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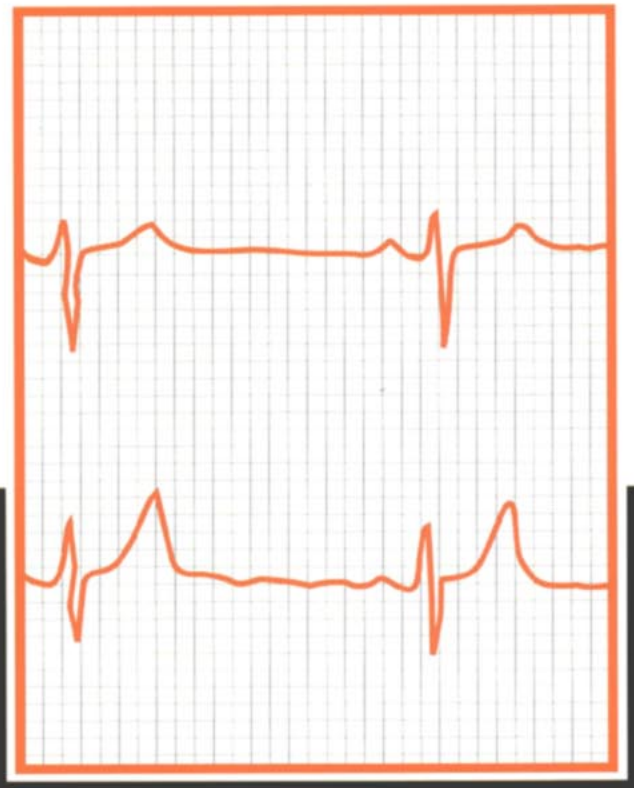


Affordable Health Care for Low Income Californians

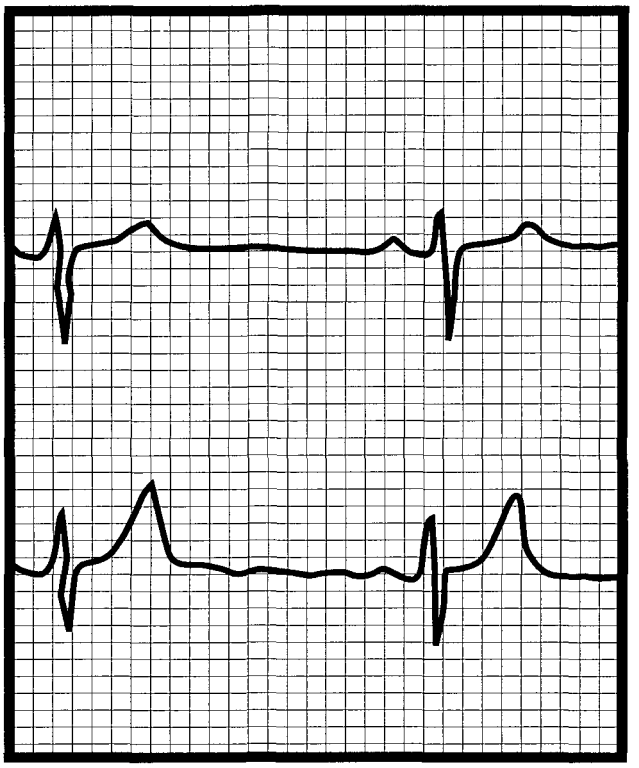
Report and Recommendations of the California Citizens Budget Commission

The Commission extends its warm appreciation to the following foundations for their generous funding support, without which this project and Report could not have been undertaken:

The California Wellness Foundation
The James Irvine Foundation
The Ralph M. Parsons Foundation, and
The Spring Street Foundation.

The Commission extends special thanks to QueensCare for funding the printing and distribution of the Report.

Time for
California Leadership



Affordable Health Care for Low Income Californians

Report and Recommendations of the
California Citizens Budget Commission

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IN MEMORIAM

KENNETH L. MADDY and FRANCIS M. WHEAT

The death of former Senator Kenneth L. Maddy was a great loss to the members and staff of the California Citizens Budget Commission, as it was to so many other organizations and individuals from all walks of life throughout the State of California, who benefited from Senator Maddy's long years of exemplary public service. Absolute integrity and complete dedication to a broad view of the public interest were the hallmarks of the Senator's public career.

Ken Maddy was a leader and a man of many talents and diverse concerns. A role he played of particular interest to the Citizens Budget Commission was as Vice Chair of the Senate Health Committee. As a Senator, he authored SB 12 (in 1987), which established traffic fines as a source for providing increased funding for emergency room services in hospitals throughout the State. In 1998, the fund created by SB 12 was renamed by the Legislature as the Maddy Emergency Medical Services Fund, a fitting tribute by his former colleagues to honor his legislative activities on behalf of publicly-funded health care.

We join the many who have honored Senator Maddy and will greatly miss his energy and talents as we promulgate this Report and seek its adoption and implementation.

Sadly, another outstanding Californian who was a member of the Commission must also be included in this memorial section. Francis M. Wheat passed away in July 2000.

Frank Wheat will be remembered as a real Renaissance man. A nationally prominent securities lawyer, Wheat was a member of the Securities & Exchange Commission from 1964 to 1969. A leader of the Bar, he served as President of the Los Angeles County Bar Association, and was a founder of the Center for Law in the Public Interest. Active in charitable affairs, Frank was President of the Alliance for Children's Rights and a Trustee of the Ralph M. Parsons Foundation. In the political arena, he was a founding director of the California Commission on Campaign Finance, another project of the Center for Governmental Studies. Perhaps best known for his conservationist activities, Frank was a leader of the 27-year fight to preserve the Mojave Desert. His 1999 book chronicling that effort is already on its way to becoming a classic of conservationist literature.

Frank Wheat was truly a man for all seasons, and will be missed by all who knew him and by the many who benefited from his life-long efforts on behalf of the common good.

ACKNOWLEDGEMENTS

The Commission extends its warm appreciation to The California Wellness Foundation, the James Irvine Foundation, the Ralph M. Parsons Foundation and the Spring Street Foundation for their generous funding support, without which this project and Report could not have been undertaken.

The Commission expresses its special thanks for sharing their expertise to the representatives of both state and county governments listed in the Preface who made presentations to the Commission during its 1999 meetings. The staffs of their agencies were also of great assistance in providing material and answering follow-up questions. We also express our appreciation to the staffs of the health care agencies, Boards of Supervisors and chief administrative offices of Alameda, Fresno, Los Angeles, Orange, San Diego, San Mateo and Santa Clara Counties who were most forthcoming and helpful with respect to the portions of Section III-D pertaining to their county health care operations, and to Dan Rabovsky of the Legislative Analyst's Office who provided invaluable assistance in connection with the background and analysis that went into the LAO Report which is the basis for Commission Recommendation Number 11.

As indicated in the Bibliography, the Commission and its staff used written and electronic information from a wide variety of public and private agencies and organizations in the preparation of this Report. In addition, we express our special thanks to the many government agencies and private organizations who provided additional information and assistance to this project, in particular the Health Care Financing Administration, the Assembly and Senate Health Committees, the Office of Statewide Health Planning and Development, the Medi-Cal Policy Institute, the Legislative Analyst's Office, the National Health Foundation, the State Library and the University of California. The staffs of these agencies and organizations, as well as many others, were most courteous and helpful, and provided the Commission with much information and many insights that would not have been available in any other manner.

The Commission also expresses gratitude to its dedicated staff. Executive Director Alexander H. Pope and former Senior Research Associate Camelia Siminescu, with the able assistance of Center President Robert M. Stern and former President Tracy Westen, assisted the Commission in its deliberations and in the preparation of this Report. The Commission and its staff relied, both in its meetings and throughout the preparation of this Report, on the knowledgeable commentary of its consultants, Kim Belshé and Lucien Wulsin Jr., without whose contributions the research and analysis underlying this Report could not have been timely completed. Craig B. Holman helped with substantive research, Rebecca Schwaner created the graphics and bibliography, and Linda Watson prepared the layout of the Report for publication.

PREFACE

Almost all knowledgeable experts agree that California's publicly-funded health care system is plagued by a number of serious problems and badly in need of major reforms.

For that reason, the California Citizens Budget Commission has been engaged in an 18-month process of studying and analyzing the functioning of that health care system. The Commission's study focused on the health care delivery systems of some of the State's largest counties, in particular Alameda, Fresno, Los Angeles, Orange, San Diego, San Mateo and Santa Clara Counties.

In three separate meetings, the Commission heard from a number of highly qualified representatives of both state and county governments, including Kim Belshé, then the Director of the California Department of Health Services; Mary Dewane, the CEO of CalOPTIMA (the County Organized Health System of Orange County); Charles R. Jervis, the Director of the San Bernardino County Medical Center; David J. Kears, the Director of Alameda County Health Services; Burt Margolin, Los Angeles County Senior Health Advisor (and former Health Crisis Manager); and Michael Murray, the Executive Director of the Health Plan of San Mateo.

During its meetings, the Commission was able to arrive at consensus on a number of specific Recommendations. The Members of the Commission feel strongly that the adoption of these Recommendations would make a vast improvement in the operation and effectiveness of California's public health care system. That system would be consolidated, simplified and expanded to the benefit of taxpayers, beneficiaries and all Californians.

The Commission's Preliminary Report containing these Recommendations was released in February at the time the Governor's proposed state budget was being made public and the Legislature was beginning its 2000 Session. The Commission is now releasing this Final Report containing the full background and analysis underlying the Recommendations. It is the Commission's hope that its ability to reach consensus on these Recommendations among an experienced leadership group with widely divergent political views will point the way for the Legislature and the Governor to make these needed reforms in California's publicly-funded health care system in the near future.

For readers not familiar with the terms used in health care materials, a Glossary and List of Acronyms is provided in Appendix A. Also appended in Appendix B is a Bibliography, primarily consisting of the references included in the footnotes. A more complete bibliography of the relevant material on publicly-funded health care would be voluminous and beyond the scope of this Report. In addition, the complexity of California's public health care systems is illustrated in Appendix C, the Quick Guide to Medi-Cal (Special) Programs used by Los Angeles County's eligibility staff.

EXECUTIVE SUMMARY

Introduction

California spends more than $25 billion annually in federal, state and local funds on a complex and conflicting array of publicly-financed health care programs. Despite this impressive level of spending, at present many low-income residents who are eligible for existing programs are poorly served, and there are still over 7,000,000 Californians without health insurance, the great majority of them from low income "working poor" families with inadequate access to affordable health care. Nor is the State's present strong economy proving to be an effective overall solution to these problems. In recent years, in fact, the numbers of low income uninsured Californians have increased at rates exceeding 20,000 per month.

The Administration, the Legislature, the Counties of California and the State's health care plans and providers have an exciting opportunity at this time to make an important difference in the lives of many of those who must rely on publicly-supported programs for their health care needs. With the state budget in surplus, decreasing unemployment, a strong economy and the availability of tobacco settlement funding, the Commission is convinced that high priority attention should be paid to the improvement of our current system of publicly-funded health care. That system needs to be consolidated, simplified and expanded to provide affordable access to health care insurance for a maximum number of those Californians who currently lack that access.

Each one of the Commission's Recommendations has merit as a separate and distinct improvement in our present system of publicly-funded health care. However, they are interrelated and presented here as a package that will function most effectively if the Recommendations are implemented together as a complete reform program.*

*As indicated in Part I, this set of Recommendations does not cover California's mental health, preventive and long-term care public health programs. Those programs, and the proper balance among all public health programs, are of equal importance to those covered here. However, limitations of time and resources prevented them from being considered by the Commission and included within the scope of these Recommendations.

The Commission's Findings

A. Promptly Institute an Aggressive Program of Streamlined Enrollment Procedures.

Large numbers of persons eligible for California's publicly-funded health care programs are not enrolled -- in large part due to complicated welfare-based enrollment procedures. As a prime example, over 60% of California's uninsured children are eligible for, but not enrolled in, those programs.

Applicants are often faced with a system that appears to have been designed as much for exclusion as for using its best efforts to get all eligible individuals enrolled. Enrollment in Medi-Cal (the State's principal public health care program for the low income population) is normally processed by County social service staff -- who are primarily engaged in determining eligibility for welfare benefits and whose functions are often focused on preventing fraud and abuse of the welfare system.

Failure to enroll eligible individuals leaves them out of many preventive health programs and can result in such persons later receiving expensive emergency care services that might have been avoided or provided much more cheaply in a routine outpatient procedure.

B. Adopt a Simplified Income-based Eligibility Standard for All Programs.

Varying eligibility standards for the many current publicly-funded health care programs create costly administrative complexity and result in an inequitable and illogical system that is exceedingly difficult for recipients to navigate. As a result of these varying eligibility requirements, many low income families have different family members eligible for different programs and other members who remain uninsured with no affordable coverage available. Many eligibility standards have cut-off limitations where a small change in assets, family income or status makes the difference between full benefits and total ineligibility. Such requirements can be significant disincentives to seeking better employment opportunities.

In general, the Aid to Infants and Mothers (AIM), Healthy Families and Medi-Cal programs provide access to health care coverage for pregnant women and infants in families with incomes up to 300% of the Federal Poverty Level (FPL), for children up to 250% of FPL and for Medi-Cal-eligible families up to 100% of FPL, respectively. However, many other similarly situated low income individuals, who fall outside this patchwork of eligibility requirements, remain ineligible for publicly-funded coverage and without access to affordable health insurance coverage -- including, in particular, a large number of "working poor" adults in low wage jobs which increasingly do not offer medical coverage as a benefit.

In the event of a need for expensive emergency care, or of a major illness or injury (especially one involving hospitalization, job loss or disability), many previously ineligible individuals and families may thereby become eligible for Medi-Cal coverage. Even for those who do thus become eligible, the result is expensive episodic care rather than the regular care, including preventive programs, that could improve well-being and prevent many treatable health problems from becoming serious or chronic.

C. Consolidate Existing Programs into a Unified Publicly-Funded Health Care System.

California's publicly-supported health care "system" consists of a bewildering array of categorical programs administered by multiple State and local agencies. Traditional political and geographic boundaries often unduly restrict the effective organization and delivery of health care services. As with eligibility standards, the result is a complex, user-unfriendly system that often results in the illogical and unfair treatment of its intended beneficiaries.

Responsibility for California's public health care system is shared between a variety of State and county agencies without effective overall direction or even coordination. At the State level, administrative responsibility is shared between the Department of Health Services and the separately-constituted Managed Risk Medical Insurance Board. The newly created Department of Managed Care exercises regulatory control over Health Maintenance Organizations (HMOs), and the independent California Medical Assistance Commission negotiates contracts for providing hospital services for the Medi-Cal program. Locally, typical large county health departments have to understand and manage a dozen or more separate funding streams from all levels of government, over which they have little or no control, in trying to maintain adequate financing of the health care programs for the administration of which they are primarily or partially responsible. A number of those programs (such as Medi-Cal) themselves have multiple subcategories with differing levels of control and responsibility.

D. Seek More Flexibility in the Use of Federal Funding.

Federal Disproportionate Share Hospitals (DSH) funding provides support for costly hospital-based services, but not for the physician- and clinic-based outpatient programs that emphasize prevention and are fundamental to most managed care plans. A county can lose substantial federal funding by diverting patients from an expensive inpatient and emergency room-based system to a system based on less costly outpatient primary care.

The DSH program was originally established to support safety-net hospitals (almost all county, health care district and University of California hospitals) when they were the core of publicly-funded health care in California. At that time hospitals and other health care providers were compensated primarily on a cost basis with little incentive to reduce costs by maximizing less expensive physician- and clinic-based procedures. As the focus

of publicly-supported health care programs has shifted toward managed care and away from hospital-based procedures, the federal DSH funding formulas have not been modified to accommodate that shift.

E. Increase Funding to Provide Broader Health Care Coverage for the Uninsured--Particularly for Working Poor Families.

Currently, California's public health care programs are geared primarily for very low income beneficiaries with limited ability to contribute to the costs of their care (although many very low income persons remain ineligible). At the other end of the spectrum, California's middle class population is provided with health insurance principally through job-based coverage. In between is a large population of the working poor with incomes above Medi-Cal limits but without access to affordable health insurance coverage either through their jobs or in the private market.

With the state budget in surplus and the availability of $1 billion annually in tobacco settlement funding for the next 25 years, there will never be a more opportune time than the present to make health insurance coverage available, at an affordable cost, to all low income Californians.

The Commission's Recommendations

A. California's Public Health Care System Should Promptly Institute an Aggressive Program of Streamlined Enrollment Procedures.

Recommendation 1: Make enrollment procedures simple and user-friendly.

Recommendation 2: Increase the Medi-Cal period of continuous eligibility.

Recommendation 3: Utilize non-welfare programs with maximum public contact for enrollment.

Recommendation 4: Provide automatic eligibility for those who are presumptively qualified.

Recommendation 5: Minimize the welfare stigma.

Recommendation 6: Minimize legal immigrants' fears of using government health care programs.

B. A Single, Simplified, Income-Based Eligibility Standard for All Public Health Care Programs Should be Adopted as Soon as Possible.

Recommendation 7: Replace complex and inequitable eligibility requirements with a simple income-based eligibility standard for all publicly-funded health care programs.

C. All Existing Health Care Programs Should be Consolidated Into a Unified Publicly-Funded Health Care System.

Recommendation 8: Consolidate all publicly-funded health care programs. Administer those programs regionally--with clear lines of authority and statewide standards for eligibility and benefits.

Recommendation 9: In counties that operate their own health care facilities, separate the payor and provider functions to minimize conflicts of interest in administration, especially with respect to reform implementation.

D. The State Should Seek Greater Flexibility in the Use of Federal DSH Funding.

Recommendation 10: Seek federal waivers allowing flexibility in the use of Federal Disproportionate Share Hospitals funding so that such funds can be used for providing health care to the medically indigent regardless of site.

E. The State Should Finance a Program of Broad Health Care Coverage for the Uninsured -- Particularly for the Working Poor.

Recommendation 11: Adopt and implement the Family Coverage Model proposed in 1999 by the Legislative Analyst's Office as soon as possible.

Recommendation 12: Use tobacco settlement money primarily to finance broader access to affordable health care coverage for uninsured low income Californians.

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PROVIDING AFFORDABLE HEALTH CARE FOR LOW INCOME CALIFORNIANS

PART I INTRODUCTION

The Nation. The rapid advance of medical science in the 20th Century has transformed American medicine into a major growth industry with a sprawling array of hospitals, medical practitioners, public health agencies, health insurance companies, health maintenance organizations (HMOs), pharmaceutical companies and many other entities and groups. In 1996 the United States spent 13.6% of our gross national product (one trillion dollars) on health care expenditures[1] -- far more in amount and percentage than any other country. Current spending continues at that same high level.

The United States spends one trillion dollars per year on health care -- far more in amount and percentage of GNP than any other nation.

Despite this massive national commitment, the United States health care system is unbalanced and full of contradictions. That system is simultaneously the most expensive and the least inclusive of any major industrialized nation. On the one hand, the United States leads the world in Nobel laureates in medicine, in research and treatment centers of international reputation, and in the availability of high-tech medical procedures that were unimaginable a decade ago. At the same time, dissatisfaction with the HMOs that provide the bulk of care to middle class Americans is at an all-time high, the medical care inflation rate the HMOs were created to combat threatens to break out again, and an estimated 44 million Americans are without health insurance of any sort.

The long-sought national goal of providing adequate health care at a reasonable cost to our entire population has long remained elusive. Senior citizens have coverage for the majority of their medical needs through the Medicare program. Although many are poorly served, most of our lowest income citizens have access to broad health care coverage through Medicaid. The vast bulk of the middle class has access to employment-based health care coverage. Those who do not fit neatly into covered categories, however, are often left out of the system -- particularly a very large number of the working poor whose employers do not offer health care coverage.

Forty-four million Americans have no health insurance.

California. These problems are nowhere more acute than in California. The State's current system of publicly-funded health care for low income residents is needlessly complex and poorly organized. Despite large expenditures (an estimated $25 billion in 1999-2000), the system neither serves the target low-income population effectively or fairly, nor spends the taxpayers' money in a truly cost-effective manner. In addition, an estimated 7,300,000 California residents (well over 20% of the State's population) are

[1] Health Care Financing Administration, *Brief Summaries of Medicare & Medicaid, National Health Care Overview* (by Mary Onnis Waid), on the Administration's website at: www.hcfa.gov/pubforms/actuary/ormedmed, p. 2 (in printout).

without health care coverage -- a number that has, despite the strong economy, grown steadily in recent years. The State has a large number of employers, mostly small, who do not offer health benefits -- as well as a substantial low income population that has difficulty navigating the complex and often confusing system of publicly-funded health care resources that are available.

Many of California's working families have no health insurance.

The Commission believes that a number of important steps can and should be taken which will markedly improve our current public health care system and expand its coverage. They are set forth in detail in Part IV below. The Commission urges that these steps be taken promptly in this time of economic expansion (our current "fat" years), so that they will be in place well before the inevitable financial strains of the next major downturn in the economy (the "lean" years to follow). Although there will be substantial initial costs in following this course, which can be substantially off-set by using tobacco settlement revenues, the State is currently in a position to afford that cost; the structural reforms recommended would make the public health care system more efficient and better able to deal with the increased financial pressures of any future economic downturn.

It should be emphasized at the outset that this Report is limited to an analysis of California's publicly-funded health care system (which provides services primarily to low income children and adults under 65). The Report does not deal with privately-financed health care (overwhelmingly job-related) nor in detail with the federally-operated and financed Medicare program for those 65 and older. Also excluded are programs for long-term care (primarily for the elderly, blind and disabled) and for the treatment of mental health problems, as well as the preventive health programs that have long been considered a government responsibility in the United States. This is not to say that those programs, or achieving a proper balance between all public health programs, are less important than the health care problems dealt with here. However, limitations of time and resources made a broader study and report beyond the scope of what the Commission could realistically accomplish in this Report.

The focus of this Report is on publicly-funded health care for low income children and non-disabled adults under 65. Job-based health insurance and other privately-funded health care, Medicare for seniors, mental health services and long-term care for the disabled are beyond the scope of this Report.

As clearly demonstrated in this Report, dealing with California's vast and complex publicly-funded health care system for children and adults under 65 is a worthy objective in and of itself. The Commission will be satisfied if this Report can achieve the result of moving forward the process of rationalizing and improving health care delivery to those Californians who must rely on the public sector for those services.

PART II HISTORICAL DEVELOPMENT OF PUBLIC HEALTH CARE PROGRAMS IN THE UNITED STATES AND IN CALIFORNIA

Summarizing the development of the present public health care system is important to a proper understanding of that system. The complexities, inconsistencies and gaps in today's programs can best be understood in their historical context.

During the 20th century, and throughout its history, the nation has had a full spectrum of political leadership -- from the liberalism of Woodrow Wilson, Franklin Roosevelt and Lyndon Johnson to the conservative administrations of William Howard Taft, Herbert Hoover and Ronald Reagan. These leaders reflected a fundamental ambivalence in the American character -- on the one hand, generosity and a willingness to help those in need, and on the other hand, a tight-fisted fiscal approach, chary of doling out public money to the undeserving.

The development of our public health care programs mirrors these conflicting tendencies. Following the liberal approach, the enactment in 1965 of Medicare (for seniors) and Medicaid (for the poor) first generated massive federal support for the expansion of public health care programs. Medicaid, implemented in California as Medi-Cal, currently provides publicly-funded health care to over 5,000,000 Californians. Medi-Cal has been administered, however, during much of its existence, in a restrictive manner similar to programs of income assistance (welfare), with strict adherence to its onerous verification, documentation and reporting requirements.

There is a fundamental ambivalence in America's public health care system: generosity and a willingness to help those in need, but also a tight-fisted fiscal approach reluctant to dole out public money to the undeserving.

In California, going back to the 19th Century, counties have been the ultimate safety net in providing health care services to those in need. Medi-Cal substantially reduced but did not eliminate this responsibility. The counties' financial ability to meet this need has been particularly difficult in the two decades since the passage of Proposition 13, which restricted the ability of counties to generate their own revenues to meet perceived program needs. The State has provided financial support for county health care programs, but the level of that support has often been reduced when the State's own financial condition worsened.

Over the years, in addition to Medi-Cal for the very low income population, a variety of federal and state programs have been enacted directed at particular problems and populations. The result of these piecemeal enactments is today's patchwork of federal, state and county programs, important to those who are eligible, but leaving millions of Californians dependent on the varying, underfunded and incomplete county safety nets.

A. The National Context

1. EARLY HISTORY

The nation has followed a long evolutionary process in developing our current health care system. "In the isolated communities of early American society, the sick were usually cared for as part of the obligations of kinship and [local] mutual assistance. But as larger towns and cities grew, treatment increasingly shifted from the family and lay community to paid practitioners, druggists, hospitals, and other commercial and professional sources selling their services competitively on the market."[2]

In the 20th Century, the rising costs of medical care created financial difficulties not only for the poor but for middle-class families as well, generating widespread interest in health insurance as a means of spreading the risks of medical expenses. By the 1930s, there was general agreement on the need for some form of health insurance to alleviate the ever-increasing cost of medical care.

On the private side, the development of the private insurance system in the U.S. was under the influence of hospitals and doctors that sought to support the existing forms of health care delivery. Private insurance "piggy-backed" on existing organizations, such as hospitals, the life insurance industry and the medical profession, and was focused primarily on improving affordable access to hospital care for middle-class patients.[3]

Private health insurance expanded rapidly during World War II. This trend continued after the war.

Private health insurance coverage expanded rapidly during World War II. Fringe benefits were increased to compensate for government limits on direct wage increases. This trend continued after the war because private health insurance (mostly developed in connection with employment) was especially needed and wanted by middle-income people. "Channeling health insurance through employment helped satisfy many interests simultaneously. As a fringe benefit, health insurance benefited the employer as well as the worker, solved problems in the marketing of private insurance, gave the providers protection against a government program, and offered the unions. . . a means of demonstrating concern for their members."[4]

The fringe-benefit approach did not, obviously, benefit the retired, the self-employed, those in low-paying jobs, or the unemployed. In 1950, Congress sought to improve access to medical care for needy individuals who were receiving public income assistance

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[2] Paul Starr, *The Social Transformation of American Medicine*, BasicBooks (1982), p. 22.
[3] *Ibid.*, pp. 331-32.
[4] *Ibid.*, p. 333. For a critical analysis of the tax implications of this approach, and its consequences, see Holman W. Jenkins Jr., *Managed Care, We Hardly Knew Ye,* The Wall Street Journal, August 4, 1999, p. A-23. See also Lucien Wulsin Jr., *California at the Crossroads -- Choices for Health Care Reform* (1994), pp. 34-35.

by providing federal support in the financing of state payments to providers of medical care for those individuals. In 1960, the Kerr-Mills bill provided medical assistance for aged persons who, although not necessarily poor, still needed assistance with medical expenses. A more comprehensive improvement in the provision of medical care, especially for the elderly, became a major congressional priority. In 1965, during the Great Society era, these political pressures culminated in Congressional passage of comprehensive legislation establishing both the Medicaid and Medicare programs as part of the Social Security Act.

In 1965 Congress created the Medicaid and Medicare programs to provide federal support for health care programs for seniors and the very poor.

The **Medicaid** program was established in response to the perceived inadequacy of medical care available to the medically indigent. Medicaid funded federal matching funds to state-administered health care programs for the very poor, in particular those eligible for public income assistance (welfare). The **Medicare** legislation providing government-financed health care for seniors was a combination of Democratic and Republican measures. Part A was the Democratic approach of compulsory hospital insurance program under Social Security and was established in response to the specific medical care needs of the elderly (and, in 1973, of the severely disabled as well). Part B was the Republican-sponsored program of voluntary government-subsidized insurance to cover physicians' charges.

In 1977, the **Health Care Financing Administration (HCFA)** was established within the U.S. Department of Health and Human Services to administer both the Medicaid and Medicare entitlement programs under unitary leadership. This makes HCFA the world's largest health insurance entity. Together, the Medicaid and Medicare programs paid over $350 billion for health care services in 1996 -- more than one-third of the nation's total health care bill and almost three-quarters of all public spending on health care.[5]

2. MEDICAID and MEDICARE

MEDICAID. Although Medicaid is the dominant public program for financing basic health and long-term care services for the lowest-income Americans, only approximately one-half of low income Americans are covered by the program -- primarily because eligibility depends not only on income but also on categorical linkage to public income support programs (principally welfare programs for the very low income population and for the elderly, blind and disabled) or membership in particular demographic groups (primarily children and pregnant women). Governed by complex benefit formulas, developed incrementally over the years, Medicaid spending varies substantially by beneficiary group, even among similar-sized or adjacent states, and even within a single state.[6]

Only one-half of low-income Americans are covered by Medicaid.

[5] Health Care Financing Administration, *op. cit.* note 1, p. 3.
[6] David Liska, *Medicaid: Overview of a Complex Program*, the Urban Institute, Assessing the New Federalism: Issues and Options for States Series (Number A-8, May 1997), p. 1.

Financing. Although Medicaid is administered by the states, federal guidelines require states to cover specific categories of people (primarily those on welfare) and types of services. States following the guidelines receive federal matching grants based on their Federal Medical Assistance Percentage (FMAP), calculated in accordance with each state's average per capita income and ranging from a low of 50% to a high of 83%.

Within the federal guidelines, states have considerable flexibility in establishing their own eligibility criteria, benefit packages and payment policies. This flexibility and the differences in their respective average income levels cause large variations among the states in coverage and expenditures. In 1994, some states covered 60% of their low income populations [up to as much as 150% of the federal poverty level (FPL)] while others provided coverage of only 40% of lower income people with much lower FPL eligibility limits. In 1997, program expenditures totaled $160 billion (including $95.4 billion in federal funds) to finance a wide range of services for over 41 million individuals.[7]

States have considerable flexibility in establishing their own eligibility criteria and benefit packages.

Table 1

Federal Medicaid Programs: Interstate Comparisons
Ten Most Populous States

	Medicaid % of State Budget	Annual Eligibles as % of Total Pop+	Expenditures, Total Funds*	Unduplicated Annual Eligibles*	Expenditures Per Eligible	FMAP** %
All States	20.0	15.5	$ 160,528,502,653	41,564,821	$ 3,865	
California	17.1	19.8	$ 16,240,099,854	6,386,720	$ 2,543	50.23
Texas	24.9	14.5	$ 9,600,126,934	2,804,810	$ 3,423	62.56
New York	33.4	17.8	$ 24,525,116,698	3,229,052	$ 7,595	50.00
Florida	16.1	14.2	$ 6,447,889,401	2,086,479	$ 3,090	55.79
Pennsylvania	26.4	14.4	$ 8,075,706,681	1,725,452	$ 4,680	52.85
Illinois	23.7	15.6	$ 6,503,829,004	1,868,205	$ 3,481	50.00
Ohio	20.8	13.3	$ 6,443,156,403	1,490,994	$ 4,321	59.28
Michigan	19.5	14.0	$ 5,560,326,710	1,365,795	$ 4,071	55.20
New Jersey	22.2	10.7	$ 5,478,127,337	859,279	$ 6,375	50.00
Georgia	18.3	16.5	$ 3,584,015,676	1,237,616	$ 2,896	61.52

+Numbers of optional benefits and Medicaid population as percentage of total are as of federal fiscal year 1996.
*Federal Fiscal Year 1997 sources: National Assoc. of State Budget Officers and the federal Department of Health and Human Services, Health Care Financing Administration
**Federal Medical Percentage

SOURCE: Governor's Budget Summary 2000-2001, Health and Human Services, p. 116.

Although nondisabled adults and children in low-income families (the focus of this Report) make up almost three-quarters of all Medicaid beneficiaries, they accounted for only 32.3% of direct Medicaid spending. In contrast, the elderly and disabled,

[7] John K. Iglehart, *The American Health Care System -- Medicaid*, The New England Journal of Medicine, Volume 340, Number 5 (February 4, 1999), pp. 1-2.

constituting the remaining 27% of the recipients, were responsible for more than two-thirds of total direct spending.[8]

Historically, Medicaid has been primarily for those on welfare, mostly the elderly and disabled and very low income families.

Eligibility. Historically, Medicaid eligibility has been tied to eligibility for cash assistance to the very low income population, primarily seniors and the disabled eligible for the Supplemental Security Income/State Supplementary Payment (SSI-SSP) programs and families with children eligible for the Temporary Assistance to Needy Families (TANF) program -- previously Aid to Families with Dependent Children (AFDC).

In recent years, Congress and many states (including California) have expanded Medicaid coverage to poverty-related groups, children and pregnant women in particular, whose income is above the level that would qualify them for cash assistance. Despite these expansions, in 1994 well over half of all Medicaid recipients (58%) still qualified because they also received cash assistance.[9]

Services Provided. Federal guidelines require coverage of a broad range of services, including:

- inpatient and outpatient hospital services,
- physician and nurse practitioner services,
- laboratory and X-ray services,
- nursing home and home health care services,
- children's vaccines and periodic screening, diagnosis and treatment services,
- qualified health center services, and
- prenatal and family planning services.

Under Medicaid, states are required to cover a minimum range of services, including both hospital and outpatient services.

The most frequently offered optional services are prescription drugs, clinic services, mental health services and intermediate care facilities for the mentally retarded.

Disproportionate Share Hospitals (DSH). The DSH program is the only segment of Medicaid, in addition to administrative expenses, in which payments are not made to or for specific individual recipients. Instead, DSH provides financial assistance for hospitals that serve a disproportionately high share of medically indigent patients (both Medicaid recipients and low-income individuals with no health care coverage).

MEDICARE. In general, Medicare covers everyone over 65 years of age, regardless of income, as well as the disabled. Coverage is normally provided automatically to persons age 65 and over who are entitled to Social Security benefits. As life spans have increased and the nation's elderly population has continued to grow larger, Medicare has become the nation's single largest source of payment for medical care.[10] In 1998, approximately

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[8] *Ibid.*, p. 2.

[9] See Leighton Ku, *How the New Welfare Reform Law Affects Medicaid*, the Urban Institute, New Federalism: Issues and Options for States (Series A, No. 5, February 1997).

[10] John K. Iglehart, *The American Health Care System -- Medicare*, The New England Journal of Medicine, Volume 340, Number 4 (January 28, 1999), p. 1. Although Medicare is by far the largest health insurance

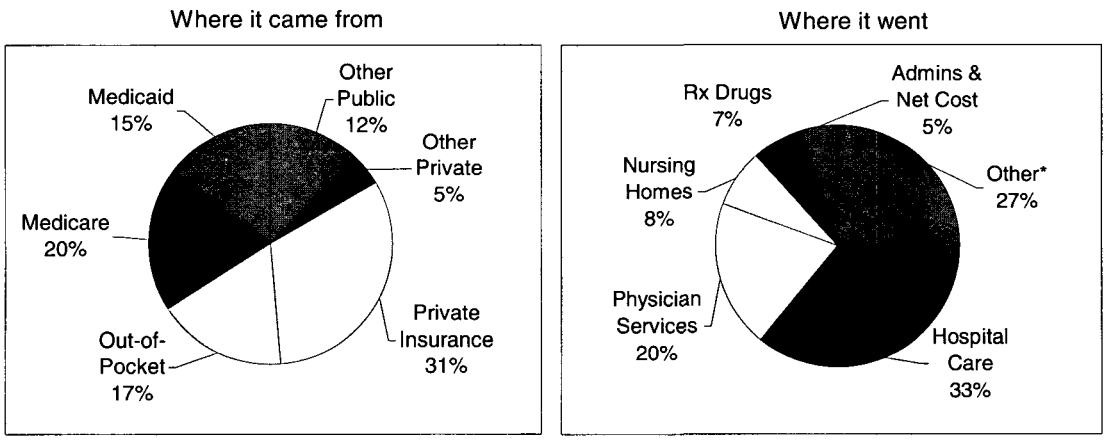
38 million persons were enrolled in Medicare -- including almost 3,800,000 in California.[11]

For those wishing to expand their Medicare coverage to include a more complete spectrum of health care services, supplemental coverage is available from a number of insurance companies, HMOs and other private sector insurers and plans. The federal government requires that this "Medicare Supplement" coverage be offered in one of ten standard formats (Plans A-J) with the insurers and plans competing over price and various extra benefits.

Subsidy programs are available to help low-income senior citizens and people with disabilities cope with the growing costs of their Medicare deductibles, co-payments and Part B premiums. Individuals with incomes up to 135% of the Federal Poverty Level are eligible for such assistance. The implementation of these so-called "buy-in" programs has been slow. Nationally, it is estimated that in 1998 between three and four million individuals eligible for such benefits (over 40%) did not receive them.[12]

Table 2

THE NATION'S HEALTH DOLLAR IN 1997



*Other includes dentist services, other professional services, home health, durable Medi-Cal products, OTC medicine and sundries, public health, research and construction.

SOURCE: Health Care Financing Administration, Office of the Actuary, National Health Statistics Group.

program in the United States, because health care for low income individuals and families is the primary focus of this Report, Medicare will be only briefly summarized here.

[11] On the Health Care Financing Administration website at: www.hcfa.gov under "stats and data," Medicare Enrollment, Medicare State Enrollment for 1998.

[12] Families USA Foundation, Report entitled: *Shortchanged: Billions Withheld from Medicare Beneficiaries* (July 1998), pp. 1-2. According to the Foundation's calculations, California had a very low percentage of eligibles not receiving such benefits -- only 9%-12%. *Ibid.*, p. 3.

B. The California Story: County Responsibility, State & Federal Funding

Since the beginning of the last century, California has made provisions for providing publicly-funded health care to the poor. Begun at the county level, this effort experienced a major escalation in 1965 with the advent of the federally-supported Medicaid program. Since that time, the federal and state governments have been the main sources of funding for providing health care to the medically indigent. However, even with the availability of large additional resources, the overall "system" remained inadequate -- splintered, irregular and leaving a large segment of the working poor, and many others, dependent on inadequately-financed county safety nets.

The Original "Safety Net" Providers -- County Hospitals. In contrast to many areas, California has long had a well developed system of publicly-funded health care for the poor. Counties, not the State, have been the providers of last resort with primary responsibility for the uninsured low income population. As early as 1900, there were 59 county hospital facilities (most of them combined with a poorhouse). By 1950, 49 of the State's 58 counties (with 98% of the State's population) operated county hospitals, financed primarily through local property taxes.[13]

Prior to 1965, county programs, largely based on county hospitals, were the primary health care resource for California's medically indigent population.

This county "safety net" responsibility has long been reflected in Section 17000 of the State Welfare and Institutions Code.[14] Health and Safety Code Sections 1441 and 1445 empowered counties to operate their own hospitals, and those hospitals were originally the principal providers of government-financed "safety net" health care.

Originally, California's county hospitals did not operate in competition with private sector medical care. Generally they were open only to the medically indigent, thus filling the gaps left by the private sector and creating a dual track health system — private hospitals for those who were insured or could otherwise afford to pay; county hospitals for the poor.[15]

The Advent of Major Federal Support. Initially, the main focus of state and federal health care support was on the elderly. The first such significant program in 1957 was entitled Public Assistance Medical Care. This was followed by the similar Medical Assistance for the Aged program. Most of the care provided by these programs was delivered in county hospitals.[16]

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[13] Elinor Blake & Thomas Bodenheimer, *Closing the Doors on the Poor: The Dismantling of California's County Hospitals, A Health PAC Report*, Health Policy Advisory Center (February 1975), pp. 10-11.

[14] Passed in 1965, Section 17000 is based on sections of the Welfare & Institutions Code as it was originally codified in 1937. Those sections were themselves based on provisions of prior law.

[15] Although county hospitals did not turn away patients for inability to pay, as is still the case today, care was not necessarily free. 42% of counties sent bills to all patients, and the other 58% sent bills to those adjudged as having the ability to pay. Blake & Bodenheimer, *op. cit.* note 13, pp. 10-13.

[16] California Department of Health, Office of Planning and Program Analysis, *County Health Care Costs and Services in California Counties*, County Health Care Costs Study, Report to the Legislature (SCR 117), (February 1978), p. 1.

The Medi-Cal Program. With the passage of the Medicaid law in 1965 (implemented in California as the Medi-Cal program), the federal government became a major source of funding for health care for large numbers of the very poor of all ages. Medi-Cal was intended to integrate the private and public health care systems by giving indigents the ability to buy into the mainstream private system. However, Medi-Cal's low reimbursement rates for physicians made it difficult for recipients in many areas to find private doctors willing to care for them,[17] and few private doctors sent their paying patients to county safety net facilities. Thus, even with major federal and state financial support in place through Medi-Cal, in many areas public hospitals continued to be major direct providers of care for the poor.

Medicaid was implemented in California as the Medi-Cal program. Medi-Cal provides the bulk of federal and state funding for health care services for California's lowest income residents.

The Medi-Cal program brought the State into indigent health care funding in a major way with its requirement that federal funds be matched at the state level. In 1970 Medi-Cal spending was $1.1 billion; that tripled to $3.3 billion by 1977[18] and has continued to escalate since that time.

Other Public Providers. The University of California has five Schools of Medicine (connected with the UC Davis, Irvine, Los Angeles, San Diego and San Francisco campuses). The hospital facilities at the UC Davis, Irvine and San Diego Medical Centers are former county hospitals (taken over by the University during the 1960s) and continue to provide large amounts of care to the uninsured low income population in their areas. In addition, that population is served in a number of areas by public Health Care District facilities. Half of California's 72 rural hospitals, as well as a number of hospital-based clinics, are operated by Health Care Districts. (See Sections III-A-4 & 5 below.)

California Medical Assistance Commission (CMAC). An early cost-containment effort by the State to reign in rapidly increasing Medi-Cal hospital costs was the 1982 creation of CMAC as an independent agency to negotiate per diem rates with hospitals providing services to Medi-Cal beneficiaries.[19] CMAC's negotiations and contract rates

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[17] This problem persists in some areas to the present day, especially for specialty physicians. In a letter to the Commission dated February 28, 2000, the Chairman of the California Access to Specialty Care Coalition encloses a study done by the California Orthopaedic Association, dated April 4, 1999, concluding that Medi-Cal reimbursement rates frequently do not even cover an orthopedist's overhead costs for either office visits or surgery. The letter goes on to state that the Coalition believes that the Medi-Cal system also needs to be streamlined to eliminate other significant barriers to physician participation. Some relief may be in sight with respect to the problem of low reimbursement rates. In the May Revision to the Governor's Budget for 2000-01 (p. 30), the Governor proposes to increase rates for Medi-Cal providers by an average of 10% at a cost of $385 million.

[18] California Department of Health, *op. cit.* note 16, p. 1.

[19] CMAC feels that its Selective Provider Contracting Program (SPCP) is much more cost-effective than Medi-Cal's traditional cost-based reimbursement system. The average 1998-99 SPCP Medi-Cal contract rate of $862 per day is well below the average per diem rate of $1,289 for Medi-Cal's cost-based reimbursement contracts in that year. CMAC estimates that by using the concepts of competition and negotiation, it saved the State almost $7 billion during its first 16 years of operations. California Medical Assistance Commission, *1999 Annual Report to the Legislature*, pp. 1 & 2.

are confidential; as a result it is possible to have two similar hospitals located near each other with quite different negotiated rates.[20]

In so-called "closed" areas, which include most of urban California, Medi-Cal beneficiaries must (except for emergencies) receive Medi-Cal-funded inpatient care at one of the hospitals which have contracted with CMAC (numbering 251 in 1999 -- approximately one-half of the State's total number of hospitals). Some of the more rural areas of the State, where there is little or no competition in providing hospital services, are "open," with Medi-Cal beneficiaries able to use any available facility. Hospitals in those areas are reimbursed by Medi-Cal for their reasonable and necessary costs.

MIAs and the Indigent Uninsured. During the 1950s and 1970s, county costs for providing health care to indigents not covered by Medi-Cal escalated dramatically -- net county costs rose from $284 million to $649 million between 1967 and 1974.[21] In response, in 1971 the Legislature provided Medi-Cal eligibility (and partial State funding) for Medically Indigent Adults (MIAs), including those whose income level, while low, had made them ineligible for Medi-Cal.

The passage of Proposition 13 in 1978 (cutting property taxes in half and limiting the ability of the counties and the State to increase other taxes) had a severe negative impact on the ability of counties to fund their share of indigent health care. To help the counties in the aftermath of Proposition 13, the State created a block grant program (part of the AB 8 "bail out" legislation) to help pay for the health care of the low income uninsured persons who were not eligible for State aid through the Medi-Cal program.

In 1983, the State decided it could no longer continue to finance the MIA program and abolished it. The State transferred all responsibility for the MIAs back to the counties and provided block grants to finance MIA medical care costs -- but at only 70% of the level of the previous State funding base. This funding was part of the annual budget process, and a series of gubernatorial vetoes further reduced MIA funding during the 1980s to less than one-half of its original level.

MISP and CMSP. At the same time, the Medically Indigent Services Program (MISP) was established which provided state funds to the large counties to help pay for the costs of delivering health care services to their indigent uninsured. The small county equivalent was called the County Medical Services Program (CMSP) for the 34 small counties with populations under 300,000. Pursuant to CMSP, the State Department of Health Services contracted with the small counties to administer their health care programs for the uninsured medically indigent.

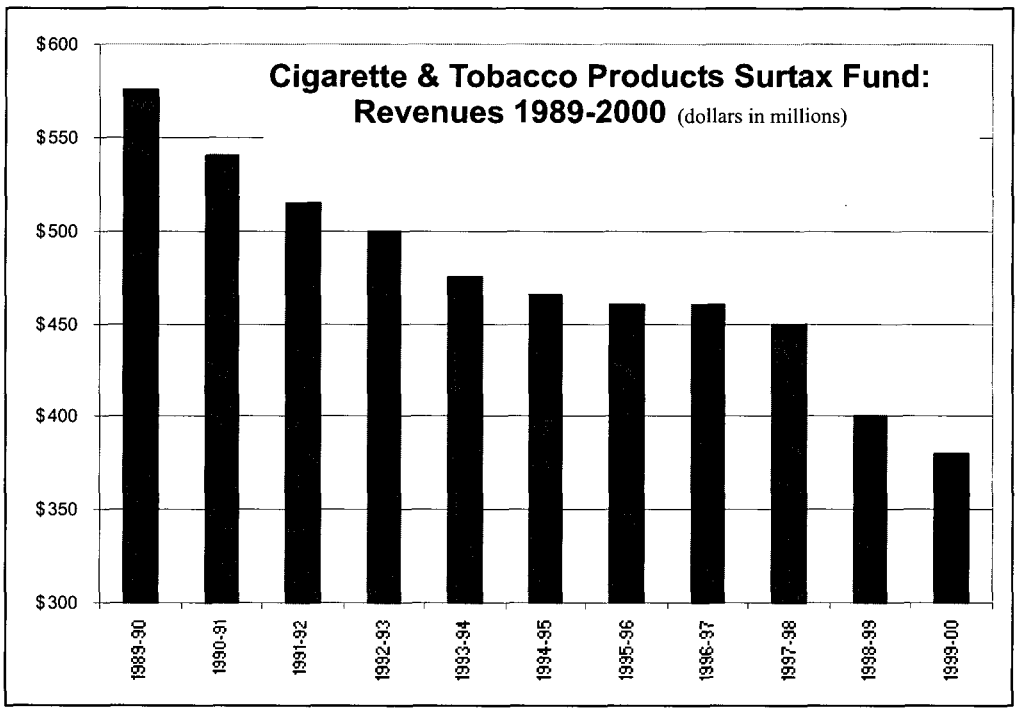
County health care funding from the Proposition 99 tobacco tax increase has declined as the use of tobacco products has decreased.

Proposition 99. In 1988, California's voters passed Proposition 99, which added 25 cents to the cigarette tax, the proceeds to be spent primarily for anti-smoking programs and to help fund county programs for providing health care to the low income

[20] Stephen Zuckerman, Teresa Coughlin *et al., Health Policy for Low-Income People in California,* The Urban Institute & Laguna Research Associates, Assessing the New Federalism series (1998), p. 30. Page references are to a printout of the Internet version of this report available at: http://newfederalism.urban.org/html/hpca.htm.
[21] State Department of Health, *op. cit.* note 16, p. 1.

uninsured. Proposition 99 also funded a variety of new State programs. (See Sections III-A-2 & 3 below.) Initially, Proposition 99 generated over $500 million for these various programs, but this amount has steadily decreased since that time as the use of tobacco products has declined. This decline creates a particular problem for the counties who are the main residuary recipients, receiving only what is left after allocations have been made for the caseload-driven Proposition 99 programs.[22]

Table 3



SOURCE: Governor's Budget Summary 1999-2000, p. 128.

Realignment. Financial pressures continued, and in 1991 the State decided to "realign" indigent health care financing and take it out of the annual budget process. AB 8 funding and the residual MIA allocations to the counties were replaced by state tax subventions of one-half cent of the sales tax and a fixed portion of vehicle license fees which were assigned to the counties for health, mental health and social service programs. Originally projected at $940 million for 1991-92, the actual health care allocation for that fiscal year was reduced to $833 million due to the downturn in the economy. Since that time, however, Realignment revenues have steadily increased as California's economy has improved.

In the 1991 Realignment legislation, the Legislature transferred a fixed portion of sales tax and vehicle license fee revenue to the counties for health care and social service programs. This tax base gives the counties a funding source not subject to the annual budget process in Sacramento.

[22] Governor's Budget Summary 1999-2000, pp. 27-28.

Disproportionate Share Hospitals (DSH) Funding Program. Simultaneously with Realignment, the federal DSH funding program also developed into a major source of revenue for hospitals providing services to California's low income population. Unlike the rest of Medi-Cal, federal DSH money is matched not by the State but instead by public (but not private) facilities -- county and health care district hospitals and the University of California Medical Centers.

DSH hospitals receive federal funds for serving low income persons who have no private health insurance. The federal DSH program requires local matching funds. The match comes entirely from government hospitals, not the State, although DSH funds go to private as well as to public hospitals.

SB 855. Following the lead of other states, the passage of SB 855 in 1990 required public hospitals to make contributions, which were used as the public matching funds for federal DSH subventions. These intergovernmental transfers (IGTs) are, in turn, matched by federal dollars and then distributed to qualifying public and private hospitals on the basis of their Medi-Cal and indigent uninsured case loads. In the following fiscal year (1991-92), these IGTs reached almost $1.1 billion thus enabling the DSH program to expand to the $2.2 billion level without the expenditure of additional State money.[23]

SB 1255. 1991 saw the passage of SB 1255, creating a similar but much smaller program providing federal matching funds ($342 million in 1996-97) for those DSH facilities which maintain emergency rooms and trauma centers (as 67 of California's 123 DSH hospitals do).[24] These rate augmentations are entirely discretionary with the California Medical Assistance Commission (CMAC) -- and are, like all CMAC rate determinations, confidential. Although there is no set formula on how much each hospital will receive in SB 1255 payments, no hospital has ever lost money in return for the voluntary transfers.[25]

C. The 1990s -- Major Changes Continue

1. SHIFTS IN FEDERAL FUNDING
- **LIMITATIONS ON DSH SUPPORT**
- **CREATION OF CHIP: THE NEW FEDERAL CHILDREN'S HEALTH INSURANCE PROGRAM**

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[23] In that year, DSH spending reached almost 18% of total Medi-Cal spending. Zuckerman, Coughlin *et al.*, *op. cit.* note 20, p. 13.

[24] Lucien Wulsin Jr. & Jan Frates, *California's Uninsured: Programs, Funding and Policy Options* (1997-), p. 17. This report is available on the Internet at: http://work-and-health.org/itup/reports.html. Unless otherwise indicated, page references are to a print-out of the Internet version. To distinguish this report from other reports by Wulsin and co-authors, the word "Uninsured" will appear in all *op. cit.* references to it. Previously, in 1987, the Legislature had passed SB 12 imposing additional penalty assessments on motor vehicle moving violations and creating the Emergency Medical Services Fund with the proceeds. The Fund is used primarily to make payments to physicians who provide uncompensated emergency room care. *Ibid.*, p. 19. In 1998 the name was changed to the Maddy Emergency Medical Services Fund in honor of the late Senator Kenneth Maddy of Fresno, the author of SB 12. Health and Safety Code Section 1797.98(a). See *In Memoriam* page above.

[25] Zuckerman, Coughlin *et al.*, *op. cit.* note 20, p. 32.

At the federal level, the early 1990s were a period of particular concern due to the continued rapid increase in the costs of federally-supported health care programs -- followed, at the end of the decade, by additional fiscal pressures generated by the successful bipartisan effort to balance the federal budget. For the medically indigent, the principal negative impacts were the federal welfare reform legislation substantially reducing the number of welfare recipients with their automatic eligibility for Medi-Cal, plus a series of major restrictions on the DSH program. On the plus side was the creation of CHIP, a federal effort to attack the problem of the high rate of uninsured children in the families of the working poor.[26]

Federal support for low income health care programs moved in both directions during the 1990s. Federal DSH funding was limited in a number of ways. At the same time, the new CHIP program was established to provide health care for uninsured children from low income families.

Disproportionate Share Hospitals (DSH) Cutbacks. At the start of the 1990s, expenditures in the DSH program were escalating very rapidly (reaching $17.5 billion and 15% of all Medicaid spending by 1992). Federal legislation in 1991 and 1993 drastically slowed the growth in DSH payments by largely banning provider donations and capping provider taxes, putting a ceiling on federal DSH payments of 12% of total Medicaid costs, and requiring that DSH payments to a particular hospital could not exceed its unreimbursed costs of providing care to Medicaid and uninsured patients.[27]

1997 Balanced Budget Act. Later in the decade, federal DSH expenditures were further limited by the 1997 Balanced Budget Act (1997 BBA). That Act established new state-specific DSH allotments and required that DSH payments for managed care enrollees must be made directly to hospitals rather than to managed care organizations, thus precluding such payments from being included in the capitation rates.[28] A 1998 study by the Urban Institute estimates that the 1997 changes could result in an 11% reduction in the previously anticipated level of DSH spending during the next five years (a total of almost $6 billion).[29]

Children's Health Insurance Program (CHIP). In 1997, the Clinton Administration proposed and Congress passed (as part of the 1997 BBA) legislation creating CHIP, a new federal health care program for low-income children. The federal share of CHIP costs in California is 65% (almost one-third more than California's normal Medi-Cal share). The CHIP program was enacted in response to the large and increasing number of uninsured children (nationally, more than 10.6 million in 1996), particularly those in

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[26] Not to be confused with the California Healthcare for Indigents Program in accordance with which the State Department of Health Services provides Proposition 99 tobacco tax funding to the 24 larger counties that operate their own uninsured low income health care programs. See Section III-A-6-b below, and Governor's Budget Summary 1999-00, p. 128.

[27] Teresa Coughlin & David Liska, *The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues,* the Urban Institute, New Federalism: Issues and Options for States series (No. A-14, 1997), pp. 3-5.

[28] *Ibid.*, pp. 5-6. See Sections 4721(a)(1) & (d) of the 1997 BBA amending 42 U.S.C. Sections 1396r-4(f) & (i).

[29] Coughlin & Liska, *op. cit.* note 27, p. 6. In 1999, some of the 1997 BBA restrictions were delayed and extended by the Congress in response to complaints from state and local governments.

"working poor" families. In implementing CHIP, states must submit a plan for approval by HCFA. During CHIP's first year, 37 state plans -- with an anticipated ultimate enrollment of two million -- were approved (including California's).[30]

2. CALIFORNIA: FUNDING PRESSURES, MANAGED CARE AND THE HEALTHY FAMILIES PROGRAM (HFP)

Starting with the passage of Proposition 13, which set off California's wide-ranging "tax revolt" in 1978, state and local taxes in California declined from among the highest in the nation to the middle ranks by the early 1990s.[31] The demand for public services, however, did not decline correspondingly, leaving the State with a constant budgetary tug-of-war between programs competing for a share of the reduced tax base. Resolving such competing demands was particularly difficult during the recessionary period of the early 1990s, when revenue turned down but spending pressures increased. Budgetary pressures have eased during the last several years as California's economy has turned around dramatically with State revenues exceeding budget estimates by approximately $4 billion in both 1997-98 and 1998-99 and almost $6 billion in 1999-00.

In its 1999 Session, the Legislature encouraged Medi-Cal enrollment by simplifying the application process and also extended coverage to more low income Californians. The extensions will offer coverage for an estimated 380,000 Californians not previously eligible.[32]

a. Managed Care Becomes Prevalent For Medi-Cal Primary Care Programs

Managed care has a long history in California's publicly-funded health care system.[33] For the most part, however, at the start of this decade most publicly-funded health care was delivered in the traditional fee-for-service (FFS) manner. The 1990s have seen a renewed push to managed care for most Medi-Cal recipients (other than the elderly and disabled). The traditional cost-based FFS reimbursement system for primary care had a built-in incentive for more surgeries, hospitalizations and other expensive specialty care. In contrast, the managed care system emphasizes less expensive outpatient care and early interventions -- making it, at least in theory, a less expensive and more cost-effective method of delivering primary health care services.[34]

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[30] Statement of Nancy-Ann DeParle, Administrator of the Health Care Financing Administration before the House Commerce Committee, Subcommittee on Health & Environment on September 18, 1998.

[31] On a per capita basis, California's total state and local tax burden ranked an average of fourth nationally during the 1970s. That average dropped to ninth during the 1980s and 17th in recessionary 1993-94. On a percentage-of-income basis, the decline was more dramatic. California's average national rank during most of the 1970s was fifth, falling to 20th during the 1980s and 34th in 1993-94. See Tables 41 & 47 in the Economic Report of the Governor 1999. Not published but available on the Department of Finance website, www.dof.ca.gov, under Financial and Economic Data.

[32] Senate Office of Research reports, *1999 Legislation Relating to Health Care Access and the Health Care Safety Net* (September 1999), pp. 1-2, and *Highlights of the Legislative Accomplishments -- Health Care* (1999), pp. 1-2 & 7-8.

[33] Zuckerman, Coughlin *et al.*, *op. cit.* note 20, p. 25.

[34] Managed care "represents a change in the way consumers pay and medical providers are reimbursed, from a fee for each service method to a fixed total amount per person (per capita) for a set period of time, such as one year. In other words, instead of a payment occurring each time a service such as surgery is

Currently, California is in the process of implementing a so-called Strategic Plan under which most non-SSI/SSP Medi-Cal beneficiaries (children and non-disabled adults under 65) will be required to enroll in managed care.[35] By 1999, 2.6 million of the 5.1 million Medi-Cal beneficiaries, just over 50%, were in Medi-Cal managed care.[36] [For the elderly, disabled and other categorical beneficiaries, however, enrollment will continue to be optional (and rare).]

During the 1990s, over one-half of California's Medi-Cal beneficiaries were enrolled in managed care. Children and non-disabled adults under 65 are now required to enroll in Medi-Cal managed care plans. This transition has been difficult for some counties with hospital-based public health care systems.

This transition to managed care is particularly difficult for counties with public hospital-based health systems. Problems for hospital-based systems are exacerbated by their dependence on Disproportionate Share Hospitals subsidies that are generally not available for the clinic-based outpatient treatment, which is fundamental to the managed care systems called for by the Strategic Plan. Also, there can be resistance to the new emphasis on managed care and outpatient treatment from some elements of the existing county and teaching hospital establishment (i.e., particular employee unions, hospital administrators and medical professionals).

Ironically, as the Strategic Plan is nearing its enrollment objectives, managed care for middle class citizens are coming under increasing attack. Legislators at both state and federal levels are imposing increasing requirements on HMOs and reducing their previous immunity from negligence litigation. The inflation in health care costs that the HMOs were created to combat appears to be on the rise,[37] and the future success of managed care generally appears less certain than had previously been hoped.[38] It should be noted, however, that California's managed care capitation rates[39] appear to be well below the national average.[40]

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given, the consumer pays a fixed amount per year and the provider has a fixed amount -- or 'budget' -- for the year. This is called 'capitation.' Second, instead of providers operating as solo practitioners, they are part of a comprehensive system of providers in order for the overall use of services to be managed. This results in greater efficiency from the system and greater effectiveness for the patient. Thus, a capitated, single budget is managed by a system of care providers -- managed care." Bruce Bronzan, *The Revolution in Health Care,* California Journal (August 1995), p. 20.

[35] Wulsin & Frates (Uninsured), *op. cit.* note 24, p. 27.

[36] Governor's Budget Summary 2000-01, pp. 114 & 116.

[37] Center for Studying Health System Change, *Tracking Health Care Costs: Long-Predicted Upturn Appears*, Issue Brief Number 23 (November 1999).

[38] In a Wall Street Journal op. ed. piece, Holman W. Jenkins Jr. argues that the managed care revolution has already run its course and is on the way out. *Managed Care, We Hardly Knew Ye, op. cit.* note 4. For a more detailed description of some of the difficult financial problems facing the health care industry nationally, particularly those aspects managed care was designed to solve, see Sharon Bernstein, *Health Plans Seek to Address Consumer Ire,* Los Angeles Times (April 6, 2000), pp. A-1 & 22. On the Times website at: www.latimes.com/archives. Except for very recent items, the Times has a charge for using its archives. This availability applies also to the Times articles cited in notes 84, 99, 117, 179, 181, 185-87, 189, 201, 213, 215 & 293. All cited newspaper articles are listed in Part IV of the Bibliography (Appendix II).

[39] "Capitation" is defined in note 34 above.

[40] John Holahan, Suresh Rangarajan & Matthew Schirmer, *Medicaid Managed Care Payment Methods and Capitation Rates: Results of a National Survey,* the Urban Institute, Assessing the New Federalism series,

b. The Healthy Families Program (HFP)

When Congress passed the Children's Health Insurance Program (CHIP) in 1997, California was estimated to have 1.6 million children -- 17% of all children aged 17 and under -- with no health coverage. Nearly 75% of those children came from families with incomes below 200% of the Federal Poverty Level (FPL) and thus were apparently eligible for either CHIP or Medi-Cal. CHIP was implemented in California by a modest expansion of Medi-Cal eligibility (to cover all children in families with incomes below 100% of FPL) and the creation of HFP. Under HFP, the State was to provide medical, dental and vision insurance coverage for all children in families with incomes below 200% of FPL but too high to be eligible for Medi-Cal. CHIP was initially projected to serve up to 580,000 California children at a cost of approximately $500 million ($175 million State and $375 million federal).[41] In March 1998 the Health Care Financing Administration approved California's State Plan for HFP, and implementation began in July 1998.

CHIP has been implemented in California through the creation of the HFP program. With HFP, all uninsured children living in families with incomes up to 200% of the Federal Poverty Level (recently raised to 250%) became eligible either for children's Medi-Cal or enrollment in an HFP health insurance program.

Occasional Paper Number 26 (May 1999). With respect to the private sector, a survey conducted by William M. Mercer, Inc. for the California HealthCare Foundation found that for small California employers in 1998, the average annual cost of HMO coverage was $2283 per employee, compared to a national average in that year of $2758. *Employer-Sponsored Health Insurance: A Survey of Small Employers in California* (August 1999), pp.19-20. See also Medi-Cal Policy Institute, *Capitation Rates in the Medi-Cal Managed Care Program,* Report Prepared by PricewaterhouseCoopers LLP (May 1999).

[41] California Department of Health Services, the *Healthy Families State Plan* and *Healthy Families State Plan Summary* are located on the Department's website at: www.dhs.cahwnet.gov/org/Director/healthy_families. (The *Summary* is under Healthy Families Program Overview.) It was estimated that at that time one in four California children (2.3 million) were enrolled in Medi-Cal.

PART III CALIFORNIA'S CURRENT PUBLICLY-FUNDED HEALTH CARE SYSTEM

The paradoxes pointed out in Part I of this Report are readily apparent in California's publicly-funded health care system as presently constituted. Currently, the State and county governments spend well over $25 billion of the taxpayers' money (including federal subventions)[42] on a system that is poorly coordinated, unnecessarily complex and overlapping, expensive to administer, lacks fundamental fairness, and leaves over 7,000,000 Californians, largely the working poor, without health insurance coverage.

California's $25 billion publicly-funded health care system has many excellent programs and facilities. At the same time, it is unnecessarily complex, poorly coordinated and leaves over 7,000,000 Californians, mostly from working poor families, with no health insurance coverage.

Providing an adequate explanation of the internal contradictions and inconsistencies of California's complex "system" of health care programs and facilities to a foreign visitor would be a difficult, if not impossible task. The visitor would surely be impressed by the new, state-of-the-art San Bernardino and Santa Clara County Hospitals, by the five world-famous University of California Medical Centers with their billion dollar annual budget, by the network of 250 hospitals with State contracts to serve the low income population, by the magnitude of Los Angeles County's extensive system of public hospital facilities, by the availability of emergency room (ER) treatment for all comers, regardless of ability to pay, and, perhaps most of all, by the high level of spending on public health care programs in California.

On the negative side, the visitor would wonder why it is necessary for California to spend millions of unproductive dollars on eligibility determinations, why the State maintains such a plethora of separate, often narrowly-focused, health care programs (*e.g.*, the AIM program which serves approximately 17,000 recipients statewide whose family incomes are within a particular narrow band), why there are multiple separate, state-wide systems for providing health care services to the medically indigent (*i.e.*, Medi-Cal, HFP and county programs for the uninsured), or why these programs are unavailable, beyond the ER stage, to so many low income Californians on a seemingly arbitrary basis. Equally puzzling would be the great variations among the programs for the uninsured in the various counties, making the quality and even availability of care dependent on the location of a person's residence (especially difficult to justify in the large metropolitan areas with their largely arbitrary and almost invisible county boundaries).

The explanation for this bewilderingly complex but incomplete system is, as set forth in the preceding Part II, largely historical. Much of it was developed in response to particular perceived needs. Unfortunately, there is at present no effective administrative mechanism for coordinating and prioritizing eligibility and services on a state-wide basis or for promptly modifying the system as needs and priorities change. That leadership has to come from Sacramento; and, so far, the Governor and the Legislature have not taken the initiative to unify the system or set state-wide standards for the present divided and irregular service delivery mechanisms.

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[42] Governor's Budget 2000-01, p. 66 of the Health and Human Services Section.

Section III summarizes California's publicly-funded health care system in the following four sub-sections:

A. Descriptions of the major public health care programs currently in operation in California.
B. A brief summary of the funding sources for those programs.
C. An outline of the administrative structure of the public health care systems.
D. Short descriptions of the present public health care system in seven representative large counties (in which over half of the State's population resides).

A. THE PROGRAMS: Publicly-funded Health Care Programs for Low Income Californians

The $20 billion plus Medi-Cal program provides health care to over 5,000,000 of California's lowest income residents. Although the bulk of the spending is for high-cost elderly and disabled recipients, the majority of recipients are those on whom this Report focuses -- children and non-disabled adults under 65. One of the nation's most generous Medicaid programs in terms of the services offered, Medi-Cal is also one of the most complex and cumbersome in terms of eligibility determinations. Vast amounts are spent annually in making difficult, often arbitrary, individual eligibility determinations and requiring recipients to update their status every 90 days.

California's largest public health program by far is the State-administered Medi-Cal program. For those not covered by Medi-Cal, the counties remain as the providers of last resort for the medically indigent.

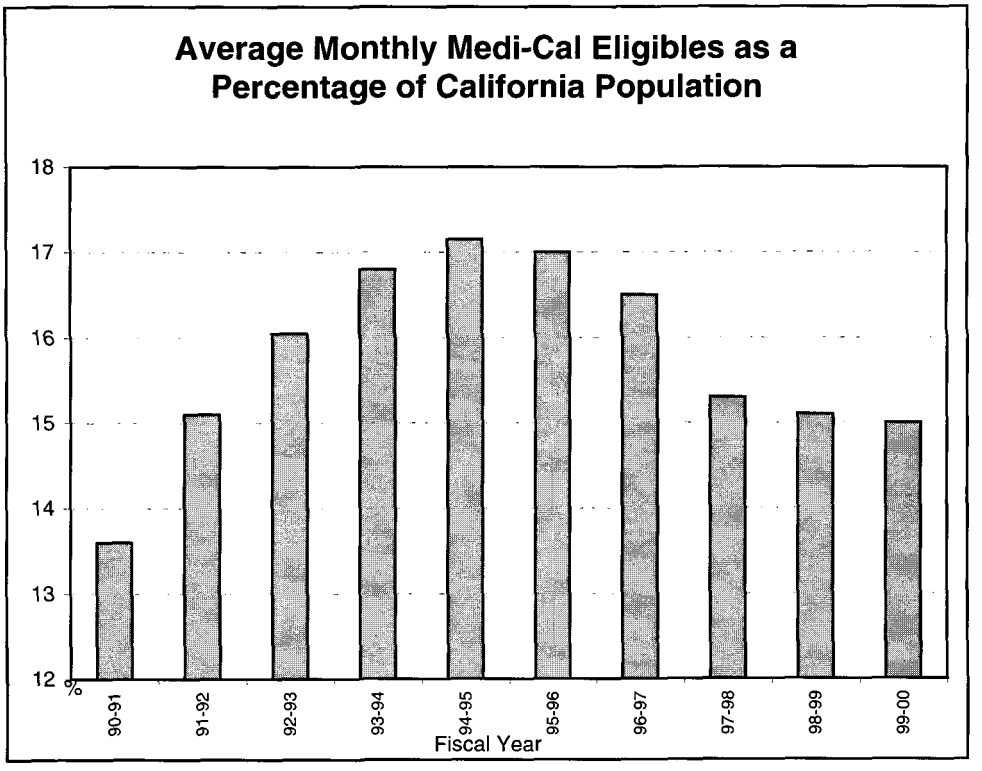
At a much lower level, for those not eligible for Medi-Cal, the State also provides a number of more narrowly targeted health care programs including the Healthy Families Program and other children's programs, Aid to Mothers and Infants for pregnant women and infants, and the Major Risk Medical Insurance Program for those unable to obtain private health insurance.

Underlying the many State programs, the counties remain as the providers of last resort. As such, they supply widely varying levels of health care services to the medically indigent who do not qualify for the State-administered programs.

1. THE MEDI-CAL PROGRAM

The Medi-Cal program is by far the largest State health care program. Medi-Cal enrollment, comprising roughly one-sixth of the State's population, peaked at 5,421,262 in 1995 at the end of California's recent recession and has slowly declined since that time as the State's economy has improved and welfare reform has reduced the State's welfare rolls.

Table 4



SOURCE: Governor's Budget Summary 2000-2001, Health and Human Services, p. 115.

a. Eligibility

Medi-Cal eligibility is a complex amalgam of income and asset tests. Most welfare recipients qualify for Medi-Cal and constitute the bulk of its recipients. Qualification for Medi-Cal has to be confirmed every 90 days, and documentation requirements are extensive.

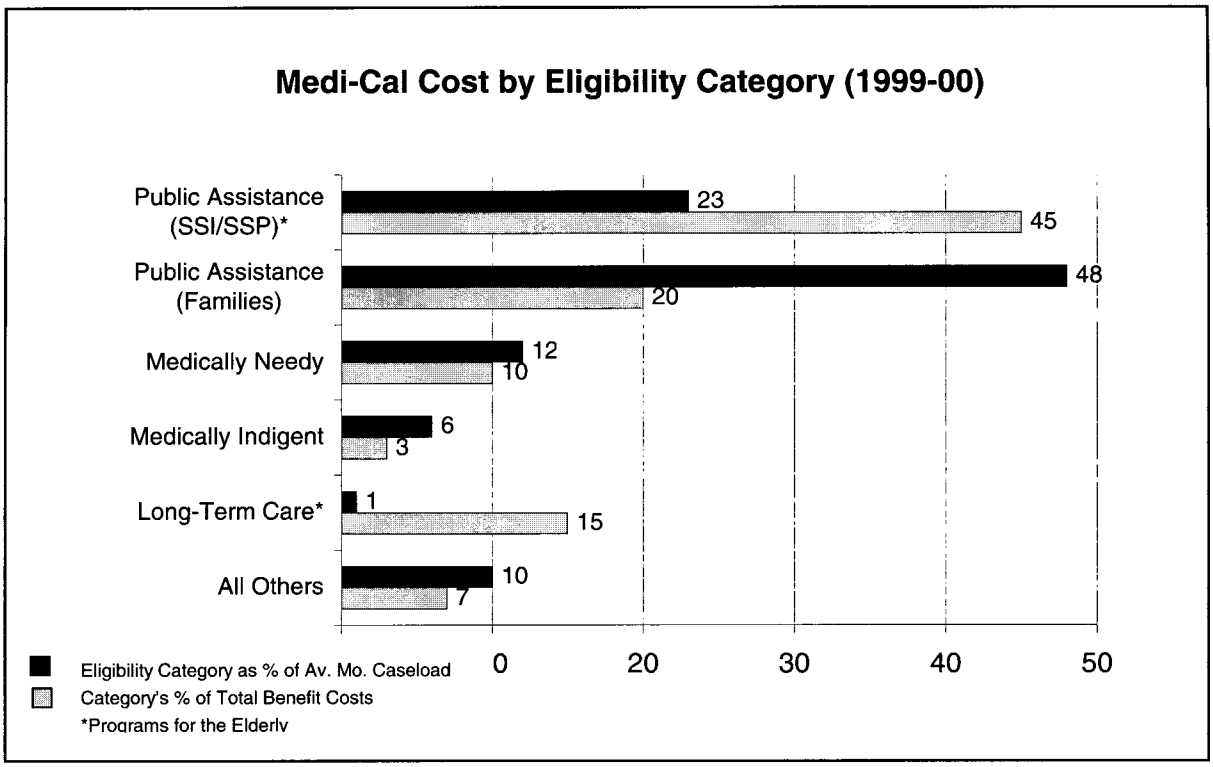
In general, eligibility for Medi-Cal is dependent on income level, on the value of assets held, and on categorical (demographic) status. The mind-boggling complexity of its eligibility requirements (necessitating over 100 separate aid codes)[43] results primarily from the fact that Medi-Cal is actually an amalgam of many programs, added incrementally over the years, whose funding is shared by the state and federal governments.

Most of California's Medi-Cal recipients qualify because they are receiving cash assistance (welfare). In fact, those qualifying for most welfare programs are normally automatically issued a Medi-Cal card at the same time. For those not receiving welfare

[43] The Medi-Cal Policy Institute recently published a booklet briefly describing all the various Medi-Cal programs, eligibility groups and aid codes. The booklet is 42 pages long; it required a two-page appendix just to list all the aid codes in small type. *The Guide to Medi-Cal Programs* (1999). Los Angeles County's *Quick Guide to Medi-Cal (Special) Programs* (February 1999), produced for the use of its own trained Department of Public Social Services eligibility workers, takes four 8" x 14" pages, again in small print. A copy is attached to this Report as Appendix III.

assistance, family members (but not adults without children) are eligible if family income does not exceed 100% of the Federal Poverty Level (FPL).[44]

Table 5



SOURCE: Governor's Budget Summary 1999-2000, Health and Human Services, p. 122.

Other individuals defined as medically indigent or needy are covered as well. Those with incomes above the eligibility levels may also qualify if they do not have sufficient income to take care of unusually expensive health care needs.[45] (They may "spend down" to the medically needy eligibility level.)

Asset Limitations. In addition to these income limitations, Medi-Cal also imposes complex asset limitations which, in general, exclude adults with significant assets of any sort -- other than a family home. (Children are excepted -- see Section III-A-3-a below.) Not only are these limitations restrictive, they are accompanied by extensive verification and documentation requirements and are imposed on a very short-term basis requiring that all recipients revalidate their eligibility every three months by filing quarterly status reports.[46]

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[44] Medi-Cal Policy Institute, *op. cit.* note 43, p. 21. Specified categories of pregnant women and children in families with somewhat higher incomes (from 100% to 200% of the FPL) also qualify. *Ibid.*, pp. 29-31. Also see the website of the Institute at: www.medi-cal.org.

[45] Medically needy individuals whose incomes exceed a certain amount must, however, contribute a share of the cost of their medical coverage. *Ibid., pp. 25-27.*

[46] Although the 1997 Balanced Budget Act allows states to provide children with continuous eligibility in Medicaid for 12 months and managed care enrollees for six months, regardless of fluctuations in family income, California has, to date, not elected those options. However, in the May Revision of the Governor's Budget for 2000-01 (p. 29), the Governor proposes that the quarterly reporting requirement be eliminated,

Table 6

Medi-Cal Eligibility for Family Coverage

	Income Limits*		Asset Limits*	
	Mo. Amt.	% of Poverty	Value	Vehicle Exemptions
Section 1931(b)				
Applicant	$ 1,032^	74%^	$3,300	Needed for business/emplmt/transpt of disablec
Ongoing	$ 2,124	153%	$3,300	$4,650 of value for each other vehicle.
Transitional Medi-Cal				
First 6 mo.	no limit	NA	no limit	
Next 18 mo.	$ 2,575	185%	no limit	
Medically Needy				
Family	$ 1,190	86%	$3,300	
	add SOC**	add SOC**		

^ Since changed to 100% of Poverty.

* Requirements for a family of four, effective July 1999. Section 1931(b) Applicant and Medically Needy Family amounts include a $90/mo. work expense deduction. Up to $175 per child per month ($200 if under age 2) additional deduction allowed for child care expenses.

** Share of Cost (SOC)--families with higher incomes may pay a share of cost. If a family member is disabled, then earnings are subject to an additional deduction of $654 plus half of the earnings.

SOURCE: Legislative Analyst's Office, *A Model for Health Coverage of Low Income Families,* Figure 3, p. 9 (June 1, 1999).

Despite this seemingly endless number of eligibility categories, a number of low income adults have no eligibility under any of the specified categories. Adults under 65, no matter how low their income or how few their assets, are not eligible for Medi-Cal unless they are disabled (including those who are blind or reside in a nursing home), have deprived children at home, or are pregnant.[47]

Adults under 65 are not eligible for Medi-Cal unless they are disabled, pregnant or have deprived children at home.

User Un-Friendly Administration. In addition to the complexity of the eligibility requirements themselves, historically the Medi-Cal program has generally not been administered in a user-friendly manner. Although it is a State-administered program, California's 58 counties are responsible for making Medi-Cal eligibility determinations. These determinations, especially for outpatient services, have been done, for the most part, through county Departments of (Public) Social Services (DSS) whose principal function is to administer county welfare programs. During most of the last two decades, a good deal of the emphasis in the DSS bureaucracies has been on strict application of eligibility rules and extensive documentation requirements to eliminate potential fraud.

Welfare Stigma. Combined with the natural reluctance of many people to accept "charity," applying for Medi-Cal has thus been a difficult and intimidating experience for

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starting on January 1, 2001, and that the State shift to an annual qualification basis (at an estimated cost of $115 million for fiscal 2000-01).

[47] Medi-Cal Policy Institute, *op. cit.* note 43, p. 25.

most applicants. This negative atmosphere (often referred to generically as "welfare stigma") has been a significant factor in limiting usage of the Medi-Cal program. Existing asset tests, documentation/reporting requirements and old computer programs are still part of the program; and eligibility workers may still display the negative attitudes toward potential health care recipients that were once prevalent.[48]

Medi-Cal eligibility has typically been handled by county welfare eligibility workers focused on applying the eligibility and documentation rules strictly to prevent potential fraud.

Transitional Medi-Cal (TMC). Since 1990, California families who leave welfare, many of whom go to low-wage jobs with no health benefits, have been eligible for the TMC program which extended their Medi-Cal coverage for up to one year even though family income may have gone above normal Medi-Cal limits. TMC coverage for adults has recently been extended for a second year (at State expense, the extension not being eligible for matching federal funding).[49]

The importance of TMC was heightened by the passage of the federal Welfare Reform Act of 1996. With a majority of Medi-Cal recipients qualifying through their receipt of welfare, the reduction in the welfare caseloads could also reduce the number of those qualifying for and being enrolled in Medi-Cal -- despite the fact that Medi-Cal eligibility standards remained unchanged. To minimize such a result, the reform legislation officially "delinked" the two programs; it became a major objective of TMC to assist and encourage recipients to leave welfare by continuing their eligibility for Medi-Cal.

Although the TMC program extends Medi-Cal coverage for up to two years, in 1997 less than 10% of those eligible were enrolled in TMC.

TMC has not, however, had great success in retaining those leaving the welfare rolls. According to Legislative Analyst's Office estimates, less than 10% of those leaving the welfare rolls in 1997 were enrolling in the first six months of TMC, and less than half of those that did enroll participated in the second six months of coverage.[50] "Welfare stigma" problems and a lack of effective continuity of coverage enrollment procedures appear to be major factors in the low level of TMC usage.[51]

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[48] As commented by the authors of a recent study of an analogous health care outreach program, "On the local level, the major lesson that was apparent from this case study regards the difficulty of implementing a new program through a long-established county welfare bureaucracy. In California's counties, Medi-Cal eligibility is still closely tied to eligibility for cash assistance and Food Stamps, and a complex system of rules, forms, and computer software has grown around all of these programs, linking them inextricably and hampering even the best-intentioned efforts toward change. For example, applicants for Medi-Cal in Santa Clara County are still being given a list, last revised fifteen years ago of 'papers needed at your cash assistance/Medi-Cal care appointment.' According to state officials, at least seven of these 16 items are not required for Medi-Cal eligibility determination. . . However, no attempt is made to inform applicants that they do not need to bring in all 16 items on the list." Renee Schwalberg *et al.*, *Making Child Health Coverage a Reality: Case Studies of Medicaid and CHIP Outreach and Enrollment Strategies,* Kaiser Commission on Medicaid and the Uninsured (September 1999), pp. 49-50.

[49] Medi-Cal Policy Institute, *op. cit.* note 43, p. 23.

[50] See Medi-Cal Policy Institute, *Transitional Medi-Cal Fact Sheet* (July 1998), p. 3.

[51] See Medi-Cal Policy Institute report, *Speaking Out . . .What Beneficiaries Say About the Medi-Cal Program* (March 2000), p. 18; Caitlin Rother, *Many in county lose Medi-Cal unnecessarily,* San Diego Union-Tribune (April 17, 2000).

Immigrant Eligibility. In 1996, non-citizen immigrants represented approximately 19% of California's population, almost three times the national average. Federal law makes immigrants entering the country after August, 1996 ineligible for Medicaid. The State Legislature, however, has not excluded such persons and they remain eligible for Medi-Cal (at State expense, except for emergency services).[52]

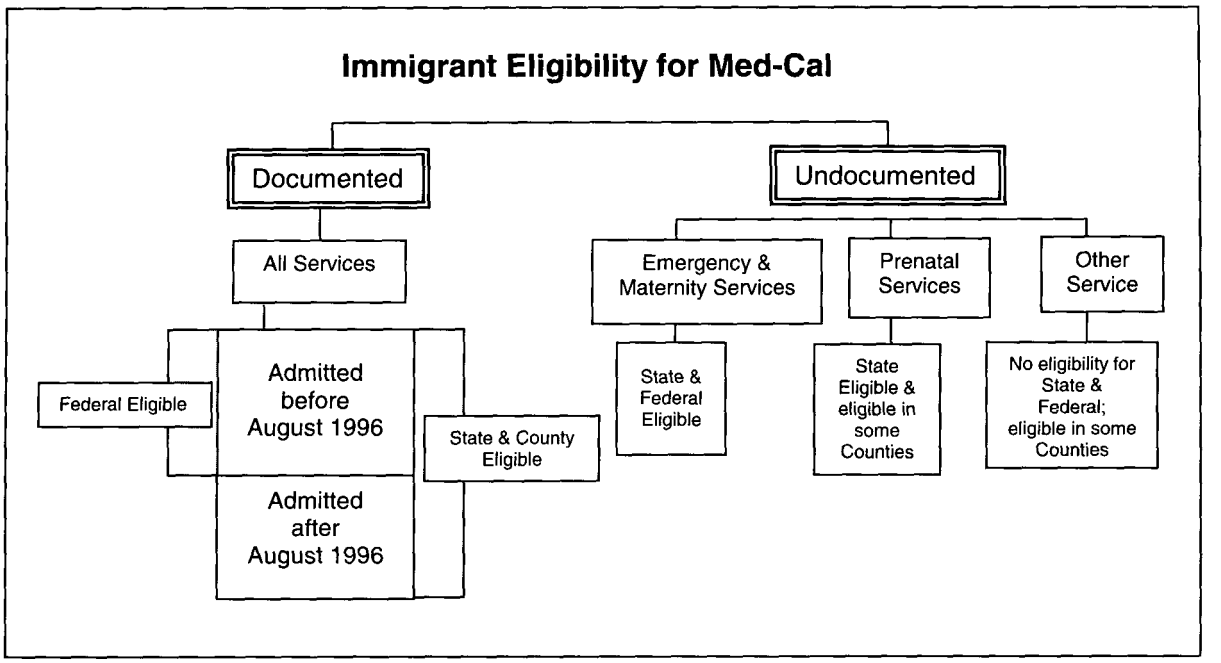
The situation with respect to California's large number of undocumented aliens is even more complex. They are eligible under federal Medicaid law only for emergency and maternity services. Since 1986, the State has also provided prenatal services for pregnant women to approximately 70,000 undocumented women. This has occurred in the face of opposition from the previous Administration, ineligibility under the provisions of the federal welfare reform law, and the approval by the voters in 1994 of the now-defunct Proposition 187 (declaring undocumented immigrants to be ineligible for a range of government health and welfare programs).[53] This controversy has been resolved by the Legislature and the current Administration in favor of continuing to provide such prenatal services.[54]

In 1999, the INS finally eliminated the receipt of Medi-Cal benefits as a consideration in making citizenship and sponsorship determinations for immigrants. The new INS regulations on this issue are still not well known in the immigrant community -- making many immigrants reluctant to enroll in Medi-Cal.

The immigrant community is concerned that accepting public health care benefits would be a factor in Immigration and Naturalization Service (INS) determinations of eligibility for citizenship (and for sponsorship of other family members desiring to enter the United States). Citizenship can be denied to a person who is determined to be in danger of becoming a "public charge." Only in 1999 did the INS finally adopt regulations stating that the receipt of health benefits would not be a factor in making "public charge" determinations.[55] These new regulations are still not well known and understood by many immigrants, and there may still be apprehension about their permanence. As a result, many eligible immigrants may still be reluctant to enroll themselves and their children in Medi-Cal (or other publicly-funded health care programs).

[52] Zuckerman, Coughlin *et al., op. cit.* note 20, pp. 15 & 54 (Table 1).
[53] *Ibid.*, pp. 15-16.
[54] Senate Office of Research, *Highlights of the Legislative Accomplishments -- Health Care* (1999) *op. cit.* note 32, p. 2 (cost included in the 1999-00 state budget).
[55] See publication of the new regulations in the Federal Register, Vol. 64, No. 101 (May 26, 1999), p. 28676 *et seq.* (amending 8 Code of Federal Regulations, Part 212 and adding Part 237).

Table 7



SOURCE: See notes 52 and 54 above.

b. Services

California's Medi-Cal program is one of the most generous in the nation in terms of the range of services covered. In addition to the services required to be provided by federal law (see Section II-A-2 above), Medi-Cal also covers 32 of the 34 optional services for which federal matching funds are available -- excluding only private duty nursing and medical social worker services.

c. Disproportionate Share Hospitals (DSH) Program.

SB 855. As indicated above, the DSH program, authorized in California by SB 855, is an important source of funding for the State's indigent health care system. With federal subsidies of about $1.2 billion in 1998-99, DSH constituted a major source of funding for the State's 123 DSH hospitals.[56] The DSH program, however, suffers from inherent limitations resulting from its origin as a support program primarily serving public safety net hospitals.

The DSH program provided $1.2 billion in federal subsidies for California hospitals in 1998-99. Since such DSH subsidies are limited to hospitals, the program creates an incentive to maximize expensive hospital care rather than the less costly outpatient care emphasized by the Medi-Cal managed care plans.

[56] Governor's Budget for 2000-01, Health and Human Services section, p. 57. The federal match is approximately equal to the California contribution (all from local sources).

Most basically, DSH payments go only to qualifying hospitals based on the amount of Medi-Cal and uninsured care provided. This creates incentives to maximize expensive hospital care -- as opposed to less costly outpatient care which is basic to the managed care plans that have come to dominate the delivery of Medi-Cal services.

A second fundamental problem stems from the increasing number of private hospitals that are now seeking to serve Medi-Cal patients -- whose care can provide profitable reimbursement rates when the DSH subsidy is added on top of the basic daily rates negotiated by the California Medical Assistance Commission (CMAC). This is in sharp contrast to the situation with respect to uninsured patients for whom the private hospitals generally provide very little care[57] while public hospitals, as last resort providers, often receive little or no compensation to cover their costs of care.[58] The competition for Medi-Cal patients is especially fierce in the areas of the State with excess hospital capacity. (California currently has an estimated overall occupancy level in its hospitals of under 50%.) The 1997 Annual Report of CMAC showed $363 million of DSH money going to private hospitals and $327 million going to county hospitals -- a huge increase over the 1992 totals of roughly $150 million to private hospitals and $650 million to county hospitals.[59]

This shift in Medi-Cal patients is reducing the public hospitals' return on the Intergovernmental Government Transfers they make which provide the required state match for financing the entire DSH program. The counties operating public hospitals thus have less revenue available to subsidize the health care they are required to provide to the uninsured indigent population. The counties feel that the net federal DSH revenue is critical to their ability to provide services to the indigent uninsured.[60] Private sector providers defend their failure to provide extensive services to the uninsured by pointing out that they do not share in the State revenue going to the counties for indigent health care (primarily from Realignment funds).[61]

Currently, DSH funds are divided roughly evenly between private and public hospitals. DSH spending is scheduled to be reduced by about 20% over the next several years, pursuant to the provisions of the 1997 Balanced Budget Act. This reduction will exacerbate the conflict between the private and public hospitals for the remaining DSH funding.

As indicated above, provisions of the 1997 Balanced Budget Act (1997 BBA) will have a substantial adverse impact on California's DSH receipts. The State is projected to lose a cumulative $460 million in anticipated DSH funding over the next five years, with federal DSH spending in 2002 estimated to be 20% less than in 1995-96.[62]

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[57] Unless they have contracts with a county or other public agency, private hospitals have no source of reimbursement for the cost of services to the uninsured and, therefore, a strong financial disincentive to provide such services.

[58] See Zuckerman, Coughlin *et al.*, *op. cit.* note 20, pp. 30-31.

[59] Wulsin & Frates (Uninsured), *op. cit.* note 24, pp. 15-16 (1997 hard copy version).

[60] See Zuckerman, Coughlin *et al.*, *op. cit.* note 20, p. 30.

[61] Three major private hospitals in central Los Angeles, with Medi-Cal patients making up approximately one-half of their patient case-loads in 1996-97, reported that they would be in a deficit situation without their DSH subsidies. *Ibid.*, pp. 35-36.

[62] *Ibid.*, pp. 8 & 31.

The 1997 BBA contained special provisions giving California a one-year exception (later extended to a second and then a third year) from some of the provisions restricting federal DSH payments[63] (see the 1997 BBA portion of Section II-C-1 above). At present, there is an uneasy truce between the public and private hospitals under a State-sanctioned agreement that the DSH federal funding will be divided roughly equally between the two groups. When the BBA exception does finally expire, the public-private hospital conflict will reemerge and become even more acute because of the BBA's restrictive provisions.[64]

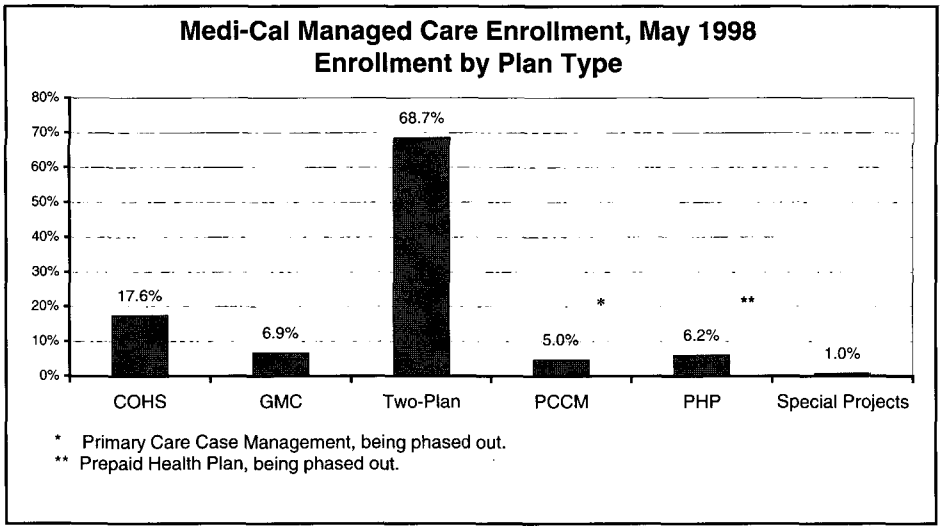
SB 1255. The smaller SB 1255 program has grown very substantially in the last few years. SB 1255 payments increased from approximately $180 million in 1992-93 to almost $700 million in 1996-97. Unlike the SB 855 program, public hospitals are not required to provide the local match for their private competitors. In 1994-95, county hospitals were the recipients of 80% of the SB 1255 funding.[65]

d. Administrative Responsibility.

The State is ultimately responsible for the Medi-Cal program. With respect to the focus of this Report, health care for children and non-disabled adults under 65, there are a number of formats for providing the now-prevalent managed care services in the large counties. In most of the large counties, the State contracts with a county-created Two-Plan Model to administer the program. Similarly, with respect to the five County Organized Health System (COHS) counties, the California Medical Assistance Commission (CMAC) contracts directly with the COHSs who operate the program in their counties. For the two Geographic Managed Care (GMC) counties (San Diego and Sacramento), CMAC contracts with each of the various plans and insurers who provide Medi-Cal services in those counties. For 39 of the smaller counties, the State Department of Health Services contracts with the counties to operate the Medi-Cal program directly.

[63] 1997 BBA Section 4721(e) amending 42 U.S.C. Section 1396r-4(g)(2).
[64] Zuckerman, Coughlin *et al.*, *op. cit.* note 20, p. 31.
[65] *Ibid.*, p. 32; Wulsin & Frates (Uninsured), *op. cit.* note 24, pp. 17-18 (1997 hard copy version). (SB 1255 funds were the mechanism for the 1996 federal "bail out" of Los Angeles County, and continue to be an important share of its health care budget. See Section III-D-3 below.)

Table 8



SOURCE: Medi-Cal Policy Institute, *Understanding Medi-Cal: The Basics* (1999), p. 10.

Two-Plan Model Counties. Under the Two-Plan model, Medi-Cal beneficiaries choose from two plans: (1) a county-run Local Initiative, which must be open to all Disproportionate Share Hospitals and traditional safety net providers (both public and private) and (2) a commercial plan. Beneficiaries in the Two-Plan model who do not select between the Local Initiative and the mainstream HMO are assigned to the Local Initiative up to a level sufficient to maintain federal DSH funding for the county.[66] After that level has been reached, beneficiaries are generally split equally between the Local Initiative and the commercial plan.

The Two-Plan model is established in 12 of the most populous counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus and Tulare.

County-organized health systems (COHS). Under the COHS system, the Board of Supervisors creates a single county-operated agency to contract with the California Medical Assistance Commission (CMAC) to provide all Medi-Cal services. A COHS is required to provide, on a capitated at-risk basis, all the basic benefits covered by Medi-Cal and to administer a comprehensive managed health care delivery system for all Medi-Cal primary care beneficiaries residing in the county. Beneficiaries are normally given a choice of providers or plans within the COHS. For beneficiaries not making a choice, counties are able to make their own auto-assignment rules. Most have rules that provide advantages to safety net providers.

COHSs are unitary county-run managed care plans which provide services to all children and family Medi-Cal recipients in the county.

Federal law restricts the use of the COHS model in California. Initially, there were only five COHS counties: Santa Barbara and San Mateo have been operating since the 1980s;

[66] Zuckerman, Coughlin *et al., op. cit.* note 20, p. 28.

Solano, Santa Cruz and Orange Counties began in the mid-1990s.[67] As of July 1997, close to 400,000 Medi-Cal beneficiaries were being served in COHS counties (over half of them in Orange County).

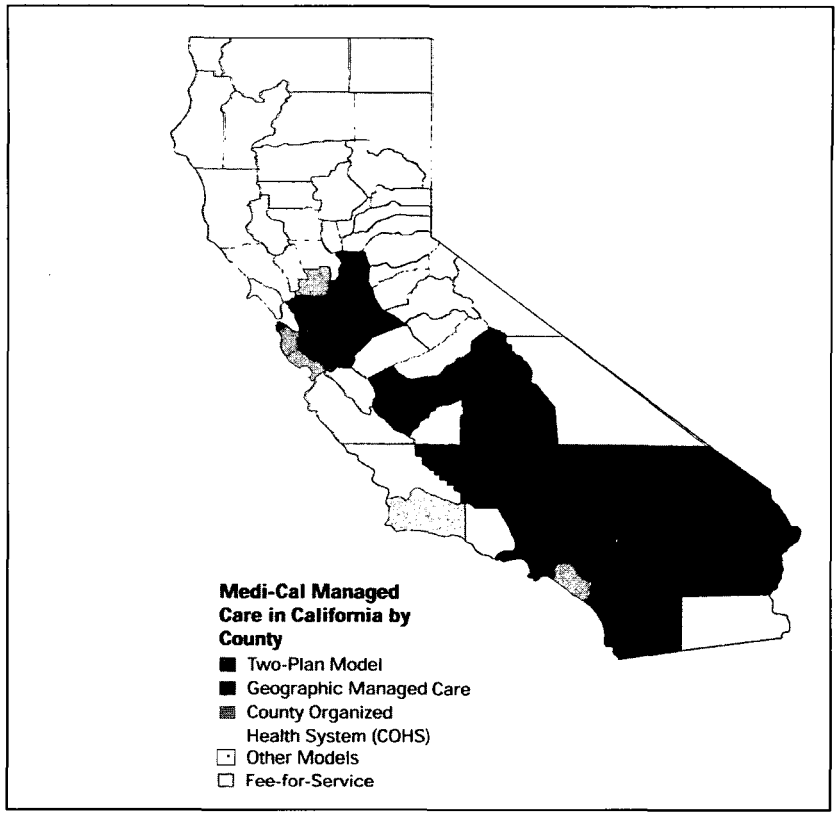
Geographic Managed Care (GMC) Counties. The GMC system has been implemented in Sacramento and San Diego counties. In those counties, CMAC contracts with multiple private sector plans located in different geographic sections of those counties so as to give each eligible recipient access to one or more reasonably convenient providers. Sacramento County implemented its GMC in 1994. At that time, CMAC negotiated contracts with 11 managed care plans to cover the County's Medi-Cal population on a mandatory enrollment basis. In 1997, 139,000 beneficiaries were enrolled in Sacramento County. San Diego County began its GMC implementation in late 1998. (See Section III-D-5 below.)

In the two GMC counties, the California Medical Assistance Commission (CMAC) contracts directly with multiple managed care plans to provide services to Medi-Cal recipients (who may select among the contracting plans).

Smaller Counties. Rural areas encompass 80% of California's geography but only 13% of its population. The State administers the Medi-Cal program directly in 39 of the smaller counties, operating primarily on a fee-for-service basis.

[67] Within the federal restrictions, the Solano County COHS has recently expanded to include Napa County, and the Santa Cruz County COHS is currently expanding to cover Monterey County as well. Medi-Cal Policy Institute, *Medi-Cal Managed Care,* Medi-Cal Facts Number 8 (March 2000).

Table 9



SOURCE: Medi-Cal Policy Institute, *Understanding Medi-Cal: The Basics* (1999), p. 11.

2. SMALLER PROGRAMS ADMINISTERED BY THE STATE DEPARTMENT OF HEALTH SERVICES (STATE DHS)

a. The California Children Services Program (CCS)

The CCS program was a pioneering effort by the State, beginning in 1927, to provide health care services for low income people. CCS covers low income children with serious medical conditions or disabilities. Children under 21 who have a CCS-eligible condition qualify for CCS if they meet any one of the following criteria: enrolled in Medi-Cal, enrolled in the Healthy Families Program (HFP), uninsured with an annual family income of less than $40,000, or projected to expend more than 20% of annual family income on treatment. The State funds and administers the CCS program in combination with the counties. Medi-Cal covers CCS funding for children enrolled in Medi-Cal at the normal federal-state funding match. HFP covers CCS funding at a federal-state-county match of 65% to 17.5% to 17.5%. For other children the financing is 50% State and 50% county. Most

CCS is a state- and county-administered program providing services to approximately 130,000 children from low income families with serious, high-cost medical conditions.

counties independently authorize services and provide case management for eligible children, irrespective of funding source.[68]

CCS currently serves almost 150,000 children.[69] Three-quarters of these children are also Medi-Cal enrollees who receive primary care services through capitated Medi-Cal payments and specialized care through CCS on a fee-for-service basis. CCS expenditures in 1997-98 were estimated to be over $85 million in state and county funds combined (not including Medi-Cal).

b. The Child Health and Disability Prevention (CHDP)

CHDP is primarily a preventive health care program originally established in 1974. Through the Program, eligible children can obtain regular preventive health assessments as well as needed immunizations. CHDP is administered locally by county health departments and delivered an estimated 500,000 screening exams in 1997-98.[70]

CHDP is a state- and federally-funded preventive health care program for low income children administered locally by county health departments.

Children eligible for CHDP services include those up to age 21 who qualify for Medi-Cal, other children from families with incomes up to 200% of the Federal Poverty Level, and young children in Head Start and state preschool programs. Children with health problems are eligible to receive necessary follow-up treatment identified in the screening process either through Medi-Cal or through a separate state-funded program.

CHDP expenditures (in excess of $80 million in 1997-98) come from Medi-Cal, HFP, Proposition 99 tobacco taxes and the State General Fund.[71]

c. Other State DHS Programs

The State DHS also contracts with 34 of the smaller counties to operate the County Medical Services Program (CMSP) to provide health care to medically indigent adults under 65 who are not eligible for Medi-Cal.[72] (See Section III-A-6-b below.) In addition,

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[68] Medi-Cal Policy Institute, *The California Children Services Program (CCS) and Medi-Cal,* Medi-Cal Fact Sheet Number 5 (August 1998).

[69] California Budget Project, *Health Coverage Programs Available To Low-Income Californians* (April 2000). This single sheet publication by the Project is an excellent short summary of seven major State-administered health care programs for the low income population.

[70] Wulsin & Frates (Uninsured), *op. cit.* note 24, p. 22. Because of declining tobacco tax revenue, the May Revision of the Governor's Budget for 2000-01 proposes that the State General Fund backfill CHDP support from Proposition 99 in the amount of $60 million (p. 29).

[71] The Children's Partnership, *Reaching 100% of California's Children with Affordable Health Insurance: A Strategic Audit of Activities and Opportunities* (September 1998), p. 26.

[72] CMSP health care payments to providers for 1998-99 totaled almost $170 million, with approximately $13 million being spent on county eligibility administration. The bulk of the financing came from the State: Realignment ($124.4 million), Proposition 99 ($10 million) and General Fund ($20.2 million). Only $5.5 million came from county funds. FAX transmittal to the Commission from CMSP on January 29, 2000

the State DHS administers a number of smaller targeted programs for particular groups, primarily those living in medically underserved areas and those with limited access to health care due to cultural or language barriers.[73]

3. PROGRAMS ADMINISTERED BY MRMIB -- THE MANAGED RISK MEDICAL INSURANCE BOARD

MRMIB is an independent, appointed board, operating with its own staff separate from the State DHS. Its programs are all insurance programs -- qualifying recipients receive premium support for health care coverage which they receive from their choice among a designated group of plans and insurers.

a. Healthy Families Program (HFP)

In general, HFP provides health insurance coverage for children through age 18 in families with incomes too high for Medi-Cal but below 250% of the Federal Poverty Level. Families are responsible for sharing the cost of coverage by paying $7 to $9 per child per month with a sliding scale ceiling of $14 to $27 for all their children. Families choosing a health plan with the most safety net providers in their area receive a $3 per month per child discount.[74] Some policy makers were concerned that HFP would cause employers and employees to drop current dependent coverage in order to take advantage of its subsidized coverage. To help minimize such "crowd out," coverage is generally denied to children who were covered by employer-sponsored health insurance within the preceding 90 days.[75]

The Healthy Families Program provides health insurance for children in families with incomes above the Medi-Cal limit but below 250% of the Federal Poverty Level. There is no asset requirement, and 12 months of continuous eligibility are guaranteed for qualifying children. Low monthly premiums are required. The program is administered by a State agency with eligibility determinations made on a centralized basis using mail-in applications.

As a new and separate program, HFP was designed to avoid much of the welfare stigma attached to the Medi-Cal program: (1) by charging premiums and providing care through applicant-selected health plans (including a number of commercial plans),[76] (2) by operating its own separate eligibility

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of *Approved CMSP FY 1999-2000 Budget*. The State contribution, capped at $20.2 million, was eliminated in the 1999-00 state budget and proposed to be eliminated permanently in the Governor's proposed 2000-01 budget. Governor's Budget Summary 2000-01, pp. 123-24.

[73] The bulk of these programs are administered by the Primary and Rural Health Care Systems Branch of the Department. See the Branch's website at: www.dhs.ca.gov/pcfh/pcrh/index.htm.

[74] Healthy Families State Plan, on the website of the California Department of Health Services, *op. cit.* note 41. See also The Children's Partnership, *op. cit.* note 71, p. 23.

[75] Medi-Cal Policy Institute, Medi-Cal Fact Sheet entitled, *Health Insurance Expansion for Children* (1998), p. 2.

[76] HFP uses a "rate-band" approach for qualifying the plans and insurers available to enrollees. All plans and insurers that meet coverage requirements and have rates within 10% of the two lowest bids are qualified to participate in HFP. Legislative Analyst's Office, *A Model for Health Coverage of Low-Income Families* (June, 1999), p. 20.

staff in Sacramento (using a mail-in application procedure rather than the face-to-face interviews with welfare eligibility workers that have been the norm for Medi-Cal), (3) by reducing the documentation and verification requirements, and (4) by doing outreach (with State-trained "application assistants") through community-based organizations and programs, health care providers and insurance agents (all of whom can receive fees for successful enrollments). Also, HFP has no family asset limitations,[77] broadening eligibility and reducing the paperwork requirements of the application process. In addition, HFP guarantees 12 months of continuous eligibility for children who qualify, in contrast to the quarterly reporting requirements that are still standard for the Medi-Cal program.[78]

Despite improvements in the application process and extensive outreach, HFP and children's Medi-Cal still remain far below their potential combined enrollment. The joint application, although much reduced from its original format, is still four pages long with eight pages of instructions. The continued existence of the two separately-administered programs and the retention of reporting and verification procedures not required by federal law also contribute to this situation.

HFP experienced a number of difficulties in its start-up phase. For example, the original complex 28-page joint HFP/Medi-Cal application form was a major barrier to enrollment. Starting in 1999, a number of improvements were made in the application process. The joint application form has been reduced to four pages (although there are still eight pages of instructions and a large accompanying booklet with 16 pages of general information followed by 65 pages detailing the plans available in all 58 counties), and mail-in enrollment is now allowed for children in both programs.[79]

Over 130,000 children were enrolled in HFP's first year of operation, ending in June 1999, and the 200,000 enrollment level was reached before the end of 1999.[80] With its family income limit now raised to 250% of the Federal Poverty Level and Medi-Cal's more generous income deduction schedule now applicable to HFP as well, HFP was budgeted for 2000-01 at $336 million with coverage estimated at 370,000 children as of June 2000.[81]

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[77] Asset requirements were also eliminated from children's Medi-Cal by a statutory change effective in March 1998. Marilyn Ellwood, *The Medicaid Eligibility Maze: Coverage Expands, but Enrollment Problems Persist -- Findings from a Five-State Study,* Mathematica Policy Research, Inc. & the Urban Institute, Assessing the New Federalism series, Occasional Paper Number 30 (December 1999), p. 35.

[78] *Ibid.*

[79] The cover letter for the application described is dated December 2, 1999. Prior to the start of HFP, all Medi-Cal applicants were required to be interviewed face-to-face. Claudia Page and Crystal Hayling, *Opening the Door -- Improving the Healthy Families/Medi-Cal Application Process (Executive Summary),* Medi-Cal Policy Institute (October 1998), p. 2.

[80] Healthy Families Program (HFP), *Healthy Families Program Monthly Enrollment Reports -- Subscribers Enrolled by County (*data from July 1999 and January 2000). On the HFP segment of the Managed Risk Medical Insurance Board website at: www.mrmib.ca.gov/MRMIB/HFP/HFPReports.html.

[81] Governor's Budget Summary 2000-01, p. 27. The federal government approved the HFP expansion to 250% of FPL on November 23, 1999. In the May Revision of the Governor's Budget for 2000-01 (pp. 28

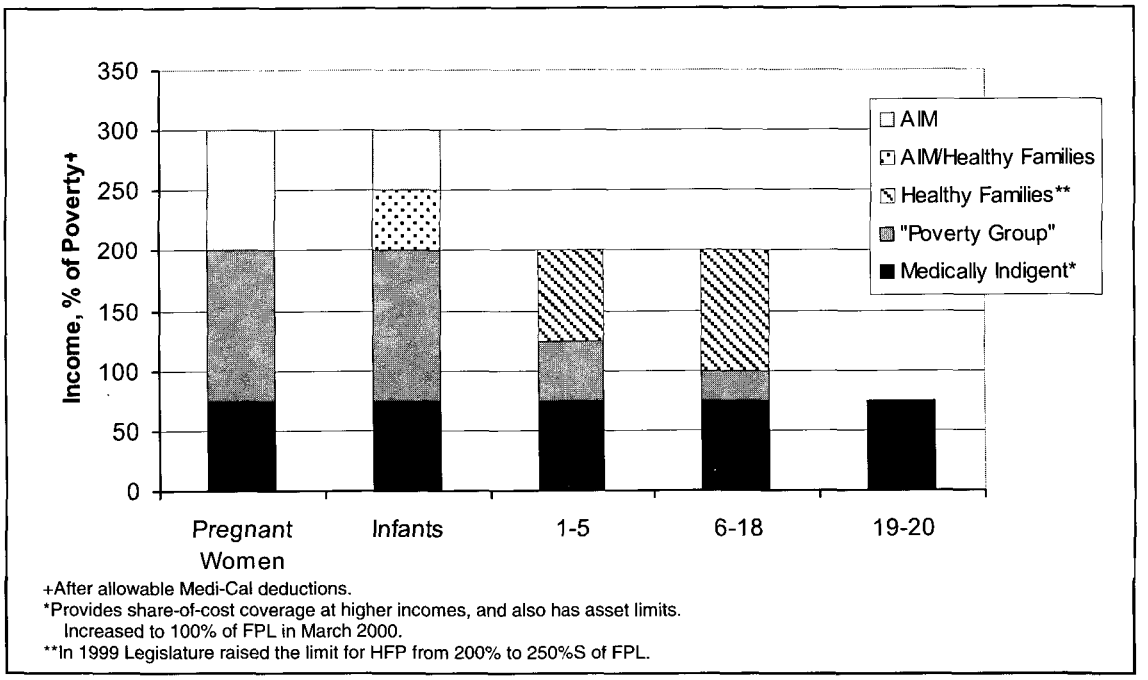
Members of the same family can be eligible for different programs with different services and different providers.

Despite the improvements made, the eligibility process for HFP and Medi-Cal for children is still made needlessly cumbersome and expensive by the continued existence of the two similar programs with separate application processes, by the complex and arbitrary dividing line between the two programs (see chart below), and by the retention of various verification and reporting requirements not required by federal law.[82]

As a result, members of the same family can be eligible for different programs and services and be forced to use different plans and providers for their medical services.[83]

Table 10

Children & Pregnant Women Eligibility for Health Coverage (June 1999)



SOURCE: Legislative Analyst's Office, *A Model for Health Coverage of Low-Income Families*, Figure 4., p. 11 (June 1, 1999).

The problems facing those responsible for enrollment in the HFP and Medi-Cal for children programs are well illustrated by the eligibility status of uninsured children. As Table 11 shows, of the approximately 2,000,000 uninsured children in California at the

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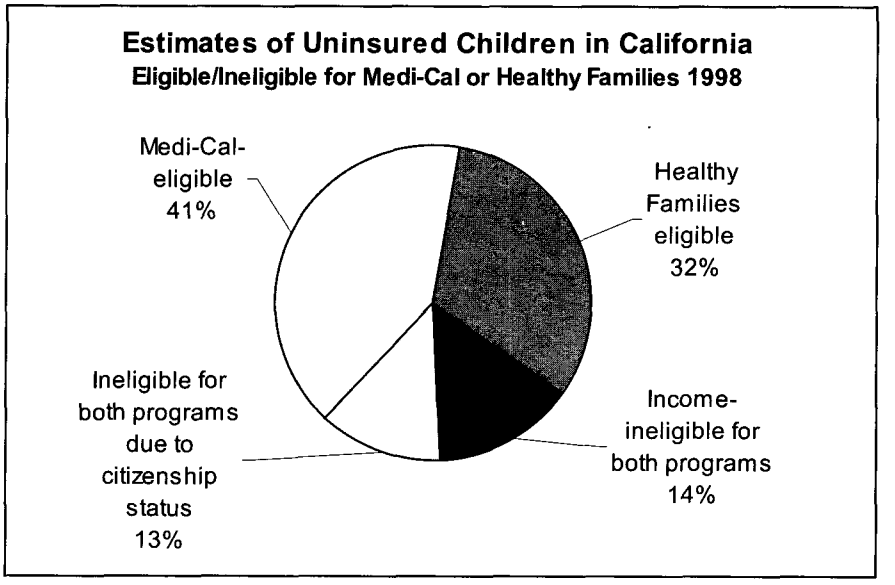
& 37), the Governor proposes adding $59 million to the 2000-01 state budget to cover all 639,000 children estimated to be eligible in June 2001.

[82] For a discussion of this last aspect of children's Medi-Cal, see Page and Hayling, *op. cit.* note 79, p. 5.

[83] Legislative Analyst's Office (LAO), *op. cit.* note 76, pp. 11-13. As the LAO points out, one result of this complexity is large administrative costs for the State and the counties.

end of 1998, almost three-quarters were estimated to be eligible either for Healthy Families or Medi-Cal but not enrolled in either of those programs. As a result of the State's inability to enroll children in HFP more quickly, California may lose as much as $700 million in 1997 federal HFP allocations which will revert to the federal government if not spent by September 2000.[84]

Table 11



SOURCE: *Comparison of Medi-Cal and Healthy Families Programs for Children in California,* Kaiser Commission on Medicaid and the Uninsured, Preliminary, March 2000, p. 18.

b. Access for Infants and Mothers (AIM)

Begun in 1992, the AIM program subsidizes health insurance for women with incomes between 200 and 300% of the Federal Poverty Level (FPL) who are pregnant and/or have infant children. AIM benefits include hospital delivery and full health services during pregnancy and 60 days postpartum. With its narrow focus, AIM's average monthly new enrollments have been limited to between 250 and 450 women and their infants. Its enrollment as of January 2000 was over 17,000 mothers and infants.[85] AIM participants receive their care from one of nine participating health plans, the dominant one being Blue Cross with about 50% of the enrollment. Plans participate as full-risk providers with negotiated capitation rates.

The AIM program subsidizes health insurance for women with incomes between 200 & 300% of FPL who are pregnant or have infant children. Its enrollment currently exceeds 17,000.

Enrollees pay income-based subscriber contributions -- two percent of gross family

[84] *Los Angeles Times* editorial, *Health Funds in Danger* (May 27, 2000), p. B-9.
[85] California Budget Project, *op. cit.* note 69.

income adjusted for family size. In 1998, the average subscriber contribution for the basic service package was $804. The program is supported by about $40 million from Proposition 99 tobacco tax revenues and subscriber premiums.

c. Major Risk Medical Insurance Program (MRMIP)

MRMIP provides health insurance for Californians who are unable to obtain coverage in the private health insurance market. As of April 1999, MRMIP had served almost 58,000 persons since it opened in 1991 and had enrollment of 21,000. Services in the program are delivered through contracts with six health insurance providers, again the largest being Blue Cross with nearly three-quarters of the enrollees. Program participants pay premiums which are supplemented by MRMIP to cover the full cost of the insurance. In 1998-99, the $85 million cost of the program was funded by $40 million in Proposition 99 tobacco tax revenues and subscriber premiums.[86]

d. Pacific Health Advantage (PHA) -- (formerly Health Insurance Plan of California -- HIPC)

HIPC was established in 1992 as a statewide small-employer health insurance purchasing pool administered by MRMIB to allow small businesses to join together to leverage their purchasing power in an effort to make coverage more affordable and accessible. In 1999 HIPC was privatized under the PHA name.[87]

Over 7,800 businesses and 140,000 Californians have participated in one or more of HIPC-PHA's 21 participating health plans. Enrollment continues to expand steadily, but still constitutes less than two percent of the small-group market in California as a whole.

HIPC-PHA uses data on enrollees' health risks, derived from the previous year's claims, to adjust premiums received by insurers in order to reduce the effect of risk selection on the insurers' cash flows.[88]

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[86] Managed Risk Medical Insurance Board (MRMIB), *California Major Risk Medical Insurance Program(MRMIP) -- 1999 Fact Book* (August 1999). On the Board's website at: www.mrmib.ca.gov. MRMIP enrollees are experiencing sharp increases in their premiums for the year 2000. National Journal Group Inc., Item 4 of the January 31, 2000 issue of *California Healthline,* published each week day via e-mail for the California HealthCare Foundation (e-mail address: news-support@chcf.org).

[87] Some of PHA's start-up problems are summarized in a contemporaneous newspaper article. Mitchel Benson, *Privatized Insurance Pool Goes From Bad to Worse,* The Wall Street Journal (July 7, 1999), p. CA-1.

[88] Zuckerman, Coughlin *et al.*, *op. cit.* note 20, p. 20.

4. UNIVERSITY OF CALIFORNIA HOSPITALS

The University of California has five Schools of Medicine (connected with the UC Davis, Irvine, Los Angeles, San Diego and San Francisco campuses), all of which include Medical Centers operated by the University to support their clinical teaching programs. With their tripartite mission of teaching, research and public service, the administration and financing of the Medical Centers (with a 1998-99 budget in excess of $1.7 billion) has been complex and often uncertain in the constantly changing world of public health care financing. Collectively, the Centers comprise the second largest Medi-Cal provider in the State.[89]

The three former county hospitals (UC Davis, Irvine and San Diego) have traditionally provided a high percentage of care to the medically indigent. As qualified Disproportionate Share Hospitals, these three Medical Centers had, through 1997-98, received a net benefit of over $466 million in SB 855 and SB 1255 funding. The UC hospital system was subject to having the State divert previously available funding to other uses during the recession of the 1990s ($280 million in 1992-93 through 1994-95).[90]

In connection with their teaching mission, the UC Medical Centers can incur a number of unique costs which may not be fully reimbursed under Medi-Cal's per diem reimbursement rate limitations. In response to this situation, the Medi-Cal Medical Education Supplemental Payment Program was created by the State in 1996. This source of additional funding is available to other major teaching hospitals as well.[91]

The five UC medical schools all operate medical centers which are, collectively, the State's second largest Medi-Cal provider. Their annual budget exceeds $1.7 billion. The hospitals operated by three of the five medical schools are former county hospitals taken over by the University during the 1960s.

As is typical of large public hospitals, the UC Centers rely on a mix of funding streams to pay their costs. In 1997-98, almost half of patient days at the UC Centers were paid for through Medicare (24%) and Medi-Cal (24%). Another large segment were covered by private payor plans, both managed care (40%) and fee-for-service (2%). The remaining 10% of patient days were covered by county and other State supported programs or paid for directly by the patients.[92] With federal programs currently providing almost one-half of the net operating revenue of the UC Medical Centers, the reductions in federal support

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[89] University of California Board of Regents, *1999-2000 U. C. Regents' Budget for Current Operations -- Teaching Hospitals*, pp. 132-34.
[90] *Ibid.*, pp. 133 & 137-39.
[91] Welfare & Institutions Code Sections 14085.7-8.
[92] These statistics are aggregates for the entire UC System. The patient mix is quite different for the UCLA and UCSF Medical Centers than it is for the three former county hospitals.

called for by the 1997 Balanced Budget Act -- including, in particular, federal support for graduate medical education -- are a major budgetary concern to the University.[93]

5. HEALTH CARE DISTRICTS

California has 74 Health Care Districts. Currently, 50 of those Districts operate acute care hospitals, primarily in rural areas, and the balance operate a variety of clinics, ambulance services and other health care facilities and programs.[94]

6. THE ULTIMATE SAFETY NET: COUNTY PROGRAMS FOR THE UNINSURED

a. California's Uninsured Population

Background. It might seem that the programs outlined above should provide access to health care for almost all Californians. To the contrary, in 1998 there were still an estimated 7,300,000 California residents without health insurance coverage.[95]

Non-elderly Californians have a substantially lower rate of health insurance than does the rest of the nation, largely due to California's very low rate of job-based insurance.

Non-elderly Californians had a substantially higher level of those without health insurance coverage (24%) than did the rest of the nation (17%).[96] This lower level of health insurance was largely due to the fact that California had the lowest rate of job-based health insurance of all 50 states.[97]

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[93] Although there is no real dispute about the magnitude of the cuts in federal subsidies to teaching hospitals as a result of the 1997 BBA, there is considerable controversy about the merits of the cuts imposed by Congress. Tom Abate, *Teaching Hospitals Hobbled by Medicare Subsidy Cuts -- Some say funding has created glut of physicians*, San Francisco Chronicle (June 17, 1999), p. A-11.

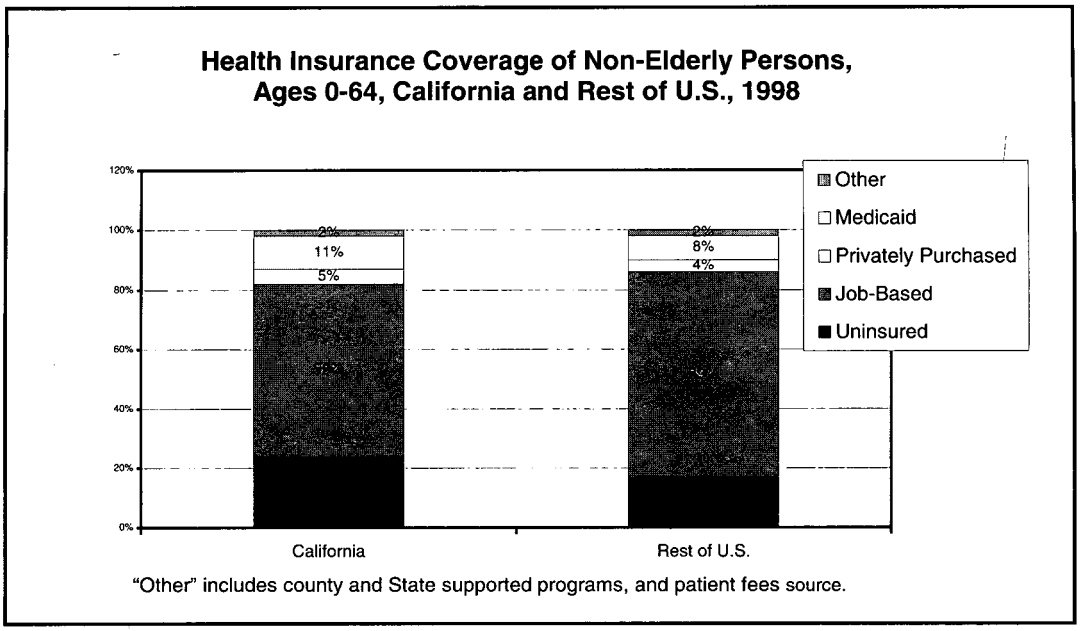
[94] For a critique of the activities of some of the 24 Districts not currently operating hospitals, see Little Hoover Commission, *Special Districts: Relics of the Past or Resources for the Future?* (May 2000), pp. 48-51.

[95] Helen Halpin Schauffler, E. Richard Brown *et al.*, *The State of Health Insurance in California, 1999,* University of California (January 2000), p. 3. Nor is this a short-term phenomenon. 40% of non-elderly adult Californians without coverage in 1999 have either never had coverage or been without it for more than five years. *Ibid.,* pp. 34-35.

[96] This differential would have been greater but for the State's high rate of Medicaid (Medi-Cal) participation (11% vs. 8% for the rest of the country). *Ibid.*, p. 5.

[97] *Ibid.*, pp. 5-6. In 1997, California's proportion of employers not offering health insurance (20.6%) was over 40% higher than the national average (14.6%). Helen Halpin Schauffler, E. Richard Brown *et al.*, *The State of Health Insurance in California, 1998*, University of California (January 1999), p. 30. California's low rate of job-based insurance coverage may be exacerbated by the State's large number of smaller employers. Health insurance rises dramatically with firm size. In 1999, only 41% of firms with 3-9 employees offered health insurance coverage. This increased to 62% for firms with 10-50 employees and to 94% for larger firms. Schauffler, Brown *et al.*, *op. cit.* note 95, p. 45.

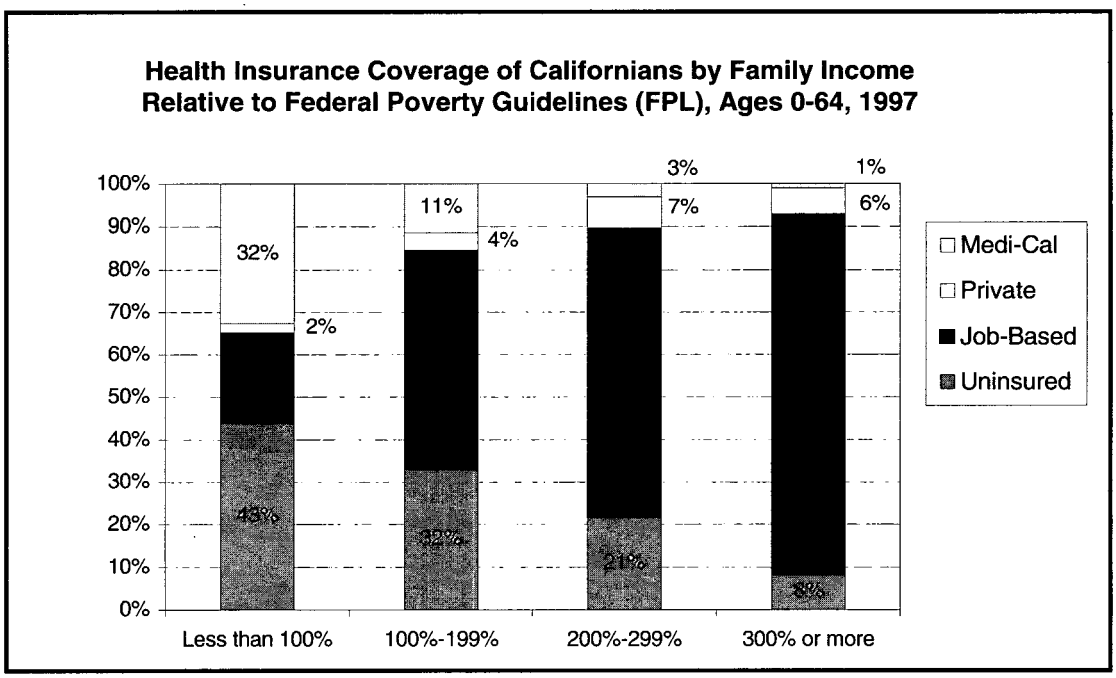
Table 12



SOURCE: Schauffler and Brown, *The State of Health Insurance in California 2000*, p. 6

As might be expected, the level of job-based health insurance increases sharply as the level of family income increases.

Table 13

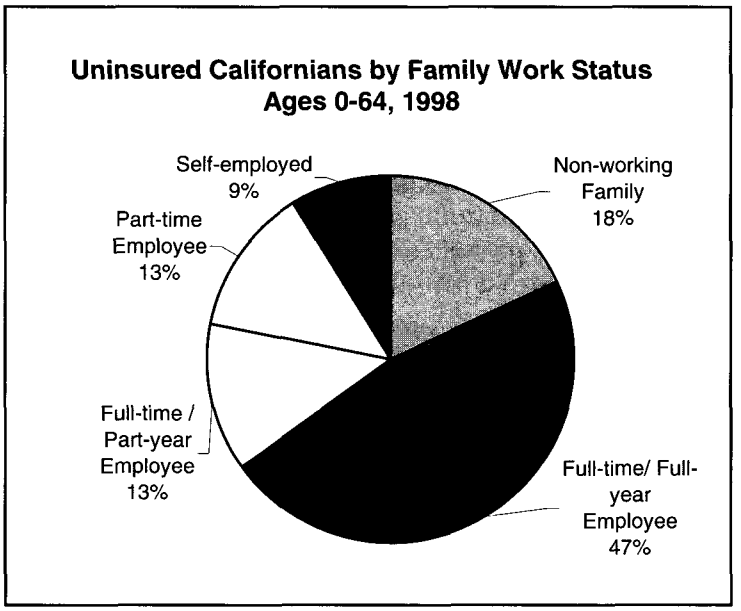


SOURCE: Schauffler and Brown, *The State of Health Insurance in California 1998*, p. 11.

Nevertheless, California's large uninsured population consists primarily of low wage workers. In 1998, approximately one-half of all uninsured families had at least one family member employed full time for the entire year; and less than one-fifth of the uninsured population came from families with no employed family members.

California's large uninsured population consists primarily of low wage workers and their families.

Table 14



SOURCE: Schauffler and Brown, *The State of Health Insurance in California 1999*, p. 14.

Ethnicity also had a significant correlation with the level of health insurance. In 1998, only 15% of non-Latino white Californians under 65 lacked health insurance. This percentage rose to 22-23% for those with Asian backgrounds and African-Americans, and to 40% for Latinos.

Despite the present boom in the economy, the number of uninsured has been steadily increasing. This increase includes children -- the decline in Medi-Cal enrollment has not been off-set by Healthy Families Program enrollment.

Unfortunately, this lack of health insurance coverage is increasing. Between 1995 and 1998, the percentage of Californians covered by Medi-Cal dropped 3%, from 14% to 11% -- presumably due to the improving job market and the impact of the welfare reform program. The increase in job-based coverage, however, was only 1% (from 57% to 58%). The resulting numerical increase in the uninsured population was 276,000 in 1997 alone (an average of 23,000 per month). Nor was this increase limited to adults. Despite the advent of the Healthy Families Program (HFP),

the children's uninsured rate rose from 17% in 1995 to 21% in 1998, as their Medi-Cal coverage rate dropped by a full 5%.[98] In terms of actual numbers, it is estimated that from 1997 through 1999 children's Medi-Cal enrollment dropped by 270,000 while off-setting HFP enrollment was substantially less at 210,000.[99]

b. Counties and Other Providers of Last Resort

County Health Care for the Uninsured. For the large uninsured low income population which is not eligible for Medi-Cal, or for any of the other programs outlined above, California's counties (and charitable health care providers) are the providers of last resort. Under Welfare and Institutions Code Section 17000, the counties remain as the ultimate health care safety net.[100]

Typically, the uninsured, low income individual in need of non-emergency health care services will end up at a facility either operated by or contracting with the local county. Other providers normally do not treat people without proof of an ability to pay for their services (usually cash or a health insurance card). At a county outpatient facility, if Medi-Cal or other eligibility cannot be established, the recipient will usually have a choice of paying a flat fee ($30-$45 in Los Angeles, for example) without means testing or being accepted, if qualified, for care under the county's indigent health care program. Counties have widely varying cut-off levels for those considered to be indigent and a similar variety of sliding scales for required co-payments depending on the financial status of the recipient.[101]

Under State law, the counties remain as the providers of last resort, particularly for the large number of medically indigent adults who do not qualify for Medi-Cal. There are no state-wide standards for coverage or required sliding scale co-payments. Such standards vary widely among the counties, especially with respect to outpatient care.

Emergency room (ER) care must, by law, be provided to all comers by all ER facilities. However, in private facilities the uninsured patients are often transferred to a public facility once they are stabilized. If a recipient is uninsured and unable to pay, the ER provider may bill the State (where there is eligibility under Medi-Cal, the SB 12 Emergency Medical Services program, or another State program) or the county (again, to the extent a county program is available). Even where a hospital does not receive a direct

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[98] *Ibid.*, pp. 3-4 & 23-24.

[99] Bob Rosenblatt, *Benefits Can Be a Tough Sell,* Health Dollars & Sense column in the Health section of the Los Angeles Times (January 10, 2000), p. S-4. See also Families USA Foundation, *One Step Forward, One Step Back (October 1999), pp. 15 & 23.*

[100] In a case involving Sacramento County, this statutory county obligation was recently reiterated and confirmed by the California Supreme Court in a unanimous decision on November 22, 1999. *Hunt v. Superior Court, 21* Cal.4th 984.

[101] Means testing at non-county facilities may also vary considerably among the different facilities. Such facilities often apply different standards than those normally applied at county facilities in the counties where they are located.

payment with respect to services provided to a specific recipient, such services may be a part of the uncompensated care which qualifies it to receive Disproportionate Share Hospitals payments.

Hospital facilities will generally do their best to qualify indigent patients for Medi-Cal (or other publicly-funded programs) from which the provider has the assurance of getting paid. For less expensive outpatient services, facilities may encourage recipients to make cash payments rather than having to go through the procedure of establishing eligibility for State or county programs, preparing the necessary paperwork, and then having to wait for payment.

In a number of low income areas, private clinics also provide services. Some of these clinics do Child Health and Disability Prevention (CHDP) exams for which they are able to bill the State under the CHDP program. (See Section III -A-2-b above.) Additional services are generally done on a sliding scale cash basis.

Administration of County Programs. The present county health care system for the indigent uninsured has been built up piecemeal over the years. It varies substantially from county to county since counties have had considerable autonomy in designing programs to fulfill their often very different standards and requirements in discharging their responsibilities as the health care providers of last resort.

With respect to the delivery of services, the counties fall into three major categories: (1) the large "public hospital" counties, (2) the large "private provider" counties without a public hospital, and (3) the 34 smaller, more rural counties whose health care programs are run by the State on a "contract back" basis pursuant to the County Medical Services Program (CMSP). (See Section III-D below for examples of the first two categories.)

In the larger counties, there is a basic split between the public and private provider formats. Some counties deliver the bulk of their services through facilities owned and operated by the county, while others have privatized their entire delivery system. Similarly, counties vary with respect to the types of facilities where services are delivered. Most depend on hospital-based systems, but others have extensive networks of outpatient clinics.

Public Hospital Counties. The large public hospital counties (including Alameda, Contra Costa, Los Angeles, Riverside, San Bernardino, San Francisco and Santa Clara) maintain dual roles as providers and purchasers of health care services. As providers, they deliver care in county-owned hospitals and clinics. As purchasers, some additionally contract with private providers for care to the uninsured. A few of these counties issue Medi-Cal-style eligibility cards to recipients; others grant eligibility for fixed periods (normally six to twelve months). San Francisco determines eligibility (and financial responsibility) episodically when care is sought.

Alameda and Los Angeles Counties contract extensively with community clinics. Contra Costa County has developed an organized HMO delivery system for its Medically Indigent Adults (MIAs). However, many of the public hospital counties (San Francisco and Contra Costa in particular) contract with relatively few private providers and deliver most services through their own facilities. Such systems generally rely heavily on a hospital-based approach to providing care for the uninsured.

Private Provider Counties. Three of the large private provider counties (Orange, Sacramento and San Diego) turned over their county hospitals to the University of California more than three decades ago, and a fourth (Fresno) transferred its hospital to a private non-profit entity in 1997. All of the private provider counties contract with and reimburse hospitals, clinics and private physicians to deliver services to the uninsured. Some county programs, such as San Diego's, have tested managed care models and contracted with community clinics to be the focal points of an organized delivery system for the uninsured. Fresno and Orange Counties, in contrast, have historically provided care to the uninsured primarily through hospital/emergency room-based systems. (See Section III-D below.)

Smaller Counties. Pursuant to the County Medical Services Program (CMSP), the State Department of Health Services (State DHS) contracts with the State's smaller counties to provide medical and dental care to MIAs aged 21-64 with marginal incomes but not eligible for Medi-Cal. The CMSP governing board is comprised of county supervisors, county administrators, welfare directors, health administrators and representatives from the State Health and Human Services Agency.

CMSP is basically a mini-Medi-Cal program without the automatic enrollment for welfare recipients that brings in most Medi-Cal enrollees. Although there are outreach efforts to inform people about CMSP, most often the entry points are the financial screening at hospitals and other health care facilities or at welfare offices (where those not eligible for welfare assistance may still be informed of their eligibility for CMSP services). In 1998, CMSP covered 40,000 individuals in 34 counties.[102]

County health care services for the uninsured medically indigent are provided in most counties on an episodic basis rather than in a managed care format.

Payment of Providers. With only occasional exceptions (such as the San Diego example above, the capitated primary care program in San Bernardino County, and the all-inclusive capitated program in Contra Costa County), health care in both private provider and public hospital counties is provided largely on an episodic basis rather than in a managed care format that would lend itself to a capitated payment arrangement. CMSP provider payments are made on a fee-for-service basis to

[102] See the County Medical Services Program pages on the website of the California Department of Health Services under the Office of County Health Services at: www.dhs.ca.gov/cmsp.

over 2,000 participating health care professionals and over 200 hospitals and clinics annually.[103]

Charitable Care. California hospitals and clinics report quarterly to the State Office of Statewide Health & Planning Development (OSHPD) on the amounts they would normally bill for the charitable care they provide. (Physicians and other individual health care providers do not.) Those reports indicate that the total amount charged for charitable care by hospitals (and written off) was in excess of $600 million dollars in 1998.[104] Additional amounts of medical services are provided to the uninsured low income population without charge or at reduced rates by physicians and other medical practitioners and by health care organizations of various types. A number of HMOs, especially those operating on a non-profit tax-exempt basis, subsidize low fee programs. Numerous non-profit organizations, many focusing on particular medical problems, provide referrals to providers willing to donate services for those with no access to needed care. A number of foundations, including some of California's largest, provide major funding to a wide spectrum of health care providers and projects. Without the contributions made by such individuals and organizations, the health care obligations faced by the public health care safety net would be substantially larger than it now is.

Conclusion. Among the uninsured population, children fare by far the best. With the new higher eligibility standard for the Healthy Families Program (HFP), most such children are eligible either for HFP or Medi-Cal (or perhaps for the California Children's Services program if they have serious or long-lasting medical problems). For uninsured low income adults under 65 not eligible for Medi-Cal, however, the prospects are much bleaker. Unlike most Medi-Cal enrollees, only a small percentage are eligible for managed care plans and a majority are entitled to service only at overcrowded county facilities with the long waits

Most children from low income families who do not currently have health insurance coverage are eligible for either children's Medi-Cal or the Healthy Families Program. For low income adults under 65 who are not eligible for Medi-Cal, the great majority are entitled to service only at overcrowded county-funded facilities with the long waits and lack of practitioner continuity that are typical of such facilities.

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[103] County Medical Services Program, *A County-State Partnership in Health Care* (undated two-page fact sheet received by the Commission in 1998).

[104] Information on Hospital Charity Care for 1998 supplied by FAX from OSHPD. Also available on OSHPD website at: www.oshpd.ca.gov. For a detailed analysis of the OSHPD data on the amount of uncompensated care (charitable care plus bad debts) provided by California's non-federal hospitals, see Robert Seidman, *Economic Burden of Uncompensated Hospital Care in California,* San Diego State University (March 1998). For 1998, primary care clinics reported to OSHPD "charity care" (sliding scale adjustments plus free care) of almost $80 million. *California Primary Care Clinics, Financial and Utilization Data, Calendar 1998* (state-wide totals). Again, information supplied by FAX to the Commission from OSHPD and available on the website of the Office. In 1997, primary care community clinics reported providing care to over 2,250,000 patients with net revenue of $393.6 million -- 80% of that total coming from publicly-funded health care programs. Of their reported gross charges, 11% ($58.3 million) was for charitable care. Campos Communications, *1997 Community Clinic Fact Book* (March 1999), p. 32.

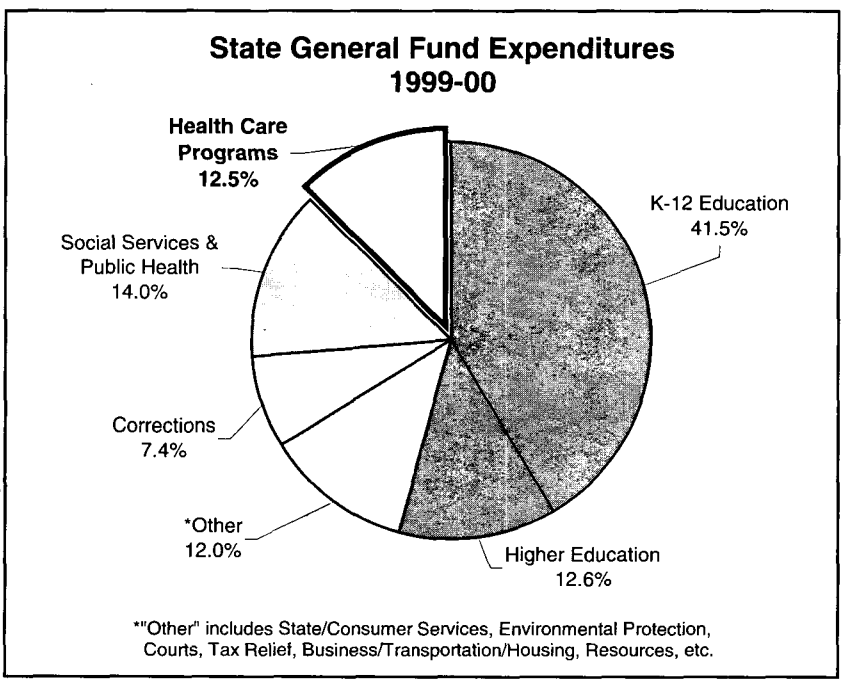
and lack of practitioner continuity that are typical of such facilities. Many avoid seeking care until a health problem arises for which urgent or emergency treatment is required.

B. THE FUNDING: Summary of Expenditures and Revenue Sources

Total spending on health care services for California's low income children and adults under 65 by state government alone (including federal subventions) amounted to $22 billion in 1998-99 and is budgeted for over $25 billion in 1999-00.[105] The level of such health care spending is determined in Sacramento and Washington. Since the passage of Proposition 13, the counties have had limited resources and fiscal authority and are dependent on federal and State funding to discharge their safety net responsibilities.

Health and social services spending is a major portion of total State expenditures. At 27% of budgeted General Fund expenditures in 1998-99, such spending ranked second only to the 42.5% share of K-12 education. With almost one-half of the health and social services spending total devoted to publicly-funded health care services, health care spending represented approximately one-eighth of all State General Fund expenditures.

Table 15



SOURCE: Legislative Analyst's Office, California Spending Plan, 1999-00.

A comparison of the current Administration's 1999-00 state budget with that of the 1997-98 budget year -- the last budget of the prior Administration -- gives an indication of the changes in priorities (together with the continued improvement in the State's economy and the impact of welfare reform).

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[105] Governor's Budget 2000-01, Health and Human Services, pp. 39-40.

The Health portion of the budget covers public health services, mental health, agency expenses, debt service and various other miscellaneous expenses in addition to Medi-Cal and other health care programs. Medi-Cal was over 40% of the Health item in both budgets; however, in 1997-98, there was no increase in Medi-Cal funding from the prior year while in 1999-00 there was a 5% increase, despite the declining caseload.[106]

Table 16

State Budget Percentages for Major Programs
General Fund Expenditures

	1997-98 Budget	increase or decrease from prior year's figure	1999-00 Budget	increase from prior year's figure
K-12 Education	41.6%	↑ 9.9%	41.5%	↑ 11.1%
Higher Education	12.5%	↑ 6.9%	12.6%	↑ 7.7%
Health	15.4%	↑ 2.5%	15.7%	↑ 4.2%
Social Services	12.7%	↓ 1.5%	10.8%	↑ 2.7%
Corrections	7.6%	↑ 5.2%	7.4%	↑ 4.0%
Overall Budget		↑ 8.0%		↑ 8.8%

SOURCE: Legislative Analyst's Office, *California Spending Plans, 1997-98 & 1999-00*

For the 1998-99 fiscal year, Medi-Cal expenditures were over $20 billion -- approximately 90% of public health care spending.[107] Of that total, $10.5 billion came from federal funds,[108] almost $7 billion from State General Fund spending through the State Department of Health Services (State DHS), $1.4 billion in the budgets of other state departments, and $1.4 billion in local matching funds from public hospitals for the federal Disproportionate Share Hospitals (DSH) program.[109] As set forth previously (in Section II-A-2-and in Table 5), the bulk of Medi-Cal spending goes for services to

[106] Governor's Budget Summaries for 1997-98 (pp. 97 & 105) and 1999-00 (pp. 111 & 119).
[107] The precise percentage can only be estimated for the reasons set forth in the following three paragraphs.
[108] In 1996, California's federal matching share (Federal Medical Assistance Percentage -- FMAP) was the statutory minimum of 50%. For 1998, the State's FMAP rose slightly to 51.23% and for 2000 it is 51.67%. On the federal Health Care Financing Administration's website at: www.hcfa.gov/medicaid/mcaid.htm (under Medicaid Budget & Expenditure Information). Also at: http://aspe.os.dhhs.gov/health/fmap.htm. The federal share includes both DSH (SB 855) and SB 1255 funding.
[109] Medi-Cal Policy Institute, *Medi-Cal Info, FAQ#7.* On the Institute's website at: www.medi-cal.org/resources (click on FAQ). The State generates federal revenue for itself for administrative costs and other uses by not returning to local entities the full amount of their contributions (augmented by the amount of federal matching funds generated by those contributions). This "administrative fee" was established for budgetary reasons during the recessionary years of the early 1990s, and reached a high of $239 million in 1994-95. As the State's finances have improved, the "fee" has been reduced accordingly and is budgeted for under $55 million for 2000-01. Governor's Budget Summary 2000-01, pp. 118-19.

elderly and disabled recipients and long-term care. Only about one-third -- approximately $7 billion -- goes for the low income children and non-disabled adults under 65 who are the majority of Medi-Cal recipients and the focus of this Report. Out of the Medi-Cal total, over $ 950 million was spent by the counties for eligibility determinations and related administrative expenses.[110]

At a much lower level, Healthy Families Program (HFP) spending totaled $132 million in 1998-99, its start-up year in California (65% federal and 35% State). (HFP spending escalated rapidly to a budgeted total of $323 million for 1999-2000.[111]) Other State General Fund spending in 1998-99 in the other programs administered by the State Department of Health Services for the programs summarized in Section III-A-2 above totaled well over $100 million.[112]

At the county level, the State provided $1.2 billion in Realignment funding for health care services in 1998-99.[113] Also that year, Proposition 99 tobacco tax revenue for health-related services totaled approximately $400 million.[114] County contributions (primarily from property tax revenues) are more difficult to determine. State DHS financial data for 1998-99 show a "Net County Cost" for inpatient and outpatient health care services of approximately $1.3 billion, with $341 million of that from county resources.[115] Others have estimated substantially higher amounts.[116]

Smaller, but still substantial additional amounts of spending on health care for low income Californians come from still other sources. Low and no-cost health care is

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[110] Governor's Budget for 2000-01, p. 51. The Legislative Analyst's Office estimates that about one-half of that amount could be saved by the adoption of its "Family Coverage Model" plan. See Commission Recommendation 11 in Part IV below.

[111] Governor's Budget Summary 1999-2000, p. 131.

[112] Governor's Budget for 2000-01, Health and Human Services, p. 44.

[113] Governor's Budget Summary 2000-01, p. 144.

[114] Governor's Budget Summary 1999-2000, pp. 127-28. Of that amount, approximately $180 million was budgeted for clinic and county indigent health programs. Governor's Budget Summary 1998-99, p. 125. Tobacco revenue is expected to continue to decline due to the continuing reduction in the sale of tobacco products (which will presumably be accelerated by virtue of the higher taxes on those products resulting from the passage of Proposition 10 in 1998). Governor's Budget Summary 2000-01, pp. 120-22.

[115] California Department of Health Services, *County Health Services -- Budget/Actual Data -- Fiscal Year 1998-99* and *Fiscal Year 1998-99 Final Maintenance of Effort (MOE) Calculation -- Adjusted for Growth.*

[116] Exact amounts are difficult to determine due to the complexity of health care funding sources (see, *e.g.*, the Los Angeles County budget detail in Section III-D-3 below), the lack of a standardized county accounting system, and the intermixing of various health related programs. In addition to the amounts listed in the DHS estimates, an undetermined amount of SB 855 Disproportionate Share Hospitals money -- half of which comes from county matching funds -- is also spent on the uninsured. See California Budget Project, *Who Funds the Health Care Safety Net*, Budget Watch, Vol. 32, (April 1997), pp. 6 & 7; Legislative Analyst's Office, *LAO Analysis of the 1996-97 Budget Bill -- Health and Social Services, Crosscutting Issues* (1996), p. 3.

available to veterans from the federal Veterans Health Administration.[117] Local Health Care Districts also provide services to low income residents, particularly in rural areas.[118] Private hospitals and clinics reported providing charitable health care services of approximately $700 million in 1998.[119] Other amounts, such as services provided by individual physicians and other health care practitioners, are difficult even to estimate.

A substantial amount of potential new funding will be available to the State and the counties from the tobacco litigation settlement (estimated to be approximately one billion dollars annually for the next quarter century).[120] Also, Proposition 10, passed in 1998, is expected to provide over $600 million annually for child development programs (like Proposition 99 funding, declining in proportion to the decrease in the use of tobacco products). Some of that money may ultimately be allocated to children's health care programs.

C. THE STRUCTURE: The Administration of California's Public Health Care System

1. THE FEDERAL GOVERNMENT

With limited exceptions, the federal government does not administer health care programs for California's low income population. The Medi-Cal program and the Healthy Families Program, which use the bulk of federal health care funding in the State, are administered by State agencies. (Outside the scope of this Report, the Health Care Financing Agency does directly administer the Medicare program for those over 65, including many low income seniors.)

2. STATE ADMINISTRATIVE STRUCTURE

Much of the administrative structure of California's publicly-funded health care system is historic rather than the product of a thoughtful overall design related to current needs. The result is that today funding and responsibility are often divided at all three levels of government -- with the lack of accountability and proper incentives that such separation tends to generate.

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[117] More detailed information is available on the website of the Department of Veterans Affairs at: www.va.gov/health/elig/index.html. See Peter M. Warren, *Clinics Help Usher in Wider Care for Vets,* Los Angeles Times (November 13, 1998), pp. A-3 & 31.

[118] Despite having taxing authority, the Health Care Districts generate less than 5% of their revenues from levying taxes. Their funding and operations are, in practice, very similar to those of non-profit community hospitals.

[119] See note 104 and accompanying text above.

[120] After the Governor's Budget for 1999-2000 initially allocated that money to the General Fund, the Legislature passed AB 100 which would have required that the tobacco funds be spent for health purposes. However, the Governor vetoed AB 100, leaving the issue open for further consideration in the 2000 Session of the Legislature. Veto Message dated September 28, 1999.

a. The Health and Human Services Agency

Sitting atop California's publicly-funded health care system is the Health and Human Services Agency. Its Secretary is appointed by and directly responsible to the Governor for all of the State's health and welfare programs. The Agency is the umbrella for nine departments (including Health Services) and four independent agencies (including the Managed Risk Medical Insurance Board) -- but not for the California Medical Assistance Commission or for the Department of Managed Care, which is in the Business, Transportation and Housing Agency.

b. Department of Health Services (State DHS)

With responsibility for Medi-Cal and the other health care programs summarized above, and also for a wide range of other public health activities, the State DHS is one of the largest departments in state government. It has over 5500 employees budgeted in 1999-00 for the Sacramento headquarters and over 60 field offices throughout the State. Although the Department does not exercise direct administrative authority over the California Department of Social Services (State DSS) and the county social services departments which are responsible for Medi-Cal eligibility determinations, it has a written Memorandum of Understanding with the State DSS with respect to eligibility standards, and it is the appellate body for potential recipients who are denied eligibility.

c. The Managed Risk Medical Insurance Board (MRMIB)

Created as an independent agency in 1990 to advise on strategies for reducing the numbers of those without health care insurance and to administer programs established for that purpose, MRMIB currently administers the Healthy Families Program, Aid to Infants and Mothers, and the Major Risk Medical Insurance Program.[121] The Board has three members. Its Chairman is appointed by the Governor and the other two members are appointed by the Legislature.[122]

d. The California Medical Assistance Commission (CMAC)

CMAC was established in 1982 to contract with hospitals wishing to provide services to Medi-Cal beneficiaries and ensure that sufficient beds are under contract to serve the Medi-Cal population. As summarized above, CMAC also negotiates payment rate contracts for Medi-Cal services with the State's five County Operated Health Systems and with the 17 plans providing services in the two Geographic Managed Care counties. CMAC has seven appointed Commissioners. The appointments are for four-year terms: two appointments are made by the Senate, two by the Assembly and three by the Governor.

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[121] Until last year it also administered the Health Insurance Plan of California. See Section III-A-3-d above.

[122] Managed Risk Medical Insurance Board website: www.mrmib.ca.gov.

e. Department of Managed Care

Through the beginning of 2000, the Department of Corporations had oversight responsibilities over health insurance plans. All prepaid health plans were required to be licensed by the Department after demonstrating their capacity to perform (including a showing of both medical and administrative qualifications and experience). There had been considerable negative commentary about the performance of the Department with respect to regulation of the HMOs. As a result of 1999 legislation, a new Department of Managed Care was created to take over the regulation of health care service plans as of July 1, 2000.

f. The University of California Medical Centers

The governing body for the University of California Medical Centers is the University's Board of Regents. The Governor, Lieutenant Governor, Assembly Speaker, Superintendent of Public Instruction, President of the University and President and Vice President of the UC Alumni Associations are *ex officio* Regents. A current student is also selected by the other Regents to serve a one-year term. The other 18 Regents are appointed by the Governor for 12-year terms.[123] Each Medical Center hospital is headed by a Hospital Director who is appointed by a committee with representatives from the hospital staff, from the Dean's Office in the School of Medicine and from the campus Chancellor's Office.

3. LOCAL ADMINISTRATIVE STRUCTURE

In California's governmental structure, counties are political subdivisions of the State, responsible for administering many State programs at the local level pursuant to rules established by the Governor and the Legislature. While organizational structure varies, the powers of a county can only be exercised by its Board of Supervisors or under the Board's authority. Unlike the separation of powers that characterizes the federal and state governments, the Supervisors exercise both legislative and executive authority, not only setting policy and controlling the county budget, but also acting as the administrative heads of county departments and programs.[124]

County health departments are normally administered by a Director appointed by either the Supervisors or their Chief Administrative Officer and responsible to them for the activities of the department. However, although the county health departments are responsible for the health care programs of their counties, many do not themselves operate the health care facilities providing the services for those programs. As illustrated in the following Section III-D, many counties have established independent public agencies or contracted with other public entities to administer various parts of their health care programs, including county hospitals, and a number have privatized part or all of their health care operations.

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[123] UC Regents website at: www.ucop.edu/regents/regents.html.

[124] See California State Association of Counties' website at: www.csac.counties.org.

The 74 Health Care Districts are independent special districts formed in accordance with Health and Safety Code Section 32000 *et seq.* They are created by a vote of the electorate and are governed by elected boards of directors (normally five in number).

4. OPERATIONAL CONTROL

The federal government follows a middle course with respect to administrative control of the programs it funds. Although supplying almost one-half of the financing for Medi-Cal, the federal Health Care Financing Administration (HCFA) neither administers the program (as it does the Medicare program for seniors) nor follows the "hands off" block grant approach (instituted for major federal social service programs as part of the welfare reforms of the 1990s). Instead, the Medi-Cal program is administered by the State Department of Health Services (State DHS) operating within the parameters of a detailed federal statute and lengthy HCFA regulations.[125] Similarly, the Healthy Families Program (HFP) is administered by a state agency, the Managed Risk Medical Insurance Board (MRMIB), although the State's plan for the operation of HFP required federal approval.[126] [Implementation of a number of the Commission's Recommendations would require HCFA waivers to secure needed flexibility in State/county use of Medi-Cal funds, especially Disproportionate Share Hospitals (DSH) funding.[127]]

Operational control of California's public health care system is a complex mixture. The federal government exercises its control over Medi-Cal and other federally-supported programs only indirectly through statutory and regulatory provisions and oversight. Separate state agencies administer managed care Medi-Cal and the Healthy Families Program through contracts with local insurers, plans and providers. For the medically indigent uninsured, the large counties administer their own separate programs, while the small counties contract with the State Department of Health Services to administer the health care programs in their areas.

In the large counties, the State contracts separately in each county for the managed care portion of the Medi-Cal population. In the Two-Plan Model and County Organized Health System (COHS) counties, the State DHS generally contracts with the Local Initiative or the COHS entity which, in turn, contracts with plans and providers (including county facilities) to supply health care services to the recipients. The Local Initiatives and COHSs are operated independently of the county Departments of Health Services, although most of their governing boards are appointed by the county Boards of Supervisors. For the two Geographic Managed Care counties, the State DHS contracts

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[125] Code of Federal Regulations, Title 42, Chapter IV, Subchapter C, Parts 430-56.

[126] See Section II-C-2-b above.

[127] See, e.g., the Los Angeles County Section 1115 waiver summarized in Section III-D-3 below. Many states have been required to secure Section 1115 and other federal waivers for various programs. See Laura Summer, *State-Subsidized Health Insurance Programs for Low Income Residents: Program Structure, Administration and Costs*, The Commonwealth Fund, Improving Health Care Coverage and Affordability series (April 1998), p. 3.

with Healthy San Diego in San Diego County and directly with a number of plans in Sacramento County. (See Section III-D below.)

In the 34 smaller counties, the State DHS administers the Medi-Cal program directly. In addition, DSH, Proposition 99 and SB 12 emergency room funding go directly to private providers bypassing county control. For HFP, MRMIB contracts directly with private and public insurers and plans to provide coverage for the recipient children.[128]

The counties remain responsible, under Welfare and Institutions Code Section 17000, for maintaining the safety net for California's large uninsured population. Although the large counties either provide or contract for the health care services they make available to the uninsured in discharge of their Section 17000 responsibilities, such health care operations function with minimal oversight by the State -- despite the fact that they are primarily (and in some counties completely) supported by State Realignment and Proposition 99 funding. As set forth in Section III-A-6-b above, 34 of the smaller counties contract with the State DHS to provide services to their medically indigent uninsured populations pursuant to the County Medical Services Program.

Coordination of public programs with private organizations and programs is often minimal. Public agencies lack comprehensive information about the amount and nature of the services being provided or available in their own areas.

5. CONCLUSION

As summarized above, California's publicly-funded health care system consists of one large and many separate smaller programs enacted by the federal and state governments over the years, underlain by a pre-existing county-provided "safety net" which has no secure financial underpinning. There is no comprehensive organizational structure and no effective leadership being exercised on the issue of providing a common level of eligibility and service for low income Californians on a state-wide basis. The result is the costly, unequal and incomplete "system" that exists today -- despite the high level of spending in the State on health services for the poor.

Only the Governor and the Legislature clearly have the authority and the responsibility to make state-wide reforms in the State's publicly-funded health care system.

The solutions to the existing inadequacies in this system lie primarily within the purview of the Governor and the Legislature. The federal HCFA bureaucracy has neither the expertise nor the mission to provide such leadership at the State level. At the local level, although the counties have the statutory safety net responsibility, their finances are controlled by the State and they have no mechanism for establishing and maintaining statewide standards for eligibility and services.

In contrast, the Governor and the Legislature unquestionably have the power to deal with public health care's most pressing problems. The Legislature sets the rules for eligibility

[128] HFP eligibility determinations are done by MRMIB staff in Sacramento. See Section III-A-3-a above.

and level of service. The Governor, and the Legislature to a lesser extent, appoint the administrators who run the state-wide programs. It is well within the missions of the State Health and Human Services Agency and the State Department of Health Services, led by gubernatorial appointees, to play a strong leadership role in reforming the system state-wide. County safety net programs can certainly be integrated into a reform program through the fiscal, statutory and regulatory authority of the State.

Accordingly, the Governor and the Legislature have full authority to pursue the reforms advocated by the Commission in the following Part IV of this Report: streamlined enrollment procedures, simplified eligibility standards, consolidation of present programs, seeking more flexibility in the use of federal funds, and extending coverage to a maximum number of the medically indigent uninsured.

D. COUNTIES: Descriptions of Seven Large County Health Care Systems

As indicated above and in this section, there is great variety in the health care programs provided by California's 58 counties. This section of the Report summarizes the present public health care programs in seven of the State's largest counties (whose total population comprises almost 60% of the State total): Alameda, Fresno, Los Angeles, Orange, San Diego, San Mateo and Santa Clara Counties. These counties were selected so as to provide a representative sampling of the widely varying types of programs and administration that are in operation in the State's large counties.

1. ALAMEDA COUNTY

With the establishment of a new Hospital Authority to operate its county hospital and a Two-Plan Model for its Medi-Cal recipients, Alameda County has effectively separated the operation and administration of its public health care system from the direct supervision and control of its Board of Supervisors. Health care services are available to the indigent uninsured up to 200% of the Federal Poverty Level (FPL) with sliding scale contributions expected from those over 100%. A long range County objective is the full integration of its uninsured health care program into the Local Initiative to unify all of the County's services to the medically indigent.

County Overview

Alameda County's 1999 population of over 1.4 million made it California's seventh most populous.[129] The County's 1997 per capita income of $29,683 ranked it 13% above the statewide average of $26,218.[130] An estimated 12% of its population (170,000) was below the Federal Poverty Level (FPL) in 1993,[131] and approximately 16% of county residents were uninsured in 1997-98.[132]

Organization of County Health Care Services

The Alameda County Health Care Services Agency is the umbrella organization for all Alameda County health care services. The Agency has undergone a constant series of budget cuts over the last decade. In a recent cost-containment restructuring its six constituent departments were combined into three program areas (Medical Care, Behavioral Care Services and Public Health) resulting in both integration of services and cost savings. In addition, Alameda County has developed new governance structures and, by so doing, has shifted from a provider to a purchaser of direct medical care.[133]

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[129] California Department of Finance, *January 1999 County Rankings By Population*, on the Department's website at: www.dof.ca.gov/html/Demograp/Rankcnty.htm. The county population and rank data in the Co. Overview portion of following Sections III-D-2 through III-D-7 are all from this same website location.

[130] California Department of Finance, on the Department's website at: www.dof.ca.gov under the California County Profiles in the Financial and Economic Data section. Also the source of the per capita income data for the following six county sections (see note 129 above).

[131] Medi-Cal Policy Institute, *Medi-Cal County Data Book* (July 1999), p. 6. Again, the source of the percentage below FPL data in the following six county sections (see note 129 above) at various pages.

[132] Lucien Wulsin Jr., Ari Shofet & Jan Frates, *Clinics, Counties and the Uninsured* (October 1998), p. 10. To distinguish this report from other reports by Wulsin and co-authors, the word "Clinics" will appear in all *op. cit.* references to it. As with the other unattributed data in the following county sections, this report is the source of the uninsured resident data (see note 129 above).

[133] Presentation to the Commission by David J. Kears, Director of the Alameda County Health Care Services Agency on March 29, 1999. See the Agency home page on the County website at: www.co.alameda.ca.us/health/index.htm.

At the center of the County's health care service delivery system is the recently created Alameda County Medical Center Hospital Authority, an independent authority exclusively dedicated to the administration of the County Medical Center (the former county hospital system). The 11-member Board of the Authority is appointed by the County Board of Supervisors. On July 1, 1998, the governance, operations and maintenance of the County's hospitals and clinics were transferred to the Hospital Authority under an agreement providing, *inter alia*, that the County will pay the Hospital Authority to provide the bulk of its indigent care services.[134] (The Authority also contracts with the County's Local Initiative to provide Medi-Cal services.) County hospital workers have been transferred from the county civil service system to the new Authority. All children's health care services continue to be provided by the private non-profit Children's Hospital Medical Center of Northern California.

The Medical Center includes three hospital campuses and five community based ambulatory care centers. During the FY1997-98 the Medical Center had 379 licensed and staffed beds for inpatient care and provided medical care in over 333,000 outpatient and emergency visits.[135]

In addition, Alameda County has a strong network of private community clinics. There are 35 such clinics in the County, two-thirds of them having Federally Qualified Health Center certification. In 1996, the clinics had over 440,000 patient visits, a one-third increase from 1991.[136]

The Medi-Cal Program

The Alameda Alliance for Health is the Local Initiative in the County's Two-Plan Model for its Medi-Cal managed care beneficiaries; the commercial plan is Blue Cross. The Alliance had 75% of the approximately 100,000 Medi-Cal enrollees at the end of 1998. The Alliance's provider network includes all County and community health centers and all major Medi-Cal hospitals, as well as a number of smaller private providers. The Alliance provides, in addition to regular medical services, a 24-hour nurse line, transportation to appointments, and a number of preventive care information programs. Operating since January 1996 in partnership with local private health care providers, the Alliance is governed by an independent Board of Governors with representatives from both public and private providers as well as Medi-Cal beneficiaries.[137]

The Alliance is also the Community Provider Plan for the Healthy Families Program and had enrolled over 2,600 children in the Program by January 2000 (well over half of total County HFP enrollment of 4,850).[138]

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[134] County of Alameda Summary Financial Information Statement (January 31, 1999), pp. 19 & viii.
[135] *Ibid.*, p. 20.
[136] Wulsin, Shofet & Frates (Clinics), *op. cit.* note 132, p.13.
[137] Alameda Alliance for Health, *1998 Fact Sheet*, pp. 1-2.
[138] Managed Risk Medical Insurance Board, *op. cit.* note 80.

The Indigent Uninsured

All uninsured County residents with incomes below 200% of FPL are eligible for the County's indigent health care program. Sliding scale fee contributions are expected for those with incomes between 100% and 200% of FPL.[139] The full scope of Medi-Cal services are available, provided they are delivered within the network of County Medical Center facilities and county-supported clinics.[140] Specialty care is delivered at the Medical Center or, if necessary, by private providers on a fee-for-service basis.[141]

The County's Medically Indigent Care Reporting System reports to the State show a heavy trend during the 1990s toward a more outpatient-centered delivery of care, as follows:

- a 54% increase in outpatient visits between 1991-92 and 1995-96,
- a 46% decrease in emergency room visits between 1993-94 and 1995-96,
- a 25% decrease in inpatient days between 1992-93 and 1995-96.[142]

In 1998-99, of the health care services provided to the uninsured at the County Medical Center and the community clinics, 57% were for outpatient care, 34% for inpatient services and 7% for emergency services.[143]

Financing

In 1997, total Medi-Cal managed care funding was $103 million in capitation payments to the Two-Plan providers.[144] For 1998-99, Alameda County budgeted $62 million for care to the indigent uninsured.[145]

As with all county health care programs, the vast bulk of the financing for the County system comes from federal and state sources. An Urban Institute study, focusing on Highland Hospital (the County's principal hospital facility), provides the following financial analysis: For the 1993-94 through 1997-98 fiscal years, Highland Hospital had an average annual operating deficit (basically expenses less patient fees) of over $138 million. Nearly all (95%) of that annual deficit was covered by federal DSH funds and state subventions (Realignment and Proposition 99). If the County's Section 17000 indigent care responsibilities are considered to be funded by Realignment,

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[139] Wulsin, Shofet & Frates (Clinics), *op. cit.* note 132, p. 10.
[140] The Highland and Children's Hospitals are the two largest Medi-Cal providers in Alameda County and also the principal providers of services to the uninsured. They are the only DSH hospitals in the County. However, the great bulk of the uncompensated hospital care is provided by Highland; under 10% of Children's Hospital patients do not eventually qualify for Medi-Cal or some other publicly-supported health care program. Jack A. Meyer et al, *The Role of Local Governments in Financing Safety Net Hospitals: Houston, Oakland, and Miami*, the Urban Institute, Assessing the New Federalism series, Occasional Paper Number 25 (June 1999), pp. 29-30.
[141] In 1997-98, private hospitals received $16 million in DSH payments to subsidize their services to the uninsured. Wulsin, Shofet & Frates(Clinics), *op. cit.* note 132, p. 13.
[142] County of Alameda, *op. cit.* note 134, p. 2.
[143] Wulsin, Shofet, & Frates (Clinics), *op. cit.* note 132, p. 10.
[144] Medi-Cal Policy Institute, *op. cit.* note 131.
[145] Wulsin, Shofet, & Frates (Clinics), *op. cit.* note 132, p. 10.

Proposition 99, Disproportionate Share Hospitals funding and the County General Fund, such spending for those five fiscal years averaged $124 million with just $2.6 million (2%) coming from the County. As the Institute concludes, "what California has, in essence, is a state/federally funded system of county hospitals."[146]

The County's community clinics exhibit the same dependence on federal funding. In 1996-97, those clinics had revenues and expenses of approximately $56 million, a 46% increase from 1991. During that same period, clinic Medi-Cal revenue doubled, but County reimbursements for services to the uninsured increased only slightly -- topping out at $7.5 million (13% of total clinic revenue) in 1998-99.[147]

Future Prospects

There is a broad consensus in the Alameda medical community on the need for continued reform efforts to improve the health care delivery system for the medically indigent. The County has plans to expand its Healthy Families Program/Medi-Cal enrollment outreach efforts and increase coverage for low wage workers (especially among its large immigrant population). As indicated above, however, unless the County is willing to change its fiscal approach to health care, such outreach and increased coverage efforts will have to be financed from the limited existing fiscal resources available to the County Health Care Services Agency. In addition, as federal support for mandatory cost-based reimbursement to Federally Qualified Health Centers (FQHCs) is terminated, pursuant to the provisions of the 1997 Balanced Budget Act, the County's community clinic network will face a severe financial squeeze if State FQHC support is not maintained at present levels.

One particularly encouraging recent development for the County was an offer by a physician group to treat all AIDS patients on a fixed-cost basis and a similar offer from another physician group to treat all patients in the final states of renal disease. Such arrangements would take those high-cost patients out of the general financing pools and greatly facilitate the problem of overall cost control.

As in many areas, Alameda County has experienced an on-going controversy concerning privatization -- in particular over the possibility of closing Highland Hospital and transferring its caseload to private sector hospitals (some of which have excess capacity). Advocates of such privatization have asserted that it would result in lower costs and improved quality. Defenders of the present public hospital system, including Highland's 3500 unionized employees, deny that privatization would improve quality or cost-effectiveness. They express the fear that there would be a loss of the safety net mission in carrying out the County's Section 17000 mandate if services were contracted out to private facilities.[148]

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[146] Meyer *et al.*, *op. cit.* note 140, pp. 32-34.
[147] Wulsin, Shofet, & Frates (Clinics), *op. cit.* note 132, p. 13.
[148] Meyer *et al.*, *op. cit.* note 140, p. 35.

A longer range objective of the Health Care Services Agency is to include the indigent uninsured and other uninsured populations in the Local Initiative and to consolidate their care with the Medi-Cal program.

2. FRESNO COUNTY

Having closed its County Hospital, Fresno County is no longer a provider of health care services. Medi-Cal managed care services are provided through a Two-Plan Model with no Local Initiative and two commercial health plans as the only options. The County contracts with the non-profit Fresno Community Hospital to provide services to the indigent uninsured. With its hospital-based system, Fresno County was second only to Los Angeles County in the amount of federal Disproportionate Share Hospitals funding received in 1997-98.

County Overview

Fresno County's population of just under 800,000 ranks it tenth in size in California. It is the only agricultural county included in this Report. Fresno's average annual per capita income in 1997 of $19,179 is the lowest of the seven counties covered -- 27% below the State average. In 1993, an estimated 28% of its population was below the Federal Poverty Level.[149]

Organization of County Health Care Services

Fresno is a Two-Plan Model county for Medi-Cal recipients. The Fresno County Model is unique because both of its plans -- Health Net, and Blue Cross CaliforniaCare Health Plan -- are commercial plans; there is no public Local Initiative. During 1998, the average monthly Medi-Cal enrollment in the two commercial plans totaled just over 116,000.[150] Blue Cross dominates the Healthy Families Program (HFP) enrollment for Fresno County with over 70% of the County's 5,584 enrollments at the start of 2000.[151]

The County contracts with the Fresno Community Hospital to provide health care services to low income individuals not eligible for Medi-Cal or HFP. Approximately 18,700 such persons received services in 1999.[152]

Transformation of Fresno Community Hospital

For many years Fresno County operated its own County Hospital which, in addition to its County obligations, had a major teaching responsibility through its affiliation with the

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[149] See notes 129-32 for the sources of the data in this paragraph.
[150] Medi-Cal Policy Institute, *op. cit.* note 131, p. 25.
[151] Managed Risk Medical Insurance Board, *op. cit.* note 80.
[152] FAX from the Clerk of the Board of Supervisors (February 29, 2000).

University of California at San Francisco (UCSF) School of Medicine. The Hospital was a large (over 400 beds), old, poorly equipped facility with a level-one trauma and burn center. Over the years the Hospital did constant battle with various officials over fire and safety code violations, earthquake standards and accreditations. It was also in a continuous struggle with other County priorities for scarce funds, which led to problems ranging from a lack of adequate equipment and supplies to a poor quality of key administrative personnel.

With the increasing budget constraints and the prospect of decreased federal Disproportionate Share Hospitals (DSH) funding, the situation at the County Hospital became ever more critical. With the advent of Medi-Cal managed care on the horizon, as well as the substantial oversupply of hospital beds in the area, Fresno's private hospitals became more and more interested in serving Medi-Cal recipients. The combination of all these factors gave rise to a realization that the County Hospital was in jeopardy and that a new approach to serving the medically indigent population had to be planned.

NEW APPROACHES*

Babies First

Fresno Healthy Start is a project dedicated to reducing high infant mortality rates in Fresno County by providing prenatal services and information to pregnant women. This consortium of community members and health providers is run by the County's Department of Community Health, and is using a federal grant to pay for a media campaign to make people aware of the services available.[153]

Fresno Community Hospital was a non-profit, community-based, inner city hospital situated in the downtown area a short distance from the County Hospital. The Community Hospital also had a very large Medi-Cal and uninsured low income clientele but was, like all hospitals in the area, over-bedded and in serious need of planning a new future for itself. In contrast to the County Hospital, Fresno Community Hospital was better funded and had a community-based Board of Directors, a superior physical facility, and a more skilled professional and administrative staff.

A variety of civic, governmental and medical leaders from the community came together for what became a multi-year process of deliberation and planning around the central question of what forms of cooperation, collaboration and restructuring of the providers for Fresno's medically indigent population would most benefit the community as a whole.

What ultimately emerged was a proposal to merge the County Hospital and Fresno Community Hospital in a planned multi-year transition resulting in a single, newly remodeled medical center and the phasing out of the old County Hospital. The final agreement between the Community Hospital and the County included a complete transfer of both the County's Medi-Cal caseload and its uninsured indigent care responsibilities in

[153] Nzong Xiong, *Babies First Aims to Lower Fresno County's Infant Mortality*, Fresno Bee (June 3, 1999), p. B-6. Available for a charge through the Archives file on the Bee website at: www.fresnobee.com.

accordance with performance standards set by the agreed contract. Also included in the agreement were the development of a brand new trauma and burn center at the remodeled hospital and the transfer of the UCSF teaching program with an increased emphasis on more primary care training.

This creative project was agreed to in 1997 and is now in its third year of implementation. It is considered to be an overall success with significant improvement for patients, staff and the Fresno community as a whole.

Financing

With respect to Medi-Cal managed care, in 1997 Fresno County's two private plans received approximately $86 million in capitation payments. In DSH allocations, Fresno received $76 million for 1997-98 -- the second highest allocation in the State despite the number of counties with much larger populations.[154]

For the uninsured, the County's contract with the Fresno Community Hospital calls for the Hospital to receive substantially all of the County's Realignment and Proposition 99 health care funding. In 1998-99, the Community Hospital received just over $14,450,000 in Realignment and $2.5 million in Proposition 99 funds.[155]

Model for the Future?

Fresno's example of cooperation and consolidation among similar community-based health care services is a model for combining public values and private practices. Fresno County has voluntarily left the role of public provider and assumed instead the role of health policy leader within the community. The County now concerns itself with maximizing efficiency, performance and results rather than with the task of maintaining a large and antiquated hospital facility in a radically changing medical market place. In its reciprocal shift, the Fresno Community Hospital has taken on the role of a fully integrated provider for the Medi-Cal and uninsured indigent populations with the job of applying private sector best-management practices, resources and planning to what had traditionally been a government responsibility.

If Fresno's total privatization approach is successful over the long-run, it may very well be a model for other counties no longer willing and able to operate major health care facilities and programs within their county structures -- although the focus on hospital-based services may not be a feature other counties will wish to emulate.

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[154] Medi-Cal Policy Institute, *op. cit.* note 131, p. 128.

[155] The balance of the County's Realignment health funding of $35 million went to public health activities. Approximately $200,000 (8%) of the Proposition 99 funds went to other private hospitals and physicians. Telecoms of Commission staff with the Financial Officer of the County's Human Services System (May 3 & 4, 2000).

3. LOS ANGELES COUNTY

Los Angeles County's massive public health care system is the second largest local system in the United States. In 1998-99, the County Department of Health Services budget exceeded $2.5 billion, and total public health care spending in the County was more than double that amount. The nation's largest Medicaid-only managed care plan is operated by the County.

In 1995-96, the County experienced a fiscal crisis, largely due to a projected $600 million deficit in its health care budget. To help solve this funding shortfall, the County was able to obtain additional federal funding as part of a five-year Medicaid Demonstration Project (which included a Section 1115 Waiver). That Project called for the County to shift its health care delivery system away from its heavy dependence on hospital-based care in the direction of sharply increased clinic-based outpatient care. The County has substantially reduced its hospital beds and increased ambulatory care, but has not been able to meet all of the goals originally called for by the Project. With the five years running out, the County is currently involved in a protracted negotiation with the federal government for an extension of the Project period.

County Overview

Los Angeles County's population of almost ten million makes it the nation's largest and exceeds that of 42 states.[156] The 1997 average per capita income of $25,719 was just below the State average. Almost 24% of the County's residents were below the Federal Poverty Level (FPL) in 1998, approximately 18% were Medi-Cal recipients (1.7 million),[157] and an estimated 30% were uninsured (2.7 million).[158]

Public health care expenditures for the County are equally awesome. For Medi-Cal alone, 1997 total expenditures were almost $4.8 billion.[159] For the uninsured, the County itself is the main provider. In 1996-97 there were approximately 800,000 recipients of health care services at a total cost to the County of $720 million.[160] Thus total Los Angeles County expenditures on publicly-funded health care in that year exceeded $5.5 billion.

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[156] The County has almost 30% of California's population. Medi-Cal County Policy Institute, *op. cit.* note 131, p. 42.

[157] Lucien Wulsin Jr., Ari Shofet, Sepi Djavaheri & Jan Frates, *Counties, Local Initiatives & Clinics,* materials prepared for the 1999 Insure the Uninsured Conference, p. 9. To distinguish this report from other reports by Wulsin and co-authors, the words "ITUP Conf." will appear in all *op. cit.* references to it.

[158] See notes 129-32 for the sources of the unattributed data in this paragraph.

[159] Medi-Cal Policy Institute, *op. cit.* note 131, p. 42.

[160] Wulsin, Shofet, Djavaheri & Frates (ITUP Conf.), *op. cit.* note 157, p. 9.

Organization of County Health Services

For Medi-Cal managed care, Los Angeles County uses a Two-Plan model. L.A. Care Health Plan, the Local Initiative, does not itself contract for health care services. Instead, it contracts through Plan Partners, a consortium of six commercial and Medi-Cal-only HMOs and the Community Health Plan (CHP), the County's own managed care plan (the nation's largest Medicaid-only plan).[161]

Although L.A. Care Health Plan considers preserving the County's own system of safety net hospitals and clinics to be a "key component" of its mission, L.A. Care is separate from the County structure. Established by special statute in 1994 (SB 2092), L.A. Care's 13-member Board of Governors has only four members from the County. The other nine members represent primarily providers (five members) and also include a Plan Partner representative, a consumer advocate and a member-consumer. In addition, L.A. Care has established a strong network for community input and support. It has 11 regional advisory committees (composed of advocates, members and providers) and an umbrella Executive Community Advisory Committee which has the authority to place motions directly on the agenda of the Board of Governors.[162]

The competing commercial plan is Health Net which subcontracts with Molina Medical Centers and Universal Health Plan for providing part of its services to Medi-Cal recipients.

At the center of the Los Angeles County system for providing health care to the County's uninsured medically indigent population is the County's Department of Health Services (LA DHS) whose Director is appointed by and directly responsible to the County Board of Supervisors. LA DHS is one of the largest health care providers in the United States with over 21,000 employees[163] and 1997-98 "final actual" revenues of $2.25 billion.[164]

Services for the uninsured are provided by LA DHS primarily through its own facilities. In 1998, the Department operated six county hospitals and 29 health centers. It also operated seven health centers jointly with private organizations and had public/private partnership contracts for 122 clinic sites.[165] The LA DHS health care system operates on an open basis - all uninsured County residents are eligible to receive services. Those with incomes over 133% of FPL are expected to pay on a sliding scale basis.[166]

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[161] *Ibid.*, p. 8.
[162] L.A. Care Health Plan, *1998 Annual Report,* pp. 2 & 16-18.
[163] County of Los Angeles -- 1997-98 Final Budget, p. 105.
[164] Mark Finucane, Director, LA DHS, *Letter to the Commission of November 6, 1998*, Attachment II, Exhibit C.
[165] *Ibid.*, Attachment II, p. 4. The number of health centers and clinics fluctuates depending on need, available funding and other factors.
[166] Wulsin, Shofet, Djavaheri & Frates (ITUP Conf.), *op. cit.* note 157, p. 9.

The Medi-Cal Program

Full scale implementation of Medi-Cal managed care in Los Angeles County commenced in 1998. Average monthly enrollment for that year was 800,000,[167] 60% in L. A. Care and 40% in Health Net.[168]

L. A. Care's private participating plans include Blue Cross, Care 1st Health Plan, Kaiser, Maxicare, Tower Health and United Health Plan. The seventh plan, the County's Community Health Plan (CHP), is a federally-qualified HMO and has expanded its provider network to include private physician medical groups.[169] L.A. Care's total provider network includes approximately 3,500 primary care physicians, 16 Federally Qualified Health Centers, 23 community clinics and 119 hospitals.[170]

Including those at subcontractors Molina and Universal, Health Net recipient members have access to approximately 2,000 primary care physicians and 6,500 specialists.[171]

Healthy Families Program (HFP)

Los Angeles County has by far the largest HFP enrollment in the State. As of January 2000, its 68,600 enrollees were 31% of the State total. (Orange County was second with under 8%.) The County's enrollment was running at about 4,000 per month. Among HFP's 10 Los Angeles plans, Blue Cross was the most successful in enrolling new HFP members with over 27,000 (almost 40%); the County's CHP was second with over 12,000 (18%); Health Net and Kaiser had 10,600 and 7100 respectively. L. A. Care and Molina were not effective competitors with only about 3,000 each. Hispanics were by far the largest ethnic group with over 60% of the County's enrollment; no other ethnic group had as much as 10%.[173] Clearly, there are many eligible children who remain to be enrolled, but it appears that

SUPPORT FOR CHILDREN

The Alliance for Children's Rights

The Alliance provides free legal services and social service referrals for children in foster care, homeless and runaway children, and those in need of adoptive families. The Alliance also works to resolve difficulties these children encounter in obtaining Medi-Cal, DentiCal or Healthy Families coverage and services. The Alliance's staff is certified to enroll children in those programs. In addition, The Alliance works to provide care continuity for Medi-Cal children with primary care physicians. In medical emergencies, The Alliance obtains expedited court approval for children's Medi-Cal services.[172]

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[167] Medi-Cal Policy Institute, *op. cit.* note 131, p. 43.
[168] *Ibid.*, pp. 42-43.
[169] Telecom of June 9, 2000, between Commission staff and the Office of Managed Care in the LA DHS Executive Office.
[170] L.A. Care, *1998 Annual Report*, p. 6.
[171] California Department of Health Services, *Medi-Cal newsletter*, Vol. 1, Issue 1 (September 1997), p. 2.
[172] The Alliance for Children's Rights, *1997 Annual Report.*
[173] Managed Risk Medical Insurance Board, *op. cit.* note 80.

present procedures and competition among the various plans is encouraging steady progress toward reaching HFP's potential.

The Indigent Uninsured

Important in understanding the context of Los Angeles County's programs for the uninsured is the Section 1115 Waiver which resulted from the County's 1995-96 fiscal crisis. At that time the County came perilously close to insolvency with a projected deficit of $1.2 billion, one-half coming from LA DHS. The former County CAO suggested the possibility of closing the health deficit by shutting down the LA County-USC Medical Center, the largest public hospital in the country, and laying off thousands of health care workers. To avoid such a draconian solution, the County, in conjunction with the State, was able to negotiate a Medicaid Demonstration Project for Los Angeles County, often referred to as the Section 1115 Waiver Project.[174] (Los Angeles is the only California county for which such a waiver has been granted.)

The Waiver agreement permits the County to obtain, *inter alia*, federal matching funds for outpatient care for the indigent. The match for Waiver funds, however, has to come entirely from County funds; the State does not provide financing for the Waiver program. The Waiver arrangement allowed the County to stabilize its immediate fiscal situation (with an infusion of an additional $364 million of federal money) in return for entering into a five-year reform program calling for a more than one-third reduction in hospital beds, a 50% increase in out-patient care, and better coordination with private sector facilities also providing services to the medically indigent.[175]

After the federal government approved the Section 1115 Waiver (and with State authorization secured as well), the County did begin to fund public/private partnerships for clinics and other private providers willing to contract to deliver outpatient care to the uninsured.[176] However, the LA DHS system for providing health care to the uninsured remains dominated by the six hospitals the County continues to operate and the inpatient-oriented revenue streams they generate. Two-thirds of uninsured indigent care continues to be for inpatient and emergency care[177] with the County still providing 85% of care to the uninsured in County hospitals.[178]

This continued reliance on hospital-based care creates on-going financial problems for LA DHS. DSH funding is still fundamentally based on the amount of services provided to Medi-Cal recipients and the uninsured in hospital facilities. As competition from private hospitals has increased due to Medi-Cal's favorable inpatient reimbursement rates (when DSH allocations are included) and LA DHS's Medi-Cal service revenue has been

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[174] See Mark Baldassare, Michael A. Shires, Christopher Hoene & Aaron Koffman, *Risky Business: Providing Local Public Services in Los Angeles County,* Public Policy Institute of California (2000), pp. 42-45.
[175] Wulsin & Frates, *op. cit.* note 24, pp. 14-15; Executive Summary of the Medicaid Demonstration Project (as revised on February 21, 1997), p. I-3.
[176] Wulsin, Shofet, & Frates (Clinics), *op. cit.* note 132, p. 25.
[177] *Ibid.*, p. 9.
[178] Finucane letter, *op. cit.* note 164, Attachment II, p. 3.

reduced as a result, the Department is losing and stands to lose even more of the state and federal funds on which it is heavily dependent.

Bureaucratic difficulties also contribute to the Department's problems. In addition to the inevitable bureaucratic inertia inherent in any organization the size and complexity of LA DHS, staff disruptions and reductions are also inevitable in any major shift toward an outpatient clinic-based system. (See discussion in "Prospects for the Future" below.)

THE CUTTING EDGE

Health Fair for the Homeless

LA DHS co-sponsors an annual Health Fair for the Homeless. Homeless individuals are offered medical services by service providers and nonprofit organizations, some of whom bring trailers, doctors and nurses. In 1999 more than 1,000 people received health screenings, referrals and information about other services for the poor. Numerous homeless persons had their teeth, blood pressure and hearing checked, and a number were screened for breast or prostate cancer, tuberculosis and HIV.[179]

As a result of these various pressures, changes in the pattern of health care for the uninsured have not all developed to the extent that had been projected at the time of the Section 1115 Waiver agreement. Impacted by the threatened closure of County facilities prior to the Waiver, outpatient visits to County hospitals were flat from 1991 through 1996, and visits to County clinics were down. Similarly, total inpatient days decreased 30%, and emergency room (ER) visits were down 17%.[180] Since the Waiver agreement came into effect, inpatient and ER services have continued to decline and there has been a substantial increase in private clinic-based services. However, hoped for expenditure reductions have not been achieved,[181] and, as pointed out above, the County's indigent care system continues to be focused on hospital-based services.

Financing

The annual budget of LA DHS is, obviously, an ultimate example of the complexities of public health care financing in the State of California. Total revenues for 1998-99 were $2,563,952,439 (including an SB 855 carryover from 1997-98 of over $150 million). The Department's estimated actual expenditures for the year of $2,325,489,236 left a difference of $238,463,203 as a carry over to 1999-2000. That level of revenues and expenditures made LA DHS the largest Los Angeles County department and the second largest local public health system in the nation.

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[179] Caitlin Liu, *Medi-Cal Help Offered to Homeless at Health Fair,* Los Angeles Times (June 10, 1999), p. B-3.

[180] Wulsin, Shofet, Djavaheri & Frates (ITUP Conf.), *op. cit.*, note 157, pp. 9-10.

[181] See articles in local media, *e.g.*, Jessica Toledano, *County Daunted by Task of Fixing Its Health System,* Los Angeles Business Journal (December 14, 1998), pp. 1 & 53 and Nicholas Riccardi, *County Health Dept. Far Short of Savings Goal,* Los Angeles Times (December 9, 1998), p. B-1.

Federal funding (net of the County's Intergovernmental Transfers used by the State to match federal DSH funding) was the principal source of revenue for LA DHS, at $1,447,251,207 accounting for over 56% of total 1998-99 revenue, broken down as follows:

DSH (SB 855) (including a carryover of $153,267,000)	$333,706,155	(13.0%)
SB 1255	306,200,000	(11.9%)
Medi-Cal Fee-For-Service services (including Targeted Case Management (TCM)]*	357,572,438	(13.9%)
Section 1115 Waiver Project	$146,323,357	(5.7%)
Community Health Plan*	85,409,344	(3.3%)
Medicare	106,044,008	(4.1%)
Other Federal funding [including grants]*	111,995,905	(4.4%)

As these numbers emphasize, LA DHS received a very large amount of federal funding for hospital-based services.[182]

The next largest source was State funding, which provided $660,584,730 (over 25% of revenue), broken down as follows:

Realignment (Sales Tax & Vehicle License Fees)	$405,452,377	(15.8%)
Proposition 99 (including Health Education)	68,577,000	(2.7%)
Other State Funding (Grants & for inspections and other services performed)**	186,555,353	(7.3%)

Other revenue sources included:

Intercounty Transfers (services for other county departments) & Miscellaneous	$218,366,999	(8.5%)
Insurance & Self Pay (from recipients)	78,424,503	(3.1%)

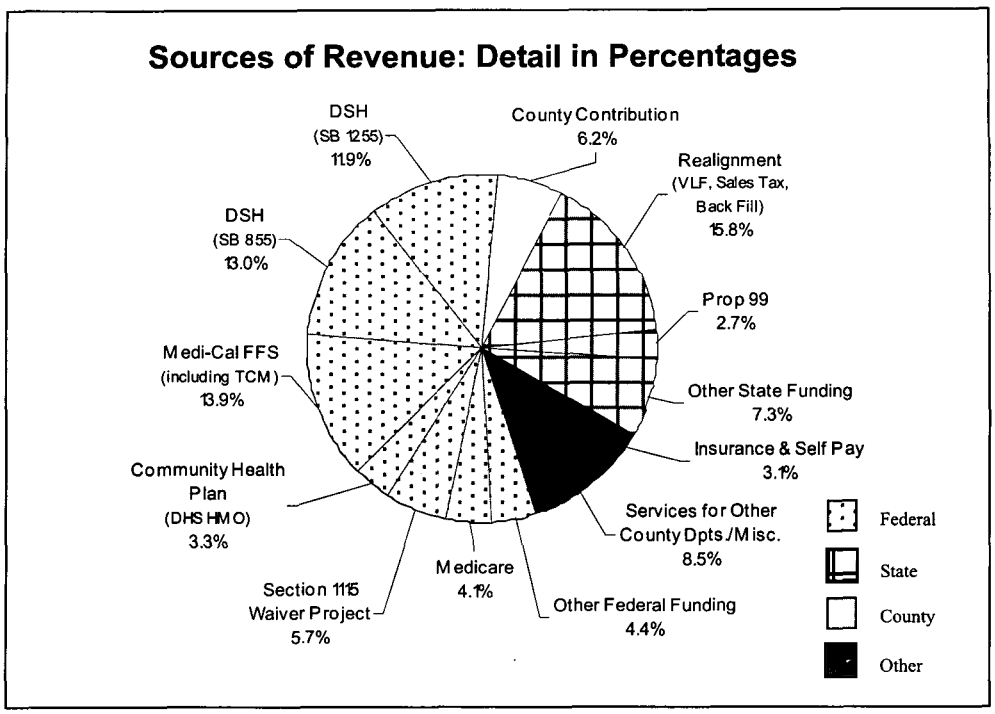
The share of the County from its other revenue sources was:

Net County Contribution	159,325,000	(6.2%)[183]

* These federal items include the State's matching share of approximately 50%.
**This item includes mental health funds which are approximately 50% federal funds.

[182] The SB 855 plus SB 1255 total of $639,906,155 was 25% of the Department's revenue for the year.
[183] Budget numbers provided to the Commission by the Los Angeles County Department of Health Services, Office of Director Mark Finucane (DHS Finance, Controller's Division) in March 2000. By way of comparison, 14 years previously in 1984-85, the federal and State revenue roles were reversed. Total health revenues (including a modest amount for preventive programs as well as for health care) were $1.1 billion, of which $265 million was federal (24%), $524 million from the State $(48%), and $111 million from county property taxes (10%). County of Los Angeles Data Guide 1984-85, p. 32.

Table 17



SOURCE: Los Angeles County Department of Health Services (see note 183)

Prospects for the Future

Prognostications about the future of indigent health care in Los Angeles County cannot be made with any degree of assurance. For the long term, efforts by the County to consolidate its uninsured programs with Medi-Cal have so far found no support in either Sacramento or Washington. The County is also interested in the possibilities of providing for the uninsured through some type of combination of public and private efforts.[184]

In the meantime, a variety of important developments are taking place. A particularly high profile conflict concerns the main building in the LA County/USC Medical Center which was badly damaged in the 1994 Northridge earthquake and needs to be rebuilt. A long-continuing controversy has arisen with respect to the size of the new hospital. Pointing to the County's commitment to reduce the number of beds in County hospitals called for in the 1115 Waiver agreement, a four to one majority of the Board of Supervisors voted to limit the size of the replacement structure to 600 beds. The Supervisor in whose district the Medical Center is located has pushed vigorously for a 750-bed replacement hospital. This controversy has escalated to the Sacramento level. Language in the 1999-2000 state budget documents favoring the 750-bed solution was

[184] Wulsin, Shofet, Djavaheri & Frates (ITUP Conf.), *op. cit.* note 157, p. 10.

removed from the final budget by the Governor with a line-item veto.[185] Compromise proposals for the construction of a 60- to 100-bed facility in the East San Gabriel Valley have not, as yet, been agreed to and a final resolution remains in doubt. This problem illustrates the inherent difficulties involved in having operational decision-making for health care facilities and programs made directly by elected officials.[186]

Another significant development has been the effort of the Union of American Physicians and Dentists to organize the LA DHS's 800 physicians. In May, 1999, the Union effort was successful by the heavy majority of 341-182. The County's health care system restructuring and resulting lay-offs (which included some physicians) were important issues in the election. As a Los Angeles Times writer summarized their position, "Union leaders vowed to slow down the health department's restructuring efforts, to focus more on patient care, and to try to replace lost emergency room and support staff."[187] Obviously, LA DHS plans have to take into account the fact that its already largely unionized workforce now includes even its highest paid employees -- County physicians.

Most basically, the County's Section 1115 Waiver agreement was for a five-year period ending in 2000. As indicated above, the LA DHS budget would be severely strained without the Waiver funding. However, also as pointed out above, the County has, while making substantial progress, so far fallen well short of the original goals set forth in the Waiver agreement calling for reducing hospital beds and increasing outpatient care.[188] County officials and the Administration have been in constant negotiations over whether and how the Demonstration Project and the Section 1115 Waiver should be extended.[189] It seems likely that some agreement for an extension will be reached. What form that arrangement will take, particularly in light of the developments set forth in the preceding two paragraphs, remains to be seen.[190]

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[185] See numerous articles in the local media, e.g., Dan Morain & Tina Daunt, *Budget Used to Pressure Supervisors on Hospital,* Los Angeles Times (June 15, 1999), pp. B-1 & 2, Josh Meyer & Max Vanzi, *Wilson Sides With County on Hospital,* Los Angeles Times (August 22, 1998), pp. B-1 & 2 and Josh Meyer, *Fight Over Hospital Plan Escalates,* Los Angeles Times (July 12, 1998), pp. B-1 & 6.

[186] In 1996, the Supervisors rejected a proposal by its own Health Crisis Manager to set up a new health authority, composed of seven recognized health experts, to formulate county-wide health care policy for presentation to the Board of Supervisors on a simple yes/no basis (similar to the federal base closure procedure). Recommendation to the Board on "Governance of the Department of Health Services" from the Health Crisis Manager (December 12, 1995).

[187] Nicholas Riccardi, *L.A. County Doctors Vote Decisively to Unionize,* Los Angeles Times (May 29, 1999), pp. A-1 & 22.

[188] See articles cited in note 185 above.

[189] See, e.g., articles by Nicholas Riccardi in the Los Angeles Times: *How a Once-Positive Prognosis Turned Dire* (June 4, 2000), pp. B-1 & 7, *County Ups the Ante in Health Care Funding Fight* (May 24, 2000), pp. B-1 & 10 and with Richard Simon, *County to Press U.S. to Extend Waiver* (May 6, 1999), pp. A-1 & 26. One item the County is pushing to include is a joint effort with the Los Angeles Unified School District and other school districts in Los Angeles County to develop a program of Medi-Cal/Healthy Families Program enrollment plus school-based or school-linked preventive and primary care health services at district schools.

[190] The Public Policy Institute study cited above concludes that county government has no clear solution to the problem of funding health care services for its large uninsured population. Baldassare, Shires, Hoene & Koffman, *op. cit.* note 174, p. xi.

4. ORANGE COUNTY

Like Fresno County and San Diego County, Orange County does not provide health care services directly. All Orange County Medi-Cal recipients are served by CalOPTIMA, California's largest COHS. CalOPTIMA neither provides services itself nor contracts directly with providers. Rather, it operates through contracts with 12 health care networks – both HMOs and Physician-Hospital Consortia which are unique to Orange County. CalOPTIMA is also exceptional in providing managed care not only to the family recipient population but also to the elderly, blind and disabled (including long-term care eligibles), to foster care families, and to higher income recipients who make partial payment for the services they receive. The County's programs for the uninsured are, for the most part, hospital-based and are operated on a contracted risk pool basis which is very cost-effective, but limited in scope by the low level of funding provided.

County Overview

Orange County's population of almost 2.8 million makes it the third most populous county in the State. Although Orange County is a relatively affluent community with average per capita income of over $30,000 in 1997 (14% above the State average), and has only 12.6% of its population under the FPL, almost 250,000 residents rely on Medi-Cal for their health care coverage,[191] and nearly 335,000 residents 18 and older (17%) are without any type of health insurance coverage.[192]

Organization of County Health Care Services

The County's Medi-Cal program is operated by CalOPTIMA, the State's largest County Organized Health System (COHS). CalOPTIMA is a separate entity, governed by its own Board of Directors (who are, however, appointed by the County Supervisors). The seven-member Board includes one Supervisor and three provider representatives. All of the Board meetings are public.[193] CalOPTIMA provides services through contracts with 17 licensed health care networks -- both HMOs and Physician-Hospital Consortia (PHCs). The PHCs were designed and created in connection with the establishment of CalOPTIMA and are unique to Orange County.[194] Like other Medi-Cal managed care programs, CalOPTIMA receives its revenue from the State on a capitated full risk basis through contracts negotiated with the California Medical Assistance Commission.

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[191] Medi-Cal Policy Institute, *op. cit.* note 131, p. 64.
[192] Orange County Health Needs Assessment Project, *Orange Countywide Health Needs Assessment, Spring Report, 1999, Executive Summary, Community Health: Working the Puzzle,* p. 21. See notes 129-32 for the sources of the unattributed data in this paragraph.
[193] Mary Dewane, CEO, CalOPTIMA, *Remarks to the Commission* on June 15, 1999.
[194] Wulsin, Shofet, Djavaheri & Frates (ITUP Conf.), *op. cit.* note 157, insert following p. 12.

For the uninsured, in 1998-99 the County's Medical Services for Indigents (MSI) program provided health care services to approximately 17,000 eligibles. The County also provided services to an additional number of users with funding from the State's California Healthcare for Indigents Program (CHIP), from the California Children's Services program (CCS) and from the Emergency Medical Services Fund (EMSF) using court fines.[195] These programs are the responsibility of the County's Health Care Agency which operates the MSI program through a contractual agreement with a shared risk pool which funds services by hospitals, physicians, community clinics and other providers. Services for the CHIP and EMSF programs are likewise provided through contractual arrangements.[196] The Health Care Agency does not itself provide health care services.

The Medi-Cal Program

CalOPTIMA is a public/private partnership which began full operations in October, 1995, after an extensive four-year period of study and input from numerous interested groups and individuals. As a COHS, CalOPTIMA serves the entire Orange County Medi-Cal population. Unlike other Medi-Cal managed care models which serve primarily children and families, CalOPTIMA also provides services to the aged, blind and disabled and long-term care eligibles, to the foster care population, and to recipients whose higher income levels require that they pay for part of the cost of the services received.[197] CalOPTIMA's method of payment to its participating plans is a modified fee-for-service (FFS) system -- initial payments are made based upon an FFS schedule followed by final reconciliation payments that spread all remaining capitated funds in a proportional allocation.

Since its inception, CalOPTIMA has developed a very broad provider network, which includes about 500 primary care physicians, more than 2,000 specialists, 24 hospitals and 18 community clinics. The University of California's Medical Center in Orange (formerly the county hospital and now the teaching hospital for the UC Irvine Medical School) and the non-profit Children's Hospital of Orange County have traditionally served Medi-Cal patients and continue to be CalOPTIMA'S largest providers.[198]

Addressing local concerns, CalOPTIMA's procedures provide protections for the County's traditional and safety net providers. As in most other Medi-Cal managed care programs, CalOPTIMA's auto assignment policy targets traditional and safety net hospitals as well as community clinics in an effort to ensure the success and viability of the County's safety net. In addition, CalOPTIMA requires that participating PHCs and HMOs include a minimum number of traditional safety net physicians in their networks.[199]

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[195] Hope Hagen, Medical Services for Indigents Interim Program Manager, County of Orange, Health Care Agency, *Letter to the Commission (and enclosure) of March 31, 2000.*
[196] Wulsin, Shofet, Djavaheri & Frates (ITUP Conf.), *op. cit.* note 157, p.11.
[197] *Ibid.*, insert following p. 12.
[198] Dewane, *op. cit.* note 193.
[199] Wulsin, Shofet, Djavaheri & Frates (ITUP Conf.), *op. cit.*, note 157, insert following p. 12.

CalOPTIMA is also the largest participating plan for children enrolled in the Healthy Families Program (HFP). Its total HFP enrollment exceeded 8,000 in January 2000, over 42% of the County total. Blue Cross was second with just over 5,000 (26%); other plans were all less than 2,000.[200]

The Indigent Uninsured

Orange County's Medical Services for Indigents (MSI) program involves the County and the private medical community in a public/private partnership to deliver health care to the County's indigent population. Health care decisions are made through collaboration among the Healthcare Association of Southern California (representing hospitals), the Orange County Medical Association, the Coalition of Orange County Community Clinics, other safety net providers, local government and non-profit groups.[202] For 1999-2000, eligibility for MSI is limited to legal resident adults with incomes at or below 200% of the Federal Poverty Level needing care necessary to protect life, prevent significant disability, or prevent serious deterioration of health.[203]

*****AN IDEA THAT WORKS*****

School Health Van

Healthy Tomorrows is a program using two mobile medical units (vans) to provide health screenings for poor children at Santa Ana's elementary schools through a partnership between the Children's Hospital, the County's Social Services Agency, Cal State Fullerton and the Santa Ana USD. Immunization rates have doubled since the beginning of the program in 1993. The staff also discusses preventive education with parents, and refers students from low income families to hospitals or physicians who provide free or low-cost services.[201]

The County has a master MSI contractual agreement, negotiated annually, with 25 hospitals which receive funds for their services through a shared risk pool. The County pays a negotiated fixed amount into the shared risk pool which is shared among the providers in proportion to the amount of services actually provided.[204] The County does not have contracts with community clinics or individual physicians, who participate in the MSI program on an "any willing provider" basis. In 1999-2000, 62% of the funding for the MSI Agreement was budgeted

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[200] Managed Risk Medi-Cal Insurance Board, *op. cit.* note 80.

[201] Seema Mehta, *Health Care Van's on a Roll*, Los Angeles Times, Metro Section of the Orange County edition (June 21, 1999).

[202] Hagen, *op. cit.* note 195.

[203] Orange County Health Care Agency, *Medical Services for Indigents, Provider Manual* (5th edition, July 1998), p. 7.

[204] Using this fixed-cap arrangement, Orange County was able to negotiate an inpatient daily rate of $816 in 1993-94. The comparable figure for that year in Los Angeles County's county hospitals was $1300 per patient day. See Reason Public Policy Institute, Privatization Database, *County Health Care -- Best Practices/Case Studies,* p. 2. On the Institute's website at: http://privatization.org/Collection/SpecificServiceAreas/Health--local.html.

for hospital services (including emergency and outpatient services), 24% for physicians, 9% for pharmacy providers and 2% for the community clinics.[205]

Despite the seeming extensiveness of this network, the County is among the lowest in California with respect to health care funding, ranking second to last in per capita spending for the approximately 21,000 individuals it has served annually during the past three years. The County's program tends to be an episodic, emergency care-based system[206] with minimal follow-up care or preventive services being provided.[207] The total County budget for the MSI Agreement in 1999-2000 was $42 million (primarily State-supplied Realignment funds with only $7.4 coming from the County General Fund).[208] A recent actuarial study estimated that the cost of treating Orange County's indigents is roughly $80 million.[209]

Financing

With respect to Medi-Cal, CalOPTIMA's 1998-99 budget was in excess of $500 million. The Disproportionate Share Hospitals (DSH) program also provided 1997-98 funding to Orange County hospitals of over $60 million.[210] The biggest recipient of that funding was the University of California Irvine Medical Center. However, in the judgment of the University, the DSH funds received by it still fall far short of covering its shortfall in costs for providing services to the uninsured.[211]

As indicated above, the County's programs for the uninsured are at a much more modest level. Out of a total 1999-2000 County Budget of $3.9 billion, the County allocated approximately $311 million to all types of health programs (including mental health, substance abuse, correctional health and traditional public health programs). Of that amount, about $83 million went to programs specifically for the low income uninsured (including MSI, EMSF, CCS, preventive programs for mothers and children, and dental health). In 1999-2000, the adopted budget for the MSI Agreement was $42 million, of which $26 million was for hospitals, $10 million for physicians and $4 million for pharmacy providers.[212]

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[205] Hagen, *op. cit.* note 195.

[206] For example, the Orange County Health Needs Assessment Project reports that in 1998 over 18% of all Orange County residents had used hospital emergency room services during the last year. *op. cit.* note 192, pp. 9 & 13.

[207] Dewane, *op. cit.* note 193. Despite the low level of funding and the emphasis on hospital-based care, a study conducted by the Center for Studying Health Sustem Change found that uninsured Orange County residents had a relatively easy time obtaining medical care. There was disagreement, however, as to the proper interpretation of the Center's findings. Peter Cunningham and Peter Kemper, *Ability to Obtain Medical Care for the Uninsured -- How much Does It Vary Across Communities?,* published in the Journal of the American Medical Association, Volume 280, No. 10 (September 9, 1998), p. 921 *et seq.*

[208] Hagen, *op. cit.* note 195. A portion of County funds provides a match for Realignment funds and a portion is discretionary. Janice Wirth, Division Manager, County of Orange, Health Care Agency, *Letter to the Commission of November 12, 1998, Attachment*, p. 1.

[209] Dewane, *op. cit.* note 193.

[210] Medi-Cal Policy Institute, op. cit. note 131, p. 65.

[211] Dewane, *op. cit.* note 193.

[212] Hagen, *op. cit.* note 195.

Future Prospects

For CalOPTIMA, a 1999 adjustment in the State's reimbursement rates put Orange County's Medi-Cal program on a much sounder financial footing.[213] With respect to funding levels for services to the uninsured, prospects are overhung by the fact that since its 1994 bankruptcy Orange County has been faced with a substantial debt load ($2.72 billion in 1996-97).[214] However, the County has worked with local health care providers and other interested parties to develop a list of strategic health priorities in the anticipation of the receipt of some portion of the County's tobacco settlement funds. Those discussions are continuing.[215]

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[213] The adjustment enabled CalOPTIMA to make an average 19% adjustment in its payments to providers. Peter Warren, *CalOPTIMA Funding Boost to Increase Fees for Providers,* Los Angeles Times (September 9, 1999).

[214] State Controller's Office, *Orange County page of Government at a Glance -- Counties.* On the Controller's website at: www.sco.ca.gov.

[215] What proportion of the tobacco settlement funds should be spent on health care services is an issue of considerable controversy in Orange County. A coalition of health care activists has been circulating initiative petitions calling for 80% of such funds to be spent on anti-smoking programs and health care. A majority of the Supervisors appear to favor spending most of the money on jail expansion and debt repayment. The issue may not be settled in time to avoid a vote on the proposed initiative in November. Peter Warren, *Health Initiative Gains Steam,* Los Angeles Times Orange County edition (April 25, 2000).

5. SAN DIEGO COUNTY

As with Fresno and Orange Counties, San Diego County provides no health care services directly. The largest Geographic Managed Care (GMC) county, San Diego's Medi-Cal services are provided through contracts with seven health plans. Services to the uninsured are provided through a large and long-established network of community clinics which use associated inpatient and emergency room facilities. The County itself provides only a modest amount of funding to the clinic network, and as mandatory federal support for cost-based reimbursement to the community clinics ends, the clinics are facing a less secure financial future. The County is attempting, so far unsuccessfully, to increase efficiency and reduce costs by integrating its uninsured indigent programs into its GMC system. A more immediate positive development is the decision of the County to spend its entire share of the tobacco settlement proceeds on health programs.

County Overview

San Diego County's 1999 population of over 2.8 million made it the State's second largest. The County's 1997 per capita income of $24,965 was 5% below the state average, but it was nevertheless also below the State average (17.4%) in the percentage of its population living below the Federal Poverty Level (16.3%). Approximately 645,000 County residents (27% of those under 65) are without health insurance. Located on the Mexican border, the County is also faced, as are many California counties, with the challenge of having substantial numbers of undocumented immigrants who are not eligible, beyond emergency care, for public assistance with respect to the costs of their health care.[216]

Organization of the County's Health Care System

Like Fresno and Orange, San Diego County operates no county hospital or clinics and delivers no health care services directly.

For Medi-Cal, the Geographic Managed Care (GMC) model was implemented by the County in late 1998 for providing services to Medi-Cal managed care beneficiaries (in a program entitled Healthy San Diego). Under GMC, the County contracts with seven health plans to deliver those services.[217]

Health care services for uninsured indigents are provided primarily through County Medical Services (CMS) -- a managed care program operated by the County's large

[216] See notes 129-32 for the sources of the data in this paragraph.
[217] Medi-Cal Policy Institute, *op. cit.* note 131, pp. 78-79.

network of community clinics, physicians and other private providers, private hospitals and the University of California San Diego Medical Center.[218]

The Medi-Cal Program

As indicated above, 1998 saw a major reorganization of Medi-Cal in San Diego. Previously, managed care health services had been delivered by a group of health plans pursuant to contracts with the State in formats no longer in use. In 1998, the Community Health Group and Sharp Health Plan were by far the largest of those plans, enrolling an average monthly total of 88,749 out of a total enrollment of 118,521.[220]

NEW HEALTH CARE FUNDING

Tobacco Settlement Proceeds

San Diego County is well ahead of most other counties in its planning for the use of funds from the tobacco litigation settlement for health care. It is anticipated that the County will receive nearly $945 million from the tobacco settlement by the end of 2025. In February, 1999, the county supervisors voted unanimously to use the settlement funds for health programs, and authorized the director of the Health and Human Services Agency to develop a policy for spending the anticipated revenue.[219]

In late 1998, after a long planning effort involving a broad spectrum of community stakeholders, the County began the implementation of Healthy San Diego, one of the State's two GMC programs. Seven health plans were awarded contracts to provide health care services for Medi-Cal beneficiaries: Blue Cross, Kaiser, Community Health Group, Sharp Health Plan, HealthNet, UCSD Health Plan and Universal Care (all but two of which had previous State contracts).[221] All of San Diego's Medi-Cal managed care enrollees will be required to enroll in one of these seven plans.[222] A federal Section 1915(b)(1) waiver was required for the implementation of the GMC program.

With respect to the Healthy Families Program (HFP), San Diego County had over 16,000 enrollments in January 2000. Almost 70% of those enrollments were in the Sharp Health Plan (just under 6,000) and the Community Health Plan (over 5,000). Blue Cross with 2,300 enrollments (14%) was the only other plan with over 1,500 enrollments.[223]

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[218] Robert K. Ross, M.D., former Director of the San Diego County Health and Human Services Agency, *Letter to the Commission of October 16, 1998.*

[219] Ronald Powell, *Tobacco Settlement Funds to go to Health*, San Diego Union Tribune (February 17, 1999), p. B-1. As of the end of March, only one other county (Alameda) had taken similar action. National Journal Group Inc., *op. cit.* note 86, Item 4 of the March 21, 2000 issue. Since that time, Los Angeles County has followed suit; and the issue is under active consideration in a number of other counties as well.

[220] Medi-Cal Policy Institute, *op. cit.* note 131, p. 79.

[221] *Ibid.*

[222] *Ibid.*, p. 78.

[223] Managed Risk Medical Insurance Board, *op. cit.* note 80.

The Indigent Uninsured

The County Medical Services (CMS) program is a managed health care delivery system organized to provide health services to San Diego's medically indigent uninsured population. San Diego County was a pioneer in capitated delivery models; the County has had capitated contracts with community clinics since the 1970s.[224] The CMS program provides services to persons in urgent need of medical care for serious health problems who are U.S. citizens or legal residents, 21-64 year old permanent residents of San Diego County, and poor but not categorically eligible for Medi-Cal.

The CMS program is based on primary outpatient care delivered, along with case management, through the community clinics. Emergency care and acute hospital inpatient services (including nursing home and rehabilitation facilities) are provided by other facilities. CMS also has an Emergency Room Diversion Program established by the community clinic system to educate and redirect patients from emergency room (ER) utilization for non-emergency services. In 1997-98, the CMS program provided the following services (to over 20,000 recipients): 15,450 ER episodes, 22,743 hospital days and 79,184 outpatient visits, of which 45,600 were clinic visits and 33,584 were specialty physician and outpatient hospital visits.[225]

Financing

In 1997, prior to the start of San Diego's GMC program, Medi-Cal managed care expenditures totaled over $100 million. For the 1997-98 fiscal year, San Diego hospitals received just over $60 million in federal Disproportionate Share Hospitals (DSH) funding, ranking only sixth in the State with respect to the receipt of such funds.[226]

In that year, San Diego County allocated approximately $39 million of the Realignment and Proposition 99 funds it received from the State for uninsured indigent care. Of that amount, approximately $36 million went to the CMS program ($29.4 million from Realignment and $6.4 million from Proposition 99). Of the $36 million, the bulk went for hospital, physician and pharmacy services ($29.8 million) and the balance to clinic outpatient services ($5.6 million).[227]

Future Prospects

San Diego County faces substantial future funding pressures in its publicly-financed health care programs. With respect to Medi-Cal, in addition to the previously programmed reductions in DSH funding, the elimination of mandatory federal support for cost-based reimbursement for Federally Qualified Health Centers could be a substantial

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[224] Wulsin, Shofet, Djavaheri, & Frates (ITUP Conf.) , *op. cit.* note 157, p. 13. See San Diego County Board of Supervisors, *Policy A-67, Background section.*
[225] Ross letter, *op. cit.* note 219, pp. 1-2.
[226] Medi-Cal Policy Institute, *op. cit.* note 131, pp. 79 & 129.
[227] Ross letter, *op. cit.* note 219.

problem for San Diego's community clinics if State support is reduced since 92% of their funding comes from the federal and state governments. This dependence on outside funding results from the decreasing level of County General Fund spending on indigent health care (which dropped, as State Realignment funding increased, from over $25 million in 1990-91 to $4 million in 1996-97).[228]

The County Health & Human Services Agency had hoped to alleviate some of these difficulties by integrating its CMS program into Healthy San Diego (in effect, creating a unitary County health care program),[229] although some of the participating plans and providers were opposed to such integration and the plan has not, as yet, moved forward. A more concrete positive development for the future prospects of San Diego County's indigent health care programs is the action of its Board of Supervisors, highlighted above, in earmarking all of the County's tobacco settlement funds for health programs.

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[228] San Diego County Regional Healthcare Advisory Council, *Partners in Health: Report of the National Panel on Public-Private Strategies to Improve the Health of San Diegans, Background section* (February 1998), p. 11. On the County's website at: www.co.san-diego.ca.us/cnty/bos/sup2/RHAC/intro.html.
[229] Wulsin, Shofet, Djavaheri & Frates (ITUP Conf.), *op. cit.* note 157, p. 14.

6. SAN MATEO COUNTY

San Mateo County is one of the State's most affluent; the County's per capita income is more than 40% above the State average and its percentage of population below the Federal Poverty Level (FPL) is the State's second lowest. For Medi-Cal managed care enrollees, mainstream services are made available; San Mateo's long-established County Organized Health System (COHS) includes as providers all local hospitals and 90% of the County's physicians. For the uninsured, the County operates newly modernized facilities (including a county hospital being completely reconstructed to current standards). Coverage is provided for those with incomes up to 200% of FPL, but enrollment fees and small co-payments are required from all recipients.

County Overview

San Mateo County had a 1999 population of 723,000 making it the 13th largest county in California. Its per capita income of just under $40,000 was 52% above the statewide average, and the County's percentage of population below the FPL (6.9%) was the second lowest in the State. Nevertheless, in 1998 approximately 21% of the population (over 120,000 people) had no health care insurance coverage.[230]

Organization of County Health Care Services

San Mateo County provides health care for its Medi-Cal population (averaging just under 43,000 in 1998) through its COHS -- the Health Plan of San Mateo (HPSM).[231] The entire Medi-Cal program is operated on a capitated, managed care basis by HPSM which has its own independent Board of Directors (appointed by the County Supervisors but with a majority of provider and user representatives). HPSM's financial support comes entirely from the State on a capitated basis negotiated annually with the California Medical Assistance Commission.

The San Mateo County Health Services Agency oversees the County's services to the uninsured, including the County Health Center (the county hospital) and nine County-operated regional clinics. Care is provided up to 200% of FPL, but enrollment fees and small co-payments are required from all recipients. The Health Services Agency is directly responsible to the County Board of Supervisors.

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[230] See notes 129-32 for the sources of the data in this paragraph.
[231] Medi-Cal Policy Institute, *op. cit.* note 131, p. 87.

The Medi-Cal Program

Recognizing the inadequacy of San Mateo County's Medi-Cal program in the 1980s, representatives of the medical community and county leaders persuaded the County Board of Supervisors to establish a San Mateo Health Commission which, in turn, created HPSM in 1987. Using an open panel approach (any qualified provider may participate), the Plan now has contracts with 90% of the physicians practicing in the County, as well as all 12 regional hospitals, more than 100 pharmacies and roughly 250 non-physician providers of all sorts.[233] As a result, recipients are in the medical "main stream," receiving care from the same providers as other health care users (and minimizing the Medi-Cal stigma often attached to such publicly-funded health care). Unlike many of California's Medi-Cal managed care programs, HPSM is open not only to children and families, but also the elderly and disabled, and, for emergency care, to undocumented immigrants.[234]

EFFECTIVE OUTREACH

Health Van

The County operates a mobile health van to facilitate providing care to the uninsured population (including, in particular, immigrants who may be fearful of using government facilities). Along with the medical services provided in the van (treatment for injuries and illnesses, and tests for TB, high blood pressure, and Sexually Transmitted Diseases including HIV), outreach workers are available to counsel patients and refer them to local medical centers if further care is needed.[232]

HPSM's revenues come from the State on a capitated bases ranging from 95% to 99% of the fee-for-service (FFS) equivalent. HPSM is at full risk for providing the full range of Medi-Cal services to its members. This includes those whose eligibility is determined retroactively, giving the Plan no incentive to try to avoid adverse risks. Primary Care Physicians (PCPs) and hospitals are organized into risk pools. The PCPs are paid on a capitated basis and the hospitals per diem (both risk-adjusted). With respect to both, there is a 10% hold-back that can be used to fund deficits in the risk pools. Any surplus is divided between the providers and HPSM. The Plan has never run a deficit (and uses its share of the surplus for program enhancements). Specialists are paid on an FFS basis at substantially higher than standard Medi-Cal rates. HPSM's administrative expenses comprise 8% of its revenues.[235]

Program enhancements implemented by HPSM include its Prenatal Care Program (resulting in a more than 50% reduction in hospital maternity stays, particularly those connected with premature and low birth weight babies), HealthRide (providing taxi service when the normal transportation mode is not available), an expanded Drug

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[232] Julia Sommerfeld, *Mobile Unit Salves Health Care Woes*, San Mateo County Times (March 1, 1999), p. 1.
[233] California Association of Health Insuring Organizations, *Emphasizing the CARE in Medi-Cal Managed Care* (undated), p. 9.
[234] Michael Murray, HPSM Executive Director, *Remarks to the California Citizens Budget Commission* (March 29, 1999), pp. 4-5.
[235] *Ibid.*

Formulary, numerous outreach activities and support for a number of local projects.[236] HPSM also provides an Ombudsman program designed to augment the Plan's existing problem-solving system with an independent legal counselor who responds to member problems prior to the initiation of the formal complaint and grievance process.[237]

The Indigent Uninsured

The San Mateo County Health Center is the core of the County's health care program for the medically indigent uninsured. The Center is in the midst of a major program of construction and renovation. A new 227-bed inpatient facility, a Nursing Wing and an Outpatient Clinic were completed in 1998. A Diagnostic & Treatment Center is due for completion in 2000 and remodeling of the 1954 hospital building a year later.[238] The Health Center received the highest score of any Bay Area hospital surveyed by the Joint Commission on Accreditation of Health Care Organizations, a national accreditation agency.[239] The County's outpatient clinics have certification as Federally Qualified Health Clinics.[240]

Under the County's Medically Indigent Adult program, only those not eligible for Medi-Cal with incomes below 200% of FPL are eligible to receive services from County facilities. The County charges a $150 enrollment fee up front ($250 for families, plus $50 for each family member over three). In addition, recipients pay small co-payments (e.g., $5 for office visits and prescriptions). Income determination is based on self-declarations; there is no verification procedure. In 1998, County facilities provided service to approximately 18,000 users.[241]

Financing

With respect to Medi-Cal funding, HPSM's total 1997 expenditures were in excess of $80 million for managed care and approximately $59 million for FFS costs (all but $13 million of that for long-term care). Disproportionate Share Hospitals payments to San Mateo hospitals that year totaled only $5 million.[242]

San Mateo County's adopted budget for 1998-99 included $252 million for all health programs, 30% of the total County budget.[243] The Health Center's budget for that year was $87.5 million. (Of the much smaller 1994-95 health care spending for the uninsured,

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[236] *Ibid.*, p. 6.
[237] California Association of Health Insuring Organizations, *op. cit.* note 233, p. 10.
[238] Information provided to the Commission by the San Mateo County Health Services Agency and Health Center. The Center's website is: www.health.co.san-mateo.ca.us/smchc.html.
[239] San Mateo County, *1998 Annual Report*, p. 8.
[240] Wulsin, Shofet, Djavaheri & Frates (ITUP Conf.), *op. cit.* note 157, p. 19
[241] See notes 238 & 239.
[242] Medi-Cal Policy Institute, *op. cit.* note 131, pp. 86-87.
[243] San Mateo County, *op. cit.* note 239, p. 4 (*1998-99 San Mateo County Approved Budget).*

60% went for outpatient care, 26% for hospital inpatient care and 12% for emergency services.[244])

Future Prospects

For Medi-Cal, HPSM's management is most concerned about receiving adequate revenue in the future. The State's reimbursement level lags behind the rates paid to providers and does not reflect quality improvement monitoring.[245] Legislative mandates of various sorts are also a problem as are the relatively uncontrollable increases in drug costs. At the federal level, restrictions on the upper limit of payments are also a serious problem (particularly because of high administrative, housing and labor costs in the San Mateo area).[246]

San Mateo County's initial Healthy Families Program enrollment procedures were not effective. At the end of 1998, the program had less than 400 enrollees.[247] That number had increased to approximately 1,800 by January 2000.[248] Similarly, the County will need to expand the enrollment in its program for the uninsured if that program is to have a major impact on the large number of residents (over 120,000) who still have no health coverage.

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[244] Wulsin, Shofet, Djavaheri & Frates (ITUP Conf.), *op. cit.* note 157, p. 18. Two years later the uninsured programs received $16 million in Realignment funds and $2.5 million from Proposition 99. *Ibid.*
[245] The 10% increase in Medi-Cal reimbursement rates proposed by the Governor in his May Revision to the state budget for 2000-01 (including $67 million for managed care plans) should help to alleviate this problem. See note 17.
[246] Murray, *op. cit.* note 234, p. 7.
[247] Managed Risk Medical Insurance Board, *op. cit.* note 80. See Wulsin, Shofet, Djavaheri & Frates (ITUP Conf.), *op. cit.* note 157, pp. 18 & 19.
[248] Managed Risk Medical Insurance Board, *op. cit.* note 80.

7. SANTA CLARA COUNTY

With the bulk of the Silicon Valley within its borders, Santa Clara County has a high per capita income level and a low percentage of its population under the Federal Poverty Level (FPL). The County's new state-of-the-art county hospital is the centerpiece of its health care system for the medically indigent. The new hospital, together with seven satellite regional clinics, provides the bulk of the care for the indigent uninsured (covered up to 200% of FPL) and has provider contracts with both plans in the County's Two-Plan Model for Medi-Cal managed care beneficiaries.

County Overview

Santa Clara County's 1999 population of 1.7 million made it California's fourth largest.[249] The 1997 per capita income of $37,856 was 44% above the statewide average; and only 9% of its residents were living below the FPL, a lower rate than all but six other counties. Nevertheless, at that time almost 16% of the County's population (264,000 people under age 65) had no health insurance coverage.[250]

Organization of County Health Care Services

For Medi-Cal managed care, Santa Clara is a Two-Plan Model county with the Santa Clara Family Health Plan (SCFHP) as its Local Initiative, and Blue Cross CaliforniaCare Health Plan as the commercial plan. The SCFHP is governed by a County Health Authority whose 11-member Board of Directors is appointed by the Board of Supervisors (and includes two Supervisors).

Santa Clara County's health care programs for the indigent uninsured are operated under the direction of the Santa Clara Valley Health and Hospital System (SCVHHS), created in 1993 through the consolidation of the Health Department and the Santa Clara Valley Medical Center (VMC), the county hospital.[251]

The VMC provides outpatient, inpatient and emergency care. Specialized services include a trauma center, rehabilitation services and regional burn and poison information centers.

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[249] See notes 129-32 for the sources of the unattributed data in this paragraph.

[250] An April 26, 1999, article by Cindy Ling in The Business Journal of San Jose indicates that a recent study by the Community Benefits Coalition found that the then current uninsured level had dropped to 13%.

[251] Santa Clara County Executive, Office of Budget and Analysis, *County Government Handbook -- FY 1997* (December 1996), p. 3-8.

Outpatient services are also provided at seven satellite health centers located throughout the County -- a majority of them qualified as Federally Qualified Health Centers (FQHCs). Financed by a $258 million county bond issue, the Medical Center built a new, state-of-the-art 394-bed facility (the North Tower), completed in 1998, which now houses its principal facilities. The VMC is a teaching hospital, affiliated with the Stanford University School of Medicine.[253] Although most services for the uninsured are provided by the VMC, the County also provides funds to community clinics for providing such services, and will reimburse private providers for any specialty services not available through the VMC.[254]

USING THE SCHOOLS

Interagency Cooperation

SCVHHS (along with the Social Services Agency, and the Probation and Police departments) is involved in the School-Linked Services Program, an interagency cooperative model created in 1994. The Program operates at 13 school sites providing comprehensive health and human services to school children. [252]

The Medi-Cal Program

Pursuant to the Strategic Plan of the State DHS, all Medi-Cal enrollees are required to choose between SCFHP (the Local Initiative) and Blue Cross (the commercial plan), or are assigned to one of them. As a "safety net" provider, the County's VMC contracts with both plans.[255] During 1998, SCFHP had an average of over 38,000 enrollees and Blue Cross almost 30,000.[256]

Healthy Families Program (HFP)

Santa Clara County has not had great success in HFP enrollment. Its initial efforts, centered on the use of the County's welfare system workers, produced only 1,400 enrollments by the end of 1998.[257] Enrollment procedures were improved in 1999. However, enrollment of approximately 6,000 by January 2000 was still only 2.8% of total State enrollment[258] (far less than the County's 5% share of the State's total population[259]). Over 60% of County enrollment was in the County-operated Santa Clara Family Health plan -- almost the entire balance split between Blue Cross and Kaiser.[260]

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[252] *Ibid.* p. 3-7.
[253] *Ibid.*, pp. 1-16 & 3-11 - 3-13.
[254] Wulsin, Shofet, Djavaheri & Frates (ITUP Conf.), *op. cit.* note 157, p. 19.
[255] Santa Clara County Executive, *op. cit.* note 251, p. 3-12. See the Santa Clara Valley Health and Hospital System website at: http://claraweb.co.santa-clara.ca.us/agencies.htm.
[256] Medi-Cal Policy Institute, *op. cit.* note 131, p. 91.
[257] *Ibid.*, p. 90. Those initial efforts are described in a study done for the Kaiser Family Foundation. Renee Schwalberg *et al.*, *op. cit.* note 48, pp. 35-42.
[258] Managed Risk Medical Insurance Board, *op. cit.* note 80.
[259] Medi-Cal Policy Institute, *op. cit.* note 131, p. 123.
[260] Managed Risk Medical Insurance Board, *op. cit.* note 80.

The Indigent Uninsured

Santa Clara County maintains an "open door" policy at its health care facilities. All uninsured medically indigent residents with incomes up to 200% of the Federal Poverty Level (FPL), including both documented and undocumented immigrants, are able to receive health care services through the VMC and the community clinics. Sliding scale fee contributions are expected for those with family incomes over 100% of FPL. The full scope of Medi-Cal services are available. In 1996-97, there were approximately 60,000 users.[261]

Financing

Medi-Cal managed care payments to the Two-Plan participants for 1997 totaled $68 million.[262] Total federal Disproportionate Share Hospitals payments for 1997-98 were almost $60 million (of which the largest share went to the VMC).[263]

For FY1996-97, Santa Clara County spent $76 million on health care services for the indigent uninsured -- $62 million for care delivered at the VMC (the county hospital), $11.5 million for services at the county clinics, and the remaining $1.5 million for services at community clinics. Of the funds received by the VMC, $19 million came from Realignment and $6 million from Proposition 99.[264]

As with Los Angeles County, the budget numbers in Santa Clara County's *County Government Handbook -- FY 1997* are a good example of the complexities of California's health care financing. From the County's General Fund (over which the Board of Supervisors had discretionary control over only approximately 10%), SCVHHS expenditures of $245 million in 1997-98 were 20% of total expenditures. All health care expenditures, however, including federal and state subventions, totaled a far larger $592 million, 31% of total County spending, including almost $345 million for the VMC alone.

The VMC operates as a County Enterprise Fund. In theory, its revenue from fees and subventions should off-set all of its expenses. For 1997-98, however, its expenditures of $345 million exceeded revenues, necessitating a County subsidy of approximately 10%.[265]

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[261] The sliding scale fees for outpatients in the late 1990s were 10% of the charges for patients with incomes from 100 to 150% of FPL, 20% up to 175% and 30% up to 200%. Wulsin, Shofet, Djavaheri & Frates (ITUP Conf.), *op. cit.* note 157, p. 19.
[262] Medi-Cal Policy Institute, *op. cit.* note 131, p. 91.
[263] *Ibid.* Also see Santa Clara County Executive, *op. cit.* note 251, p. 3-3.
[264] Wulsin, Shofet, Djavaheri & Frates (ITUP Conf.), *op. cit.* note 157, pp. 19-20.
[265] Santa Clara County Executive, *op. cit.* note 251, pp. 1-16 & 3-1.

Future Prospects

It is difficult to predict the future course of Santa Clara County's public health care system. Programs for the medically indigent uninsured could be combined with Medi-Cal and Healthy Families and integrated into the Two-Plan model. Alternatively, the County may continue to operate its own uninsured system on a parallel track with the evolution of the federally-supported programs.[266]

8. CONCLUSION

As can be seen from these summaries of the seven county programs, there is no coherent pattern to California's locally-operated public health care system.

For the very low income population, the massive Medi-Cal program is administered by the State Department of Health Services, with state-wide contracting done separately (and confidentially) by the California Medical Assistance Commission (CMAC). However, the actual operation of managed care Medi-Cal is done primarily on the basis of county, not state or even regional geography. For San Diego, a Geographic Managed Care county, CMAC contracts directly with health plans who in turn contract with providers and enroll recipients. Orange and San Mateo are County Organized Health System counties, with single systems, one private and the other public, that contract with CMAC for their State reimbursement. The others are Two-Plan Model counties -- again organized very differently from each other: ranging from the county hospital-based programs of Los Angeles and Santa Clara Counties to the private non-profit hospital-dominated program of Fresno County.

The public health care programs of the seven counties summarized above confirm the state-wide pattern. For California's low income population, children and adults eligible for Medi-Cal fare by far the best. They are able to enroll in programs providing a broad range of services at little or no cost. Uninsured adults under 65 must rely on widely varying county programs that are underfunded and provide care primarily on an episodic basis without the preventive and follow up care that is available to most Californians.

Children fare by far the best in California's public health care system. Those from the lowest income families qualify for no-fee Medi-Cal. Above that level, children from families up to 250% of the Federal Poverty Level qualify for the Healthy Families Program (HFP) -- a separate, largely federally-funded program run on a state-wide basis by the independent Managed Risk Medical Insurance Board (MRMIB). Equally important, MRMIB spends over $20,000,000 annually on an advertising and outreach program to enroll eligible children in HFP (and Medi-Cal).

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[266] Wulsin, Shofet, Djavaheri & Frates (ITUP Conf.), *op. cit.* note 157, p. 20.

For those not qualifying for Medi-Cal or HFP, the county programs for the uninsured are the last resort. For such individuals, once again the counties vary widely. San Diego's program is based on its large network of community clinics. San Mateo's program charges a fee (regardless of income level) and low co-payments. The other counties provide varying levels of service at either primarily county facilities (Los Angeles and Santa Clara) or contracted facilities (Fresno and Orange) or both (Alameda). Most services in these five counties are done on an episodic, as needed basis (often through emergency room facilities) with little follow up and required payments, if any, arranged at the time services are provided.

The conclusions from these summaries are clear. In the counties covered, as in most parts of the State, California's federally-supported programs do provide a very large amount of low or no-cost Medi-Cal services to a large segment of the low income population (over five million annually for Medi-Cal alone). The other side of that coin is, of course, the sad fact that an even greater number of Californians do not qualify for these programs and are presently without adequate access to affordable regular health care coverage. They must rely, instead, on the episodic care available from county programs. In addition, there is a fundamental lack of fairness in the county-operated programs due to the wide variation among those county programs, making the level of care as dependent on geography as on medical urgency or financial need.

The great variations among the counties, and among the many categorical programs themselves, do offer an opportunity for amassing experience with different approaches and methods. However, the State lacks an effective and timely mechanism for developing a "best practices" consensus and using the lessons learned to advantage on a wide-spread basis. Moreover, there are large unproductive administrative costs in operating a system that is as divided, overlapping and conflicting as now exists. Such costs could be greatly reduced if a single, simplified program could be instituted state-wide, or even on a regional basis.

PART IV THE COMMISSION'S RECOMMENDATIONS: UNIQUE OPPORTUNITIES FOR PUBLICLY-FUNDED HEALTH CARE IN CALIFORNIA

Introduction

The Administration, the Legislature, the counties of California and the state's health care plans and providers have an exciting opportunity at this time to make an important difference in the lives of many of those who must rely on publicly-supported programs for their health care needs. With the state budget in surplus, decreasing unemployment, a strong economy and the availability of tobacco settlement funding, the Commission is convinced that high priority attention can and should be paid to the immediate improvement of our current system of publicly-funded health care. That system needs to be consolidated, simplified and expanded to provide affordable access to health care insurance for a maximum number of those Californians who currently lack that access.

Each one of the Commission's Recommendations has merit as a separate and distinct improvement in our present system of publicly-funded health care. However, they are interrelated and presented here as a package that will function most effectively if the Recommendations are implemented together as a complete reform program.*

Synopsis

Problems: California spends more than $25 billion annually in federal, state and local funds on a complex and conflicting array of publicly-financed health care programs. Despite this impressive level of spending, at present many low-income residents who are eligible for existing programs are poorly served, and there are still an estimated 7,300,000 Californians without health insurance, the great majority of them from low income "working poor" families with inadequate access to affordable health care. Nor is the State's present strong economy proving to be an effective overall solution to these problems. In recent years, in fact, the numbers of low income uninsured Californians have increased at the rate of better than 20,000 per month.

**As indicated in Part I above, this set of Recommendations does not cover California's mental health, preventive and long-term care public health programs. Those programs, and the proper balance among all public health programs, are of equal importance to those covered here. However, limitations of time and resources prevented them from being considered by the Commission and included within the scope of these Recommendations*

Recommendations: To create a truly comprehensive and cost-effective publicly-funded health care system in the State of California, the Commission strongly recommends that the State:

A. Promptly institute an aggressive program of streamlined enrollment procedures (*Recommendations 1-6*);
B. Adopt a single, simplified, income-based eligibility standard for all programs (*Recommendation 7*);
C. Consolidate existing programs into a unified publicly-funded health care system (*Recommendations 8 & 9*);
D. Seek more flexibility in the use of federal funding (*Recommendation 10*); and
E. Finance broader health care coverage for the uninsured, particularly for the working poor (*Recommendations 11 & 12*).

Discussion of Recommendations

A. Streamlined Enrollment Procedures

Problem: Large numbers of persons eligible for California's publicly-funded health care programs are not enrolled -- in large part due to complicated welfare-based enrollment procedures. Applicants have often been faced with a system that seemed to be designed as much for exclusion as for using its best efforts to get all eligible individuals enrolled.[267]

Example: Almost three-quarters of California's uninsured children are eligible for, but not enrolled in, California's publicly-funded health care programs.[268]

Example: Enrollment in Medi-Cal (the State Medicaid program providing health care to the very low income population) is normally processed by County social service workers primarily engaged in determining eligibility for welfare benefits.[269]

As the large number of eligible but unenrolled children and adults under 65 shows, lack of effective enrollment is a major cause of the large number of low income persons without health insurance in the State. Failure to enroll eligible individuals leaves them out of many preventive health programs, and can result in such persons later receiving expensive emergency care services that might have been avoided or provided at less cost in a routine outpatient procedure.[270]

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[267] See Section III-A-1-a above, particularly notes 43 & 48 and accompanying text.
[268] Schauffler & Brown *et. al.*, & etc., *op. cit.* note 95, p. 31.
[269] See Section III-A-1-a above, particularly the text between Notes 47 & 48.
[270] Estimates of the cost of treating uninsured individuals who come into emergency rooms each year range from $500 million to over $1 billion. Emelyn Rodriguez, *Health-care epidemic deepens,* California Journal (May 2000), p. 14.

A multi-pronged approach will be required to have a major impact on these enrollment problems, as set forth below. The Commission recommends that the State begin immediately to develop and implement a comprehensive program of more effective enrollment procedures, including the following specific steps:

Recommendation 1: Make enrollment procedures simple and user-friendly.

A number of efforts are currently underway along these lines. For example: The 1999-00 State Budget provided funds for substantially expanding the use of mail-in applications for health care programs. The present application form for children covers both children's Medi-Cal and the Healthy Families Program (HFP -- the State version of the federal Children's Health Insurance Program).[271] San Bernardino County uses a single-sheet application form for its County Medical Services program. Such practices need to be expanded and replicated statewide, and combined with the Commission's other reform recommendations set forth below, to achieve a truly effective, user-friendly enrollment process.

Recommendation 2: Increase the Medi-Cal period of continuous eligibility.

Increasing the span of eligibility for Medi-Cal to six months or one year, as permitted by federal law and already in effect for HFP,[272] would greatly reduce administrative expense and give preventive health programs an opportunity to operate more effectively.

Recommendation 3: Utilize non-welfare programs with maximum public contact for enrollment.

For example, with California's compulsory school attendance laws, the State's public and private school systems may offer the best opportunity for making sure that our low income population, at least during its school-age years, has access to publicly-funded health care programs -- including preventive programs -- as well as treatment for conditions requiring professional medical attention.[273]

Recommendation 4: Provide automatic initial eligibility for those who are presumptively qualified.

For example, it is estimated that almost one-half of the children participating in the Food Stamp Program and other federal supplemental food programs already meet income

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[271] See Section III-A-3-a above, particularly the text at note 79.

[272] See Section III-A-3-a above. This reform is included in the Governor's May Revision of the Governor's 2000-01 Budget (see note 46). The Commission strongly urges the Legislature to approve the Governor's recommendation in the 2000 legislative session.

[273] Consumers Union, *A Golden Opportunity -- Improving Children's Health Through California's Schools* (March 2000), contains a summary of current efforts to implement such a program as well as an extensive analysis of the problems and opportunities it affords. See also note 189 at the end of Section III-D-3 above.

requirements similar to those for Medi-Cal or HFP.[274] Subject to meeting legal residency requirements, they could be automatically enrolled in those health care programs.[275]

Recommendation 5: Minimize the welfare stigma.[276]

The modest financial participation of some recipients in HFP (based on income level) can help to create a sense of participation and ownership in that program. Similarly, a number of county health care programs find that some prefer to make modest payments rather than attempting to qualify for publicly-funded coverage.

Along these same lines, the Governor has suggested that the State seek a waiver from the federal government to give families with children eligible for Medi-Cal the option of enrolling instead in HFP, "especially if that choice eliminates the perception of stigma associated with receipt of public assistance benefits that may discourage those currently eligible from enrolling for health care coverage."[277] The Commission commends any such effort and supports its inclusion in whatever program of health care reforms is put forward by the Administration and the Legislature.

Finally, the participation of county Departments of (Public) Social Services in the Medi-Cal eligibility process should be limited to those being enrolled in the federal Temporary Aid to Needy Families program (or other welfare programs for whom public health care eligibility is automatic) in order to minimize the association of health care programs with the welfare system in the perception of potential enrollees. For the same reason, the Alameda Alliance for Health, L. A. Care Health Plan and a number of other county Local Initiatives avoid the use of the Medi-Cal name in their activities to assist in minimizing the stigma often associated with welfare-related programs. All counties should be encouraged to do the same.

Recommendation 6: Minimize legal immigrants' fears of using government health care programs.

The long-delayed 1999 Immigration and Naturalization Service regulation, clarifying that the receipt of health care benefits will not be considered in determining immigration status, should be aggressively publicized; and every effort should be made to insure that

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[274] *Ibid.*, p. 33; 100% Campaign, *Express Lane Eligibility: How California Can Enroll Large Numbers of Uninsured Children In Medi-Cal & Healthy Families* (February 2000), pp. 1 & 2. Nationally, the estimates are that almost three-quarters of all low income uninsured children are currently enrolled in programs operated by the United States Departments of Agriculture and Labor. Genevieve M. Kenney, Jennifer M. Haley & Frank Ullman, *Most Uninsured Children Are in Families Served by Government Programs,* the Urban Institute, Assessing the New Federalism series (December 1999), p. 1.

[275] There are privacy problems with this approach that will have to be resolved. Simply giving the names of free lunch recipients to the State for possible Medi-Cal/HFP enrollment would be in violation of current federal law. A coalition of non-profit organizations, entitled the 100% Campaign (website: www.100percentcampaign.org), is already promoting a program along these lines (presumably structured to resolve the privacy problems). The coalition is the sponsor of SB 1821, now pending in the State Senate.

[276] See the Transitional Medi-Cal paragraphs in Section III-A-1-a and the second paragraph of Section III-A-3-a above.

[277] Governor's Budget Summary 1999-2000, p. 26.

the new regulation becomes permanent federal policy. To date, dissemination efforts by public agencies have not been extensive, especially at the State level; and a considerable degree of misinformation and apprehension still remains in the immigrant community.[278]

B. Simplified Income-Based Eligibility Standard

Problem: Varying eligibility standards for the many current publicly-funded health care programs create costly administrative complexity[279] and result in an inequitable and illogical system that is often exceedingly difficult for recipients to navigate.

Example: In general, the Aid to Infants and Mothers (AIM), HFP and Medi-Cal programs provide access to health care coverage for pregnant women and infants in families with incomes up to 300% of Federal Poverty Level (FPL), for children up to 250% of FPL and for Medi-Cal-eligible two-parent families up to 100% of FPL, respectively. However, many other similarly situated low income individuals, who fall outside this patchwork of eligibility requirements, remain ineligible for these publicly-funded programs and are without access to affordable health insurance coverage – including, in particular, a large number of "working poor" adults in low wage jobs that increasingly do not offer medical coverage as a benefit.[280]

Example: As a result of these differing eligibility requirements, many low income families have different family members eligible for various programs and other members who remain uninsured with no affordable coverage available.[281]

Example: Many eligibility standards have cut-off limitations where a small change in assets, family income or status makes the difference between full benefits and total ineligibility.[282] Such requirements can be significant disincentives to seeking better employment opportunities.

Example: In the event of a need for expensive emergency care, or of a major illness or injury (especially one involving hospitalization, job loss or disability), many previously ineligible individuals and families may thereby become eligible for Medi-Cal coverage. Even for those who do thus become eligible, the result is expensive episodic care rather than the regular care, including preventive programs, that could improve well-being and prevent many treatable health problems from becoming serious or chronic.[283]

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[278] See the third paragraph of the Immigrant Eligibility portion of Section III-A-1-a above.
[279] See note 110 and accompanying text and the concluding paragraphs of Section III-A-3-a above, and the Costs analysis under Recommendation 11 below.
[280] The programs are summarized in Section III-A above. With respect to the gaps in coverage see Section III-A-6-a above.
[281] See, *inter alia,* the concluding paragraphs of Section III-A-3-a above.
[282] With respect to Medi-Cal and HFP, see Sections III-A-1-a and III-A-3-a above.
[283] See Section III-D-8 above.

Recommendation 7: Replace complex and inequitable eligibility requirements with a simple income-based eligibility standard for all publicly-funded health care programs.

An income-based system would relate directly to current earning power and be relatively easy to administer (and to verify since most income comes from sources whose records can be checked -- for example, copies of tax returns or even pay stubs can be used to verify income). It should be noted, however, that such a system could create certain apparent inequities. Some low income families may, for various reasons, have substantial assets and still be eligible for the same subsidized care as families with minimal possessions.

C. A Unified Publicly-Funded Health Care System

Problem: California's publicly-supported health care "system" consists of a bewildering array of categorical programs administered by multiple State and local agencies. Traditional political and geographic boundaries can unduly restrict the effective organization and delivery of health care services. As with eligibility standards, the result is a complex user-unfriendly system that often results in the illogical and unfair treatment of its intended beneficiaries.[284]

Example: From the user view-point, having different family members enrolled in different programs is, perhaps, the most difficult problem to understand and handle.[285] Families can have a mother enrolled in AIM, one or more children enrolled in HFP and a father dependent on the county safety net. For low income people, often working long hours with limited available transportation, the differing requirements, locations and hours of operation of these separate programs may make obtaining adequate health care services a time-consuming, if not insuperable problem.

Example: Administratively, responsibility for the bulk California's public health care system is divided between a variety of State and county agencies.[286]

At the State level, responsibility is exercised by the Health & Human Services Agency, the Department of Health Services and the Managed Risk Medical Insurance Board. The newly created Department of Managed Care exercises regulatory control over Health Maintenance Organizations (HMOs), and the California Medical Assistance Commission purchases hospital services for the Medi-Cal program.

Locally, a typical large county health department has to understand and manage a dozen or more separate funding streams from all levels of government, over which it has little or no control, in trying to maintain adequate financing for the health care programs for

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[284] See the text between notes 47 & 48 and Sections III-A-6-b and III-D-8 above.
[285] See Table 10 and the text at note 82 above.
[286] The administrative structure is briefly summarized in Section III-C above.

which it is primarily or partially responsible.[287] A number of those programs (such as Medi-Cal[288]) themselves have multiple subcategories with differing levels of control and responsibility.

Recommendation 8: Consolidate all publicly-funded health care programs. Administer those programs regionally -- with clear lines of authority and statewide standards for eligibility and benefits.

All publicly-funded outpatient and inpatient health care programs should be consolidated and administered regionally, with clear lines of administrative authority. The State should have the responsibility of establishing statewide standards for eligibility and benefits for all of those programs. Flexibility and experimentation should be encouraged, and a major effort made to identify and reward those regions and leaders willing to break out of the traditional patterns of health care delivery and develop more user-friendly and cost-effective methods of providing services.

The State's largest counties that are regional in size (i.e., Los Angeles and San Diego),[289] should continue the present all-inclusive managed care models for Medi-Cal and integrate those programs with the county programs for the uninsured. The other urban areas should provide incentives for the counties to combine their programs on a regional basis.

The 34 smaller counties where the State now administers both programs should integrate the Medi-Cal program with the County Medical Services Program (CMSP) for the uninsured to provide "one-stop" services to recipients. The option of joining this integrated program should be made available to other counties.

Efforts along these lines are already underway in some areas. For example, Riverside and San Bernardino Counties have combined their Medi-Cal managed care programs, and Napa and Solano Counties have a combined County Organized Health System.

Integrating the County safety net health care programs (primarily CMSP and the large-county Medically Indigent Services Program) with Medi-Cal and other statewide programs would require reconsideration of Welfare and Institutions Code Section 17000 and the health care safety net obligations it currently places on the counties. Any modification of those obligations will be controversial and will require a clear delineation of exactly where the ultimate safety net and financing obligations lie. Reform should move in the direction of combining, as much as possible, the funding and program responsibilities at the same levels of government.

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[287] See, for example, the summary of the budget of the LA County Department of Health Services in the Financing portion of Section III-D-3 above.
[288] See note 43 in Section III-A-1-a above.
[289] The Los Angeles and San Diego programs are summarized in Sections III-D-3 and III-D-5 above.

Recommendation 9: In counties that operate their own health care facilities, separate the payor and provider functions to minimize conflicts of interest in administration, especially with respect to reform implementation.

In a number of counties, the Board of Supervisors and a health care agency reporting directly to them are in charge both of allocating available health care funding and also of the operation of the county's publicly-funded health care programs and facilities. In such counties, there is a built-in tendency to protect and maximize the county programs when, as is so often the case, there is not sufficient funding to provide for all programs at an optimum level.

A number of counties have sought to reduce the inherent conflicts at the Board of Supervisors level by establishing independent health care agencies with their own boards of directors. In Alameda County, for example, the County Medical Center is operated by a new Hospital Authority established by the Supervisors in 1998. Although appointed by the Supervisors, a number of the Authority's board members represent private providers and beneficiaries. Fresno County has gone even further and essentially privatized its publicly-funded health care system by closing the county hospital and contracting with (Fresno) Community Medical Center for the County's health care needs. In these counties, the conflict of interest problems are minimized by shifting operational control from the Supervisors to independent boards of directors, with the Supervisors retaining direct control only of setting overall policy and fiscal decision-making. A number of counties have similar arrangements; in others, the Board of Supervisors has continued in direct control of the county's Department of Health Services. [290]

D. Flexibility in the Use of Federal Funding

Problem: Federal Disproportionate Share Hospitals (DSH) funding provides support for costly hospital-based services, but not for the physician- and clinic-based outpatient programs that emphasize prevention and are fundamental to most managed care plans. A county can, in fact, lose substantial federal funding as a result of simply diverting patients from an expensive inpatient and emergency room-based system to a system based on less costly outpatient primary care.

The DSH program was originally established to support safety-net hospitals (almost all county and University of California hospitals) when they were the core of publicly-funded health care in California. At that time hospitals and other health care providers were compensated primarily on a cost basis with little incentive to reduce costs by maximizing less expensive physician- and clinic-based procedures. As the focus of publicly-supported health care programs has shifted toward managed care and away from hospital-based procedures, the DSH funding formulas have not been modified to accommodate that shift.

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[290] See the discussion of problems related to the direct control arrangement in Los Angeles County in the second paragraph of the Prospects for the Future portion of Section III-D-3 above.

Almost any comparison of the pattern of DSH allocations shows the disparities in the present system. The State's DSH allocations are skewed the most in terms of cash flow by the largest county. With its heavily hospital-oriented delivery system and its unique Section 1115 federal waiver, Los Angeles County received over $500 million of the State's $1.1 billion 1997-98 DSH allocations (46%), well in excess of its 34.7% share of the Medi-Cal population. For another example, in 1997-98 Orange and San Diego Counties, with 11% of the State's Medi-Cal population, received that same share of DSH allocations; but much smaller Fresno and San Francisco Counties, with just 6% of Medi-Cal recipients, received the same 11% share of DSH allocations.[291]

Recommendation 10: Seek federal waivers allowing flexibility in the use of federal Disproportionate Share Hospitals (DSH) funding so that such funds can be used for providing health care to the medically indigent regardless of site.

Clearly, a state-wide federal waiver, similar to elements of the one secured by Los Angeles County in 1996, would greatly assist other counties in making the best use of available DSH funding. The greater flexibility that could be permitted under the state-wide waiver would be especially valuable to California in this period of overall DSH funding reductions.

Achieving a state-wide Section 1115 federal waiver to accomplish Recommendation 10, in the face of the continuing budget reductions mandated by the Balanced Budget Act of 1997 as well as the pressures to keep the federal budget in balance, would be controversial and difficult. However, from the earlier Bradley-Gore debate on health care issues and the differing positions taken by the remaining Presidential candidates on those issues,[292] it appears probable that broader health care coverage will be a major topic of discussion in the 2000 Presidential campaign and may provide a more favorable federal attitude toward such a waiver.

E. Financing Broader Health Care Coverage for the Uninsured -- Particularly for the Working Poor

The enactment of the reform program set forth above would rationalize California's publicly-funded health care system and give the public more confidence that these large public expenditures are being effectively spent to provide maximum health benefits to those most in need. With such a program in place, or at least in process, the Commission believes that a more comprehensive attack on the problems of our very large uninsured population could be undertaken. In particular, the Commission strongly urges the adoption of the following two-step program.

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[291] See Medi-Cal Policy Institute, *op. cit.* note 131, pp. 125-27 & 128-29.
[292] See notes 293 & 294.

Recommendation 11: Adopt and implement the Family Coverage Model proposed in 1999 by the Legislative Analyst's Office as soon as possible (Step One).

In its 1999 Report, entitled *A Model for Health Coverage of Low Income Families,* the Legislative Analyst's Office (LAO) sets forth a proposal for covering all California families with children up to the 250% of the Federal Poverty Level. Although such coverage excludes all childless adults, the LAO proposal would be a major advance in making health care insurance generally affordable. It is directed particularly at a large segment of the working poor now lacking access to such coverage.[293] In maximizing its financial feasibility, the LAO proposal includes the substance of a number of the Recommendations also advocated by the Commission in its reform program (as detailed in the Costs section below).

For these reasons, the Commission believes that the LAO proposal should be a high priority and given serious consideration as the current Administration and the Legislature decide which programs merit an additional allocation of expenditures within the constraints of the State's limited resources.[294] The LAO Model proposal has the following key elements.

Administrative Simplicity: Under the LAO Model, the Medi-Cal and Healthy Families (HFP) programs would be merged into a single combined program. The Medi-Cal asset limitations would be eliminated and eligibility determined on a simple gross income test.

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[293] There is substantial political support at the national level for providing health insurance coverage to the parents of children enrolled in the federal Children's Health Insurance Program (the Healthy Families Program in California). National Journal Group Inc., *op. cit.* note 86, Item 8 in the issue of January 21, 2000. At that time, the President formally proposed such coverage as part of an overall ten-year program for expanding coverage for the uninsured. The White House, Office of the Press Secretary, *Clinton-Gore Administration Unveils Major New Health Insurance Initiative* (Press Release of January 19, 2000). Along with many other media entities, the Los Angeles Times endorsed such a program in its lead editorial on January 23, 2000 (p. M-4).

[294] For a strong plea from the former Governor of Colorado that the magnitude of our uninsured population is the nation's most pressing health care problem, see Richard Lamm, *A Misuse of the Next Dollar,* on the Commentary page of the Los Angeles Times (October 29, 1999), p. B-9. Among the Presidential contenders, ex-Senator Bill Bradley called for providing health insurance coverage to the entire low income population. Although losing to Vice President Al Gore in the Presidential primaries, Bradley's focus on the problem of the uninsured had a broad appeal and undoubtedly served to attract far more attention to the problem than it might otherwise be receiving, both from the voting public and from the other Presidential candidates. For the positions of the Republican candidate, Governor George W. Bush, on some of these issues, see his speeches of April 11 & 12, 2000 on his website at: www.georgewbush.com. Democratic candidate Vice President Al Gore's positions are set forth under Agenda -- Heath & Health Care on his website at: www.algore2000.com. In the Congress, Representative John Tierney and others have introduced legislation (HR 4412) providing for federal grants to selected states to fund demonstration projects for universal health care coverage with simplified administration.

Mail-in applications would be standard and quarterly reporting replaced by annual reapplications (a federal requirement) plus a one-page semi-annual update.[295] The HFP "rate band" approach would be used, allowing participation by all qualified health plans and insurers offering rates within 10% of the lowest bidders (among which participating families could choose for their health care coverage).[296]

Minimizing "Crowd-Out": Any program designed to provide subsidies to the low wage population will be faced with the so-called "crowd-out" problem. Low wage employees eligible for low or no-cost publicly-financed health care programs, such as Medi-Cal and HFP, have an economic incentive not to accept jobs providing employment-based health care coverage with higher premiums and/or more limited benefits. Similarly, employers of low wage employees may be less inclined to provide health benefits (or to grant compensating wage raises) if their employees are eligible for publicly-funded health benefits.

With its higher income limits, crowd-out is a serious concern for the LAO Model. To minimize crowd out, the Model would include a sliding scale of premiums starting at approximately $40 per month for family coverage (modestly above the HFP limit of $27 per month) and rising to $80 per month (2.3% of the income of a family of four at 250% of the Federal Poverty Level).[297] Like HFP, the LAO Model includes a three-month "black out" period -- families with job-based coverage during the last three months would not be eligible. Also like HFP, there would be limited retroactive coverage to discourage families from skipping preventive care and waiting until a serious illness or injury occurred before enrolling. In addition, to help maintain the employer contributions in existing health insurance programs, the LAO Model would offer a buy-in program, subsidizing employee premiums to make job-based programs more affordable for low wage employees.[298]

There is no simple solution to these crowd-out problems. However, the Commission feels that a strong effort must be made by the Administration and the Legislature to develop a program for a large working but uninsured segment with limited or no access to affordable health care insurance and dependent on the fragmented and underfunded system of health care provided by California's 58 counties. This would be a sensible alternative to the State's current top and bottom heavy pattern of broad coverage for most of the poorest residents with their access to publicly-funded care and for the middle class population with its job-based insurance.

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[295] See Recommendations 1, 2 & 7 above.

[296] See note 76 in Section III-A-3-a above.

[297] A 1995 U. S. General Accounting Office survey of firms with over 1000 employees found that the median employee share for single coverage was $27 and for family coverage was $85. Legislative Analyst's Office, *op. cit.* note 76 , p. 21.

[298] The mechanics of integrating the plethora of different job-based plans (with their varying co-payments and deductibles, employee premiums, and benefit limitations) would be a complex and difficult problem. The LAO Model suggests requiring that all HMOs and health insurers be required to offer a standard Model Family Plan and to calculate a conversion premium for the cost of converting other coverages to the Model Plan. *Ibid.*, p. 23. The conversion premium would be used by the State in determining the amount of subsidy required to provide standard coverage to the affected employees.

Maintaining Federal Participation: In order to make the LAO Model financially viable, it would be necessary to obtain federal participation at the usual Medi-Cal and HFP rates. A number of the features of the Model would require a federal Section 1115 waiver to maintain that participation -- not an easy task. As the LAO proposal notes, however, the State of Wisconsin received a Section 1115 waiver in 1999 for its similar "Badger Care" program, indicating that such a waiver could be obtained by California.[299]

Costs: The LAO recognizes the difficulty of estimating the cost of its proposal. The following estimates are, therefore, at best approximations of the prospective costs of adopting the LAO Model proposal.

The LAO estimates that over 900,000 uninsured children would be eligible for health insurance under its plan, almost all of whom are now eligible for Medi-Cal or HFP coverage. They further estimate that a similar number of parents would be eligible, most of them not now eligible for any publicly-funded health coverage. The Model estimates the costs for two scenarios:

(1) raising the level of children's coverage from the current estimated 70% to 80%, and
(2) raising that level to 90%.

Both scenarios assume that all the parents of enrolled children would also enroll.

The LAO estimates a gross cost to the State of $560 million for Scenario One and $750 million for Scenario Two. That would be off-set by premium revenue of $25-35 million and estimated administrative savings of approximately $125 million. (It should be noted that the administrative savings result from the inclusion of reforms substantially similar to Commission Recommendations 1, 7 and 10, plus a partial implementation of Recommendation 8.) The net cost to the State, therefore, is estimated to be in the $200 to $400 million range.

This estimate does not include savings to county safety net programs from the reduced number of persons relying on those programs for needed health care services (an amount which could off-set county losses from the decline in Proposition 99 tobacco tax revenue due to decreasing tobacco use).

Recommendation 12: Use tobacco settlement money primarily to finance broader access to affordable health care coverage for uninsured low income Californians (Step Two).

Even with the LAO *Family Coverage Model* in place, there would still be an estimated three million adults with incomes up to 200% of the Federal Poverty Level with limited or no access to affordable health care insurance.

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[299] *Ibid.*, p. 27. See Wisconsin Department of Health & Family Services, *BadgerCare Program Summary* (December 21, 1999 update), p. 3. On the Department's website at: www.dhfs.state.wi.us/BadgerCare/factsheets/programsummary.htm.

The rough annual cost of providing a minimum program of health care coverage for that population would be approximately $3 billion (at $83 per month per individual -- totaling $1000 annually).[300] The estimated annual amount of current public health care spending for these individuals at present is roughly $2 billion (mostly in county programs and emergency care). The net cost of a comprehensive program would, on that basis, approximate $1 billion -- an amount in the same range as the estimated tobacco settlement funds the State and local government will be receiving annually for the next 25 years.[301]

The substance of Recommendation 12 has demonstrated strong support in the Legislature.[302] In addition, it is fully consonant with the actions of the Governor in proposing to allocate all of the tobacco settlement funds expected to be received by the State in 2000-01 for health care purposes.[303] Therefore, if presented to the Administration, the Legislature and key leaders in the health care field with the other Commission Recommendations as part of a carefully designed and cost-effective overall reform package, it may be possible to convince the key Sacramento decision-makers to support Recommendation 12 and make use of tobacco settlement funds to broaden considerably access to affordable health insurance coverage for low income Californians.[304]

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[300] According to the California Association of Health Plans (CAHP), this rate is average for Medi-Cal payments to HMOs. See CAHP's press release, *Association of Health Plans Releases Data On Health Care Costs and the Uninsured* (December 2, 1999), p. 2. Also, as the CAHP's press release comments, keeping costs at a minimum will be important to the financial feasibility of providing coverage to the 7,000,000 Californians currently lacking any type of coverage. *Ibid.*

[301] Legislative Analyst's Office, *What Will It Mean for California? The Tobacco Settlement.* LAO Report (January 14, 1999).

[302] See note 120 at the end of Section III-B above.

[303] May Revision to Governor's Budget for 2000-01, p. 33. In addition, at the end of the 1999 legislative session, an important first step was taken in the direction of providing access to affordable health care for all Californians. The Legislature passed and the Governor signed SB 480 which requires the Secretary of the Health and Human Services Agency to develop "a process by which the options for achieving universal health care coverage can be thoroughly examined." A report to the Legislature on the results of that process is due by December 1, 2001. A staff person to head up the implementation of SB 480 has already been hired by the Agency. Separately, there are parallel efforts, both in the Legislature and from other public and private agencies, to provide additional funds for a broad, independent study of the options for providing universal health care coverage in California.

[304] See note 218.

PART V. CONCLUSION

The Governor and the Legislature have made education their highest priority. State funding is the prime support for all levels of education in California and deserves its status as the State's number one financial priority.

However, the Commission believes that the second largest State expenditure category, publicly-funded health care, has not received the attention it deserves. As set forth above, the effectiveness of the major public investment in health care services leaves much to be desired -- and, despite the very large expense of our current health care programs, too large a segment of the State's population is still without proper health care coverage.[305]

The Recommendations set forth above directly address the principal deficiencies in the State's public-funded health care system. The Commission believes strongly that adoption of these Recommendations will make the current system more cost-effective and user-friendly and enable the State, and the counties, to make great progress in the process of **providing access to affordable health insurance coverage for the many Californians who still lack that needed protection.**

The size and complexity of our publicly-funded health care system make it difficult for the average citizen to comprehend. The diversity of our population and the ever-changing technology of health care also make the subject an inherently difficult one for the non-expert to understand and stay current. However, the Commission is convinced that these very basic Recommendations will greatly assist in rationalizing the system, broadening its public support and moving close to the goal of making access to basic health care coverage available to all Californians.[306]

Finally, the Commission feels that **it is important to move forward with these reforms as quickly as possible.** As emphasized previously, they need to be implemented during the current period of economic expansion so that they will become effective before the fiscal pressures of the next economic downturn. Equally important, these reforms should be put in place promptly so that California's public health care system can take full advantage of the revolutionary changes in health care treatment and preventive techniques that are sure to occur over the next several decades. New scientific

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[305] A recent article in the California Journal calls the large and increasing number of uninsured Californians a "growing epidemic." Rodriguez, *op. cit.* note 270, p. 10.

[306] The Commission recognizes that many knowledgeable health care experts have called for more drastic programs of reforming the nation's publicly-funded health care system. A "single-payer" procedure along the lines of Medicare has many advocates, as does the use of the tax system to finance universal coverage [see,. *e.g.,* David Kendall, *Getting on the Fast Track to Universal Coverage,* The New Democrat Blueprint, Vol. 6 (Spring 2000), p. 24 *et seq.*]. However, the Commission consensus is that the middle-of-the-road, incremental reforms set forth in Part IV of this Report are the most realistic approach at this time. A single-payer plan was overwhelmingly rejected by California voters when on the ballot in 1994, and such major changes in the federal tax code do not appear to be politically possible at present. In contrast, the 12 reform Recommendations set forth above build on our current public health care system, are financially feasible, and have both strong advocates in Sacramento and also a broad appeal to the voters and the general public.

discoveries, new therapies and new technologies follow each other with ever-increasing speed. Many of these new high-tech therapies and procedures are difficult and expensive. If we are to avoid becoming a two-track society of medical "haves" and "have nots," **we need a public health care system that is unified and comprehensive**. Such a system will best be able to utilize the new knowledge and new technologies as they are developed on a cost-effective basis, and to make their benefits available to all Californians.

APPENDIX A

GLOSSARY AND LIST OF ACRONYMS

AFDC: Aid to Families with Dependent Children. Former federally supported cash assistance program (welfare) for children in very low income families. Now replaced by Temporary Assistance to Needy Families (TANF).

AIM: Access for Infants and Mothers. Subsidized health insurance program for pregnant women with incomes from 200 to 300% of FPL (Federal Poverty Level) and their infants up to age two. Administered by MRMIB (the Managed Risk Medical Insurance Board). Care delivered through contracting health plans and insurers.

CalOPTIMA: The State's largest County Organized Health System (COHS), providing services to all Medi-Cal enrollees in Orange County.

CalWORKS: California Work Opportunity and Responsibility to Kids. Provides welfare-to-work services and grants to families with children. Begun in 1997 as part of California's implementation of the federal welfare reform legislation.

CCS: California Children's Services. State funded program for children under 21 with qualifying serious congenital conditions or chronic illnesses. Family annual income limit of $40,000; more if cost of care expected to exceed 20% of adjusted gross income.

CHDP: Child Health and Disability Prevention. California's version of the federal Early and Periodic Screening Diagnosis and Treatment Program (EPSDT) which is required by Medicaid for TANF children. Screens for physical and mental health problems and arranges treatment. In California, children in families with incomes up to 200% of FPL are eligible for CHDP.

CHIP (federal): Children's Health Insurance Program. A federal program, established in 1997, to provide federal financial support for state programs of health care for children from low income families. Implemented in California by the Healthy Families Program (HFP).

CHIP (state): California Healthcare for Indigents Program. Provides Proposition 99 (tobacco tax) funding to large counties that discharge their health care safety net responsibilities (as required by Health & Safety Code Section 17000) by operating their own medically indigent health care programs. CHIP is administered by the State Department of Health Services (State DHS).

CMAC: California Medical Assistance Commission. The California state agency which negotiates reimbursement rates for Medi-Cal hospital services and also the

capitation rates for the County Organized Health Systems (COHSs) and for the managed care plans in the Geographic Managed Care (GMC) counties.

CMSP: County Medical Services Program. State-operated program providing health care services for the uninsured medically indigent in 34 smaller counties on a contract basis.

COHS: County Organized Health System. Unified, county-operated managed care plan for all Medi-Cal beneficiaries in the county.

DSH: Disproportionate Share Hospitals. Under the DSH program, hospitals which serve a high proportion of low-income patients (both Medi-Cal and uninsured), are eligible for supplemental payments (from federal funds matched by local funds) to cover their extra costs.

DSS: Department of Social Services: The State and county DSSs administer the State's programs of income assistance (welfare). Some of those departments are called Departments of Public Social Services (DPSS).

EPSDT: Early Prevention, Screening, Diagnosis and Treatment. This federal program provides health preventive services for Medicaid children. (See CHDP.) EPSDT supplemental services are medically necessary services which are not otherwise part of the State's covered benefits.

FFS: Fee-For-Service. Method of billing for health services under which a provider charges and is paid separately for each patient encounter or service rendered.

FMAP: Federal Medical Assistance Percentage. The percentage of federal participation in state Medicaid programs. Adjusted annually in relation to a state's average per capita income.

FPL: Federal Poverty Level. Federal definition of poverty, adjusted for family size and revised annually. Used in establishing eligibility for most means-tested federal and state public assistance programs.

FQHC: Federally Qualified Health Center. A community health center which qualifies to receive reimbursement on a full-cost basis for delivering Medi-Cal services.

GMC: Geographic Managed Care. Medi-Cal managed care model offering beneficiaries a choice of plans which have negotiated contracts with CMAC.

HCFA: Health Care Financing Administration. The federal agency within the Department of Health and Human Services which directs the Medicaid and Medicare programs.

HFP: Healthy Families Program. A new federal and state funded program providing health insurance coverage, with sliding-scale premium contributions, to children in families with incomes above Medi-Cal limits up to 250% of FPL.

HIPC: Health Insurance Plan of California. Small business (2-50 employees) purchasing pool established in and administered by MRMIB. Privatized in 1999 – now called Pacific Health Advantage and operated by the nonprofit Pacific Business Group on Health.

HMO: Health Maintenance Organization. An entity which contracts to provide (either directly or through contracts with independent providers) an agreed set of health care services to enrollees for which the entity is paid a fixed amount by each person or family unit enrolled. The payment is fixed without regard to the amounts of actual services provided to any individual enrollee.

HPSM: **Health Plan of San Mateo.** San Mateo County's COHS.

Medicaid: A federal program providing matching funds for state programs which provide health care services to the very low income population (primarily those receiving welfare assistance).

Medi-Cal: The short name for the California version of the federal Medicaid program.

MIA: Medically Indigent Adults. Low income uninsured adults aged 18-64 who are not eligible for Medi-Cal or other federal or state health care programs.

MICRS: Medically Indigent Care Reporting System. A program, operated by the State DHS, to collect and report data on the indigent health care services provided by counties.

MISP: Medically Indigent Services Program. The principal county-administered program in the large counties for providing health care services to the medically indigent uninsured population.

MRMIB: Managed Risk Medical Insurance Board. A state agency, governed by a board of three appointed members, which operates the AIM, MRMIP and HFP programs.

MRMIP: Major Risk Medical Insurance Program. A program to provide health insurance for those who are unable to obtain coverage in the private health insurance market.

MSI: Medical Services for Indigents. An Orange County program providing services to the medically indigent.

OSHPD: Office of Statewide Health Planning & Development. The California state agency which collects and reports hospital and clinic financial and utilization data.

PCP: Primary Care Physician. Physicians to whom managed care plan members are assigned who are primarily responsible for providing health care services to those members. In some plans, PCPs act as "gate keepers" whose authorization must be obtained before a member may seek specialty care from other providers.

PHC: Physician-Hospital Consortia. Physician-hospital groups organized to provide health care services to Medi-Cal enrollees in Orange County.

Proposition 99: Additional tobacco tax, created by initiative in 1988, which funds anti-smoking educational activities and health care services for the low income population. Proposition 99 funds support, *inter alia,* AIM, CHDP, MRMIP and county programs for the medically indigent uninsured.

Realignment. State tax subvention to counties for indigent health care. Replaced State Proposition 13 "bail out" (AB 8) and residual state MIA funding with one half cent of the state sales tax and a portion of the vehicle license fees collected in each county.

SCFHP: Santa Clara Family Health Plan. The Santa Clara County Local Initiative, one of two Santa Clara County health care programs for Medi-Cal managed care (the other being the commercial Blue Cross CaliforniaCare Health Plan).

SCVHHS: Santa Clara Valley Health and Hospital System. Santa Clara County's health care programs for the indigent uninsured are operated under the direction of the Santa Clara Valley Health and Hospital System, created in 1993 through the consolidation of the Health Department and the Santa Clara Valley Medical Center, the County hospital.

Section 1115 Waiver. Obtained by state application (through the State DHS) to HCFA under Section 1115 of the Social Security Act on behalf of a local government agency (e.g., Los Angeles County) to allocate and use Medicaid funds with more flexibility than the Medicaid program guidelines normally allow (on a revenue-neutral basis). Los Angeles County's 1115 Waiver allows the County, *inter alia,* to use federal Medicaid revenues for more outpatient services.

Section 17000: Section 17000 of the Welfare and Institutions Code pursuant to which California's counties are designated as the providers of last resort for the uninsured medically indigent.

SSI/SSP: Supplemental Security Income/State Supplemental Payment. Federal and State funded programs of public income assistance for elderly, blind and disabled persons (who are normally also eligible for Medi-Cal).

State DHS: California Department of Health Services. The State DHS administers Medi-Cal and most other State health care programs.

TANF: Temporary Assistance to Needy Families. New name for AFDC, with time limits and stronger work/training requirements.

TMC: Transitional Medi-Cal. A program, administered by the State, that extends Medi-Cal coverage for up to 24 months for families who leave welfare due to new or increased earnings from employment.

Two-Plan Model: A Medi-Cal managed care system for the 12 largest counties. Medi-Cal beneficiaries may enroll in either a "mainstream" (commercial) HMO or the "Local Initiative," a county-operated health plan.

VMC: Valley Medical Center. The Santa Clara County county hospital that was consolidated with the Health Department in 1993 to create the Santa Clara Valley Health and Hospital System, which operates Santa Clara County's health care programs for the indigent uninsured.

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The Department of Veterans Affairs: www.va.gov
Health site is under "Benefits and Services"
Current Population Survey (Federal): www.bls.census.gov/cps

State of California

Department of Finance: www.dof.ca.gov
Department of Health Services: www.dhs.cahwnet.gov
Department of Social Services: www.dss.cahwnet.gov
Governor's Home Page: www.governor.ca.gov
Legislative Analyst's Office: www.lao.ca.gov
Managed Risk Medical Insurance Board: www.mrmib.ca.gov
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www.oshpd.state.ca.us
State Assembly: www.assembly.ca.gov
State of California's Home Page: www.state.ca.us
State Controller's Office: www.sco.ca.gov
State Senate: www.sen.ca.gov
University of California Regents: www.ucop.edu/regents/regents.html

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Journal of the American Medical Association: www.jama.com
Los Angeles Times: www.latimes.com
New England Journal of Medicine: www.nejm.com
Oakland Tribune: www.oaklandtribune.com
Orange County Register: www.ocregister.com
New York Times: www.nyt.com
San Diego Union-Tribune: www.uniontrib.com
San Jose Mercury News: www.sjmercury.com
San Mateo Times: www.sanmateotimes-ang.com
The Wall Street Journal: www.wsj.com
Washington Post: www.washingtonpost.com

Private Organizations

Blue Cross: www.bluecares.com
George W. Bush Campaign: www.georgewbush.com
California Budget Project: www.cbp.org
California Center for Health Improvement: www.policymatters.org
The California Endowment: www.calendow.org
California HealthCare Foundation: www.chcf.org
California State Association of Counties: www.csac.counties.org
Health services for each county are found under each county's website. To locate a Website for any county in California, use this website, then click on "Counties Close-Up," then "Counties' Websites."
The California Wellness Foundation: www.tcwf.org
Center for Health and Public Policy Studies: http://chpps.berkeley.edu
Center for Studying Health System Change: www.hschange.org
The Commonwealth Fund: www.cmwf.org
Community Clinic Association of Los Angeles County: www.ccalac.org
Council of State Governments (includes all states by region):
www.csg.org
Families USA Foundation: www.familiesusa.org
Al Gore Campaign: www.algore2000.com
Health Consumer Alliance: www.healthconsumer.org
Institute of Medicine (affiliated with the National Academy of Sciences:
www.iom.edu
Insure the Uninsured Project: www.work-and-health.org/itup
The James Irvine Foundation: www.irvine.org
The Kaiser Family Foundation: www.kff.org
Kaiser Permanente: www.kaiserpermanente.org
Medi-Cal Policy Institute: www.medi-cal.org
National Chamber Foundation: www.uschamber.com/ncf
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Pacific Business Group on Health: www.pbgh.org
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COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC SOCIAL SERVICES

QUICK GUIDE TO MEDI-CAL PROGRAMS (Administered in Most DPSS Districts)

Program:	Persons Eligible:	Immigration Status:	Benefits:	Property Limits:	Income Limits:	Deductions/Allocations/Comments:
1931(b) Aid Code: • *Full Scope (1931(b)-Only* 3N • *Restricted (1931(b)-Only* 3V	AFDC-linked Families with children to 18 (to 19 if in school);AFDC-linked Pregnant Women Applicant: Person/family not on 1931(b) in any of 4 mos. preceding appl. Recipient: Person/family who received 1931(b) in 1(or more) of any of 4 mos. preceding appl.	Satisfactory Immigration Status California Residency Non-Satisfactory Immigration Status California Residency	Full Scope Zero Share of Cost Emergency and pregnancy related services only Zero Share of Cost	MAO Limits (See Regular MAO) EXCEPT: 1 person Family - $3000 *Personal Property* (includes vehicles): *Generally*, value is determined in accordance with **Food Stamp property rules not MAO's**. *Real Property*: *Generally*, value is determined in accordance with AFDC rules in effect 7/16/96.	Net Income Limits (see details on Income Level Chart PA 1305 C) Apply allowable income deductions FIRST IMPORTANT: Use 1931(b) Budget Sheets for Applicant or Recipient when determining Income eligibility	Applicants Income Deductions: *Generally*, regular AFDC-MN deductions apply (Listed under "Income Limits" for Regular Medi-Cal on reverse side) Recipients Income Deductions: ◦ *Any income:* court-ordered child/spousal support paid and $50 from child/spousal support received. ◦ *Disability-based income* (SSA and/or private disability):Up to $240 ◦ *Earned income* (includes temporary worker's compensation [TWC] and SDI): Up to $240 (an additional $120 per person allowed if more than 2 persons in the family have income) plus ⅓ of the remainder and child care.
Transitional Medi-Cal (TMC) (50244) Aid Code: *First Year* *1st 6 Mos.* *Full Scope* 39 *Restricted* 3T *2nd 6 Mos.* *Full Scope* 59 *Restricted* 5T *Second Year* ① *Full Scope* 5X *Restricted* 5Y	AFDC-linked Families who lost cash-based *or* 1931(b) Medi-Cal **due to earnings** & received aid in at least 3 of the 6 mos. prior to ineligibility ① 2nd year Parents and children, 19 or older (The assumption is that children under 19 will get no-cost Medi-Cal or Healthy Families.)	Satisfactory Immigration Status California Residency Non-Satisfactory Immigration Status California Residency	Full Scope Zero Share of Cost Emergency and pregnancy related services ONLY Zero Share of Cost	None	Initial 6 Mos. - None Second 6 Mos. - Average countable earnings no greater than 185% of FPL. Child Care Deduction allowed (See details on Income Level Chart on PA 1305 C)	Initial 6 Mos. No eligibility requirements other than the family must continue to have a child living in the family & the family must reside in California. Second 6 Mos. Requires that in addition to the above, the family must remain employed, received Initial TMC for entire 6-mos. period & meet certain reporting requirements. Period of Eligibility Benefits begin the month in which the family became ineligible for AFDC/CalWORKs or 1931(b) or should have been considered ineligible for a cash aid payment. ① 2ND Year will be implemented with 1931(b) Program.
Four Month Continuing (50243) Aid Code: *Full Scope* 54 *Restricted* 5W	Families who lost cash aid or 1931(b) M/C **based** (wholly or in part) to collection or increased collection of child/ spousal support & received aid in at least 3 of the 6 mos. prior to ineligibility to cash aid	Satisfactory Immigration Status California Residency Non-Satisfactory Immigration Status California Residency	Full Scope Zero Share of Cost Emergency and pregnancy related services ONLY Zero Share of Cost	N/A	N/A	Period of Eligibility Benefits begin the month in which the family became ineligible for AFDC/CalWORKs or should have been considered ineligible for a cash aid payment. Restricted benefits allowed if ineligible for 1931(b) due to increased collection of child/spousal support.
Expanded Children's Percentage (50262.6) Aid Code: •*Pregnant* *Full Scope* 44 *Restricted* 48 •*Infant (0-1 yr)* *Full Scope* 47 *Restricted* 69 •*Child (1-6)* *Full Scope* 72 *Restricted* 74 •*Child (6-19)* *Full Scope* 7A *Restricted* 7C	Children to 19 Pregnant Women	Satisfactory Immigration Status California Residency Non-Satisfactory Immigration Status California Residency	Full Scope for children Pregnancy-only for pregnant women Zero Share of Cost Emergency/restricted for children Pregnancy-only for pregnant women Zero Share of Cost	Disregarded NOTE: If property holdings are generating **income** to the family, that **income** must be verified and applied to the income computation	At or below 200% of FPL Pregnant women and/or child under 1 yr At or below 133% of FPL Child age 1 to 6 At or below 100% of FPL Child age 6 to 19 (See details on Income Level Chart on PA 1305 C)	Income Deductions: ◦ Up to $90 per working person from earned income; ◦ child care; ◦ court ordered child/spousal support paid; ◦ $50 from child/ spousal support received.
Healthy Families Insurance Program Aid Code (MEDS): 9H	Uninsured Children 1 to 19 *If ineligible* to No-SOC Medi-Cal	Eligible Qualified Alien (admitted to U.S. before 8/22/96) California Residency	Full Scope Low-cost monthly premiums of $4 to $9 per child, up to $27 per family. Co-payments of $5 for some services.	Disregarded	Up to 200% of the FPL (See details on Income Level Chart on PA 1305 C)	◦ Interested persons should be directed to call (800) 880-5305 for information. ◦ Mail-in Applications can be obtained at County DPSS Offices.

Program:	Persons Eligible:	Immigration Status:	Benefits:	Property Limits:	Income Limits:	Deductions/Allocations/Comments:
Regular Medi-Cal (MAO) Aid Code: • *Aged* 14/17 • *Blind* 24/27 • *Disabled* 64/67 • *AFDC-Linked* 34/37 • *Medically Indigent:* *Pregnancy* 86/87 *Child* 82/83 • *Minor Consent* ② All Minors: *Pregnancy* 7N 12 & Over: *Other Services* (No Mental Health) 7M (With Mental Health) 7P Under 12: *Family Planning & Sexual Assault Only* 7R	• Aged, Blind, Disabled • AFDC-linked Families • Pregnant women • Children to 21 (Medi-Cal Only [Medically Indigent] and/or Minor Consent Services ②)	Satisfactory Immigration Status California Residency Non-Satisfactory Immigration Status California Residency	Full Scope May or may not have a Share of Cost ③ Emergency and pregnancy related services only Not eligible to Minor Consent Services ② May or may not have a Share of Cost ③	Home and 1 car are exempt Family Size: 1 - $2,000 6 - $3,600 2 - $3,000 7 - $3,750 3 - $3,150 8 - $3,900 4 - $3,300 9 - $4,050 5 - $3,450 10 - $4,200 ④ Different limits may apply to Sneede class persons	Based on Family Size and Maintenance Need Level (see Income Level Chart PA 1305 C) ④ Different limits may apply to Sneede class persons Income Deductions: *AFDC linked* - Up to $90 per working person from earned income; child care; court ordered child/spousal support paid; $50 from child/spousal support received; health insurance premiums. *Aged, Blind, Disabled* - $65 plus ⅓ of the remainder from earned income; $20 from any income; ⅓ of support from absent parent for disabled child; health insurance premiums.	② Minor Consent Services (See Section 50147.1) Children up to 21 years who live with their parents/ guardian can be eligible to Sensitive Services under their own case. The parent's income and resources ARE NOT COUNTED in these cases. Services related to: • *Pregnancy* • *Family planning (non-pregnant minor)* • *Sexual Assault* • *Venereal disease (12 or older)* • *Drug or alcohol abuse (12 or older)* • *Sexually transmitted disease (12 or older)* • *Mental health care Outpatient Only (12 or older)* ③ Medi-Cal eligible persons over the Maintenance Need Level (MNL) have a share of cost (SOC) unless they qualify for no cost Medi-Cal under the 1931(b) Program, Sneede rules or the Federal Poverty Level (FPL) Programs. ④ Under Sneede, financial responsibility is limited to spouse-for-spouse and parent-for-child. Sneede rules apply when the family has excess property and/or a share of cost and includes any of the following members: • *A child with nonexempt property and/or income,* • *Unmarried parents living together with a mutual child,* • *A stepparent, or* • *A caretaker relative.* When Sneede rules apply, the income and property of family members is allocated among family members based on spouse-for-spouse and parent-for-child responsibility. Special Maintenance Need Level and Property Limit rules are used.
Qualified Medicare Beneficiary (QMB) (50258) Aid Code : *SSI* 93 *QMB-only* 80	Entitled to enroll in Medicare Part A / Has HIC#. NOTE: QMB eligible person can be: MAO SSI QMB-only	Satisfactory Immigration Status (50301[b]) California Residency	State pays Medicare A&B premiums, co-insurance & deductibles BIC Issued/ Restricted	$4,000 (but if on Medi-Cal the $2,000 limit applies)	100% of the FPL	Income Related Work Expenses *(IRWE)* which includes expenses of a working disabled QMB client that are necessary to become or remain employed. (50045.1). (NOT applicable in evaluating income for Medi-Cal benefits.) NOTE: Medicare Part B Premium is $45.50 (Effective 1/99) *Health insurance premiums not allowed in computation.*

Medicare Reimbursement Programs: SLMB, QI-1 and QI-2 are handled at District 80 and are listed on the Quick Guide to *Special* Programs

MEDI-CAL BENEFIT WAIVER PROGRAMS

These waiver programs provide care at home as an alternative to institutionalized health care. No special Medi-Cal eligibility rules apply. Other Waiver Programs (handled at District 80) are listed on the Quick Guide *to Special* Programs.

Program:	Persons Eligible:	Comments:
In-Home Medical Care Waiver (IHMC)	Individuals who would require care in an acute hospital for at least 90 consecutive days.	Referral from DHS In-Home Operations Section (IHO) required. Services include, but are not limited to, case management, skilled nursing, home health aides, utility coverage, and minor physical adaptations to the home.
Nursing Facility Level of Care Waiver (NF)	Physically disabled adult (over age 21) Medi-Cal recipients who would require nursing facility or subacute services for at least 90 consecutive days.	Referral from DHS In-Home Operations Section (IHO) required. Services similar to those of the Model-NF waiver (See Special Programs Reference Guide). NOTE: If ineligible under regular MAO refer to MODEL- NF WAIVER Program In Quick Guide to *Special* Programs chart.
DHS Acquired Immune Deficiency Syndrome (AIDs) Waiver	Limited to individuals with AIDS or symptomatic HIV disease who would otherwise require care in skilled nursing facilities or acute hospitals.	Referral from DHS Office of AIDS required. Services include, but are not limited to, skilled nursing, non-emergency medical transportation, equipment and minor physical adaptations to the home.
Department of Aging Multipurpose Senior Service Program (MSS)	Limited to frail elderly individuals who would otherwise require care in nursing facilities.	Referral from the Department of Aging required. Services include, but are not limited to, case management, adult social day care, housing assistance, protective services, personal care, respite care, transportation, meal services and special communications.

REVERSE OF PART 1

QUICK GUIDE TO MEDI-CAL *SPECIAL* PROGRAMS (Administered at the Medi-Cal Long Term Care District)

Program:	Persons Eligible:	Immigration Status:	Benefits:	Property Limits:	Income Limits:	Deductions/Allocations/Comments:
Specified Low-Income Medicare Beneficiary (SLMB) (50258.1) Aid Code: *8C*	Persons ineligible to QMB due to excess income & entitled to Part A Medicare	Satisfactory Immigration Status California Residency	State pays Medicare Part B (Buy-In) (Entitled to 3 mos. retroactive coverage) No BIC	$4,000 (twice the SSI property limit) $6,000 - spouse couple	Above 100% but less than 120% of the FPL (See Chart on PA 1305 C)	Income Related Work Expenses (IRWE) (50045.1) (NOT applicable in evaluating income for Medi-Cal benefits.) NOTE: Medicare Part B Premium is $45.50 (Effective 1/99) *Health Insurance Premiums not allowed* in computation
SLMB "Qualifying Individual-1" (QI-1) Aid Code: *8D*	Same as SLMB	Satisfactory Immigration Status California Residency	Same as SLMB (Buy-In) (Entitled to 3 mos. retroactive coverage) No BIC	Same as SLMB	At or above 120% but less than 135% of FPL (See Chart on PA 1305 C)	Income Related Work Expenses (IRWE) (50045.1) (NOT applicable in evaluating income for Medi-Cal benefits.) *Health Insurance Premiums not allowed in computation*
SLMB "Qualifying Individual-2" (QI-2) Aid Code: *8K*	Same as SLMB	Satisfactory Immigration Status California Residency	Reimbursement of $12 annually (Entitled to 3 mos. retro coverage) No BIC	Same as SLMB	At or above 135% but less than 175% of FPL (See Chart on PA 1305 C)	Income Related Work Expenses (IRWE) (50045.1) (NOT applicable in evaluating income for Medi-Cal benefits.) *Health Insurance Premiums not allowed in computation*
Qualified Disabled & Working Individuals (QDWI) (50256) Aid Code: *8A*	Persons entitled to enroll in Medicare Part A for disabled & working (under 65 years of age) who lost SSA benefits due to employment	Satisfactory Immigration Status California Residency	Medicare Part A (Premium Only) 3 mos. retro eligibility *if* entitled to enroll in Part A during the retro period No BIC	$4,000 (twice the SSI property limit) (50421.5)	200% of FPL (See Chart on PA 1305 C) Net nonexempt income shall be determined following SSI methodology.	Income Related Work Expenses (IRWE) (50045.1) (NOT applicable for evaluating income for Medi-Cal benefits) $20 Any Income Disregard *Health Insurance Premiums not allowed in computation*
DDS HCBS Waiver Dept of Developmental Services (DDS) Home and Community-Based Services	Developmentally disabled persons who are property ineligible or have a SOC	Satisfactory Immigration Status California Residency	Provides care at home as an alternative to institutionalized health care	Parental and/or spousal resources not considered; spousal impoverishment rules apply if appropriate	Parental and/or spousal income not considered; spousal impoverishment rules apply if appropriate Use maintenance need for one ($600)	Referral from DDS Regional Centers required. Services provided include, but are not limited to, homemaker, home health, personal care, respite, environmental modifications, transportation, skilled nursing and communication aides.
Model-NF Waiver DHS Model Nursing Facility	Persons who require nursing facility or subacute services for 90 consecutive days and are property ineligible or have a SOC	Satisfactory Immigration Status California Residency	Provides care at home as an alternative to institutionalized health care	Parental and/or spousal resources not considered; spousal impoverishment rules apply if appropriate	Parental and/or spousal income not considered; spousal impoverishment rules apply if appropriate. Use maintenance need for one ($600)	Referral from DHS In-Home Operations (IHO) Section required. Services provided include, but are not limited to, case management, skilled nursing, language services, home health aids, and adaptations to the home.
Tuberculosis (TB) (50268) Aid Code: *7H*	Adult or child infected w/TB & not eligible to M/C under federally mandated programs	Satisfactory Immigration Status California Residency	Zero Share of Cost (for TB Related Services Only) BIC Issued/Restricted	$2,000 - Individual Limit not increased *even* if the applicant and/or spouse have children in the home. ①	TB Income Standard $1,073(01/98) $1,085 (01/99) (Updated Annually) Standard not changed when spouse or child of applicant is in the home. ②	① See MPIH #317, dated 11/16/94, Article 5 Section II B 3 for Property Eligibility Determinations ② See MPIH #317, dated 11/16/94, Article 5 Section II B 4 for Income Eligibility Determinations
Pickle (Pickle Handbook) Aid Code: • *Aged* 16 • *Blind* 26 • *Disabled* 66	Must meet ALL criteria: Currently receives SSA RSDI benefits; was eligible for & received both RSDI & SSI/SSP (after 4/77); was terminated from SSI/SSP for any reason; received RSDI COLA since SSI/SSP term; would be eligible to SSI/SSP if RSDI COLA Disregarded	Satisfactory Immigration Status California Residency	Zero Share of Cost BIC Issued/Full Coverage	SSI Property Rules $2,000 - 1 person $3,000 - 2 persons Use Pickle Resource Worksheet (DHS 7037)	SSI Income Rules Use Pickle Financial Eligibility Worksheet (DHS 7021)	RSDI COLA Disregard Computation (DHS 7029) Compute Pickle Determinations for all eligible and/or ineligible spouse's RSDI benefits. Pickle determinations must be completed at Intake, at yearly redeterminations, & at the time of the annual RSDI COLA.

QUICK GUIDE TO MEDI-CAL *SPECIAL* PROGRAMS - 2 (Administered at the Medi-Cal Long Term Care District)

Program:	Persons Eligible:	Immigration Status:	Benefits:	Property Limits:	Income Limits:	Deductions/Allocations/Comments:
Disabled Adult Children (DAC) (Pickle Amendment) Aid Code: • *Blind* 6A • *Disabled* 6C	Be at least 18 yrs; determined blind or disabled before age 22 yrs; SSI/SSP termed due to increased SSA children's benefits (on or after 7/1/87)	Satisfactory Immigration Status California Residency	Zero Share of Cost BIC Issued/Full Coverage	SSI Property Rules (Same computations as Pickle)	SSI Income Rules (Same computations as Pickle) (Recipient's income ONLY - Parent's SSA income excluded)	RSDI COLA Disregard Computation (DHS 7029) Pickle determinations must be completed at Intake, at yearly redeterminations & at the time of the annual RSDI COLA.
Disabled Widow(ers) (Pickle Amendment) Aid Code: 36	Lost SSI/SSP because of SSA COLA increase; not currently eligible to Medicare Part A; eligible to receive early widow(er)s benefits under SSA ③④	Satisfactory Immigration Status California Residency	Zero Share of Cost BIC Issued/Full Coverage	SSI Property Rules (Same computations as Pickle)	SSI Income Rules (Same computations as Pickle)	RSDI COLA Disregard Computation (DHS 7029) ③ Coverage is available until these widow(er)s become eligible for Medicare Part A Hospital Insurance. ④ Title II - Old Age, Wife, Husband, Child, Widow, Widower, Mother or Father's Insurance Benefits. Pickle determinations must be completed at Intake, yearly redeterminations & at the time of the annual RSDI COLA.
Special Treatment Program-Only (STP-O) (50817[b]) Aid Code: • *Dialysis* 71 • *TPN* 73	Receive or need Dialysis or Parenteral Hyperalimentation *(aka: Total Parenteral Nutrition (TPN))* & would be eligible under MN or MI except for excess property) ⑤	Satisfactory Immigration Status California Residency	Dialysis or TPN services ONLY BIC Issued/Restricted	Determine **Annual Net Worth** (ANW): Combined total of annual gross income + net market value of all non-exempt real & personal property (See Procedures Manual Section 17C-5 for property exemptions) ☞	Determine **% obligation** if ANW is $5,000 or more **@ 2% for each $5,000.** EXAMPLE: ANW = $15,000 $15,000 ÷ $5,000 = 3 3 x 2% = 6% % Obligation = 6% (Beneficiary pays 6% of charges)	NOTE: **% Obligation** is the amount beneficiary pays toward the net cost of each dialysis or TPN service. Example: If % Obligation is 6%, then beneficiary pays 6% of net cost of each dialysis treatment. IMPORTANT: If ANW is less than $5,000, beneficiary pays nothing. ⑤ Exception: Persons aged 21 to 64 who receive dialysis or who receive or need TPN services do not need to meet Medi-Cal required disability criteria. (DO NOT REFER TO DED)
Special Treatment Program - Supplemental (STP-S) (50817[c]) Aid Code: • *Dialysis* 71 • *TPN* 73	Receive or need dialysis or TPN services; employed or self-employed & *gross earned income* exceeds *Maintenance Need* for one person. Approved or eligible to MAO as MN or MI w/SOC ⑥	Satisfactory Immigration Status California Residency Non-Satisfactory Immigration Status California Residency	Dual Eligibility to MAO as MN or MI with SOC *and* Dialysis or TPN services BIC Issued/Full Coverage Restricted to Renal Dialysis Only BIC Issued/Restricted	Determine ANW: Combined total of annual gross income + net market value of all non-exempt real & personal property (See Procedures Manual Section 17 C-5 for property exemptions) ☞	Determine **% obligation** if ANW is $5,000 or more **@ 1% for each $5,000.** EXAMPLE: ANW = $15,000 $15,000 ÷ $5,000 = 3 3 x 1% = 3% % Obligation = 3% (Beneficiary pays 3% of charges)	**% Obligation** is same as STP-O IMPORTANT: If ANW is less than $5,000, beneficiary pays nothing. ⑥ Exception: Persons aged 21 to 64 who receive or who receive or need TPN services are not required to meet Medi-Cal required disability criteria. (DO NOT REFER TO DED)
Long Term Care (LTC) Aid Code: •*MNO* *Aged* 13 *Blind* 23 *Disabled* 63 •*MI Adult* 53◆ •*Non-PRUCOL* *Alien* 55♦	Persons who are receiving in-patient medical care lasting more than the month of admission and expected to last for at least one full calendar month after the month of admission.	Satisfactory Immigration Status California Residency Aliens denied PRUCOL (50302) California Residency	Full Scope and nursing home care for MNO Only ◆ Restricted to nursing care only for MI Adult ♦ Restricted to nursing care only for aliens denied PRUCOL	$2,000 (MAO limits) Community Spouse Resource Allowance (CSRA): $80,760 (01/98)$81,960 (01/99) (Updated Annually) of couple's assets (community & separate) can be retained by the at-home spouse (See AD # 3167, dated 1/1/90)	$35 Maintenance Need for personal needs. Remainder goes to LTC facility unless Allocations/Allowances apply. ☞	Spousal Allowance Maximum: $2,019 (01/98) $2,049 (01/99) Used to determine the maximum income an LTC spouse may give to the at-home spouse (50563.5). Dependent Care Allocation: ⅓ the difference between the relative's income & the maximum dependent relative allowance. Home Maintenance Allowance: 133⅓ of Inkind Allowance (if LTC person has documented proof he/she is expected to return within 6 months). (50605[b]).

REVERSE OF PART 2

Health Care Recommendations of the California Citizens Budget Commission

Promptly Institute an Aggressive Program of Streamlined Enrollment Procedures.

1. **Make enrollment procedures simple and user-friendly.**
2. **Increase the MediCal period of continuous eligibility.**
3. **Utilize non-welfare programs with maximum public contact for enrollment.**
4. **Use automatic initial eligibility for those who are presumptively qualified.**
5. **Minimize the welfare stigma.**
6. **Minimize legal immigrants' fears of using government health programs.**

Adopt a Simplified Income-based Eligibility Standard For All Programs.

7. **Replace complex and inequitable eligibility requirements with a simple income-based eligibility standard for all publicly-funded health care programs.**

Consolidate Existing Programs into a Unified Publicly-Funded Health Care System.

8. **Consolidate all publicly-funded health care programs. Administer those programs regionally– with clear lines of authority and state-wide standards for eligibility and benefits.**
9. **In counties that operate their own hospitals and other health care facilities, separate the payor and provider functions of the counties to minimize conflicts of interest in administration, especially with respect to reform implementation.**

Seek More Flexibility in the Use of Federal Funding.

10. **Seek federal waivers allowing flexibility in the use of federal Disproportionate Share Hospitals funding so that such funds can be used for providing health care to the medically indigent regardless of site.**

Increase Funding to Provide Broader Health Care Coverage for the Uninsured - Particularly for Working Poor Families.

11. **Adopt and implement the Family Coverage Model proposed by the Legislative Analyst's Office.**
12. **Use tobacco settlement funds primarily to finance broader access to affordable health care coverage for uninsured low income Californians.**

CGS

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