A Summary of Health Care Financing for Low-Income Individuals in California, 1998 to 2006

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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.

The fifth edition of this 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 now 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 and 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 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 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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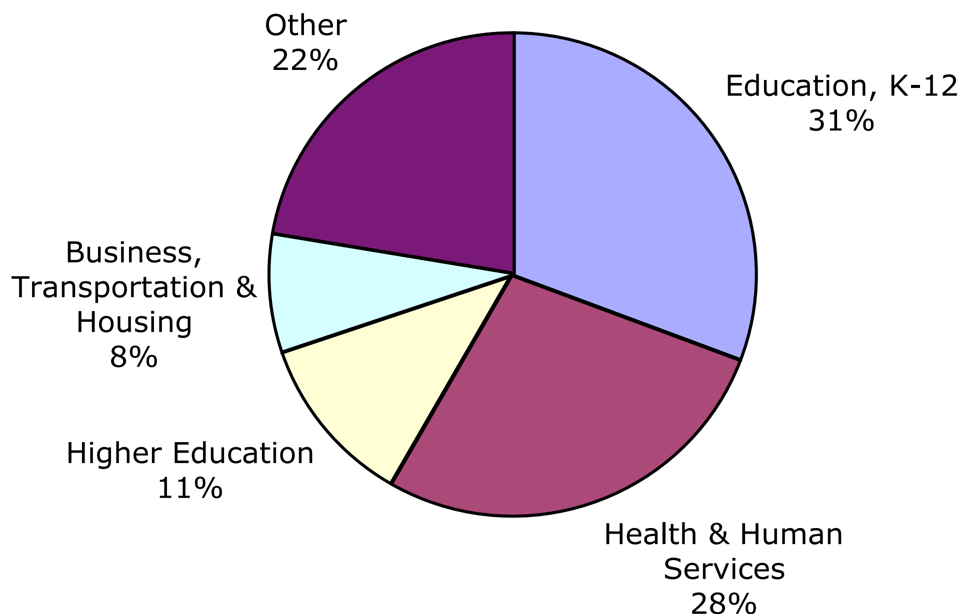
OVERVIEW OF STATE BUDGET

Total state expenditures in the 2006-07 Budget are expected to be $131.4 billion, which includes $101.3 million from the State's General Fund. Revenues for the State include the State's general fund ($101.3 billion), and special funds ($26.6 billion). State General Fund Revenues are projected to grow by 1.7% in SFY 06-07.

In aggregate, spending for health and human services accounts for 27.5% of the total state budget in SFY 2006-07 (Figure 1). It is the second largest budget category, trailing only spending for primary education from kindergarten through 12th grade.

Figure 1: Expenditures by Department as a Proportion of the Total State Budget SFY 2006-07*



Total = $131.4 Billion

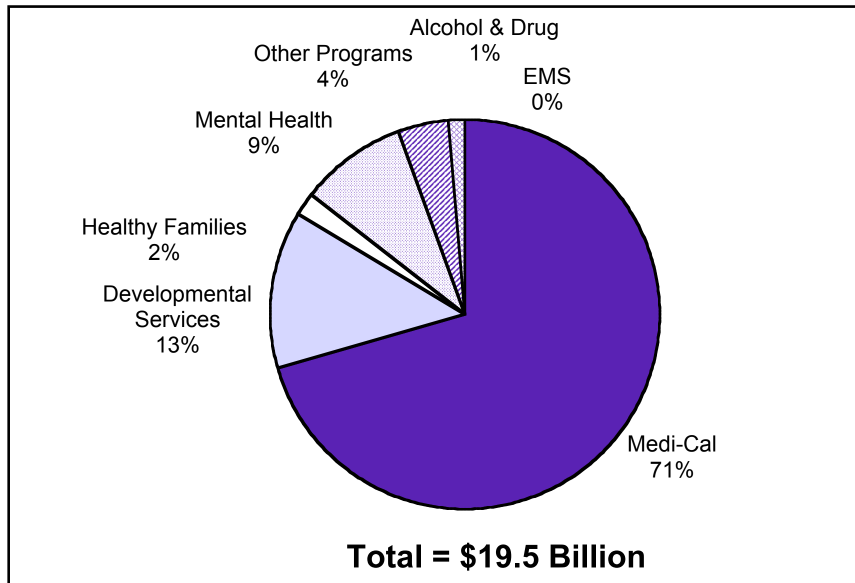
SOURCE: Department of Finance, California State Budget 2006-2007.
*Figure includes revenues from the General Fund and the Economic Recovery Bonds.

General Fund expenditures for state health and human service programs in 2006-07 are proposed to increase 13% from 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 General Fund spending (Figure 2).

Figure 2: General Fund Expenditures for Health Programs, SFY 2006-07



SOURCE: Legislative Analyst's Office (LAO), Major Features of the 2006 California Budget, July 2006

After several years of modest growth, Medi-Cal spending growth accelerated beginning in 2001 and is expected to increase to $35.1 billion in federal and state funds ($19.5 billion General Fund) in SFY 2006-07 (Table 1). Costs per enrollee grew, fueled by growth in pharmaceuticals, nursing facilities, and inpatient hospital services (Governor's Budget Summary 2006-07). Numbers of program participants grew in response to eligibility expansions and a declining private job market for employment based coverage.

After Medi-Cal, In-Home Support Services and Developmental Services comprise the next largest health budget items, each accounting for $3.9 billion. The Healthy Families program is projected to spend nearly $1 billion in federal and state funds due to enrollment growth that is projected to increase from 781,000 in 2005-06 to 859,000 in 2006-07 -- a 10% increase. [1] Approximately $72.2 million ($34.2 million from the General Fund) is allotted to enroll children who are eligible for Medi-Cal and the Healthy Families Program, but not currently enrolled, and to retain coverage for children who are already enrolled. [2] Realignment allotments for county health, mental health and social service programs are projected to grow from $4.363 billion to $4.594 billion, a 5% growth between 2005-06 and 2006-07, of which more than a third is for county health. The Governor's Proposed FY 2006-07 Budget does not separate the allotment for county health from mental health and social services. (Table 1)

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[1] Source: Legislative Analyst's Office, Major Features of the 2006 California Budget, July 2006

[2] Source: Legislative Analyst's Office, Major Features of the 2006 California Budget, July 2006

Table 1: Major Health Care Expenditures by the State of California, *SFY 1998-2006

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

*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 and 06-07 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 2004-5.

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

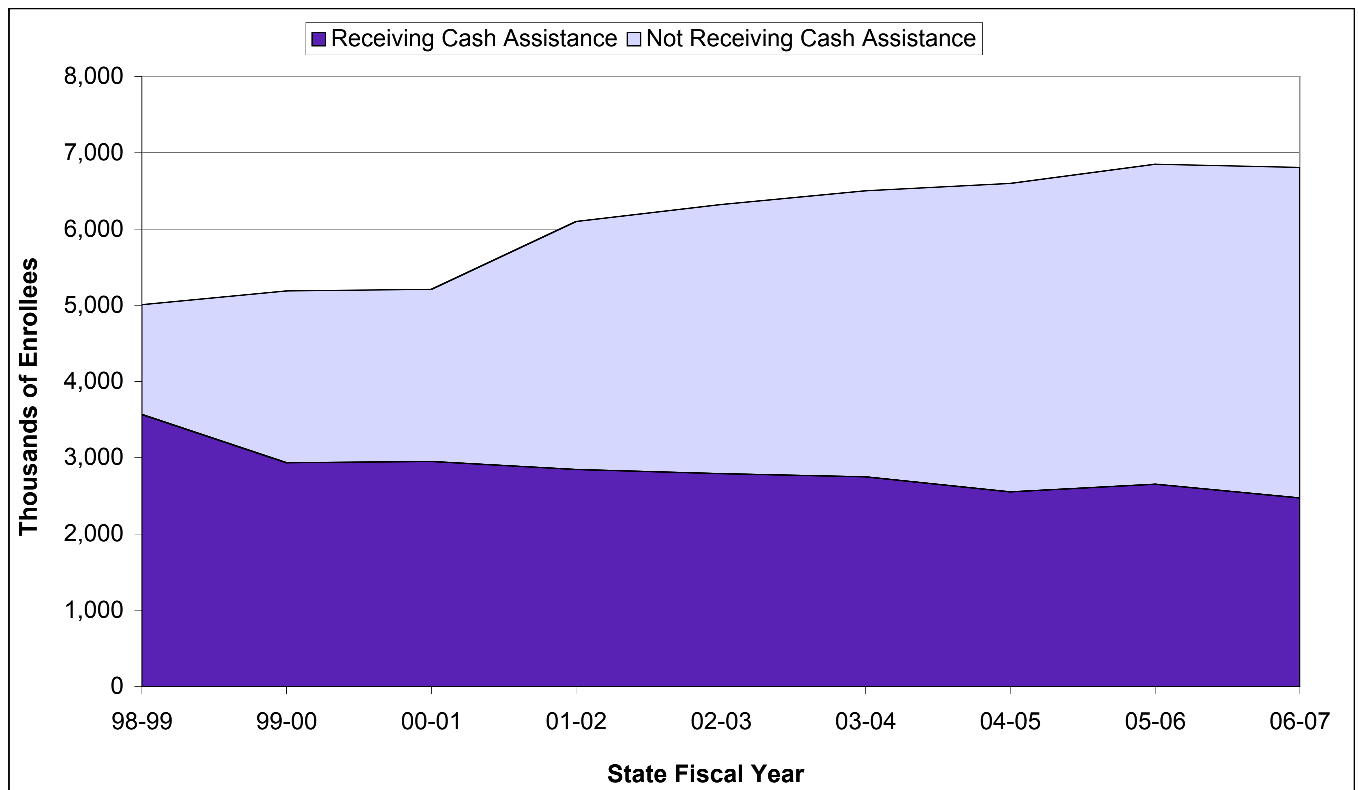
SECTION 1: HEALTH INSURANCE COVERAGE OF LOW-INCOME CALIFORNIANS

THE MEDI-CAL PROGRAM

Medi-Cal Enrollment[3]

Overall, those eligible for Medi-Cal though public assistance have decreased since 1996; however, overall Medi-Cal caseloads have increased (Figure 3). There is a continual growth in Medi-Cal caseloads. In 2006-07, caseloads are expected to grow by 85,000 and result in total of 6.7 million average monthly eligible. Enrollment growth is due to losses in employment-based health coverage combined with eligibility expansions and simplifications in the enrollment process, such as 12 months of eligibility for children, enacted over the past few years. Most of the enrollment growth has been in 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. Cases for the aged, blind, and disabled are expected to increase by 51,000 or 3% in 2006-07. [4]

Figure 3: Medi-Cal Enrollment by Eligibility Category, 1998-99 to 2006-07



*Estimated
SOURCE: Department of Finance, Governor's Budget Summary, 2006-07.

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[3] Source: Department of Finance, Governor's Budget Summary, 2006-07.
[4] Source: Legislative Analyst's Office. Analysis of the 2006-07 Budget Bill, February 2006.

In 2005-06, there were more than 6.5 million persons enrolled in the program. Medi-Cal enrollment among welfare families declined from 2.4 million in 1998-99 to less than 1.28 million in 2005-06 (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, but then increased to 249,000 in 2005-06. The earlier enrollment declines were more than offset by gains in family coverage under section 1931(b). Coverage for undocumented immigrants declined between 1998-99 and 2000-01, rebounded in 2001-02, but declined again in 2003-04. Enrollment for long-term care beneficiaries accounts for approximately 1% of all Medi-Cal beneficiaries.

Table 2: Overview of Medi-Cal Enrollment, By Eligibility Category, 1998-99 to 2006-07
(In Thousands)

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	**6580**	**2,576**	1354	1222	**2,702**	271	2365	66	**649**	188	108	85	250	**78**
2005-06	**6580**	**2,518**	1276	1242	**2,935**	307	2565	63	**633**	192	101	82	249	**69**
2006-07*	**6665**	**2,493**	1258	1235	**2,909**	342	2505	62	**643**	197	105	83	250	**70**

SOURCES: Department of Health Services, Medi-Cal Beneficiary Profile, Beneficiaries by age and Demographics 2006; Estimated Average Monthly Certified Eligibles, Fiscal Years 2001-07; The Medi-Cal Policy Institute, 2002; Legislative Analyst's Office, Analysis of, 2006-07 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. [5] Reflecting the racial diversity of the state, Medi-Cal beneficiaries are predominantly people of color. More than half (52%) are Latino. [6] Approximately 11% of beneficiaries are African American and 3.7% are Asian-Pacific Islanders.[7] Whites comprise 21% of all Medi-Cal beneficiaries. [8]

Medi-Cal Spending

Total federal and state Medi-Cal expenditures are projected to increase to $35.1 billion in 2006-2007 (Figure 4). This represents almost a 70% increase from 1998-99.

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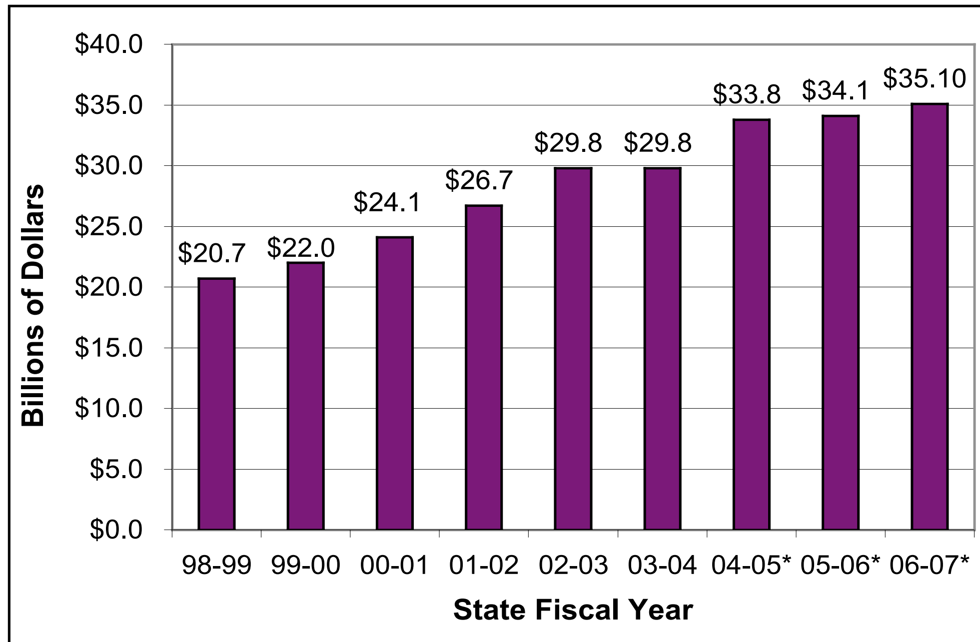
[5] Source: Department of Health Services, Medi-Cal Beneficiary Profile, Beneficiaries by Age and Demographics, January 2006,

[6] Ibid

[7] Ibid

[8] Ibid

Figure 4: Total Federal and State Medi-Cal Expenditures, 1998-99 to 2006-07



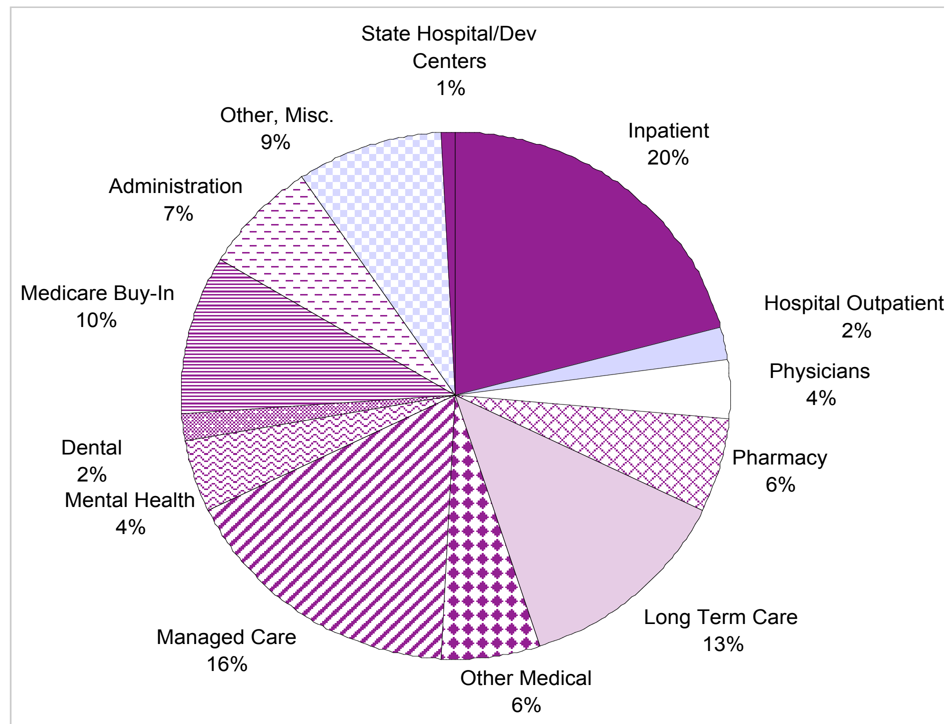
*Estimated
SOURCES: Department of Health Services, Governor's Budget Summary 2006-07.

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 20 percent of total (Figure 5). Payments to managed care comprise the next largest expenditure at 16 percent. Long-term care facilities received 13% of Medi-Cal funding. Administrative costs account for 7% of total Medi-Cal spending, of which about half is for county administration of eligibility.

The effect of Medicare Part D is also substantial to Medi-Cal expenditures. The state will no longer pay for drugs for the majority of those who are dually eligible, this will reduce drug costs for this category of individuals by approximately $1.8 billion in 2006-2007.[9] Due to a "clawback measure," California will not keep the majority these savings. The state must return 90% to the federal government in 2006.[10] Over the next nine years, the claw back percentage will be reduced by 1.66% per a year until state contributions reach 75% of their estimated drug savings on dual eligibles.[11] Afterwards, clawback payments will remain set at that percentage of estimated savings.[12]

[9] Source: Legislative Analyst's Office. 2006-07 Budget Analysis, February 2006.
[10] Ibid
[11] Ibid
[12] Ibid

Figure 5: Medi-Cal Expenditures by Service Category, FY 2006-07



SOURCES: California Department of Health Services. Medi-Cal Expenditures by Service Category, May 2006 Estimate; Department of Health Services. County Administration Funding Summary May 2006

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 a child enrolled in fee-for-service.[13]* In comparison, expenditures for the elderly and disabled exceeded $10,000 per beneficiary due to higher costs associated with acute and long-term care services.[14] Most of the growth in program spending has been for services to the aged and disabled.

California spends less per beneficiary than other states ($5,509 per beneficiary in 2004 compared to the national average of $6,895) 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.[15]

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[13] 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.

[14] Source: California HealthCare Foundation, *Medi-Cal Facts and Figures, A look at California's Medicaid Program*, January 2006

[15] Source: Department of Finance, Governor's Budget 2006-07, Proposed Budget Summary

Enrollment & Retention

Over three quarters of all beneficiaries (77%) remain enrolled in Medi-Cal after one year; retention rates differ across beneficiary groups. Only 11% of individuals who pay a share of their costs retain coverage, while 90% of SSI/SSP recipients continue coverage after a year.[16]

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. The One-e-App will allow families to determine eligibility and apply for many health and social services programs via the Internet. The Governor's 2006-07 budget includes $9.6 million funding to simplify the enrollment processes for children's health programs through Health-e-App.[17] However, significant barriers remain, such as the complexity of the application process, difficulty obtaining required documentation, lack of information about the program and, for immigrant families, and fear that enrolling in Medi-Cal may jeopardize their goals of attaining citizenship.

The 2006-07 budget also provides major funding to facilitate Medi-Cal enrollment. This includes $22.6 million ($9.3 million from the General Fund) for counties to perform outreach and enrollment activities and $48.2 million ($27 million from the General Fund) to handle expected caseload growth due to simplifications in Medi-Cal redetermination.[18]

On February 8, 2005, President Bush signed into law the federal Deficit Reduction Act of 2005 (DRA) Citizen/Identity Requirements.[19] The DRA made changes to Medicaid by requiring that individuals who claim to be U.S. citizens or U.S. nationals must demonstrate proof of this status and identity upon applying or renewing their Medicaid coverage. [20] There is concern that this process will delay coverage or disqualify individuals who have difficulty obtaining documentation. [21] Collecting the necessary evidence may also be a costly and time-consuming process for low-income individuals, those with disabilities, the homeless, and Hurricane Katrina Victims.[22] States are permitted to use cross-matches with vital statistic agencies and the Social Security Administration to alleviate these complications for SSI beneficiaries. [23]

Managed Care

Between 1997 and 2005, enrollment in Medi-Cal managed care nearly doubled from 1.8 million to 3.3 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 2005. The number of 2005 enrollees in the geographic managed care (GMC) system increased from 143,000 to 339,000 with the implementation of GMC in San Diego County in 1998. Enrollment in the state's eight County Organized Health Systems (COHS) increased from 378,000

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[16] Source: California HealthCare Foundation, *Medi-Cal Facts and Figures, A look at California's Medicaid Program*, January 2006
[17] Source: Department of Health and Human Services, 2006-07 Budget
[18] Source: Department of Finance, Enacted Budget, 2006-07
[19] Source: Department of Health Services, Medi-Cal Website
[20] Source: Kaiser Commission on Medi-Caid Facts, New Requirements for Citizenship Documentation on Medicaid, July 2006
[21] Ibid
[22] Ibid
[23] Ibid

in 1997 to 565,000 in 2005. COHS counties include Yolo, Napa, Solano, San Mateo, Santa Cruz, Monterey, Santa Barbara, and Orange.

Table 3: Medi-Cal Enrollment by Type of Managed Care Plan, 1997-2005
(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

SOURCES: DHS Annual Managed Care Statistical Reports, Medi-Cal Beneficiaries by Managed Care Plan January 1997 to May 2005, Overview of Medi-Cal Beneficiaries-Profile-By-County File, January 2006
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 dedicates significant funds to continue the growth in Medi-Cal managed care enrollment. By 2006-07, managed care enrollment is expected to increase to 3.4 million. [24] In 2006-07, approximately 345,000 beneficiaries are expected to be enrolled in GMCs and 585,000 are expected to be enrolled in COHS. [25]

$1.5 million (50% from the General Fund) is allocated to the Managed Care Expansion into 13 Counties initiative for 2006-07. [26] The budget also allows for the creation of 16.2 new positions within this program.[27] The Managed Care Expansion will involve beneficiaries in El Dorado, Imperial, Kings, Lake, Madera, Marin, Mendocino, Merced, San Benito, San Luis Obispo, Sonoma, Placer, and Ventura counties. The program will begin a 12 to 18 month phase in process beginning in January 2007.[28] The Managed Care Expansion into 13 Counties initiative is expected in shift 262,000 children and parents into managed care by FY 2008-09.[29]

Additionally, the budget includes $936,000 from the General fund to phase in the expanded enrollment of seniors and persons with disabilities into Medi-Cal Managed care in two counties.[30] Consistent with the current practice, the aged and disabled would enroll in COHS where available.[31] Another program dedicated to increase managed care program is the Coordinated Care Management Pilot Project. The budget allocates $473,000 ($208,000 from the General

[24] Source: Department of Health and Human Services, 2006-07 Budget
[25] Department of Health and Human Services, 2006-07 Budget
[26] Department of Finance, Governor's 2006-07 Budget
[27] Ibid
[28] Medi-Cal Redesign, Medi-Cal Redesign Fact Sheet,
[29] Medi-Cal Redesign, Updated Medi-Cal Redesign Fact Sheet, August 2005
[30] Department of Finance, Governor's 2006-07 Budget
[31] Medi-Cal Redesign, Updated Medi-Cal Redesign Fact Sheet, August 2005

Fund) in 2006-07 to establish this project. [32] The project is designed to coordinate the provision of health care for beneficiaries with serious mental chronic health conditions.

Access to Care[33]

Medi-Cal reimbursement rates in California are about 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 Medi-Cal traditional. Additionally, most seniors and disabled individuals have dual coverage through Medicare and Medi-Cal. Through their Medicare coverage, which has higher rates than Medi-Cal, they attain greater access to medical care.

Utilization[34]

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.

[32] Ibid
[33] Ibid.
[34] Ibid.

MANAGED RISK MEDICAL INSURANCE BOARD (MRMIB) PROGRAMS[35]

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). The Health and Human Services funding for MRMIB in 2006-07 is $1.193 billion.[36]

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 percent 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 756,0000 in April 2006 with total expenditures of almost $807 million (Table 4). Enrollment among children is expected to grow to more than 867,000 in 2006-07 with expenditures of over $1 billion.

Table 4: Healthy Families Enrollment and Expenditures, SFY 1998-2006

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

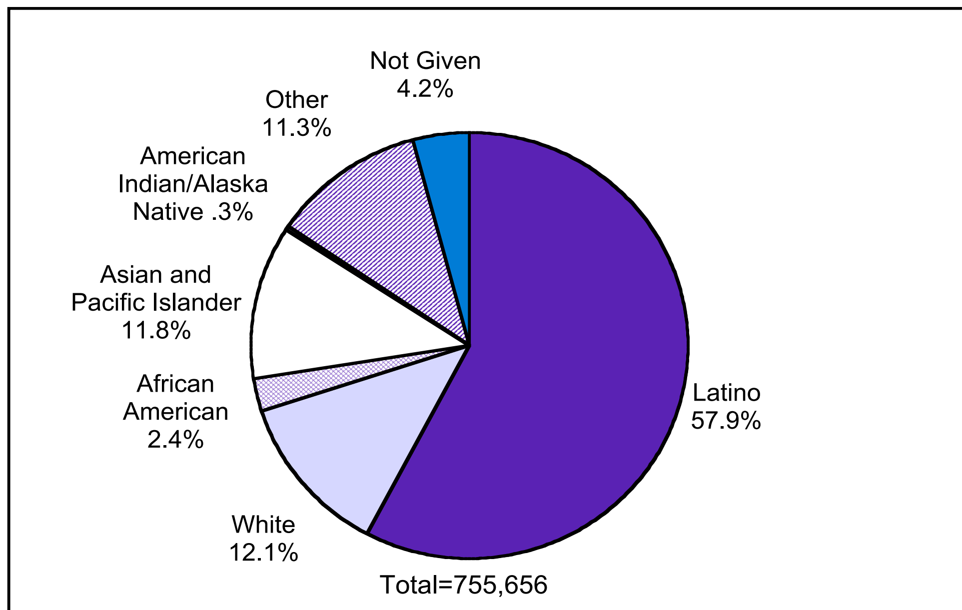
*Projected.

SOURCES: California Department of Finance, Governor's Budget Summary, 2006-07; MRMIB Healthy Families Program Monthly Enrollment Reports, May 2006

Healthy Families is an ethnically diverse program. Approximately three in five (58%) beneficiaries are Latino (Figure 6). Approximately one in eight (12%) beneficiaries are White, 12% are Asian/Pacific Islander, 3% are African American, and 0.3% are American Indian/Alaska Native. The majority (54%) of Healthy Families beneficiaries reside in one of five Southern California counties: Los Angeles (27%), Orange (9%), San Diego (9%), San Bernardino (8%), and Riverside (8%).[37]

[35] Source: California Department of Finance, Governor's Budget Summary 2004-05, 2005-06, & 2006-07
[36] Source: Department of Health and Human Services, Proposed 2006-07 Budget
[37] Source: Department of Health Services, Healthy Families Program, April 2006

Figure 6: Ethnicity of Healthy Families' Subscribers, April 2006



SOURCE: MRMIB website, Health Families Program, April 2006

Major Risk Medical Insurance Program (MRMIP*)*

MRMIP offers insurance to individuals with health conditions, who cannot obtain private insurance. In April 2006, 8,937 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 for their perceived higher risk. 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 reenactment.[38]

Thirty-four percent of MRMIP subscribers are between 50 and 64 years old followed by 30-49 years old (34%) and under 29 years old (29%).[39] Whites comprise a disproportionate share of MRMIP subscribers (61.1%) compared to their percentage of the total state population. More than half of the subscribers (51%) are enrolled with Blue Cross.[40] Kaiser Permanente, Blue Shield, and Contra Costa Health Plan are the other private health plans participating in MRMIP.[41] Projected spending in SFY 06-07 is $40 million.[42] State contributions have remained at the same level since 1989-90, while other state's programs, such as Minnesota's, saw expansions in funding.

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[38] Source: California Major Risk Medical Insurance Program, 2006 Fact Book March 2006.
[39] Source: MRMIB Website, Highlights of the 2006-2007 Governor's Budget, January 2006
[40] Ibid
[41] Ibid
[42] Source: Department of Finance, Governor's Budget Summary, 2006-07.

Table 5: MRMIP Enrollment, By Demographic Characteristics, April 2006

Category	Number Enrolled	Proportion Enrolled
TOTAL	**8,937**	**100.00%**
Subscribers	8,542	96.0%
Dependents	17	0.2%
Health Plans		
Blue Cross	4,586	51.3%
Kaiser (North & South)	2,436	27.3%
Blue Shield HMO	426	4.8%
Contra Costa	72	0.8%
Race/Ethnicity		
White	5460	61.1%
Asian/Pacific Islander	715	8.0%
Latino	1037	11.6%
Other	1233	13.8%
African American	393	4.4%
American Indian	9	0.1%

SOURCE: MRMIB website, MRMIP Subscriber and Health Plan Data: April 2006 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.[43] By April of 2006, a total of 10,932 women and children were enrolled in AIM. [44] This 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 2006-2007 is $120.4 million, a $5 million increase over the 2005-06 revised 2005 Budget Act level.[45]

Additionally, the 2005-06 Budget Act expanded the use of federal SCHIP funds to support prenatal services provided by AIM and Medi-Cal.[46] This will reduce California's General Fund and Proposition 99 contributions. The 2006-07 budget allots approximately $88 million in state funds and $163 million in SCHIP funds to these services.

[43] Source: MRMIB website
[44] Source: MRMIB website
[45] Source: Department of Finance, Enacted Budget 2006-2007
[46] Legislative Analyst's Office, 2006-07 Budget Analysis

Table 6: AIM Enrollment, as of April 2006

Category	Proportion Enrolled
TOTAL	**100.0% (n = 10,932)**
Women	30.0% (n = 6691)
Infants	70.0% (n = 4241)
Health Plans*	
Blue Cross HMO & EPO	59.70%
Health Net	24.00%
Kaiser (North & South)	7.10%
Molina Healthcare	6.50%
Other	3.20%
Race/Ethnicity*	
Latina	46.50%
White	23.60%
Asian/Pacific Islander	16.30%
Unknown	11.60%
African American	1.60%
American Indian	0.30%
Counties*	
Los Angeles	23.20%
San Bernardino	5.60%
Monterey	6.90%
San Diego	12.60%
Riverside	5.70%
Orange	6.90%
Other	39.10%

SOURCE: MRMIB website, Aim Subscriber and Health Plan Data: April 2006 Summary .
* Current Mothers only

Since April 2006, 46% of new (women) beneficiaries have been Latina, 24% were White, and 16% 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 (7%) and San Diego (13%). The proportions of enrollment in AIM in other counties include: Los Angeles (23%), Orange (7%), and Riverside (6%).

PRIVATE HEALTH INSURANCE COVERAGE[47]

In 2003, California passed SB 2 (Burton and Speier) requiring larger employers to provide coverage for their employees or pay a fee into a state purchasing pool operated by MRMIB beginning in 2006. It is estimated that up to one million previously uninsured Californians would have been covered by this measure, if fully implemented.[48] The legislation was repealed by a narrow margin via a referendum of the State's voters in November 2004.

Employer-Based Coverage

- Twelve million Californians between the ages of 18-64 were covered all year by employment-based health insurance in 2003, which is approximately 54% of the 18-64 years old population and accounts for nearly 90% of all California employees (California Health Interview Survey, 2003).

- Sixty-six percent of California businesses offered health insurance in 2006, which was similar to 2005. Eight-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, a change from the previous years (CHCF Employer Health Benefits Survey 2005).

- Seventy-five percent of workers in firms that offer coverage are eligible for coverage. The workers who were ineligible for coverage are mainly due to waiting periods or minimum work-hour rules (CHCF Employer Health Benefits Survey 2005).

  - When offered, most (86%) of those eligible accept coverage (CHCF Employer Health Benefits Survey 2005).

Among uninsured employees who were eligible for employer sponsored health insurance, only 14.7 percent of individuals who decline coverage do so 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). Forty-five percent rejected employer-based coverage due to high share of cost. (California Health Interview Survey 2003)

- On average, worker contributed $492 annually for single coverage and $2,883 for family coverage (Employer Health Benefits Survey 2005).

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[47] Unless otherwise noted, information on employer-based health insurance was obtained from the California HealthCare Foundation, Kaiser Family Foundation/Health Research and Educational Trust (HRET) California Employer Health Benefits Survey, March 2005, Kaiser Family Foundation/HRET National Employer Health Benefits Survey, 2005, at www.hret.org.

[48] California HealthCare Foundation, The Health Insurance Act of 2003: an Overview of SB 2 (November 2003).

- The share of premiums paid by workers were 13% for single coverage and 29% for family coverage. Worker contributions varied by firm size. In smaller firms (33-199 employees), twenty-eight percent of employees paid more than $360 a month for family coverage. In contrast, sixteen percent of employees of larger firms (200 or more employees) paid more than $360 a month for family coverage.

- Nearly all employers with more than 200 employees offer health insurance. The offer rate is much lower among small businesses. Fifty-seven percent of businesses with 3-9 employees in California offer health insurance (Employer Health Benefits Survey 2005).

- Nearly half (49%) 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 2005).

- Large employers in California with more than 200 employees are very likely to offer employees a choice in health plans, with 92% offering more than one plan. Only 64% of small employers offer workers a choice of plans.

- Health insurance premiums continue to rise. In California, premiums rose by 8.2% in 2005, which was more than twice the California inflation rate (3.9%). Thirty-two 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. [49]

Individual Coverage

- In 2003, approximately 1.7 million people in California were covered by privately purchased health plans throughout the year (California Health Interview Survey, 2003). The individual insurance market accounts for about 5.4 percent of the non-elderly population (ages 0-64) (California Health Interview Survey, 2003). In contrast, the Current Population Survey finds that 8.2 percent (approximately 2.6 million) of the nonelderly population purchased individual insurance in 2003.[50]

- In 2003, thirty-eight percent of those buying individual insurance were self-employed.[51] Approximately eighteen percent of those with individual insurance have incomes below 200% of the Federal Poverty Level and nearly twenty six percent are between the ages of 35 and 54 and fifteen percent are individuals younger than 35, and 38 percent are 55 and over.[52]

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

- Another recent study reports that nearly thirty percent of Americans between the age of 18 and 65 are potential candidates for individual health coverage; however only eight percent

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[49] Source: California HealthCare Foundation, California Employer Health Benefits Survey, 2005
[50] Source: U.S. Census Bureau, CPS Data Collected in Year 2005, Current Population Survey (CPS) Table Creator
[51] Source: California HealthCare Foundation, Snapshot: Individual Health Insurance Market 2005
[52] Source: California HealthCare Foundation, Snapshot: Individual Health Insurance Market 2005

purchase coverage through the individual market.[53] The individual market is reaching less and less of its candidates, declining from over a 33% of its 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 in purchasing coverage – there are fewer restrictions on insurance underwriting practices, less security in access and retention on average, less price transparency and thus less ability to compare market prices.

- 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.[54]

[53] Ibid

[54] See Veronica Richardson, Overview of the Uninsured, Statewide 2004 (Insure the Uninsured Project October 2005) at www.itup.org. Average statewide premium for standard HMO coverage for a fifty-year-old individual was $366 per month in 2004 and premiums for roughly comparable HMO coverage ranged from as low as $243 to as high as $428 per month.

UNINSURED CALIFORNIANS[55]

Despite the presence of public and private health insurance programs, 6.6 million nonelderly Californians were uninsured for all or part of the year in 2003, which is greater than 20% of the state population. In 2003 approximately 4.8 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 6.6 million Californians that lacked health insurance, nearly a million children under 18 are uninsured, which constitutes approximately 10% of the children in California. According to estimates 800,000 children were uninsured at a point in time. Approximately 5.6 million of the uninsured were adults between the ages of 18 and 64, constituting approximately 26% of all adults 18-64 years old.

In 2003, the number of uninsured children declined to nearly 972,000, an approximately 2% decrease since 2001 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 not enrolled in the state's Medi-Cal and Healthy Families programs. The uninsured rate for children below the poverty line dropped 6.9 percentage points

Individuals with incomes below 200% of the Federal Poverty Level (FPL) comprise 63.1% (4.1 million) of the nonelderly uninsured population. Most of the uninsured have low incomes. Over one in seven (15%) persons with incomes between 200 and 300% of the FPL are uninsured. [56] The annual income representing the FPL for a family of three in 2006 was $16,600, equal to about $8.30 an hour for a full time full year worker.

Approximately 13 percent of California's workers are uninsured, overwhelmingly because they are not offered coverage at work. Workers and their family members account for over 76.2% of uninsured Californians.

The uninsured population is demographically diverse (Table 7). In 2003, 3.4 million Latinos (who were under 65 years old) were uninsured, which comprise 51% of the state's total uninsured and 35% of all Latinos under 65 years old. Approximately 620,000 Asian/Pacific Islanders had no coverage for their health expenditures and slightly more than 1.9 million Whites were uninsured.

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[55] Source: California Health Interview Survey (CHIS) 2003 unless otherwise noted

Table 7: Uninsured Persons (<65 years old) in CA, By Race, 2003

Race	Total Number Uninsured (n = 6,588,000)	Proportion of Total Uninsured	Proportion of Racial Group Uninsured
Latino	3,388,108	51.0%	34.7%
White	1,901,196	29.0%	13.2%
Asian	620,256	9.0%	16.8%
African American	369,070	6.0%	17.0%
Other	202,250	3.0%	23.0%
American Indian/Alaska Natives	107,120	<2.0%	26.0%

SOURCE: California Health Interview Survey (CHIS), 2003.
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, CPS and SIPP

The 2003 California Health Interview Survey (CHIS) measured the rate of the state's uninsured by county and region by using a sample size nearly eight times that used in the Current Population Survey (CPS). The CHIS data reflects a much more accurate assessment of the uninsured than previous 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 2003 CHIS reports 4.8 million are uninsured at a point in time and a total of 6.6 million uninsured at some point during a 12-month period. The 2003 CHIS report shows a decline in employment-based coverage and increases in public coverage, particularly for children.

The federal CPS (Current Population Survey) 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 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).[57]

In March 2003, Families USA released a report showing roughly 11 million uninsured Californians. This figure reports Californians who are uninsured at any point over a two-year time frame. It is based on yet a third survey referred to as Survey of Income and Program Participation (SIPP).

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

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[57] US Census Bureau, 2004-2005 Data

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

Background

In California, counties are responsible for 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.[58] Counties can be grouped into four 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 and 4) hybrid counties with public clinics and private hospitals.

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.[59] The principal funding streams supporting county care to the uninsured are realignment, tobacco funds, net county disproportionate share hospital (DSH) funding and county match, and in some counties tobacco litigation settlements.

Between 1997-98 and 2005-06, realignment payments to counties increased by nearly one-third from $1.11 billion to $1.58 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 2005-06, Los Angeles County received $520 million, nearly 33% of all realignment funds distributed statewide. Realignment funding per uninsured California resident is approximately $240 in 2005-06.[60]

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[58] 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.

[59] 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.

[60] Figure was derived by dividing the estimated 2005-06 state realignment allotments to selected counties by the estimated number of uninsured from CHIS 2003.

Table 8: State Realignment Allotments to Selected Counties, SFY 1997-98 to 2005-06
(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

* Estimated.
† Total for SFY 2003-06 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 Medi-Cal 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 for 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 9: County Indigent Health care Clients for 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 four different models of county health systems are: counties with public hospitals (provider counties), counties with private providers (payor counties), counties with a hybrid of county clinics and private hospitals (hybrid counties) and small counties which collaborate in a Medi-Cal like system for indigent adults (small counties). There are enormously wide variations in eligibility, funding and access to services in these very different delivery systems.[61] 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 10: 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 11: Financing by County Type

	Provider Counties	Payor Counties	Hybrid Counties	CMSP Counties
Realignment	Yes	Yes	Yes	Yes
Prop 99	Yes	Yes	Yes	Yes
Net County DSH	Yes	No	No	No
Net SB 1255	Yes	No	No	No
County Match	Yes	Yes	Yes	Yes
FQHC	Yes	No	Yes	No

County Indigent Health Care Programs: 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.[62]

Between 1997-98 and 2005-06, total funding for the CMSP increased from $183 million to $238 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 82% in 2005-06. Hospital settlements declined from $28 to $15 million. Due to increases in other funding, state

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

general funds were deferred in the current fiscal year, but funds were authorized for the next five years. Proposition 99 funds[63] also have been phased out. County fund and third party-payer information was unavailable.

Table 12: Sources of Revenue for County Medical Services Program (CMSP), 1997-98 to 2005-06
(In Thousands)

SFY	Total	Realignment	General Fund	Hospital Settlements	Proposition 99	County Funds	Third-Party Payers
1997-98	$182,971	$110,749	$20,237	$27,929	$12,514	$5,459	$2,083
1998-99	$184,755	$ 124,382	$20,237	$17,801	$9,983	$5,459	$3,825
2002-03*	$215,364	$169,000	$0	$20,000	$0	$5,459	$14,700
2003-04*	$221,184	$175,000	$0	$20,000	$0	Not Available	Not Available
2004-05*	$235,627	$176,000	$0	$20,000	$0	Not Available	Not Available
2005-06*	$238,130	$197,246	$0	$15,000**	$0	Not Available	Not Available

Approved budget.
*Estimated
**Includes other recoveries
SOURCE: Legislative Analyst's Office, CMSP Governing Board Budget, 2005-06 and CMSP Website Accessed July 2006

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, which totaled $219 million in 2004-2005.[64]

County Indigent Health Care Programs: California Healthcare for Indigents Program (CHIP)

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 $44.8 million in 2005-06 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.

[63] Proposition 99 levied a $0.25/pack tax on tobacco products beginning in 1988. The proceeds were designated for health care for the uninsured.
[64] CMSP Website, County Medical Services Program: Summary of Claims and Costs by Claim Type FY 2002-2003 to FY 2004-2005

Table 13: California Healthcare for Indigent Program (CHIP) Allotments to Selected Counties, SFY 1998-99 to 2005-06

(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

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

County Indigent Health Care Programs: 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 and significantly increased again in 2005-06 to approximately $4.8 million (Table 14). In 2005-06 the five most populated rural counties (Butte, Marin, Shasta, Solano and Sonoma) received more than half (54 percent) of total RHS funding. The remaining rural counties received very modest payments under the program, with Alpine County receiving less than $1,000 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 14: Rural Health Services (RHS) Allocations to Selected Counties, SFY 1998-99 to 2005-06

(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

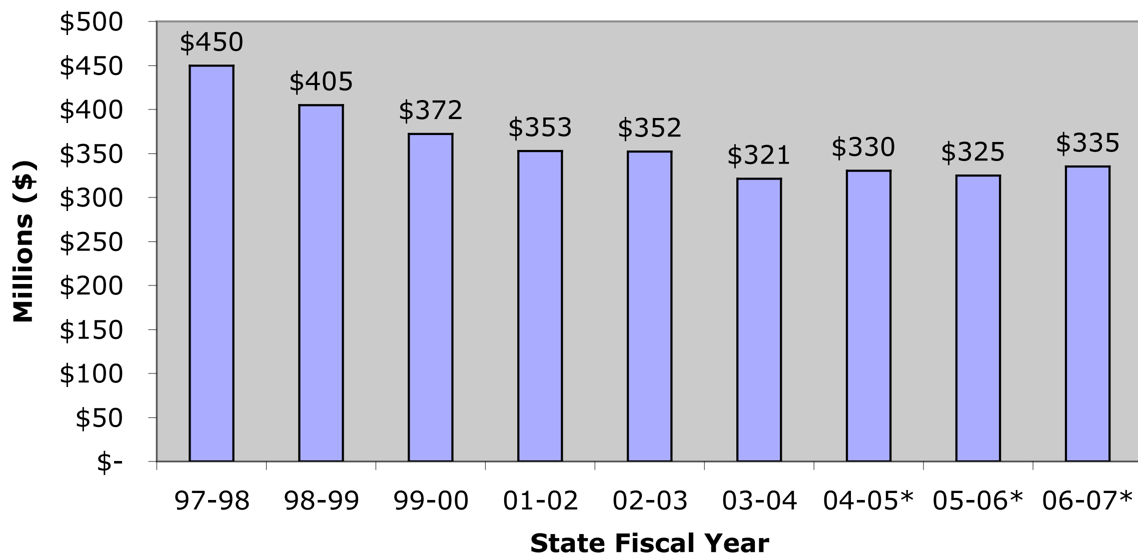
SOURCE: Department of Health Services, Office of County Health Services, Allocation Tables

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 $335 million in special funds in 2006-07 (Figure 7).

Figure 7: Proposition 99 Revenues, State Fiscal Year (SFY) 1998-99 to 2006-07



*Estimated
SOURCE: Governor's Budget Summary 2006-07

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 accounts dedicated to counties (CHIP and RHS) rose significantly in 2005-2006 as funds previously diverted to other programs for the uninsured were returned to these programs. The account dedicated to AIM steadily grew until the proposed Fiscal Year 2005-06 Budget when the state proposes to secure federal matching funds for AIM services to pregnant women.[65] AIM funding levels are expected to increase in 2006-07 to approximately $56.2 million.[66]

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

Table 15: 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 16: Estimated Annual Tobacco Settlement Payments to California, 1999-2016

Year	Revenue
1999	$157,084,894
2000*	$220,700,944
2001*	$256,317,292
2002*	$350278820
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 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 17: Projected Tobacco Settlement Payments to Selected Counties, 2006

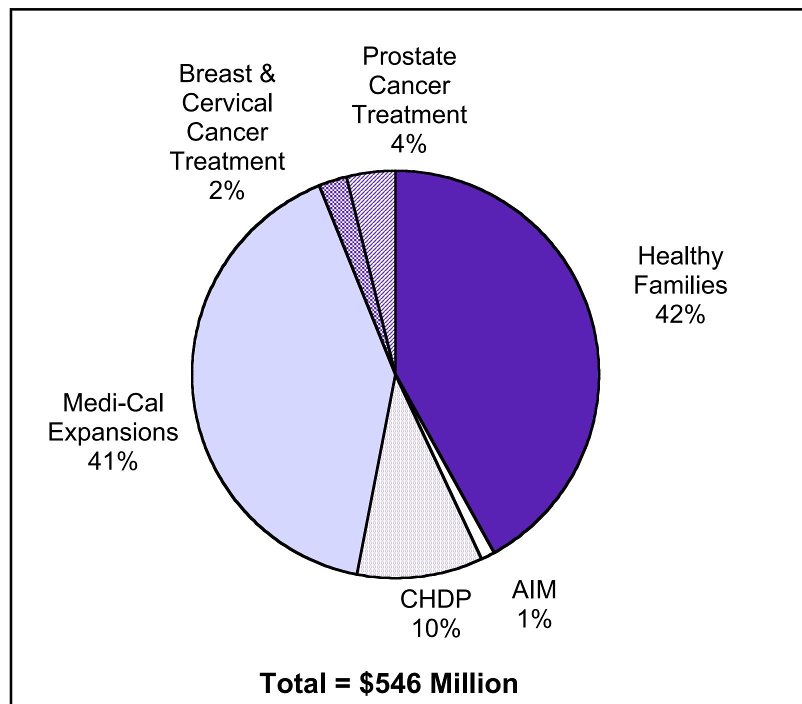
Counties	Total Payment: 2006 (In Millions)
Alameda	$14.1
Los Angeles	$93.3
Orange	$27.9
San Bernardino	$16.8
Tulare	$3.6
TOTAL: California Counties	**$368.8**

SOURCE: Office of Attorney General, Projected Annual Payments to Local Governments from Tobacco Settlement based on Cigarette Consumptions by Global Insight, October 2002.

In 2002-03, $546 million in state Tobacco Settlement Funds was allocated for health programs. This figure included $72 million carried over from the previous year. Forty-two percent of the funds supported the Healthy Families program. An approximately equal amount (41%) funded Section 1931 (b) coverage expansions and breast and cervical cancer treatment under Medi-Cal (Figure 8). Funds were also allocated for state-funded breast and cervical cancer treatment and prostate cancer treatment programs, CHDP and AIM.[67]

[67] LAO, State Spending Plan 2002-03.

Figure 8: California's Tobacco Settlement Expenditures, by Program, SFY 2002-03



SOURCE: LAO, State Spending Plan, 2002-03

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, and be a county resident.[68] Premiums are generally $4-$12 per a child per a month and co-pays range from $5-$15 for most services.[69] Eighteen counties currently offer Healthy Kids Coverage, covering roughly 88,397 children as of May 2006.[70]

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68 California Healthcare Foundation, Children's Health Insurance Programs: Facts and Figures, June 2006

69 Ibid

70 Ibid

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.[71] 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).[72] From these combined sources, counties receive on average $345 per uninsured resident for the costs of all county health programs, including public health services.[73]

- 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 less than 7% the cost of employer sponsored PPO plans and approximately 11% of employer sponsored HMO plans (Figure 9).

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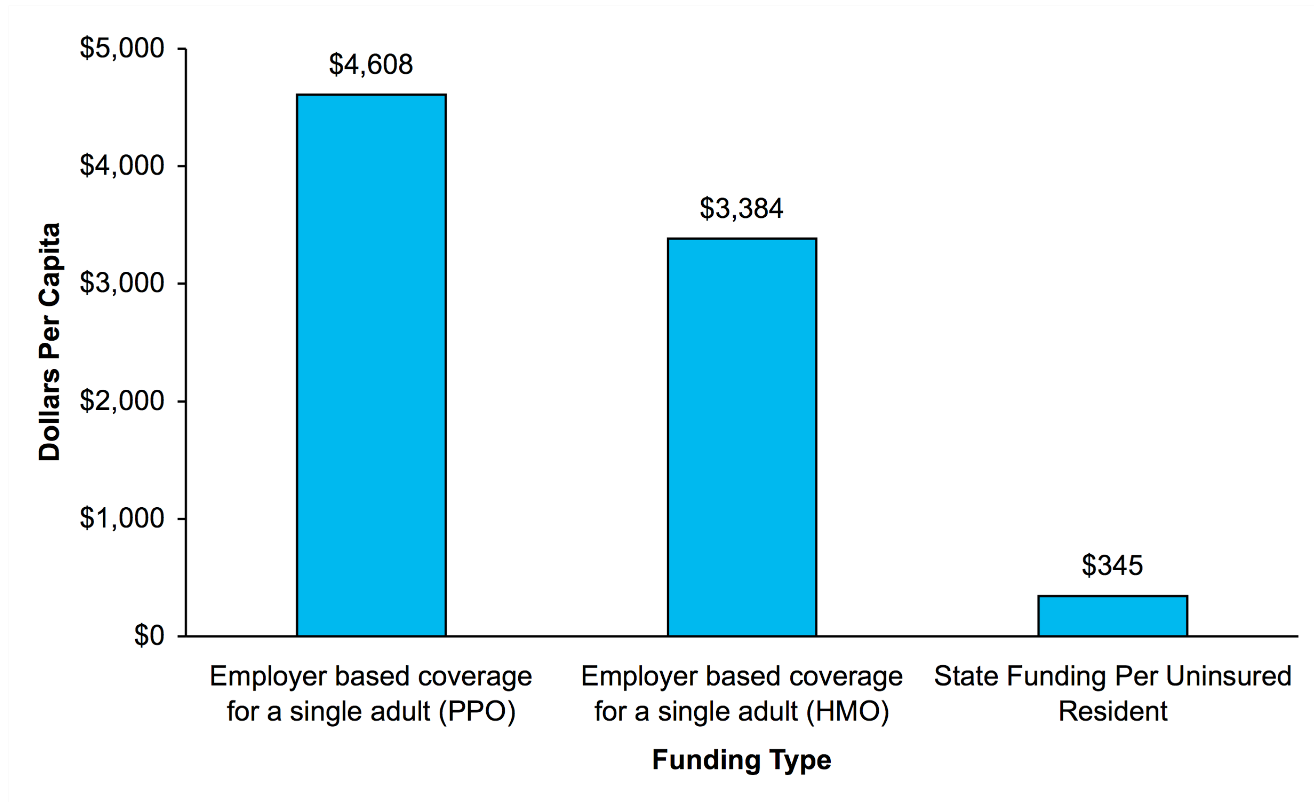
[71] Counties may choose to spend their realignment funds on programs such as public health services to all county residents and on county care to the uninsured, but counties must spend their Prop 99 funds on care to the uninsured.

[72] 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; many 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 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.

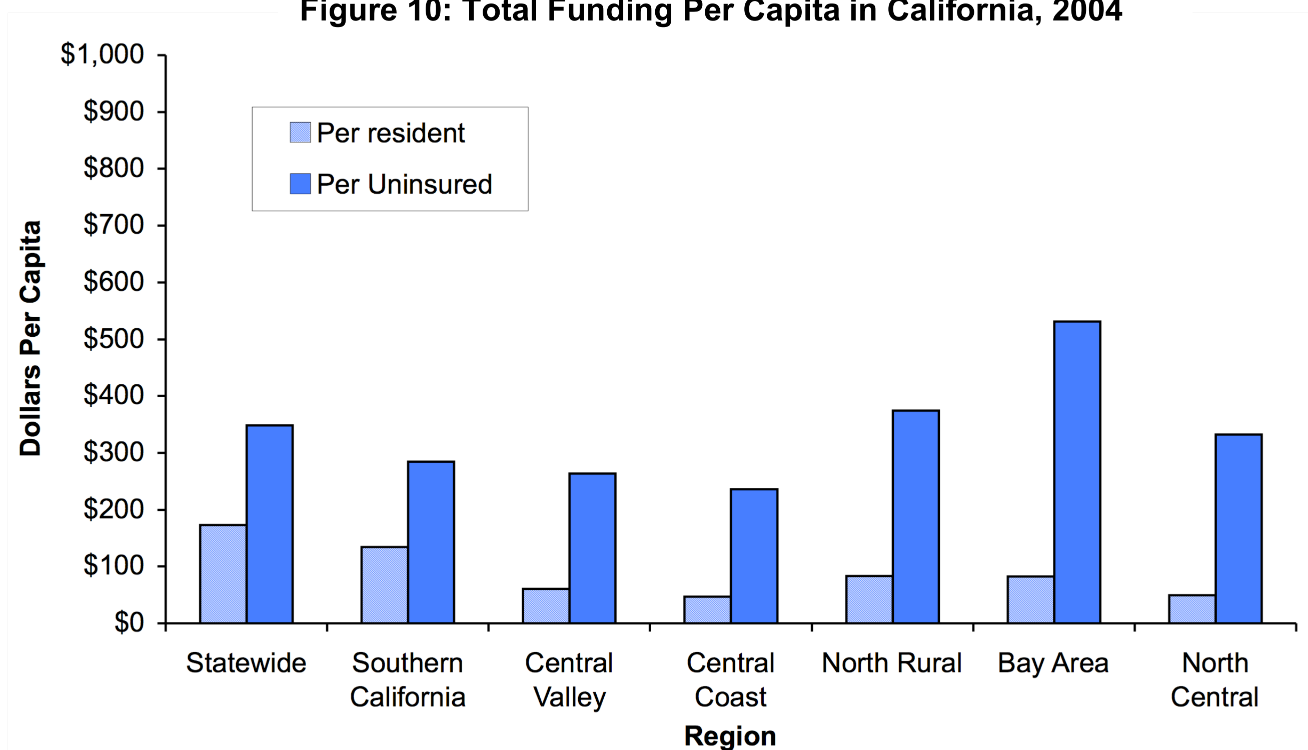
[73] We divided county health funding by the numbers of uninsured as reported in the 2003 CHIS report.

Figure 9: Public Funding per Uninsured Vs. Annual Cost of Employer Based Coverage



Source: Office of Statewide Health Planning and Development 2005 and California HealthCare Foundation, California Employer Heath Benefits Survey, 2005

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 $230 per uninsured, county resident and highest in the Bay Area region.



SOURCE: Office of Statewide Health Planning and Development, 2005

There is also wide variation in funding for county health within the regions. In the Southern California, Central Coast and Central Valley regions, counties with higher funding had twice as much funding per uninsured as those counties with the lowest funding. In the Bay Area, the county with the highest funding had three times as much funding per uninsured as the counties with the lowest funding in the same region. In the Northern Rural region, counties with the most funding had nearly 225% more funding per uninsured than counties with the lowest funding. Inter-county variations in the North Central region were less than two to one from high to low.

California counties pay annually for about 77.5 inpatient days and 78 emergency visits per 1000 uninsured;[74] this is a hospital use rate less than one-third that of an insured adult in California. Counties pay for 628 outpatient visits per 1000 uninsured; this is a physician use rate of about one sixth that of an insured adult in California.[75] These figures are highly variable by county with those counties with the most funding per uninsured paying for more services and those counties with the least funding per uninsured paying for well below these averages.

[74] We averaged the hospital's OSHPD reports on county funded days and visits and the MICRS reports on county funded days and visits and divided by California's uninsured as reported in CHIS, 2003

[75] We added MICRS reports on county funded outpatient visits with OSHPD data on CMSP funded community clinic visits and divided by California's uninsured as reported in CHIS, 2003

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 40 years old or older, earn less than 200% FPL, and have limited or no health insurance to pay for necessary treatment.[76] The same eligibility requirements apply for women to receive free cervical cancer screening except the age requirement is 25 years old or older.

The Breast Cancer Early Detection Program performed a total of 190,000 breast and cervical cancer screenings.[77]

There are three main sources of federal and state funding for breast and cervical cancer:[78]

- 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 2006-07 the Breast and Cervical Cancer Treatment Program will receive approximately $1.9 million in funds, half in General Funds.[79] Appropriations for the Breast Cancer Preventative Health Services program increased from $33 million in 1998-99 to $35 million in 2006-07. [80]

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 2006-07 budget and is expected to treat nearly 367 patients in the fiscal year.[81]

Family PACT[82]

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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[76] Source: California Department of Health Services, Cancer Detection Section, September 2002.
[77] Source: Breast Cancer Early Detection Program, Cancer Detection Section Information Packet, January 2005.
[78] Source: California Department of Health Services, Cancer Detection Section, September 2002.
[79] Source: Department of Health and Human Services, 2006-07 Budget
[80] Source; Governor's 2006-07 Proposed Budget
[81] Source; Governor's 2006-07 Proposed Budget
[82] 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 .75 million to 1.55 million. [83] The program's expenditure in FY 2003-04 totaled $414 million and increased to an estimated $450 million in 2005-06.[84]

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). This includes a $2.6 million increase in the current fiscal year to purchase additional adult flu vaccines.

During the same period, funding for the state's tuberculosis control program increased from $12.2 million to $13.9 million (Table 18). In 2004, tuberculosis case rates in California were an average of more than 8.2 per 100,000 compared to the national average of less than 4.9 per 100,000.[85]

Table 18: 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.

[83] Source: California Department of Health Services. FACT Sheet on Family Pact: An Overview, Version 2, updated February 2006
[84] Source: California Department of Health Services. FACT Sheet on Family Pact: An Overview, Version 2, updated February 2006
[85] Source: Department of Health Services; Tuberculosis Control Branch: Report on Tuberculosis in CA, 2004;

CHILDREN'S MEDICAL SERVICES PROGRAMS[86]

The proposed 2006-07 State Budget allocated approximately $252 million to Children's Medical Services Programs, which is an increase of $8.7 million from the 2004-05 Budget. 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.

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 $101 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 approximately CHDP health screens (Table 19). The Governor's proposed budget for CHDP in 2006-07 increased from 2005-06 by 95%.[87]

Table 19: State Expenditures for the 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	Not Available
2006-07*	$3,700,000	Not Available

*Estimated

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

[86] Source: Governor's Budget Highlights, 2006-07.

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

California Children's Services (CCS)[88]

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 that the users of CCS grew slightly in 2004-05.

Table 20: 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.[89] 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 to 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.[90]

Table 21: 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.

[88] Source: Department of Health Services. California Children's Services.
[89] LAO 2003-04 Budget Analysis
[90] Source: Governor's Budget 2006-07

Genetically Handicapped Persons Program (GHPP)[91]

The Genetically Handicapped Persons Program (GHPP) provides health coverage for Californians 21 years old 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 years old with GHPP-eligible Medi-Cal conditions who are not financially eligible for CCS. There is no maximum income requirement for GHPP, however, families with incomes greater than the 200% 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.

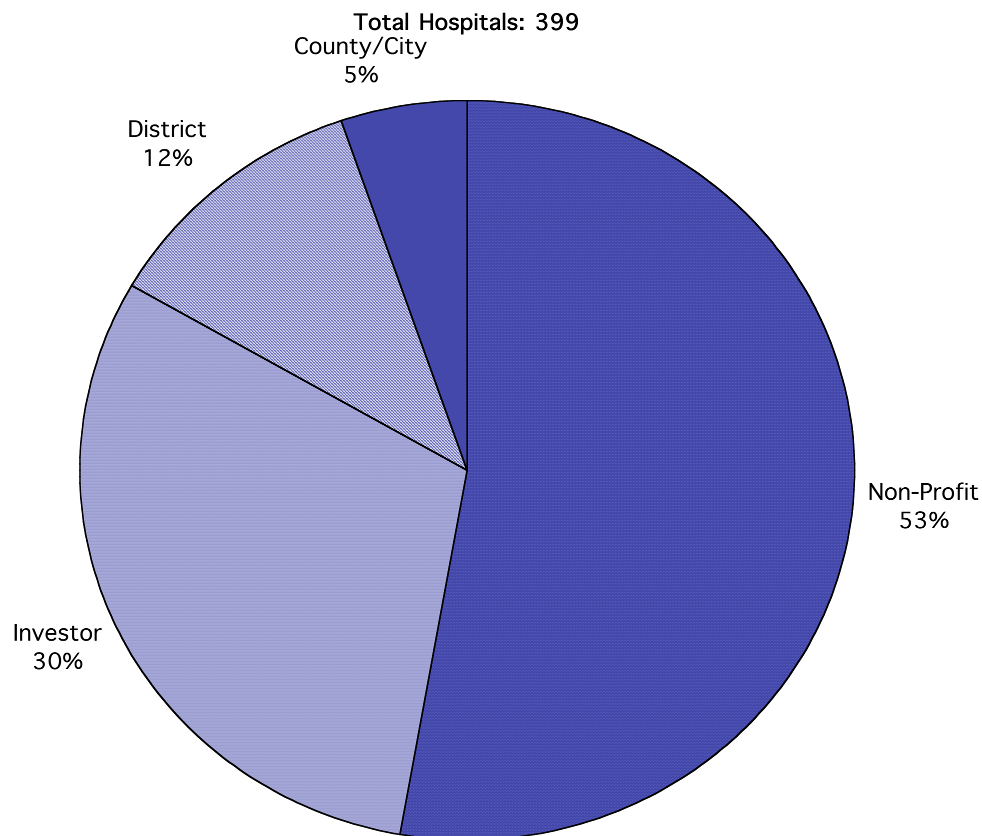
[91] Sources: Governor's Budget Summary, 2004-05; Legislative Analyst's Office, Analysis of the 2004-05 Budget.

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 399 comparable hospitals[92] in California, more than half (53%) are non-profit, approximately one-third (30%) are investor-owned, and the remaining are county/city (5%) or district (12%) hospitals (Figure 11). The number of investor-owned hospitals declined from 159 to 121 between 1997 and 2004.

Figure 11: Distribution of Hospitals in California by Type of Control, 2004

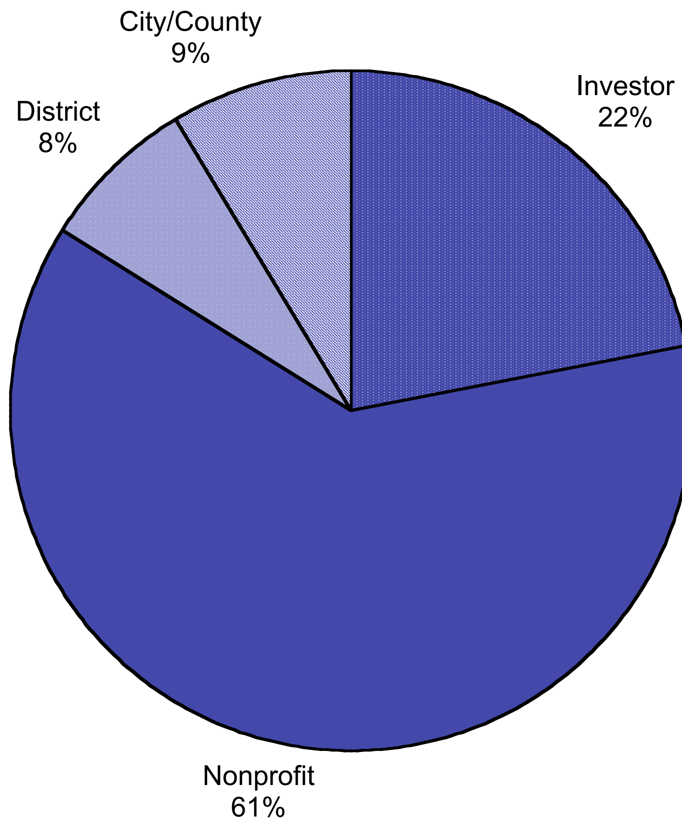


SOURCE: Office of Statewide Health Planning and Development, 2005

In 2004, California hospitals had a total of 74,657 available hospital beds. Nonprofit hospitals had the greatest proportion of hospital beds (61%), followed by investor hospitals (22%) (Figure 12).

[92] 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 12: Distribution of Available Beds in California by Type of Control, 2004
Total Beds: 74,657



SOURCE: Office of Statewide Health Planning and Development, 2005

In 2004, hospitals in California had approximately 17.5 million inpatient days (Table 22), which is a less than 1 percent decrease from the previous year. Medicare paid for 40% of all inpatient days and Medi-Cal covered 29% of inpatient days. Third party private insurance accounted for approximately 24% of all days. While Medicare accounted for the largest percentage of all inpatient days in the state in 2004, private insurance accounted for the highest share of outpatient and emergency room visits (40%). About 6% of hospital services represent care to the uninsured – more than half are reimbursed by counties and less than half are bad debt and charity care. Overall, county indigent programs accounted for 4% of inpatient days and 7% of outpatient visits.

In 2004, Medi-Cal patients had the longest average length of stay among payers at 6.6 days, reflecting skilled nursing facility use in hospitals. Medicare and Medi-Cal managed care payers had substantially shorter hospital lengths of stay (4.7. and 4.3 days respectively) in 2004 than fee for service Medicare (6.6 days), fee for service Medi-Cal (7.3 days) or county indigent (5.9 days) programs.

Table 22: Hospital Use, By Payment Source, 2004

Source of Payment	Inpatient Days	Average Length of Stay (Inpatient)	Outpatient Visits (Including ER)
Total	17,529,174	5.7	42,035,823
Medicare	40%	6.3	26%
Medi-Cal	29%	6.6	22%
Private Insurance	24%	4.4	37%
County Indigent	4%	5.5	7%
All Other Payers	3%	6.2	7%

SOURCE: Office of Statewide Health Planning and Development, 2002, 2003, 2004, 2005.

The payer mix is different for the four types of hospitals. At city and county hospitals, 71% of inpatient days were reimbursed by Medi-Cal (49%) and county indigent programs (22%) in 2004 (Table 23). In contrast, either Medicare or private insurance covered 64% of the patient days at investor-owned hospitals. Nonprofit hospitals mirror the distribution of payers for all hospitals in the state. At nonprofit hospitals, 41% of all inpatient days were reimbursed by Medicare, 27% by private insurance, and 25% by Medi-Cal. California hospitals provided 42.9 million outpatient visits, of which 9.4 million occurred in emergency departments. County hospitals account for 8% of inpatient days, 13% of outpatient visits, and 11% of emergency room visits.

Table 23: Hospital Utilization* by Payer and Type of Control, 2004

Type of Utilization	All Hospitals	Investor	Nonprofit	District	City/County
Total Inpatient Days	17,529,174	3,528,077	11,071,815	1,378,596	1,571,467
Medicare	6,952,492	1,645,504	4,552,530	507,073	247,385
Medi-Cal	5,062,979	962,224	2,793,912	539,471	767,372
Private Insurance	4,192,684	789,297	3,033,788	221,673	147,926
County Indigent	729,942	59,782	293,249	24,007	352,904
All Other	591,077	71,270	398,336	65,591	55,880
Outpatient Visits					
Total Outpatient Visits	42,035,823	4,770,831	28,530,833	3,311,204	5,722,955
Emergency Room VIsits	9,407,350	1,641,757	5,888,952	874,631	1,002,010

*Analysis only includes comparable hospitals.
SOURCE: Office of Statewide Health Planning and Development, 2005.

In 2004, hospitals generated $47.5 billion in net patient revenues and spent $47.1 billion in operating expenditures (Table 24). Among all hospitals, private insurance payments (42%) and Medicare (30%) represent the largest source of payments followed by Medi-Cal (21%). County indigent funded care represents 3% 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 24: Net Hospital Revenues, * by Type of Hospital and Revenue Source, 2004

Net Revenues	All Hospitals	Investor	Nonprofit	District	City/County
Medicare	$14,058,408,193	$2,695,230,399	$10,015,929,405	$924,881,812	$422,366,577
Medi-Cal	$10,266,540,612	$992,418,493	$4,757,022,595	$416,722,985	$4,100,376,539
Private Insurance	$20,040,436,648	$2,887,535,504	$15,738,587,625	$907,811,702	$506,501,817
County Indigent	$1,492,312,678	$32,012,952	$317,331,586	$22,926,906	$1,120,041,234
Other	$1,625,287,479	$390,072,400	$1,011,777,252	$164,925,497	$58,512,330
Net Patient Revenue	$47,482,985,610	$6,997,269,748	$31,840,648,463	$2,437,268,902	$6,207,798,497
Total Operating Expenses	$47,143,366,703	$7,139,994,855	$32,473,480,944	$2,523,040,160	$5,006,850,744

*Analysis includes comparable general medical hospitals.
SOURCE: Office of Statewide Health Planning and Development, 2005.

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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 2004 alone, hospitals reported $4.9 billion in bad debt and charity care charges; the actual cost of bad debt and charity care (charges multiplied by the hospital cost to charge ratio) was $1.4 billion or 3 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 25: Bad Debt and Charity Care Charges, By Type of Control, 2004

Category	All Hospitals	Investor	Non-Profit	District	City/County
Bad Debt	$3,186,751,258	$734,847,307	$2,043,491,356	$245,798,507	$162,614,088
Charity Care	$1,687,327,356	$411,569,259	$1,011,652,845	$64,818,321	$199,286,931

SOURCE: Office of Statewide Health Planning and Development, 2005

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 (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.[93]

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

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).

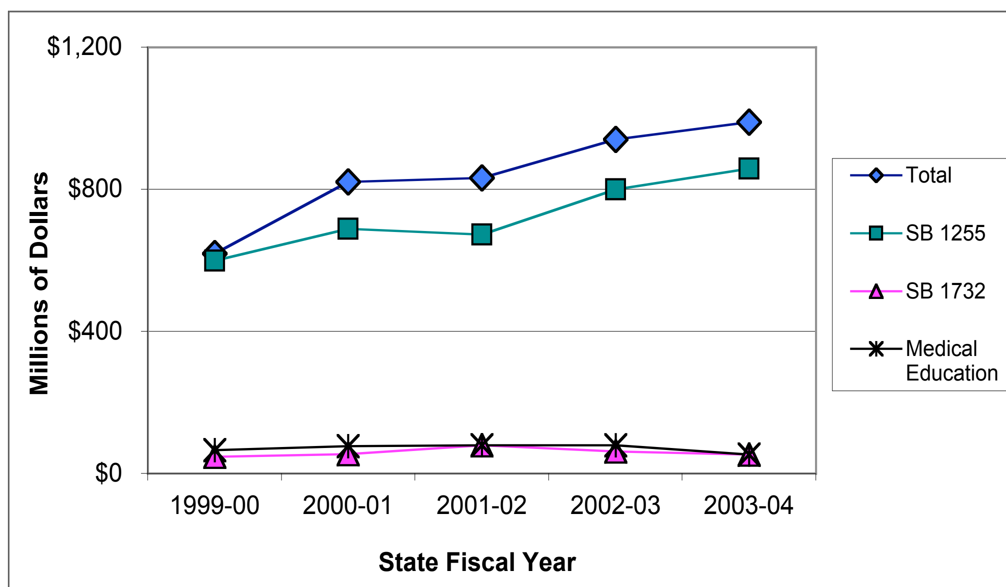
Table 26: State Supplemental Payments to California Hospitals, 1999/00-2005/06

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

Figure 13: 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 Medicaid and uninsured.[94] Qualifying hospitals generally have a low-income utilization rate of 25 percent or more.[95]

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 27: 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

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

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

California is required to demonstrate expenditures in order to receive the federal DSH match. 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 28: 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 have 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.[96] In response to the threat of losing this funding, California requested a Medi-Cal Section 1115 Hospital Waiver from the federal government.

Medi-Cal Section 1115 Hospital Waiver[97]

In September 2005, CMS awarded California with a five-year Section 1115 Medi-Cal 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.[98] SB 1100 also makes allowances for stabilization funding for increases in patient volume and rising health care costs.[99]

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

[96] Source: Medi-Cal Hospital Waiver Implementation, Understanding the 2005 Hospital Financing Waiver, Questions and Answers, August 2005, Peter Harbage and Jennifer Ryan
[97] Ibid
[98] Ibid
[99] Ibid

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).[100] The waiver now limits California's use of IGTs to matching the difference between 100 and 175 percent of a hospital's uncompensated cost. [101] It permits California to utilize certified public expenditures (CPEs) of designated public hospitals for the non-federal share of DSH payments.[102] 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.[103] 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.[104] The SNCP is budgeted in 2006-07 for $586 million (Table 29).[105] 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 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 has passed legislation, SB 1448, authored by Senator Kuehl to distribute the coverage expansion funds on a competitive grant basis.

Table 29: 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

*Estimate

**Separate public and private figures are currently unavailable

Department of Health and Human Services, 2006-07 Budget

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100 Jonathan Freedman points out that public hospital's certified public expenditures (CPEs) are have already been serving as the non-federal share for Medi-Cal FFS payments. Under the waiver, these CPEs will be doing double duty since the state will not be placing a match.

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

102 Ibid

103 Ibid

104 Ibid

105 Source: Health and Human Services, Governor's 2006-07 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, certified public expenditures (CPE), 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 are 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 2006-07 budget allocates $542 million to Virtual DSH, half of which is funded by the state.[106]

Instead 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 2006-07 is $247 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 to payments made to private hospitals. Approximately $100 million will be allocated to distressed hospitals over the lifetime of the waiver. In 2006-07, approximately $13 million is budgeted to the Distressed Hospital Fund.

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

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

FREE AND COMMUNITY CLINICS

The 808 licensed primary care clinics reporting to OSHPD represent another important component of the health care safety net in California. As of June 2006, 374 of these clinics were Federally Qualified Health Centers (FQHCs) and 75 were FQHC look-alikes.[107] In 2004, 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), 66% of patients were adults age 20 or over while 35% were children 19 and under in 2004. Sixty-six percent of patients were women in 2004. A rapidly increasing number of middle-aged adult patients between 45 and 64 visited community clinics between 1997 and 2004.

Table 30: Unduplicated Patients in Private Primary Care Clinics, * By Age, 1997-2004
(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

* Includes both community and free clinics, but not dental clinics.
SOURCE: Office of State Health Planning and Development, Annual Report of Primary Care Clinics 1997-2005.

The total number of patient visits increased 10% between 2003 and 2004, by approximately nine hundred thousand (Table 31). In 2004, 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 other payers all increased during this period. Between 1997 and 2004, clinics experienced a large decrease in the number of CHDP visits.

Table 31: Visits at Private Primary Care Clinics, * By Payment Source, 1997-2004
(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[108]	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	1834	344	429	615	393

*Includes both community and free clinics, but not dental clinics.
SOURCE: Office of State Health Planning and Development, Annual Report of Primary Care Clinics 1997-2005
Note: Other State includes Family PACT, Breast Cancer and Healthy Families

In 2004, free and community clinics received revenues totaling almost $1.6 billion (Table 32) – an increase of nearly 16%. Clinics receive funds through grants, contracts, health insurance, and

[107] Office of Statewide Health Planning and Development, 2006
[108] Managed care is included in the Medicare, Medi-Cal and Private insurance categories in the OSHPD report beginning in 2001.

direct payments for services. Grants and contracts accounted for 24% of total clinic revenues while Medi-Cal accounted for 31%. Grant funding increased from $302.1 million in 1997 to $387 million in 2004. Revenues from Medi-Cal increased from $421 million in 2003 to $494 million in 2004.

Table 32: Total Revenues at Private Primary Care Clinics, * By Payment Source, 1997-2004

(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	-

*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 1991-2004.

Each unduplicated patient used community clinics for an average of 3.2 visits in 2004 (Table 33). Medicare patients visited clinics on average 5.4 times in 2004, while uninsured patients averaged 4.1 visits. Payments for the uninsured and Medi-Cal patients represented the vast majority, 80%, of net patient revenues.

Table 33: Clinic Use and Patient Revenues, 2004

Payment Source	Patients	Visits	Average Annual Visits per Patient	Net Patient Revenues*
Total	3,445,060	11,095,232	3.2	$1,068,340,617
Uninsured	1,240,432	5,142,601	4.1	$359,519,590
Medi-Cal	1,140,072	3,900,979	2.8	$493,888,646
Healthy Families	69,055	194,637	2.8	$24,751,954
Medicare	155,625	848,091	5.4	$100,318,144
Private Insurance	220,081	615,508	2.8	$64,324,422
Other Coverage	619,815	393,416	0.6	$25,537,861

* Net patient revenue does not include grants and contracts.
SOURCE: OSHPD, Annual Report of Primary Care Clinics, 2004.

The average payment for each encounter differs considerably across payers. Reflecting the cost-based reimbursement received by Federally Qualified Health Centers (FQHCs), CMSP/MISP and Medi-Cal produced the highest average revenue per visit at $133 and $127 respectively in 2004 (Table 34). Programs such as EAPC and CHDP only paid between $65 and $71 per encounter. Clinics experienced a substantial increase in payment rates from private insurance between 1997 and 2004. The categories of county, self-pay and the state Family PACT program are the largest components of clinics' revenues for uninsured patient visits.

Table 34: Average Revenues Per Visit at Private Primary Care Clinics, By Payment Source, 1997-2004

Year	Average FFS	Medicare	Medi-Cal	CHDP	MISP	CMSP	EAPC	Other State	Private Insurance	Self-Pay
1997	$56	$66	$78	$46	$48	$58	$41	$53	$54	$36
1998	$58	$67	$81	$42	$34	$69	$43	$59	$60	$36
1999	$60	$77	$86	$46	$23	$75	$42	$67	$58	$41
2000	$64	$72	$89	$51	$31	$78	$47	$65	$70	$48
2002	$87	$137	$115	$64	$116[109]		$68	$78	$89	$52
2003	$89	$126	$121	$64	$116[110]		$68	$64	$95	$52
2004	$110	$118	$127	$71	$133		$65	$70	$105	$56

* 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 1997-2004.

The uninsured account for nearly 36% of free and community clinic patient visits – about .8 annual visits per California uninsured resident. County payments amount to nearly 30% of clinics' net patient revenues for uninsured patients; a number of counties, however, do not reimburse clinics for their care to the uninsured. In 2004, free and community clinics' uncompensated care for the uninsured (cost of uninsured visits minus uninsured revenues) was $117 million or 11% of clinics' net patient revenues (Table 35).[111]

Table 35: Clinics Uninsured Revenues, 2004

Total Uninsured Revenues	County	Self Pay	Family PACT	EAPC	CHDP	Breast Cancer
$359,519,590	$103,098,793	$66,377,324	$128,808,033	$38,011,157	$16,320,266	$6,584,147

SOURCE: OSHPD, Annual Report of Primary Care Clinics, 2004.
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 three 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 clinic to clinic, county to county and hospital to hospital.

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[109] CMSP and MISP data were reported in one combined category in the OSHPD report.
[110] CMSP and MISP data were reported in one combined category in the OSHPD report.
[111] We multiplied costs per visit by uninsured visits minus uninsured revenues.

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