massachusetts, Fall 2008." *Health Affairs* 28 (4): 578–87.

Long, Sharon, Lokendra Phadera, and Victoria Lynch. 2010. *Massachusetts Health Reform in 2008: Who Are the Remaining Uninsured Adults?* Minneapolis: State Health Access Reform Evaluation.

Los Angeles Department of Public Health. Office of AIDS Programs and Policy. "Overview: California's 1115 Waiver: Impact on Los Angeles County's HIV Population." Available at www.publichealth.lacounty.gov/aids/HealthcareReform/Overview11154-11.pdf.

Lewin Group. 2010. "The Impact of the Medicaid Expansions and Other Provisions of Health Reform on State Medicaid Spending." Staff Working Paper #12. Available at www.lewin.com/content/publications/Lewin_Impact_of_Medicaid_Expansions_on_State_Spending.pdf.

Mallik-Kane, Kamala, and Christy A. Vischer. 2008. "Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration." Washington DC: Urban Institute Justice Policy Center.

Marshall, Catherine, and Gretchen Rossman. 2010. *Designing Qualitative Research*. 5th ed. Thousand Oaks, CA: Sage Publications.

McConville, Shannon, and Helen Lee. 2008. "Emergency Department Care in California: Who Uses It and Why?" *California Counts* 10 (1). Public Policy Institute of California. Available at www.ppic.org/content/pubs/cacounts/CC_808SMCC.pdf.

McWilliams, J. Michael. 2009. "Health Consequences of Uninsurance among Adults in the United States: Recent Evidence and Implications." *Milbank Quarterly* 87 (2): 443–94.

National Alliance of State and Territorial AIDS Directors. 2011. National ADAP Monitoring Project Annual Report. Available at www.statehealthfacts.org/comparetable.jsp?ind=542&cat=11.

Passel, Jeffrey S., and D'Vera Cohn. 2009. *A Portrait of Unauthorized Immigrants in the United States.* Washington DC: Pew Hispanic Center.

Pourat, Nadereh, Ana E. Martinez, and Gerald F. Kominski. 2011. *Californians Newly Eligible for Medi-Cal under Health Care Reform.* Los Angeles: UCLA Center for Health Policy Studies.

Sengupta, Ria, and Christopher Jepsen. 2006. "California's Community College Students." Paper, Public Policy Institute of California. Available at www.ppic.org/main/publication.asp?i=720.

Sommers, Benjamin, and Arnold M. Epstein. 2010. "Medicaid Expansion—The Soft Underbelly of Health Care Reform?" *New England Journal of Medicine* 363 (22): 2085–87.

Somers, Stephen, Allison Hamblin, James Verdier, and Vivian Byrd. 2010. *Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States.* Hamilton, NJ: Center for Health Care Strategies.

Sommers, Benjamin, and Sara Rosenbaum. 2011. "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges." *Health Affairs* 30 (2): 228–36.

About the Authors

Helen Lee is a policy fellow at the Public Policy Institute of California. Her research interests include the social determinants of health (with a particular emphasis on health behaviors), racial/ethnic diversity, immigrant acculturation, and child health and well-being. Before coming to PPIC, she was a National Institutes of Health predoctoral fellow and worked as a research assistant in the Population Studies Center at the University of Pennsylvania. She holds an M.A. in demography and a Ph.D. in sociology from the University of Pennsylvania.

Shannon McConville is a policy associate at PPIC. Before joining PPIC, she was a research training fellow in the Health Services and Policy Analysis program at the University of California, Berkeley; a senior research associate at the Department of Health Research and Policy at Stanford University; and a project manager in the Lewis Center for Regional Policy Studies at the University of California, Los Angeles. Her research interests include health care access and outcomes among vulnerable populations and the confluence of place, poverty, and health. She holds a B.A. in political science from California Polytechnic State University, San Luis Obispo, and a master's degree in public policy from the University of California, Los Angeles.

Acknowledgments

The authors thank Kim Belshé, Laura Hill, Lee Kemper, Jennifer Tolbert, and Lynette Ubois for offering careful and insightful comments on earlier drafts of this paper—they have strengthened the content considerably. Gary Bjork offered helpful editing assistance. Kristel Acacio provided invaluable research support in the focus group design and implementation phases, and Kimberly Kay Hoang capably provided critical coding assistance. We are extremely grateful to the staff at Nichols Research for their professional expertise and guidance throughout the focus group process—from recruitment to moderating assistance. In particular, we thank Jane Rosen, Elida Avina, and Celsa Garcia for their hard work. We are also indebted to the focus group respondents who were generous enough to share their time and opinions with us.

This research was supported by funds from the California Program on Access to Care (CPAC), California Policy Research Center, University of California, and Grant Number HNN05A. The views and opinions expressed do not necessarily reflect those of the Regents of the University of California, CPAC, its advisory board, or any State or County executive agency represented thereon.

PUBLIC POLICY INSTITUTE OF CALIFORNIA

Board of Directors

PPIC | PUBLIC POLICY INSTITUTE OF CALIFORNIA

The Public Policy Institute of California is dedicated to informing and improving public policy in California through independent, objective, nonpartisan research on major economic, social, and political issues. The institute's goal is to raise public awareness and to give elected representatives and other decisionmakers a more informed basis for developing policies and programs.

The institute's research focuses on the underlying forces shaping California's future, cutting across a wide range of public policy concerns, including economic development, education, environment and resources, governance, population, public finance, and social and health policy.

PPIC is a private operating foundation. It does not take or support positions on any ballot measures or on any local, state, or federal legislation, nor does it endorse, support, or oppose any political parties or candidates for public office. PPIC was established in 1994 with an endowment from William R. Hewlett.

Mark Baldassare is President and Chief Executive Officer of PPIC.
John E. Bryson is Chair of the Board of Directors.

PUBLIC POLICY INSTITUTE OF CALIFORNIA
500 Washington Street, Suite 600
San Francisco, California 94111
phone: 415.291.4400
fax: 415.291.4401
www.ppic.org

PPIC SACRAMENTO CENTER
Senator Office Building
1121 L Street, Suite 801
Sacramento, California 95814
phone: 916.440.1120
fax: 916.440.1121