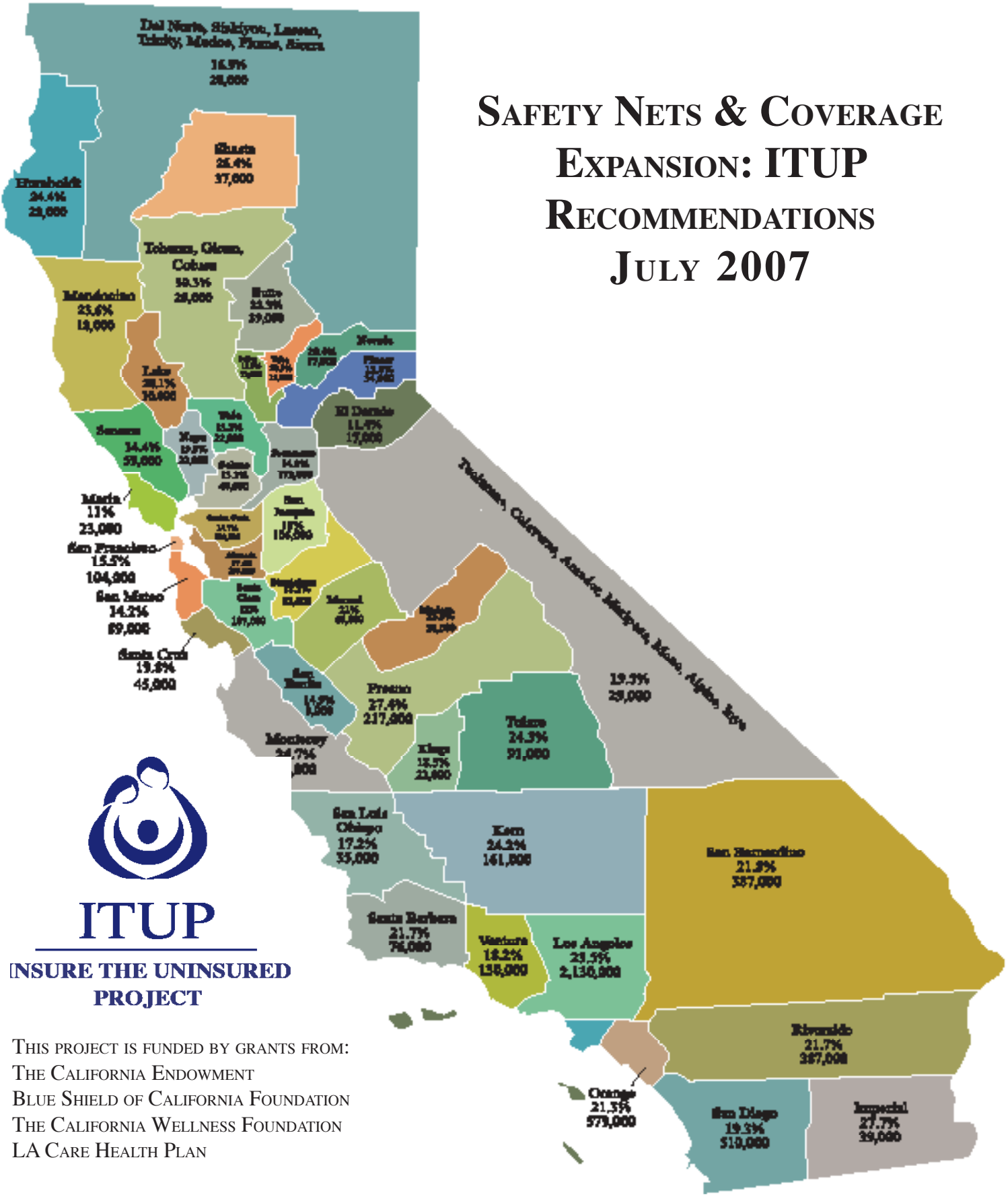
Insure the Uninsured Project

Safety Nets & Coverage Expansion: ITUP Recommendations July 2007



ITUP

INSURE THE UNINSURED PROJECT

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Source: *Number and Percentage of residents uninsured all or part of last 12 months, age 0-64*, 2005 CA Health Interview Survey

SAFETY NETS AND COVERAGE EXPANSION: ITUP RECOMMENDATIONS

California has a diverse and extensive safety net, comprised of free and community clinics, public and private hospitals, emergency room, on-call and volunteer physicians, county health departments and county operated health plans. The roles of the safety net include care for uninsured patients, Medi-Cal patients, and patients with no other access to services.

In 2007 California has the potential to adopt far-reaching reforms in expanding coverage for the uninsured. These reforms would ease the burdens of uncompensated and underfinanced care to the uninsured. Each of the six different proposals pending before the state legislature has a different approach to extending coverage for the uninsured and thus a different impact on local safety net providers.

Our purpose in this paper is to de-mystify issues of coverage expansion and local safety nets so there is adequate information for safety net stakeholders to develop consensus on the strongest possible proposal for expanded coverage. For this paper we interviewed urban and rural clinics, county health directors and local health plan leaders. The recommendations in this paper are ITUP's own; they are informed by our conversations, communications and feedback with our interviewees and interested members of our Board of Advisors.

BACKGROUND ON CALIFORNIA'S SAFETY NET

County Health Programs:
County health is the largest system of care to the uninsured and the repository of state, federal and county funds to care for the uninsured. It spends over $1.7 billion caring for 1.45 million uninsured patients.[1]

Counties are responsible under Welfare and Institutions Code Section 17000 for health care to indigent county residents. More specifically the state of California in 1983 shifted from the state to the counties responsibility for care to medically indigent adults (MIAs), individual adults and couples who are not otherwise eligible for federal matching payments under Medi-Cal – i.e. not parents with children living at home, nor disabled, nor aged.

County indigent health is vastly under-funded, widely diverse and slowly evolving from episodic, emergency room centered care towards managed care delivery systems. Some counties are extraordinary policy pioneers with strong relationships between clinics, hospitals and local managed care plans.

Our past reviews of county health programs in California[2] noted the following:

- Funding and spending for county health programs are inadequate to provide care and coverage for the

1 Chen and Wulsin, A Summary of Health Care Financing for Low Income Individuals in California (October 2006) at www.itup.org/reports

2 See www.itup.org/reports and www.itup.org/regional-workgroups.

uninsured indigent adults and both funding streams and spending have slow or, in some cases, negative growth [3]

AVERAGE COUNTY SPENDING ON CARE TO THE UNINSURED COMPARED TO THE AVERAGE COST OF COVERAGE FOR INSURED ADULTS

	Annual cost of care/coverage
County spending on indigent health care to the uninsured per uninsured	$267[1]
County spending on care per uninsured adult without minor children below 200% of FPL[2]	$1143
County spending on health care per unduplicated user	$1197[3]
Projected cost per uninsured indigent adult enrolled in Medi-Cal managed care	$2124[4]
Average cost of employment based HMO coverage for a single insured adult	$4100[5]

- County funding for all county health services was $3.8 billion in the most recent fiscal year; it is spent on indigent health, public health and other county health. Care to the uninsured indigent in county systems is paid for from a multiplicity of funding sources including: state realignment and Prop 99, federal Medi-Cal DSH and Safety Net Care Pool (SNCP), county match, over-match and tobacco litigation settlement, patient out of pocket, among others.[4]

Realignment	Prop 99	Required county match	Net County DSH and SNCP	County Share of Tobacco Litigation Settlement
$1.5 billion	**$30 million**	**$341 million**	**$1.6 billion**	**$372 million**

- Of total available funding, counties spent on average 57% of available funds for indigent health over the two most recent years for which we have complete reported data.[5] The remainder is divided between public health and other county health services. "Other" county health services include the county share of the CCS program[6], and may include the costs of uncompensated care for Medi-Cal patients, local

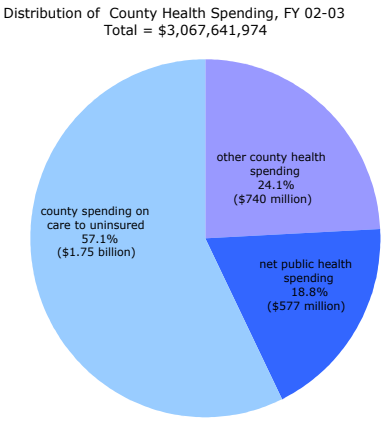
3 Funding growth fails to keep pace with medical inflation and growth in the numbers of uninsured.

4 We included realignment, Prop 99, county match, net county DSH, federal Safety Net Care Pool funding and tobacco settlement in this calculation, but did not include county over-match. ITUP, Overview of California's Uninsured (November 2006) at www.itup.org Realignment funds and the mandatory county match must be spent on county health. County match funds are frozen at 1988 levels and have not increased since while realignment has steadily and slowly grown. Proposition 99 must be spent on care to the uninsured. County over-match funds are discretionary with each county and in the case of Alameda and Los Angeles counties have been generated in part by special voter approved parcel taxes, which must be spent as directed in the initiatives. Medi-Cal disproportionate share hospital (DSH) federal funding must be spent on uncompensated care for Medi-Cal and uninsured patients. Federal Safety Net Care Pool (SNCP) funding must be spent on the uninsured. Tobacco Litigation Settlement (TLS) funds may be spent on the uninsured as many large counties have chosen to do or may be spent on other county purposes. In Orange County, Proposition H governs the distribution of TLS funds.

5 See Fox, ITUP Presentation to Working Committee on Waiver Development and Medi-Cal Expansion (April 25, 2007) at www.itup.org. County indigent health spending is a combination of county reported data through County Medical Services (CMSP) and the Medically Indigent Care Reporting System (MICRS) Net county public health spending accounts for about $535 million or one sixth of the county health pie and is based on county reported spending. "Other county health" is a residual figure derived by subtracting indigent county health and net public health from county health revenues; it may be significantly understated.

6 The county match for CCS in 2006 was $196 million. See Chen and Wulsin, A Summary of Health Care Financing for Low

teaching programs for medical professionals, hospital rebuilding and other local county health priorities.



- Funding is inequitably distributed by county and by region.[7]

Region	Funding per uninsured
North Rural	$374
North Central	$287
Bay Area	$417
Central Coast	$236
Central Valley	$218
Southern California	$285

Realignment funds are based on nearly thirty-year-old distribution formulas that have not been updated to reflect changing demographics and badly disadvantage some counties and regions. Poor regions such as the Central Valley and fast growth counties in the Inland Empire and Southern California counties are particularly disadvantaged.

Prop 99 tobacco tax funding for county health is only a small share of total tobacco taxes because the state government has directed these funds to a variety of state programs covering the uninsured such as AIM for pregnant women and infants. Certain federal funds only go to those counties, which own and operate public hospitals.

- Over-all spending followed funding – i.e. the regions with the most funding spent the most on care to the uninsured and regions with the least funding spent the least on care to the uninsured[8]

Income Californians 1998-2006 (Insure the Uninsured Project, October 2006) at www.itup.org

7 Wulsin and Hickey, Counties, Clinics, Hospitals, Health Plans and California's Uninsured (October 2003) at www.itup.org/regional-workgroups. We divided realignment, county match, Proposition 99 and net County DSH funds by the numbers of uninsured in each region. The funding inequities are not linked to regional or county poverty rates but are due to funding formulas and distributions that date back as far as thirty years.

8 Ibid. We divided regional funding by the numbers of uninsured and regional spending by the numbers of uninsured – 6.6 million over the course of the year (as opposed to 4.9 million at a point in time).

Average regional spending per uninsured	Highest regional spending per uninsured	Lowest regional spending per uninsured
$267	$658	$113

County spending on care to the uninsured is largely driven by the state and federal dollar allotments and the county match mandated by the state. Boards of Supervisors decide how much funding to allocate to indigent health. Some counties allocate additional county discretionary funds to support care to the uninsured; others choose not to do so.

Realignment and Net County DSH Allotments by County

COUNTY	Realignment per Uninsured County Resident	Total Realignment	Net County DSH per Uninsured County Resident	Total Net County DSH
Alameda	$253	$59,040,961	$122	$28,448,566
Butte	$351	$13,078,424	$0	-
Contra Costa	$267	$30,072,526	$87	$9,790,431
Del Norte	$322	$1,937,878	$0	-
El Dorado	$283	$7,476,476	$0	-
Fresno	$195	$37,055,179	$0	-
Humboldt	$474	$12,965,604	$0	-
Imperial	$375	$12,971,578	$0	-
Kern	$153	$25,194,902	$126	$20,835,838
Kings	$277	$6,516,636	$0	-
Lassen	$346	$2,044,583	$0	-
Los Angeles	$222	$471,793,381	$90	$191,040,957
Madera	$211	$6,432,613	$0	-
Marin	$749	$14,898,042	$0	-
Mendocino	$234	$4,160,753	$0	-
Merced	$154	$8,564,705	$0	-
Modoc	$815	$1,198,471	$0	-
Monterey	$134	$12,176,536	$45	$4,082,465
Napa	$181	$6,319,673	$0	-
Nevada	$198	$4,029,129	$0	-
Orange	$139	$83,851,883	$0	-
Placer	$176	$5,309,331	$0	-
Plumas	$387	$1,696,022	$0	-
Riverside	$115	$47,329,833	$56	$23,116,813
Sacramento	$256	$49,151,971.07	$0	-
San Benito	$193	$2,425,438.24	$0	-
San Bernardino	$135	$53,843,272.83	$82	$32,887,500
San Diego	$167	$95,579,447.97	$0	-

San Francisco	$782	$89,986,470.44	$254	$29,171,182
San Joaquin	$188	$21,031,207.65	$101	$11,300,344
San Luis Obispo	$163	$6,818,084.51	$0	-
San Mateo	$206	$20,965,215.57	$46	$4,730,909
Santa Barbara	$170	$12,539,195.97	$0	-
Santa Clara	$234	$50,531,813.86	$199	$43,054,286
Santa Cruz	$200	$8,459,888.77	$0	-
Shasta	$320	$11,212,187.11	$0	-
Siskiyou	$458	$3,144,035.70	$0	-
Solano	$422	$16,091,112.43	$0	-
Sonoma	$381	$25,629,300.63	$0	-
Stanislaus	$178	$16,821,626.92	$0	-
Sutter	$376	$6,154,802.56	$0	-
Tehama*****	$281	$10,541,843.94	$0	-
Trinity	$845	$1,780,649.23	$0	-
Tulare	$172	$15,275,854.86	$0	-
Ventura	$157	$19,688,777.35	$73	$9,137,867
Yolo	$218	$5,429,071.47	$0	-
Yuba	$409	$5,116,769.45	$0	-
Statewide	**$214**	**$1.424 billion**	**$61**	**$407,597,158**

***** Colusa, Glenn, Lake, & Tehama Counties
Source:
DHS, Office of County Health Services, Realignment FY 2003-04, SB 855 Actual Transfers
County and Non Co Hospitals: FY 2003-04, 2003 CHIS (6.6 Million Uninsured Over One Year Period

- County spending on the uninsured as a percentage of county health revenues varied widely by region (two year average)[9]

Bay Area	Central Coast	Central Valley	North Central	North Rural	Southern California
61%	**37%**	**40%**	**70%**	**118%**	**77%**

These unanticipated spending variations may be partly a function of differing local political priorities for care to the uninsured. It is unrelated to "need" for funding, as the Central Valley and Central Coast regions both have high reported rates of uninsured.

- Care followed funding – i.e. the counties that spent the most provided the most services in inpatient days per 1000 uninsured and outpatient visits per uninsured (average and range).

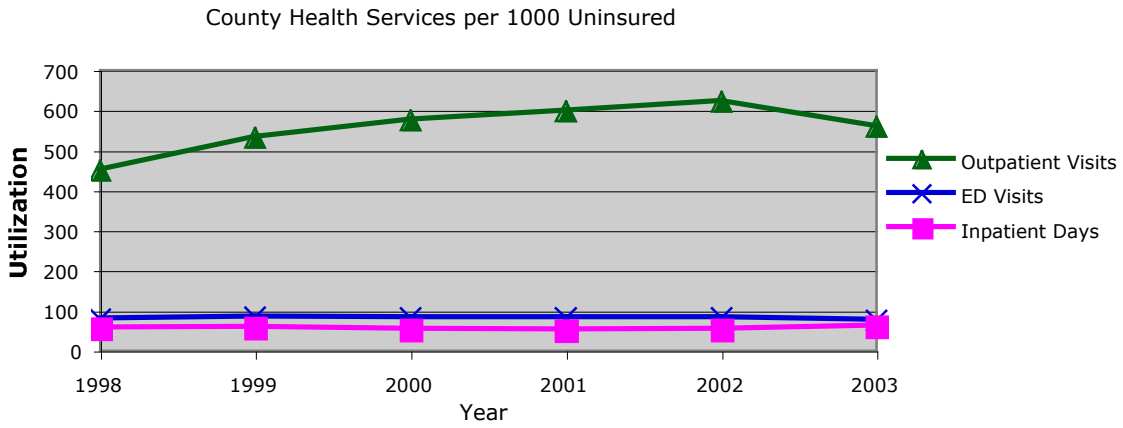
We compared care to uninsured adults through county health programs with care to insured adult populations

9 Ibid.

in a well-managed HMO. Not surprisingly uninsured patients receive far less care in an under-funded system; the care deficit is most severe for outpatient visits. The variability in care among county systems is extreme and may be explained by a combination of funding inequities, different local priorities and inconsistent county reporting.

Average inpatient days per 1000 insured adults	Average county inpatient days per 1000 uninsured[6]	Highest county inpatient days per 1000 uninsured	Lowest county inpatient days per 1000 uninsured
235	**76**	**103**	**27**
Average outpatient visits per insured adult	Average county outpatient visits per uninsured[7]	Highest county outpatient visits per uninsured	Lowest county outpatient visits per uninsured
3.9	**0.6**	**2.1**	**0.3**
Average ER visits per insured adult	Average county ER visits per 1000 uninsured[8]	Highest county ER visits per 1000 uninsured	Lowest county ER visits per 1000 uninsured
154	**72**	**101**	**21**

- Care in county health programs was concentrated in hospital services though it was slowly evolving towards outpatient settings.[10]



Source: Office of County Health Services

Over a six year period that included a serious recession where counties were pinched by declines in funding and increased demands for services by the newly uninsured, California counties increased access to outpatient care for the uninsured and maintained their levels of inpatient and emergency services.

- Many provider counties have heavily invested in rebuilding their public hospitals, and these serve as strong and competitive foundations for local delivery systems.[11]

Counties with county hospitals have rebuilt their facilities, improved plant and equipment at remarkable rates over the past decade; not all facilities have yet been rebuilt, and several still face rebuilding and financing

10 ITUP, Where are the Uninsured Now: a Ten Year Overview (February 2007) at www.itup.org More than 50% of expenditures is situated in hospital emergency room or hospital inpatient settings and a significant amount of outpatient care costs is concentrated in hospitals as well.

11 California's Uninsured: Ten Years of Change 1995-2005 (Insure the Uninsured Project, 2006) at www.itup.org

challenges to meet state seismic requirements.[12] For the most part, the new facilities have attracted and maintained high occupancy rates in the re-built facilities and contributed to the strong competitive position of these counties in Medi-Cal managed care. There are some public facilities that are in serious trouble financially, and at least one, the Martin Luther King facility in Los Angeles, has had serious quality of care issues. The reputation of these latter facilities does not make them conducive as a building block.

- Some counties have invested in expanding and strengthening their primary care delivery networks. Some counties have made remarkable strides in expanding primary care. In Los Angeles and Santa Clara, this has been done in collaboration with private, non-profit free and community clinics, following the model developed in Alameda County. In the Inland Empire counties and Ventura, public clinics were expanded.

To compete successfully in the Medi-Cal managed care market, counties with public hospitals must have a well-balanced delivery system with a strong foundation in primary care. Some counties, including San Francisco, San Mateo and Santa Clara, are now considering their managed care delivery networks for Medi-Cal and the uninsured, following the model initially pioneered in Contra Costa County.

Strengthening primary care systems for the uninsured through collaboration with free and community clinics occurred in payor counties, such as Orange and San Diego, as well.

There is surprisingly little county funding of community clinic networks in the Central Valley, Central Coast and North Central regions. This may change in some of these counties who recently received federal coverage expansion funds. In the small, mostly rural CMSP counties, community clinics' care to uninsured adults is reimbursed comparably to Medi-Cal.

- There are five major types of county systems for the indigent uninsured:
  - Thirty five small counties participate in the County Medical Service Program (CMSP),[13] which pays providers for their care to indigent uninsured adults with incomes up to 200% of FPL
  - Provider counties such as Los Angeles, San Francisco, Kern or Riverside that deliver care in their own public hospitals and clinics to the uninsured who use the county health system[14]
  - Payor counties such as Orange and San Diego that pay private providers for their care to indigent, uninsured adults[15]
  - Hybrid counties such as Santa Barbara, Sacramento or Tulare that operate public clinics for the uninsured and pay private hospitals for their care to indigent uninsured adults[16] and

12 Ibid.

13 These small counties limit coverage to MIAs – medically indigent uninsured adults without minor children and income of less than 200% of FPL. Participating CMSP Counties, see http://www.cmspcounties.org/about/participating_counties.html (accessed April 11, 2007).

14 These large mostly urban counties operate public hospitals and clinics that are open to all uninsured patients. They have sliding fee schedules for patients with limited ability to pay.

15 These large urban counties restrict eligibility to MIAs and typically cut off eligibility at 200% of FPL. Some further restrict eligibility to patient with a serious medical condition; thus further limiting the numbers of enrolled eligibles but not the programs' cost since 70% of medical expenses are typically associated with 10% of a given population. This restricted eligibility does impact access to preventive and primary care services for the majority of uninsured MIAs.

16 The public clinics in these counties are an important resource in providing primary care services to uninsured adults. Private

- Block grant counties such as Fresno and Merced that allocate a fixed sum to a single local hospital for care to indigent uninsured adults.[17]

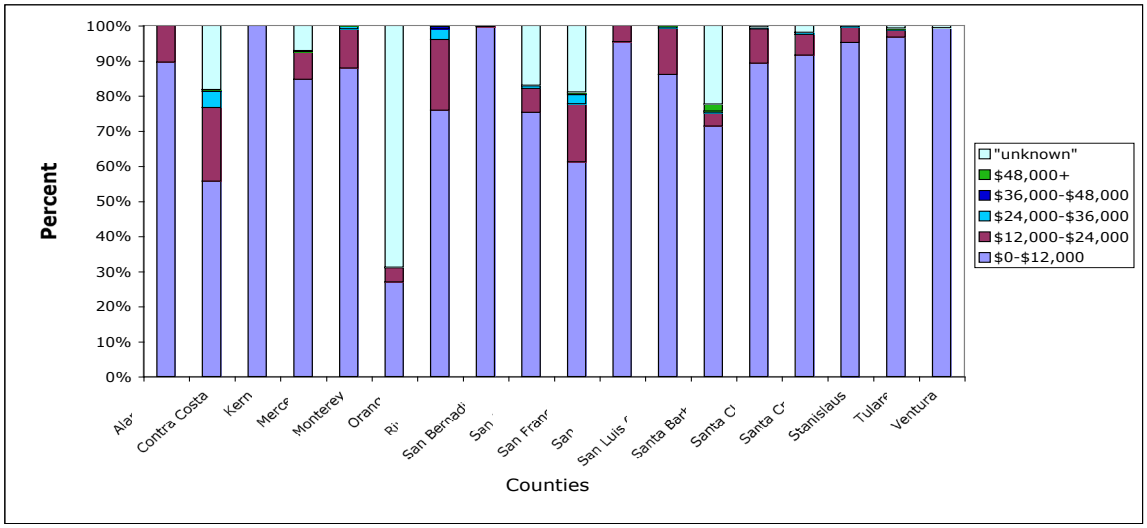
As discussed in the next section, these counties have very different perspectives on state coverage expansion for the uninsured, and those perspectives are tied and rooted to the roles of county government in the delivery system (i.e. the public or private delivery) of care to the uninsured.

- County eligibility rules vary widely with respect to income eligibility, immigration status and other eligibility rules.[18]

As county funding and delivery systems are highly variable, so too are county eligibility rules. Income limits reach as high as 500% of FPL or roughly $50,000 for an individual. They are as low as 63% of FPL or about $6,300 for an individual. Most cover adults up to 200% of FPL ($20,000 for an individual) but with cost sharing starting as low as 100% of FPL. Some counties tack on additional eligibility requirements such as serious or critical medical need, which define their system as paying for care to the acutely ill, and excluding a role for prevention. Most have resource limits and asset tests based on Medi-Cal models.

We compared income distribution for single adults using county health services. Most patients using county health programs in all but a handful of counties had very low incomes – below $12,000 annually.[19] Some counties report "unknown" for a high percent of their patients. Only a few counties, including Contra Costa and San Francisco, reported seeing a significant portion of single adult patients with incomes in excess of $12,000 annually.

Distribution of County Indigent Health Program Patients by Income



hospitals and doctors are paid for hospital-based care to the MIAs.

17 County funding is allocated to one hospital, typically the ex-public hospital, for its care to the county indigent. No funds are allocated for patients at other hospitals or for community clinic patients.

18 See California HealthCare Foundation, County Programs for the Medically Indigent (2006) at www.chcf.org

19 California Department of Health Services, Medically Indigent Care Reporting System, Fiscal Year 2003-2004 Data. Several counties, including Los Angeles County, had not completed their reports.

There is wide variability in county eligibility requirements for residents without US citizenship or legal permanent residency status. Payor counties, such as San Diego, typically exclude undocumented patients altogether. The smaller, typically rural CMSP counties, such as Humboldt, Kings or Imperial, pay for emergency services to undocumented indigent adults in a manner comparable to Medi-Cal. While counties with public facilities (provider counties) usually treat uninsured patients in their programs without regard to immigration status.

- Counties are pioneering new models of coverage for the uninsured.[20]

Bay Area counties, including Contra Costa, San Francisco, Santa Clara, San Mateo and Alameda, have pioneered new models for coverage for the uninsured with little or no state assistance. Contra Costa expanded coverage to all indigent adults up to 300% of FPL, using its county managed care system, county hospitals and clinics as the foundations of expanded coverage; this model is now spreading to other Bay Area counties. San Francisco has recently developed coverage for all uninsured county residents, using its county managed care system, county facilities, community clinics, private doctors and private hospital emergency rooms as the organized delivery system. Previously it initiated coverage for uninsured home care workers, child care workers and taxi cab drivers; some of these models spread to other counties as well. Santa Clara started the Healthy Kids coverage models, now emulated in over 18 other counties. These counties have in common a strong and competitive county hospital and county managed care plan, and deepening relationships with their non-profit community and free clinics.

The state has recently approved federal coverage expansion funds for a range of counties creating partnerships with primary care clinics, focused on improving and managing care for the chronically ill and developing the infrastructure of information technology and safety net provider relationships for successfully managed care.[21]

Safety Net Health Plans (Local Initiatives and County Organized Health Systems)
Health plans were created by county governments in response to the state's managed care initiatives in the early '80s and mid '90s and organize delivery networks featuring local safety net providers for Medi-Cal and Healthy Families patients. As creations of local government, one of their roles is to assure safety net providers a place in the sun – a guaranteed opportunity for safety net providers (whose participation in traditional commercial insurance is often minimal) to meaningfully participate in managed care for their traditional patients. Another role is to protect and enhance the viability of local safety net providers, in particular the county-owned hospitals and clinics.

In these plans, patients can choose their own plan and can choose their own primary care doctors and specialists from the plan's provider network; safety net providers compete with each other and with private practitioners to enroll patients. Local initiatives in turn compete with commercial plans in the Medi-Cal and Healthy Families programs. County Organized Health Systems (COHS) have no competitors for Medi-Cal patients but compete with commercial plans for Healthy Families enrollees. Not all plans are equally successful competitors; in the

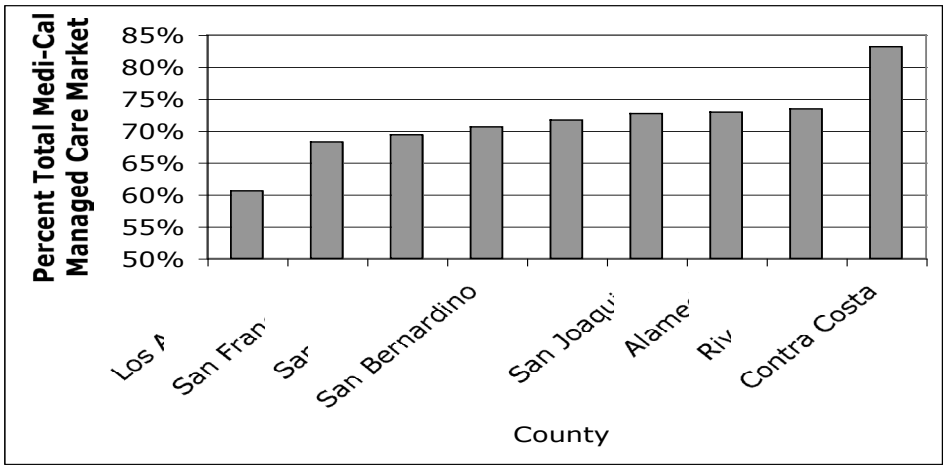
20 See Christine Chen, Coverage Initiatives: Design and Effectiveness (January 2007) at www.itup.org and Jolly Mannanal, Directory of Local Efforts to Expand Health Care Access for California's Uninsured (updated January 2007) and Mannanal, Coverage Expansion Waiver Awards: Summary (March 2007) at www.itup.org.

21 Mannanal, Coverage Expansion Waiver Awards: Summary (March 2007) at www.itup.org

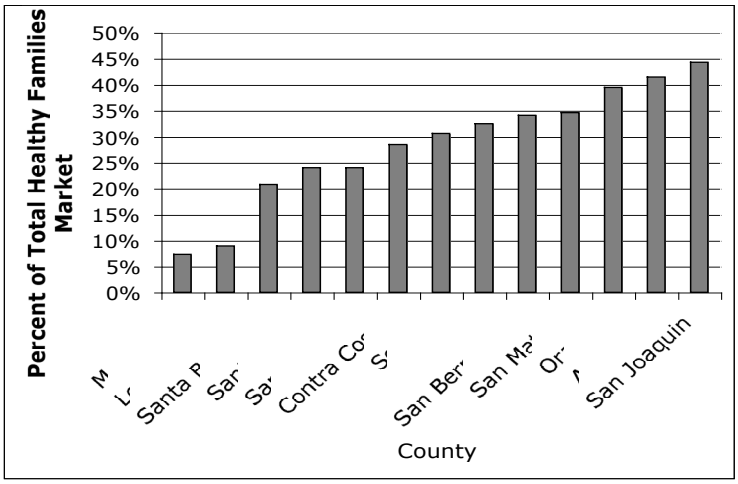
charts following we contrast enrollment in Medi-Cal and Healthy Families.

Alameda Alliance and the San Joaquin Health Plans are the most successful county operated competitors in both the Healthy Families and Medi-Cal markets. The Los Angeles plan(s) are among the least successful competitors in both markets – a 60% market share in Medi-Cal and less than 10% of the local Healthy Families market. Contra Costa Health Plans is the most successful Medi-Cal competitor.

Local Managed Care Plan's Share of Medi-Cal Managed Care Market[22]



Local Managed Care Plan's Share of Healthy Families Market[23]



22 State of California, Department of Health Services, Medical Care Statistics Section. *Medi-Cal Beneficiary-by-Month File For Month-Ending August 2003*; and State of California, Department of Health Services, Medical Care Statistics Section. *Overview for the Medi-Cal-Beneficiaries-Profiles-by-County File for July 2003 and July 2004*

23 www.mrmib.ca.gov

Medi-Cal and Healthy Families have quite different rules to promote enrollment in those plans with greatest participation by safety net providers. Medi-Cal sets a minimum threshold of a 60% market share for the local safety net plan; whereas, Healthy Families awards a premium discount to those enrollees selecting the plans with the most participating safety net providers. Safety net providers are not restricted to affiliating with one plan and can choose to participate in several plans to maximize their opportunities to enroll existing patients and attract new ones.

As discussed previously, many but not all locally owned and operated health plans reinvest their managed care savings in expanding coverage for their counties' uninsured; this is the genesis of local plans to cover all uninsured children, uninsured home care and child care providers, uninsured young adults, uninsured cab drivers and in some counties all or most uninsured adults. The plans have learned and applied valuable lessons about outreach, enrollment and participation in these pilots. Recent pilots underline the importance of coordinating with state government, which has too frequently been a bystander to these local efforts, to mix and match state and local funding; for example efforts to cover uninsured young adults or uninsured child care workers should coordinate with state programs providing maternity benefits coverage for young women and efforts to cover uninsured children should coordinate with federal and state funding for Emergency or Restricted Scope Medi-Cal.

Private Care to the Uninsured

Private hospitals, private doctors and private non-profit community clinics all deliver a large volume of care and services to the uninsured. At times and in certain counties, this is coordinated with, funded by, and supplementary to care in county health systems, but more typically this is a parallel, disconnected and occasionally a competitive system of care.

- There is a large volume of care to the uninsured that occurs outside county health systems and some but by no means all of it is uncompensated to hospitals, doctors, and clinics.

	Care to the uninsured	Uncompensated care to the uninsured	Percentage of revenues
Community clinics[9]	$495 million 5 million visits	$136 million	12.6% of clinic net patient revenues
Private hospitals[10]	$1.6 billion	$1.25billion	3% of hospital net patient revenues
Private doctors[11]	2% of physician services	Not available	2% of physician services

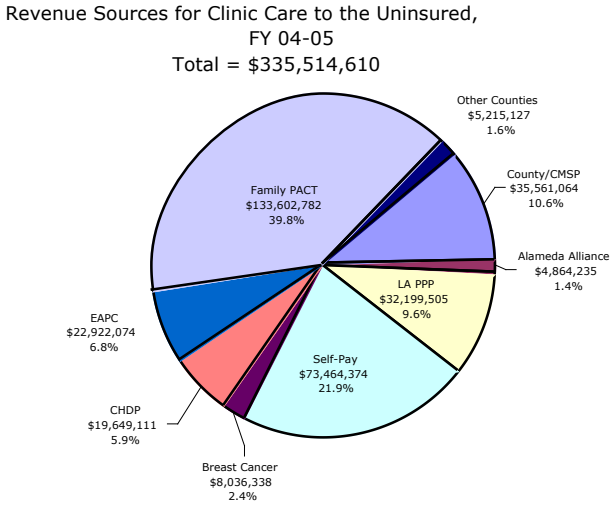
- Non-profit free and community clinics have strong funding and delivery system connections with county health programs in some counties such as Los Angeles, Alameda and San Diego, but little or no system connections or funding for care to county indigent adults in other counties.[24]

Community and free clinics now provide more primary care and preventive services to the uninsured than does county health. Clinics provide 5 million visits to the uninsured or 1.0 visits per uninsured Californian. Over the

24 We initially reviewed these arrangements in six urban counties in Wulsin, Clinics, Counties and the Uninsured (Insure the Uninsured Project, 1999) and have updated this information for all counties through our regional workgroups. Clinics in the Central Valley, Central Coast and North Central regions are most lacking in funding, referral and case management arrangements for county indigent patients. Several counties are building clinic referral, information technology and

past ten years, clinics have experienced large growth in their numbers and distribution, in their overall visits and visits by uninsured patients, and in the complexity of care and services they provide on site.[25] Without strong system connections, clinics lack adequate assured referrals for specialty services and hospital care to the uninsured and there is little ability for primary care physicians, specialists and hospitals to effectively and efficiently manage their patient's care across the different delivery systems.

- Clinic care to the uninsured is paid for by EAPC, Family PACT, counties,[26] federal 330 grants,[27] patient fees and a myriad of smaller programs.



Source: OSHPD Clinic Data, FY 04-05

This array of funding partially compensates clinics' care to the uninsured, but clinics are still left with an uncompensated care burden of about $136 million -- over 12% of clinics' net revenues. Care in some clinics may follow the money patterns of funding for state programs such as family planning or breast cancer screening.

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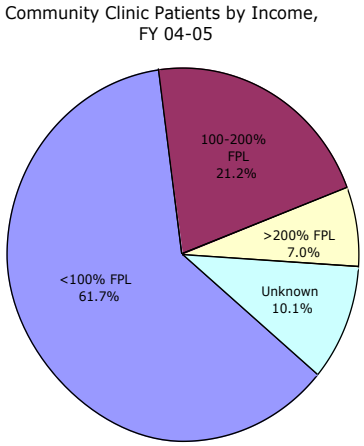
25 ITUP, Ten Year Trend Report at www.itup.org

26 Counties may reimburse patients on a fee for service basis for care to county indigents or through grants and contracts. The totality of county funding is reported by clinics either as county patient revenue or as county grants and contracts; there is little consistency in clinics reporting. County grants to and contracts with clinics were reported at $76 million; some of these grants are for care to the uninsured, some for mental health services, some for Ryan White services and other purposes.

27 Federal 330 grants are awarded to the limited numbers of clinics who are federally qualified health centers (FQHCs), these are private and nonprofit community health centers that provide comprehensive primary care services to medically underserved areas and populations regardless of patients' ability to pay. Federal grants and contracts to clinics were reported at $246 million. Grantees are also eligible for enhanced benefits, such as enhanced Medicaid/Medicare reimbursement, discounts on the costs of prescription drugs, and access to the Federal Tort Claims Act (FTCA) program for malpractice coverage.

Clinic-county working relationships and funding are particularly strong in some counties such as Los Angeles, Alameda, San Diego, Orange, Santa Clara and the rural CMSP counties. However in the Central Valley, Central Coast and North Central regions, the clinic-county funding and working relationships are in need of serious improvements.[28]

Clinics see a very low-income patient population. Over 80% of clinic patients have incomes below 200% of FPL, including over 60% with incomes less than 100% of poverty; while only 7% of clinic patients have incomes in excess of 200% of FPL.



Source: OSHPD Clinic Data 2004-05

Clinics in many communities are evolving from an episodic care model to well developed managed care providers for those with chronic illnesses. In many communities, clinics experience severe obstacles in securing specialty care for their uninsured patients in public and private hospitals. San Diego and Alameda clinics have the most highly developed infrastructure for clinic management of uninsured and Medi-Cal patients' care and costs. Los Angeles community clinics and the Los Angeles county system that funds them have made significant progress in overcoming lingering county hospital resistance to acceptance of the clinics as full partners in the delivery system. Community clinics are now a bulwark in care and enrollment in the Los Angeles Healthy Kids program; county clinics and comprehensive health centers have participated less in this coverage expansion for uninsured children due to some of the county's own internal bureaucratic obstacles.

Community and free clinics are collaborating with counties in recently approved federal coverage expansion grants.[29] These grants are designed in part to improve the quality and effectiveness of care to the chronically

28 In most counties in these regions, there is little or no county funding of clinic services to the uninsured and little collaboration between clinics and county health care to uninsured adults. See Fox, Regional Workgroup Reports 2006 at www.itup.org.

29 Mannanal, Coverage Expansion Waiver Awards: Summary (March 2007) at www.itup.org

ill uninsured. In some communities such as Kern and Ventura, the grants are a first step in county/clinic collaboration to expand coverage for the uninsured.

- Private hospitals' care to the uninsured is paid for by a mix of counties, federal DSH, Prop 99, patient out of pocket and the cost shift to private insurance.[30]

Private hospitals with emergency rooms are required as a condition of licensure to treat patients in a genuine emergency regardless of the patient's ability to pay or insurance status. Private hospital bad debt and charity care (mostly to uninsured patients) costs hospitals about $1.25 billion or 3% of total hospital expenses.

Counties pay hospitals for their care to county indigent adults; these payments total about $370 million. Private hospitals also receive federal funds for their care to the uninsured. These funds ($790 million) are comparable to the DSH and safety net care pool funds for public hospitals and help offset uncompensated care in those private facilities with a large percentage of low-income uninsured and publicly insured patients. Both private and public hospitals bill and collect payments from uninsured patients[31] and private hospitals cost shift their losses in treating the uninsured to the privately insured.

ITUP's recent studies show that bad debt and charity care in private hospitals held relatively steady at 3% of hospital expenses over the past ten years.[32] However the growth in private hospital costs of bad debt and charity care was well in excess of the growth in their federal DSH funds.[33]

In some communities, non-profit clinics and private hospitals work collaboratively in delivering care to the uninsured; in others they do not. Likewise, some private and public hospitals cooperate in caring for the uninsured while in other communities there has been some hostility and non-cooperative attitudes on both sides. Some hospital districts and hospital foundations help fund community clinics for the uninsured, and others have helped start and fund local coverage initiatives for the uninsured.[34]

- Private doctors provide care to the uninsured in their own offices, in clinics and through hospital emergency rooms.[35] National studies found that, on average, about two percent of all physician services

30 Private hospitals report receiving $372 million from counties for their care to the uninsured county indigent; some private hospitals receive significant private DSH and supplemental ($542 million and $247 million) allocations from the Medi-Cal program to pay in part for their uncompensated care to the uninsured. The cost shift occurs when providers transfer a proportion of the cost of uncompensated care from treatment to underinsured and uninsured patients to insured patients in the form of higher service fees.

31 Recent changes in California law restrict hospitals' ability to charge low income uninsured patients for their charges (a noxious practice in which hospitals billed the uninsured at an inflated figure up to four times hospital costs).

32 ITUP, Ten Year Trend Report at www.itup.org

33 Ibid.

34 See Mannanal, Directory of Local Efforts to Expand Health Care Access for California's Uninsured (updated 2007) at www.itup.org

35 Private doctors' care to the uninsured is paid for by Prop 99, SB 12 fines and fees, patient out of pocket, hospitals, counties and the private cost shift. SB 12 created and Prop 99 helps to finance an emergency medical services fund that compensates physicians for emergency care to nonpaying patients. A number of hospitals pay specialty physicians a fee for serving on emergency call panels and contract with emergency physicians for their care to uninsured patients. Many but not all counties pay private physicians for their care to county indigent patients. Many physicians continue to treat their patients who become uninsured and bill and collect at reduced rates reflecting their patients' ability to pay. Other physicians see the uninsured as volunteers or for reduced compensation at local free

are uncompensated care to the uninsured.

Private doctors who serve in emergency room settings treat large numbers of California's uninsured. Some physicians volunteer their services in community and free clinic settings to treat the uninsured. Others treat uninsured patients in their own offices at reduced fees, most typically for long time patients who are temporarily uninsured. The total volume of care to the uninsured by private doctors is not reported or measured in California, but is estimated at 2% of private physician services nationwide.[36]

In California, private doctors are paid for some of their care to the uninsured in many counties but not reimbursed at all in a number of others. Private on-call doctors are paid by their hospitals to serve on–call for uninsured patients in some hospitals but not in others. The state and counties have set up a small, uncompensated care pool, known as the Maddy fund, financed by traffic fines and Prop 99 cigarette tax funds to partially reimburse private doctors for their care to the uninsured.

There is little collaboration between private doctors and county health departments in most communities with public hospitals; there are, however, exemplary public-private programs such as Citrus Valley Health Partners in the San Gabriel Valley, Young and Healthy in Pasadena, and Operation Access in San Francisco. More commonly private physicians volunteer their services in private, non-profit community clinics.

SUMMARY

To summarize, the uninsured seek and receive care in disconnected public and private settings, some of that care is compensated by an array of public programs and some by the cost shift to the privately insured. Funding is inadequate to the needs of the patients, inequitably distributed, distributed in disconnected silos, and not likely to increase absent reform.

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and community clinics.

36 See n. 34. One third of physicians reported providing no care to uninsured patients. Hadley, Who Pays and How Much: the Cost of Caring for the Uninsured.

REFORM PROPOSALS AND THE SAFETY NET

There are six major reform proposals under consideration in California: Governor Schwarzenegger, Speaker Nunez, Senate President Perata, Senator Kuehl, the Senate Republican and the Assembly Republican proposals. They have common features and share many consistent approaches.[37] We examine in this section their impacts on safety net providers and programs.

Projected Changes in Coverage (in Millions) for Californians under Age 65

	Before Reform	After Reform		
Total Population	32.3	Governor's Plan	SB 48 Perata	AB 8 Nunez
Medi-Cal and Healthy Families	6.6	+1.6 = 8.2	+0.6 = 7.2	-0.8 = 5.8
Employer Provided	18.8	-0.1 = 18.7	-0.4 = 18.4	+1.5 = 20.3
Non-group	2.0	+0.8 = 2.8	-1.0 = 1.1	-0.6 = 1.5
Uninsured	4.9	-4.0 = 0.8	-3.4 = 1.5	-3.4 = 1.5
New Pool	NA	+1.7 = 1.7	+4.1 = 4.1	+3.2 = 3.2

Source: (Gruber, Modeling Health Reform in California, May 16, 2007)

The Governor's plan would increase Medi-Cal and Healthy Families enrollment by 1.6 million; Senator Perata's would increase enrollment by 0.6 million, and Speaker Nunez would reduce Medi-Cal and Healthy Families coverage by 0.8 million while increasing employment based coverage by 1.5 million persons.[38]

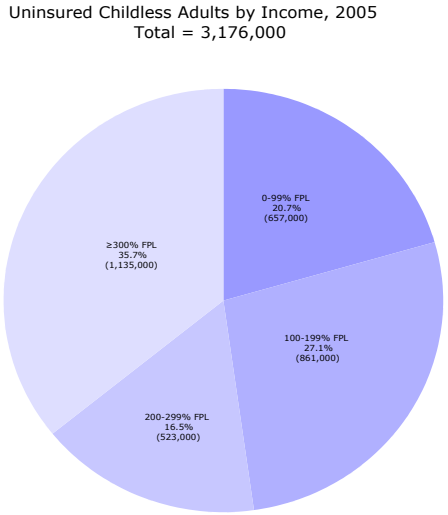
Medi-Cal managed care expansion for the Medically Indigent Adults (MIAs)[39]

Governor Schwarzenegger has proposed covering low income (below 100% of FPL) uninsured adults through an expansion of Medi-Cal managed care. This aspect of the proposal would cover about 650,000 individuals now covered by county health services, but only about one in five uninsured adults without minor children living at home. Speaker Nunez and Senator Perata would cover low income working adults through Medi-Cal managed care. The essential difference is that the Governor's plan would cover working, self employed and unemployed adults while Speaker Nunez and Senator Perata's proposals would not cover self-employed or unemployed workers, they would remain a county responsibility.

37 We reviewed these proposals in Impact of Major Health Proposals on Women's Health Coverage (Insure the Uninsured Project, June 2007) at www.itup.org/reports

38 Speaker Nunez and Senator Perata have now merged their two measures; Professor Gruber's analysis of the merged version has not yet been publicly released.

39 It is important to distinguish between the MIAs (uninsured adults without minor children living at home) and uninsured parents. The uninsured parents can be covered by expanding coverage under Medi-Cal Section 1931b as proposed by Governor Schwarzenegger, Senate President Perata and Speaker Nunez; there are about 1.5 million uninsured parents with incomes below 300% of FPL. This is a plan amendment that the federal government has no authority to deny. The MIAs can be covered by state or state and county funds as Washington state and Minnesota do or they can be covered under a Medicaid §1115 waiver as Oregon, Arizona, New York and Massachusetts do. This waiver is discretionary with the federal government; there are about 2 million uninsured adults without minor children living at home with incomes below 300% of FPL. The uninsured MIAs are a county responsibility in California; whereas uninsured parents are not and the state already pays through Medi-Cal share of cost for their most costly services when parents are seriously ill or injured, but not for the routine primary and preventive services necessary to maintain and enhance health.



Source: California Health Interview Survey 2005

The Governor's plan will leave about 0.8 million uninsured – undocumented adults with very low incomes -- and replace county responsibility for most county patients. The Speaker and Senate President's plans will leave 1.5 million uninsured; half of whom have incomes of less than 133% of FPL and nearly three quarters have incomes below 300% of FPL. Their proposals would reduce the burdens on county health programs by roughly 50%, with the greatest percentage reductions in uninsured occurring for persons with incomes between 133% of FPL and 200% of FPL.

California's Uninsured (in Millions) after Reform by Family Income

	Before Reform	After Reform		
		Governor's Plan	SB 48 (Perata)	AB 8 (Nunez
Total	4.9	0.8	1.5	1.5
Less than 133% of FPL	1.3	NA	0.7	0.7
133% of FPL to 300% of FPL	1.4	NA	0.4	0.4
More than 300% of FPL	1.2	NA	0.4	0.4

Source: Gruber, Modeling Health Reform in California (May 16, 2007)

Expanding coverage to the uninsured through Medi-Cal managed care is favorable to safety net providers such as public hospitals and community clinics as Medi-Cal includes Federally Qualified Health Center (FQHC) reimbursement for community and county clinics[40], cost reimbursement for public hospitals[41] and cross

40 FQHC reimbursement pays for a clinic's reasonable and necessary costs. Most but not all non-profit community clinics and most county clinics receive Medi-Cal FQHC reimbursement, and as a result there is little or no Medi-Cal uncompensated care in these sites.

41 As part of the recent federal hospital waiver, public and UC hospitals are paid for their reasonable and necessary costs. As a

references with hospitals' DSH[42] allocations.

1. Medi-Cal FQHC (and FQHC look-alike) reimbursement assures that most community and county clinics are paid for their actual costs of providing outpatient services. For clinics, Medi-Cal is their most favorable form of reimbursement.[43]
2. Public hospitals are paid for their actual costs of treating MediCal patients under the 2005 hospital waiver. The catch is that these counties pay the local match for their Medi-Cal reimbursement, an obligation not applied to private hospitals. Public hospitals would prefer the state to pay the match. Medi-Cal funding is the financial backbone of every county hospital.
3. Expanding coverage through Medi-Cal managed care up to 100% of FPL would pick up different percentages of each county hospital's uninsured patients.[44] A county such as Kern reports that 99% of uninsured county patients had incomes of less than $12,000 annually. In Riverside, 73% of uninsured county patients had incomes of less than $12,000 annually. Whereas San Francisco reports that only 47% of its uninsured county patients had incomes of less than $12,000 annually.
4. Federal DSH funds are allocated in California based on a public hospital's caseload of Medi-Cal and low-income patients. Switching indigent adults from county coverage to Medi-Cal coverage should not disturb respective allocations of DSH funds among hospitals. However total federal DSH funds could decline as hospitals' actual costs of uncompensated care burdens are reduced since federal DSH payments cannot exceed each individual hospital's actual cost of uncompensated care.[45]

- Expanding through Medi-Cal managed care is consistent with existing provider relationships and provides a medical home for the nearly half of uninsured MIAs who lack an existing usual source of care.[46]

Nearly half of uninsured low and moderate income (below 200% of FPL) adults lack an existing usual source of care; a third use community and county clinics, and about one fifth use private doctors. The highest priority is finding a medical home for those low-income adults without one. Safety net providers want to retain existing provider-patient relationships and transform that relationship from episodic care into a medical home for their patients and have the opportunity to serve low income uninsured patients who now lack a usual source of care.

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result there is little or no Medi-Cal uncompensated care in these sites.

42 DSH is fixed pot of federal funds for uncompensated care; it does not increase as uncompensated care increases; however under federal law it decreases as hospital uncompensated care decreases as is discussed subsequently.

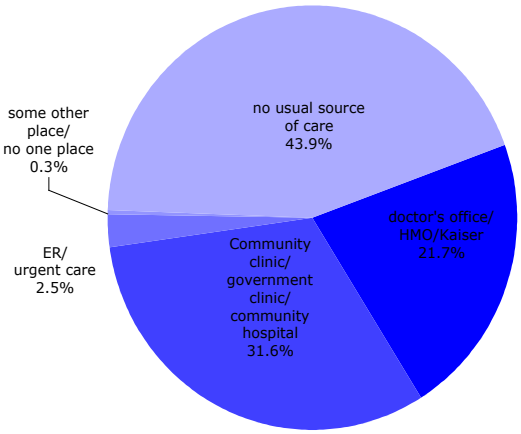
43 See Chen and Wulsin, A Summary of Health Care Financing for Low Income Individuals in California at www.itup.org/reports

44 California Department of Health Services, Medically Indigent Care Reporting System, Fiscal Year 2003-2004 Data

45 California should "capture and reinvest" these funds for coverage expansion rather than returning them to the federal government; this will require a federal waiver.

46 Nearly half (45%) the MIAs with incomes below the poverty level have no usual source of care. Nearly a third use county and community clinics. About one in five use a private doctor's office and a surprisingly low 2.5% use the hospital emergency room as their usual source of care. See Fox, ITUP Presentation to Working Committee on Waiver Development and Medi-Cal Expansion (April 25, 2007) at www.itup.org derived from 2005 California Health Interview Survey.
Medi-Cal managed care substantially reduces the percentages of persons with no usual source of care – to 6% of enrollees. See California HealthCare Foundation, Medi-Cal Facts and Figures: A Look at California's Medicaid Program (May 2007) at www.chcf.org

Usual Source of Care for Uninsured Adults, 0-199%, 2005



Source: California Health Interview Survey 2005

Safety net managed care plans provide the best opportunity for public and private safety net clinics to retain their existing patients and transform their services to a medical home model. Counties with public hospitals and public clinics already use either the two-plan or County Organized Health Systems (COHS) model of Medi-Cal managed care, which gives the counties local control over the managed care program as the counties founded these programs, appoint their governing boards and are assured a certain share of the Medi-Cal managed care market(s).[47]

- It is an easy transition to a Medi-Cal managed care model for counties and safety net providers in those counties using payor, hybrid and CMSP models as these counties are not heavily invested in their own delivery system.[48]

47 In the COHS model, there is a single local managed care plan; in the "two plan" model, a local initiative that is required to include the local safety net providers competes with a commercial plan. In general, local public hospitals and community clinics express strong support for their local managed care plans. Many community clinics hedge their bets by participating in both plans. Los Angeles is not a true two plan model county as both the local initiative and the commercial plan are umbrellas for several different plans.

48 In both payor and CMSP counties, safety net providers participate and compete for patients with other providers in the county indigent program and in Medi-Cal. Some safety net providers have strong case management capacities, infrastructure and referral relationships necessary to effectively participate in managed care; others are not as well prepared or as capable and competitive participants at this time. Primary care clinics would be helped quite dramatically as the current county systems in "payor" counties concentrate their programs' resources on the most seriously ill patients.
In block grant counties, there is no county funding for primary care clinics; Medi-Cal managed care will improve primary care and care coordination for the MIAs. It would reduce the demand for services on the ex-public hospital that is the sole source of county funded care for uninsured adults by spreading the patients to primary care sites and other local hospitals. The safety net facilities already participate effectively in Medi-Cal managed care in Fresno, and there is not yet managed care for Medi-cal patients in Merced. In some hybrid counties, the public clinics already participate effectively in both the Medi-Cal managed care system and in the county system; transition would not be difficult. Whereas in others, the public clinics solely participate in the county systems and may face difficulty with the transition to Medi-Cal managed care due to their lack of experience and roles in that market. Community clinics in these counties are not often compensated by the county for their care to uninsured patients. The shift to Medi-Cal managed care would

As nearly half of adult low-income patients have no usual source of care, they would now have medical homes either chosen from the networks offered by or assigned through Medi-Cal managed care.

CMSP counties could either merge into Medi-Cal fee for service or continue to contract with a commercial health plan for management of the program; they prefer the latter as it is more responsive and flexible and better able to manage their patients' care.

In our prior studies, hybrid and payor counties typically had the least financial resources to operate their programs for the county indigent.[49] Payor counties such as Orange and San Diego could use their existing Medi-Cal managed care plan(s) for program administration. Safety net providers in San Diego are already very experienced and well-positioned to participate in Medi-Cal managed care while those in Orange are somewhat less so. Both counties have received federal coverage expansion grants, which they are implementing with the goal of improved eligibility and improved delivery of care to the chronically ill.

In hybrid counties such as Tulare and Santa Barbara, private non-profit safety net clinics and doctors (now excluded in hybrid county programs) would have an opportunity to participate for their uninsured patients. Public clinics in those counties already participate successfully in Medi-Cal managed care and would now be reimbursed for their county indigent patients in the same manner as their Medi-Cal patients. In one of the hybrid counties, Sacramento, public clinics care for the county indigent and do not now participate in Medi-Cal managed care; they may need a transitional period and assistance from the county or local managed care plans to meet Medi-Cal managed care standards. Private hospitals would switch from county reimbursement to payment through the local managed care plan(s).[50]

- Some counties with public hospitals are concerned with the transition to a Medi-Cal managed care model for the MIAs. Some are concerned that they will not be competitive with private providers.[51] Some want a period of exclusivity (a single plan model) for their local managed care plans and safety net delivery systems so that the transition does not destabilize their hospitals.[52]

be beneficial and not difficult as they already participate for their Medi-Cal eligible patients.

49 Wulsin and Hickey, Counties, Clinics, Hospitals, Health Plans and California's Uninsured (October 2003) at www.itup.org/regional-workgroups

50 This would appear to be very favorable for private hospitals whose payment rates under county indigent programs were typically much less than Medi-Cal. See Fox, Overview of the Uninsured: Orange County (Insure the Uninsured Project April 2006) and Overview of the Uninsured: California (Insure the Uninsured Project November 2006) at www.itup.org

51 There are two relevant antecedents: mandatory managed care for families in the mid '90s and expansion of OB coverage in the late '80's and early '90s. In the transition to Medi-Cal managed care, safety net clinics and county hospitals retained and many clinics expanded their patient base. The expanded coverage for OB services occurred in a fee for service context and was accompanied by a large provider rate increase and the inception of DSH payments. At the time of expansion, county delivery rooms were horribly over-crowded and prompt pre-natal services were difficult to access in many county systems. In one very large urban county, the county Health Department did not implement the Comprehensive Perinatal Services Program. In short, private providers had strong financial incentives, patients had strong care incentives and county health was very slow to respond in improving access to care for county perinatal services.

52 Massachusetts offers safety net health plans a period of exclusivity to manage the transition to managed care. A number of California counties with public hospitals have strong primary care networks, integrated delivery systems and new hospital facilities,

Counties with public hospitals and clinics have made major public investments in infrastructure that are qualitatively different from other counties. Some are concerned that they will be less competitive with private hospitals and doctors that as of now play limited or no part in the county funded delivery system for indigent adults. Others are confident they have strong connections with their patients, affordable costs of care and the linguistic and multi-cultural skills to compete effectively in their local markets. A further difficulty is that some public systems may not have invested in developing the extent of primary care, quality assurance, cost accounting, information systems and case management capacities to allow them to flourish in managed care systems for their uninsured patients.

ITUP suggests that counties should be offered the opportunity to negotiate a period of exclusivity appropriate to the implementation challenges facing the county. We think that county and other safety net delivery systems competed effectively in Medi-Cal managed care and would do at least as well (or better) under Medi-Cal managed care for indigent adults since they have already made these systemic changes for families. If a time period for exclusivity is to be negotiated for counties and their local health plans to enhance the competitiveness of the local safety net delivery system, it should not exceed three years.

During the negotiated period of exclusivity, the local managed care system for the MIAs should meet Knox Keene standards of geographic and timely access to care, should incorporate interested free and community safety net clinics and should reimburse non-participating providers at Medi-Cal rates for genuine emergency services to plan members.

- **Medi-Cal eligibility is complex and cumbersome and should be radically simplified as part of reform.[53]**

According to one recent report, Medi-Cal has over 150 categories of coverage, "each with slightly different eligibility and documentation" and different income limits for children of different ages.[54] A reduction in complexity could also reduce administrative costs by decreasing the application processing time and therefore increasing the caseloads that workers could handle.[55]

Some simplification of eligibility categories can be done without a waiver, but a thoroughgoing simplification of eligibility will require a §1115 waiver as discussed and recommended by ITUP later.

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and they already compete effectively in Medi-Cal and Healthy Families. Some do not compete effectively in the Healthy Families program or for Medi-Cal children and might lose their patient base in a head to head competition with private providers and may need some degree of exclusivity during a specified transition time.

53 It is the erratic on-and-off nature of eligibility for Medi-Cal and Healthy Families that poses the greatest challenge for effective managed care by safety net providers and plans.

54 Simplify, Automate, and Follow the Leader: Lessons on Expanding Health Coverage for Children, California HealthCare Foundation, November 2006, http://www.chcf.org/documents/policy/SimplifyAutomateAndFollowTheLeaderIB.pdf (accessed April 11, 2007).

55 Lisa Chimento, Moira Forbes, Joel Meneges and Anna Theisen (The Lewin Group) and Nalini Pande (Medi-Cal Policy Institute), Simplifying Medi-Cal Enrollment: Opportunities and Challenges in Tight Fiscal Times, June 2003, http://www.chcf.org/documents/policy/MediCalSimpIssueBrief.pdf (accessed April 11, 2007)

- **Medi-Cal managed care still needs improvements in some communities**

Medi-Cal managed care has improved access to primary care and improved management of patient conditions as compared to the old Medi-Cal fee for service system.[56] Issues that need improvement vary from county to county: our interviewees identified different issues depending on their community -- paper provider networks, poor access to specialty care, weak systems to manage care for costly and chronically ill patients, excessive state regulation, and excessive administrative layers/costs with little productivity in managing and improving patient care and access.

Some of these improvements can be achieved with the rate increases proposed for managed care plans in the 2007-08 budget and the Governor's health reform proposal; others require sustained systemic state and plan reform efforts.

- **Medi-Cal rate increases to Medicare levels**

In general, counties and clinics supported this increase and believed it would enhance private sector participation and improve access and choice of providers for Medi-Cal patients.[57] Some clinics and counties believe that Medi-Cal "red tape" and low reimbursement rates result in limited participation and disinterest among private physicians in treating low-income families.

ITUP suggests that an increase in Medi-Cal reimbursement is long over-due; physician rates (other than for obstetrics) have been more or less flat for over twenty years; an increase to Medicare levels will somewhat increase provider participation; however it should not be over-billed as a panacea as some providers inevitably will stay out.

Commercial or Healthy Families coverage for the uninsured above the bright line

The largest share of the uninsured, over 2.3 million adults, has incomes above the poverty line and below 300% of FPL.[58] Nearly a million are working parents with children living at home; they have incomes too high to qualify for Medi-Cal. An estimated 775,000 parents have incomes between 100 and 200% of FPL ($20,000 to $40,000 for a family of four). California could increase eligibility levels under Medicaid §1931b and cover the uninsured parents of Healthy Families children.

There is a strong desire among the safety net leaders we interviewed to see children and their parents in the same plan and to even out the eligibility standards so that all family members are in the same program and plan.

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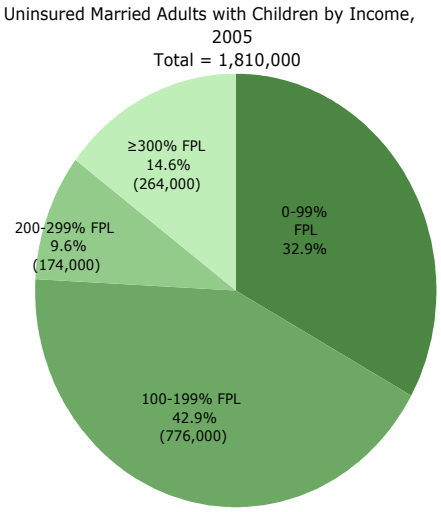
56 Medi-Cal managed care substantially reduces the percentages of persons with no usual source of care – to 6% of enrollees – and reduces avoidable hospitalizations as compared to fee for service. Medi-Cal Facts and Figures: A Look at California's Medicaid Program (May 2007) at www.chcf.org

57 This increase will not provide a measurable benefit to community and county clinics already receiving Medi-Cal FQHC or to public and UC hospitals already being paid for their reasonable and necessary costs of care.

58 UCLA Center for Health Policy Research, California Health Interview Survey 2005



Source: California Health Interview Survey 2005

The remainder of uninsured adults between 100% and 200% of FPL are working individuals without minor children living at home; of these 861,000 have incomes between 100% and 200% of FPL, and 523,000 have incomes between 200 and 300% of FPL ($20,000 to $30,000 annually).[59]

All proposals use MRMIB to purchase coverage for the uninsured over 100% of FPL, but with very different numbers of Californians covered through the pool. Senator Perata and Speaker Nunez propose "Healthy Families benchmark" coverage purchased by MRMIB for uninsured adults with incomes above 100% of FPL and up to 300% of FPL. Governor Schwarzenegger proposes "Medi-Cal benchmark" coverage, purchased by MRMIB for the uninsured above 100% of FPL and up to 250% of FPL. Under the Governor's plan, an estimated 1.7 million adults are covered through the new purchasing pool. Under Speaker Nunez' plan, 3.2 million adults and children are covered through the pool, while under Senator Perata's proposal, 4.1 million adults and children are covered through the pool. Under these proposals, most insured low and moderate income families outside the pool would also be assured "benchmark" coverage.

It is as yet unclear what benchmark means when used by the Governor and legislative leaders. Are their approaches semantic or are their real differences from Medi-Cal and Healthy Families? Does benchmark mean commercial coverage, or does it mean Medi-Cal or Healthy Families like coverage?[60] Many commercial insurers do not now participate in the Healthy Families program; there will be strong incentives to participate and compete as more individuals are covered through the pool. The major private commercial health plans such as Kaiser, Blue Cross, Blue Shield and Health Net already participate in Healthy Families and compete with

59 California Health Interview Survey 2005

60 Benchmark appears to mean actuarially equivalent to Medi-Cal and Healthy Families and the benefits package may be equal to coverage for state or federal employees or the most popular private employer coverage.

locally owned and operated public health plans for enrollment. Safety net providers participate in the public health plans and in some of the Healthy Families networks developed by commercial plans.

In general, counties and safety net clinics strongly preferred a Healthy Families like model to commercial coverage as premiums were more affordable, coverage was better, copays and deductibles were less and participation opportunities for safety net delivery systems were stronger.[61] Safety net providers and plans do not fare as well in the Healthy Families program as they do in Medi-Cal managed care. Clinics and counties with county hospitals would prefer a Medi-Cal model to Healthy Families since Medi-Cal reimburses their costs, and they have stronger participation rates in the Medi-Cal program.

Commercial coverage provides few meaningful opportunities for safety net providers' participation. Commercial coverage was substantially more expensive for plans and patients. Out of network providers were able to bill (bilk) the commercial system and patients for their "charges";[62] hospital charges now average four times their costs. Many commercial coverage plans relied quite heavily on large copays and deductibles in order to achieve affordable premiums -- a model that low and moderate income patients are unable to afford thus depriving them of necessary access to services.

Coverage should be seamless for those families and individuals whose incomes fluctuate above and below the income eligibility levels for Medi-Cal, Healthy Families and commercial coverage so that individuals do not experience gaps in coverage and the need to re-apply for coverage. While the card and extent of subscriber contribution may vary, eligibility should be uninterrupted.

The current system as well as the reform plans proposed by Speaker Nunez, Senator Perata and Governor Schwarzenegger have separate programs for individuals based on their income, this creates administrative complexities and costs for subscribers, leading to lack of continuous coverage and interruptions in health care treatment. The goal of counties and safety net clinics is a system that preserves their patients' coverage and courses of treatment.

- **Support for a "bright line" – a consistent income distinction between Medi-Cal and Healthy Families, as opposed to the zigzag eligibility that divides family members between different programs, plans and family doctors.**

61 Healthy Families is more favorable than commercial coverage for safety net providers because the Healthy Families program and Healthy Families plans make a priority to recruit safety net providers while commercial coverage plans do not. Healthy Families plans have more affordable shares of monthly premiums and out of pocket responsibilities such as co-payments for moderate-income families than does commercial coverage. Commercial coverage typically pays providers more for covered services, but most safety net providers are insignificant participants in plans' commercial networks. On the other hand commercial plans connect to employers whereas safety net plans and networks lack that critical connection.
Uninsured patients with income between 100% and 200% of FPL mirror the usual source of care patterns of the uninsured with incomes below poverty – i.e. nearly half have no usual source of care, a third use community and county clinics and one fifth receive their care from private physicians. However usual source of care patterns shift quite dramatically for the large numbers of uninsured adults with incomes over 200% of FPL – 40% seek care from private doctors, 36% have no usual source of care and only one in five receive care from community or county clinics.

62 See for example the recent approaches of Southern California hospital entrepreneurs described in Costello, "Hospital Group Rejects System and Cashes In" Los Angeles Times, July 8, 2007

Due to the general preference for the Medi-Cal program among safety net providers and plans[63], there is a strong desire to shift the "bright line" proposed by the Governor up from 100% of FPL to 133% of FPL, which is the Medi-Cal income level for young children, disabled and elderly adults.

ITUP's regional workgroup participants and the individuals we interviewed for this paper indicate that patients, plans and providers find that Healthy Families is easier to navigate than Medi-Cal, but point out that Medi-Cal has been steadily improving its responsiveness narrowing the differences with Healthy Families. Medi-Cal is a better payor for community and county clinic services. Healthy Families does not require public hospitals to pay the state match as Medi-Cal does, and public hospitals do not want to expand a model of hospital reimbursement where they must pay the match.

Thus the issues for safety net providers as between Medi-Cal and Healthy Families are 1) compensation for primary care clinics,[64] 2) program simplification, 3) local match and 4) the extent of competition/control. ITUP suggests a reform model that would import some of the simpler and less costly administrative processes used in the Healthy Families program[65] into Medi-Cal and apply Medi-Cal reimbursement models for clinic services into the Healthy Families program.

Undocumented workers

There are an estimated 1.2 million uninsured undocumented adults in California, virtually all of whom work in low wage jobs throughout the state's economy, including agriculture, restaurants and home construction. They are not equally distributed among the state's counties, but are more heavily concentrated in workplaces in the Central Valley and Southern California counties.

Under Governor Schwarzenegger's proposal, the undocumented are mandated to purchase coverage, but for the most part his proposal anticipates that undocumented adults would remain a responsibility for counties and hospital systems. Under Senator Perata and Speaker Nunez' proposal, the state would collect assessments from employers, and employees would pay sliding fee scale premiums. While it is clear that financial assessments are collected from the undocumented workers and their employers, it is less than clear to our interviewees whether the undocumented workers will participate in coverage through a state pool where they must identify their status.

The studies we reviewed found that undocumented persons used far fewer services and were much less costly to cover than US citizens or legal permanent residents.[66] Much of the care used by undocumented individuals with

63 MediCal guarantees a certain percent of the market to the local initiative plan; whereas Healthy Families offers a discount on premiums for the plan with the greatest share of safety net providers.

64 Most county and community clinics are paid at FQHC rates under Medi-Cal but not Healthy Families. Federal DSH allotments do not grow or shrink, depending on whether the uninsured are covered by Medi-Cal or Healthy Families.

65 A waiver request could simplify the public programs such that all individuals below a certain income level would be Medi-Cal eligible, all above that level would be Healthy Families eligible with premium subsidies and those with incomes above a certain level would be required to secure commercial coverage, possibly with some assistance for those with serious affordability challenges. This could correct the on-off nature of Medi-Cal and Healthy Families coverage that makes managed care difficult for publicly insured patients and safety net providers. The waiver could also modernize the Medi-Cal eligibility and administrative process and reduce costs to the state, counties and federal governments.

66 Waidman, The Potential Role for Bi-National Health Insurance (Urban Institute October 2006), and Goldman, Immigrants

insurance was for emergency and maternity services; both of which are covered under Medi-Cal.[67]

All three proposals rely on counties to care for the undocumented. Most counties without public hospitals will not provide coverage nor pay for care to the undocumented absent a state mandate with 100% state funding -- a highly unlikely eventuality. Those counties who choose to provide coverage for the undocumented will continue to do so through their own safety net delivery systems for undocumented workers and their families.

Medi-Cal coverage for the undocumented is otherwise restricted to emergency and maternity services. Federal Medicaid DSH funding is available to hospitals for uncompensated care to the uninsured regardless of their immigration status. Federal Safety Net Care pool funds may not be used for non-emergency services to the undocumented.

ITUP suggests California should share responsibility for the costs of care to the undocumented with the federal government and their employers, California can and should seek to cover emergency care to undocumented adults as part of its broader 1115 waiver application to the federal government[68] and should cover undocumented workers for a limited and affordable set of basic benefits through their employers' assessments and through their own premium contributions.

Section 17000 obligations for health care to the indigent[69]

Counties believe that Welfare and Institutions Code §17000 will become meaningless if caring for the uninsured becomes a state responsibility and should be repealed or subsumed in conjunction with state take-over. Some counties point out that the courts have not held that counties have any obligation to care for the undocumented uninsured. Advocates believe that Section 17000 health care obligations should remain in place in the context of reform.

ITUP suggests that any legislation providing state take-over of county care for the MIAs be explicit about the state's role in taking over counties' §17000 obligations. Counties should not be at financial risk for the state's performance of what are now state responsibilities. Reform should affirm that a county that participates financially in funding the state coverage for indigent uninsured adults has thereby fulfilled the counties' obligation.

County Match: Realignment, Prop 99, County Match and Overmatch

There was general agreement among the persons we interviewed that if the state took over responsibility for the

and the Cost of Medical Care Health Affairs (November/December 2006).

67 Ibid.

68 The Secretary of Health and Human Services grants section 1115 waivers to states. They permit states to use Medicaid funds in a way that does not follow federal standards, allowing states to make innovative programmatic changes that provide benefits such as increased program efficacy and expanded coverage to low-income populations. Many other states, including Oregon, Arizona, Delaware, Tennessee, Massachusetts, Vermont and New York already have secured 1115 waivers to cover adults. OBRA provisions require Medicaid to cover emergency care services to the indigent as Medi-Cal already does. A waiver to cover adults would/should allow California to secure FFP for emergency care to undocumented adults.

69 Under California's Welfare and Institutions Code § 17000, "California's counties have a duty to 'relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported by their relatives or friends, by their own means, or by state hospitals or other private institutions.'"

uninsured MIAs below 100% of FPL and for the uninsured MIAs over 100% of FPL, the state should be able to phase in an appropriate take-back of realignment funds from counties reflecting the real shift in responsibilities from the counties to the state. The state should not "take back" the county match or local tobacco settlement funds.[70]

The unresolved issue(s) are: how much realignment and other funds are used locally for indigent health programs that the state is taking over, how much funding if any is used for care to undocumented persons and any other individuals that remain a county responsibility, and how much is used for public health.[71]

ITUP suggests that for CMSP, payor, block grant and hybrid counties, it is easy to track the county expenditures on indigent adults and "take back" a combination of realignment and Prop 99 funding equal to those counties' expenditures on the indigent who become eligible for the state program(s) as they enroll and thus become a state liability.

How would a "take back" work? This can be done either as a county match up to a certain agreed upon cap (representing existing county expenditures for the populations covered), or as a re-transfer of a portion of state/county realignment funding. A third alternative, a CPE (Certified Public Expenditure) would not work well for CMSP, payor, block grant and hybrid counties, as the state not the county would be running the new program.

For counties with a public hospital and clinic system, it is difficult to prospectively disentangle the combination of state, federal and local funds and nearly impossible to currently track and disaggregate expenditures as between citizens, legal permanent residents vs. care to undocumented adults. It should be easier to do so once the state takes over responsibility for the MIAs. The Governor's proposed 50/50 split between the state and counties seems to ITUP more than fair to the counties with public hospitals, as undocumented adults comprise only twenty percent of uninsured adults; however the undocumented are not evenly distributed among the counties nor equivalently eligible for county health services in each county. The figure could be adjusted based on actual state and county fiscal experience under state take-over. The CPE model would work well for counties with public hospitals to capture and reflect the county expenditures during this interim period.

We calculated the three year running average of the counties' health program spending for the medically indigent that could readily be used as a match as follows:

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70 Tobacco settlement funds are used for care to the uninsured in a number of large counties; however this is at county discretion and not all counties use these funds for care to the uninsured. County matching requirements date back to 1978 and have not increased since then although many counties exceed their match requirements and some such as Los Angeles and Alameda secured local voter approval for tax increases devoted to care for the uninsured.
Counties should be given the opportunity to use these funds as match if they so choose or to use them for other important local health priorities.

71 Our research found that in 2002-03 counties reported spending about $1.75 billion on health care to the uninsured, $577 million on net public health and $740 million on other county health. The spending on "other county health" may be understated as it reflects a residual amount after deducting spending on the uninsured and net public health.

County Health Care Program Total Services Expenditures for the Medically Indigent, FY 2001-02, 2002-03 & 2003-04

CHIP County	2001-02	2002-03	2003-04	Average of Years Reported
Alameda	$85,350,367	$85,861,522	$81,167,106	$84,126,332
Contra Costa	$38,810,474	$37,736,761	$39,623,610	$38,723,615
Fresno	$18,037,148	$18,116,189	Not Reported	$18,076,669
Kern	$20,141,239	$13,289,498	$15,966,787	$16,465,841
Los Angeles	$801,068,780	$761,830,589	Not Reported	$781,449,685
Merced	$3,176,026	$3,257,770	$2,966,407	$3,133,401
Monterey	$10,409,060	$8,279,003	$3,493,726	$7,393,930
Orange	$52,925,586	$53,233,176	$49,740,077	$51,966,280
Placer	$3,161,877	Not Reported	Not Reported	$3,161,877
Riverside	$71,846,954	$70,117,462	$71,572,013	$71,178,810
Sacramento	$47,541,138	$57,239,471	Not Reported	$52,390,305
San Bernardino	$89,244,881	$104,048,350	$106,513,594	$99,935,608
San Diego	$56,658,017	$57,877,351	$57,032,584	$57,189,317
San Francisco	$84,882,067	$81,878,333	$128,976,789	$98,579,063
San Joaquin	$22,938,842	$25,139,204	$25,507,123	$24,528,390
San Luis Obispo	$4,174,183	$4,200,600	$3,505,276	$3,960,020
San Mateo	$43,155,512	$26,412,799	Not Reported	$34,784,156
Santa Barbara	$14,617,927	$16,204,591	$15,313,901	$15,378,806
Santa Clara	$63,635,990	$69,134,001	$76,524,480	$69,764,824
Santa Cruz	$6,294,566	$6,006,499	$5,874,333	$6,058,466
Stanislaus	$11,375,965	Not Reported	$14,662,751	$13,019,358
Tulare	$6,828,348	$6,688,201	$6,663,755	$6,726,768
Ventura	$6,357,931	$4,992,358	$4,992,649	$5,447,646
Yolo	$3,539,687	$3,606,005	$4,269,351	$3,805,014
Sum of Large Counties	$1,566,172,565	$1,515,149,733	$714,366,312	$1,567,244,178
Sum of Small Counties		$221,357,983	$246,648.547	$234,003,265
Total County Spending				$1,801,247,443

Counties with public hospitals comprise 74% of total reported county health spending, $1.3 billion and some or all of these funds may already be tied up in matches for DSH and Safety Net Care pool funds for care to the uninsured.

The interplay of state and federal laws:
The federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires that hospitals, which offer emergency services, must do so without regard to a patient's insurance status or ability to pay for services. The federal DSH program pays for hospitals' uncompensated care to the uninsured. Federal law caps DSH payments at each hospital's actual cost for unreimbursed care to the uninsured plus the difference between the hospital's actual cost of care to Medi-Cal patients and its Medi-Cal reimbursement. As California increases coverage for the uninsured and increases Medi-Cal reimbursement rates to Medicare levels, hospitals and the state are at risk of returning DSH funds to the federal government; this same "Catch 22" interplay may apply to

community clinics' §330 funds as well.[72]

ITUP suggests that California seek a federal waiver to retain and wherever necessary redistribute "at-risk" DSH funds to support coverage expansion consistent with federal law. The costs of state reform should not create windfalls for the federal government, county government or providers.

Transformation of local delivery systems

There is agreement among the safety net leaders we interviewed that local delivery systems should be transformed to place greater emphasis on primary care and preventive services, that the primary care gate keeper medical home model is a good one, and that management for chronic conditions is critical. A number of counties are already making these changes in their system, and some are receiving increased funds to do so under the federal coverage expansion grants.

Some believed their own local indigent care systems could make the adjustment from their current systems to a Medi-Cal managed care model (with strong chronic disease management, primary care and prevention services) with little dislocation. There was also a strong belief that local safety net delivery systems were superior to other networks in caring for the uninsured due to better language and cultural competency and a better understanding of the multi-faceted and intertwined social, economic and medical challenges of their patients.

Several of our interviewees pointed out the need to coalesce and coordinate medical care, substance abuse treatment and mental health services in caring for some of their patients. These programmatic intersections need improvement at the local level and are non-existent in Medi-Cal managed care.

Those public hospital systems that have been inadequately invested in primary care and are disproportionately reliant on the strengths of their emergency and hospital based services believe they will need flexibility, incentives and time to complete the necessary evolution in their delivery systems to a "medical home managed care model" rather than an episodic care model. However many public hospital systems have already made these changes, and the recent coverage expansion grants to counties allow the others to do so. Some of our interviewees suggested a state and federal role in financing the transformation of local safety nets and in assuring adequate flexibility in the flow of existing revenue streams to make transformation a fiscal possibility/reality.

ITUP suggests that providing a limited transitional period of exclusivity to local delivery systems will enable them to continue to provide culturally competent care and shift toward a primary care model.

Section 1115 waiver

There was strong support for seeking a large federal waiver that would allow all current county spending on uninsured adults to be matched by federal funds.

ITUP suggests that a waiver for the adults should not mirror Medi-Cal; its eligibility, enrollment and retention

72 Similar problems exist for clinics with 330 grants and the ADAP (AIDS Drug Assistance Program) and drug pricing for clinics and county hospitals under the 340B program. Resolution of these issues should be considered for inclusion in the waiver as well.

are complex and needlessly costly and should be simplified as discussed earlier. The waiver should incorporate some of the county indigent system's best practices and should fix and simplify Medi-Cal.[73] County health systems for example have developed much easier, quicker and less costly eligibility and enrollment systems. The waiver should preserve federal DSH and Safety Net Pool funds and re-invest them in expanded coverage for the uninsured. The waiver should give local safety net delivery systems the flexibility to retain and shift federal funds from inpatient hospital to outpatient services in their evolving delivery systems.

Local infrastructure

There was strong consensus for building on and reinforcing existing local infrastructure. ITUP believes this will smooth the transition of the newly insured into a coverage model.

Local flexibility

Local leaders believe they know and can reconcile competing local needs and interests more effectively than state programs can and are better positioned to make the necessary system changes and transitions. They believe that locally operated managed care plans are better positioned to facilitate these transitions than are statewide commercial plans or state government. Some counties are prepared to extend coverage more broadly than the Governor and legislative leadership.

ITUP recommends strong reliance on local managed care entities but with a competitive presence from at least one other plan. We suggest setting a framework where the state reform is a floor not a ceiling for counties. Those local innovators who are interested in expanding from the state base should be given the programmatic latitude to do so and a process to negotiate needed changes with the state.

Other issues from our interviews

- Some believed the Governor's proposed patient contributions were too high and unaffordable for moderate income workers; for example 6% of $25,000 (250% of FPL for an individual) is $1500 annually and not within financial reach for many uninsured adults with incomes between $20,000 and $25,000 annually.
- Some believed that the $5000 deductible for the uninsured over 250% of FPL was too large for an individual with income only slightly higher than $25,000 annually – i.e. individuals would be at financial risk for 20% of their gross annual income.
- Others suggested that the proposed 2% assessment/tax on physicians and 4% on hospitals could imperil the financial viability of local hospitals and doctors as many providers operate on thin profit margins.
- Some felt the employer contribution should be equitable as between insuring and non-offering employers – i.e. 4% of payroll was too low and it should be 6-7% of payroll to avoid creating incentives for the already insured to drop their coverage.
- Some recommended financing the reform through a variety of cost control measures to reduce over-utilization and over-payments in the existing system.

73 We recommend pooling financing from low wage employees and their employers and the self-employed with public program funding through Medi-Cal, Healthy Families and county health. We recommend that out of pocket responsibilities be graduated to the subscriber's income and targeted to promote the most efficacious care and treatment. We would also suggest that reformed managed care systems should be the exclusive choice where public subsidies are entailed and that individuals have options to pay the incremental cost of more costly plans and receive discounts for selecting qualified safety net plans and providers.

Other safety net/coverage expansion issues

Other ITUP observations that may require attention, but were not covered in our dialogue with stakeholders and safety net experts include:

- In many communities, clinics need to play a far stronger role in local managed care than they now do.[74]
- In the Bay Area, local initiatives may need to consolidate into a regional managed care plan(s).[75]
- In the Central Valley, the local initiatives need to consolidate into a safety net managed care plan(s).[76]
- In Los Angeles, the local initiative needs to become a complete, consolidated managed care plan.[77]
- In a number of communities the local initiatives are not yet successful competitors in the Healthy Families market and are not well-positioned to compete in the commercial market on behalf of the local safety nets for those uninsured covered through an extension of either Healthy Families or commercial coverage.[78] Strong state purchasing pools may allow the local initiatives to participate and compete effectively in these coverage expansion markets; it will also require an improved commitment of local safety net providers and local initiatives to compete effectively and connect with those local businesses with high percentages of uninsured workers.

(Footnotes)

1 We divided the total of MISP and CMSP spending ($1,734,899,019) by 6.6 million uninsured, the numbers of Californians uninsured over the course of a year. Some counties seek to provide care for all the uninsured. If divided by 4.9 million uninsured Californians uninsured at a given point in time, the relevant figure is $354 annually.

2 We divided the total of MISP and CMSP spending ($1,734,899,019) by 1,518,000 uninsured (CHIS data on uninsured adults without minor children and incomes below 200% of FPL). Most counties limit their programs to the MIAs (uninsured adults without minor children and incomes below 200% of FPL).

3 We divided the total of MISP and CMSP spending ($1,734,899,019) by 1,449,533 unduplicated uninsured users.

4 Jon Gruber, Modeling Health Care Reform in California (February 2, 2007).

5 California Employer Health Benefits Survey 2006 (November 2006) at www.chcf.org

6 Ibid. There is a significant difference between the hospital reported OSHPD data on county reimbursed inpatient days and the county reported MICRS and CMSP data on county reimbursed inpatient days. We averaged the two and divided by 6.6 million uninsured Californians.

7 Ibid. We used the MICRS and CMSP data divided by 6.6 million uninsured Californians; we did not use the much smaller OSHPD figure as it reports only hospital based outpatient visits.

8 Ibid. There is a significant difference between the hospital reported OSHPD data on county reimbursed emergency room visits and the county reported MICRS data on county reimbursed emergency room visits. We averaged the two.

74 While a few local community clinic associations have strong managed care capacities to assist their member clinics most do not as yet.

75 ITUP believes that county lines are not the appropriate dividing lines for health care to low income patients and that regional approaches would better serve patients and providers and reduce duplicative administrative costs and complexity.

76 Our Central Valley regional workgroup participants point to the signal ability of specific local plans to resolve local issues of access to care while other plans do not.

77 We suggest that LA Care Health Plan cease its umbrella role for plans with inconsistent missions and capacities to serve safety net patients and take over full responsibility for care and coverage for Medi-Cal and Healthy Families. This would improve the consistency and quality of managed care to low income Los Angelinos and the performance of LA's safety net providers.

78 See charts on page 11 and contrast the market shares of safety net plans in the Medi-Cal and Healthy Families programs.

9 See Chen and Wulsin, A Summary of Health Care Financing for Low Income Individuals in California (October 2006) at www.itup.org/reports We calculated the cost of care to the uninsured by multiplying uninsured visits by clinics' average cost per visit. We calculated clinic uncompensated care by subtracting clinics' uninsured revenues. We calculated percent of net patient revenues by dividing clinics' net patient revenues.

10 Ibid. We calculated the cost of uncompensated care to the uninsured by adding bad debt and charity care and multiplying by the cost to charge ratio. We calculated percent of net patient revenues by dividing by net patient revenues. We calculated care to the uninsured by adding uncompensated care to the uninsured and county compensated care to the uninsured in non-county hospitals.

11 Estimates derive from national studies cited in Hadley and Holahan, Who Pays and How Much: the Cost of Caring for the Uninsured (Kaiser Family Foundation, February 2003 at www.kff.org The authors cite studies finding that about two thirds of doctors reported providing uncompensated care to the uninsured; the other third reported they did not.