A Summary of Health Care Financing for Low-Income Individuals in California, 1997 to 2002

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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.

Given the $26 to $36 billion budget shortfall for California in the SFY 2002-3 and 2003-4 budgets, 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 determine the potential 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. Our target audience is state policy makers, advocates, health care providers, and the public.

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

Annually, researchers at the University of California, Berkley and 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.

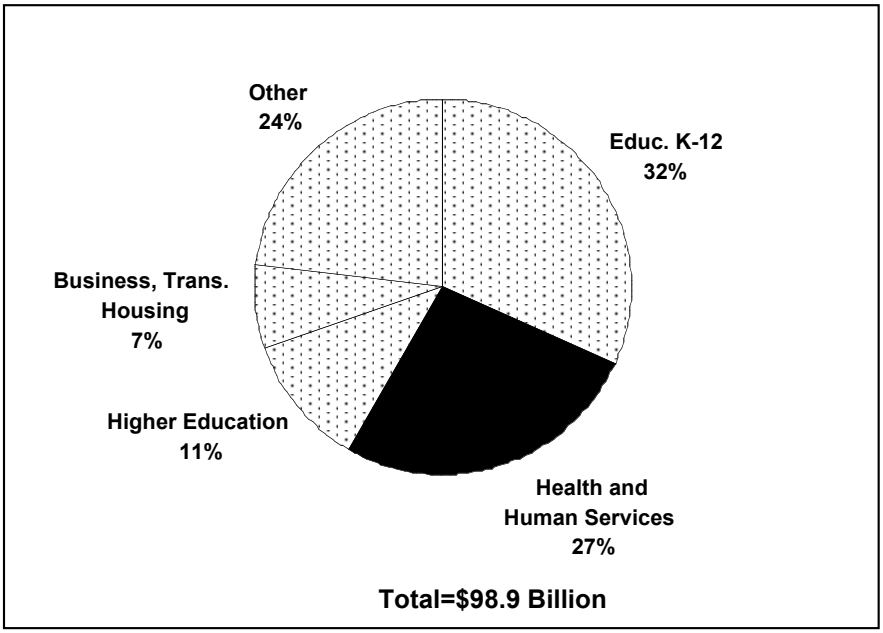
ITUP would like to thank the various officials from the Department of Health Services (DHS), the Managed Risk Medical Insurance Board (MRMIB), the California Association of Public Hospitals and the California Primary Care Association who provided valuable data and reviewed earlier drafts of this report. Unless otherwise noted, the figures reported in this document represent expenditures from the state's budgetary perspective.

For additional copies of the report or additional information, please contact Lucien Wulsin, Jr. at 310/828-0338.

OVERVIEW OF STATE BUDGET

Total state expenditures in the 2002-03 budget are expected to be $98.9 billion. This figure includes revenues from the state general fund ($76.7 billion), special funds ($19.4 billion), bond funds ($2.8 billion). In aggregate, spending for health and human services accounts for 27 percent of the total state budget in SFY 2002-03 (Figure 1). It is the second largest budget category, trailing only spending for kindergarten through 12 th grade education.

Figure 1: Expenditures by Department as a Percentage of the Total State Budget, SFY 2002-03



SOURCE: Department of Finance, California State Budget 2002-2003.

General Fund expenditures for health and human service programs are projected to increase by 3.3 percent during the current budget year. The net increase is driven by caseload and cost increases and offset by reductions to certain programs.

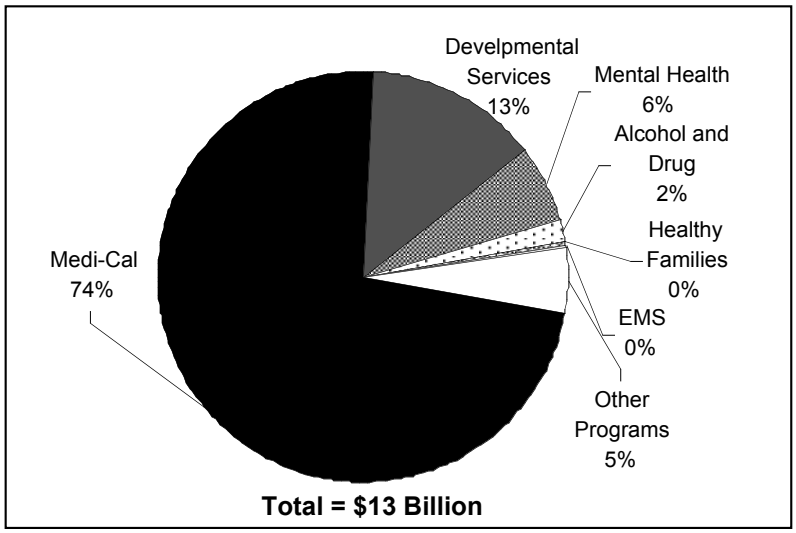
The final budget contains a number of funding changes in the health sector for the current fiscal year. It provides $51 million in federal funds to counties, other than Los Angeles, for anti-bioterrorism activities. Los Angeles County received federal payments directly for that purpose. The budget also provides $8.8 million to implement the Child Health and Disability Prevention (CHDP) Gateway program to facilitate the enrollment of low-income uninsured children into Medi-Cal and Healthy Families programs.

Despite these modest increases in funding, the Health and Human Services Agency received the largest cuts in funding of all departments under the Governor's veto message. The $177 million in cuts represents nearly 80 percent of the Governor's final expenditure reductions for all departments. The Governor's decision to delay implementation of the Healthy Family expansion to parents accounts for a large share of these reductions.

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 2002-03



SOURCE: Department of Finance, Governor's Budget Summary.

After several years of modest growth, Medi-Cal spending growth accelerated between 2000-01 and 2001-02 and is expected to increase to $26.9 billion in the current fiscal year. (Table 1) About $10.1 billion of the total comes from the state's General Fund. Expenditure growth is due in part to significant growth in Medi-Cal enrollment, which is projected to increase by 415,000 or 6.8 percent in the current fiscal year. In addition, the real cost per enrollee grew, fueled by growth in pharmaceuticals, nursing facilities, and inpatient hospital services. (Medi-Cal Policy Institute, 2002)

Beyond Medi-Cal, In-Home Support Services and Regional Centers for the Developmentally Disabled (funded in part by Medi-Cal) comprise the next largest health budget items accounting for $2.6 billion and $2.2 billion, respectively. Spending for both programs doubled between 1997-98 and 2002-03. The Healthy Families program is projected to spend more than $650 million in the federal and state funds due to enrollment growth. Realignment allotments grew from $1.1 billion to $1.5 billion during this period.

Table 1: Major Health Expenditures by the State of California,* SFY1997-2003

State Fiscal Year	Medi-Cal	In-Home Support Services	Regional Centers for Developmentally Disabled	Realignment Allotments	Healthy Families
1997-98	$18,311,800,000	$1,195,300,000	$1,167,900,000	$1,114,853,000	N/A
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	$1,430,734,000	$549,600,000
2002-03	$26,920,000,000	$2,608,200,000	$2,215,500,000	$1,517,390,000	$651,500,000

* 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 account for a portion of total spending.

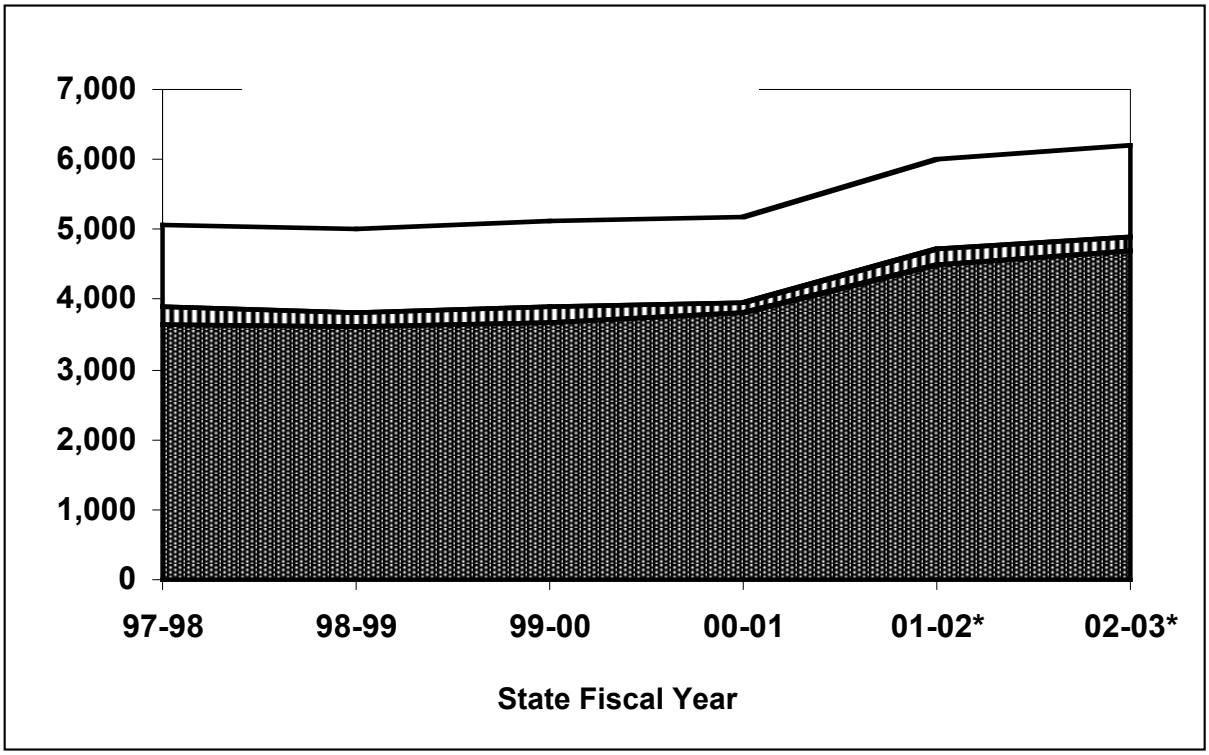
SECTION 1: HEALTH INSURANCE COVERAGE OF LOW-INCOME CALIFORNIANS

THE MEDI-CAL PROGRAM

Medi-Cal Enrollment

Between 1997-98 and 2000-01, total Medi-Cal enrollment increased slightly from 5.1 million to 5.2 million. Between 2000-01 and 2001-02 enrollment grew to 6.1 million. It is projected to grow to 6.5 million during the current fiscal year. (Figure 3) Enrollment growth is due to eligibility expansions and simplifications in the enrollment process enacted over the past few years. The majority of Medi-Cal beneficiaries are families and children. Although the aged and disabled comprise a small percentage of total beneficiaries, they account for the majority of Medi-Cal spending.

Figure 3: Medi-Cal Enrollment by Eligibility Category, 1997-98 to 2002-03



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

As of June 2002, there were more than 6.1 million persons enrolled in the program. Medi-Cal enrollment among welfare families declined from 2.6 million in 1997-98 to 1.6 million in 2001-02. (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 289,000 to 135,000. These enrollment declines, however, were more than offset by gains in coverage under section 1931(b). Coverage for undocumented immigrants declined between 1997-98 and 2000-01, but rebounded in 2001-

02. Enrollment for long-term care beneficiaries remained steady at 70,000, accounting for just over 1 percent of all Medi-Cal beneficiaries.

Table 2: Overview of Medi-Cal Enrollment, By Eligibility Category, 1997-98 to 2002-03
(In Thousands)

State Fiscal Year	Total	Cat.-Linked	Low-Income Families	SSI/SSP	Cat.-Related	Medically Needy	1931(b)	Long-Term Care	Women/ Children	200% Poverty	133% Poverty	100% Poverty	Medically Indigent	Undoc. Immig.
1997-98	**5,089**	**3,685**	2,582	1,103	**617**	548	-	69	**552**	132	93	38	289	**235**
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	1,200	**2,437**	254	2,183	70	**489**	135	109	110	135	**226**
2002-03*	**6,500**													

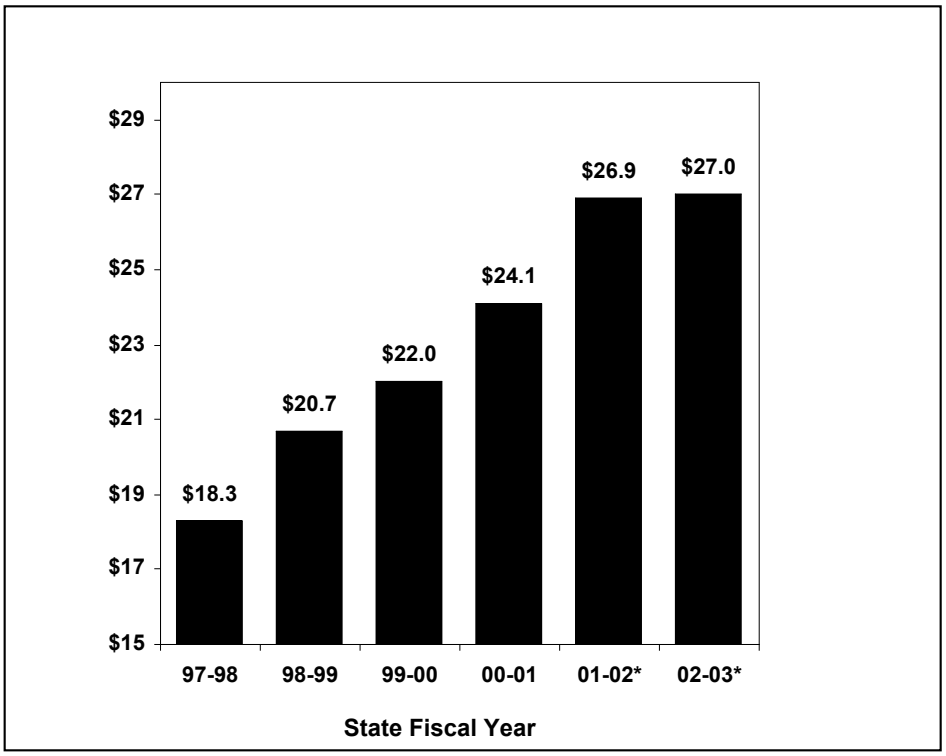
* Estimated.
SOURCES: Department of Health Services. Medi-Cal Beneficiary Profile and The Medi-Cal Policy Institute, 2002.

Due to the categorical and income eligibility requirements for adults, more than half (53 percent) of Medi-Cal beneficiaries are children under age 20. Reflecting the racial diversity of the state, Medi-Cal beneficiaries are predominantly people of color. Nearly half (46.9 percent) are Latino. Another 11.7 percent of beneficiaries are African American. Whites comprise only 23.9 percent of all Medi-Cal beneficiaries. (Medi-Cal Policy Institute, 2002)

Medi-Cal Spending

Total federal and state Medi-Cal expenditures are projected to increase to $27.0 billion in 2002-2003. (Figure 4) This represents a 50 percent increase from 1997-98.

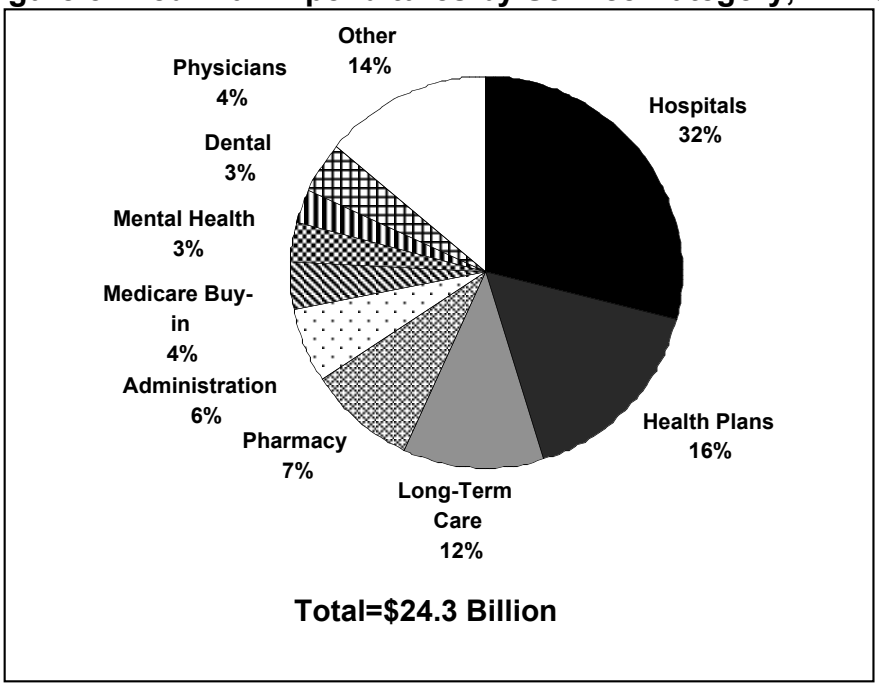
Figure 4: Total Federal and State Medi-Cal Expenditures, 1997-98 to 2002-03



* Estimated.
SOURCE: Department of Health Services and California State Budget 2002-03.

Reflecting the diverse health needs of the populations that it covers, Medi-Cal spending pays for a variety of services. Payments to hospitals represent the largest share of Medi-Cal expenditures, accounting for 29 percent of total. (Figure 5) Payments to health plans comprise the next largest expenditure at 16.3 percent. Long-term care facilities (11.9 percent) and pharmacies (8.9 percent) also received substantial funding through Medi-Cal. Administrative costs account for 6 percent of total Medi-Cal spending.

Figure 5: Medi-Cal Expenditures by Service Category, FY 2000-01



SOURCES: California Department of Health Services and The Medi-Cal Policy Institute, 2002.

Average Medi-Cal expenditures vary significantly for different groups of beneficiaries. In 1998, Medi-Cal spent $940 per child each year compared to $1,600 for their parents. In contrast, Medi-Cal spent $6,400 for each elderly enrollee and $7,800 per disabled enrollee. Individuals living in long-term care facilities can spend more than $40,000 per year.

Retention

Overall, more than three-quarters (77 percent) of all Medi-Cal beneficiaries remained enrolled in the program twelve months later. (Table 3) Retention data suggest that those individuals who are most likely to use medical services are also most likely to remain on the program. For example, nearly all (91 percent) Medi-Cal beneficiaries who are enrolled through Supplemental Security Income (SSI/SSP) remained covered. The majority of cash assistance families (80 percent), long-term care (72 percent), and aged, blind and disabled beneficiaries (68 percent) were still enrolled after twelve months. Retention rates were much lower for low-income families where four in ten (39 percent) beneficiaries were enrolled after one year. Only 13 percent of individuals enrolled in share of cost Medi-Cal remain enrolled after 12 months.

Table 3: Medi-Cal 12-Month Retention Rates for Major Aid Categories, 1994-1998

Starting Year	All	SSI/SSP	Long-Term Care	Cash Assistance Families	M/C Only Families	M/C Only Aged, Blind, and Disabled	Share of Cost	Miscellaneous
1994	75%	90%	72%	78%	35%	64%	8%	18%
1995	73%	90%	73%	75%	36%	70%	9%	10%
1996	60%	86%	63%	66%	24%	54%	3%	10%
1997	72%	91%	73%	71%	37%	65%	11%	35%
1998	77%	91%	72%	80%	39%	68%	13%	40%

SOURCE: DHS Annual Managed Care Statistical Reports.

Managed Care

Between 1996 and 2001, enrollment in Medi-Cal managed care doubled from 1.3 million to 2.8 million (Table 4). Reflecting the implementation of the state's "two-plan model" in 12 counties, enrollment in counties operating under this system grew from 130,000 to more than 2.0 million in 2001. The number of enrollees in the geographic managed care (GMC) system increased from 145,000 to 318,000 with the implementation of GMC in San Diego County in 1998. Enrollment in the state's eight County Organized Health Systems (COHS) increased from 338,680 in 1996 to 459,000 in 2001. During this period, Prepaid Health Plans (PHPs) and Primary Care Case Management (PCCM) systems were phased out.

Table 4: Medi-Cal Enrollment by Type of Managed Care Plan, 1996-2001
(In Thousands)

Year	Total	FFS	Total Managed Care	COHS	GMC	PCCM	PHP	2-PLAN
1996	5,410	4,128	1,282	339	145	72	538	128
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

SOURCE: DHS Annual Managed Care Statistical Reports.

MANAGED RISK MEDICAL INSURANCE BOARD (MRMIB) PROGRAMS

Healthy Families

From its inception in June 1998, enrollment in Healthy Families grew to 559,000 by 2001-02. (Table 5) Total expenditures for the program in that year were $549 million. Enrollment among children is expected to grow to 624,000 by the end of the current fiscal year. These projections account for the impact of the CHDP Gateway program and delayed implementation of the expansion to parents. As of August 2002, 587,000 children were enrolled in the program.

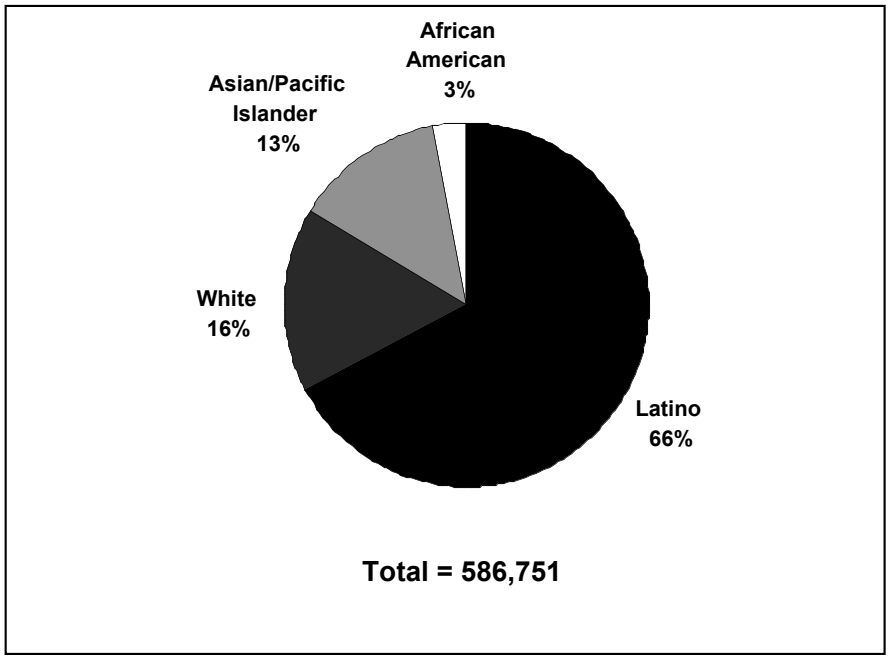
Table 5: Healthy Families Enrollment and Expenditures, SFY 1998-2003

State Fiscal Year	Enrollment	Expenditures
1998-1999	128,000	$59,379,000
1999-2000	297,000	$211,800,000
2000-2001	455,000	$400,078,000
2001-2002	559,000	$549,618,000
2002-2003*	624,000	$651,488,000

*Projected.
SOURCE: California Department of Finance.

Healthy Families is an ethnically diverse program. Two in three beneficiaries are Latinos. Less than one in five (16 percent) beneficiaries is white, 13 percent are Asian/Pacific Islander and only 3 percent are African American. The majority of Healthy Families beneficiaries reside in one of five Southern California counties (Los Angeles, Orange, San Diego, San Bernardino, and Riverside).

Figure 5: Ethnicity of Healthy Family Subscribers, August 2002



SOURCE: MRMIB website accessed October 2002

Managed Risk Medical Insurance Program (MRMIP*)*

MRMIP offers insurance to individuals with health conditions, who cannot afford or obtain private health insurance. In September 2001, 16,598 people subscribed to the program. (Table 6) Only 5 individuals enrolled in August 2002 because current enrollment exceeds the cap of 14,658. Another 1,586 people are currently on a waiting list to enroll.

Half of MRMIP subscribers are between 50 and 65 years old. Whites comprise a disproportionate share of MRMIP subscribers compared to their percentage of the total state population. The majority of subscribers (10,945) are enrolled with Blue Cross. Kaiser and Blue Shield are the other private health plans participating in MRMIP.

Table 6: MRMIP Enrollment, By Demographic Characteristics, September 2002

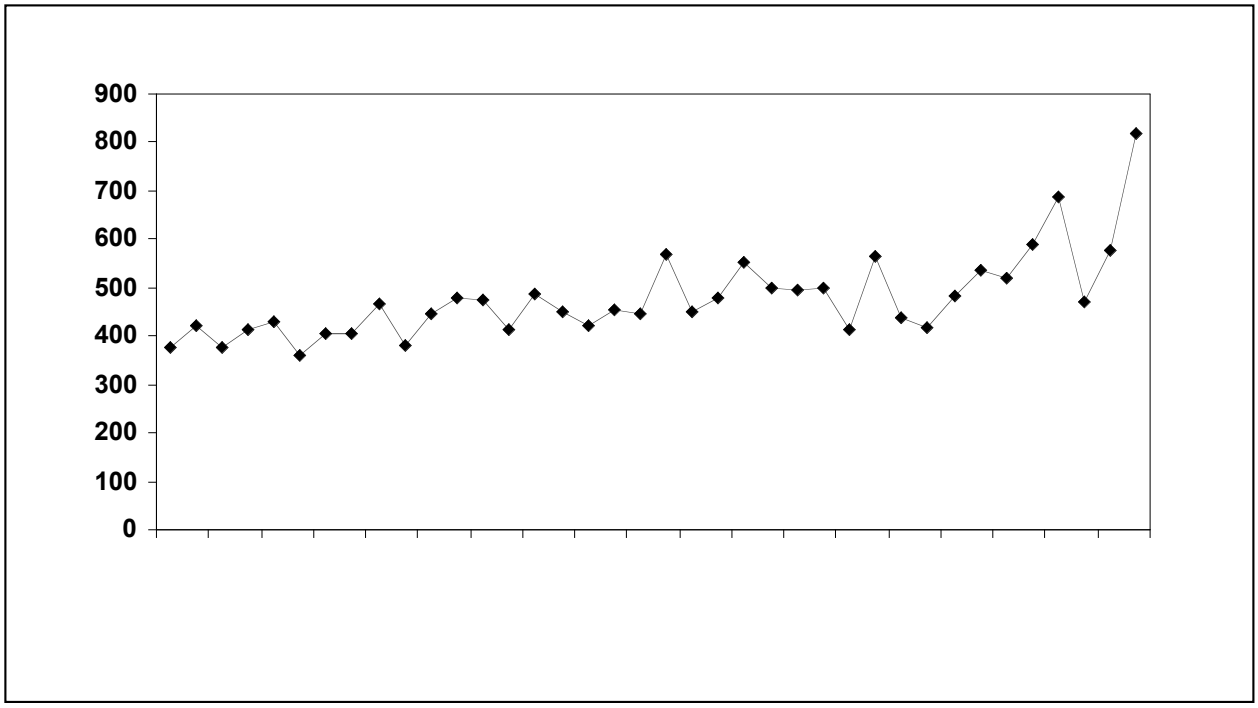
Category	Number
Total	**16,598**
Subscribers	15,608
Dependents	990
Health Plans	
Blue Cross	10,945
Kaiser	3,730
Blue Shield	1,878
Contra Costa	45
Total	**16,598**
Race/Ethnicity	
White	12,183
Other	1,792
Asian/Pacific Islander	1,079
Latino	847
African American	515
American Indian	50

SOURCE: MRMIB website accessed in October 2002.

Access for Infants and Mothers (AIM)

AIM provides insurance coverage to pregnant women and infants with incomes below 300 percent of the Federal Poverty Level who do not qualify for Medi-Cal or Healthy Families. Before July 2001, 47,489 women and infants had enrolled in the program. Between July 2001 and 2002, an additional 7,500 women enrolled in AIM, an average of more than 600 women per month. (Figure 6)

Figure 6: New AIM Enrollment, by Month 1999-2002



SOURCE: MRMIB website accessed in October 2002.

Since July 2001, 40 percent of new beneficiaries have been Latina, 29 percent were White, and 21 percent were Asian/Pacific Islander. Approximately half of women subscribed to a Blue Cross health plan and one-quarter were enrolled in Health Net. Reflecting the higher income limits for this program, the majority of women participating in AIM live in families with annual incomes between $30,000 and $45,000.

PRIVATE HEALTH INSURANCE COVERAGE[1]

Employer Coverage

- In 2001, 13.0 million Californians received health insurance through their employer, about two-thirds of the under 65 population. (California Health Interview Survey, 2002)

- Sixty-six percent of California businesses offered health insurance in 2001, a substantial increase from 48 percent in 1999. Yet even among firms that offer coverage, not all employees are covered.
  - Overall, 79 percent of workers are eligible for coverage.
  - When offered coverage, most California workers (84 percent) accept it.
  - Only 2 percent of individuals decline coverage because they did not want it; most reported that they had access to coverage elsewhere.

- Among firms that offer insurance, part-time and temporary workers are not likely to be eligible for coverage. Only one-half (49 percent) of part-time workers and 11 percent of temporary workers were eligible for insurance.

- Nearly all employers with more than 200 employees offer health insurance. The offer rate is much lower among small business. Sixty-one percent of businesses with 3-9 employees in California offer health insurance.

- Small low-wage firms, where more than one in three workers earn less than $20,000 annually, are less likely to offer coverage. One-third (35 percent) of low-wage firms with less than 200 employees offer coverage to their employees compared to 75 percent of high-wage, small firms.

- About half (48 percent) of California workers who have insurance through their employer are enrolled in an HMO. One in four workers (26 percent) are enrolled in a PPO.

- Large employers in California with more than 200 employees are likely to offer employees a choice in health plans, with four in five offering more than one plan. Only 20 percent of small employers offers workers a choice of plans.

- More recent national data suggest that fewer small employers are offering coverage during the current economic downturn. Only 54 percent of small businesses offered coverage in 2002 down from 59 percent in 2001. In addition, employers faced 13 percent premium increases in 2002.

Individual Coverage

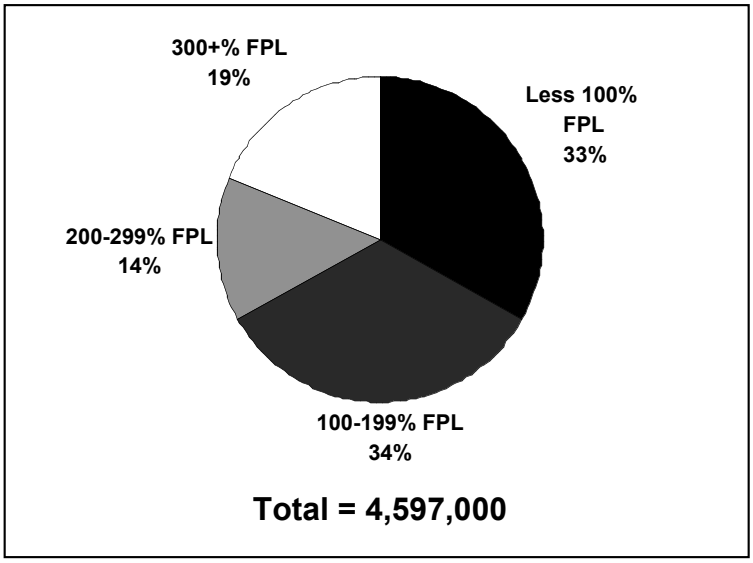
- In 2001, approximately 1.3 million people in California purchased health insurance directly from private health plans. The individual insurance market accounts for about 6.5 percent of the non-elderly population. (California Health Interview Survey, 2002)

[1] Information on employer-based health insurance was obtained from the Kaiser/HRET California Employer Health Benefits Survey, March 2002 and Kaiser Family Foundation/HRET National Employer Health Benefits Survey, September 2002.

UNINSURED POPULATION

Despite the presence of public and private health insurance programs, 16 percent of Californians are uninsured. In 2001, 4.6 million Californians under age 65 lacked health insurance. This total included 1.1 million children less than 20 years old and 3.5 million adults between 20 and 64. Low-income individuals with incomes below 200 percent of the Federal Poverty Level comprise two-thirds (67 percent) of the uninsured population. (Figure 7)

Figure 7: Uninsured, by Poverty Level, 2001



SOURCE: California Health Interview Survey, 2001.

The uninsured population consists of minorities. In 2001, 2.5 million Latinos were uninsured, 56 percent of the state total. Another 440,000 Asian/Pacific Islanders had no coverage for their health expenditures. Slightly more than 1.3 million Whites were uninsured.

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

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

In California, counties are responsible for provision of health care to indigent 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 pay maintenance of effort (MOE) for indigent care. Counties can be grouped into three broad categories based on their size, location, and delivery system: 1) small, rural counties, 2) large counties with public hospitals, and 3) large counties without public 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. [2]

Between 1996-97 and 2001-02, realignment payments to counties increased by 20 percent from $1.0 billion to $1.35 billion. (Table 7) All 58 counties and three cities (Berkeley, Long Beach, and Pasadena) receive realignment funds. During this period, all 58 counties and three cities experienced 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 2001-02, Los Angeles County received $456 million, one-third of all realignment funds distributed.

Table 7: State Realignment Allotments to Selected Counties, SFY 1995-96 to 2001-02
(In Thousands)

State Fiscal Year	Total	Alameda	Los Angeles	Orange	San Bernardino	Tulare
1996-97	$1,063,381	$45,749	$374,957	$63,932	$31,089	$9,033
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*	$1,354,886	$56,623	$456,374	$80,378	$48,226	$13,749

* Estimated.
SOURCE: Office of County Health Services, Department of Health Services.

County indigent health care programs finance inpatient, outpatient, and emergency medical services for uninsured residents. Latinos comprised more than one-half (54 percent) of all indigent patients. In 1999-00, the state and all counties spent a total of $1.36 billion to provide services to 1.3 million patients. (Table 8) Los Angeles County alone accounted for more than half of all indigent patients served and total indigent care expenditures for the state. Not surprisingly inpatient stays generated significant expenditures per user. Counties

[2] For more information about the financing of health care for the uninsured in California, please see Lucien Wulsin and Janice Frates. "California's Uninsured: Programs, Funding, and Policy Options." Oakland, CA: California Health Care Foundation. July 1997.

that operated a publicly funded health care delivery system had significantly higher per patient costs than counties without a public delivery system. For example, Kern County spent more than $3,500 per indigent patient while Orange County spent only $465 per patient. Non-provider counties also had lower expenditures per inpatient user. Los Angeles had the highest expenditures per inpatient at $11,619 while Tulare County spent only $4,731.

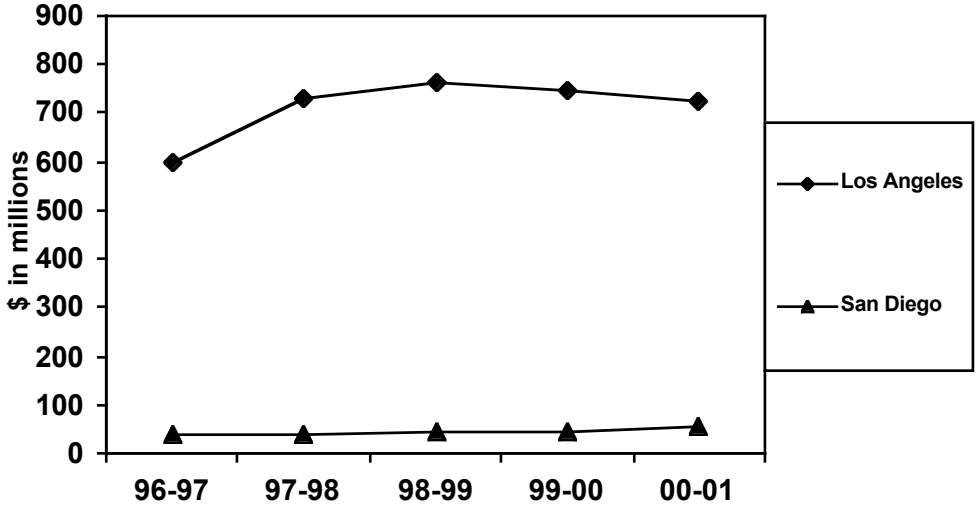
Table 8: County Indigent Health Care Clients and Expenditures for Selected Services in Selected Counties, SFY 1999-00

County	Unduplicated Patients	Expenditures per Patient	Expenditures per Inpatient	Expenditures per Outpatient	Expenditures per Emergency Service Patient	Total Expenditures
All Counties	**1,341,800**	**$1,040**	**$9,843**	**$525**	**$379**	**$1,398,000,000**
Los Angeles	701,000	$1,063	$11,619	$500	$368	$744,000,000
San Francisco	67,300	$1,131	$9,827	$568	$350	$76,000,000
Santa Clara	72,500	$1,040	$10,574	$426	$740	$75,000,000
Orange	103,300	$465	$4,744	$246	$443	$48,000,000
San Diego	52,000	$886	$7,889	$451	$514	$46,000,000
Kern	5,700	$3,512	$10,938	$1,669	$677	$20,000,000
Fresno	17,900	$927	$4,888	$461	$207	$17,000,000
Tulare	4,200	$1,581	$4,731	$848	$387	$6,600,000

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

County expenditures for the indigent increased at very different rates in different counties between 1996-7 and 2001-2. (Figure 8) Although indigent care spending was highest in Los Angeles County, little growth occurred from 1997-8 to 2000-01. San Diego County's reported expenditures grew by 36 percent from 1996-7 to 2000-01.

Figure 8: Total County Indigent Expenditures for Los Angeles and San Diego Counties 1996-97 to 2001-02



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

County Medical Services Program (CMSP)

The County Medical Services Program (CMSP) funds both inpatient and outpatient medical services provided to low-income persons in 34 small, rural counties. In order to qualify for CMSP, individuals must be uninsured medically indigent adults, earning less than 200 percent of FPL and not eligible for Medi-Cal.

Between 1997-98 and 2002-03, total funding for the CMSP increased from $183 million to $215 million, and individual revenue sources changed considerably. (Table 9) During this period, realignment funds increased as a percentage of total funds from 67 percent in 1997-98 to 79 percent in 2002-03. Third-party payments also increased dramatically from $2 million to $14.7 million. County funding remained constant at $5.5 million and hospital settlements declined from $28 to $20 million. Due to increases in other funding, state general funds were deferred for the current fiscal year, but funds were authorized for the next five years. Proposition 99 funds also have been phased out. Proposition 99 levied a $.25/pack tax on tobacco products in 1988. The proceeds paid for health care for the uninsured.

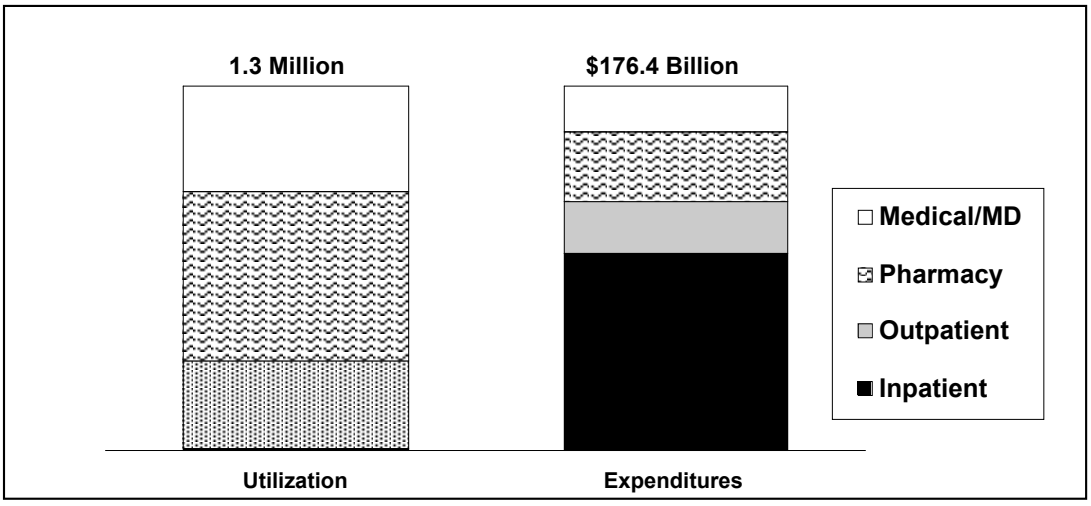
Table 9: Sources of Revenue for County Medical Services Program (CMSP), 1997-98 to 2002-03 (In Thousands)

State Fiscal Year	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

* Approved budget.
SOURCE: Legislative Analyst's Office.

In 2000, CMSP provided 1.3 million total visits with total expenditures of $176.4 billion. (Figure 9) The majority of CMSP funds paid for hospital care. Although there were only 10,600 hospital inpatient stays, they accounted for more than one-half of total CMSP expenditures.

Figure 9: County Medical Services Program (CMSP) Utilization and Expenditures, 2000



SOURCE: County Medical Services Program, Department of Health Services.

California Healthcare for Indigent Program (CHIP)

Financial support for indigent medical services for children and adults in the 24 largest counties is provided through realignment and the California Healthcare for Indigents Program (CHIP) while an additional 32 rural counties receive funds through the Rural Health Services (RHS) program. Revenues from Proposition 99 provide the bulk of funds for CHIP. CHIP and RHS 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;
- provide follow-up medically necessary treatment to eligible children.

State payments to counties under CHIP declined significantly from $164 million in 1997-98 to $67.6 million in 2002-03 as an increasing portion of Proposition 99 funds were shifted to other health programs. (Table 10) All counties experienced sizeable reductions in CHIP funding. Wide variation in CHIP allocations persisted with counties that operate publicly funded hospitals receiving relatively larger allocations proportionate to their population size. For example, Los Angeles County received nearly half ($31 million) of all CHIP payments in SFY 2002-03 while Lake County received less than 0.2 percent of CHIP funds ($96,000).

Table 10: California Healthcare for Indigent Program (CHIP) Allotments to Selected Counties, SFY 1997-8 to 2002-03

(In Thousands)

State Fiscal Year	Total	Alameda	Los Angeles	Orange	San Bernardino	Tulare
1997-98	$163,592	$7,897	$72,932	$7,918	$6,358	$2,122
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	$67,596	$3,298	$31,593	$2,704	$2,780	$725

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

Rural Health Services (RHS) Program

In total, 32 counties receive appropriations for RHS, which also is administered by the Office of County Health Services within DHS. After substantial augmentation in SFY 1998-99, total funding for rural health services declined to $2.1 million in 2002-03. (Table 11) All counties experienced reductions in funding during this period. In 2002-03, the five most populated rural counties received nearly half (51 percent) of RHS funding. The remaining rural counties received very modest payments under the program, with Alpine County receiving less than $1,000 annually.

Table 11: Rural Health Services (RHS) Allocations to Selected Counties, SFY 1997-8 to 2002-03

(In Thousands)

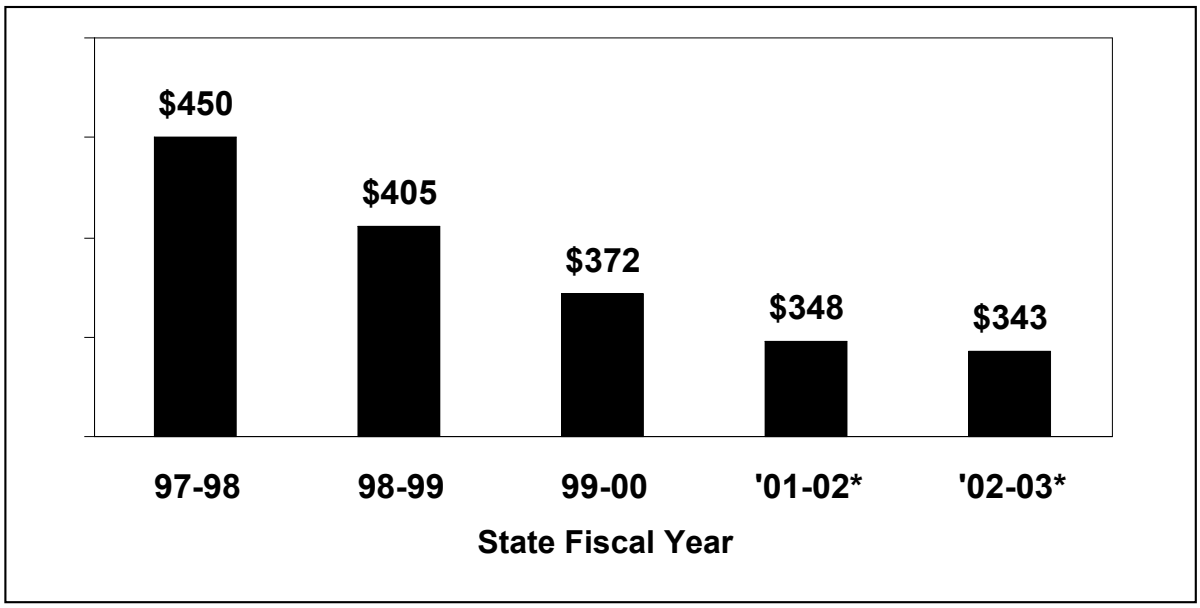
Year	Total	Butte	Humboldt	Imperial	Shasta	Solano	Sonoma
1997-98	$2,779	$255	$164	$120	$265	$318	$404
1998-99	$6,484	$503	$328	$297	$481	$780	$943
1999-00	$2,456	$190	$143	$124	$238	$263	$427
2000-01	$2,977	$217	$143	$147	$201	$370	$466
2001-02	$2,525	$190	$117	$124	$172	$311	$394
2002-03	$2,123	$161	$97	$99	$158	$260	$338

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

Tobacco Revenues

Revenues from the taxation of tobacco products are used to support multiple health programs in the state. As noted above, Proposition 99 levied a tax of $.25 per pack of cigarettes, dedicating the revenue to fund the delivery of health care services to the uninsured. Proposition 99 revenues have declined from SFY 1989-90 due to reductions in the sale of cigarettes in the state. This tax is expected to produce $343 million in special funds in 2002-03. (Figure 10)

Figure 10: Proposition 99 Revenues, SFY 1997-98 to 2002-03



*Estimated.

SOURCE: Legislative Analyst's Office and Department of Finance.

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: Managed 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), which promotes healthcare accessibility through

leadership in analyzing California's healthcare infrastructure, promoting a diverse and competent healthcare workforce, providing information about healthcare outcomes, assuring the safety of buildings used in providing healthcare, insuring loans to encourage the development of healthcare facilities, and facilitating development of sustained capacity for communities to address local healthcare issues. CHIP receives the largest, but declining portion of Proposition 99 funding. (Table 12)

Table 12: Proposition 99 Allotments, by Health Program, 1997-98 to 2002-03
(In Thousands)

State Fiscal Year	Total Spending	BCEDP	Clinic Grants	CHDP	CMSP Expansion	CHIP	RHS	MRMIP	AIM	OSHPD
1997-98	$526,012	$0	$17,764	$47,878	$12,107	$161,041	$2,779	$35,021	$39,914	$1,899
1998-99	$493,018	$0	$14,208	$49,291	$9,983	$146,387	$6,484	$46,033	$37,499	$1,837
1999-00	$496,825	$11,660	$7,653	$55,160	$5,693	$83,483	$2,456	$42,764	$45,796	$1,047
2000-01	$428,454	$9,000	$7,653	$59,882	$5,693	$84,819	$4,935	$45,000	$56,218	$998
2001-02*	$450,628	$11,200	$7,653	$63,300	$5,693	$74,917	$4,935	$40,000	$63,184	$1,047
2002-03*	$410,378	$12,700	$7,653	$17,500	$5,693	$67,596	$4,935	$40,000	$71,625	$1,047

* Estimated.
SOURCE: Legislative Analyst's Office and Department of Finance.

In 1998, California participated in the national tobacco settlement with 41 other states and several cities. The Legislative Analyst's Office estimates that between $369 million and $446 million will be paid to California as a result of the settlement. (Table 13) Thus, the national tobacco settlement will roughly double the amount of tobacco-related funds available to the state for the next 25 years. Counties and cities throughout the state are receiving additional revenue directly as a condition of the settlement.

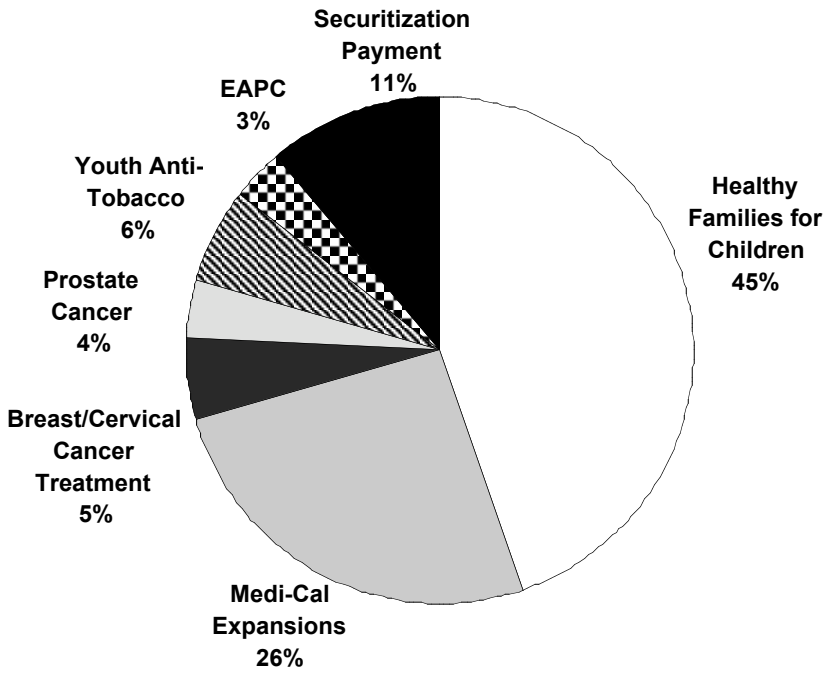
Table 13: Estimated Annual Tobacco Settlement Payments to California, 1998-2025

Year	Revenue
1998	$153,000,000
1999	$0
2000	$409,000,000
2001	$373,000,000
2002	$445,000,000
2003	$446,000,000
2004-07*	$386,000,000
2007-18*	$369,000,000
2018-25*	$441,000,000

* Annual amount.
SOURCE: Legislative Analyst's Office.

In 2002-03, $538 million in Tobacco Settlement Funds will be available for various health programs. This figure includes $64 million carried over from the previous year. Nearly half of the settlement funds will be used to fund the Healthy Families program for children living in families with incomes between 100 and 250 percent of FPL. (Figure 11) About one-quarter of the funds will be used to pay for Section 1931 (b) coverage expansions and breast and cervical cancer treatment under Medi-Cal. A portion of the funds will be used for state-funded breast and prostate cancer programs, youth anti-tobacco programs, Expanded Access to Primary Care (EAPC) clinics, and the Access for Infants and Mothers (AIM) program. The 2002-03 budget issues a $2.4 billion bond backed by Tobacco Settlement Fund revenues. As a result, $62 million of the revenues from the Tobacco Settlement Fund are committed to service debt payments in 2002-03 and $190 million for 22 years thereafter.

Figure 11: California's Tobacco Settlement Expenditures, by Program, SFY 2002-03



Total = $538 Million

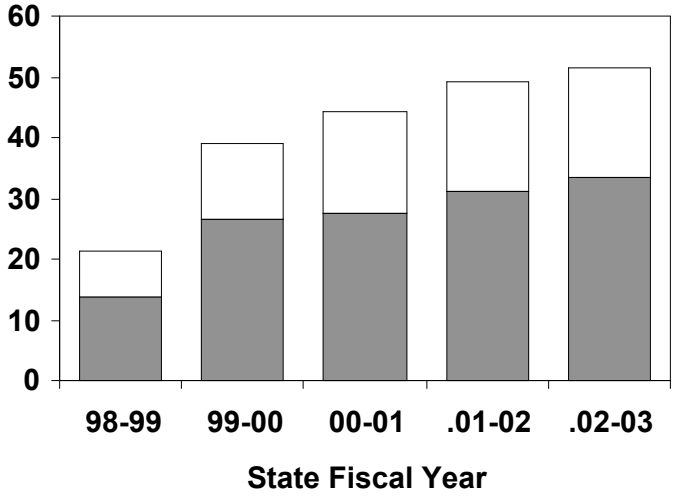
SOURCE: Department of Finance, California State Budget.

OTHER STATE HEALTH CARE PROGRAMS

Cancer Control

Although they pale in comparison to Medi-Cal in terms of the number of beneficiaries and expenditures, there are many other state-funded programs that address the specific health needs of particular populations. State spending for cancer control programs expanded dramatically between 1997-98 and 2001-02. Appropriations for the Breast Cancer Preventive Health Services program increased from $14 million to $33 million. (Figure 12) Likewise funding for the cancer control program increased from $7 million to $18 million during this period.

Figure 12: State Expenditures for Breast Cancer Prevention and Cancer Control, SFY 1998-99 to 2001-02



SOURCE: Department of Finance, California State Budget.

In 2000-01, state programs funded 230,000 breast cancer screens, 63,000 cervical cancer screens and breast cancer treatment for 2,100 women. (Table 14)

Table 14: Low-Income Women Receiving Breast and Cervical Cancer Screening in California, 2001-02

Program	Breast Cancer Screens	Cervical Cancer Screens	Breast Cancer Treatment
National Breast and Cervical Cancer Early Detection	23,000	23,000	-
Breast Cancer Early Detection	207,000	-	-
Family Pact	-	40,000	-
Breast Cancer Treatment	-	-	2,100
Totals*	**230,000**	**63,000**	**2,100**

* Women can receive both breast and cervical cancer screening; so the number of women who were screened through these screening programs is 270,000.
SOURCE: Legislative Analyst's Office.

Family PACT

Created in 1996-7, Family PACT provides comprehensive family planning services to eligible low income men and women. It is federally financed through a Medicaid 1115 waiver.

Immunization and Tuberculosis Control

Between 1998-99 and 2002-03, funding for the immunization assistance program increased from $38 million to $49 million. (Table 15) 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 15: 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

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. Reimbursements for medical treatment of conditions identified in health screens performed through local Child Health and Disability Prevention programs in small counties are made through the OCHS' Children's Treatment Program. Despite ongoing statewide efforts to increase the number of children with health insurance, expenditures for CHDP increased by 60 percent from $84 million in 1998-99 to $129 million in 2001-02. (Table 16) CHDP financed an estimated 1.9 million screenings at an average cost of $68 per screening.

In his initial 2002-03 budget, Governor Davis proposed the elimination of CHDP and transition of all current users into Medi-Cal and Healthy Families, using presumptive eligibility. After considerable debate, the Governor and the legislature agreed to retain the CHDP program, but to implement a "gateway" to enroll all eligible, uninsured children into Medi-Cal and Healthy Families. This approach should result in significant savings in CHDP expenditures.

Table 16: State Expenditures for the Child Health and Disability Prevention Program, 1998-99 to 2002-03

State Fiscal Year	Expenditures
1998-99	$83,876,000
1999-00	$84,596,000
2000-01	$118,251,000
2001-02	$129,122,000
2002-03	$58,000,000

SOURCE: Legislative Analyst's Office and Department of Finance.

California Children's Services (CCS)

California Children's Services (CCS) provides comprehensive case management, health care, and therapy to financially eligible children under 21 with special health care needs. The majority of care provided to these children is funded through Medi-Cal and Healthy Families programs. Enrollment in CCS grew 55 percent from 211,000 in 1996 to 328,000 in 2000. (Table 17) Total expenditures for the program grew from $576 million to $762 million while the average cost per user declined from $2,730 to $2,324.

Table 17: Users and Total Expenditures for California Children's Services, 1996-2000

Year	Users	Expenditures	Cost Per User
1996	210,920	$575,848,844	$2,730
1997	233,182	$562,153,198	$2,411
1998	259,712	$602,297,235	$2,319
1999	305,694	$698,055,244	$2,284
2000	327,527	$761,644,533	$2,324

SOURCE: Department of Health Services.

Only three in four (77 percent) CCS beneficiaries are eligible for Medi-Cal or Healthy Families. In addition to payments through Medi-Cal and Healthy Families, the state and counties contribute to CCS. Contributions from the state General Fund increased from $59 million to $101 million between 1998-99 and 2002-03, reflecting growth in CCS caseload. (Table 18)

Table 18: State General Fund Expenditures for California Children's Services, 1998-99 to 2001-03

State Fiscal Year	Expenditures
1998-99	$58,567,000
1999-00	$55,888,000
2000-01	$75,767,000
2001-02	$92,000,000
2002-03	$101,000,000

SOURCE: Department of Health Services and Department of Finance.

Genetically Handicapped Persons Program (GHPP)

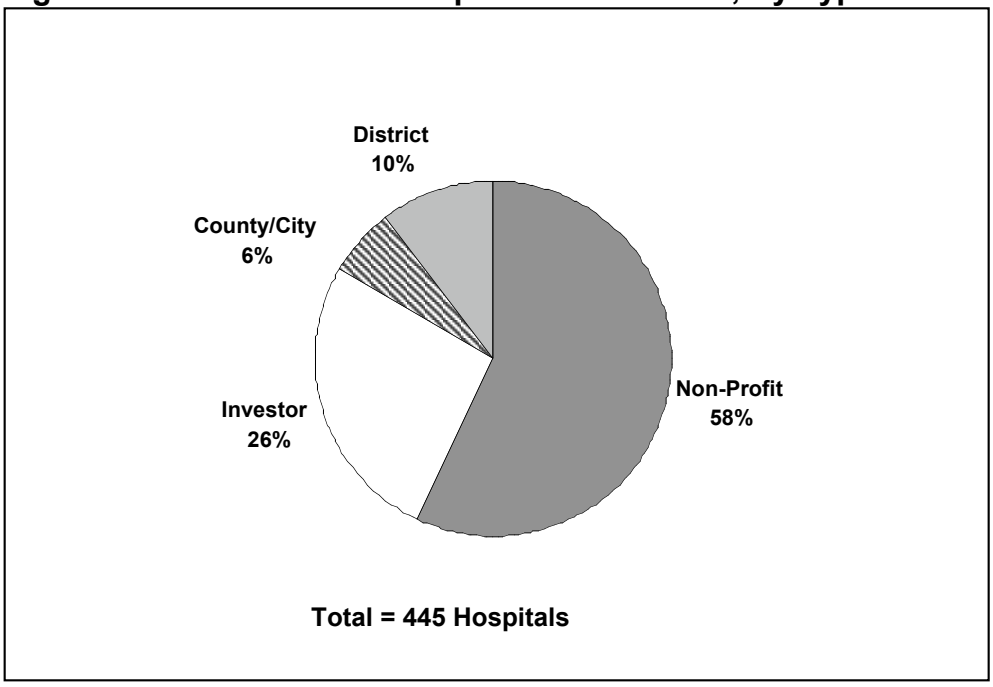
The Genetically Handicapped Persons Program (GHPP) provides health coverage for Californians 21 years old and older with specific genetic diseases including cystic fibrosis, hemophilia, sickle cell disease, and certain neurological and metabolic diseases. GHPP also serves children with GHPP-eligible medical conditions who are not financially eligible for CCS. Funding for GHPP remained at $36 million in 2002-03. This figure reflects an increase of $6 million due to caseload increases. This increase will be fully offset by the collection of rebates on blood factor products and the implementation of program efficiencies.

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 445 acute care hospitals in California, more than half (58 percent) are non-profit, one-quarter (26 percent) are investor-owned, and the remaining are county, city or district hospitals. (Figure 13) The number of investor-owned hospitals declined from 159 to 116 between 1997 and 2000.

Figure 13: Distribution of Hospitals in California, By Type of Control, 2000



SOURCE: Office of Statewide Health Planning and Development

In 2000, hospitals in California had nearly 17 million inpatient days. (Table 19) Medicare paid for 39 percent of all inpatient days while Medi-Cal and third-party paid for one-quarter of all days. Overall, county indigent programs accounted for only 3 percent of inpatient days. While Medicare accounted for the largest percentage of all inpatient days in the state in 2000, private insurance accounted for the most outpatient and emergency room visits. Medi-Cal patients had the longest average length of stay among payers at 7.2 days, reflecting skilled nursing facility use in hospitals. Managed care programs report shorter lengths of stay.

Table 19: Hospital Use, By Payment Source, 2000

Source of Payment	Inpatient Days	Average Length of Stay	Outpatient Visits (Including ER)	ER Visits
Total	16,746,547	5.7	42,599,298	14,367,510
Medicare	39%	6.2	27%	20%
Medi-Cal	28%	7.2	19%	27%
County Indigent	3%	5.5	5%	11%
Private Insurance	25%	4.2	40%	33%
All Other Payers	5%	6.1	9%	9%

SOURCE: Office of Statewide Health Planning and Development

The payer mix, however, is different for the four types of hospitals. At city and county hospitals, three-quarters (74 percent) of inpatient days were reimbursed by Medi-Cal or county indigent programs. (Table 20) In contrast, three-quarters (72 percent) of the patient days at investor-owned hospitals were covered by either Medicare or third-party coverage. Non-profit hospitals mirror the distribution of payers for all hospitals in the state. California hospitals also provided 38 million outpatient visits, of which 8 million occurred in emergency departments.

Table 20: Hospital Utilization,* by Payer and Type of Control, 2000

Type of Utilization	All Hospitals	Non-Profit	Investor	City/County	District
Total Inpatient Days	15,063,809	10,307,421	1,963,529	1,581,248	1,211,611
Medicare	5,908,801	4,344,536	906,143	186,904	471,218
Medi-Cal	4,000,321	2,230,747	458,214	852,786	458,574
County Indigent	522,313	185,118	16,410	312,521	8,264
Third-Party	3,863,140	3,035,609	516,079	132,975	178,477
All Other	769,234	511,411	66,683	96,062	95,078
Outpatient Visits					
Total Outpatient Visits	37,589,519	27,360,281	2,172,776	5,540,827	2,515,635
Emergency Room Visits	8,005,418	5,435,458	835,033	1,020,592	714,335

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

In 2000, hospitals generated $30.4 billion in net patient revenues and spent $30.7 billion. (Table 21) Three-quarters of revenues were generated by inpatient services and one-quarter from outpatient services. Among all hospitals, third-party payments (33 percent) and Medicare (33 percent) represent the largest source of payments followed by Medi-Cal (21 percent). County indigent care represents only 4 percent of hospitals' net revenues.

Once again, the relative importance of funding sources varies considerably across different types of hospital. Non-profit hospitals rely on a mixture of third-party, Medicare, and Medi-Cal revenues while city and county hospitals rely heavily on Medi-Cal and county indigent revenues. In contrast, more than three-quarters of the net revenues of investor-owned hospitals come from Medicare and third-party payers.

Table 21: Net Hospital Revenues,* by Type of Hospital and Revenue Source, 2000

Net Revenues	All Hospitals	Non-Profit	Investor	City/County	District
Medicare	$ 10,117,788,728	$ 7,942,438,414	$1,146,182,276	$352,562,873	$ 676,605,165
Medi-Cal	$ 6,937,481,388	$ 2,972,560,074	$ 427,647,685	$ 3,331,902,328	$ 205,371,301
County Indigent	$ 1,441,202,803	$ 247,259,721	$ 33,437,671	$ 1,150,627,993	$ 9,877,458
Third-Party	$ 10,552,864,561	$ 8,695,090,184	$ 1,008,524,320	$ 276,178,556	$ 573,071,501
Other	$ 1,529,727,509	$ 1,118,830,382	$ 211,320,560	$ 68,948,282	$ 130,628,285
Net Patient Revenue	**$30,393,835,862**	**$20,969,548,606**	**$ 2,808,648,290**	**$ 5,020,587,074**	**$ 1,595,051,892**
Total Operating Expenses	**$30,743,769,762**	**$22,150,951,888**	**$2,894,143,133**	**$4,012,363,714**	**$1,686,311,027**

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

Supplemental Hospital Payments

In addition to direct payments for services, California hospitals receive supplemental payments from a number of federal and state sources to compensate them for uncompensated care provided to the uninsured. The largest supplemental payment to hospitals is the Disproportionate Share Hospital (DSH) program under Medicaid. Overall in 2000, hospitals in the state received $1.9 billion in DSH gross payments although they only net about half of this total. (Table 22) Under California's Medicaid DSH funding formulas, the state's county, university and district hospitals pay 49 percent of these costs so the net federal payments are equal to slightly more than one-half of the total. Hospitals reported $2.4 billion in bad debt and charity care charges; the actual cost of bad debt and charity care was $1.0 billion or 3 percent of hospitals' net operating expenses.

Table 22: Hospital Utilization and Supplemental Payment, by Type of Control, 2000

Category	All Hospitals	Non-Profit	Investor	City/County	District
Bad Debt	$1,559,654,769	$1,033,002,398	$220,099,231	$207,442,497	$99,110,643
Charity Care	$852,659,567	$616,908,298	$55,568,829	$145,947,151	$34,235,289
DSH Funds Received	$1,972,466,704	$551,979,001	$ 77,431,577	$1,340,833,313	$ 2,222,813
Net DSH Funds Received	$986,233,352	$275,989,501	$38,715,789	$670,416,657	$1,111,407

SOURCE: Office of Statewide Health Planning and Development.

Federal DSH payments to California hospitals declined from roughly $1.1 billion in 1999 to $0.9 billion in 2003, as a result of caps established in the Balanced Budget Act of 1997 and amended in the 2000 Budget Act. (Table 23) The University of California hospitals receive roughly 10 percent of public net DSH payments and contribute about 10 percent of intergovernmental transfers (IGT). The 2002-03 budget increases the fee the state charges public and University of California hospitals for the Disproportionate Share Hospital (DSH) program by $55 million, resulting in General Fund savings. These same hospitals are also subject to new federal regulations that reduce the so- called upper payment limit (UPL), which will reduce hospital revenues by an estimated $250 million or more in federal funds each year beginning March 19, 2002.

Table 23: DSH Payments in California, 1999-2003

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	$503,265,859	$486,993,451	$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

SOURCE: California Association of Hospitals and California Association of Public Hospitals

Beyond DSH, California provides additional state funds to hospitals through a number of mechanisms. In total, these supplemental payments accounted for slightly less than $1 billion in 1996-97. They grew to $1.6 billion in 2000-01, which generated net federal revenues of $821 million. (Table 24) The largest source of these additional payments is SB 1255 (Emergency Services and Supplemental Payment Fund), which accounted for more than three-quarters of supplemental payments each year during this period. Publicly owned facilities contribute the intergovernmental transfers to finance supplemental payments.

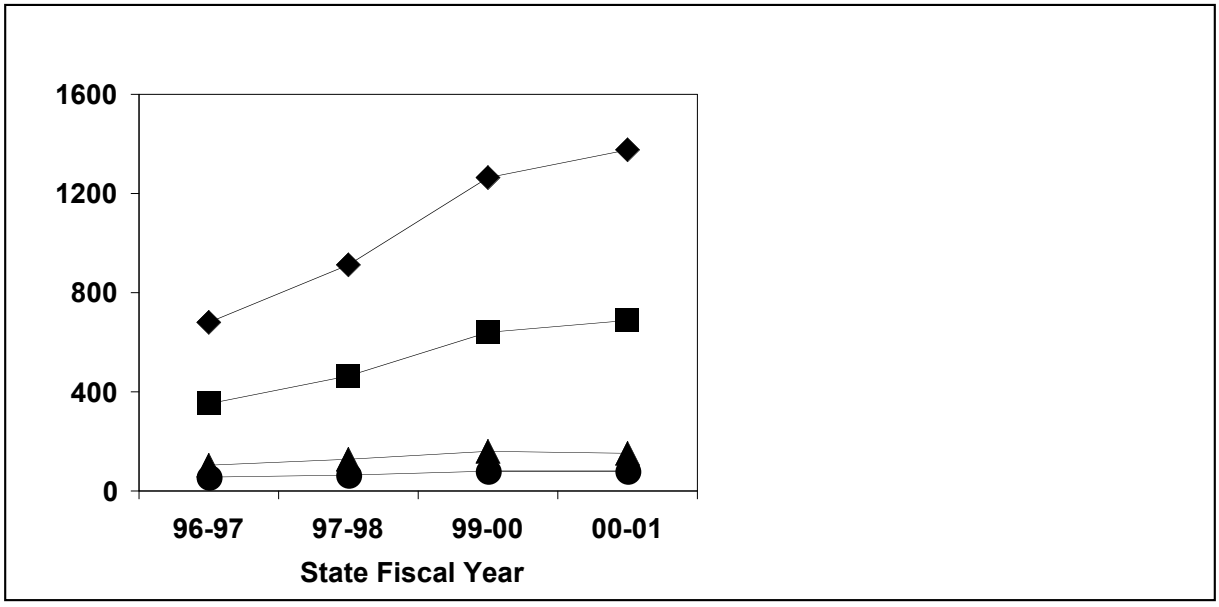
Table 24: State Supplemental Payments to California Hospitals, 1996/97-2000/01

Year	Total Payments	SB 1255	SB 1732	1115 Waiver	Medical Education	AB 761
1996-97	$ 971,149,000	$ 684,321,000	$ 29,828,000	$152,000,000	$ 105,000,000	$ -
1997-98	$ 1,098,400,000	$ 909,620,000	$ 59,700,000	$ 152,000,000	$ 129,080,000	$ -
2000-01	$ 1,641,148,000	$1,377,555,000	$108,943,000	$ -	$ 154,650,000	$ 650,000

SOURCE: California Medical Assistance Commission Annual Reports and California Association of Public Hospitals.

Because of the complex matching requirements for hospitals to participate in these programs, they net only half of the payments. (Figure 14)

Figure 14: Net Supplemental Payments to California Hospitals, 1996/97-2000/01



SOURCE: California Medical Assistance Commission Annual Reports and data from California Association of Public Hospitals

FREE AND COMMUNITY CLINICS

The 732 licensed primary care clinics represent another important component of the health care safety net in California. In 1999, they provided health care services to more than 2.8 million patients in 1999, about 10 percent of the total state population. (Table 25) According to data from Office of Statewide Health Planning Development (OSHPD), roughly 62 percent of patients were adults over age 20 while 38 percent were children under 19. Nearly two in three clinic patients were women in 2000. An increasing number of middle-aged adult patients between 45 and 64 visited community clinics between 1996 and 2000.

Table 25: Unduplicated Patients in Private Primary Care Clinics,* By Age, 1996-2000
(In Thousands)

Year	Total Patients	Ages 0-1	Ages 1-19	Ages 20-44	Ages 45-64	Ages 65+
1996	2,518	116	857	1,172	258	116
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

* Includes both community and free clinics.
SOURCE: Office of State Health Planning and Development, Annual Report of Primary Care Clinics 1991-2000.

Between 1996 and 2000, the total number of patient visits remained level at 9.4 million. (Table 26 In 1999, Medi-Cal beneficiaries accounted for just over one-quarter (27 percent) of all encounters while encounters by patients who paid for care out of pocket or who did not pay for care accounted for 20 percent of all visits. The number of encounters under the EAPC program, other county programs, private insurance, and other payers all increased during this period. Between 1999 and 2000, clinics experienced increases in the number of encounters paid for by the patient and those where the patient did not pay.

Table 26: Visits at Non Profit Primary Care Clinics,* By Payment Source, 1996-2000
(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
1996	9,329	2,717	1,961	1,280	512	372	272	923	161	26	453	438	214
1997	9,097	2,527	1,672	1,364	445	408	363	746	156	170	544	490	211
1998	9,420	2,597	1,737	1,340	499	410	391	836	160	58	707	426	252
1999	9,285	2,612	1,613	1,095	437	417	431	871	171	52	742	502	315
2000	9,445	2,543	1,866	1,178	485	347	372	987	158	61	702	514	231

* Includes both community and free clinics.
SOURCE: Office of State Health Planning Development, Annual Report of Primary Care Clinics 1991-2000.

In 2000, free and community clinics received revenues totaling $1.0 billion, a 33 percent increase from 1996. (Table 27) Clinics receive funds through grants, contracts, health insurance, and direct payments for services. Grants and contracts accounted for 40 percent of total clinic revenues while Medi-Cal accounted for 23 percent. Grant funding increased from $284 million in 1996 to $401 million in 2000 while Medi-Cal revenues remained level during that period. Clinics also received substantially more revenue from their clients in 2000, nearly $65 million up from $49 million in 1999.

Table 27: Revenues at Private Primary Care Clinics,* By Payment Source, 1996-2000
(In Thousands)

Year	Total Revenues	Grants	Medi-Cal	Total State	Total County	Self-Pay	Donations	Medicare	Private Insurance	HMOs
1996	$756,028	$284,428	$208,708	$62,954	$28,210	$48,007	$38,739	$31,234	$21,676	$19,907
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

* Includes both community and free clinics.
SOURCE: Office of State Health Planning Development, Annual Report of Primary Care Clinics 1991-2000.

Users of community clinics received an average of 2.9 visits in 2000. (Table 28) Medicare patients visited a clinic 4.6 times in 2000 while the uninsured had 2.8 visits. Payments for the uninsured and Medi-Cal represented the vast majority of net patient revenues. Clinics' cost of uncompensated care for uninsured patient visits is $66 million (12% of net patient revenues).

Table 28: Clinic Use and Patient Revenues, 2000

Payment Source	Patients	Visits	Average Annual Visits per Patient	Net Patient Revenues*
Total	2,815,530	8,266,338	2.9	$538,134,000
Uninsured	1,710,983	4,725,035	2.8	$240,100,000
Medi-Cal	718,577	2,542,609	3.5	$226,844,000
Medicare	106,202	485,186	4.6	$34,878,000
Private Insurance	181,066	513,508	2.8	$36,312,000

* Net patient revenue does not include grants and contracts.
SOURCE: Office of State Health Planning Development, Annual Report of Primary Care Clinics 1991-2000.

The average payment for each encounter differs considerably across payers. Reflecting the cost-based reimbursement received by Federally Qualified Health Centers (FQHCs), Medi-Cal produced the highest average revenue per visit at $89 in 2000. (Table 29) Programs such as EAPC and CHDP only paid between $47 and $51 per encounter. Each CMSP visit generated $78 for clinics in rural counties; CMSP was a significant source of payment for clinics' care to the uninsured in rural counties. Each MISP visit only generated $31 for clinics in urban counties; MISP was not a significant source of payment for care to the uninsured in urban counties. County contracts appear to be a significant funding source for clinic care to the uninsured in urban counties. Clinics experienced a substantial increase in payment rates from private insurance and from self-pay patients between 1996 and 2000. The categories of self-pay and other state programs are clinics' largest components of revenues for uninsured patient visits.

Table 29: Average Revenues Per Visit at Private Primary Care Clinics, By Payment Source, 1996-2000

Year	Average FFS	Medicare	Medi-Cal	CHDP	MISP	CMSP	EAPC	Other State	Private Insurance	Self-Pay
1996	$51	$61	$77	$48	$41	$53	$40	$37	$50	$29
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

* Includes both community and free clinics.
SOURCE: Office of State Health Planning Development, Annual Report of Primary Care Clinics 1991-2000.