

MEDI-CAL STATISTICAL BRIEF

AUGUST 2015

Medi-Cal's Historic Period of Growth

A 24-Month Examination of How the Program has Changed since December 2012

Abstract

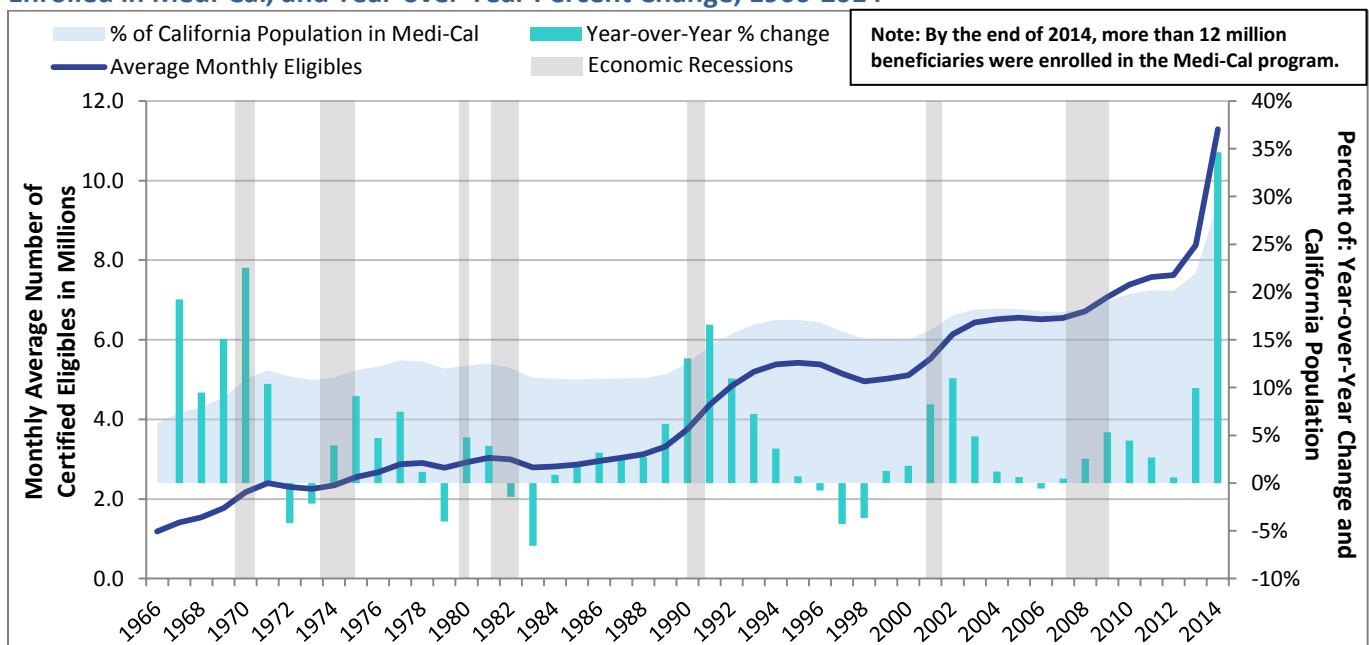
Between December 2012 and December 2014, the Medi-Cal program grew from 7.6 million individuals to more than 12 million – an increase of 4.5 million, or nearly 60%. This growth, brought about largely by newly eligible adults and the transition of children from the former Healthy Families Program, also altered the demographic composition of Medi-Cal's overall population.

Introduction

Between December 2012 and December 2014 Medi-Cal experienced unparalleled growth, adding 4.5 million individuals to the program (Figure 1). More than 75% of this increase was attributable to the 2013 transition of children from the former Healthy Families Program (HFP) into Medi-Cal, and implementation of the Patient Protection and Affordable Care Act (ACA) in January 2014.

In this statistical brief, the Department of Health Care Services' (DHCS) Research and Analytic Studies Division (RASD) discusses these two program changes as well as characteristics of the populations that each ushered into Medi-Cal. In order to better explain how the overall Medi-Cal population changed with the influx of these new beneficiaries, RASD also provides demographic trends at three points in time during different phases of these program changes.

Figure 1: Trends in Average Monthly Count of Certified Eligibles, Proportion of California Population Enrolled in Medi-Cal, and Year-over-Year Percent Change; 1966-2014



Source: Created by RASD using data from the MIS/DSS data warehouse and historical Medi-Cal enrollment data. California population data retrieved from [DOF California Population Estimates 1900-2014](#). Recession information retrieved from the [Federal Reserve Bank of St. Louis' NBER-based recession indicators](#).

Background

In 1966, the year Medi-Cal was first enacted, fewer than two million Californians, or 6% of the state's population, were enrolled in the program. Forty-eight years later, in December 2014, the number of certified eligibles had increased to 12.1 million, or nearly one-third of California's overall population. Amid periodic surges and declines in enrollment due to policy changes and economic cycles, Medi-Cal has maintained relatively consistent growth throughout its overall history. No period of growth, however, was as substantial as that seen between 2013 and 2014. From 1966 to 2012, enrollment increased at an average annual rate of roughly 4%.¹ Between 2012 and 2013, enrollment grew by 10%. But between 2013 and 2014, the program grew by an unprecedented 35% (Figure 1).

To explain the substantial increases in Medi-Cal enrollment in 2013 and 2014, RASD explored two key policy changes along with the populations they encompass: (1) the HFP transition of children from the state's Separate Children's Health Insurance Program (S-CHIP) into Medi-Cal; and (2) California's implementation of the ACA, which enrolled large numbers of individuals both newly and previously

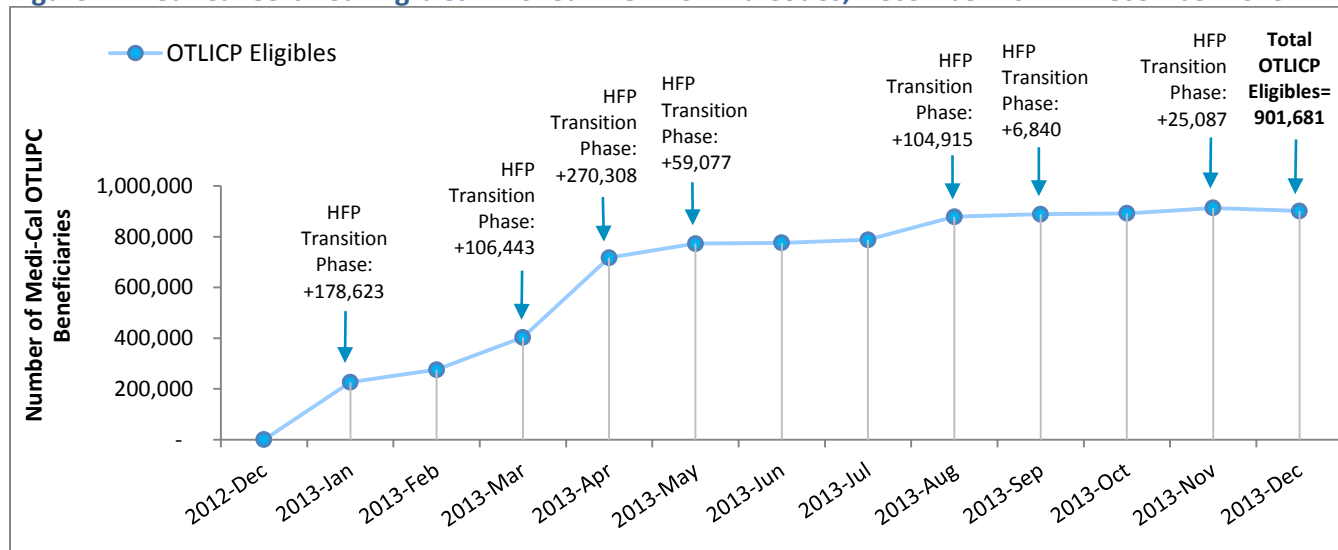
eligible for Medi-Cal. The individuals introduced into Medi-Cal as a result of these policy changes not only accounted for the dramatic surge in the number of Californians enrolled in Medi-Cal, but they also altered the demographic characteristics of Medi-Cal's overall population.

Healthy Families Program Transition

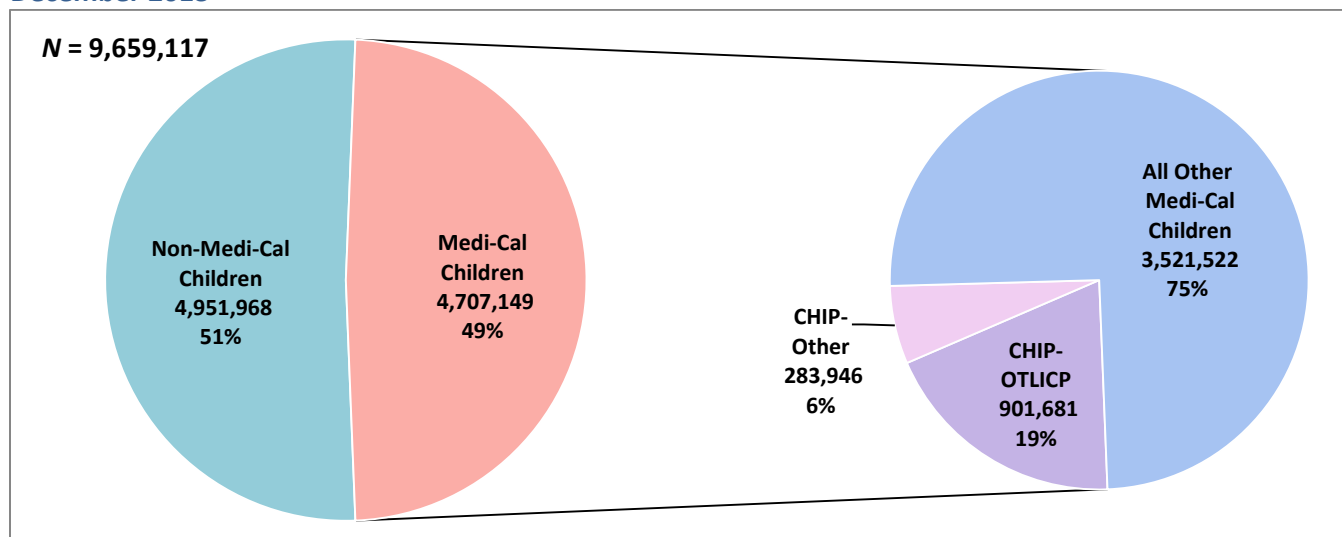
The HFP was California's version of S-CHIP, the federal health insurance program for children. The program became effective in California in 1998 for the purpose of providing low-cost health insurance to children under the age of 19 in families with household incomes too high to qualify for Medicaid (up to 250% of the Federal Poverty Level [FPL]).²

As a component of the 2012-13 California State Budget, Assembly Bill (AB) 1494 provided for the transition of all HFP enrollees into Medi-Cal under the Optional Targeted Low-Income Children's Program (OTLICP). The transition effectively dissolved the HFP and consolidated the program with Medi-Cal while retaining the increased income thresholds to ensure beneficiaries' continuity of coverage.³

Figure 2: Medi-Cal Certified Eligibles Enrolled in OTLICP Aid Codes; December 2012 – December 2013



Source: Created by RASD using data from the MIS/DSS data warehouse and transition data from the [DHCS Final Transition Report](#).

Figure 3: Distribution of California Children Ages 0-18, by Medi-Cal Enrollment and CHIP Status; December 2013

Source: Created by RASD using eligibility data from the MIS/DSS data warehouse and [population projections from the California DOF](#).

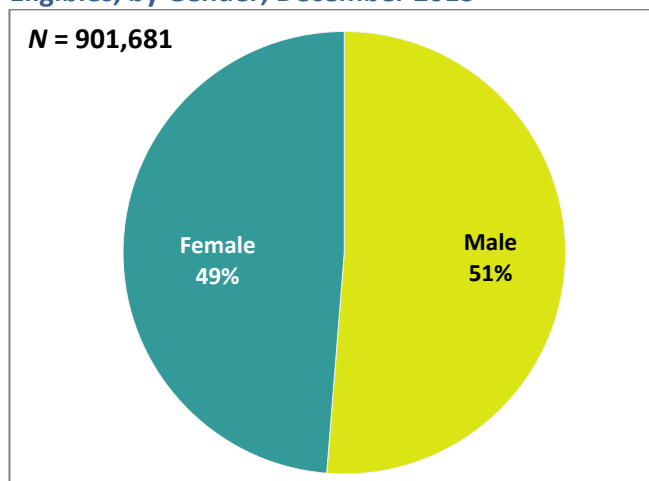
Depending on beneficiaries' county of residence and health care plan, enrollees were transitioned into Medi-Cal over several phases throughout calendar year (CY) 2013. By December 2013, more than 900,000 children were enrolled in Medi-Cal under OTLIP aid codes – 750,000 of whom had transitioned from the HFP into Medi-Cal (Figure 2).^{4,5}

Medi-Cal Children: In 2013, there were 9.6 million children under the age of 19 residing in California. Among these children, 4.7 million, or 49%, were enrolled in Medi-Cal.⁶ In December 2013, after all HFP children had transitioned into Medi-Cal, 19% of Medi-Cal's child population was part of the OTLIP. Although the HFP had been the state's separate CHIP program, some children were also enrolled in aid codes within Medi-Cal that received enhanced funding through CHIP (often referred to as M-CHIP), or in aid codes that handled the transition and presumptive eligibility between the once separate programs.⁷ These are grouped as "CHIP-Other" for the purposes of this brief (Figure 3).

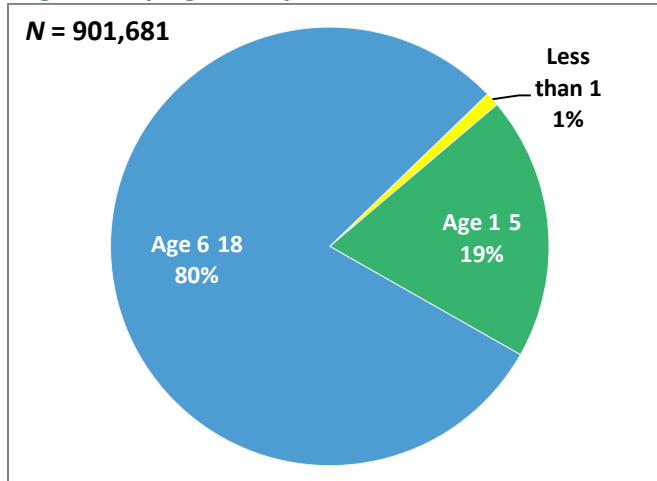
OTLIP Population Profile

The following section provides detailed information about the OTLIP beneficiaries participating in Medi-Cal after all phases of the HFP transition were complete in December 2013.

Gender: Among the OTLIP population, a slightly larger proportion were male (51%) than female (49%) (Figure 4).

Figure 4: Distribution of Medi-Cal OTLIP Certified Eligibles, by Gender; December 2013

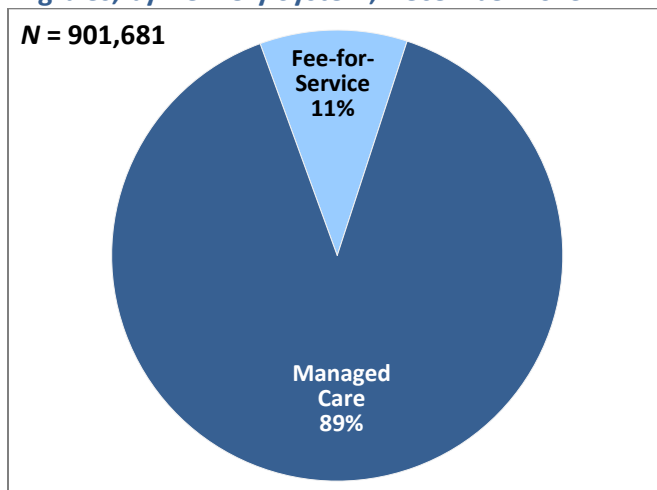
Source: Created by RASD using data from the MIS/DSS data warehouse.

Figure 5: Distribution of Medi-Cal OTLIPC Certified Eligibles, by Age Group; December 2013

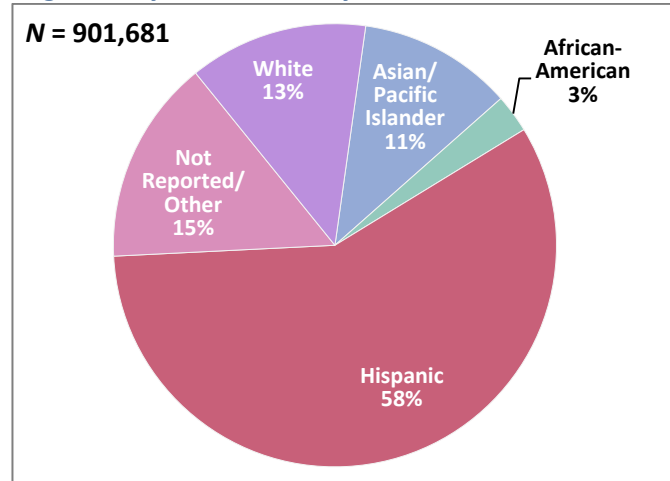
Source: Created by RASD using data from the MIS/DSS data warehouse.

Age Group: Children in the oldest age group (ages 6-18) represented the largest proportion of OTLIPC beneficiaries (80%). Children ages 1-5 constituted another 19%, and the youngest age group, infants less than one year of age, represented only 1% of all OTLIPC beneficiaries (Figure 5).

Delivery System: The majority of Medi-Cal's OTLIPC beneficiaries participated in managed care plans (89%), while a small proportion of individuals participated in Medi-Cal's traditional Fee-for-Service (FFS) model (Figure 7).

Figure 6: Distribution of Medi-Cal OTLIPC Certified Eligibles, by Delivery System; December 2013

Source: Created by RASD using data from the MIS/DSS data warehouse.

Figure 7: Distribution of Medi-Cal OTLIPC Certified Eligibles, by Race/Ethnicity; December 2013

Source: Created by RASD using data from the MIS/DSS data warehouse.

Race/Ethnicity: Among Medi-Cal's OTLIPC beneficiaries, the majority were Hispanic (58%). Beneficiaries among other racial/ethnic cohorts or whose race/ethnicity was not reported represented 15% of the population.⁸ The White and Asian/Pacific Islander cohorts constituted another 13% and 11% of OTLIPC beneficiaries, respectively. African-Americans represented the smallest proportion of OTLIPC beneficiaries (3%) (Figure 6).

ACA Implementation

In addition to the transition of children from the HFP, implementation of the ACA also dramatically altered the overall Medi-Cal population. The ACA was signed into law in 2010, and the most significant provisions were implemented in January 2014. A primary component of the law, and one that contributed to a significant increase in Medi-Cal enrollment, provided states the option to expand Medicaid eligibility to previously ineligible low-income adults ages 19-64 (at or below 138% FPL) without dependent children.⁹

On June 27, 2013, Governor Brown signed bills into law authorizing California to expand the Medi-Cal program to include this optional population effective January 1, 2014.¹⁰ Before implementation of the optional expansion, Medi-Cal primarily provided coverage to

individuals with disabilities, low-income children and their parents/caretaker relatives, pregnant women, and aged individuals. The program also covered individuals with particularly complex medical conditions, such as beneficiaries in the Breast and Cervical Cancer Treatment Program. Low-income adults without dependent children were not otherwise eligible under the established Medicaid categories. Since the state's expansion of coverage for these adults was optional, this brief refers to this population as "optional adults."

In November 2010, in preparation for the expected surge in Medi-Cal enrollment associated with the expansion of eligibility for optional adults, a waiver was granted to California titled "The Bridge to Reform Demonstration."¹¹ The Bridge to Reform gave counties the option to develop Low-Income Health Programs (LIHPs) to provide health care coverage to low-income nonelderly adults who were not yet – but would likely be in 2014 – eligible for Medi-Cal.¹²

LIHPs became active in July 2011 and provided coverage until their statutory sunset date of December 31, 2013. Among California's 58 counties, 53 opted to establish LIHPs.¹³ Roughly half of the 1.1 million optional adults added to the Medi-Cal program in January 2014 were transitioned from LIHPs and placed into non-transitional aid codes upon redetermination.

In addition to providing states the option of expanding their Medicaid programs to include adults ages 19-64 without dependent children, the ACA also mandated coverage for specific subpopulations. For example, this included extending coverage for youths who were receiving Medicaid benefits while in the state's foster care system on their 18th birthday, allowing them to retain (or regain, if they had aged out) coverage until age 26. It also required states to extend family income limits through which children ages 0-18 qualify for coverage. Such distinctions are important, but apply only to a small number of newly eligible beneficiaries.

Outreach Efforts Associated with the ACA

States were also required to develop strategies by which Medicaid application processes would be streamlined across social programs to better enable eligible individuals to enroll.¹⁴ The following sections outline some of those changes, and the ways in which they facilitated further Medi-Cal enrollment growth among both newly and previously eligible populations.

Covered California & Medi-Cal Application

Streamlining: California was one of 13 states which opted to establish its own health benefit exchange rather than use the federal portal.¹⁵ In September 2010, Governor Brown approved California's state-based health care exchange, Covered California.¹⁶ Covered California and DHCS partnered to develop the marketplace that would enable individuals to determine their eligibility for a full-priced health plan, a health plan eligible for subsidies or tax credits, or for Medi-Cal. Through this exchange, individuals are able to apply via the internet, phone, or mail. Between October 2013 (when the exchange opened) and April 2014, roughly one million newly and previously eligible individuals enrolled in Medi-Cal through Covered California.^{17,18}

Outreach and Awareness Efforts: The state underwent an extensive outreach effort, funded by grants, which aimed to inform the public of upcoming changes and provide education about health care options. This effort involved paid media, social media, customer service centers, dissemination of information at community hubs, and more.¹⁹ Much of the advertising campaign focused on Covered California, which also amounted to an indirect campaign for Medi-Cal as many individuals discovered they were eligible for Medi-Cal coverage after their incomes were deemed too low to qualify for subsidized health insurance.

An outcome of these efforts is sometimes referred to

as “the woodwork effect” – a phenomenon in which previously eligible individuals enroll in a public program due to increased public awareness.²⁰ These individuals, in effect, “come out of the woodwork,” prompted by increased awareness of the program and their potential qualification.

CalFresh Express Lane: CalFresh is California’s Supplemental Nutrition Assistance Program (SNAP), which provides financial assistance in meeting the nutritional needs of low-income families. Because income and residency requirements for CalFresh are similar to Medi-Cal’s, CalFresh beneficiaries under 65 years of age were given the option to enroll in Medi-Cal without filling out a separate Medi-Cal application.²¹ As of December 2014, approximately 185,000 individuals were enrolled in Medi-Cal under transitional CalFresh aid codes. These enrollees will be subject to eligibility redeterminations throughout 2015, at which point eligible individuals will be placed into non-transitional Medi-Cal aid codes.

Hospital Presumptive Eligibility: Qualified Medicaid-participating hospitals are allowed to determine and provide immediate, temporary

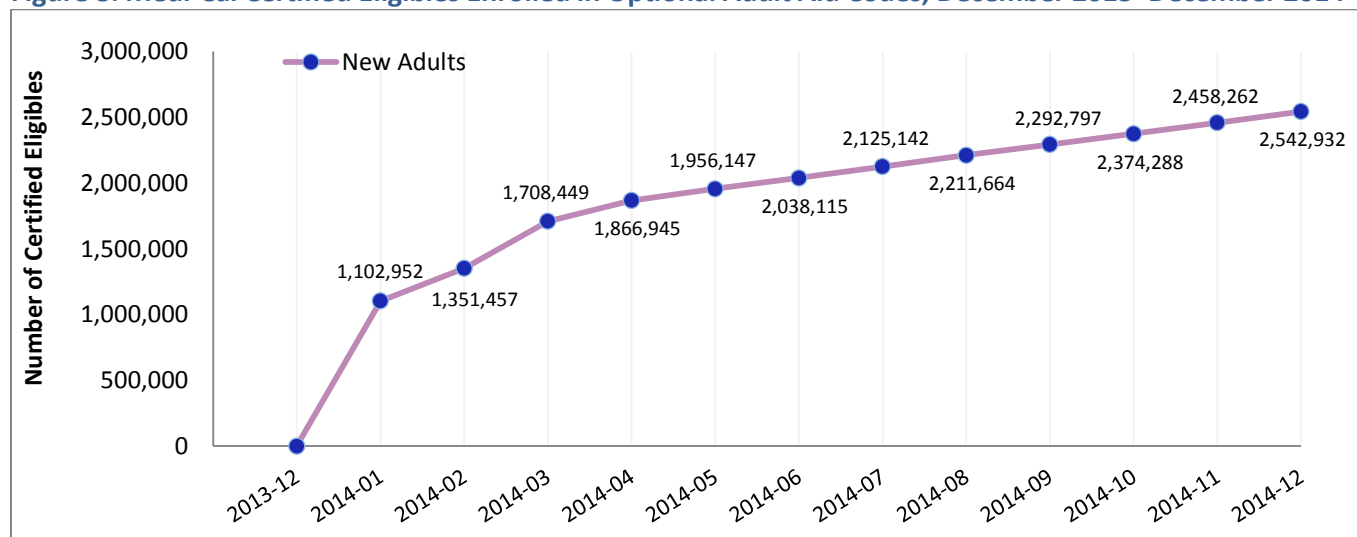
presumptive eligibility (PE) for Medicaid coverage to individuals who would likely be determined eligible upon review. Provisions in the ACA allowed states that expanded their Medicaid programs to extend this PE to include optional adults.²² During December 2014, roughly 27,000 individuals enrolled in Medi-Cal under one of the 10 new hospital PE aid codes.

Optional Adult Population Profile

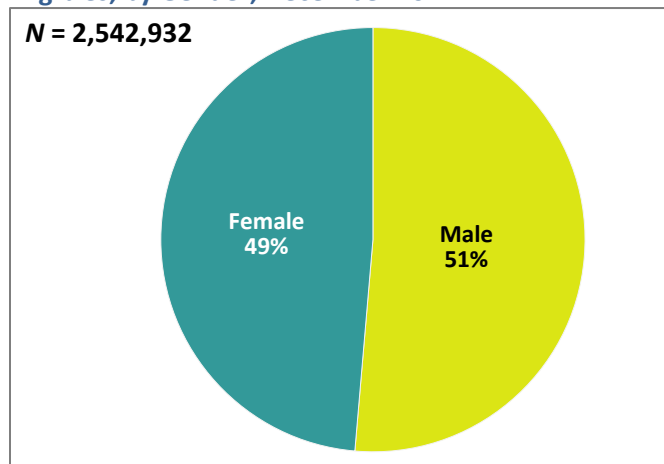
In January 2014, the first month of Medi-Cal eligibility for the optional adult population, more than one million new adults enrolled. Approximately 600,000 were transitioned from LHPs, a component of the state’s early efforts to prepare for ACA implementation. By December 2014, this population of optional adults had grown to 2.5 million.

The following section provides detailed information about the newly eligible, optional adult Medi-Cal population (ages 19-64 and <138% FPL).²³ This also includes newly eligible, optional undocumented immigrant adults entitled to a restricted scope of benefits. The data provide a point-in-time glance at the 2.5 million optional adults that had enrolled through December 2014, nearly one year after full ACA implementation in January 2014 (Figure 8).

Figure 8: Medi-Cal Certified Eligibles Enrolled in Optional Adult Aid Codes; December 2013–December 2014



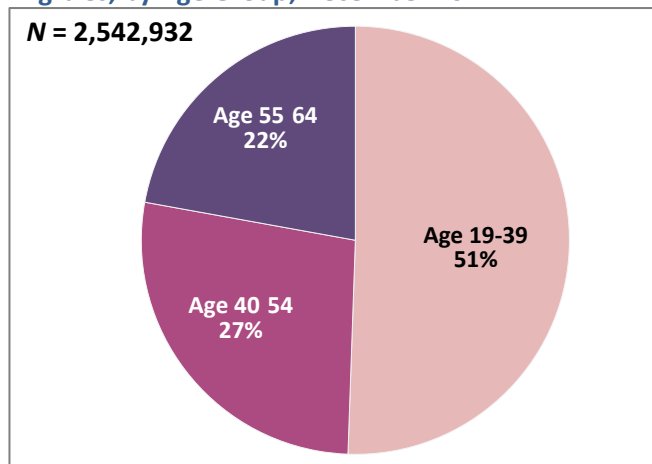
Source: Created by RASD using data from the MIS/DSS data warehouse

Figure 9: Distribution of Optional Adult Certified Eligibles, by Gender; December 2014

Source: Created by RASD using data from the MIS/DSS data warehouse.

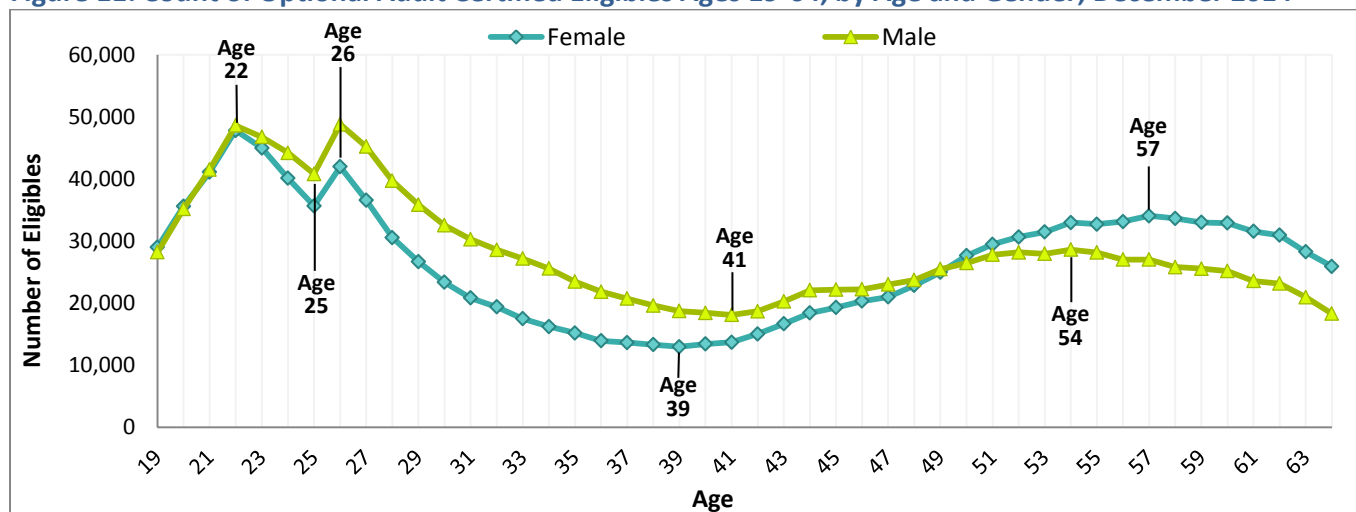
Gender: The optional adult population displayed a slightly smaller proportion of females compared to males (49% vs. 51%, respectively) (Figure 9).

Age Group: Among beneficiaries enrolled in optional adult aid codes, the majority (51%) were ages 19-39. Beneficiaries ages 40-54 comprised the second-largest group at 27%. The smallest group – although still accounting for nearly 600,000 beneficiaries – was adults ages 55-64 (22%) (Figure 10).

Figure 10: Distribution of Optional Adult Certified Eligibles, by Age Group; December 2014

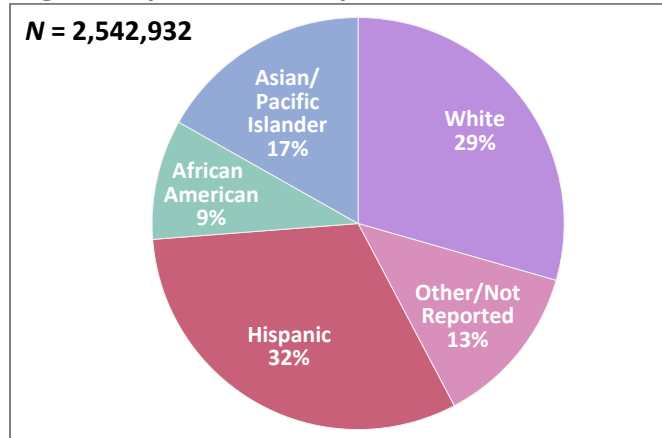
Source: Created by RASD using data from the MIS/DSS data warehouse.

When examining individual ages among the optional adult population, a bimodal distribution is seen, demonstrating a concentration of beneficiaries in the youngest and oldest age ranges. Beginning at age 26, enrollment among both genders steadily begins to decline, as the prevalence of employer-sponsored health insurance has been shown to increase.²⁴ Enrollment was lowest among individuals in the mid-range ages, between ages 39 (female) and 41 (male). Males were enrolled in higher numbers between the ages of 22 and 49, after which females comprised the majority of optional adults (Figure 11).

Figure 11: Count of Optional Adult Certified Eligibles Ages 19-64, by Age and Gender; December 2014

Source: Created by RASD using data from the MIS/DSS data warehouse.

Figure 12: Distribution of Optional Adult Certified Eligibles, by Race/Ethnicity; December 2014

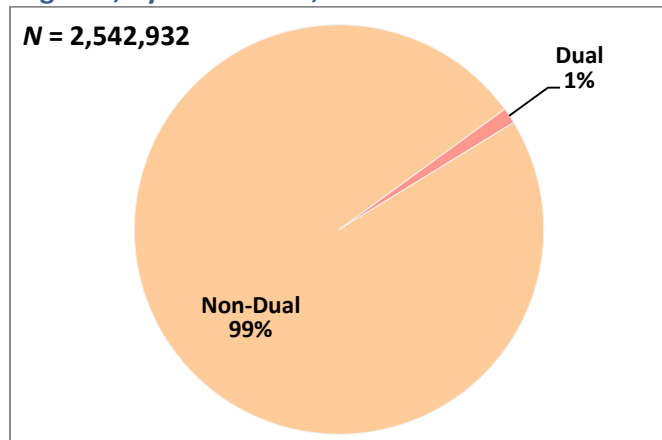


Source: Created by RASD using data from the MIS/DSS data warehouse.

Race/Ethnicity: Hispanic beneficiaries comprised the largest proportion of the optional adult population (32%), closely followed by Whites (29%). Other racial/ethnic cohorts constituted smaller proportions of the overall population, with Asians/Pacific Islanders representing 17% and those in the Other/Not Reported cohort at 13%.²⁵ African-Americans (9%) represented the smallest proportion of optional adults (Figure 12).

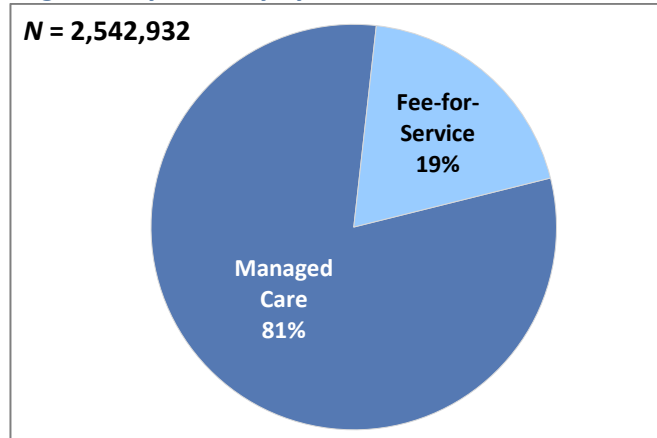
Dual Status: Dual eligibles (individuals dually eligible for both Medi-Cal and Medicare) constituted 1% of the optional adult population, while non-duals represented the remaining 99% (Figure 13).

Figure 13: Distribution of Optional Adult Certified Eligibles, by Dual Status; December 2014



Source: Created by RASD using data from the MIS/DSS data warehouse.

Figure 14: Distribution of Optional Adult Certified Eligibles, by Delivery System; December 2014

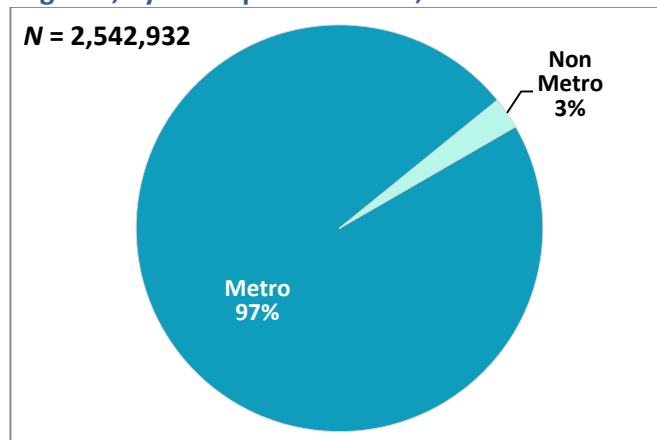


Source: Created by RASD using data from the MIS/DSS data warehouse.

Delivery System: A large majority of optional adults participated in Medi-Cal managed care (81%) as opposed to the traditional FFS delivery system (19%) (Figure 14).

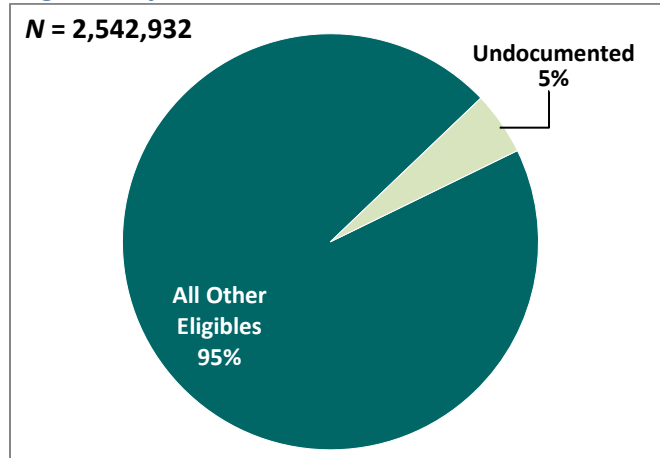
Metropolitan Status: Optional adults resided primarily in counties considered metropolitan (97%) as opposed to non-metropolitan counties (3%) (Figure 15).²⁶ This skewed distribution is typical, as the majority of California residents reside in metropolitan regions of the state.²⁷

Figure 15: Distribution of Optional Adult Certified Eligibles, by Metropolitan Status; December 2014



Source: Created by RASD using data from the MIS/DSS data warehouse.

Figure 16: Distribution of Optional Adult Certified Eligibles, by Undocumented Status; December 2014



Source: Created by RASD using data from the MIS/DSS data warehouse.

Note: Immigrants with official authorization including qualified aliens and those permanently residing under the color of law (PRUCOL) are not classified as undocumented.

Undocumented Status: Undocumented immigrants (those who reside in the U.S. without official authorization or documents)²⁸ accounted for a small proportion of the optional adult population (5%), while citizens and immigrants with authorization²⁹ represented the remaining 95% (Figure 16).

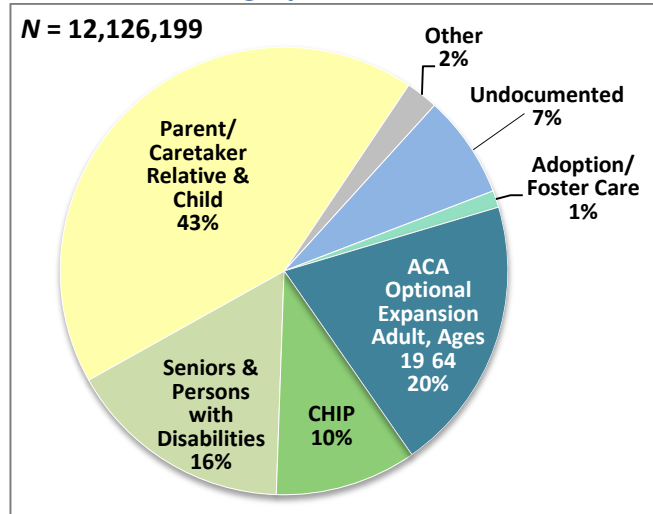
A New Medi-Cal

As a result of the HFP transition and ACA implementation, Medi-Cal has undergone profound changes that are reflected in an overall population that looks very different than it did before these changes took effect. Evaluating the distribution of beneficiaries among Medi-Cal aid categories provides a broad overview of how the population has been altered.

Aid categories are classifications used to divide beneficiaries into analytically meaningful groups. The distribution of beneficiaries among Medi-Cal aid categories following the changes previously discussed is shown in Figure 17. For more information about the aid category groupings used in this statistical brief, see the [Appendix](#).

In December 2014, Parents/Caretaker Relatives & Child (43%) represented the largest aid category. This aid

Figure 17: Distribution of All Certified Eligibles, by Post-ACA Aid Category; December 2014

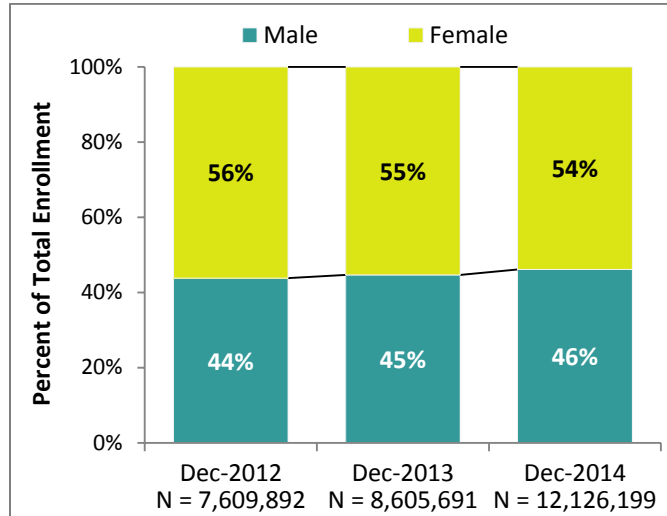


Source: Created by RASD using data from the MIS/DSS data warehouse.

category includes CalWORKs, 1931(b), and medically needy groups encompassing children and their parents or caretaker relatives. The newest aid category, ACA Optional Expansion Adults Ages 19-64, accounted for 20% of the overall Medi-Cal population. Seniors and Persons with Disabilities was the next-largest group, representing 16%. CHIP eligibles, including those enrolled under the OTLCP, constituted 10% of the Medi-Cal population. Undocumented immigrants accounted for 7%. Finally, the Adoption/Foster Care and Other aid categories comprised 1% and 2% of the Medi-Cal population, respectively.

How Has Medi-Cal's Population Changed?

The following section displays the distributional shifts by key population characteristics among the entire Medi-Cal population over three different time periods – December 2012 (before the HFP transition and ACA implementation), December 2013 (after the HFP transition and before ACA implementation), and December 2014 (after the HFP transition and ACA implementation). The characteristic distributions seen among the OTLCP and optional adult populations largely influenced the proportional influxes seen in the overall Medi-Cal population.

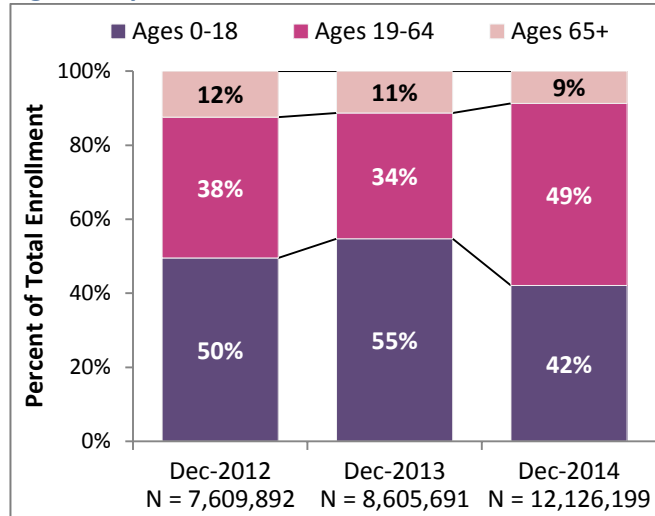
Figure 18: Distribution of All Certified Eligibles, by Gender; December 2012, 2013, and 2014

Source: Prepared by RASD using data from the MIS/DSS data warehouse.

Gender: The proportion of males among Medi-Cal beneficiaries increased slightly from 44% to 46% during the period analyzed. Females have historically been enrolled in larger numbers than males, due in part to Medi-Cal's eligibility pathways (Figure 18).

Age Group: As expected, between December 2012 and December 2013, following the transition of former HFP children, the proportion of children ages 0-18 among the overall Medi-Cal population increased by five percentage points, from 50% to 55%. Although the proportions of both adult age groups decreased, the actual number of adult beneficiaries slightly increased. By December 2014, following the optional adult expansion, a substantial increase in adult enrollment was experienced, signaling a shift toward a wider age distribution.

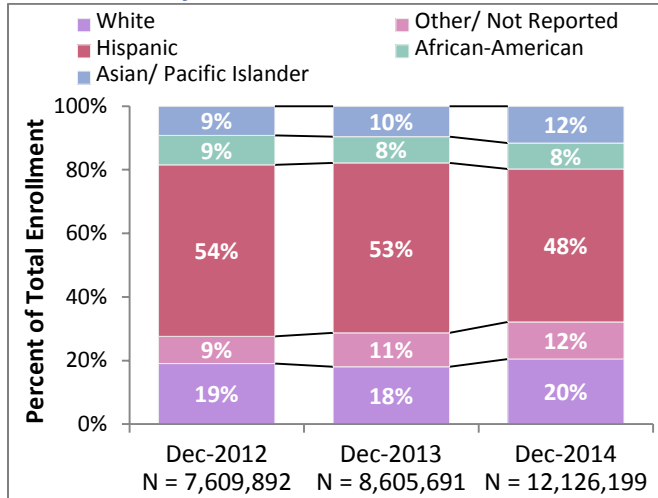
Due to various eligibility expansions designed to ensure health care coverage for the broadest child population in need, children have historically represented the majority of Medi-Cal beneficiaries.

Figure 19: Distribution of All Certified Eligibles, by Age Group; December 2012, 2013, and 2014

Source: Created by RASD using data from the MIS/DSS data warehouse.

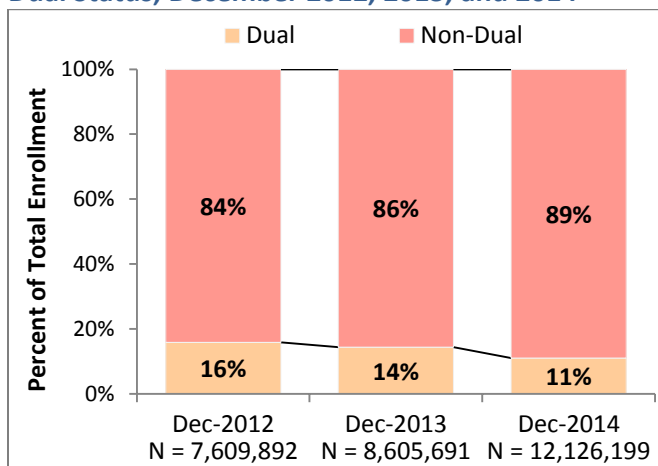
Between December 2013 and December 2014, the proportion of beneficiaries ages 0-18 decreased 13 percentage points, from 55% to 42% of the population (although the actual number of beneficiaries in this age group increased), while the proportion of adult beneficiaries ages 19-64 increased 15 percentage points, from 34% to 49%, during the 12-month period. The proportion of beneficiaries ages 65 and older decreased throughout the period analyzed, yet the number of beneficiaries in this age group slightly increased (Figure 19).

Race/Ethnicity: While the majority of racial/ethnic cohorts remained relatively stable during the period analyzed, the most apparent change was among the Hispanic group, which decreased by six percentage points between 2012 and 2014, from 54% to 48%. Conversely, the Asian/Pacific Islander cohort increased from 9% to 12%, those not reported or identifying with various other racial/ethnic cohorts increased by three percentage points,³⁰ and Whites increased to 20% of total enrollment (Figure 20).

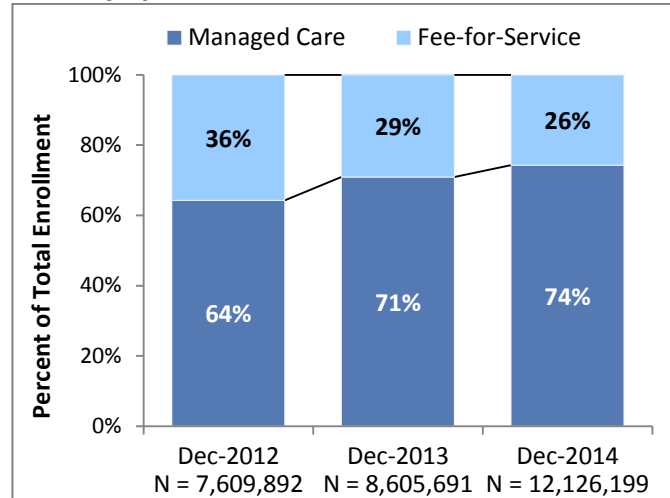
Figure 20: Distribution of All Certified Eligibles, by Race/Ethnicity; December 2012, 2013, and 2014

Source: Created by RASD using data from the MIS/DSS data warehouse.

Dual Status: Dual eligibles, or individuals eligible for both Medi-Cal and Medicare, generally comprise a minority of total Medi-Cal enrollment. Among the three time periods examined, December 2012 had the largest proportion of duals at 16%, while December 2013 and December 2014 were two and five percentage points lower, respectively. This decrease in the proportion of dual eligibles is not due to decreased dual enrollment – in fact, duals increased by nearly 40,000 enrollees during this period – but rather the increase in enrollment among individuals eligible for Medi-Cal Only (Figure 21).

Figure 21: Distribution of All Certified Eligibles, by Dual Status; December 2012, 2013, and 2014

Source: Created by RASD using data from the MIS/DSS data warehouse.

Figure 22: Distribution of All Certified Eligibles, by Delivery System; December 2012, 2013, and 2014

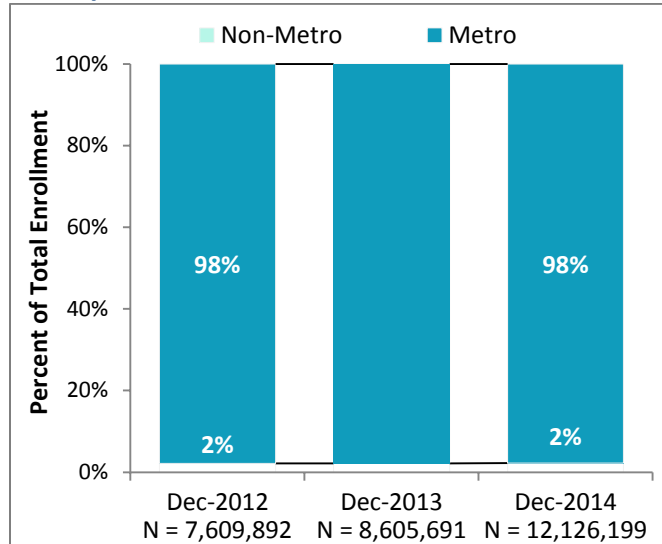
Source: Created by RASD using data from the MIS/DSS data warehouse.

Delivery System: A continuous increase in beneficiaries enrolled in a managed care plan, and a decrease in beneficiaries enrolled in the traditional FFS model, has been seen over the past several years. In 2013, this was largely due to the expansion of managed care into 28 rural, formerly FFS-only counties; and the transition of children from the HFP into Medi-Cal managed care. In addition, nearly all of the individuals in the optional adult population were required to enroll in a managed care plan.

Between December 2012 and December 2014, the proportion of beneficiaries enrolled in a managed care plan increased 10 percentage points, from 64% to 74% (Figure 22). Many new beneficiaries and those enrolled in transitional aid codes were temporarily placed in FFS until their enrollment in a managed care plan could be established.

Metropolitan Status: Even with the addition of new populations, the distribution of beneficiaries residing in metropolitan and non-metropolitan areas remained unchanged. Beneficiaries' counties of residence continued to be heavily concentrated in metropolitan (98%) compared to non-metropolitan (2%) areas (Figure 23).

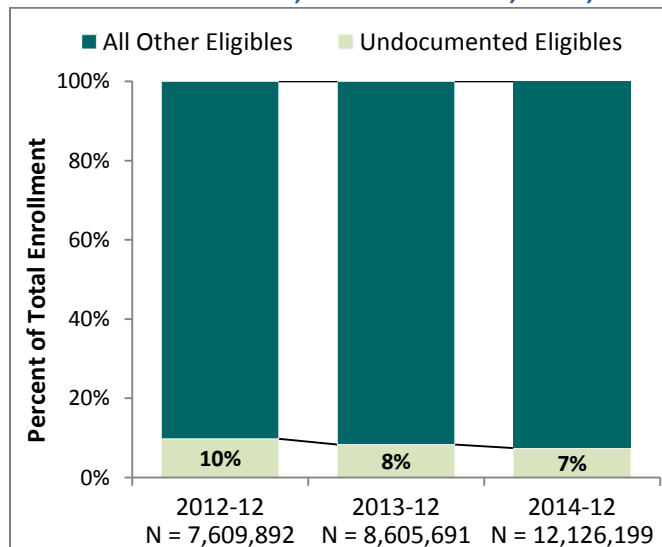
Figure 23: Distribution of All Certified Eligibles, by Metropolitan Status; December 2012, 2013, 2014



Source: Created by RASD using data from the MIS/DSS data warehouse.

Undocumented Status: The proportion of Undocumented beneficiaries decreased slightly between 2012 and 2014, from 10% to 7%, despite the addition of roughly 160,000 Undocumented beneficiaries during this period. All other beneficiaries increased from 90% to 93% of the overall Medi-Cal population (Figure 24).

Figure 24: Distribution of All Certified Eligibles, by Undocumented Status; December 2012, 2013, 2014



Source: Created by RASD using data from the MIS/DSS data warehouse.

Note: Immigrants with official authorization including qualified aliens and those permanently residing under the color of law (PRUCOL) are not classified as undocumented.

Conclusion

Between January 2013 and December 2014, the Medi-Cal program experienced increases in enrollment far greater than the program had experienced throughout its entire history. This tremendous growth was fueled at first by the transition of nearly one million children from the state's HFP into Medi-Cal, and later by the optional ACA expansion of Medicaid eligibility to low-income adults without dependent children. Implementation of the ACA not only extended eligibility to a new population, but also stimulated enrollment growth among individuals who would have been eligible prior to the expansion but had not enrolled, a phenomenon known as "the Woodwork Effect." These individuals likely enrolled due to program simplification and outreach strategies enacted by the state.

As Medi-Cal enrollment increased dramatically, the population's demographic composition was also altered in some important ways:

- Prior to the ACA expansion, children constituted roughly 50% of overall Medi-Cal enrollment. Following the ACA expansion, children no longer represented the majority age group as the influx of optional adults increased the overall proportion of adults significantly. Children now constitute 42% of Medi-Cal's overall population, while adults ages 19-64 represent 49%.
- While the number of children within Medi-Cal's population and their corresponding proportion of overall enrollment was altered by the ACA, Medi-Cal's coverage of the state's child population has expanded considerably over the past two years. Between December 2012 and December 2014, Medi-Cal extended coverage to an additional 1.3 million children ages 0-18. In December 2014, Medi-Cal provided health care coverage to 5.1 million children, representing 50% of California's child population.³¹

- The ACA optional adult expansion for individuals ages 19-64 extended coverage to more than 2.5 million Californians by December 2014. Slightly less than half, or 49%, were ages 40-64 and 540,000 were ages 55-64. Males represented a slight majority of the enrollment, constituting 51% of the 2.5 million newly eligible adults.
- Prior to 2013, females constituted approximately 55% of Medi-Cal's overall population. By 2014 the distribution shifted slightly, with males increasing by one percentage point to 46%, and females declining by one percentage point to 54%.
- The influx of the newly eligible adults ages 19-64 were almost exclusively eligible for Medi-Cal only. Therefore, the proportion of Medi-Cal's population identified as dually eligible for Medi-Cal and Medicare dropped from 16% to 11%.
- The proportion of Medi-Cal's population identifying as Hispanic decreased from 54% prior to ACA implementation to 48% after the ACA expansion. Asian/Pacific Islander, White, and Other races/ethnicities all saw increased proportions following the ACA expansion.
- The proportion of beneficiaries participating in managed care continued to increase. In December 2012, 64% of Medi-Cal's overall population participated in managed care, and by December 2014, 74% participated in managed care. The increase was driven by the state's expansion of managed care in formerly FFS-only counties, as well as the direction of newly enrolled individuals into managed care delivery systems.
- The proportion of Medi-Cal's population identified as undocumented decreased from 10% in December 2012 to 7% in December 2014.
- Other characteristics, such as geographic distribution (i.e., metropolitan vs. non-metropolitan), recognized no significant distributional shift.

In 2012, one-fifth of California's population was covered by Medi-Cal and by 2014 the proportion of California's population covered by Medi-Cal had risen to one-third. While the number of certified eligibles has continued to grow following December 2014, the monthly increases have slowed and begun to level off. Medi-Cal has undergone the largest period of growth and change in its history, and as this phase concludes we are able to realize the scope and implications of this growth, as well as its effects on the population Medi-Cal serves.

More Information on the Medi-Cal Population

The Research and Analytic Studies Division (RASD) of the Department of Health Care Services (DHCS) performed the analysis for this report. RASD compiles official statistics and performs analytical studies to assist DHCS in achieving its mission and goals. More information regarding Medi-Cal enrollment, program expenditures, and other relevant topics is available at the RASD [website](#).

Data Source

Eligibility data used in this brief were taken from the MIS/DSS data warehouse. All data were queried in July 2015, and the information presented for December 2012 and 2013 are considered final. Data for December 2014 are subject to update in subsequent

months until a period of 12 months has passed. These revisions are minor, and have historically altered the aggregate eligibility counts by less than 1%. RASD has supplemented this publication with a pivot table containing data used for this brief. In addition, a list of aid categories and aid codes used for this brief can be found in the Appendix.

Subscribe to the RASD Mailing List

Click [here](#) to receive email notifications when new statistical content is added to the RASD website. The RASB website is updated regularly with graphics, pivot tables and statistical briefs describing the Medi-Cal population, Medi-Cal enrollment trends, and other issues relevant to the Medi-Cal program and its stakeholders.

IF YOU PLAN TO CITE THIS PAPER IN A SUBSEQUENT WORK, WE SUGGEST THE FOLLOWING CITATION:

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PLEASE NOTE:

This document provides a brief summary of complex subjects and should be used only as an overview and general guide to the Medi-Cal program. The views expressed herein do not necessarily reflect the policies or legal positions of the California Health and Human Services Agency (CHHS) or the California Department of Health Care Services (DHCS). These summaries do not render any legal, accounting, or other professional advice, nor are they intended to explain fully all of the provisions or exclusions of the relevant laws, regulations, and rulings of the Medicare and Medicaid programs. Original sources of authority should be researched and utilized.

Appendix: Aid Categories, Aid Codes and Enrollment

Table 1: Medi-Cal Aid Categories

Aid Category	Corresponding Primary Aid Codes
ACA Expansion Adult Age 19 to 64*	7U, L1, M1, P3
Adoption/Foster Care	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 4A, 4E, 4F, 4G, 4H, 4L, 4M, 4N, 4S, 4T, 4W, 5K
CHIP	5C, 5D, 5E, 7X, 8P, 8R, 8X, E2, E6, E7, H0, H1, H2, H3, H4, H5, H6, H9, L2, L4, M5, T1, T2, T3, T4, T5
Other	01, 02, 08, 0A, 0L, 0M, 0N, 0P, 0R, 0T, 0U, 0V, 0W, 0X, 0Y, 13, 23, 2A, 2V, 44, 4K, 4V, 53, 5V, 63, 65, 71, 73, 76, 77, 7F, 7G, 7H, 7M, 7N, 7P, 7R, 7V, 81, 82, 83, 86, 87, 8E, 8W, F1, F2, F3, F4, F5, F6, F7, F8, G0, G1, G2, G3, G4, G5, G6, G7, G8, G9, J1, J2, J3, J4, J5, J6, J7, J8, M9, N0, N5, N6, N7, N8, N9, R1
Parent/Caretaker Relative & Child	3N, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3D, 3E, 3F, 3G, 3H, 3L, 3M, 3P, 3R, 3U, 3W, 47, 54, 59, 5X, 6R, 72, 7A, 7J, 7S, 7T, 7W, 8U, 8V, H7, H8, K1, M3, M7, P1, P2, P4, P5, P7, P9
Seniors and Persons with Disabilities	10, 14, 16, 17, 18, 1E, 1H, 1X, 1Y, 20, 24, 26, 27, 28, 2E, 2H, 36, 60, 64, 66, 67, 68, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6S, 6V, 6W, 6X, 6Y, 8G
Undocumented	1U, 3T, 3V, 48, 55, 58, 5F, 5H, 5J, 5M, 5N, 5R, 5T, 5W, 5Y, 69, 6U, 70, 74, 7C, 7K, 8N, 8T, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, L3, L5, M0, M4, M6, M8, P0, P6, P8, T0, T6, T7, T8, T9

***Note:** Although the M2 aid code is specified for Undocumented immigrants, this brief includes M2 in ACA Expansion Adult group. In describing the optional adult population in this statistical brief, optional adults were categorized using the following aid codes: 7U, L1, M1, M2, and P3.

Note: Aid category groupings were established by RASD and are used for analytical purposes only. They do not necessarily represent specific distinctions between eligibility criteria, funding sources, or any other differentiating characteristics.

End Notes

- ¹ *Note: Rate of growth found by calculating the compound annual growth rate (CAGR) from 1966-2012. (4.1%).
- ² Centers for Medicare & Medicaid Services (CMS). (2012, December). *Approval Letter for A Bridge to Reform: California's Medicaid Section 1115 Waiver*. Retrieved from <http://www.dhcs.ca.gov/provgovpart/Documents/1115amendapprovallet12312012.pdf>
- ³ [Assembly Bill \(AB\) 1494](#)
- ⁴ DHCS. (2014, February 4). *Healthy Families Program Transition to Medi-Cal: Final Comprehensive Report*. Retrieved from <http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/AppendixCHFP.PDF>
- ⁵ *Note: Medi-Cal OTLIP analysis includes all newly established and transitional OTLIP aid codes. Included in the OTLIP population analysis for this brief are the following aid codes: E6, E7, 5C, 5D, H1, H2, H3, H4, H5, T1, T2, T3, T4, T5, T6, T7, T8, T9, T0.
- ⁶ California Department of Finance (DOF), Demographic Research Unit. (2014, December). *State and County Total Population Projections by Race/Ethnicity and Detailed Age, 2010-2060 (as of July 1)*. [Excel worksheet]. Retrieved from <http://www.dof.ca.gov/research/demographic/reports/projections/P-3/>.
- ⁷ *Note: The "CHIP – Other" group analyzed in this brief includes the following aid codes: 5E, 7X, 8P, 8R, 8X, E2, H0, H6, H9, L2, L4, and M5.
- ⁸ *Note: The "Other/Not Reported" category includes those OTLIP beneficiaries whose race/ethnicity was not reported (132,962, or 14.746%); those eligibles in the American Indian/Alaskan Native cohort (1,896, or 0.210%); and those beneficiaries whose race/ethnicity data was missing (43, or 0.005%).
- ⁹ *Note: On June 28, 2012, the United States Supreme Court issued a majority opinion in *National Federation of Independent Business v. Sebelius* which found that the mandatory expansion of states' Medicaid eligibility rules to include childless adults was unconstitutional. California was one of 30 states to date, including the District of Columbia, to exercise the optional expansion of Medicaid eligibility rules.
- ¹⁰ [Assembly Bill \(AB\) 1](#) and [Senate Bill \(SB\) 1](#)
- ¹¹ Pursuant to [Section 1115 of the Social Security Act](#) (SSA).
- ¹² DHCS, Low-Income Health Program Branch. (2011, March). *California's Bridge to Reform Demonstration – Low-Income Health Program*. Retrieved from <http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/LIHP%20Fact%20Sheet.pdf>
 *Note: In January 2014, the LIHP population was transferred into Medi-Cal and into the L1 transitional aid code until a permanent aid code could be assigned.
- ¹³ DHCS. (N.D.). *LIHP Transition 30-Day Notices*. Retrieved from <http://www.dhcs.ca.gov/provgovpart/Pages/LHIPTransition30DayNotices.aspx>
- ¹⁴ Office of the Legislative Council. (2010, May). *Compilation of Patient Protection and Affordable Care Act*. SEC. 1413 [42 U.S.C. 18083] (b)(1)(A). Retrieved from <http://housedocs.house.gov/energycommerce/ppacacon.pdf>
- ¹⁵ Commonwealth Fund. (Last updated 2015, January). *Potential Impact of King v. Burwell on the ACA Marketplaces*. Retrieved from <http://www.commonwealthfund.org/interactives-and-data/maps-and-data/state-exchange-map>
- ¹⁶ [Senate Bill \(SB\) 900](#)
- ¹⁷ Covered California, DHCS. (2014, April 17). *Covered California's Historic First Open Enrollment Finishes With Projections Exceeded; Agents, Counselors, Community Organizations And County Workers Credited As Reason For High Enrollment In California*. [News release]. Retrieved from http://www.calhospital.org/sites/main/files/file-attachments/news_release_0.pdf

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- ¹⁸ Kaiser Family Foundation. (2014, July 30). Where are California's Uninsured Now? Wave 2 of the Kaiser Family Foundation California Longitudinal Panel Survey. Retrieved from <http://kff.org/report-section/where-are-californias-uninsured-now-section-1-who-got-covered/>
- ¹⁹ Covered California. (n.d.) *Marketing, Outreach, and Enrollment Assistance Stakeholder Advisory Group*. [PowerPoint webinar]. Retrieved from http://hbex.coveredca.com/stakeholders/Marketing-Outreach-Enrollment/PDFs/Background_Reading.pdf
- ²⁰ Shafrin, Jason. (2014, May 19). ACA, Medicaid Enrollment and the Woodwork Effect. *Healthcare Economist*. Retrieved from <http://healthcare-economist.com/2014/05/19/aca-medicaid-enrollment-and-the-woodwork-effect/>
- ²¹ DHCS. (2014). *ACA Medicaid Aid Code List*.
- ²² *Note: California adopted this provision in [SB X1-1, section 22](#).
- ²³ *Note: Profiles include beneficiaries in aid codes 7U for optional adults ages 19-64 who gained eligibility through the CalFresh Express Lane; L1 for optional adults who were previously enrolled in county LIHPs; P3 for optional adults in transitional HPE; M1 for optional adults who were citizens or lawfully present; and M2 for optional adults who were undocumented.
- ²⁴ Pickens, G., Moldwin, E., and Marder W. (2010, November). *Healthcare Spending Index for Employer-Sponsored Insurance: Methodology and Baseline Results*. Retrieved from http://truvenhealth.com/Portals/0/Assets/HealthInsights/TRU_15667_0415_HSI_ESI_WP.pdf
- ²⁵ *Note: The "Other/Not Reported" category includes those optional adult beneficiaries whose race/ethnicity was not reported (304,138, or 11.960%); those beneficiaries in the American Indian/Alaskan Native cohort (13,985, or 0.550%); and those beneficiaries whose race/ethnicity data was missing (1,085, or 0.043%).
- ²⁶ Geographic status derived from the USDA's Rural Classifications, which define metropolitan status by county population size, and county economic relation to metropolitan counties. For more information, see <http://www.ers.usda.gov/topics/rural-economy-population/rural-classifications/what-is-rural.aspx>
- *Note: The USDA categorizes California counties into the following two categories: (1) "Metro" includes Alameda, Butte, Contra Costa, El Dorado, Fresno, Imperial, Kern, Kings, Los Angeles, Madera, Marin, Merced, Monterey, Napa, Orange, Placer, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Solano, Sonoma, Stanislaus, Sutter, Tulare, Ventura, Yuba, and Yolo counties; (2) "Non-Metro" includes Alpine, Amador, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne counties.
- ²⁷ DOF. (2015, May). *E-5 Population and Housing Estimates for Cities, Counties, and the State, 2011-2015 with 2010 Census Benchmark*. [Excel workbook]. Retrieved from <http://www.dof.ca.gov/research/demographic/reports/estimates/e-5/2011-20/view.php>
- ²⁸ U.S. Internal Revenue Service (IRS). (2014, December 13). *Immigration Terms and Definitions Involving Aliens*. Retrieved from <http://www.irs.gov/Individuals/International-Taxpayers/Immigration-Terms-and-Definitions-Involving-Aliens>
- ²⁹ *Note: Immigrants with authorization include Qualified Aliens and those aliens classified as PRUCOL. These beneficiaries are not categorized as "undocumented."
- ³⁰ *Note: The "Other/Not Reported" category includes those beneficiaries whose race/ethnicity was not reported (1,364,050 or 11.249%); those beneficiaries in the American Indian/Alaskan Native cohort (52,736, or 0.435%); and those beneficiaries whose race/ethnicity data was missing (6,819, or 0.056%).
- ³¹ DOF. *State and County Total Population Projections 2010-2060*.
- *Note: Percentage of California child population ages 0-18 enrolled in Medi-Cal found using DOF population projections for 2014 among all individuals ages 0-18 (10,210,827) and Medi-Cal eligibles ages 0-18 during December 2014 (5,101,394).