# A Summary of Health Care Financing for Low-Income Individuals in California, 1998 to 2007

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August 2007

Prepared under grants from:
The California Wellness Foundation
The California Endowment
The Blue Shield of California Foundation
LA CARE Health Plan

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## INTRODUCTION

The financing of health care for low-income individuals in California consists of a complex web of public and private health insurance programs, direct payments for health care services and supplemental payments to providers who provide services to low-income, uninsured individuals. Each program has its own eligibility requirements, payment formulas, and benefits structure. This patchwork quilt is the result of years of incremental federal and state policies designed to increase access to care for low-income and vulnerable populations while minimizing the impact on the budget. The complexity makes it difficult to develop integrated, comprehensive strategies to expand access to these groups.

There is particular interest in understanding the funding of health care services for low-income Californians. Because of the multiple sources and methods of funding, it is difficult to forecast the exact impacts of proposed policy changes. This report explains each of the major health programs and highlights trends in health care financing for low-income and indigent populations in California, providing some context for current and future policy debates. The target audience is state policy makers, advocates, health care providers, and other interested parties.

This edition of the report is divided into three sections. It begins with an overview of enrollment and expenditure trends in the major publicly funded health insurance programs available to low-income Californians. By far, Medi-Cal continues to be the largest source of coverage and financing. It is complemented by a number of other health insurance programs that fill in its gaps in coverage. The report then reviews the multiple and overlapping state funding streams that finance health care services for low-income, uninsured individuals. Finally, it presents an overview of the health care delivery systems for these populations, including hospitals, community clinics, and specialized programs for certain sub-populations.

Biennially, researchers at the UCLA Center for Health Policy Research provide estimates of health insurance coverage trends in California using the Current Population Survey (CPS) and the California Health Interview Survey (CHIS). These documents provide valuable population-based estimates of health insurance trends in the state. An equivalent summary document, however, is not available that summarizes trends in the financing and delivery of health care services or health insurance for low-income Californians using the state's administrative data. This report was created to fill that important information gap.

ITUP would like to thank the various officials from the Department of Health Services (DHS), the newly created Department of Health Care Services (DHCS) and Department of Public Health, the Managed Risk Medical Insurance Board (MRMIB), the California Association of Public Hospitals and the California Primary Care Association who provided valuable data. Unless otherwise noted, the figures reported in this document represent expenditures from the state's budgetary perspective. ITUP would also like to thank and acknowledge Christine Chen, Peter Long, Megan Hickey, and Van Ta for their assistance in preparing earlier editions of this report. Finally ITUP would like to thank our funders: The California Endowment, The California Wellness Foundation, the Blue Shield of California Foundation and LA CARE for their generous support.

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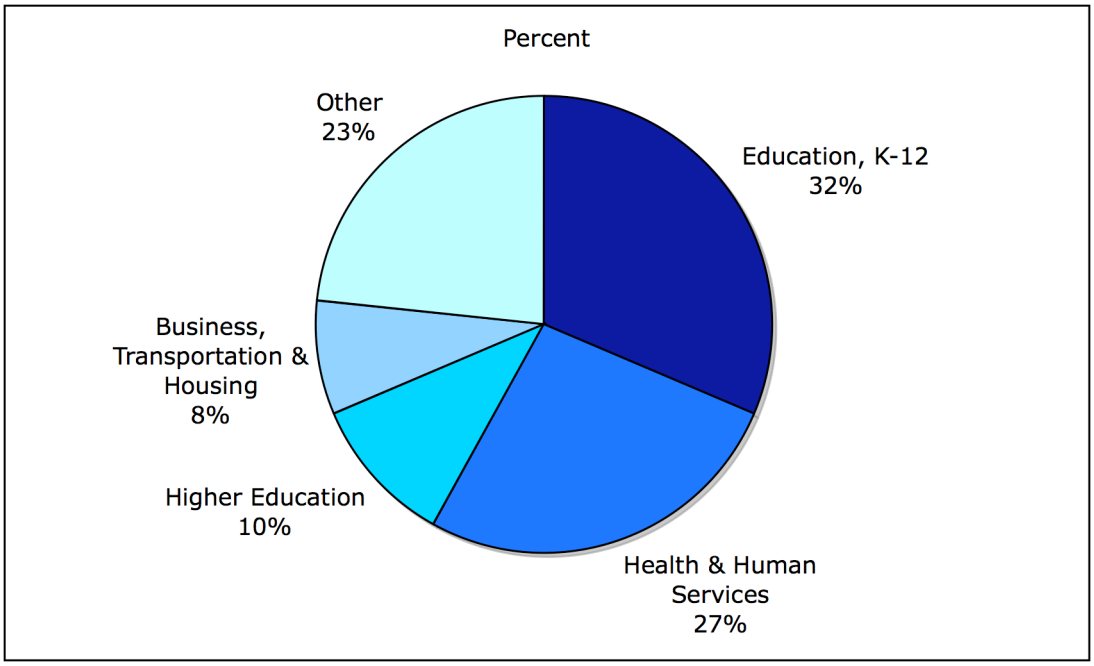
## OVERVIEW OF STATE BUDGET

Total state expenditures in the 2007-08 Budget are expected to be $143.4 billion, which includes $103.1 billion from the State's General Fund. Revenues for the State include the State's General Fund ($103.1 billion), and special funds ($27.7 billion). State General Fund Revenues are projected to grow by 7.2% in SFY 07-08.

In aggregate, spending for health and human services accounts for 26.6% of the total proposed State budget in SFY 2007-08 (Figure 1). It is the second largest budget category, trailing only spending for primary education from kindergarten through 12th grade.

**Figure 1: Expenditures of the Total State Budget by Department, SFY 2007-08***




Total = $143.4 Billion

SOURCE: Department of Finance, California Proposed State Budget 2007-2008.
*Figure includes revenues from the General Fund and the Economic Recovery Bonds.

General Fund expenditures for state health and human service programs in 2007-08 are proposed to stay roughly the same in comparison to the previous year.

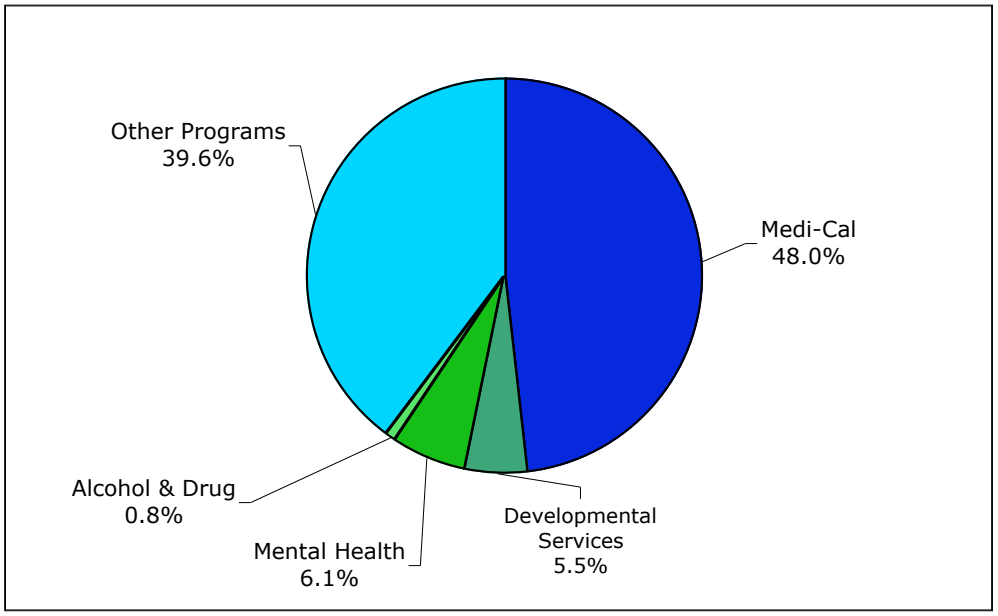
## HEALTH EXPENDITURES IN STATE BUDGET

Within the state's health and human services budget, Medi-Cal, the health and long-term care financing program for low-income individuals and persons with disabilities, represents the largest share of both the General and Total Fund spending.

For SFY 2007-2008, the Governor's Proposed Budget allots General Funds of $14.6 billion for Medi-Cal, $1.9 billion for mental health, $285 million for alcohol and drug programs, $392 million for Healthy Families, and $2.6 billion for developmental services.

After several years of modest growth, Medi-Cal spending growth accelerated beginning in 2001 and is expected to increase to $37.4 billion in federal and state funds ($14.6 billion General Fund) in SFY 2007-08 (Table 1). The number of Medi-Cal program participants grew in 2006-07 in response to eligibility expansions and a declining private market for employment based coverage. Program participants are expected to increase by 1.6% compared to SFY 2006-07.

**Figure 2: Total Fund Expenditures for Health and Human Services Programs, SFY 2007-08**




**Total = $78 Billion**

After Medi-Cal, Mental Health, In-Home Support Services and Developmental Services comprise the next largest health budget items, accounting for $4.8 billion, $4.4 billion, and $4.3 billion respectively. The Healthy Families program is projected to spend nearly $1.1 billion in federal and state funds due to enrollment growth that is projected to increase from 841,700 in 2006-07 to 915,600 in 2007-08- an 8.8% increase. Approximately $35.9 million ($16.9 million General Fund) is allotted to SB 437 implementation activities and enrollment increases in the Department of Health Cares Services (DHCS), the Department of Public Health (DPH), and the Managed Risk Medical Insurance Board (MRMIB). SB 437 establishes a pilot program, which can be expanded statewide, to allow parents to self-certify income and assets when determining their eligibility for the program. This should help ensure more children have access to health coverage by streamlining enrollment and reducing administrative barriers (Governor's Budget Summary 2007-08).

Realignment allotments for county health, mental health and social service programs are projected to grow from $4.594 billion to $4.824 billion, a 5% growth for 2006-07 and 2007-08, of which more than a third is for county health. The Governor's Proposed FY 2007-08 Budget does not separate the allotment for county health from mental health and social services. (Table 1)

**Table 1: Major Health Care Expenditures by the State of California, *SFY 1998-2007**

| State Fiscal Year | Medi-Cal | In-Home Support Services | Regional Centers for Developmentally Disabled | Realignment Allotments*** | Healthy Families |
|---|---|---|---|---|---|
| **1998-99** | $18,494,200,000 | $1,397,800,000 | $1,400,200,000 | $1,159,355,000 | $59,379,000 |
| **1999-00** | $20,492,400,000 | $1,628,300,000 | $1,617,300,000 | $1,239,294,000 | $211,800,000 |
| **2000-01** | $22,589,700,000 | $1,875,000,000 | $1,888,300,000 | $1,415,491,000 | $400,078,000 |
| **2001-02** | $25,053,700,000 | $2,378,500,000 | $2,075,500,000 | $1,420,889,000 | $549,600,000 |
| **2002-03** | $29,769,000,000 | $2,784,000,000 | $2,315,500,000 | $1,458,810,000 | $684,423,000 |
| **2003-04** | $29,532,000,000 | $3,181,000,000 | $2,571,000,000 | $1,485,819,000 | $808,422,000 |
| **2004-05**** | $31,215,700,000 | $2,724,000,000 | $2,700,000,000 | $4,135,638,000 | $839,100,000 |
| **2005-06**** | $33,300,000,000 | $3,096,000,000 | $2,866,800,000 | $4,362,896,000 | $894,900,000 |
| **2006-07**** | $35,100,000,000 | $3,916,200,000 | $3,200,000,000 | $4,594,600,000 | $1,000,000,000 |
| **2007-08**** | $37,400,000,000 | $4,382,100,000 | $3,600,000,000 | $4,824,600,000 | $1,100,000,000 |

*These programs are funded by a variety of sources such as federal government, sales taxes, tobacco taxes, and state vehicle license fees. State General Funds only account for a portion of total spending.

**Estimated

*** Governor's Proposed FY 05-06, 06-07, and 07-08 Budget reports realignment for county health, mental health and social services, but does not separately identify the county health allotment, as it had in years prior to 2004-05.

Source: California Department of Finance, Governor's Budget Summary, 2004-2005, 2005-2006, 2006-2007 & 2007-2008.

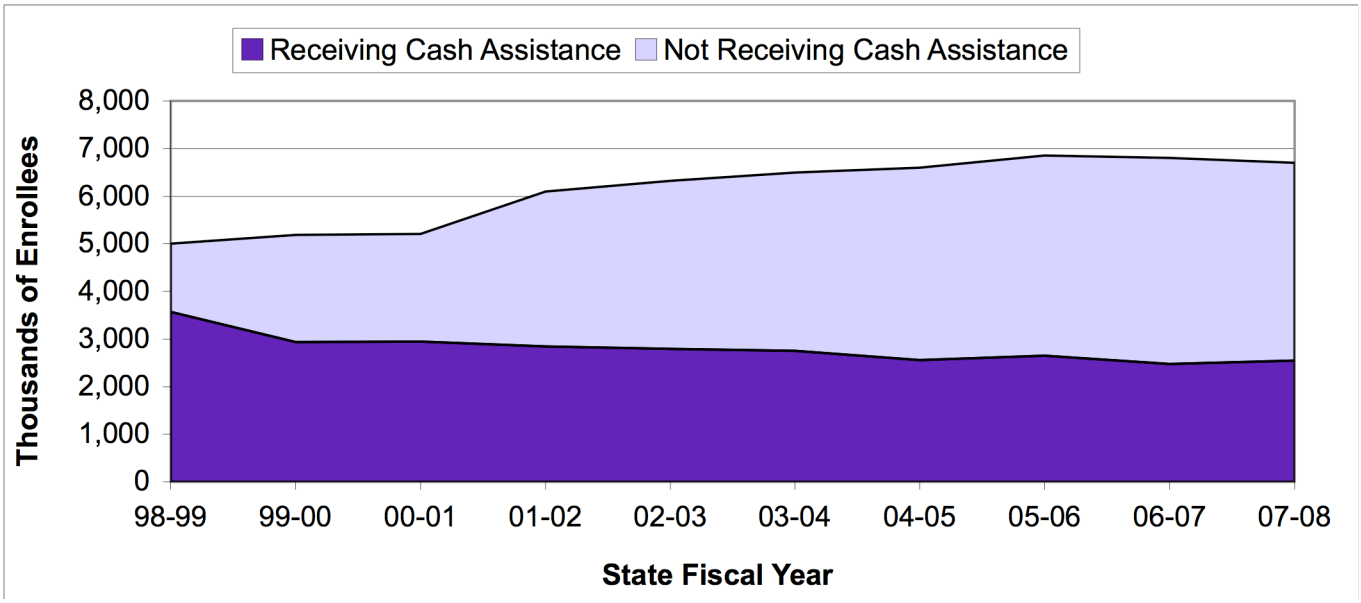
## SECTION 1: HEALTH INSURANCE COVERAGE OF LOW-INCOME CALIFORNIANS

### THE MEDI-CAL PROGRAM

#### Medi-Cal Enrollment[1]

Overall, those eligible for Medi-Cal though public assistance have steadily decreased since 1996; however, overall Medi-Cal caseloads have steadily increased. (Figure 3). In 2007-08, caseloads are expected to grow by 107,400 and result in a total of 6.7 million average monthly eligibles. Enrollment growth is due to losses in employment-based health coverage combined with some eligibility expansions and simplifications in the enrollment process enacted over the past few years, such as 12 months of eligibility for children. Most of the enrollment growth has been among working families. The majority of Medi-Cal beneficiaries are families and children. Although the aged and disabled comprise a relatively small percentage of total beneficiaries, they account for the majority of Medi-Cal spending. Enrollment for the aged, blind, and disabled is expected to increase by 2.9% to 1.7 million beneficiaries in 2007-08.

**Figure 3: Medi-Cal Enrollment by Eligibility Category, 1998-99 to 2007-08**




*Estimated
SOURCE: Department of Finance, Governor's Budget Summary, 2007-08.

In 2006-07, there were approximately 6.6 million persons enrolled in the program. Medi-Cal enrollment among welfare families has declined from 2.4 million in 1998-99 to 1.18 million projected for 2007-08 (Table 2). This decline corresponds with the implementation of federal welfare reform in California. Although families remained eligible for Medi-Cal after their welfare benefits ended, many families lost categorically linked coverage during the transition and shifted to the new 1931(b) coverage category. Enrollment for medically indigent adults and children also declined during this period from 279,000 to 135,000 between 1998-99 and 2001-02. It increased

[1] Source: Department of Finance, Governor's Budget Summary, 2007-08.

to 250,000 in 2004-05, but is expected to decline again to 228,000 in 2007-08. The earlier enrollment declines were more than offset by gains in family coverage under section 1931(b). Enrollment for long-term care beneficiaries accounts for nearly 1% of all Medi-Cal beneficiaries.

**Table 2: Overview of Medi-Cal Enrollment, By Eligibility Category, 1998-99 to 2006-07**

| State Fiscal Year | Total | Cat. - Linked | Low-Income Families | SSI/SSP | Cat. - Related | Medically Needy | 1931(b) | Long-Term Care | Women/ Children | 185% Poverty | 133% Poverty | 100% Poverty | Medically Indigent | UP |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1998-99** | **5,007** | **3,569** | 2,444 | 1,125 | **647** | 579 | - | 68 | **575** | 142 | 97 | 57 | 279 | **216** |
| **1999-00** | **5,187** | **2,935** | 1,773 | 1,162 | **1,390** | 111 | 1,209 | 70 | **655** | 167 | 127 | 97 | 264 | **207** |
| **2000-01** | **5,209** | **2,950** | 1,768 | 1,182 | **1,603** | 140 | 1,394 | 69 | **513** | 172 | 103 | 83 | 155 | **143** |
| **2001-02** | **6,100** | **2,847** | 1,647 | 1,201 | **1,918** | 254 | 1,594 | 70 | **524** | 170 | 109 | 110 | 135 | **226** |
| **2002-03** | **6,321** | **2,793** | 1,557 | 1,225 | **2,568** | 619 | 1,882 | 67 | **574** | 188 | 118 | 112 | 156 | **246** |
| **2003-04** | **6,463** | **2,664** | 1,384 | 1,280 | **2,671** | 322 | 2,280 | 69 | **635** | 194 | 132 | 148 | 161 | **220** |
| **2004-05** | **6,580** | **2,576** | 1,354 | 1,222 | **2,702** | 271 | 2,365 | 66 | **649** | 188 | 108 | 85 | 250 | **78** |
| **2005-06** | **6,580** | **2,518** | 1,276 | 1,242 | **2,935** | 307 | 2,565 | 63 | **633** | 192 | 101 | 82 | 249 | **69** |
| **2006-07*** | **6,665** | **2,493** | 1,258 | 1,235 | **2,909** | 342 | 2,505 | 62 | **643** | 197 | 105 | 83 | 250 | **70** |
| **2007-08*** | **6,702** | 2,449 | 1,184 | 1,265 | 2,270 | 327 | 1,880 | 63 | 649 | 201 | 109 | 91 | 228 | **72** |

(In Thousands)

SOURCES: Department of Health Services, Medi-Cal Beneficiary Profile, Beneficiaries by age and Demographics 2007; Estimated Average Monthly Certified Eligibles, Fiscal Years 2001-08; The Medi-Cal Policy Institute, 2002; Legislative Analyst's Office, Analysis of, 2007-08 Budget

Abbreviations- "SSI/SSP" – Supplemental Security Income/State Supplementary Payment; "UP" – Undocumented Persons

Medically needy – aged/ blind/disabled

(Category Related refers to the medically needy, 1931 (b) and Long Term Care)

(Category Linked refers to Low-Income Families and SSI/SSP)

*Estimated

Due to the categorical and income eligibility requirements for adults, more than half (53%) of Medi-Cal beneficiaries are children under age 20.[2] Reflecting the racial diversity of the state, Medi-Cal beneficiaries are predominantly people of color. More than half (53%) are Latino.[3] Approximately 10% of beneficiaries are African American and 3.2% are Asian-Pacific Islanders.[4] Whites comprise 21% of all Medi-Cal beneficiaries.[5]

## Medi-Cal Spending

Total federal and state Medi-Cal expenditures are projected to increase to $37.4 billion in 2007-2008 (Figure 4). This represents an 80% increase from 1998-99 and a 6.5% increase from 2006-2007.

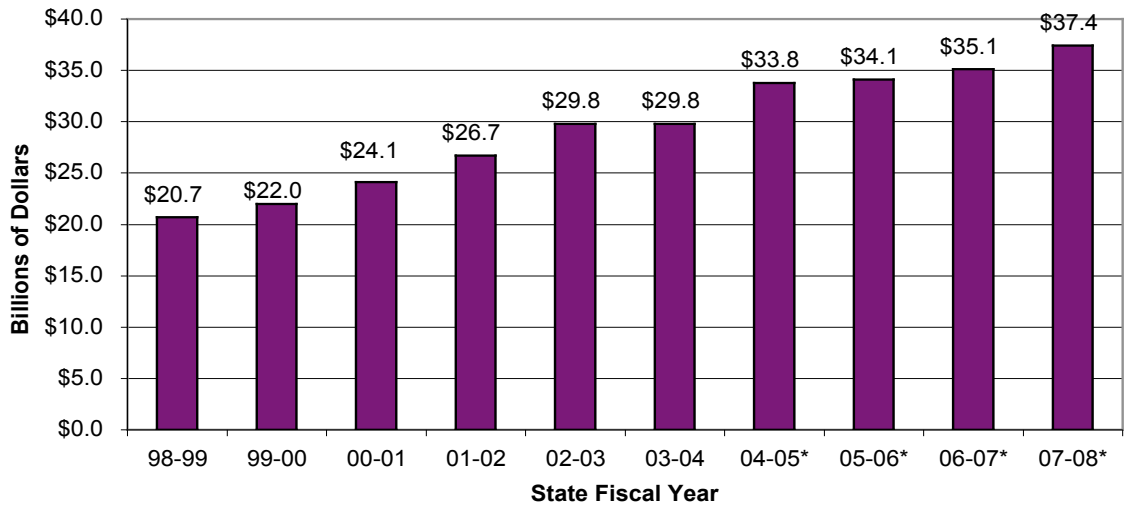
[2]Source: Department of Health Services, Medi-Cal Beneficiary Profile, Beneficiaries by Age and Demographics, January 2007,

[3] Ibid

[4]Ibid

[5]Ibid

**Figure 4: Total Federal and State Medi-Cal Expenditures, 1998-99 to 2007-08**

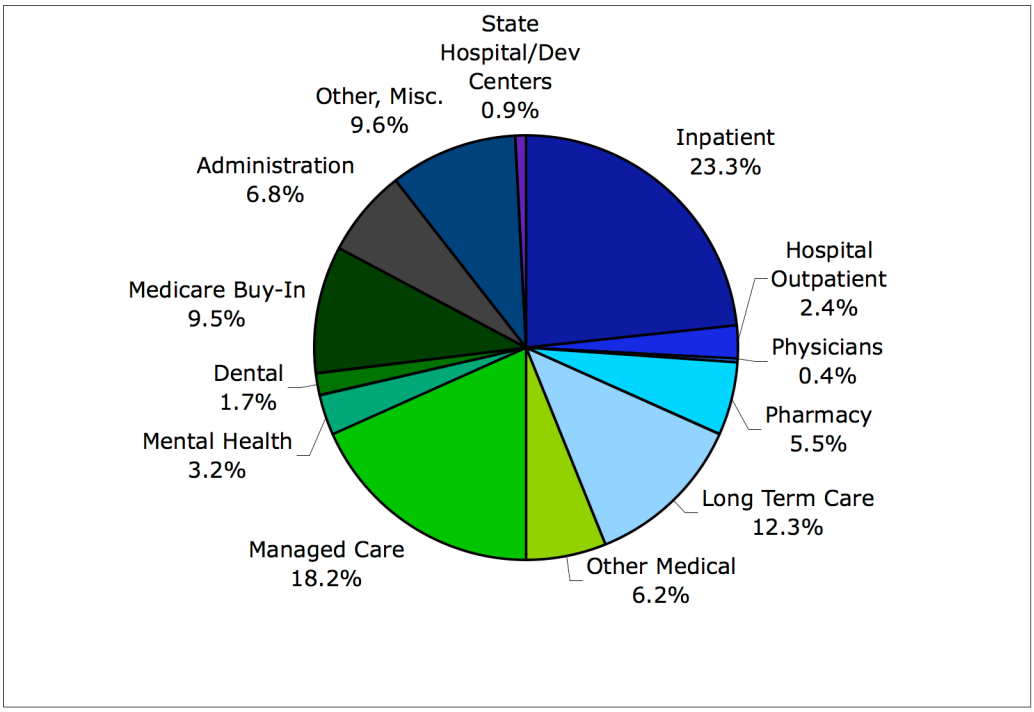



*Estimated
SOURCES: Department of Health Services, Governor's Budget Summary 2007-08.

Reflecting the diverse health needs of the populations that it covers, Medi-Cal spending pays for a variety of services. Inpatient costs represent the largest share of Medi-Cal expenditures, accounting for 24% of total (Figure 5). Payments to managed care comprise the next largest expenditure at 19%. Long-term care facilities received 12% of Medi-Cal funding. Administrative costs account for 7% of total Medi-Cal spending, of which about half is for county administration of eligibility.

In an effort to control Medi-Cal's rising pharmaceutical costs, the Governor's budget proposes switching the basis for establishing the drug reimbursement component of pharmacy claims from the Average Wholesale Price (AWP) to the Average Manufacturer Price (AMP). This will minimize potential cost shift to Medi-Cal from other drug purchasers and limit the potential for price fixing. The expected result is a General Fund savings of $44 million.

## Figure 5: Medi-Cal Expenditures by Service Category, FY 2007-08




SOURCES: California Department of Health Services. Medi-Cal Expenditures by Service Category, May 2007 Estimate; Department of Health Services. County Administration Funding Summary May 2007

Average Medi-Cal expenditures vary significantly across different beneficiary groups. Although children constitute over half of all Medi-Cal beneficiaries, expenditures in 2005 averaged only $1368 per child enrolled in managed care and $804 per child enrolled in fee-for-service.[6]* In comparison, expenditures for the elderly and disabled were $10,206 per beneficiary due to higher costs associated with acute and long-term care services.[7] Most of the growth in program spending has been for services to the aged and disabled.

California spends less per Medi-Cal beneficiary than most other states ($5,626 per beneficiary compared to the national average of $7,220) due in part to low provider payment levels, lower utilization of services, lower percentage of elderly and disabled beneficiaries, and much lower long-term care spending.[8]

[6] Source: Department of Health Services, Fiscal Analysis of SB 437 and AB 772, June 2005
*Note: These figures are based on figures from Medi-Cal family plans.
[7] Source: California HealthCare Foundation, *Medi-Cal Facts and Figures, A look at California's Medicaid Program*, January 2007
[8] Source: Department of Finance, Governor's Budget 2007-08, Proposed Budget Summary

## Enrollment & Retention

Nearly three quarters of all beneficiaries remain enrolled in Medi-Cal after one year; retention rates differ across beneficiary groups. Only 8% of individuals who pay a share of their costs retain coverage, while 89% of SSI/SSP recipients continue coverage after a year.[9]

There have been ongoing efforts to simplify and improve the enrollment process for Medi-Cal. For instance, in addition to mail-in application forms, applications can now be completed over the Internet using Health-e-App, which was approved for statewide use in 2002. One-e-App allows families to determine eligibility and apply for many health and social services programs via the Internet. For 2007-2008, the Governor has also allotted $35.9 million for SB 437, which should help ensure more children have access to health coverage by streamlining enrollment and reducing administrative barriers.[10] However, significant barriers remain, such as the complexity of the application process, other difficulties obtaining required documentation, lack of information about the program and, for immigrant families, fear that enrolling in Medi-Cal may jeopardize their goals of attaining citizenship.

## Managed Care

Between 1997 and 2006, enrollment in Medi-Cal managed care nearly doubled from 1.8 million to 3.1 million (Table 3). Reflecting the implementation of the state's "two-plan model" in 12 counties, enrollment in counties operating under this system grew from 849,000 in 1997 to more than 2.3 million in 2006. The number of 2006 enrollees in the geographic managed care (GMC) system decreased from 339,000 to 214,000. Enrollment in the state's eight County Organized Health Systems (COHS) increased from 378,000 in 1997 to 562,000 in 2006. There are five COHS currently serving eight counties: Yolo, Napa, Solano, San Mateo, Santa Cruz, Monterey, Santa Barbara, and Orange.

**Table 3: Medi-Cal Enrollment by Type of Managed Care Plan, 1997-2006**
(In Thousands)

| Year | Total | FFS | Total Managed Care | COHS | GMC | PCCM | PHP | 2-PLAN |
|---|---|---|---|---|---|---|---|---|
| **1997** | 5,151 | 3,391 | 1,760 | 378 | 143 | 22 | 367 | 849 |
| **1998** | 4,971 | 2,826 | 2,145 | 352 | 198 | 8 | 87 | 1,500 |
| **1999** | 5,041 | 2,527 | 2,514 | 377 | 324 | 2 | 7 | 1,804 |
| **2000** | 5,110 | 2,590 | 2,520 | 402 | 315 | 2 | 1 | 1,801 |
| **2001** | 5,531 | 2,704 | 2,826 | 459 | 319 | 0.1 | 0.9 | 2,047 |
| **2002** | 6,286 | 3,030 | 3,251 | 534 | 338 | 0 | 1 | 2,378 |
| **2003** | 6,412 | 3,102 | 3,305 | 546 | 338 | 1 | 1 | 2,419 |
| **2004** | 6,514 | 3,278 | 3,236 | 561 | 336 | NA | 1 | 2,338 |
| **2005** | 6,537 | 3,281 | 3,256 | 565 | 339 | NA | 2 | 2,350 |
| **2006** | 6,348 | 3,244 | 3,104 | 562 | 214 | NA | 2 | 2,326 |

SOURCES: DHS Annual Managed Care Statistical Reports, Medi-Cal Beneficiaries by Managed Care Plan January 1997 to May 2006, Overview of Medi-Cal Beneficiaries-Profile-By-County File, October 2007
Abbreviations: "FFS"- Fee for Service; "COHS"- County Organized Health Systems; "GMC"- Geographic Managed Care; "PCCM"- Primary Care Case Management; "PHP"- Prepaid Health Plan

As a part of the Medi-Cal Redesign, the 2006-07 budget dedicated significant funds to continue the growth in Medi-Cal managed care enrollment. $1.5 million (50% from the General Fund) was

[9] Source: California HealthCare Foundation, *Medi-Cal Facts and Figures, A look at California's Medicaid Program*, January 2007
[10] Governor's Budget Summary 2007-08

allocated to the Managed Care Expansion into 13 Counties initiative. [11] The Managed Care Expansion was to involve beneficiaries in El Dorado, Imperial, Kings, Lake, Madera, Marin, Mendocino, Merced, San Benito, San Luis Obispo, Sonoma, Placer, and Ventura counties. The 2007-08 Budget funding for managed care plans will be $6.2 Billion ($3.2 Billion General Fund).

As initiated in 2005, the state is scheduled to transition the first four of thirteen fee-for-service (FFS) counties (Lake, Mendocino, San Benito, and San Luis Obispo) to COHS managed care in 2008 (Governor's Budget Summary, 2007-08). Marin County is scheduled to transition from Prepaid Health Plan (PHP) to COHS and Sonoma County from PHP and FFS- Managed Care Network to COHS[12]. Additionally, Merced and Ventura counties await pending COHS authority before they can transition from FFS to new COHS[13].

Total Medi-Cal Managed Care enrollees are predicted to remain at around 3.3 million in 2007-08[14]. Approximately 340,000 beneficiaries are expected to enroll in Geographic Managed Care (GMC) and approximately 572,000 are expected to enroll in COHS[15].

## Access to Care[16]

Medi-Cal reimbursement rates in California are less than two-thirds (59%) that of Medicare rates, compared to 69% nationally. As a result of low physician reimbursement rates, the number of providers who accept Medi-Cal patients has been declining. More than half of all Medi-Cal beneficiaries report difficulties with finding a doctor, which is supported by the fact that for every 100,000 beneficiaries, there are only 46 primary care providers despite a federal minimum standard of 60 to 80. Specialized care covered by Medi-Cal is even more difficult to find, with only four Medi-Cal specialists per 100,000 beneficiaries and five surgical specialists per 100,000 beneficiaries, compared to federal minimum standards of ten and 15 per 100,000 beneficiaries, respectively.

However, most families and children are enrolled in Medi-Cal managed care plans, which have higher reimbursement rates than traditional Medi-Cal. Consequently, they may have a greater level of accessibility relative to those in traditional Medi-Cal. Additionally, most seniors and disabled individuals have dual coverage through Medicare and Medi-Cal. Through their Medicare coverage, which has higher reimbursement rates than Medi-Cal, they attain greater access to medical care.

## Utilization[17]

Utilization rates of primary care services for Medi-Cal beneficiaries are comparable to those associated with employer-based coverage. There is a 69% annual use rate for children's doctor visits under Medi-Cal, compared to 74% for such visits under employer coverage. Use rates for uninsured children's visits to a doctor are substantially lower, averaging only 41% annually.

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[11] Department of Finance, Governor's 2006-07 Budget
[12] Department of Health and Human Services, Medi-Cal Health Care Plan Codes, May 2006
[13] DHS Medi-Cal Managed Care Division, Update of Expansion Implementation Dates and Managed Care Models, September 2006
[14] Governor's Budget Summary, 2007-08
[15] Ibid.
[16] Medi-Cal Redesign, Updated Medi-Cal Redesign Fact Sheet, August 2005.
[17] Ibid.

## MANAGED RISK MEDICAL INSURANCE BOARD (MRMIB) PROGRAMS[18]

The Managed Risk Medical Insurance Board (MRMIB) administers health coverage programs to individuals who do not have health insurance and also plays a role in health care policy development. Three insurance programs administered by MRMIB include Healthy Families, Major Risk Medical Insurance Program (MRMIP), and Access for Infants and Mothers (AIM). Funding for MRMIB in 2007-08 is expected to be $1.282 billion.[19]

### Healthy Families

The Healthy Families Program provides low-cost health insurance to children in families whose incomes are too high to qualify for Medi-Cal, but are below 250%of the Federal Poverty Level (about $50,000 for a family of four). The Federal and State governments jointly fund Healthy Families. The federal to state funding match is a 2:1 ratio. From its inception in June 1998, enrollment in Healthy Families grew to approximately 814,547 in May 2007 with total expenditures of almost $916 million (Table 4). Enrollment among children is expected to grow to more than 915,000 in 2007-08 with expenditures of over $1 billion.

**Table 4: Healthy Families Enrollment and Expenditures, SFY 1998-2007**

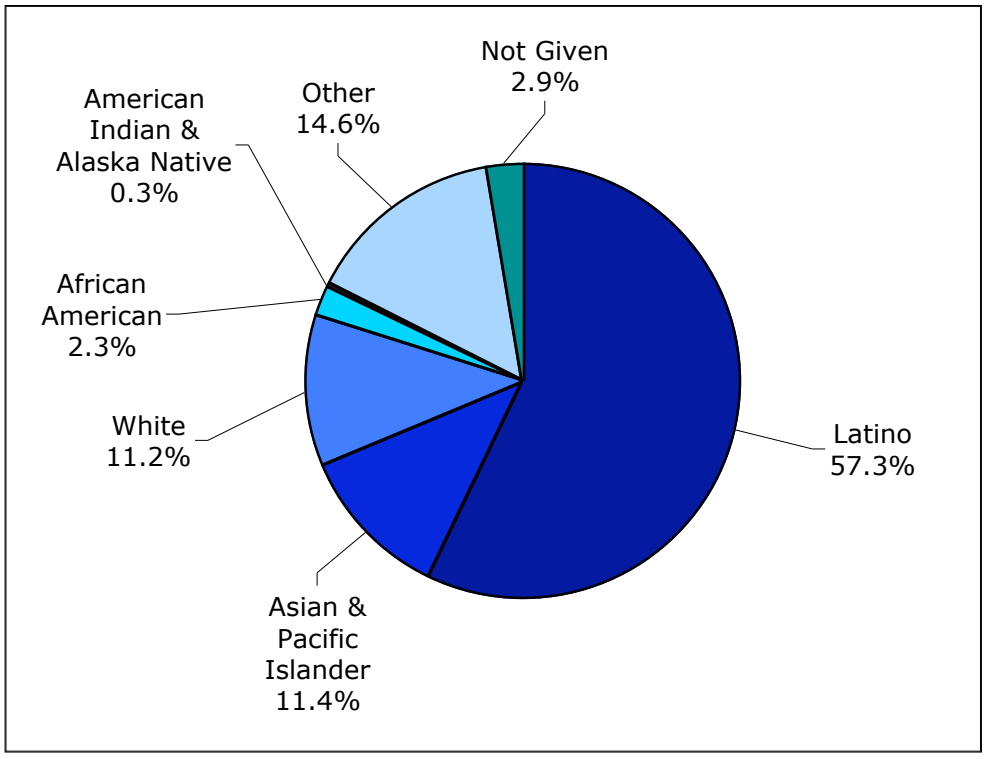
| State Fiscal Year | Enrollment | Expenditures |
|---|---|---|
| **1998-1999** | 131,816 | $59,379,000 |
| **1999-2000** | 296,538 | $211,801,000 |
| **2000-2001** | 444,723 | $389,533,000 |
| **2001-2002** | 561,631 | $546,261,000 |
| **2002-2003** | 660,316 | $692,912,000 |
| **2003-2004** | 661,939 | $761,499,000 |
| **2004-2005** | 713,900 | $806,778,000 |
| **2005-2006*** | 736,309 | $915,600,000 |
| **2006-2007*** | 867,727 | $1,027,300,000 |
| **2007-2008*** | 915,600 | $1,099,685,000 |

*Projected.
SOURCES: California Department of Finance, Governor's Budget Summary, 2007-08; MRMIB Healthy Families Program Monthly Enrollment Reports, May 2006

Healthy Families is an ethnically diverse program. Approximately three in five (57%) beneficiaries are Latino (Figure 6). Approximately one in nine (11%) beneficiaries are White, 11% are Asian/Pacific Islander, 2% are African American, and 0.3% are American Indian/Alaska Native. The majority (60%) of Healthy Families beneficiaries reside in one of five Southern California counties: Los Angeles (26%), Orange (9%), San Diego (9%), San Bernardino (8%), and Riverside (8%).[20]

[18] Source: California Department of Finance, Governor's Budget Summary 2004-05, 2005-06, 2006-07, & 2007-08
[19] California Department of Finance, Governor's Proposed Budget 2007-08
[20] MRMIB Healthy Families Program Monthly Enrollment Report, May 2007

**Figure 6: Ethnicity of Healthy Families' Subscribers, May 2007**




SOURCE: MRMIB Healthy Families Program Monthly Enrollment Report May 2007

## Major Risk Medical Insurance Program (MRMIP*)*

MRMIP offers insurance to individuals with health conditions, who cannot obtain private insurance. In May 2007, 7,833 people were enrolled in the program (Table 5). The decline in program enrollment and improvements in the waiting list are due to recent legislation (AB 1401), transitioning long time enrollees into health plans without a subsidy. In 2003, AB1401 enacted the Guaranteed Issue Pilot Program (GIP). GIP is a four-year pilot program designed to make health coverage more accessible to high-risk individuals and reduce the cost of subsidization for the state. The program was designed to share the cost of high-risk coverage between plans in the individual insurance market and the state. GIP has a sunset date of September 2007, at which time it will come under legislative review for possible reenactment.[21]

Thirty-five percent of MRMIP subscribers are between 50 and 64 years old and thirty-six percent are 30-49 years old. Only twenty-eight percent of subscribers are under 29 years old.[22] Whites comprise a disproportionate share of MRMIP subscribers (58%) compared to their proportion of the total state population. About half of the subscribers are enrolled with Blue Cross and the other half with Kaiser Permanente.[23] Blue Shield and Contra Costa Health Plan are the other private health plans participating in MRMIP. [24] Projected spending in SFY 07-08 is $40 million.[25] State

[21] Source: California Major Risk Medical Insurance Program, 2006 Fact Book March 2006.
[22] MRMIB, MRMIP Subscriber and Health Plan Data, May 2007 Summary
[23] Ibid
[24] Ibid
[25] Source: Department of Finance, Governor's Budget Summary, 2007-08.

contributions have remained at the same level since 1989-90, while other states' programs, such as Minnesota's, saw expansions in funding.

**Table 5: MRMIP Enrollment, By Demographic Characteristics, May 2007**

| Category | Number Enrolled | Proportion Enrolled |
|---|---|---|
| **TOTAL** | **7,833** | **100.0%** |
| Subscribers | 7,557 | 96.5% |
| Dependents | 276 | 3.5% |
| **Health Plans** | | |
| Blue Cross | 3,881 | 49.5% |
| Kaiser (North & South) | 3,652 | 46.6% |
| Blue Shield HMO | 254 | 3.2% |
| Contra Costa | 46 | 0.6% |
| **Race/Ethnicity** | | |
| White | Not Reported | 58.3% |
| Asian/Pacific Islander | Not Reported | 13.1% |
| Latino | Not Reported | 11.7% |
| Other | Not Reported | 14.4% |
| African American | Not Reported | 1.9% |
| American Indian | Not Reported | 0.1% |

SOURCE: MRMIB website, MRMIP Subscriber and Health Plan Data: May 2007 Summary

## Access for Infants and Mothers (AIM)

AIM provides insurance coverage to pregnant women and infants with incomes between 200 and 300% of the Federal Poverty Level who do not qualify for Medi-Cal or Healthy Families. Before July 2002, approximately 54,000 women and infants had enrolled in the program. Between July 2002 and June 2004, an additional 15,494 women and infants had enrolled in AIM.[26] In April 2006 there was a total of 10,932 enrollees (6691 women and 4241 infants). In May 2007, a total of 7,828 women were enrolled in AIM. [27] The general decrease in enrollment is mainly due to AIM infants transitioning into the Healthy Families program, which qualifies for 2/1 federal matching payments. The AIM funding for 2007-2008 is $138.7 million, an $11.2 million increase from 2006-07.[28]

[26] Source: MRMIB website

[27] Source: MRMIB, MRMIP Subscriber and Health Plan Data: May 2007 Summary

[28] Source: Department of Finance, Governor's Budget Summary 2007-2008

## Table 6: AIM Enrollment, as of May 2007

| Category | Proportion Enrolled |
|---|---|
| **TOTAL*** | **7,828** |
| **Health Plans*** | |
| Blue Cross HMO & EPO | 59.8% |
| Health Net | 23.9% |
| Kaiser (North & South) | 7.5% |
| Molina Healthcare | 6.6% |
| Other | 2.2% |
| **Race/Ethnicity*** | |
| Latina | 48.7% |
| White | 20.9% |
| Asian/Pacific Islander | 18.2% |
| Unknown | 10.4% |
| African American | 1.5% |
| American Indian | 0.3% |
| **Counties*** | |
| Los Angeles | 24.1% |
| San Bernardino | 5.9% |
| Monterey | 6.2% |
| San Diego | 15.8% |
| Riverside | 5.4% |
| Orange | 6.8% |
| Other | 35.8% |

SOURCE: MRMIB, AIM Subscriber and Health Plan Data: May 2007 Summary .
* Current Mothers only

Since May 2007, 49% of new (women) beneficiaries have been Latina, 21% were White, and 18% were Asian/Pacific Islander. Approximately 60% of women subscribed to a Blue Cross health plan and 24% were enrolled in Health Net. There are a high percentage of AIM enrollments (current Mothers only) in certain counties relative to their county population -- such as Monterey (6%) and San Diego (16%). The proportions of enrollment in AIM in other counties include: Los Angeles (24%), Orange (7%), and Riverside (5%).

## PRIVATE HEALTH INSURANCE COVERAGE[29]

### Employer-Based Coverage

- Roughly 12.3 million Californians between the ages of 19-64 were covered all year by employment-based health insurance in 2005, which is approximately 56% of the 19-64 year old population.[30]

- Seventy-one percent of California businesses offered health insurance in 2006, which was similar to 2005. (CHCF Employer Health Benefits Survey 2006) Eighty-nine percent of all employees in California work for an employer who offers coverage. Yet even among firms that offer coverage, not all employees are covered. (CHCF Snapshot: Employer-Based Health: Coverage and Cost, 2006)

    - More California employers offer coverage than the national average (71% as opposed to 61%). (CHCF Employer Health Benefits Survey 2006).

- Seventy-seven percent of workers in firms that offer coverage are eligible for coverage. Workers who were ineligible for coverage were mainly ineligible due to waiting periods or minimum work-hour rules (CHCF Employer Health Benefits Survey 2006).

    - When offered, most of those eligible (86% according to the CHCF Employer Health Benefits Survey 2006) accept coverage.

Among uninsured employees who were eligible for employer-sponsored health insurance, only 14.7 percent declined coverage because they did not want or need it (California Health Interview Survey 2003). Approximately 13.1% of eligible uninsured employees reported that they had access to coverage through another plan (California Health Interview Survey 2003). Seven percent rejected employer-based coverage due to high share of cost. (California Health Interview Survey 2003)

- On average, workers contributed $547 annually for single coverage and $2,824 for family coverage (Employer Health Benefits Survey 2006).

- The share of premiums paid by workers were 12% for single coverage and 24% for family coverage. Worker contributions varied by firm size. In smaller firms (33-199 employees), thirty-one percent of employees paid more than $360 a month for family coverage. In contrast, eleven percent of employees of larger firms (200 or more employees) paid more than $360 a month for family coverage.

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[29] Unless otherwise noted, information on employer-based health insurance was obtained from the California HealthCare Foundation, /Health Research and Educational Trust (HRET) California Employer Health Benefits Survey, 2006, Kaiser Family Foundation/HRET National Employer Health Benefits Survey, 2006, at www.hret.org.

[30] UCLA Center for Health Policy Research, One in Five Californians were Uninsured Despite Modest Gains in Coverage, October 2006

- Nearly all employers with more than 200 employees offer health insurance. The offer rate is much lower among small businesses. Sixty-two percent of businesses with 3-9 employees in California offer health insurance (Employer Health Benefits Survey 2006).

- Half of California workers who have insurance through their employer are enrolled in an HMO. Thirty-four percent are enrolled in a PPO (Employer Health Benefits Survey 2006).

- In 2005, large employers in California with more than 200 employees were very likely to offer employees a choice in health plans, with 92% offering more than one plan. Only 64% of small employers offered workers a choice of plans (Employer Health Benefits Survey 2005).

- Health insurance premiums continue to rise. In California, premiums rose by 8.7% in 2006, which was more than twice the California inflation rate (4.2%). Forty-one percent of large employers (those with 200 or more workers) stated that they are likely to increase the amount paid by employees for health insurance premiums. [31]

**Individual Coverage**

- In 2005, nearly 1.8 million people in California were covered by privately purchased health plans throughout the year (California Health Interview Survey, 2005). The individual insurance market accounts for about 5.5 percent of the non-elderly population (ages 0-64) (California Health Interview Survey, 2005).

- In 2003, thirty-eight percent of those buying individual insurance were self-employed.[32]

- In 2005, approximately twenty-one percent had incomes below 200% of the Federal Poverty Level. Thirty-two percent were between the ages of 35 and 54, fifty-four percent were individuals younger than 35, and fourteen percent are 55 and over (California Health Interview Survey, 2005).

- Individual health insurance premiums are fully tax-deductible for the self-employed, but not for other purchasers of individual health coverage.

- One study reported that nearly thirty percent of Americans between the age of 18 and 65 are potential candidates for individual health coverage; however only eight percent purchase coverage through the individual market.[33] The individual market is reaching less and less of its candidates, declining from over 33% of its potential market in 1988 to less than 26% of its market in 2004, primarily due to the rise in premiums and decline in affordability.

- In California, consumers have less protection in purchasing individual coverage than small employers do – there are fewer restrictions on insurance underwriting practices, less security

[31] Source: California HealthCare Foundation, California Employer Health Benefits Survey, 2006
[32] Source: California HealthCare Foundation, Snapshot: Individual Health Insurance Market 2005
[33] Ibid

in access and retention on average, less price transparency and thus less ability to compare market prices[34].

- ITUP reviewed and compared premiums for small employers and individual coverage in 48 of California's 58 counties and found that individual coverage is typically more costly than comparable small employer coverage. HMO premiums are highest in areas lacking provider and plan price competition and lowest in the large urban areas of Southern California where price competition is strongest.[35]

## UNINSURED CALIFORNIANS[36]

Despite the presence of public and private health insurance programs, 6.5 million nonelderly Californians were uninsured for all or part of the year in 2005, which is about 18% of the state population. In 2005, almost 4.9 million individuals were uninsured at a point in time. While uninsurance rates rose in the rest of the country, California's overall uninsured population remained constant. Declines in employer sponsored health coverage, particularly for dependents, were offset by expansions in public health care coverage programs, such as Medi-Cal and the Healthy Families Program.

Of the 6.5 million Californians that lacked health insurance, over 5.5 million were adults between the ages of 18 and 64. Uninsured adults 18 to 35 represented the largest group at 49% of uninsured Californians and 34% of all Californians in that age range. Uninsured adults aged 36 to 64 constituted 36% of uninsured Californians and 17% of all 35 to 64 year old Californians (Table 6.5).

**Table 7: Uninsured Californians by Age, 2005***

| Age Group | Total Number Uninsured (n= 6,530,000) | Proportion of Total Uninsured | Proportion of Age Group Uninsured |
|---|---|---|---|
| 0-17 | 943,000 | 14.4% | 9.6% |
| 18-35 | 3,221,000 | 49.3% | 34.8% |
| 36-64 | 2,367,000 | 36.2% | 17.8% |

*Includes those uninsured all or part of the year

Nearly a million children aged 0 to18 are uninsured. In 2005, 763,000 children were uninsured at a point in time, but 943,000 children were uninsured all or part of the year, which constitutes almost 10% of the children in California (Table 6.5). The number of uninsured children decreased by 3% from 972,000 in 2003 due to the growth in enrollment of children in the state's Medi-Cal and Healthy Families programs. There was a marked decline in the numbers of children eligible, but

[34] In a series of articles published early this year in the Los Angeles Times, Lisa Girion reported on legal actions taken against major private health insurance companies for retroactively rescinding the health coverage of some of their members reportedly because they failed to include certain pre-existing conditions.

[35] See Brooke Fox, Overview of the Uninsured, Statewide 2005 at www.itup.org. Average statewide premiums for standard HMO coverage for a fifty-year-old individual were typically around $500 per month in 2005 but ranged from as low as $396 to as high as $504 per month.

[36] Source: California Health Interview Survey (CHIS) 2005 unless otherwise noted. See also E. Richard Brown, The State of Health Insurance in California: Findings from the 2005 California Health Interview Survey, July 2007

not enrolled in the state's Medi-Cal and Healthy Families programs. The number of uninsured children below the poverty line stayed roughly the same at 353,000.

At a point in time, individuals with incomes below 200% of the Federal Poverty Level (FPL) comprised 63.1% (3 million) of the non-elderly uninsured population (CHIS 2005). Most of the uninsured have low incomes. Over fifteen percent of those with incomes between 200 and 300% of the FPL are uninsured. The FPL for a family of three in 2007 is $17,170 annually, equal to about $8.60 an hour for a full time full year worker[37].

In 2003, approximately 13% of California's workers were uninsured, overwhelmingly because they were not offered coverage at work. Workers and their family members accounted for over 76.2% of uninsured Californians.

The uninsured population is demographically diverse (Table 7). In 2005, 3.3 million Latinos (who were under 65 years old) were uninsured, which comprise almost 51% of the state's total uninsured and 34% of all Latinos under 65 years old. Nearly 690,000 Asian/Pacific Islanders had no coverage for their health expenditures and slightly less than 1.9 million Whites were uninsured.

**Table 8: Uninsured Persons (<65 years old) in CA, By Race, 2005**

| Race | Total Number Uninsured (n = 6,530,000) | Proportion of Total Uninsured | Proportion of Racial Group Uninsured |
|---|---|---|---|
| **Latino** | 3,298,000 | 50.5% | 33.7% |
| **White** | 1,861,000 | 28.4% | 12.5% |
| **Asian** | 689,000 | 10.5% | 17.7% |
| **African American** | 315,000 | 4.8% | 15.3% |
| **Other** | 293,000 | 4.4% | 21.7% |
| **American Indian/Alaska Natives** | 75,000 | 1.1% | 22.0% |

SOURCE: California Health Interview Survey (CHIS), 2005.
Note: This reflects those uninsured all year and part of the year

Research evidence suggests that the uninsured use less medical care, are less likely to receive preventive services, and more likely to forego needed care than persons with health insurance (Institute of Medicine, 2002). Several studies have found that the uninsured are more likely to suffer declines in health and more likely to die sooner than the privately insured (Institute of Medicine, 2002).

### Measuring California's Uninsured: CHIS and CPS

The 2005 California Health Interview Survey (CHIS) measured the rate of the state's uninsured by county and region. The CHIS data reflects a much more accurate assessment of the uninsured than the Current Population Survey (CPS) findings because it has a more accurate count of Medi-Cal and Healthy Families enrollment, closer to the actual program enrollment at the time of the survey. The 2005 CHIS reports 4.9 million were uninsured at one point in time and a total of 6.5 million were uninsured at some point during a 12-month period.

[37] Federal Register, Vol. 72, No. 15, January 24, 2007, pp. 3147–3148

The federal CPS figure for the uninsured at a point in time is roughly equal to the CHIS data of uninsured over the course of a year. The Federal CPS reports a 18.4% uninsurance rate for California, which is equivalent to 6.6 million uninsured individuals. The CPS survey data on the numbers of persons reporting enrollment in Medi-Cal and Healthy Families is substantially below the actual enrollment in those two programs. The most recent CPS data, collected in 2005, shows a slight increase in the percentages of Californians who are uninsured. Twenty-eight of the fifty states in the U.S. showed increasing rates of uninsured from 2003-2004. The CPS data shows a decline in employment-based coverage and an increase in enrollment in public programs. The percentage growth in the uninsured was largest among young adults (5% increase) and workers (5% increase).[38]

The next section describes the sources of funding for the health care services provided to the uninsured population in California.

[38] US Census Bureau, 2004-2005 Data www.census.gov

## SECTION 2: STATE FUNDING TO COUNTIES FOR PUBLIC HEALTH AND INDIGENT CARE

### BACKGROUND

In California, counties are responsible for the provision of health care to indigent uninsured individuals. Counties receive a mix of state and federal revenues to fund public health services and medical care for the indigent. In return, counties are required to comply with a financial Maintenance of Effort (MOE) for indigent care.[39] Counties can be grouped into five broad categories based on their size, location, and delivery system: 1) small, rural counties, 2) large counties with public hospitals, 3) large counties without public hospitals, 4) hybrid counties with public clinics and private hospitals and 5) counties with block grants to a single private hospital.

Historically, counties relied on property taxes to pay for a portion of health services for the uninsured. After the passage of Proposition 13, the legislature enacted a series of laws to shift responsibility and funding for indigent populations from the state to counties. In 1991, they combined multiple state funding streams into realignment funds that are financed through a portion of state sales taxes and vehicle license fees.[40] The principal funding streams supporting county care for the uninsured are realignment, tobacco funds, net county disproportionate share hospital (DSH) funding, safety net care pool, and county match, and in some counties tobacco litigation settlements.

Between 1997-98 and 2006-07, realignment payments to counties increased by nearly thirty-eight percent from $1.11 billion to $1.53 billion (Table 8). All 58 counties and three cities (Berkeley, Long Beach, and Pasadena) receive realignment funds. During this period, all 58 counties and three cities experienced modest increases in their realignment funds. Allotments are based on historical funding patterns under predecessor programs with equity adjustments for counties that are disadvantaged by the historical formulas. In 2006-07, Los Angeles County received $501 million, nearly 33% of all realignment funds distributed statewide. Realignment funding per uninsured California resident is approximately $235 in 2006-07.[41]

[39] This MOE requirement is tied to the receipt of Proposition 99 funds discussed later in this report. Essentially MOE requires counties to spend some of their General Purpose revenues for health programs.

[40] For more information about the financing of health care for the uninsured in California, please see Wulsin and Janice Frates. "California's Uninsured: Programs, Funding, and Policy Options." Insure the Uninsured Project. July 1997 at www.itup.org.

[41] Figure was derived by dividing the estimated 2006-07 state realignment allotments to selected counties by the estimated 6.5 million uninsured from CHIS 2005.

**Table 9: State Realignment Allotments to Selected Counties, SFY 1997-98 to 2006-07**
(In Thousands)

| State Fiscal Year | Total | Alameda | Los Angeles | Orange | San Bernardino | Tulare |
|---|---|---|---|---|---|---|
| **1997-98** | $1,114,853 | $47,324 | $385,848 | $67,253 | $34,840 | $9,996 |
| **1998-99** | $1,159,355 | $48,758 | $395,834 | $69,192 | $38,204 | $10,880 |
| **1999-00** | $1,239,294 | $51,359 | $413,946 | $72,906 | $43,742 | $12,471 |
| **2000-01** | $1,344,657 | $55,442 | $443,027 | $78,834 | $50,609 | $14,357 |
| **2001-02** | $1,390,796 | $57,238 | $457,397 | $81,291 | $52,200 | $14,810 |
| **2002-03** | $1,352,672 | $55,646 | $444,646 | $79,160 | $50,811 | $14,413 |
| **2003-04†** | $1,472,593 | $59,041 | $471,793 | $83,851 | $53,843 | $15,276 |
| **2004-05†** | $1,472,593 | $60,380 | $482,491 | $85,755 | $59,381 | $15,622 |
| **2005-06*†** | $1,584,898 | $65,093 | $520,592 | $92,447 | $59,362 | $16,841 |
| **2006-07*†** | $1,532,086 | $62,820 | $501,984 | $89,220 | $57,289 | $16,254 |

* Estimated.
† Total for SFY 2003-07 does not include funds for city health departments (Berkeley, Pasadena, Long Beach)
SOURCE: Office of County Health Services, Maintenance of Effort Calculation.

## COUNTY INDIGENT HEALTH CARE PROGRAMS

### Medically Indigent Services Program (MISP)

County indigent health care programs finance inpatient, outpatient, and emergency services for uninsured residents and vary by county. In the 24 large counties the program is known as Medically Indigent Services Program (MISP). In these counties, Latinos comprised more than one-half (53%) of all indigent patients. In 2002-03, MISP counties provided services to 1.3 million patients (Table 9). Los Angeles County alone accounted for more than half of all indigent patients served by all MISP counties. Counties that operated a county hospital based delivery system had significantly higher costs and revenues and delivered more care to the uninsured than counties without a public delivery system. Payor counties had much lower revenues, smaller expenditures and paid for less care to the uninsured.

**Table 10: County Indigent Health Care Clients: Selected Services in Selected Counties, SFY 2002-03**

| County | Unduplicated Patients | Inpatient Discharges | Outpatient Visits | Emergency Visits |
|---|---|---|---|---|
| **All Counties** | 1,347,325 | 73,568 | 3,800,160 | 518,477 |
| **Los Angeles** | 681,813 | 31,128 | 2,070,865 | 164,642 |
| **San Francisco** | 63,284 | 2,823 | 170,242 | 39,869 |
| **Santa Clara** | 79,657 | 3,797 | 130,997 | 24,606 |
| **Orange** | 118,059 | 6,802 | 440,495 | 13,967 |
| **San Diego** | 49,219 | 3,929 | 136,446 | 49,666 |
| **Kern** | 8,040 | 758 | 18,124 | 7,661 |
| **Fresno** | 18,619 | 1,424 | 52,478 | 14,556 |
| **Tulare** | 3,904 | 591 | 16,521 | 6,392 |

SOURCE: Department of Health Services, Office of County Health Services, Medically Indigent Care Reporting System, County Data.

The different models of county health systems have enormously wide variations in eligibility, funding and access to services in these very different delivery systems.[42] Each county makes its own decisions as to how much relative emphasis to place on care for the uninsured as opposed to other county health priorities, on inpatient and emergency services versus primary care and outpatient services and the mix of public and private providers to deliver services.

**Table 11: County Delivery System by County Type**

| | Provider counties | Payor counties | Hybrid counties | CMSP small counties |
|---|---|---|---|---|
| **Hospital** | Public | Private | Private | Private |
| **Doctors** | Public | Private | Public | Private |
| **Clinics** | Public and sometimes non profit community clinics | Non profit community clinics | Public and sometimes non profit community clinics | Non profit community clinics |

The structure of the county delivery system determines its access to funding for care to the county indigent uninsured. The following chart describes the funding streams available to fund care for the indigent uninsured in California's counties.

**Table 12: Financing by County Type**

| | Provider Counties | Payor Counties | Hybrid Counties | CMSP Counties |
|---|---|---|---|---|
| **Realignment** | Yes | Yes | Yes | Yes |
| **Prop 99** | Yes | Yes | Yes | Yes |
| **Safety Net Care Pool** | Yes | No | No | No |
| **County Match** | Yes | Yes | Yes | Yes |
| **FQHC** | Yes | No | Yes | Yes |
| **Net County DSH** | Yes | No | No | No |

## County Medical Services Program (CMSP)

The County Medical Services Program (CMSP) funds both inpatient and outpatient services provided to uninsured low-income persons in 34 small, rural counties. In order to qualify for CMSP, individuals must be uninsured, medically indigent adults, who earn less than 200% of the FPL and are not eligible for Medi-Cal. In 2004-05, CMSP services were used by 63,930 members.[43] On a monthly basis, approximately 40,000 indigent adults rely on CMSP benefit coverage.[44]

[42] For your county and comparisons to other counties and regions around the state please see ITUP's county reports at www.itup.org.
[43] County Medical Services Program, CMSP Website, accessed August 2006.
[44] County Medical Services Program, CMSP Website, accessed August 2007.

Between 1997-98 and 2006-07, total funding for CMSP increased from $183 million to $228 million, and individual revenue sources changed considerably (Table 12). During this period, realignment funds increased as a percentage of total funds from 67% in 1997-98 to 91% in 2006-07. Hospital settlements declined from $28 to $13 million. Due to increases in other funding, state general funds were deferred. Proposition 99 funds[45] also have been phased out. County matching funds remained the same as in previous years at around $5 million.

**Table 13: Sources of Revenue for County Medical Services Program (CMSP), 1997-98 to 2006-07**

(In Thousands)

| SFY | Total | Realignment | General Fund | Hospital Settlements | Proposition 99 | County Funds |
|---|---|---|---|---|---|---|
| **1997-98** | $182,971 | $110,749 | $20,237 | $27,929 | $12,514 | $5,459 |
| **1998-99** | $184,755 | $124,382 | $20,237 | $17,801 | $9,983 | $5,459 |
| **2002-03*** | $215,364 | $169,000 | $0 | $20,000 | $0 | $5,459 |
| **2003-04*** | $221,184 | $175,000 | $0 | $20,000 | $0 | Not Available |
| **2004-05*** | $235,627 | $176,000 | $0 | $20,000 | $0 | Not Available |
| **2005-06*** | $238,130 | $197,246 | $0 | $15,000** | $0 | Not Available |
| **2006-07*** | $228,602 | $209,079 | $0 | $13,000**† | $0 | $5,459 |

Approved budget.
*Estimated
**Includes other recoveries
† Includes Retroactive Eligibility
SOURCE: Legislative Analyst's Office, CMSP Governing Board Budget, 2006-07 and CMSP Website Accessed July 2007

In 2004-2005 CMSP paid for 433,583 outpatient visits and 11,907 inpatient visits. Hospital spending accounted for nearly 72% of total CMSP expenditures.[46]

### California Healthcare for Indigents Program (CHIP)

State financial support for indigent medical services in the 24 largest counties is provided through realignment and the California Healthcare for Indigents Program (CHIP) funded by Proposition 99 (Tobacco Tax). CHIP funds reimburse providers for uncompensated services for individuals who cannot afford care and for whom no other source of payment is available. In order to receive Proposition 99 funds, counties agree to:

- Maintain a financial level of effort;
- Report expenditure and utilization data to the Department of Health Services; and
- Provide follow-up medically necessary treatment to eligible children.

State payments to counties under CHIP decreased significantly from approximately $149 million in 1998-99 to $23.9 million in 2006-07 due to the state's diversion of Proposition 99 funds for other purposes (Table 13). Wide variations in CHIP allocations persist with counties that operate publicly funded hospitals receiving relatively larger allocations proportionate to their population size and number of uninsured.

[45] Proposition 99 levied a $0.25/pack tax on tobacco products beginning in 1988. The proceeds were designated for health care for the uninsured.

[46] CMSP Website, County Medical Services Program: Summary of Claims and Costs by Claim Type FY 2002-2003 to FY 2004-2005

**Table 14: California Healthcare for Indigent Program (CHIP) Allotments to Selected Counties, SFY 1998-99 to 2006-07**
(In Thousands)

| State Fiscal Year | Total | Alameda | Los Angeles | Orange | San Bernardino | Tulare |
|---|---|---|---|---|---|---|
| **1998-99** | $148,730 | $7,185 | $66,320 | $7,181 | $5,782 | $1,924 |
| **1999-00** | $74,621 | $3,719 | $34,578 | $3,085 | $3,013 | $827 |
| **2000-01** | $84,819 | $4,101 | $39,033 | $3,618 | $3,438 | $969 |
| **2001-02** | $71,947 | $3,550 | $33,714 | $2,902 | $2,861 | $777 |
| **2002-03** | $55,690 | $2,734 | $26,379 | $2,094 | $2,328 | $561 |
| **2003-04** | $26,899 | $1,447 | $14,032 | $549 | $1,180 | $146 |
| **2004-05** | $23,854 | $1,265 | $12,426 | $514 | $868,398 | $138 |
| **2005-06** | $44,838 | $2,253 | $21,572 | $1,636 | $1,731 | $439 |
| **2006-07** | $23,854 | $1,183 | $12,298 | $656 | $867 | $176 |

SOURCE: Department of Health Services, Office of County Health Services, Allocation Tables.

## Rural Health Services (RHS) Program

Thirty-four small counties receive RHS appropriations, also funded by Proposition 99. RHS reimburses providers who submit claims for covered services to the indigent uninsured who are not covered by any other program. After a substantial augmentation in SFY 1998-99, total funding for RHS declined to $2 million in 2003-04, significantly increased in 2005-06 to approximately $4.8 million, but then declined to $2 million again in 2006-07. (Table 14) In 2006-07 the five most populated rural counties (Butte, Marin, Shasta, Solano and Sonoma) received more than half (57 percent) of total RHS funding. The remaining rural counties received very modest payments under the program, with Alpine County receiving only $108 annually.

Small counties are allowed to contract back with the state to administer RHS on their behalf; the program administrator is the DHS Office of County Health Services. For FY 2004-05, only one small county, Solano, elected to administer its own RHS program.

**Table 15: Rural Health Services (RHS) Allocations to Selected Counties, SFY 1998-99 to 2006-07**
(In Thousands)

| Year | Total | Butte | Humboldt | Imperial | Shasta | Solano | Sonoma |
|---|---|---|---|---|---|---|---|
| **1998-99** | $6,484 | $503 | $328 | $297 | $481 | $780 | $943 |
| **1999-00** | $2,456 | $190 | $143 | $124 | $238 | $263 | $427 |
| **2000-01** | $2,977 | $217 | $143 | $147 | $201 | $370 | $466 |
| **2001-02** | $2,525 | $190 | $117 | $124 | $172 | $311 | $394 |
| **2002-03** | $2,123 | $162 | $97 | $99 | $158 | $260 | $338 |
| **2003-04** | $2,009 | $172 | $93 | $91 | $174 | $248 | $328 |
| **2004-05** | $2,210 | $215 | $104 | $82 | $301 | $246 | $367 |
| **2005-06** | $4,764 | $452 | $222 | $196 | $429 | $585 | $804 |
| **2006-07** | $2,210 | $231 | $114 | $83 | $232 | $257 | $390 |

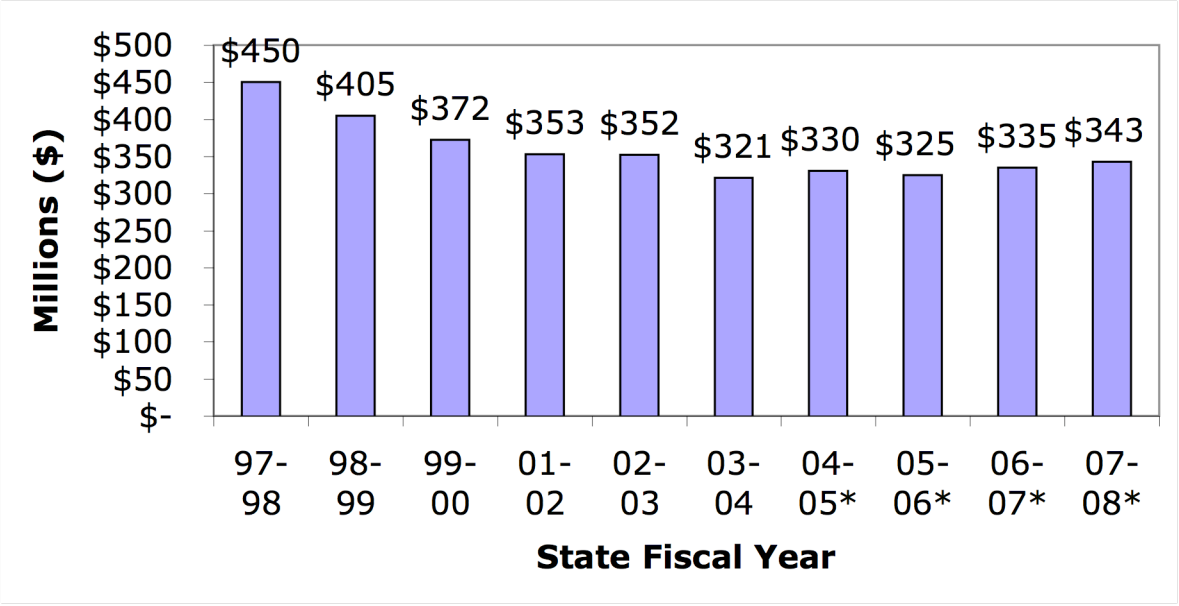
SOURCE: Department of Health Services, Office of County Health Services, Allocation Tables

## TOBACCO REVENUES

### Proposition 99

Revenues from the taxation of tobacco products are used to support multiple health programs in the state. As noted above, Proposition 99 levied a tax of $.25 per pack of cigarettes, dedicating the revenue to fund the delivery of health care services to the uninsured. Proposition 99 revenues have declined from SFY 1989-90 due to reductions in the sale of cigarettes in the state. This tax is expected to produce $343 million in special funds in 2007-08 (Figure 7).

**Figure 7: Proposition 99 Revenues, State Fiscal Year (SFY) 1998-99 to 2007-08**




*Estimated
SOURCE: Governor's Budget Summary 2007-08

Proposition 99 revenues are used for a variety of health programs serving low-income adults and children. These include: Breast Cancer Early Detection Program (BCEDP), grants to community clinics, the Children's Health and Disability Prevention (CHDP) program, CHIP, and RHS. In addition, Proposition 99 funds are used to subsidize two health insurance products: Major Risk Medical Insurance Program (MRMIP) and the Access to Infants and Mothers (AIM). Finally, Proposition 99 funds the activities of the Office of Statewide Health Planning and Development (OSHPD) (Table 15). The account dedicated to AIM steadily grew until the proposed Fiscal Year 2005-06 Budget when the state proposed to secure federal matching funds for AIM services to pregnant women.[47] AIM funding allocation is expected to increase in 2006-07 to approximately $56.2 million.[48]

[47] Legislative Analyst's Office, Analysis of the 2005-2006 Budget Bill
[48] Department of Finance, Governor's Budget Summary, 2006-07

**Table 16: Proposition 99 Allotments for Select Health Programs, 1998-99 to 2006-07**
(In Thousands)

| State Fiscal Year | Total Spending | BCEDP | CHDP | CHIP | RHS | MRMIP | AIM | OSHPD |
|---|---|---|---|---|---|---|---|---|
| **1998-99** | $493,018 | $0 | $49,291 | $148,730 | $6,484 | $46,033 | $37,499 | $1,837 |
| **1999-00** | $496,825 | $11,660 | $55,160 | $74,621 | $2,621 | $42,764 | $45,796 | $1,047 |
| **2000-01** | $428,454 | $9,000 | $59,882 | $84,819 | $2,973 | $45,000 | $56,218 | $998 |
| **2001-02** | $397,759 | $11,200 | $63,300 | $74,947 | $2,525 | $40,000 | $38,613 | $1,032 |
| **2002-03** | $361,598 | $12,700 | $17,500 | $55,690 | $2,123 | $40,000 | $75,764 | $1,047 |
| **2003-04*** | $341,682 | $15,648 | $0 | $25,213 | $2,009 | $40,000 | $91,300 | $1,047 |
| **2004-05*** | $330,000 | $9,548 | $4,200 | $21,013 | $1,047 | $40,000 | $93,764 | -- |
| **2005-06*** | $325,000 | $12,800 | NA | 44,800 | $1,047 | $40,000 | $13,670 | NA |
| **2006-07*** | $335,000 | $6,000 | NA | NA | $2,000 | $40,000 | $56,200 | NA |

*Estimated

SOURCES: Legislative Analyst's Office, Department of Finance, Budget Summary 1998-2005; Governor's Budget Summary 2005-07.Abbreviations: "BCEDP"- Breast Cancer Early Detection Program; "CHDP" – Children's Health and Disability Prevention; "CHIP"- California Healthcare for Indigent Program; "RHS"- Rural Health Services; "MRMIP" – Managed Risk Medi-Cal Insurance Program; "AIM" – Access to Infants and Mothers; OSHPD"- Office of Statewide Health Planning and Development

## National Tobacco Settlement

In 1998, California participated in the national tobacco settlement with 41 other states and several cities. The Office of The Attorney General Office estimates that between $418 million and $500 million will be paid to the state of California annually over the next ten years as a result of the settlement (Table 16). The national tobacco settlement roughly doubles the amount of tobacco-related funds available to the state for the next 10 years.

**Table 17: Estimated Annual Tobacco Settlement Payments to Counties, 1999-2016**

| Year | Revenue |
|---|---|
| **1999** | $157,084,894 |
| **2000*** | $220,700,944 |
| **2001*** | $256,317,292 |
| **2002*** | $350,278,820 |
| **2003*** | $478,074,172 |
| **2004*** | $401,172,357 |
| **2005*** | $406,915,532 |
| **2006*** | $368,797,958 |
| **2007*†** | $418,917,916 |
| **2008*†** | $453,906,265 |
| **2009*†** | $459,898,608 |
| **2010*†** | $465,164,506 |
| **2011*†** | $470,978,557 |
| **2012*†** | $476,789,349 |
| **2013*†** | $482,264,439 |
| **2014*†** | $487,568,318 |
| **2015*†** | $492,727,310 |
| **2016*†** | $498,850,581 |

*Annual amount, † Projected.

SOURCE: Attorney General: Tobacco Master Settlement Agreement Payments to California Counties and Cities 1999-2016

Counties and cities throughout the state are receiving additional revenue directly as a condition of the settlement (Table 17). Many counties use their tobacco settlements for health care to the

uninsured; some do not. There is no legal obligation as a part of the settlement for counties to spend their tobacco settlement funds on health care to the uninsured, and there is no statewide reporting on how counties spend their settlement funds.

**Table 18: Projected Tobacco Settlement Payments to Selected Counties, 2007**

| Counties | Total Payment: 2007 (In Millions) |
|---|---|
| Alameda | $14.7 |
| Los Angeles | $97.8 |
| Orange | $29.2 |
| San Bernardino | $17.5 |
| Tulare | $4.0 |
| **TOTAL: California Counties** | **$387.3*** |

*This figure includes payments from as recent as June 2007 but may change if more payments are made this year.
SOURCE: Office of Attorney General, Tobacco Master Settlement Agreement Payments to Counties and Cities 1999-2007.

## Proposition 10 Funding

State and local First Five Commissions receive Proposition 10 funding through a 50 cent per pack increase in the state's tobacco tax to improve the early childhood development of children 0-5. A portion of this funding ($700 million annually) is being used in some counties to support coverage of uninsured young children in local Healthy Kids programs also known as Children's Health Initiatives. The funds are used both for coverage and for outreach to uninsured children.
The Healthy Kids program is administered through the counties. It is designed to provide coverage for children who are ineligible for public insurance. Beneficiaries must have family incomes less than 300% of the FPL, be under age 19, be a county resident, and be ineligible for other programs.[49] Premiums are generally $4-$12 per child per month and co-pays range from $5-$15 for most services.[50] Twenty-two counties offer Healthy Kids Coverage, covering roughly 87,777 children as of April 2006.[51]

## FUNDING FOR COUNTY HEALTH PROGRAMS FOR THE UNINSURED

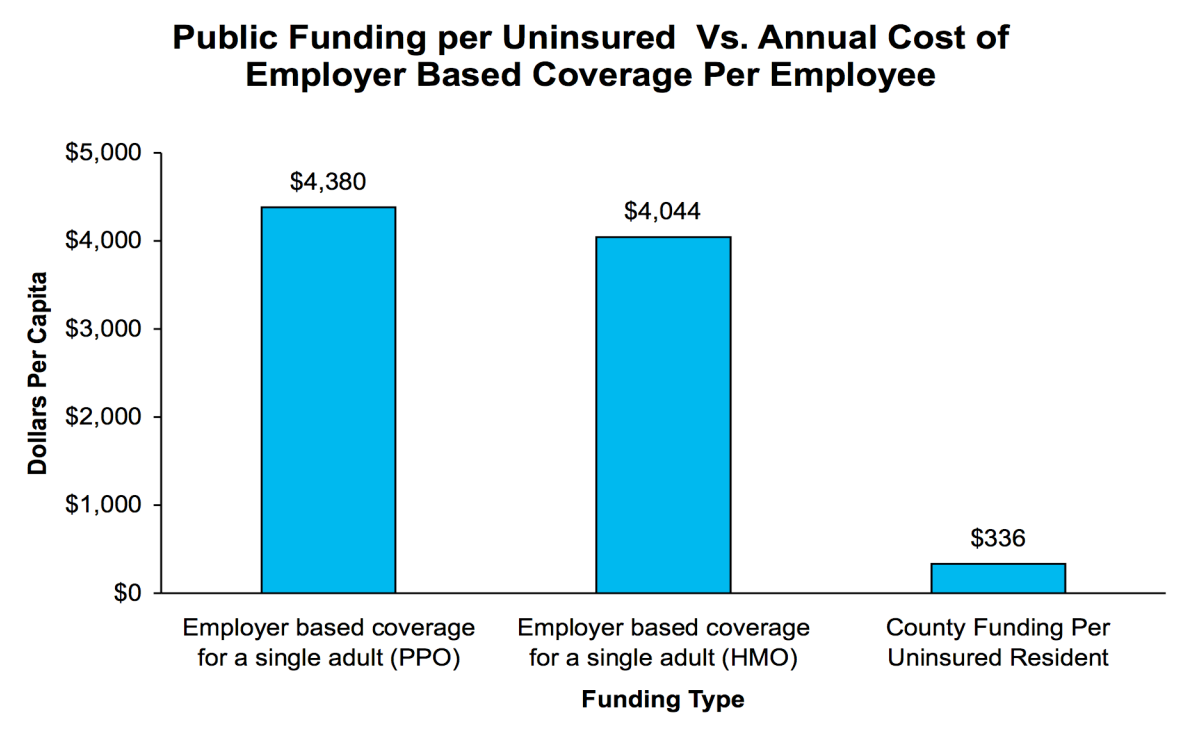
Insure the Uninsured Project (ITUP) compiled state, county and federal funding for county health programs. Included were state realignment, state Prop 99 funds to counties, federal net county DSH and required county match.[52] Excluded were sources of funding such as county overmatch, county tobacco settlement, and private hospital DSH and net SB 1255 (both of which are exclusively distributed to hospitals).[53] From these combined sources, counties receive on average

[49] California Healthcare Foundation, Children's Health Insurance Programs: Facts and Figures, June 2006
[50] Ibid
[51] Institute for Health Policy Solutions, Healthy Kids Enrollment, Wait Lists and Estimated Coverage Need, April 2006
[52] Counties may choose to spend their realignment funds on programs such as public health services to all county residents and on county care to the uninsured, but counties must spend their Prop 99 funds on care to the uninsured.
[53] ITUP's rationale for excluding net SB 1255 (about $800 million) is that we lack data on its distribution by county or by region. Our rationale for excluding tobacco settlement is that counties are not required to spend these funds on County Health; some do, some do not. We excluded county overmatch (some counties do and others do not), as counties are not required to spend these funds on county health. We excluded

$336 per uninsured resident for the costs of all county health programs, including public health services.[54]

County Health programs for the uninsured are under-funded when compared to costs of providing public or employer based coverage. ITUP compared funding for county health to the cost of employer based coverage for an average single adult. Funding for county health was approximately 7.7% of the cost of employer sponsored PPO plans and 8.3% of the cost of employer sponsored HMO plans (Figure 9).

**Figure 8: Public Funding per Uninsured vs. Annual Cost of Employer Based Coverage**



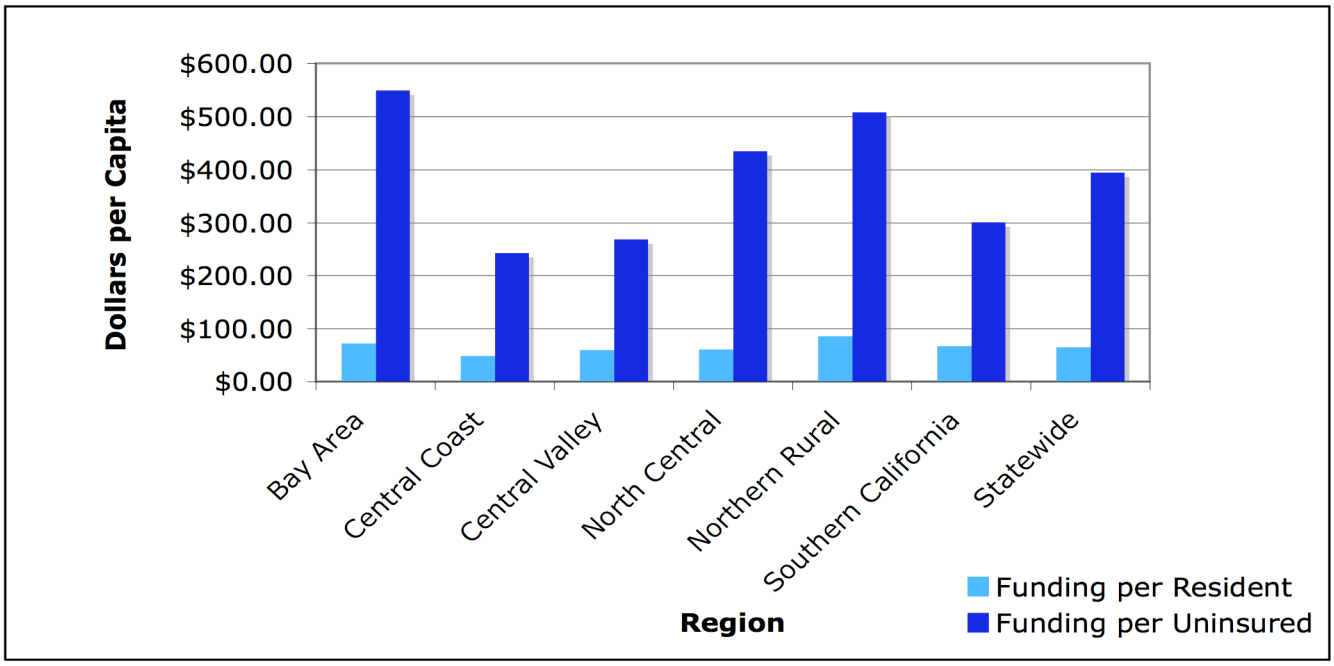

Source: California HealthCare Foundation, California Employer Heath Benefits Survey, 2006

Funding for county health per uninsured county resident is highly variable between regions and counties. Funding per uninsured county resident was lowest in the Central Coast region at roughly $243 per uninsured, county resident and highest in the Bay Area region at roughly $550.

private DSH as this funding goes directly to private hospitals for their uncompensated care to the uninsured; it is not distributed through county health programs although counties may choose to take this funding into account in their program funding decisions.

[54] We divided county health funding by the numbers of uninsured as reported in the 2005 CHIS report.

**Figure 9: Total Funding per Capita in California, 2005**[55]




SOURCE: CHIS Report 2005, OSHPD Data FY 2004-2005, 2004-2005 Disproportionate Share Hospital Projected Payments/Transfers, Office of County Health Services, and Office of County Health Services, Maintenance of Effort Allocation Tables, Final FY 04-05

There is also wide variation in funding for county health within the regions. In the Central Coast, Central Valley, and Northern Rural regions, counties with higher funding per uninsured resident had about twice as much as those counties with the lowest funding per uninsured in the same region. In the North Central region it was three times as much and in the Bay Area, the county with the highest funding per uninsured had almost nine times as much as the county with the lowest funding per uninsured.

California counties pay annually for about 64.7 inpatient days and 60.5 emergency visits per 1,000 uninsured;[56] this is a hospital use rate less than one-third that of an insured adult in California. Counties pay for 702 outpatient visits per 1000 uninsured; this is a physician use rate of less than one sixth that of an insured adult in California.[57] These figures are highly variable by county. Those counties with the most funding per uninsured pay for more services and those counties with the least funding per uninsured pay for well below these averages.

[55] Funding includes state realignment, county match, prop 99 and DSH. Total funding per region was divided by the estimated number of residents or uninsured residents as reported by CHIS 2005.
[56] We averaged the hospital's OSHPD 2005 reports on county funded days and visits and the MICRS 2002-03 reports on county funded days and visits and divided by California's uninsured as reported in CHIS, 2005. Sources used were the most recent complete reports available.
[57] We added MICRS 2005 reports on county funded outpatient visits, CMSP funded physician and outpatient visits and divided by California's uninsured as reported in CHIS, 2005

## OTHER STATE HEALTH CARE PROGRAMS

### Cancer Control

Although they pale in comparison to Medi-Cal in terms of the number of beneficiaries and expenditures, many other state-funded programs address specific health needs of particular uninsured populations.

Women are eligible to receive free breast cancer screening services if they are age 40 or older, earn less than 200% FPL, and have limited or no health insurance to pay for necessary treatment.[58] The same eligibility requirements apply for women to receive free cervical cancer screening except the age requirement is 25 or older.

During the five-year span from 2001 to the end of 2005, the Breast Cancer Early Detection Program performed a total of 430,852 breast and cervical cancer screenings in California.[59]

There are three main sources of federal and state funding for breast and cervical cancer:[60]

- Centers for Disease Control under Breast and Cervical Cancer Mortality Prevention Acts of 1990
- CA Breast Cancer Act of 1993 – 50% of revenues from a 2-cent tax on tobacco products
- Proposition 99 unallocated account

In CY 2006, the Breast and Cervical Cancer Treatment Program had 10,461 beneficiaries and its FFS expenditures were approximately $89 million[61]. In 2006-07, appropriations for the Breast Cancer Preventative Health Services program increased from $33 million in 1998-99 to $35 million. [62]

Men are eligible to receive prostate cancer screening and treatment services as needed under a similar state program (IMPACT) established in 2000. The program will receive $3.5 million in General Funds from the proposed 2007-08 budget.[63]

### Family PACT[64]

Created in 1996-97, Family PACT (Planning, Access, Care, Treatment) provides no-cost, comprehensive family planning services to eligible low-income men and women. Individuals are eligible if they are at or below the 200% federal poverty level and do not have another source of health care. Family PACT was initially funded by the State, but since 1999, it has mostly been federally financed through a Medicaid 1115 waiver (which provides 90% of the funding).

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[58] Source: Breast Cancer Early Detection Program website, October 2006 submission of NBCCEDP Minimum Data Elements (MDE).
[59] Source: Breast Cancer Early Detection Program, Cancer Detection Section Information Packet, January 2005.
[60] Source: California Department of Health Services, Cancer Detection Section, September 2002.
[61] DHS, Medi-Cal FFS Expenditures Summary Table CY 2006.
[62] Source; Governor's 2006-07 Proposed Budget
[63] Source; Governor's 2007-08 Proposed Budget
[64] Source: Department of Health Services. Family PACT Overview.

From FY 1997-98 to FY 2003-04, the number of women and men receiving services from Family PACT more than doubled from 0.75 million to 1.55 million. [65] The program's expenditures in FY 2003-04 totaled $414 million and increased to an estimated $450 million in 2005-06.[66] However, the Department of Health Services reported FFS expenditures for CY 2006 totaling $429 million.[67]

### Immunization and Tuberculosis Control

Between 1998-99 and 2002-03, funding for the immunization assistance program increased from $38 million to $49 million (Table 18). FFS Expenditures for the Tuberculosis Program, which covers eligible TB-infected individuals for TB-related outpatient services, were $148,136 in CY 2006.[68]

The current proposed budget allots $11.3 million ($5.6 million General Fund) to provide the new Human Papillomavirus Vaccine (HPV) to approximately 52,000 Medi-Cal eligible women ages 19-26. HPV was recently approved by the U.S. Food and Drug Administration and has been shown to reduce the risk of cervical cancer by up to 70%. [69]

Between 1998-99 and 2002-03, funding for the state's tuberculosis control program increased from $12.2 million to $13.9 million (Table 18). In 2005, tuberculosis case rates in California were an average of 7.9 per 100,000 compared to the national average of 4.8 per 100,000.[70]

**Table 19: Expenditures for Immunization Assistance and Tuberculosis Control Programs, 1998-99 to 2002-03**

| Year | Immunization Assistance | Tuberculosis Control |
|---|---|---|
| **1998-99** | $38,342,000 | $12,216,000 |
| **1999-00** | $38,012,000 | $21,372,000 |
| **2000-01** | $47,366,000 | $13,874,000 |
| **2001-02** | $46,266,000 | $13,874,000 |
| **2002-03** | $48,900,000 | $13,874,000 |

SOURCE: Legislative Analyst's Office.

## CHILDREN'S MEDICAL SERVICES PROGRAMS[71]

The proposed 2007-08 Budget allocates $314 million in expenditures for Children's Medical Services Programs.[72] The following main programs fall within the Children's Medical Services Programs: Children's Health and Disability Prevention Program, California's Children's Services, and Genetically Handicapped Persons Program.

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[65] Source: California Department of Health Services. FACT Sheet on Family Pact: An Overview, Version 2, updated May 2006
[66] Source: California Department of Health Services. FACT Sheet on Family Pact: An Overview, Version 2, updated May 2006
[67] DHS Medi-Cal FFS Expenditures Summary Table CY 2006
[68] [68] DHS Medi-Cal FFS Expenditures Summary Table CY 2006
[69] Governor's Budget Summary 2007-08
[70] Source: Department of Health Services; Tuberculosis Control Branch: Report on Tuberculosis in CA, 2005;
[71] Source: Governor's Budget Highlights, 2006-07.
[72] Department of Finance, Department of Health Services Detailed Budget 2007-08

In addition, the 2007-08 Proposed Budget implements a statewide comprehensive Newborn Hearing Screening Program to help identify hearing loss in infants dedicating $1.5 million (General Fund) to expand it to all California hospitals with licensed perinatal services.[73]

### Children's Health and Disability Prevention (CHDP) Program

The Children's Health and Disability Prevention (CHDP) program pays for well-child visits for low-income, uninsured children with incomes below 200% of poverty and for follow up treatment. Reimbursements for Medi-Cal treatment of conditions identified in health screens performed through local CHDP programs in small counties are made through the OCHS' Children's Treatment Program.

The initial 2002-03 budget created the "CHDP Gateway" to enroll all eligible, uninsured children into Medi-Cal and Healthy Families. The CHDP Gateway budget grew to $124 million for an estimated 173,000 children. Program funding for the residual CHDP was reduced as Medi-Cal and Healthy Families financed more services. Thus, in 2006-07 only about $3.7 million was allocated for CHDP health screens (Table 19). The Governor's proposed budget for CHDP in 2006-07 increased from 2005-06 by 95%.[74] In CY 2006, FFS expenditures for CHDP totaled $124,169,209.[75]

**Table 20: State Expenditures: Child Health and Disability Prevention Program, 1998-99 to 2006-07**

| State Fiscal Year | Expenditures | CHDP Gateway |
|---|---|---|
| **1998-99** | $83,876,000 | |
| **1999-00** | $84,596,000 | |
| **2000-01** | $118,251,000 | |
| **2001-02** | $129,122,000 | |
| **2002-03** | $99,000,000 | |
| **2003-04** | $15,840,000 | |
| **2004-05*** | $4,200,000 | $101,000,000 |
| **2005-06** | $1,900,000 | $124,000,000[t] |
| **2006-07*** | $3,700,000 | Not Available |

*Estimated

[t] Figure for calendar year 2006, fiscal year data was not available.

SOURCES: Legislative Analyst's Office, Analysis of the 2003-04, 2004-05, 2005-06, 200-07 Budget Bill, and Department of Finance.

### California Children's Services (CCS)[76]

The California Children's Services (CCS) program provides comprehensive case management, health care, and therapy to financially eligible children under 21 with special health care needs due to designated physical limitations and chronic diseases. The majority of care provided to these children is funded through the Medi-Cal and Healthy Families programs. Table 20 reveals

[73] Department of Finance, Governor's Proposed Budget Summary 2007-08

[74] Source: Department of Health Services, May 2006 Medi-Cal Estimate: Summary of Regular Policy Changes, FY 2006-07

[75] DHS, Medi-Cal FFS Expenditures Summary Table CY 2006

[76] Source: Department of Health Services. California Children's Services.

that the users of CCS grew slightly. The CCS FFS expenditures reported for CY 2006 were $1,307,441,270.[77]

**Table 21: Users and Total Expenditures for California Children's Services, 2002-2005**

| SFY | Users | Expenditures | Cost Per User |
|---|---|---|---|
| **2002-03** | 172,340 | $1,261,256,000 | $7,318 |
| **2003-04** | 172,354 | $1,416,067,000 | $8,215 |
| **2004-05*** | 177,374 | $1,414,167,000 | $7,973 |

*Estimated

SOURCES: Governor's Budget Summary 2003-04, 2004-05; Legislative Analyst's Office Analysis of the 2003-04, 2004-05 Budget; and Governor's Budget 2004-05, 2004-05 Governor's Budget Highlights: Department of Health Services

In 2003, approximately 75% of CCS beneficiaries were enrolled in Medi-Cal and an estimated 13% were enrolled in the Healthy Families Program.[78] The state and counties contribute equally to CCS for children ineligible for Medi-Cal or Healthy Families.

Contributions for the state-only program (for beneficiaries who do not qualify for Medi-Cal or Healthy Families) increased by approximately 40% between 2002-03 and 2006-07 (Table 21). In 2006-07, CCS funding for the state-only program is projected at $196 million ($44 million from the General Fund and $47 million from the federal "safety net care pool"). The caseload estimate for the state-only program is 38,797, a three percent increase over 2005-06.[79]

**Table 22: State-Only Program Expenditures for California Children's Services, 2002-2003 to 2006-2007**

| State Fiscal Year | Expenditures |
|---|---|
| **2002-03** | $142,486,000 |
| **2003-04*** | $146,260,000 |
| **2004-05*** | $142,000,000 |
| **2005-06*** | $181,000,000 |
| **2006-07*** | $196,000,000 |

* Estimated

SOURCE: Legislative Analyst's Office, Analysis of the 2003-2004, 2004-05, 2006-07 Budget; Governor's Budget 2004-05, 2005-06, 2006-07.

## Genetically Handicapped Persons Program (GHPP)[80]

The Genetically Handicapped Persons Program (GHPP) provides health coverage for Californians 21 years and older with specific genetic diseases including cystic fibrosis, hemophilia, sickle cell disease, and certain neurological and metabolic diseases. GHPP also serves children under 21 with GHPP-eligible Medi-Cal conditions who are not financially eligible for CCS. There is no

[77] DHS, Medi-Cal FFS Expenditures Summary Tables CY 2006

[78] LAO 2003-04 Budget Analysis

[79] Source: Governor's Budget 2006-07

[80] Sources: Governor's Budget Summary, 2004-05; Legislative Analyst's Office, Analysis of the 2004-05 Budget.

maximum income requirement for GHPP, however, families with incomes greater than 200% of FPL pay based on their family size and income.

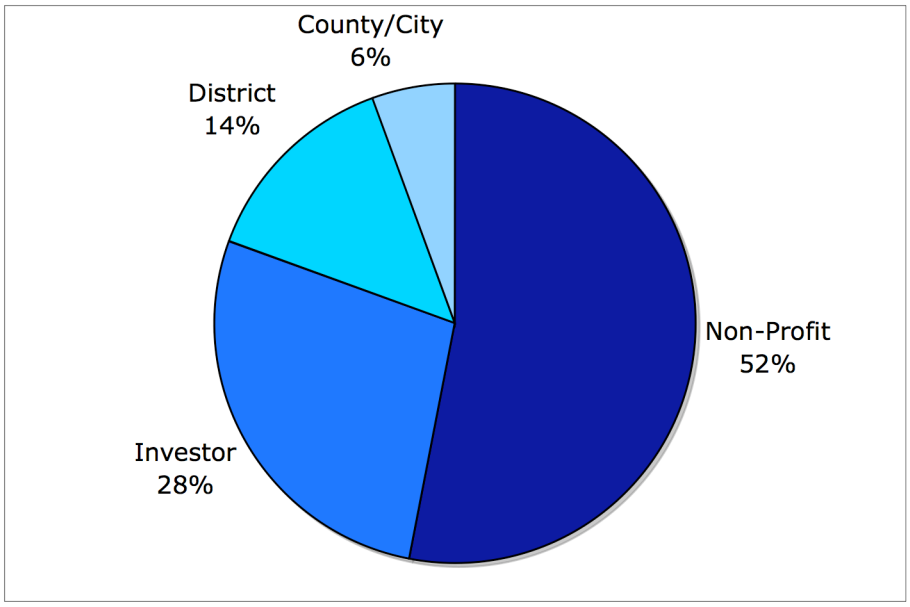
Funding for GHPP in 2006-07 is expected to be approximately $56 million, which is a 12% increase from 2005-06.

## SECTION 3: THE HEALTH CARE SAFETY NET

## HOSPITALS

Hospitals comprise a vital component of the safety net health system that provides the majority of health care services to low-income Californians without health insurance. Of the 334 comparable hospitals[81] in California, more than half (52%) are non-profit, close to one-third (28%) are investor-owned, and the remaining are county/city (6%) or district (14%) hospitals (Figure 11). The number of investor-owned hospitals declined from 159 to 121 between 1997 and 2004 and further decreased to 92 in 2005.

**Figure 10: Distribution of Hospitals in California by Type of Control, 2005**

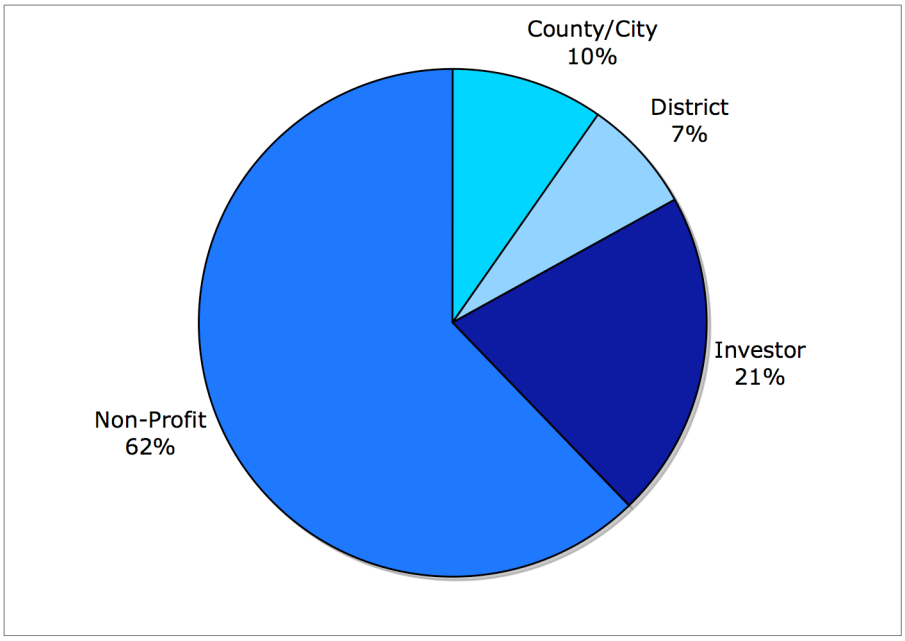



SOURCE: Office of Statewide Health Planning and Development, Hospital Annual Financial Data, 2006

In 2007, California hospitals had a total of 78,889 available hospital beds. Nonprofit hospitals had the greatest proportion of hospital beds (62%), followed by investor hospitals (21%) (Figure 12).

[81] Comparable hospitals are acute care hospitals and do not include psychiatric facilities, long-term care hospitals or prepaid health plan hospitals such as Kaiser Permanente hospitals.

**Figure 11: Distribution of Available Beds in California by Type of Control, 2007**
Total Beds: 78,889




SOURCE: OSHPD, Hospital Quaterly Financial Data 2007

In 2005, hospitals in California reported almost 16.5 million inpatient days (Table 22), which is close to a six percent decrease (about one million less) from the previous year. Medicare paid for 40% of all inpatient days and Medi-Cal covered 30% of inpatient days. Third party private insurance accounted for approximately 23% of all days. While Medicare accounted for the largest percentage of all inpatient days in the state in 2005, private insurance accounted for the highest share of outpatient and emergency room visits (36%). Overall, county indigent programs for the uninsured accounted for 4% of inpatient days and 6% of outpatient visits.

In 2005, Medi-Cal patients had the longest average length of stay among payers at 6.5 days, reflecting skilled nursing facility use in hospitals. Medicare and Medi-Cal managed care payers had shorter hospital lengths of stay (6 and 4.3 days respectively) in 2005 than fee for service Medicare (6.3 days) or fee for service Medi-Cal (7.3 days). County indigent programs had an average length of stay of 4.7 days.

## Table 23: Hospital Use*, By Payment Source, 2005

| Source of Payment | Inpatient Days | Average Length of Stay (Inpatient) | Outpatient Visits (Including ER) |
|---|---|---|---|
| **Total** | 16,406,234 | 5.5 | 40,680,185 |
| Medicare | 40% | 6 | 27% |
| Medi-Cal | 30% | 6.5 | 23% |
| Private Insurance | 23% | 4.2 | 36% |
| County Indigent | 4% | 4.7 | 6% |
| All Other Payers | 4% | 5.7 | 8% |

*Analysis only includes comparable hospitals.
SOURCE: Office of Statewide Health Planning and Development, 2006.

The payer mix is different for the four types of hospitals. At city and county hospitals, 72% of inpatient days were reimbursed by Medi-Cal (52%) and county indigent programs (20%) in 2005 (Table 23). In contrast, Medicare or private insurance covered 67% of the patient days at investor-owned hospitals. Nonprofit hospitals generally mirror the distribution of payers for all hospitals in the state; 41% of all inpatient days were reimbursed by Medicare, 27% by private insurance, and 26% by Medi-Cal. California hospitals provided 40.7 million outpatient visits, of which 7.5 million occurred in emergency departments. County hospitals provided for 9% of inpatient days, nearly 14% of outpatient visits, and 10% of emergency room visits.

## Table 24: Hospital Utilization* by Payer and Type of Control, 2005

| Type of Utilization | All Hospitals | Investor | Nonprofit | District | City/County |
|---|---|---|---|---|---|
| **Total Inpatient Days** | 16,406,234 | 3,062,411 | 10,457,297 | 1,392,423 | 1,504,103 |
| Medicare | 6,516,139 | 1,463,418 | 4,332,536 | 529,313 | 200,872 |
| Medi-Cal | 4,943,833 | 888,877 | 2,723,405 | 551,661 | 779,890 |
| Private Insurance | 3,783,712 | 600,634 | 2,831,951 | 221,207 | 129,920 |
| County Indigent | 570,951 | 45,142 | 212,786 | 19,272 | 293,751 |
| All Other | 591,599 | 64,340 | 356,619 | 70,970 | 99,670 |
| **Outpatient Visits** | | | | | |
| Total Outpatient Visits | 40,680,185 | 4,098,295 | 27,572,214 | 3,332,822 | 5,676,854 |
| Emergency Room VIsits | 7,558,608 | 1,298,209 | 4,709,939 | 739,739 | 810,721 |

*Analysis only includes comparable hospitals.
SOURCE: Office of Statewide Health Planning and Development, 2006.

In 2005, hospitals generated $47.1 billion in net patient revenues and spent $46.8 billion in operating expenditures (Table 24). Among all hospitals, private insurance payments (44%) and Medicare (31%) represent the largest source of payments followed by Medi-Cal (19%). County indigent funded care represents 1.4% of hospitals' net revenues.

Hospitals also receive other sources of funding for their uncompensated care to the uninsured and to Medi-Cal beneficiaries; this will be discussed in the next section.

**Table 25: Net Hospital Revenues, * by Type of Hospital and Revenue Source, 2005**

| Net Revenues | All Hospitals | Investor | Nonprofit | District | City/County |
|---|---|---|---|---|---|
| Medicare | $14,726,726,993 | $2,693,699,795 | $10,528,361,984 | $1,018,050,772 | $486,614,442 |
| Medi-Cal | $8,908,134,208 | $951,839,692 | $4,977,537,838 | $465,198,223 | $2,513,558,455 |
| Private Insurance | $20,971,119,205 | $2,849,479,308 | $16,512,024,635 | $1,034,483,210 | $575,132,052 |
| County Indigent | $675,746,298 | $50,427,058 | $436,558,634 | $22,517,486 | $301,404,822 |
| Other | $1,699,661,117 | $351,129,764 | $1,076,852,426 | $193,283,414 | $78,395,513 |
| **Net Patient Revenue** | $47,116,549,523 | $6,896,575,617 | $33,531,335,517 | $2,733,533,105 | $3,955,105,284 |
| **Total Operating Expenses** | $46,896,646,138 | $6,796,634,592 | $32,379,031,691 | $2,758,550,924 | $4,962,428,931 |

*Analysis includes comparable general medical hospitals only.
SOURCE: Office of Statewide Health Planning and Development, 2006.

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## Supplemental Hospital Payments

California hospitals incur significant uncompensated care costs by providing services to Medi-Cal beneficiaries and the uninsured. In 2005, hospitals reported $1.5 billion in bad debt and charity care costs; about three percent of hospitals' total operating expenses (Table 25). Consequently, California hospitals receive supplemental payments from a number of federal and state sources to reimburse them for their uncompensated care.

**Table 26: Bad Debt and Charity Care Costs*, By Type of Control, 2005**

| Category | All Hospitals | Investor | Non-Profit | District | City/County |
|---|---|---|---|---|---|
| Bad Debt/Charity Care[82] | $1,512,723,543 | $178,180,538 | $982,541,514 | $116,675,739 | $322,912,120 |

*Analysis includes comparable general medical hospitals only.
SOURCE: Office of Statewide Health Planning and Development, 2006

Until recently, California's hospitals received state supplemental payments that included SB 1255 (Emergency Services and Supplemental Payment Fund), SB 1732 (additional fund to DSH for capital construction costs), the Medical Education Fund, and AB 761 (Rural Emergency Services and Supplemental Payment Fund). They also received major federal funding through from the Disproportionate Share Hospital (DSH) program under Medicaid. However, the passage of the Section 1115 Waiver in September of 2005 is changing the face of many of these supplemental payment programs. The waiver and its effects will be discussed in more detail in the following section.

In total, state supplemental payments accounted for $1.4 billion in 1999-00 and grew to nearly $2 billion in 2003-04 (Table 26). Publicly owned facilities contribute the intergovernmental transfers

[82] Bad debt/charity care for the uninsured is adjusted to reflect hospitals' cost of care. This is achieved by multiplying their reported figure by their cost to charge ratio. For all hospitals statewide this ratio is 3.61 to 1.

(IGTs) to finance these state supplemental payments. IGTs are defined as public funds that are transferred from one level of the government to another or from one agency to another.[83]

The largest state supplemental payment program has been SB 1255, which reimburses hospitals for providing uncompensated care to Medi-Cal beneficiaries and the uninsured. SB 1255 accounted for more than three-quarters of supplemental payments each year during 1999-2004. SB 1732, which is allocated to public hospitals for construction projects, increased from $123.7 million in 2002-03 to $124.9 million in 2003-04. The Medical Education Program funds a hospital's medical education costs related to health care services provided to Medi-Cal beneficiaries; this amount was similar in 2003-04 from the previous three fiscal years. AB 761, which is a supplemental reimbursement to small and rural hospitals with standby emergency rooms that are not eligible for SB 1255, funded $75,000 for small rural California hospitals in 2003-04. Because of the local public matching requirements in these programs, hospitals net only half of the payments (Figure 13).

**Table 27: State Supplemental Payments to California Hospitals, 1999/00-2005/06**

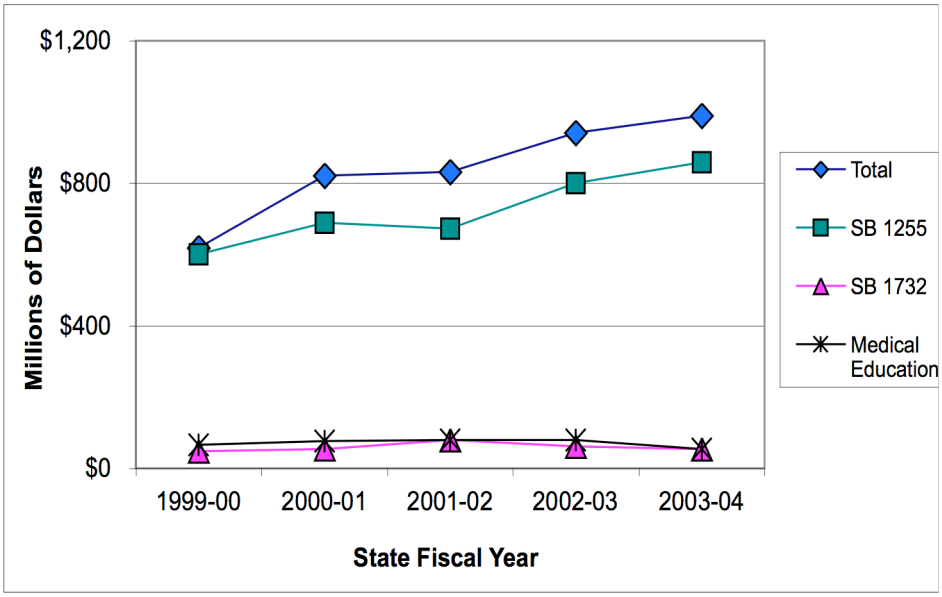
| Year | Total Payments | SB 1255 | SB 1732 | Medical Education | AB 761 |
|---|---|---|---|---|---|
| **1999-00** | $1,427,300,000 | $1,200,000,000 | $94,900,000 | $132,400,000 | $0 |
| **2000-01** | $1,641,798,000 | $1,377,555,000 | $108,943,000 | $154,650,000 | $650,000 |
| **2001-02** | $1,663,419,000 | $1,344,715,000 | $159,354,000 | $159,350,000 | $0 |
| **2002-03** | $1,882,400,000 | $1,600,000,000 | $123,700,000 | $158,700,000 | $0 |
| **2003-04** | $1,977,698,000 | $1,718,714,000 | $107,209,000 | $157,700,000 | $75,000 |
| **2004-05*** | Not available | $1,611,286,000 | Not available | Not available | Not available |
| **2005-06*** | Not available | $1,615,320,000 | $124,900,000 | Not available | Not available |

* Estimated

SOURCE: California Medi-Cal Assistance Commission Annual Reports, and Governor's Budget 2004-05, 2005-06

[83] Source: Medi-Cal Hospital Waiver Key Terms, Peter Harbage and Jennifer Ryan, August 2005

## Figure 12: Net Supplemental Payments to California Hospitals, 1999/00-2003/04




SOURCE: California Medi-Cal Assistance Commission Annual Reports.

The Disproportionate Share Hospital (DSH) program is the largest supplemental payment program and will continue to play an important role under the waiver. It was created in response to a federal Medicaid law that mandated states to make additional payments to public and private facilities serving high percentages of Medicaid and uninsured patients.[84] Qualifying hospitals generally have a low-income utilization rate of 25 percent or more.[85]

In 2005, California hospitals received $2 billion in DSH gross payments for providing uncompensated care to these populations, although they only net about half of this total (Table 27). Roughly half the total net federal DSH of $1 billion in 2005 went to public hospitals and half went to private hospitals.

### Table 28: DSH Payments in California 1999-2005

| Year | Total | Federal | Public net | Private net | County/Public IGT |
|---|---|---|---|---|---|
| **1999** | $2,094,117,647 | $1,068,000,000 | $617,165,976 | $551,467,927 | $1,026,117,647 |
| **2000** | $1,898,039,216 | $968,000,000 | $503,265,859 | $486,993,451 | $930,039,216 |
| **2001*** | $2,040,034,000 | $1,020,017,000 | $530,408,840 | $510,008,500 | $1,020,017,000 |
| **2002** | $2,110,415,174 | $1,055,207,587 | $519,258,646 | $506,191,250 | $1,055,207,587 |
| **2003** | $1,814,513,110 | $907,256,550 | $444,340,426 | $433,158,384 | $907,256,550 |
| **2004** | $2,478,178,000 | $1,239,089,000 | Not Available | Not Available | $1,239,089,000 |
| **2005** | $2,001,530,000 | $1,000,765,000 | Not Available | Not Available | $1,000,765,000 |

*Estimate

SOURCES: California Department of Health Services, California Association of Public Hospitals and Governor's Budget 2005-06, 2006-07. In 2006, approximately 2.1 billion in total and according to LAO about the proposed budget about 708 million in local funds

[84] Source: Section 1902(a)(13)(A)(iv) of the Social Security Act, 42 U.S.C. 1396a(a)(13)(A)(iv).

[85] Source: Medi-Cal Hospital Waiver, Key Terms, Peter Harbage and Jennifer Ryan, August 2005

Under California's Medicaid DSH funding formulas, the state's county, university and district hospitals pay slightly less than half of uncompensated costs and net federal payments represent the rest of DSH funding. Net federal DSH payments to California hospitals were approximately $1.0 billion in 2005 (Table 28).

**Table 29: DSH Payments By Hospital Type, 2004**

| Category | All Hospitals | Investor | Non-Profit | District | City/County |
|---|---|---|---|---|---|
| DSH Funds Received | $2,064,692,567 | $151,447,681 | $488,025,988 | $5,457,085 | $1,419,761,813 |
| Net DSH Funds Received* | $1,032,146,283 | - | - | - | - |

*Estimate
SOURCE: Office of Statewide Health Planning and Development, 2005

Prior to the waiver, California used local funds, known as intergovernmental transfers (IGTs), to fulfill state matches for federal DSH payments. Federal officials challenged the use of IGTs to fund DSH programs and rate supplements in California and other states, putting federal DSH funding for California's hospitals at risk. Federal concern over IGTs stemmed from difficulty tracing and verifying these transactions.[86] In response to the threat of losing this funding, California requested a Medi-Cal Section 1115 Hospital Waiver from the federal government. California is now required to demonstrate certified public expenditures in order to receive the federal DSH match.

## Medi-Cal Section 1115 Hospital Waiver[87]

In September 2005, CMS awarded California a five-year Section 1115 Medicaid Hospital Waiver. This waiver allows the state to make large changes in the Medi-Cal system by altering the way the program finances treatment at private and public hospitals. It is also an integral part of the Medi-Cal Redesign, which is geared towards improving the program's efficiency and expanding coverage to uninsured populations.

The waiver is accompanied by SB 1100, the Medi-Cal Hospital/Uninsured Care Demonstration Project Act. This piece of legislation provides the framework for implementing the waiver. It establishes a set level of baseline Medi-Cal funding for safety net hospitals. The baseline funding is designed to ensure that hospitals receive at a minimum the Medi-Cal inpatient payments they received in 2004-05.[88] SB 1100 also makes allowances for stabilization funding in response to increases in patient volume and rising health care costs.[89] The Governor's Proposed Budget allots $56 million for stabilization funding for 2007-08.

[86] Source: Medi-Cal Hospital Waiver Implementation, Understanding the 2005 Hospital Financing Waiver, Questions and Answers, August 2005, Peter Harbage and Jennifer Ryan
[87] Ibid
[88] Ibid
[89] Ibid

As the 1115 Waiver is gradually implemented, a greater distinction will be made between financing mechanisms for private and public hospitals, including the reform or replacement of many of the preexisting supplemental payment systems.

Under the waiver, public hospitals will receive all Disproportionate Share Hospital (DSH) program funding (SB 855) as of September of 2006, including all DSH funds previously allocated to private hospitals. This increases the DSH funding available to public hospitals for care to the uninsured. DSH can only be allocated for true uncompensated care in hospital settings.

The state's system of fulfilling the non-federal share of DSH matches will change. In the past, California relied heavily on using intergovernmental transfers (IGTs). The waiver now limits California's use of IGTs to matching the difference between 100 and 175 percent of a hospital's uncompensated costs.[90] It permits California to utilize certified public expenditures (CPEs) of designated public hospitals for the non-federal share of DSH payments.[91] Generally, CPEs are funds that counties, state university teaching hospitals, or other public entities certify as having been used to provide covered services to Medi-Cal beneficiaries or uninsured patients.

In place of SB 1255 and the Medical Education Program, public providers are now receiving funds from the Safety Net Care Pool (SNCP). The purpose of SNCP is to pay for health care coverage of the uninsured. SNCP funds recipients may include state public hospitals, clinics, or other provider types who have incurred uncompensated medical care costs from providing services to the uninsured.[92] SNCP funds can only be used on the uninsured.

The SNCP makes a fixed amount of federally funding available to pay for coverage of the uninsured and implement managed care for the aged and disabled.[93] The SNCP is budgeted for $578 million in the Governor's 2007-08 Budget (Table 29).[94]

Annually, an additional $180 million in federal funds is made available to California in order to expand coverage for the uninsured. This sum is contingent on the state fulfilling certain elements of the "Medi-Cal Redesign." California forfeited these additional funds in its first two years of implementation due to its unwillingness to require aged, blind, and disabled Medi-Cal beneficiaries to enroll in managed care plans.

The state passed legislation, SB 1448, authored by Senator Kuehl, to distribute the state's $180 million in coverage expansion funds on a competitive grant basis. The Department of Health Services received seventeen applicants representing 40 counties. Applicants were ranked and 10 counties were selected to receive funds: Los Angeles, San Francisco, Santa Clara, Orange, Contra Costa, San Diego, Kern, Ventura, Alameda and San Mateo.[95]

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[90] Source: Medi-Cal Hospital Waiver Implementation, The 3 Waivers: Medicaid Hospital Financing in California, Iowa, and Massachusetts, Peter Harbage and Andy Schneider

[91] Ibid

[92] Ibid

[93] Ibid

[94] Source: Health and Human Services, Governor's 2006-07 & 2007-08 Budget

[95] Insure the Uninsured Project, Health Care Coverage Initiative: Program Summary of Selected Applicants, April 2007

**Table 30: California Counties' Coverage Expansion Funds Annual Allotments[96]**

| Selected County | Annual Allotment |
|---|---|
| Los Angeles | $ 54,000,000 |
| San Francisco | $ 24,300,000 |
| Santa Clara | $ 20,700,000 |
| Orange | $ 16,800,000 |
| Contra Costa | $ 15,200,000 |
| San Diego | $ 13,000,000 |
| Kern | $ 10,000,000 |
| Ventura | $ 10,000,000 |
| Alameda | $ 8,200,000 |
| San Mateo | $ 7,500,000 |

**Table 31: Supplemental Payments under Medi-Cal Hospital Financing 2004-2006**
(In thousands)

| Year | Public DSH | Private DSH | Safety Net Pool | SB 1255 | Medi-Cal Hospital Per-Diem Payments | Distressed Hospital Fund | SB 1732 |
|---|---|---|---|---|---|---|---|
| **2005-06**** | $2,001,530 | | $586,000 | $6,320 | $693,973 | $13,416 | $124,900 |
| **2006-07*** | $2,065,160 | $0 | $586,000 | - | $708,141 | $13,362 | NA |
| **2007-08*** | $1,614,917 | $0 | $578,427 | - | NA | $14,606 | NA |

*Estimate
**Separate public and private figures are currently unavailable
Department of Health and Human Services, 2006-07 & 2007-08 Budget

Designated public hospitals will receive increased reimbursement through the waiver for their actual costs of care to Medi-Cal patients. They will no longer receive Medi-Cal per-diem payments through negotiated contracts with the California Medical Assistance Commission (CMAC). Instead, they will be reimbursed based on their cost of care to Medi-Cal patients. Public entities will benefit through this new mechanism because they will be compensated for their actual cost of care. This drastically reduces public hospitals' uncompensated care for Medi-Cal patients. This program became effective as of August 2005. These additional payments were expected to reach $708 million in 2006-2007 (Table 29).

In lieu of DSH, private hospitals will receive funds through a new private supplemental program (Virtual DSH) to reduce the cost of providing uncompensated care. The State general funds will be the source of Virtual DSH financing. A concern with this methodology is that Virtual DSH funding will fluctuate based on the state's budgetary health. The 2007-08 budget proposal allocates $477 million to Virtual DSH, half of which is funded by the state.[97]

[96] Ibid

[97] Source: California Department of Health Services, May 2006-07 Medi-Cal Estimates: Summary of Regular Policy Changes, FY 2007-08

In lieu of the original SB 1255 and Medical Education Program, private hospitals will receive funding from the SB 1255 Private Supplemental Program. The Private Supplemental Program's projected funding level in 2007-08 is $292 million, half of the contribution is from the state.

Another supplemental payment program is the Distressed Hospital Fund. This program is available to private and public hospitals. However, federal funds are only available for payments made to private hospitals. Approximately $100 million will be allocated to distressed hospitals over the lifetime of the waiver. In 2007-08, approximately $14 million is budgeted to the Distressed Hospital Fund.

Additionally, no changes will be made to SB1732, which pays for public hospitals' capital expenditures.

## FREE AND COMMUNITY CLINICS

The 850 licensed primary care clinics reporting to OSHPD represent another important component of the health care safety net in California. As of September 2006, 379 of these clinics were Federally Qualified Health Centers (FQHCs) and 76 were FQHC look-alikes.[98] In 2005, licensed primary care clinics provided health care services to more than 3 million patients, about 9% of the total state population (Table 30). According to data from the Office of Statewide Health Planning and Development (OSHPD), 64% of patients were adults age 20 or over while 35% were children 19 and under in 2005. Sixty-six percent of patients were women in 2005. A rapidly increasing number of middle-aged adult patients between 45 and 64 visited community clinics between 1997 and 2005.

**Table 32: Unduplicated Patients in Private Primary Care Clinics, * By Age, 1997-2005**
(In Thousands)

| Year | Total Patients | Ages 0-1 | Ages 1-19 | Ages 20-44 | Ages 45-64 | Ages 65+ |
|---|---|---|---|---|---|---|
| **1997** | 2,431 | 100 | 832 | 1,125 | 266 | 107 |
| **1998** | 2,691 | 107 | 925 | 1,212 | 327 | 121 |
| **1999** | 2,770 | 115 | 979 | 1,211 | 338 | 127 |
| **2000** | 2,828 | 111 | 975 | 1,229 | 377 | 136 |
| **2002** | 3,022 | 110 | 1,003 | 1,344 | 425 | 140 |
| **2003** | 3,263 | 103 | 1098 | 1,458 | 491 | 146 |
| **2004** | 3,445 | 111 | 1,099 | 1,534 | 565 | 163 |
| **2005** | 3,715 | 120 | 1,202 | 1,632 | 591 | 168 |

- Includes both community and free clinics, but not dental clinics.
Subcategories may not add up to total due to rounding.
SOURCE: Office of State Health Planning and Development, Annual Report of Primary Care Clinics 1997-2006.

The total number of patient visits increased nearly 5% between 2004 and 2005, by approximately five hundred thousand visits (Table 31). In 2005, Medi-Cal beneficiaries accounted for 35% of all encounters while encounters by patients who paid for care out of pocket or who did not pay for care accounted for 15% of all visits. The number of encounters under Medicare, Medi-Cal, and

[98] Office of Statewide Health Planning and Development, 2006

other payers all increased during this period. During this time period, clinics experienced a large decrease in the number of CHDP visits.

**Table 33: Visits at Private Primary Care Clinics, * By Payment Source, 1997-2005**
(In Thousands)

| Year | Total | Medi-Cal | Self-Pay/ No Pay | Managed Care | Medicare | CHDP | EAPC | Other State | CMSP/ MISP | Other County | Private Insurance | Other Payers |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1997** | 9,097 | 2,527 | 1,672 | 1,364 | 445 | 408 | 363 | 746 | 326 | 544 | 490 | 211 |
| **1998** | 9,420 | 2,597 | 1,737 | 1,340 | 499 | 410 | 391 | 836 | 218 | 707 | 426 | 252 |
| **1999** | 9,285 | 2,612 | 1,613 | 1,095 | 437 | 417 | 431 | 871 | 223 | 742 | 502 | 315 |
| **2000** | 9,445 | 2,543 | 1,866 | 1,178 | 485 | 347 | 372 | 987 | 219 | 702 | 514 | 231 |
| **2002** | 9,246 | 3,091 | 1,444 | NA | 650 | 282 | 474 | 1, 250 | 301 | 613 | 625 | 331 |
| **2003** | 10,182 | 3,486 | 1,625 | NA[23] | 727 | 246 | 523 | 1,470 | 310 | 614 | 561 | 420 |
| **2004** | 11,095 | 3,901 | 1,661 | NA | 848 | 229 | 586 | 1,834 | 344 | 429 | 615 | 393 |
| **2005** | 11,648 | 4,177 | 1,758 | NA | 824 | 277 | 586 | 1,949 | 310 | 1094[t] | 662 | 389 |

*Includes both community and free clinics, but not dental clinics.
t Includes Alameda, San Diego and Los Angeles counties
SOURCE: Office of State Health Planning and Development, Annual Report of Primary Care Clinics 1997-2006
Note: Other State includes Family PACT, Breast Cancer and Healthy Families

In 2005, free and community clinics received revenues totaling more than $1.6 billion (Table 32) – an increase of nearly 6%. Clinics receive funds through grants, contracts, health insurance, and direct payments for services. Grants and contracts accounted for 28% of total clinic revenues while Medi-Cal accounted for 33%. Grant funding increased from $302.1 million in 1997 to $486 million in 2005. Revenues from Medi-Cal increased from $493 million in 2004 to $568 million in 2005.

**Table 34: Total Revenues at Private Primary Care Clinics, * By Payment Source, 1997-2005**
(In Thousands)

| Year | Total Revenues | Grants | Medi-Cal | Total Other State+ | Total County | Self-Pay | Donations | Medicare | Private Insurance | HMOs |
|---|---|---|---|---|---|---|---|---|---|---|
| **1997** | $795,257 | $302,059 | $196,523 | $72,808 | $43,621 | $48,219 | $40,295 | $29,310 | $26,399 | $22,702 |
| **1998** | $842,286 | $304,550 | $211,427 | $83,323 | $48,001 | $52,112 | $43,755 | $33,518 | $25,763 | $27,001 |
| **1999** | $920,163 | $355,303 | $223,902 | $95,616 | $50,492 | $49,235 | $47,230 | $33,616 | $29,135 | $22,457 |
| **2000** | $1,008,996 | $401,480 | $226,885 | $101,157 | $55,287 | $64,745 | $43,556 | $34,878 | $36,313 | $33,047 |
| **2002** | $1,260,655 | $406,537 | $349,767 | $160,022 | $82,621 | $54,037 | $46,666 | $89,433 | $55,236 | - |
| **2003** | $1,462,037 | $388,184 | $420,772 | $159,943 | $77,534 | $58,989 | $65,126 | $92,018 | $53,538 | - |
| **2004** | $1,605,064 | $386,552 | $493,889 | $155,513 | $75,673 | $66,377 | $61,611 | $100,318 | $64,324 | - |
| **2005** | $1,696,804 | $486,862 | $568,057 | $200,486 | $77,839 | $73,464 | $62,948 | $99,537 | $65,484 | - |

*Includes free and community clinics, but not dental clinics.
+Includes EAPC, CHDP, Family PACT, Healthy Families & Breast Cancer Programs
SOURCE: OSHPD, Annual Report of Primary Care Clinics 1997-2006.
Notes: "Total County" for 2005 includes County/MISP, Other Counties, and Alameda/SD/LA.
"Grants" for 2005 include Federal, State, County/Local and Private Other Revenue Funds

Each unduplicated patient used community clinics for an average of 3.1 visits in 2005 (Table 33). Medicare patients visited clinics on average 5.4 times in 2005, while uninsured patients averaged 4.1 visits. Payments for the uninsured and Medi-Cal patients represented the majority, 68%, of clinics' net patient revenues.

## Table 35: Clinic Use and Patient Revenues, 2005

| Payment Source | Patients | Visits | Average Annual Visits per Patient | Net Patient Revenues* |
|---|---|---|---|---|
| **Total** | 3,715,302 | 11,648,909 | 3.1 | $1,110,885,874 |
| **Uninsured** | 1,297,539 | 5,351,028 | 4.1 | $335,514,610 |
| **Medi-Cal** | 1,234,238 | 4,177,542 | 3.4 | $568,058,072 |
| **Healthy Families** | 87,632 | 244,000 | 2.8 | $16,277,720 |
| **Medicare** | 152,976 | 824,630 | 5.4 | $99,537,057 |
| **Private Insurance** | 244,705 | 662,123 | 2.7 | $65,484,761 |
| **Other Coverage** | 698,212 | 389,586 | 0.6 | $26,013,654 |

* Net patient revenue does not include grants and contracts.
SOURCE: OSHPD, Annual Report of Primary Care Clinics, 2006.

The average payment for each encounter differs considerably across payers. Reflecting the cost-based reimbursement received by Federally Qualified Health Centers (FQHCs), Medi-Cal and Medicare produced the highest average revenues per visit at $135 and $120 respectively in 2005 (Table 34). Programs such as EAPC and CHDP only paid on average between $39 and $70 per encounter. Clinics experienced a substantial increase in payment rates from private insurance between 1997 and 2005. The categories of county, self-pay and the state Family PACT program are the largest components of clinics' revenues for uninsured patient visits.

## Table 36: Average Revenues Per Visit at Private Primary Care Clinics, By Payment Source, 1997-2005

| Year | Average FFS | Medicare | Medi-Cal | CHDP | MISP | CMSP | EAPC | Other State | Private Insurance | Self-Pay |
|---|---|---|---|---|---|---|---|---|---|---|
| **1997** | $53 | $66 | $78 | $46 | $48 | $58 | $41 | $53 | $54 | $36 |
| **1998** | $59 | $67 | $81 | $42 | $34 | $69 | $43 | $59 | $60 | $36 |
| **1999** | $57 | $77 | $86 | $46 | $23 | $75 | $42 | $67 | $58 | $41 |
| **2000** | $78 | $72 | $89 | $51 | $31 | $78 | $47 | $65 | $70 | $48 |
| **2001** | $84 | $134 | $123 | $35 | $80 | | $46 | $60 | $65 | $46 |
| **2002** | $50 | $137 | $115 | $64 | $116 | | $68 | $78 | $89 | $52 |
| **2003** | $65 | $126 | $121 | $64 | $116 | | $68 | $64 | $95 | $52 |
| **2004** | $96 | $118 | $127 | $71 | $133 | | $65 | $70 | $105 | $56 |
| **2005** | $95 | $120 | $135 | $70 | $114 | | $39 | $66 | $98 | $55 |

* Includes both community and free clinics, and does not include dental clinics.
* Other State includes Free, Breast Cancer, Family PACT, and Healthy Families
SOURCE: OSHPD, Annual Report of Primary Care Clinics 1997-2006.
Note: CMSP and MISP data were reported in one combined category in the OSHPD report starting 2001.

**Uninsured patient visits account for nearly 46% of community and free clinic patient visits – about 0.4 clinic visits per uninsured California resident.** The uninsured also represent 35% of California community and free clinic patients. County payments amount to 22% of clinics' net patient revenues for uninsured patients; a number of counties, however, do not reimburse clinics for their care to the uninsured. In 2005, free and community clinics' reported uncompensated care

for the uninsured (cost of uninsured visits minus uninsured revenues) was $421 million[99] (Table 35).[100]

**Table 37: Clinics' Uninsured Revenues, 2005**

| Total Uninsured Revenues | County | Self Pay | Family PACT | EAPC | CHDP | Breast Cancer |
|---|---|---|---|---|---|---|
| $335,514,610 | $77,839,931 | $73,464,374 | $133,602,782 | $22,922,074 | $19,649,111 | $8,036,338 |

SOURCE: OSHPD, Annual Report of Primary Care Clinics, 2006.
Note: County includes CMISP, Alameda/SD/LA, and Other Counties

Cautionary Note: ITUP urges reader caution on individual county, hospital and clinic reported data on care and patient revenues for the uninsured. In cross-checking between MICRS, CMSP and OSHPD data during our years of review of county, clinic and hospital reports, ITUP staff found substantial reporting errors from some counties, some hospitals and some clinics and extensive inconsistency in data reporting from year to year, clinic to clinic, county to county and hospital to hospital.

[99] This figure would represent nearly 25% of their total operating revenues and is therefore unlikely to be entirely accurate.
[100] We multiplied costs per visit by uninsured visits minus uninsured revenues.

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