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Enrollment in Health and Nutrition Safety Net Programs among California's Children

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Summary

High enrollment in safety net programs for low-income children has long been a priority in California. In January 2014, major expansions in health insurance coverage programs under the Affordable Care Act (ACA) catalyzed efforts to better integrate safety net programs. Because these programs serve overlapping populations, integrating administration across them can increase participation, improve the client experience, and lower administrative costs. This report focuses on enrollment in public health insurance and nutrition assistance programs primarily among low-income children, using recent historical data to look both at statewide patterns and county-level factors that influence enrollments. As California increases efforts to achieve full participation for those qualified, examining these patterns can help inform plans to expand program integration. It can also help illuminate the role local administration plays so that policymakers can develop strategies that support counties coping with rising enrollments during times of economic stress.

More than half of all California children and about 85 percent of low-income children participate in one or more public health insurance and nutrition assistance programs—Medi-Cal, which provides no-cost and low-cost health insurance, monthly CalFresh benefits, school meals, and specified foods from WIC. The state supervises these programs, and local entities—including county government, local WIC agencies, and school districts—administer them.

Because all of these programs require low family income to qualify for benefits, worsening job opportunities during and after the recent recession resulted in higher program participation across the state. Indeed, at the state level increases in participation outstripped the growth in need. Across all programs, increased county resources to administer programs helped to boost enrollments among low-income children. At the same time, we find that the sharply weaker economy tended to offset these gains.

As of 2012, nearly all low-income California children ages 0–4 and about four in five older children were enrolled in at least one health or nutrition program. From the point of view of attaining full enrollment in these programs, this is good news. Still, some children enrolled in one or more of the nutrition assistance programs lacked health insurance, indicating that there is still room for improvement.

To build on the positive momentum brought about by the ACA and to move toward full enrollment across counties, state policymakers can make use of our findings in several ways. They can aim to have funding allocations for program administration keep pace with changes in the low-income population. They can consider increasing resources for counties with relatively low program enrollments. They can take advantage of ACA funding for information technology (IT) investments through 2015 in order to implement a higher degree of program integration. This latter step can, in turn, help to identify and enroll uninsured family members who may be eligible, and could be especially critical for counties during times of economic downturn, when eligibility may outpace administrative capacity.

Contents

Technical appendices to this paper are available on the PPIC website:
www.ppic.org/content/pubs/other/215LBR_appendix.pdf

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Abbreviations

ACA	Affordable Care Act
CalWORKs	California Work Opportunity and Responsibility to Kids
CDE	California Department of Education
DHCS	California Department of Health Care Services
DPH	California Department of Public Health
DSS	California Department of Social Services
LEA	Local Education Agency
MRMIB	Managed Risk Medical Insurance Board
NSLP	National School Lunch Program
SNAP	Supplemental Nutrition Assistance Program
TANF	Temporary Assistance for Needy Families
WIC	Supplemental Nutrition Assistance Program for Women, Infants, and Children

Introduction

In this report, we focus on enrollment in public health insurance and nutrition assistance programs among low-income children—a particular population of concern, and one for which high enrollment in health and nutrition programs has been a longstanding priority.[1] One quarter of children in California—about 2.3 million—are estimated to live in poverty. If not for social safety net program assistance, an additional 1.28 million would live in families without the resources to meet basic needs (Bohn et al., 2013; Wimer et al., 2013). Despite the importance of safety net programs, there is evidence of under enrollment in Medi-Cal and CalFresh relative to the size of California's eligible population.[2] Furthermore, the percentage of children not in poverty due to their families' participation in social safety net programs appears to vary regionally (Bohn and Danielson, 2014). Finally, there is evidence nationally that children are not always enrolled in the combination of safety net programs for which they are eligible (Todd, Newman, and Ver Ploeg, 2011), which may also be the case in California.

The expansion of health insurance under the Affordable Care Act (ACA) has as its goal maximizing coverage for all legal residents. This has catalyzed broader efforts at both the state and federal levels to further integrate health and human services program administration in order to improve participation in programs and to increase government efficiency (Legislative Analyst 's Office, 2014; Dorn et al., 2013, Dorn and Peters, 2014). Recognizing the role administration plays in improving program access, the ACA included provisions to streamline the enrollment process—standardizing income eligibility and investing in information technology (IT) systems to make enrolling in subsidized insurance coverage more straightforward.

California took advantage of this funding and created new streamlined systems to process enrollment. However, policymakers also retained the longstanding delegation of authority to counties to administer eligibility and enrollment for the Medi-Cal program. Local administration allows for greater flexibility and control to serve the needs of different communities, but it does raise questions of efficiency and equity. Ultimately, these are federally supported programs with uniform eligibility guidelines across the state, even the nation (Belshé and McConville, 2013; Danielson, 2013). Fostering equity throughout California is an important policy goal.

Even before policy changes ushered in by the ACA, children have had the broadest access to public health insurance, nutrition, and cash assistance. Over the past decade, public insurance expansions for children—coupled with outreach and policy efforts to connect all children to insurance and other safety net supports—became a policy goal.[3] Now that the ACA has made maximized health insurance enrollment and program integration a policy priority, we can benefit by examining historical patterns of children's participation.

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[1] The creation of the federal State Children's Health Insurance Program (S-CHIP) and other state and local efforts throughout California over the past decade have been focused on expanding insurance coverage opportunities for children. Federal law mandates automatic enrollment of school children in NSLP if they receive CalFresh, CalWORKs, or have certain other characteristics. Federal law allows states to enroll children in WIC if they fall within higher income eligibility guidelines for Medi-Cal. All of these efforts were accompanied by targeted strategies to maximize enrollment in available programs.

[2] In particular, in 2011 about 84% of California's eligible children and 63% of eligible adults are enrolled in Medi-Cal and just over half of eligible residents enroll in CalFresh. This places California in the middle range relative to other states for Medi-Cal participation and near the bottom for CalFresh (Cunnyngham, Sukasih, and Castner, 2014; Kenney et al,. 2012).

[3] Availability of public health insurance programs for children expanded well before the economic downturn with the creation of the federal Children's Health Insurance Program (CHIP) in 1998 and additional county-level efforts (Healthy Kids) in California that began early this decade. Although both CHIP and Healthy Kids programs were already established, targeted outreach and enrollment campaigns, including the availability of electronic, web-based enrollment tools, increased access over the past decade for all children's health insurance programs.

What we discover by doing so can help inform efforts to integrate programs moving forward—not just for children, but for families as well. It can also provide context to help us understand the role local administration may play in differential enrollment levels across the state. That understanding can inform strategies to support enrollment goals across the state, particularly when the number eligible is changing rapidly.[4]

In this report, we first provide an overview of the programs available to California children and describe statewide trends in enrollment over the past decade, including during the recent recession. We focus primarily on Medi-Cal and CalFresh, large-scale programs that enroll millions of low-income children, although they are not limited to children. We also make some comparisons to participation in two other programs focused solely on children: the National School Lunch Program (NSLP) and the Special Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC).[5] Next, we examine differences in enrollment levels for low-income children across counties to better understand how changes in economic need, administrative capacity, and enrollment opportunities affect program participation. Finally, we look at patterns of low-income children using multiple health and nutrition programs and discuss how "horizontal integration"—the pursuit of connections across safety net programs—might help maximize enrollment in health insurance affordability programs among other family members.

[4] With the expansion of Medi-Cal, the state role in funding county administrative costs for enrollment has been in flux. The governor's 2015–16 budget proposal notes the state's intention to review the budgeting methodology once the new eligibility system is fully functional.
[5] The technical appendices also provide comparative analysis of two other programs. The first is CalWORKs, California's cash assistance program for low-income families with children. The second is the predecessor program to the Targeted Low-Income Children's Program, which was known as Healthy Families, and which served children with incomes below 250% of FPL who did not meet the income criteria for Medi-Cal. This program was centrally administered, but beginning in 2013 children enrolled in Healthy Families were transitioned to the Targeted Low-Income Children's Program, which is county-administered as part of Medi-Cal.

The Scope of California's Health and Nutrition Safety Net for Children

Although diverse, the four health and nutrition assistance programs described in Table 1 share overlapping goals and eligibility criteria. All require family incomes to be below a defined percentage of the federal poverty line to qualify for benefits. All are intended to improve outcomes for low-income children—and often low-income adults—by providing them with access to health care and adequate nutrition. Statewide, these programs serve millions of children. Depending on the program, between 1.14 million and 3.78 million children were enrolled as of July 2012.

TABLE 1
Major public health and nutrition assistance programs that serve children

Program name	Number of children statewide (2012)	Eligibility thresholds (2012)	Limited to children?	Age of children served	Local administration
Medi-Cal	3.78 million	100%–200% (depending on age of child)	No, but non-disabled adult beneficiaries are custodial parents (expanded in 2014)	0–18	Counties
CalFresh	2.23 million	130% FPL	No	0–17	Counties
National School Lunch Program (NSLP)	3.33 million	185% FPL	Yes	5–17*	Local education agencies/school districts
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	1.14 million	185% FPL	No, but adult beneficiaries are pregnant, postpartum, or breastfeeding mothers	0–4	Local WIC agencies

NOTES: Eligibility thresholds for the Medi-Cal program have changed since 2012. As of January 2014, children up to 150% FPL are eligible for no-cost, Medi-Cal coverage. As of 2013, children with incomes up to 250% of FPL are eligible for the Targeted Low-Income Children's Program. Until 2013, children with income levels higher than the age-specific Medi-Cal thresholds were eligible for the Healthy Families, the state's Children Health Insurance Program. Typical age ranges of children served are shown, but persons older than 18 may be enrolled under special circumstances. For example, the NSLP is available to some pre-school aged children.

Differing income thresholds, age qualifications, and immigration status are three major reasons for varying program size. Although all programs target low-income children, income eligibility thresholds vary across programs.[6] At the low end, to qualify for no-cost health insurance through Medi-Cal, older children must have family incomes under 100% of the federal poverty level (FPL)—about $1,650 per month for a family of three.[7] CalFresh serves families with incomes up to 130% of FPL.[8] NSLP provides free school lunch (and often other meals) to school-aged children in families living under 130% of FPL and low-cost meals to those between 130% and 185% of FPL. In addition, children who receive CalFresh are automatically eligible for free school meals.[9] Finally, WIC provides vouchers for specific foods, along with nutrition education. It serves

[6] Definitions of countable income and assets, along with family units, vary across programs. Across all programs families are allowed certain deductions from their gross income amount. Major categories of deductions include a portion of earnings, child support payments, expenses for child care and housing.
[7] The eligibility thresholds for Medi-Cal increased on January 1, 2014 when the state expanded the Medi-Cal program under the ACA. The eligibility threshold for no-cost Medi-Cal coverage for older children is now 150% of the FPL.
[8] Eligibility for CalFresh is not restricted by age.
[9] Children enrolled in CalWORKs, California's main cash assistance program, children who are in foster care, homeless, migrant, and runaway children are also all categorically eligible for free meals.

children ages 0–4 and in general employs a higher income eligibility cut-off (185% of FPL). WIC also uses the Medi-Cal income cut-off when the latter is higher.[10]

Beyond income and age, another important aspect of eligibility is immigration status. In order to qualify for Medi-Cal and CalFresh, children must generally be documented as legal residents or citizens.[11] WIC and school lunch do not require such documentation. Although we do not have precise information on undocumented status, available estimates suggest the vast majority of children of undocumented immigrants are citizens and thus likely eligible for safety net programs if income qualified (Passel and Taylor, 2010).

Another defining aspect of all of these programs is that they are locally administered. This means local entities have primary responsibility for processing enrollment. California's 58 counties enroll Medi-Cal and CalFresh recipients, 84 local agencies administer the WIC program, and the more than 1,000 school districts across the state manage school meals enrollment.

Why do eligible people not enroll?

A number of factors could contribute to under enrollment in safety net programs. They include familiarity with the programs and their benefits, the costs of applying and keeping eligibility current (both the time involved and potentially other costs, such as taking time off from work or finding child care), and the degree to which a program is perceived positively.[12] Although constrained by state and federal regulations, there may be opportunities for local entities that administer these programs to increase enrollment among low-income populations by reducing these barriers. Context shapes these factors substantially. For example, regions with higher immigrant populations may need to address informational barriers, while areas exposed to fluctuating economic conditions may need to find ways to adapt to relatively large caseload changes within a single year. When we examine the impact of some of these factors to explain different enrollment levels across counties, we find some interesting results.

[10] Until 2013, infants under 200% of FPL were eligible for Medi-Cal, a higher income threshold than for WIC. Children 5 and under were eligible if family incomes are under 133% of FPL. When the Targeted Low-Income Children's Program was begun within the Medi-Cal program (replacing the standalone Healthy Families program), these income thresholds rose to 250% of FPL for all children. Pregnant, post-partum, and breastfeeding women who meet the other program criteria are also eligible for WIC.

[11] There are a few exceptions to this. Medi-Cal pays for emergency services for undocumented immigrants and also includes a PRUCOL eligibility category for full-scope Medi-Cal benefits. Certain refugee groups are also eligible.

[12] A review of the academic literature focused on examining participation rates in social safety net programs provides evidence about the role of three factors generally offered to explain low take-up among eligible populations -- stigma, transaction costs and administrative burden, and lack of information. The research evidence suggests that the level of administrative burden lowers program "take-up," while automatic or default enrollment procedures increase participation. The review finds little support for the proposition that stigma influences participation, but acknowledges the difficulty of adequately testing stigma (Currie, 2004).

Defining the eligible population

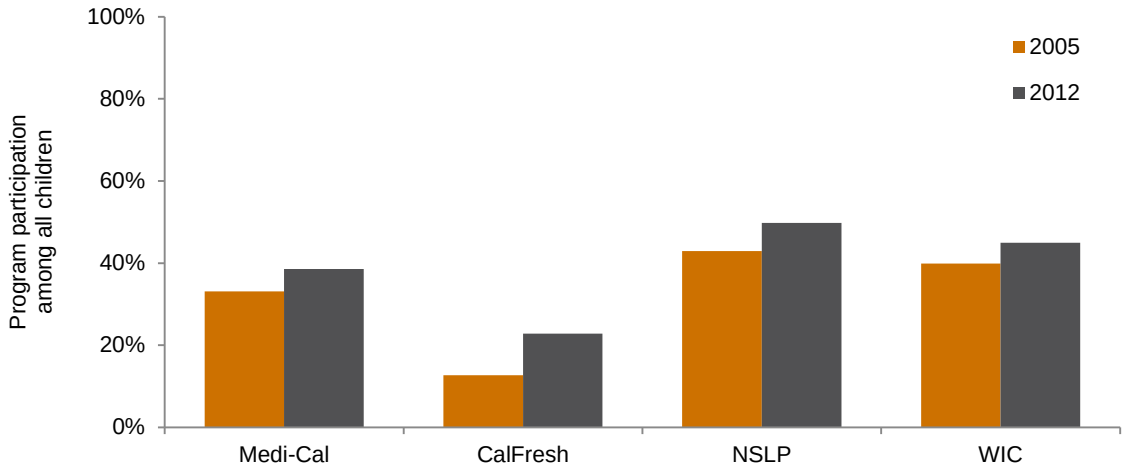
In this paper, we report both shares of all children participating in health and nutrition programs and shares of low-income children enrolled in these programs. Neither approach provides a precise estimate of the share of *eligible* children who receive benefits from one or several programs. The share of eligible children enrolled (often referred to as the take-up or participation rate) is a ratio of the actual caseload—as measured in administrative records—to the pool of all eligible children. Producing a reliable estimate depends on accurately estimating the denominator of the ratio. This task is accomplished using survey, not administrative, data. Multiple differences between the concepts measured in large-scale, high-quality survey data and administrative data make such a calculation complex. Principal differences include annual rather than monthly income reporting, insufficient information on sources of income and assets, and imperfect detail about family relationships, immigration status, and precise age.

Estimates of the share of low-income children receiving benefits from health or nutrition program do provide an approximate sense of the reach of the program relative to the intended target population.

Enrollments grew during the recent recession

The share of California's children enrolled in safety net programs grew over the past decade. As of July 2012, nearly 40 percent of all children ages 0–18 in the state were enrolled in the Medi-Cal program, compared to 33 percent in 2005 (Figure 1). CalFresh serves a smaller proportion of California's children, but participation increased the most dramatically during the recent recession, growing from 13 percent to 23 percent of all children. School lunch enrollment grew by 7 percentage points to half of all age-eligible children between 2005 and 2012. Participation in WIC was also substantial (about 45 percent of all children ages 0–4) and also grew over the period.

FIGURE 1
Health and nutrition safety net programs served a larger share of all California children as the economy worsened



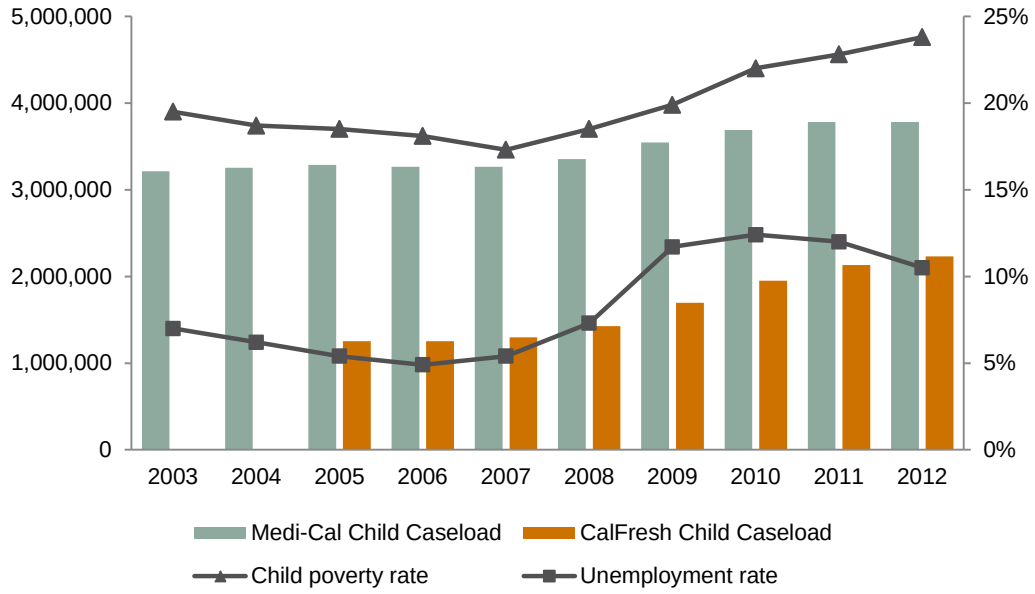
SOURCE: California Department of Health Care Services, Medi-Cal annual enrollment reports; California Department of Social Services, MEDS database; California Department of Education; California Department of Public Health; National Cancer Institute SEER population data.

NOTE: Program enrollment is based on enrollment totals for the month of July in the given year. The denominator used for enrollment rates for Medi-Cal andCalFreshis the total number of children aged 0 to 18 even if program eligibility based on age may be more or less restrictive. Denominators used for NSLP is school-aged children ages 5–18. Denominator used for WIC is children ages 0–4.

Variation in eligibility is the primary factor we expect to see driving changes in enrollment. During the Great Recession and after, California saw a massive deterioration in economic opportunities. The unemployment rate rose from an average of 5.4 percent in 2007 to a high of 12.4 percent in 2010 and continued to be above 10 percent through 2012 (Figure 2). Concurrent with worsening employment prospects, child poverty rates also rose over this period. In 2007 California's child poverty rate had reached a decade low of slightly more than 17 percent, but by 2012 it had increased by more than 6 percentage points to more than 23 percent.[13] Child participation in health and nutrition safety net programs increased statewide as worsening economic conditions enlarged the number of potentially eligible children.

[13] Here and below the estimates refer to official rather than supplemental poverty rates.

FIGURE 2
Caseloads increased as the economy worsened and child poverty rates climbed



SOURCE: California Department of Health Care Services, Medi-Cal annual enrollment reports; California Department of Social Services, MEDS database; US Census Bureau, Small Area Income and Poverty Estimates; California Employment Development Department.

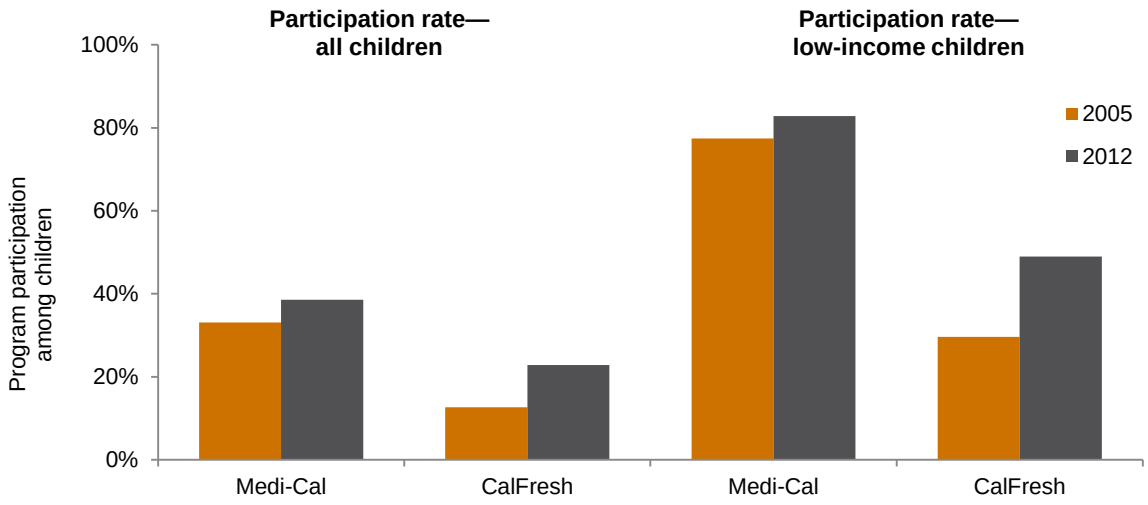
NOTE: Annual caseloads are for children under age 19 and based on total enrollment as of July of the given year. Unemployment rates are also based on July. The child poverty rate is an annual measure.

Empirical models suggest that for every percentage point increase in the unemployment rate, counties saw a 0.6 percentage point increase in the share of children enrolled in Medi-Cal and a 1.1 percentage point increase in the share of children receiving benefits from CalFresh.[14] To put this in context, half of counties experienced an increase in their unemployment rates of 5.8 percentage points or greater between 2005 and 2012. The quantitative models imply that such a change drives up the share of all children participating in Medi-Cal by 3.2 percentage points and the share enrolled in CalFresh by 6.4 percentage points—or the majority of the actual change that occurred.[15]

At the same time, Figure 3 indicates that between 2005 and 2012 *both* the share of all children and the share of low-income children participating in Medi-Cal and CalFresh increased.[16] This suggests that statewide the increase in participation outstripped the increase in need—good news from the point of view of attaining full enrollment. In the next section, we shift our focus to the county level, examining factors that may play a role in the varying enrollment levels of low-income children across the state.

[14] These models hold constant a broad range of other factors at the county level, including child poverty, the race-ethnic and age composition of the child population, and characteristics of county administration. See Technical Appendices A through C for a detailed description of the modeling strategy, data sources, and empirical estimates.
[15] Other research that examines program caseloads nationally has established that they do respond strongly to economic expansions and recessions. See, for example, Bitler and Hoynes (2013), Danielson and Klerman (2013), and Klerman and Danielson (2011).
[16] The share of low-income children participation in WIC and NSLP also increased over the time period.

FIGURE 3
The share of low-income children enrolled also increased during recent recession



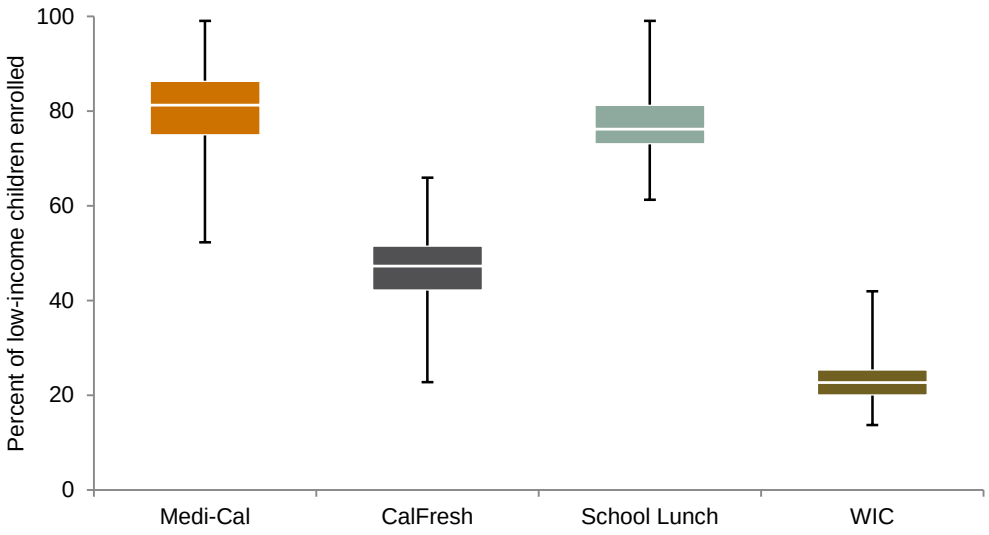
SOURCE: California Department of Health Care Services, Medi-Cal annual enrollment reports; California Department of Social Services, MEDS database; U.S. Census Bureau, Small Area Health Insurance Estimates.

NOTE: The denominator for low-income participation rates is the child population age 19 and under with family income below 200% of the FPL.

Factors That Drive Differences in Program Enrollment among Low-Income Children

The share of low-income children enrolled in safety net programs differs widely from county to county in California. Figure 4 shows this full range across all 58 counties.[17] Medi-Cal enrollment ranges from a low of 52 percent to about 100 percent. The spread is similarly broad for CalFresh, and slightly narrower for WIC and school lunch. These variations reflect a multitude of factors that differ across counties. To complicate matters even more, these factors are all evolving at once. This is particularly true of the past decade, during which California experienced a severe recession and deep budget cuts.

FIGURE 4
Program use among low-income children varied across counties and programs in 2012



SOURCE: California Department of Health Care Services, Medi-Cal annual enrollment reports; California Department of Social Services, MEDS database; California Department of Education; California Department of Public Health; US Census Bureau, Small Area Health Insurance Estimates.

NOTE: The denominator for low-income participation rates is the child population age 19 and under with family income below 200% of the FPL, regardless of the specific age or income eligibility thresholds for the different programs. As discussed in the text, programs actually differ in their age and income eligibility thresholds.

In order to clarify what may be affecting program enrollments, we examine three sets of specific factors that were changing within counties over the past decade and assess whether they have the potential to narrow differences across counties in the share of low-income children enrolled. Two groups of factors that contain elements that may be amenable to policy intervention include county administrative resources and opportunities for program enrollment that exist outside of county offices. A third critical factor that we consider is the changing economic climate.[18] We analyze program caseload data reported by the different

[17] This figure uses a "box and whiskers plot." The lower edge of the box denotes the relatively low enrollment (25th percentile) county, the upper edge of the box indicates the relatively high enrollment (75th percentile) county, and the line in the middle, the median county. The whiskers denote the full range from lowest to highest. Each 25 percentage points demarcates approximately 15 counties out of California's 58 counties.
[18] In this section, we rely on a standard empirical strategy to isolate the roles of different types of factors that may affect program enrollment. This regression-based strategy, however, is not fool-proof. We discuss threats to the validity of our findings in Technical Appendix B. We do not

state departments that oversee each program.[19] We combine these caseload data in quantitative models with information on county demographics, economic conditions, administrative capacity, and other county-level resources obtained from federal survey and federal and state administrative data sources.

Nearly 98 percent of California's children reside in 35 of the state's 58 counties.[20] For methodological reasons we focus on these 35 larger counties. Although the specific findings in this section of the report apply just to these counties, we believe the information has value for thinking about how to improve enrollment across all counties. For a detailed discussion of our data and methodological approach, see the technical appendices that accompany this report. In the following subsections, we will discuss first the factors that appear to have no effect on enrollments, and then move to those that do.

Enrollment opportunities and outreach

When we examine factors having to do with changes in outreach activities and enrollment opportunities within counties, we discover that these do not seem to affect levels of enrollment. Access to programs varies across counties based on the extent of opportunities for enrollment, including the number of visits children make to community health clinics and hospitals, and the prevalence and outreach of community-based organizations.[21] Although the measures of enrollment opportunities we incorporate in our quantitative models do vary considerably across the 35 largest counties, we find no systematic associations between enrollment and observed changes in this group of factors. We also look at information collected by the Department of Social Services for the CalFresh program to determine whether adoption of certain county outreach practices are associated with changes in program enrollments among low-income children. Again, we do not find that the specific changes we measure are systematically associated with increased enrollments.[22]

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focus on differences across counties that are largely unalterable in the short run (for example, their degree of urbanization).We also do not examine statewide or national changes—for instance the 2009 American Recovery and Reinvestment Act, or "stimulus bill"—that may have played a role in changing program participation.

[19] Note that the concepts of "participation" vary across programs, but generally represent enrollment. For Medi-Cal, counts represent certified eligibles as of July of each year, regardless of whether they used health care. For WIC, counts include those who were certified in the program and who were issued a food voucher as of July of each year (most, but not all, redeem vouchers received). For CalFresh, counts represent those who were issued benefits on an EBT card as of July of each year. Finally, school lunch counts include those enrolled in free or reduced-price meals as of October of each year (regardless of whether they decided to eat school meals).

[20] We list all 58 counties and their share of the child population in 2012 in Appendix A.

[21] We quantify opportunities for enrollment using measures of child patients at community health clinics and hospitals, given that health care providers often facilitate enrollment in Medi-Cal and are also one of the most common sites for CalFresh materials and application forms. Additionally, for public health insurance and, to a lesser degree, nutritional programs, enrollment could be related to the health status and need for services among children within the county. The availability of other community-based resources, including organizations providing individual and family social services, could also enhance the ability of people to become aware of and enroll in safety net programs. Finally, knowledge about program availability and eligibility criteria is another important component of access and could vary based on the language abilities of potentially eligible populations, but we do not find that changes in the percentage of the population that is non-English speaking are associated with program enrollments.

[22] Specifically, we measure whether a county employs one or more of four practices: use of eligibility workers stationed outside of welfare offices (for example, in health clinics or employment offices), availability of outreach materials geared towards non-citizens, use of local media public service announcements, and whether or not counties enabled enrollment at ten or more different types of locations. Counties have broad discretion as to the level and types of outreach strategies they employ, and these outreach practices plausibly capture differences in county culture. Other research has found that differing outreach strategies employed for public health insurance programs do have an impact on enrollment levels (Aizer, 2007; Cousineau et al., 2011). We modeled outreach strategies both as a single index (number of outreach strategies employed) and as five separate factors. In neither case did we obtain significant estimates.

Local administration

The U.S. Department of Health and Human Services classifies California as "state supervised and county administered." This means that state-level departments respond to federal requests and supervise county approaches to program administration, but California's 58 counties engage in outreach to inform residents of their potential eligibility, process applications, and provide case management assistance. County welfare departments are the primary enrollment entity for both Medi-Cal and CalFresh. School districts administer the school lunch program and local WIC agencies are responsible for the administration of that program.

We find statistically significant and positive relationships for both these measures. We consider two aspects of county administrative capacity: full-time equivalent (FTE) county employees assigned to public welfare administration and the combined dollar amount of Medi-Cal, CalFresh, and CalWORKs funding the state provides for county administration. [23] Even though state funding allocations for Medi-Cal, CalFresh, and CalWORKs county administration does capture factors other than personnel, these two measures are related: counties make decisions about employment levels based at least in part on available resources. Perhaps more important, these allocations are an annual signal of the level of resources available to support program enrollments, while staffing levels are a longer-term county decision. To capture the impact these county resources may have on enrollment levels and account for varying sizes of counties, we divide both measures by the low-income population.[24]

In other words, holding a range of other factors constant, when county administrative resources relative to the size of the low-income population increased, the share of low-income children enrolled in CalFresh and Medi-Cal grew. For example, our research indicates that for every additional public welfare employee relative to every thousand low-income county residents, we estimate an increase of 0.7 percentage points in CalFresh enrollment and an increase of 1.0 percentage point in Medi-Cal enrollment. For every additional $10 in funding for administration relative to each low-income county resident, we estimate an increase of 0.6 percentage points in CalFresh enrollment and an increase of 2.0 percentage points in Medi-Cal enrollment.[25]

In reality, three quarters of counties saw declines in per capita county public welfare employees over the period 2005-2012. This was due both to generally declining numbers of county employees and to increasing numbers of low-income county residents. We find that a typical county decline in per capita welfare

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[23] There is evidence that counties tend to pool funds across safety net programs to cover shared administrative costs (Logan and Klerman, 2008; Rosenstein, et al., 2012). Medi-Cal allocations made up over half of total state administrative allocations for CalFresh, CalWORKs, and Medi-Cal in every year between 2005 and 2012. We use the initial allocations made at the beginning of the fiscal year rather than adjusted allocations that are determined toward the end of the fiscal year. While it could be the case that counties expect to be reimbursed for documented expenditures according to funding formulas, there is evidence that this has not been always the case in recent years (Rosenstein, et al., 2012). In other words, it is reasonable to suppose that counties acted in accordance with the level of state funding initially allocated for their administrative costs.

[24] We note that the current approach to allocating state funds for county administration of Medi-Cal is currently based on projected caseloads rather than low-income population. See Appendix C for a further discussion. In our analysis, we divide both FTE counts and total administrative funding by the number of county residents estimated to have incomes below 150 percent of FPL, an estimate of the low-income population potentially eligible for these programs. Low-income, unauthorized immigrants are of necessity included in these estimates of county low-income populations. Our empirical strategy does adjust for unchanging county differences in factors such as the size of their unauthorized populations. However, there is unavoidable mis-measurement in our estimate of changing county resources given that unauthorized populations are more affected by labor market fluctuations and that the unauthorized population was dropping during this time period.

[25] Note that the administrative funding variables shown in Appendix C are scaled to be an additional $100 per low-income resident. If the denominator of the funding allocation variable is specified as the entire population instead of the low-income population *or* as the anticipated caseload, the coefficient turns negative. We interpret these differences to mean that the estimates are sensitive to the definition of the population potentially eligible for the programs. See Appendix Tables C8 and C9 and the accompanying discussion for more details and additional robustness checks.

employees is linked to a 1.2 percentage point drop in the share of low-income children enrolled in CalFresh and a 1.7 percentage point decline in the share of low-income children enrolled in Medi-Cal.[26]

As a share of low-income county residents, state allocations for administration of these programs grew over the period, but peaked in most counties before 2012. Still, 32 of the 35 largest counties saw overall increases between 2005 and 2012. We find that a typical increase in administrative funding is associated with a 4.2 percentage point increase in the share of low-income children enrolled in CalFresh, and a 12.4 percentage point growth in the share of low-income children enrolled in Medi-Cal.[27] These are impressive increases. Yet as we show next, they were offset by reductions in enrollments engendered by the economic downturn.

The Role of Policies

Does research find generally that policies drive social safety net program enrollment? Yes, but the evidence is mixed: some, but not all, measured policy changes show a statistically significant relationship with the size of the caseload.

SNAP (the federal name for CalFresh) is a program that has experienced considerable policy change over the late 1990s and into the 2000s. Studies focusing on specific state-to-state policy changes find evidence that policies intended to reduce the burden of applying for and remaining enrolled in SNAP do increase caseloads (Kornfeld, 2002; Kabbani and Wilde, 2003; Hanratty, 2006; Ratcliffe, McKernan, and Finegold, 2008; Mabli, Martin, and Castner, 2009; Klerman and Danielson, 2011). However, the policy changes can account for only a relatively small share (around one sixth) of the actual caseload increase that occurred over the 2000s (Klerman and Danielson, 2011).

While these nationwide studies are not directly applicable to the context of county-administered programs, they do suggest that factors both within and outside of county control likely play a role in program enrollments and that effective strategies to maximize enrollment among those eligible are not necessarily obvious.

Local economic opportunities

As noted above, half of the 35 largest counties saw increases in their unemployment rates of at least 5.8 percentage points between 2005 and 2012. Such a change is associated with a 13.7 percentage point decrease in enrollment in Medi-Cal and a 5.6 percentage point decrease in CalFresh participation among low-income children.[28] In other words, the extraordinary change in the economy during and after the Great Recession appears to have *retarded* progress towards full enrollment in these programs among children. This is not

[26] The median change in the number of public welfare employees per 1,000 county residents under 150 percent of FPL was -0.0025 over the period 2007 to 2012. Increases in per capita county employees is associated with a statistically significant increase in NSLP enrollments, but is not associated with statistically significant changes in Healthy Families or WIC participation. The relationship between welfare employees and NSLP enrollment is consistent with an interpretation of counties directly enrolling CalFresh and CalWORKs students in NSLP using administrative data matches.

[27] The median change in state administrative allocations per every 1,000 county residents under 150 percent of FPL was $617 over the period 2005 to 2012. Increases in per capita administrative allocations are also associated with statistically significant increases in WIC and NSLP participation among low-income children, but a decrease in Healthy Families participation.

[28] For NSLP, enrollments among low-income children are also negatively associated with the unemployment rate. We do not find a statistically significant relationship between the unemployment rate and either WIC or Healthy Families participation.

because program enrollments shrank—we have seen that both Medi-Cal and CalFresh grew robustly—but rather because the number of those eligible grew faster than the number enrolled.

There are several reasons why this might be the case. First, those newly eligible for a safety net program due to job loss might not have been aware of their eligibility, or not have realized it in a timely way. Or they might not have taken the steps to apply because they did not expect to remain eligible for a lengthy period of time. Even though the precise mechanism is unclear, the evidence does suggest that when eligibility is changing rapidly, program enrollments may not keep pace. This dynamic underscores the need to step up enrollment efforts when eligibility expands.

Altogether, our models show that the combined effects of the weakening economy and the changes in county administrative capacity are important in determining health and nutrition program enrollments among low-income children. Counties and the state can make use of this information now, to target the low-income population and aim to keep pace with, or even outpace, changes in this population in order to support enrollments. And even though state and county resource allocation decisions are complex, these findings demonstrate that increasing resources for counties with relatively low program enrollments is a promising strategy for boosting enrollments. In the next section of this report, we will explore how integrating administration of programs that serve overlapping populations might also be part of the solution, not just for individual counties, but also helping to maximize enrollments statewide.

Horizontal Integration—a Gateway to Greater Access

California's health and nutrition safety net programs are designed to serve families, individuals, and children of overlapping populations. The ACA is expanding opportunities to make enrollment in one program a gateway for accessing others. This "horizontal integration"—eligibility determination and enrollment across multiple safety net programs—can increase participation, improve the client experience, and lower administrative costs. All these benefits can in turn help to alleviate what we have seen in the previous section—how enrollments can lag when the economy is in trouble and eligibility outpaces the administrative capacity of counties to keep up.

Program integration for children was a priority in California even before the ACA. For example, the state used a federal option to pilot a project aimed at simplifying Medi-Cal enrollment for school lunch program participants. Likewise, school districts are using administrative data matching to automatically certify students in CalFresh for school lunch. As we will show below, even with these pre-ACA efforts, there is room for improvement in integrating programs and increasing enrollment, particularly among school-aged children.

The ACA could also facilitate even greater integration across health and human services programs for low-income families and individuals, and invites further consideration of the vision of integration in California (Legislative Analyst's Office, 2014). Expanded health insurance options make it possible to connect more people to programs for which they may be eligible. Likewise, current program enrollments make it possible to identify people who may be newly eligible for Medi-Cal or subsidized coverage in Covered California. For example, the state's Express Lane Enrollment Project uses CalFresh enrollment to qualify people for Medi-Cal without the need for an application or determination for 12 months. More than a quarter of a million Californians—233,000 adults and more than 48,000 children—have been enrolled in Medi-Cal that way.[29] The success of this program underscores the potential of horizontal integration to enroll people in available health insurance options.

How often are low-income children enrolled in multiple health and nutrition programs?

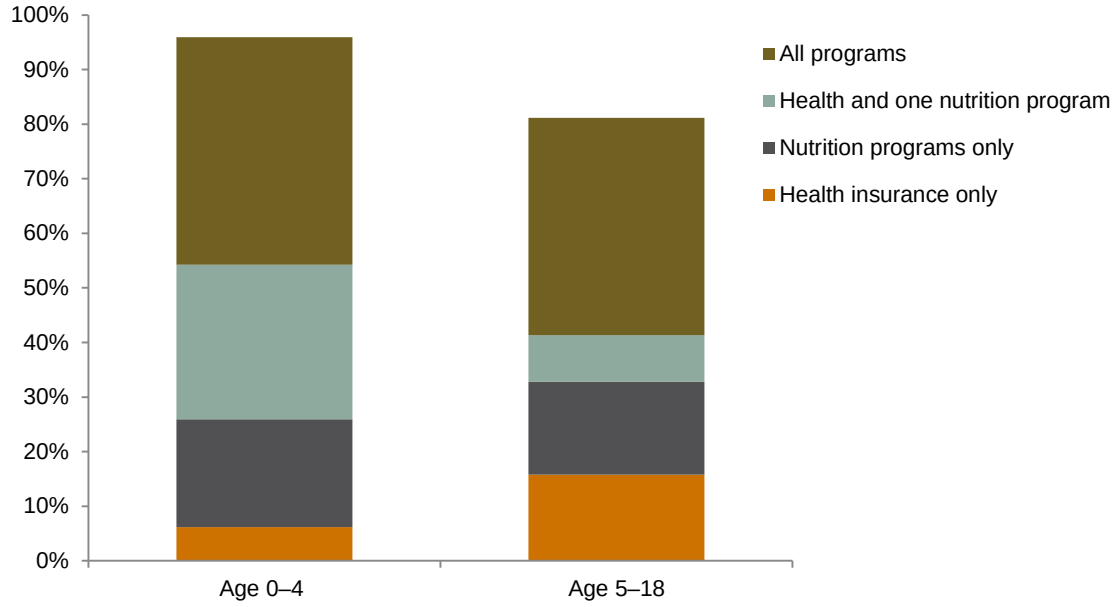
Despite the interest in horizontal integration, available data makes it difficult to assess the degree to which families and children participate in multiple safety net programs. Administrative enrollment data generally provide a highly accurate picture (and are the source we rely on earlier in this report). But they are collected and typically reported program-by-program. Moreover, although there are state efforts underway to provide more information on crossover enrollment , data on multiple program use are not routinely made available or examined. Administrative data also lack information on unenrolled family members who may be eligible. However, large-scale household survey data do offer the opportunity to examine usage of multiple safety net programs, albeit with some limitations.[30] We use a combination of information from the American

[29] Enrollment reported as of December 5, 2014 by the California Department of Health Care Services.
[30] Inaccurate reporting of program participation—due to misunderstanding, forgetting, or stigma—is a concern, as is the documented under-reporting of safety net program usage in major household surveys (Meyer et al., 2009; Davern et al. 2009.)

Community Survey with aggregated administrative data on nutrition programs to provide a more complete picture (see Bohn et al., 2013, and Appendix D for more information).

This picture shows us that California's low-income children make considerable use of safety net programs—particularly infants and young children (Figure 5). Regardless of age, four in ten participate in all available programs—public health insurance, CalFresh, and either WIC or the school lunch program. About 95 percent under age 5 and 80 percent ages 5–18 make use of at least one program. Bundling of public health insurance with only one nutrition program is much more prevalent among children under five than older children.

FIGURE 5
Nearly all low-income young children make use of at least one program but fewer school-aged, low-income children do



SOURCE: American Community Survey, 2012.

NOTE: Low-income children are those with family incomes under 200 percent of FPL. Public health program participation includes Medi-Cal, Healthy Families, or other public insurance and refers to enrollment by the child. Nutrition programs include CalFresh, NSLP, and WIC. Participation in CalFresh is based on someone in the household receiving benefits, while NSLP and WIC is based on child participation. For more information, refer to Appendix D.

Despite the relatively high level of combining health and nutrition programs among low-income children, 25 percent of young children and 33 percent of school-aged children are enrolled in either public health insurance only or nutrition programs only. There are reasons why children may not need certain program benefits for which they may be eligible. The most obvious example is low-income children not enrolled in public health insurance may already have coverage through another source.

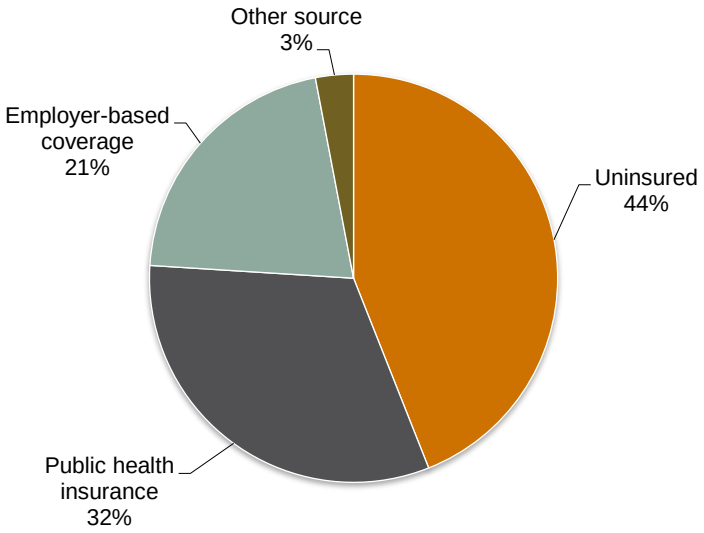
However, when we look at children who do not participate in any programs or participate in only nutrition programs–about 40 percent of school-aged children and 30 percent of young children are uninsured. Income thresholds for CalFresh may limit the eligibility of some children, but it is less clear why children would not make use of the school lunch or WIC programs, given those programs' higher income thresholds and

relative ease of applying. Nevertheless, as we have shown, there is room for improvement in enrollment and in integrating programs, particularly among school-aged children.

Opportunities to connect low-income adults to insurance coverage

Increasing program integration could capitalize on low-income children's relatively high rates of participation, in order to reach parents or other adults in their families who may be newly eligible under the ACA for Medi-Cal or subsidized health insurance coverage through Covered California. Nearly 2.5 million adults live in families with low-income children who participate in at least one health or nutrition program – and prior to the ACA coverage expansions, about 45 percent of those adults lacked health insurance (Figure 6).[31] Even beyond this group, the 21 percent with employer-based coverage—depending on the employee cost-sharing and affordability of the employer plan—may find subsidized or no-cost coverage through Covered California or Medi-Cal to be a viable alternative. Enhanced horizontal integration could facilitate the identification of those adults to help them obtain coverage.

FIGURE 6
Many uninsured adults lived with a child participating in at least one health or nutrition safety net program



SOURCE: American Community Survey, 2012

NOTE: Includes non-elderly adults age 19 to 64 who are in family units with at least one child that is participating in a public health insurance or nutrition program.

Because we are looking at historical data, the figures we use are based on information that pre-dates the ACA coverage expansions. The proportion of uninsured Californians has undoubtedly declined given the larger-than-expected enrollments in Medi-Cal and Covered California during the first year of the ACA. Still, millions remain uninsured. Using family connections to other safety net programs could help to change that for the better.

[31] An unknown share of these adults are likely undocumented immigrants and are not eligible for subsidized health insurance coverage under the ACA coverage expansions.

Conclusion

Maximizing enrollment in health insurance is a new policy goal under the ACA, one that affects not just those who became newly eligible for coverage as of January 2014, but also those who were previously eligible but not enrolled. During the first year of ACA implementation, the increase in Medi-Cal enrollment was sizable—much larger than expected—and involved delays in processing new enrollees. This experience underscores the need to understand the drivers of enrollment, potential sources for local-level differences, and the opportunities more integrated systems could offer.

Throughout the state, enrollment in health and nutrition safety net programs among low-income children—a group for whom eligibility has not changed substantially because of the ACA—is quite high and did expand over the recent economic downturn. However, there are differences in enrollment levels among children across counties. What drives these differences depends in large part on how we define the target population. When we focus on the share of *all* children enrolled, changes in economic conditions such as local area unemployment rates and child poverty rates account for the lion's share of observed differences. However, when we focus on the enrollments among *low-income* children, we see that county public welfare personnel and state funding allocations for program administration are systematically associated with enrollments in both CalFresh and Medi-Cal.

Since administrative resources play a role in differential enrollment levels among low-income populations, it is important to use them strategically to maximize enrollment. Horizontal integration is one way to streamline enrollment processes and ease the administrative burden on both those applying for benefits and the government entities responsible for enrollment. Because safety net programs target overlapping populations, integrating them has the potential not only to maximize enrollments for children, but also to expand participation by reaching uninsured adults newly eligible for subsidized health insurance. Broadening integration beyond programs administered by counties—specifically WIC and the school lunch program—could assist in increasing their reach.

Among low-income children, particularly infants and young children, we see a relatively high level of bundling health and nutrition programs. About 70 percent of low-income children under age five benefit from both, and about half of low-income school-aged children are recipients of public health insurance and at least one nutrition program. Even so, particularly among school-aged children, it appears that improvements can be made, some of which are already underway.

The changes brought about by the ACA, including requirements for more streamlined enrollment processes for public health insurance programs and large federal investments for IT eligibility and enrollment systems, clearly offer opportunities to improve the enrollment process for health insurance programs. In addition, state policymakers have coupled California's Medi-Cal expansion with special efforts to streamline access to additional safety net programs[32] and there have been calls for state legislators to set out a vision for future integration of health and social safety net programs. Moving forward, it will be important to monitor enrollment levels in conjunction with changing administrative processes and resource allocations. It will also be important to take advantage of available IT resources to facilitate increased integration across safety net programs, particularly before the window on federal investments closes at the end of 2015. [33]

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[32] Recent legislation includes *Strengthening the Connection between CalFresh and Medi-Cal* (AB 191) and *Aligning Opportunities for Health* (SB 1002).

[33] The governor's recently released budget proposal acknowledges the need for increased county resources to administer the Medi-Cal program and indicates continued monitoring to assess additional funding needs. A new Medi-Cal county administration budgeting methodology is planned for once the impacts of changes in eligibility systems and enrollment processes brought about the ACA are better known.

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