A Summary of Health Care Financing for Low-Income Individuals in California, 1998 to 2003

Lucien Wulsin, Jr., JD, Peter Long, MHS, Megan Hickey, MPP, Karen Ishimaru
Insure the Uninsured Project
www.work-and-health.org
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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 persistent state budget shortfall for California beginning in the SFY 2002-3 and recent reductions in vehicle license fees, 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 third 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.

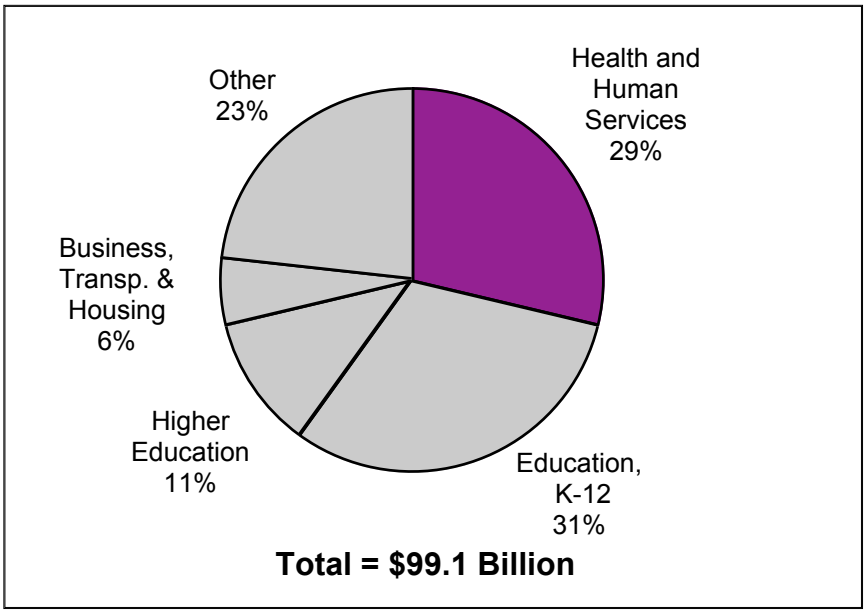
ITUP would like to thank the various officials from the Department of Health Services (DHS), the Managed Risk Medical Insurance Board (MRMIB), the California Association of Public Hospitals and the California Primary Care Association who provided valuable data and reviewed earlier drafts of this report. 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 2003-04 budget are expected to be $96.4 billion. This figure includes revenues from the state general fund ($71.1 billion), special funds ($20.5 billion) and bond funds ($7.5 billion). In aggregate, spending for health and human services accounts for 29 percent of the total state budget in SFY 2003-04, which remains unchanged in the 2004-05 budget proposal (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 Percentage of the Total State Budget, SFY 2004-05



SOURCE: Department of Finance, California State Budget 2004-2005.

General Fund expenditures for health and human service programs are projected to increase by 4.1 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.

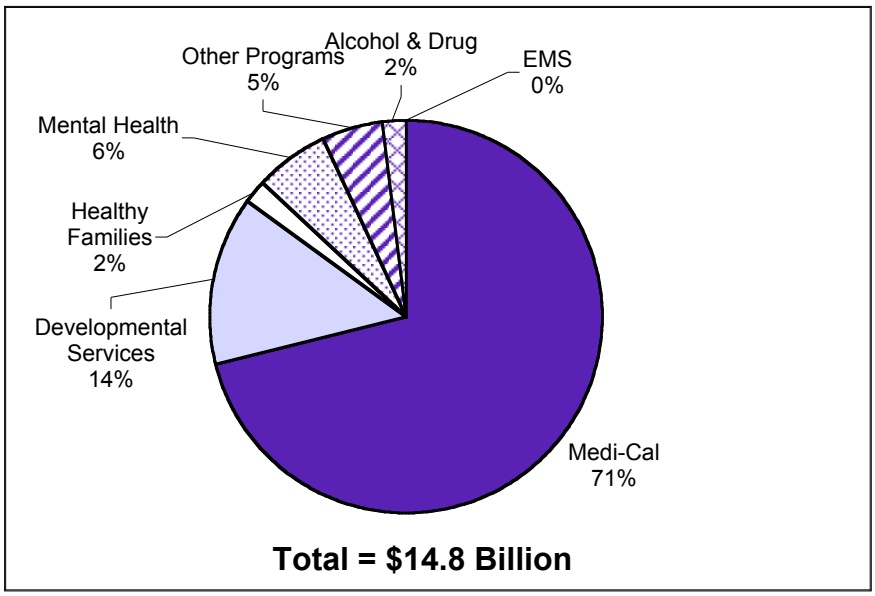
Governor Schwarzenegger has proposed further mid-year reductions in spending to reduce the state's budget deficit. He also rescinded increase in the vehicle license fee implemented under the previous administration. A portion of these funds had been used by counties to pay for health care for uninsured individuals.

The current reductions come on the heels of $177 million in cuts in the previous fiscal year. In 2002-03, the Health and Human Services Agency received the largest cuts in funding of all departments under the Governor's veto message. The delayed implementation of the Healthy Family expansion to parents accounted for a large share of these past 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 2003-04



SOURCE: LAO, California Spending Plan, 2003-2004.

After several years of modest growth, Medi-Cal spending growth accelerated beginning in 2001 and is expected to increase to $31.5 billion in federal and state funds ($11.6 billion General Fund) in the current fiscal year (Table 1). Costs per enrollee grew, fueled by growth in pharmaceuticals, nursing facilities, and inpatient hospital services (Medi-Cal Policy Institute, 2002).

After 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 $2.7 billion respectively. Spending for both programs doubled between 1998-99 and 2003-04; IHSS is proposed to be reduced by $89 million in 2005-05 by eliminating payments for caretaker relatives. The Healthy Families program is projected to spend more than $844 million in the federal and state funds due to enrollment growth that is proposed to be capped in 2004-05. Realignment allotments for county health grew very slowly from $1.2 billion to $1.5 billion during this period.

Table 1: Major Health Care Expenditures by the State of California,* SFY 1998-2004

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*	$31,545,000,000	$2,721,000,000	$2,728,000,000	$1,536,126,000	$844,307,000

*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.
Source: California Dept. of Finance, Governor's Budget Summary, 2003-04 and 2004-5.

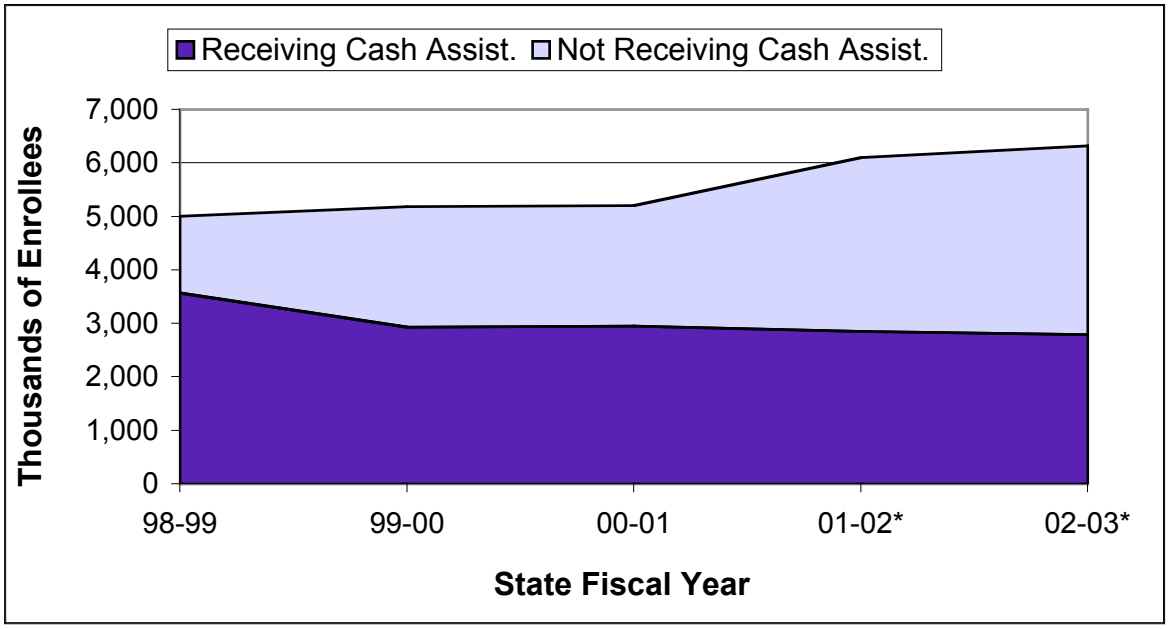
SECTION 1: HEALTH INSURANCE COVERAGE OF LOW-INCOME CALIFORNIANS

THE MEDI-CAL PROGRAM

Medi-Cal Enrollment

Between 1998-99 and 2000-01, total Medi-Cal enrollment increased slightly from 5.1 million to 5.2 million. Between 2000-01 and 2002-03 enrollment grew to 6.3 million (Figure 3). Enrollment is projected to grow to 6.5 million in 2003-04 and 6.8 million in 2004-05. Enrollment growth is due to a slow economy with large job losses combined with eligibility expansions and simplifications in the enrollment process 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.

Figure 3: Medi-Cal Enrollment by Eligibility Category, 1998-99 to 2002-03



*Estimated
SOURCE: Department of Finance, Governor's Budget Summary, 2003-2004, 2004-2005.

As of July 2003, there were more than 6.4 million persons enrolled in the program. Medi-Cal enrollment among welfare families declined from 2.4 million in 1998-99 to 1.6 million in 2002-03 (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 156,000 in 2002-03. 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, but rebounded in 2001-02 and continued to grow in the following fiscal year. Enrollment for long-

term care beneficiaries decreased slightly in 2002-03 to 67,000, accounting for just over 1 percent of all Medi-Cal beneficiaries.

Table 2: Overview of Medi-Cal Enrollment, By Eligibility Category, 1998-99 to 2003-04
(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.
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	**1,918**	254	1,594	70	**489**	135	109	110	135	**226**
2002-03	**6,321**	2,793	1,557	1,236	**2,568**	619	1,882	67	**526**	140	118	112	156	**246**

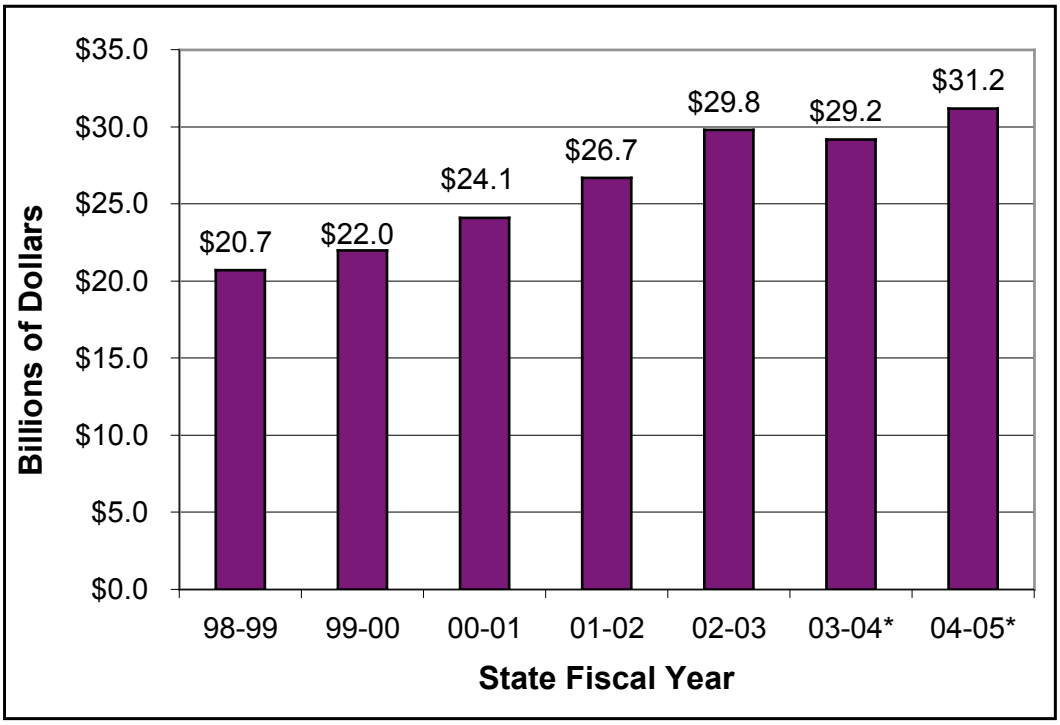
SOURCES: Department of Health Services, Medi-Cal Beneficiary Profile and The Medi-Cal Policy Institute, 2002.

Due to the categorical and income eligibility requirements for adults, more than half (51 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 (49.2 percent) are Latino. Another 11.1 percent of beneficiaries are African American. Whites comprise only 23.2 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 $31.2 billion in 2004-2005 (Figure 4). This represents a 51 percent increase from 1998-99.

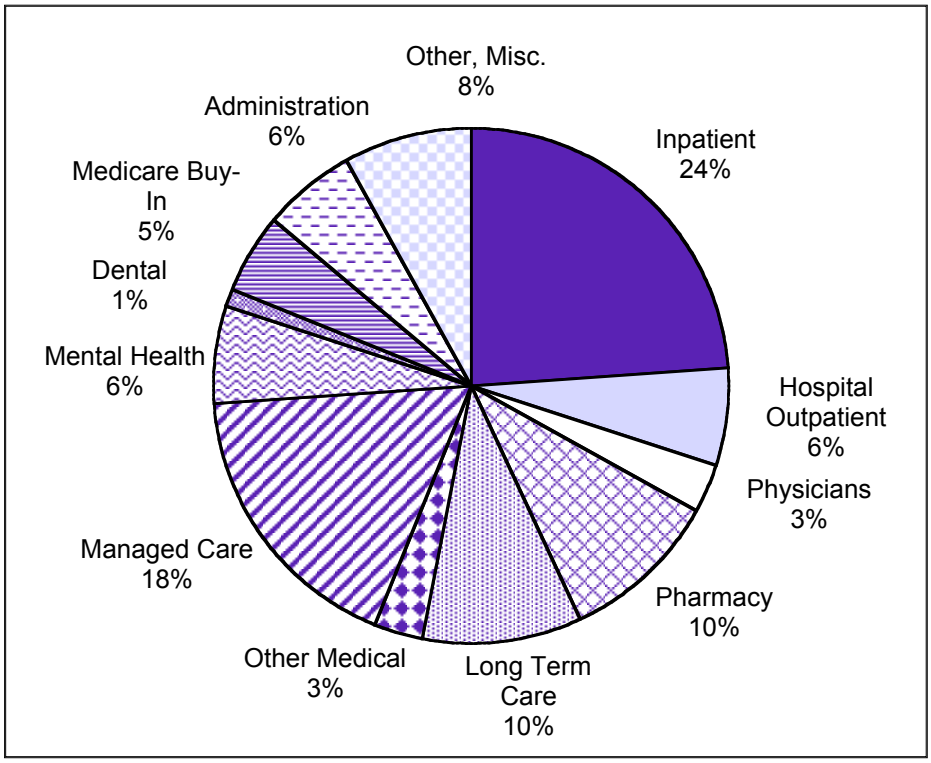
Figure 4: Total Federal and State Medi-Cal Expenditures, 1998-99 to 2004-05



*Estimated
SOURCES: Department of Health Services, Governor's Budget Summary 2002-03 – 2004-05.

Reflecting the diverse health needs of the populations that it covers, Medi-Cal spending pays for a variety of services. Inpatient costs represent the largest share of Medi-Cal expenditures, accounting for 24 percent of total (Figure 5). Payments to health plans comprise the next largest expenditure at 18 percent. Long-term care facilities and pharmacy each received 10% of Medi-Cal funding. Administrative costs account for 6% percent of total Medi-Cal spending.

Figure 5: Medi-Cal Expenditures by Service Category, FY 2003-04



SOURCES: California Department of Health Services, November 2002 Estimated Medi-Cal Spending.

Average Medi-Cal expenditures vary significantly across different beneficiary groups. Although children constitute over half of all Medi-Cal beneficiaries, expenditures in 2001 averaged only $1,229 per child compared to over $8,000 per beneficiary for the elderly and disabled due to higher costs associated with acute and long-term care services. Long-term care represented over half of the costs per beneficiary for the elderly. Most of the program spending growth has been for services to the aged and disabled.

California spends less per beneficiary than other states ($4,465 per beneficiary in 2002 compared to the national average of $6,528) due in part to low provider payment levels and a lower percentage of elderly and disabled beneficiaries.[1]

Enrollment & Retention

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. Another application tool, the One-e-App, is currently being tested in pilot program. The One-e-App will allow families to determine eligibility and apply for all health and social services programs. 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, fear that enrolling in Medi-Cal may jeopardize their chances of attaining citizenship.

[1] California HealthCare Foundation, *Medi-Cal Facts and Figures, A look at California's Medicaid Program*, January 2004.

Over three quarters of all beneficiaries (77%) remain enrolled in Medi-Cal after one year, although retention rates again differ across beneficiary groups. Only 13% of individuals who pay a share of their costs retain coverage, while 91% of SSI/SSP recipients continue coverage after a year.[2]

Managed Care

Between 1997 and 2002, 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 to more than 2 million in 2002. The number of 2002 enrollees in the geographic managed care (GMC) system increased from 143,000 to 338,000 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 in 1997 to 534,000 in 2002.

Table 3: Medi-Cal Enrollment by Type of Managed Care Plan, 1997-2002
(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

SOURCE: DHS Annual Managed Care Statistical Reports.

Access to Care[3]

Medi-Cal reimbursement rates in California are about two-thirds (65%) that of Medicare rates, compared to 81% 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 medical specialists per 100,000 beneficiaries and five surgical specialists per 100,000 beneficiaries, compared to ten and 15 per 100,000 beneficiaries, respectively, overall.

Utilization[4]

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

[2] Ibid
[3] Ibid.
[4] Ibid.

MANAGED RISK MEDICAL INSURANCE BOARD (MRMIB) PROGRAMS

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 $38,600 for a family of four). Healthy Families is jointly funded by the Federal and state governments and is administered by the Managed Risk Medical Insurance Board (MRMIB). The federal to state funding match is a 2:1 ratio. From its inception in June 1998, enrollment in Healthy Families grew to more than 620,000 in 2002-03 (Table 4). Total expenditures for the program in that year were more than $650 million. Enrollment among children is expected to grow to 727,000 by January 2004. These projections account for the impact of the CHDP Gateway program and delayed implementation of the expansion to parents. Governor Schwarzenegger has proposed capping enrollment in an effort to reduce state expenditures.

Table 4: Healthy Families Enrollment and Expenditures, SFY 1998-2004

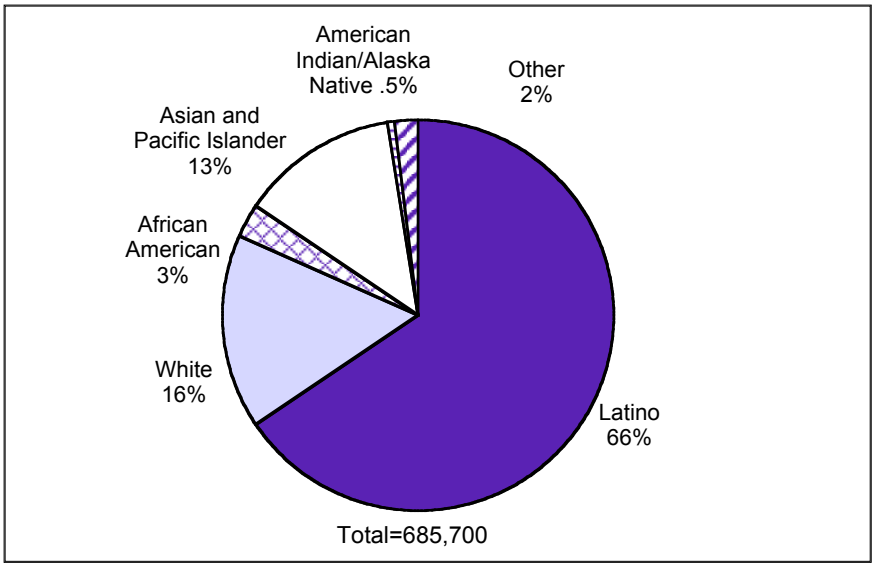
State Fiscal Year	Enrollment	Expenditures
1998-1999	128,000	$59,379,000
1999-2000	297,000	$211,800,000
2000-2001	455,000	$400,078,000
2001-2002	559,000	$549,618,000
2002-2003	624,000	$651,488,000
2003-2004*	727,000	$794,474,000
2004-2005*	737,000	$839,100,000

*Projected.

Sources: California Dept. of Finance, May Revision 2003-04, Governor's Budget Summary 2004-05

Healthy Families is an ethnically diverse program. Approximately two in three (66 percent) beneficiaries are Latinos. Approximately one in six (16 percent) beneficiaries is white, 13 percent are Asian/Pacific Islander, 3 percent are African American, and 0.5 percent are American Indian/Alaska Native (Figure 6). The majority of Healthy Families beneficiaries reside in one of five Southern California counties (Los Angeles, Orange, San Diego, San Bernardino, and Riverside).

Figure 6: Ethnicity of Healthy Family Subscribers, November 2003



SOURCE: MRMIB website accessed January 2004

Managed Risk Medical Insurance Program (MRMIP*)*

MRMIP offers insurance to individuals with health conditions, who cannot afford or obtain private health insurance. In September 2003, 7,088 people subscribed to the program (Table 5).[5]

41 percent of MRMIP subscribers are between 50 and 65 years old. Whites comprise a disproportionate share of MRMIP subscribers (66 percent) compared to their percentage of the total state population. Half of subscribers (50%) are enrolled with Blue Cross. Kaiser Permanente and Blue Shield are the other private health plans participating in MRMIP. Projected spending in SFY 03-04 is $40.1 million, a seventeen percent decrease since SFY 01-02.[6]

Table 5: MRMIP Enrollment, By Demographic Characteristics, September 2003

Category	Number
Total	**7,088**
Subscribers	6,674
Dependents	414
Health Plans	
Blue Cross	3,535
Kaiser	2,543
Blue Shield	931
Contra Costa	79
Total	**7,088**
Race/Ethnicity	
White	4,671
Asian/Pacific Islander	808
Other	744
Latino	737
American Indian	57
African American	7

SOURCE: MRMIB website accessed in January 2004.

[5] This enrollment figure reflects a 58% decrease since October 2002, due to legislation that provides commercial coverage to enrollees after 36 months of program participation.
[6] Governor's Budget, 2003-04.

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 2002, approximately 54,000 women and infants had enrolled in the program. Between July 2002 and December 2003, an additional 11,547 enrolled in AIM, an average of 964 beneficiaries per month. Total spending for SFY 02-03 was $96.4 million. Projected costs for 03-04 total $117.5 million.[7]

Table 6: AIM Enrollment July 2002-December 2003, By Demographic Characteristics

Category	Number
Total	
Subscribers	11,568
Health Plans	
Blue Cross	6,414
Health Net	2,750
Sharp	993
Kaiser	846
Other	565
Race/Ethnicity	
Latino	4,793
White	3,264
Asian/Pacific Islander	2,482
Unknown/Other	746
African American	224
American Indian	51
Income	
$20,000-$25,000	136
$25,000-$30,000	564
$30,000-$35,000	199
$35,000-$40,000	2,478
$40,000-$45,000	2,717
$45,000-$50,000	1,671
$50,000	2,070

SOURCE: MRMIB website accessed in January 2004.

Since July 2002, 41 percent of new beneficiaries have been Latina, 28 percent were White, and 22 percent were Asian/Pacific Islander. Approximately 55% of women subscribed to a Blue Cross health plan and 24% were enrolled in Health Net. Reflecting the higher income limits for this program, 45 percent of women participating in AIM live in families with annual incomes between $35,000 and $45,000 and 32 percent have annual incomes above $45,000.

[7] Legislative Analyst's Office. Analysis of the 2003-04 Budget.

PRIVATE HEALTH INSURANCE COVERAGE[8]

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 will be covered by this measure, if fully implemented.[9] The legislation faces legal challenges and a referendum before it can be put into operation.

Employer-Based 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).

- 65 percent of California businesses offered health insurance in 2002, only a slight decrease from 66 percent in 2001. Yet even among firms that offer coverage, not all employees are covered.
  - 83 percent of workers in firms that offer coverage are eligible for coverage.
  - When offered, most (87 percent) of those eligible accept coverage.
  - Only 1 percent of individuals decline coverage because they did not want it; most (66%) reported that they had access to coverage elsewhere. Twenty-one percent reject due to high share of cost.

- Among firms that offer insurance, part-time and temporary workers are not likely to be eligible for coverage. Forty-six percent of part-time workers and six percent of temporary workers were eligible for insurance. Both rates have decreased by three and five percentage points, respectively, since 2001.

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

- Over half (54 percent) of California workers who have insurance through their employer are enrolled in an HMO. Thirty 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 73 percent offering more than one plan. Only 21 percent of small employers offer workers a choice of plans.

- More recent national data suggest very little change in the number of small employers who offer coverage. Sixty-five percent of small businesses offered coverage in 2003 down from Sixty-six percent in 2002.

[8] Information on employer-based health insurance was obtained from the Kaiser/HRET California Employer Health Benefits Survey, February, 2003 and Kaiser Family Foundation/HRET National Employer Health Benefits Survey, September 2003.

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

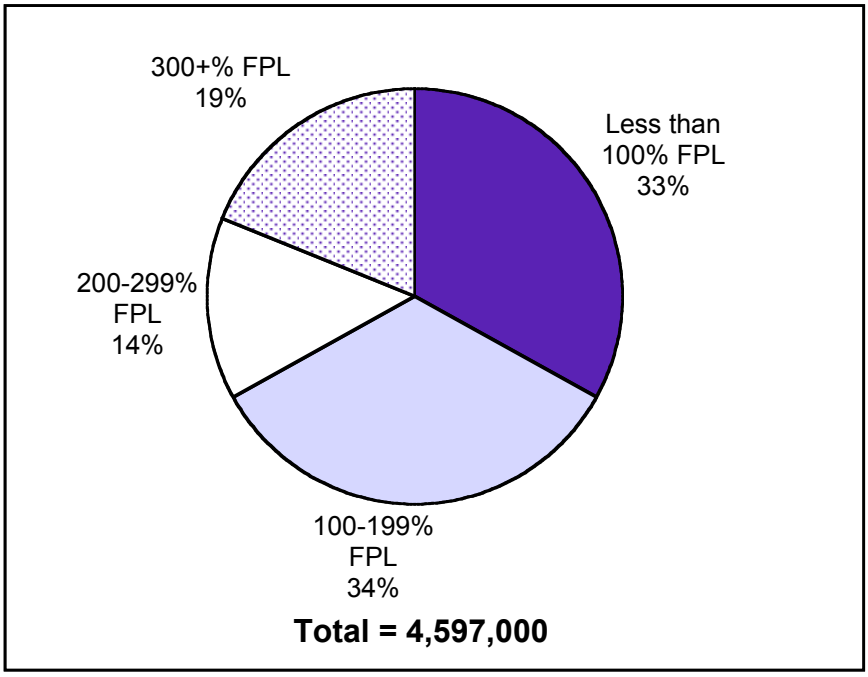
Individual Coverage

- 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)

UNINSURED POPULATION

Despite the presence of public and private health insurance programs, 16 percent of Californians are uninsured at a given time. 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 Under 65 yrs., by Poverty Level, 2001



SOURCE: California Health Interview Survey, 2002.

The uninsured population is demographically diverse. 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.

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 than the privately insured (Institute of Medicine, 2002).

The 2001 California Health Interview Survey (CHIS) measured the rate of the state's uninsured by county and region by using a sample size nearly ten 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 county of MediCal and Healthy Families enrollment, closer to the actual program enrollment at the time of the survey. CHIS reports 4.5 million uninsured at a point in time versus a total of 6.2 million uninsured at ay time during a 12-month period. The federal CPS (Current Population Survey) figure for the uninsured at a point in time is roughly equal to the CHIS uninsured over the course of a year. The most recent CPS data from October 2003 shows no significant change in California's uninsured. The next CHIS report is

due at the end of the summer of 2004. It may show a decline in employer sponsored coverage and increase in public coverage.

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 SIPP (Survey of Income and Program participation).

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 comply with a financial 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.[10] The recent rollback of increase to the vehicle license fee could limit realignment funding if it is not restored by the legislature.

Between 1997-98 and 2002-03, realignment payments to counties increased by 20 percent from $1.1 billion to $1.5 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 2002-03, Los Angeles County received $507.2 million, one-third of all realignment funds distributed statewide.

Table 7: State Realignment Allotments to Selected Counties, SFY 1997-98 to 2003-04
(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*	$1,539,498	$63,475	$507,222	$90,257	$57,943	$16,437
2003-04*	$1.475,853	$60,724	$485,253	$86,242	$55,379	$15,712

* Estimated.
SOURCE: Office of County Health Services, Maintenance of Effort Calculation.

Medically Indigent Services Program (MISP)

County indigent health care programs finance inpatient, outpatient, and emergency medical services for uninsured residents and vary by county. Medically Indigent Services Program (MISP) funds inpatient and outpatient medical services provided to low-income persons in the 24 large

[10] 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.

counties. In these counties, Latinos comprised more than one-half (53 percent) of all indigent patients. In 2000-01, MISP counties spent a total of $1.4 billion to provide services to 1.4 million patients (Table 8). Los Angeles County alone accounted for more than half of all indigent patients served and total indigent care expenditures for all MISP counties. Not surprisingly inpatient stays generated significant expenditures per user. Counties that operated a publicly funded health care delivery system had significantly higher per patient costs than counties without a public delivery system. Payor counties also had lower expenditures per inpatient user. San Francisco had the highest expenditures per inpatient at $13,600 while Tulare County spent only $7,850.

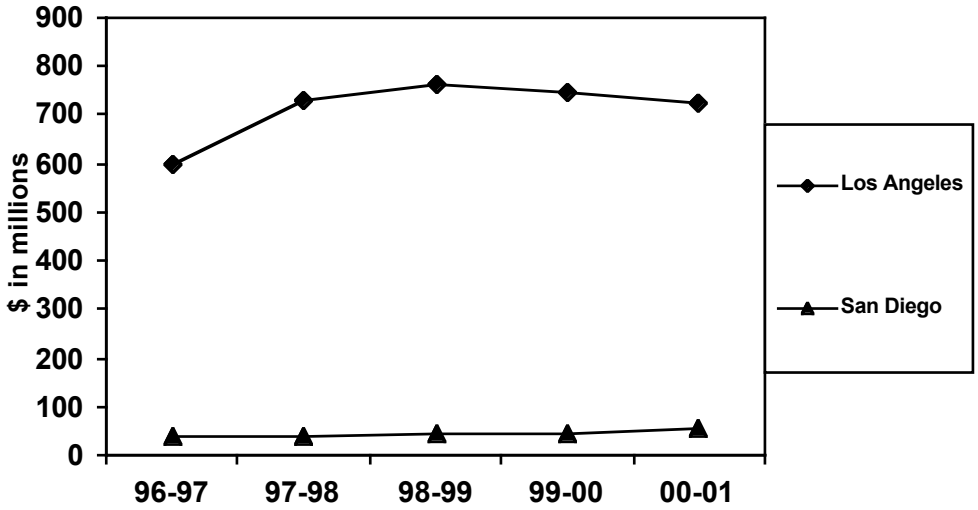
Table 8: County Indigent Health Care Clients and Expenditures for Selected Services in Selected Counties, SFY 2000-01

County	Unduplicated Patients	Expenditures per Patient	Expenditures per Inpatient	Expenditures per Outpatient	Expenditures per Emergency Service Patient	Total Expenditures
All Counties	**1,409,539**	$1,011	$10,742	$517	$355	$1,424,974,958
Los Angeles	747,244	$1,007	$12,543	$470	$366	$752,171,168
San Francisco	62,881	$1,291	$13,578	$630	$463	$81,161,731
Santa Clara	75,124	$727	$6,706	$371	$551	$54,644,781
Orange	109,267	$433	$5,841	$228	$200	$47,290,925
San Diego	51,313	$1,027	$7,784	$551	$475	$52,693,807
Kern	8,150	$2,076	$11,281	$1,031	$453	$16,917,782
Fresno	18,901	$929	$5,412	$525	$237	$17,562,982
Tulare	6,447	$1,141	$7,850	$628	$169	$7,355,847

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 1997-8 and 2000-1 (Figure 8). Although indigent care spending was highest in Los Angeles County, it actually decreased 2 percent between 1998-99 and 2000-01. San Diego County's reported expenditures grew by 25 percent from 1998-99 to 2000-01.

Figure 8: Total County Indigent Expenditures for Selected Counties 1997-98 to 2000-01



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 2003-04, total funding for the CMSP increased from $183 million to $221 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 2003-04. 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 beginning in 1988. The proceeds paid for health care for the uninsured. County fund and third party-payer information was unavailable.

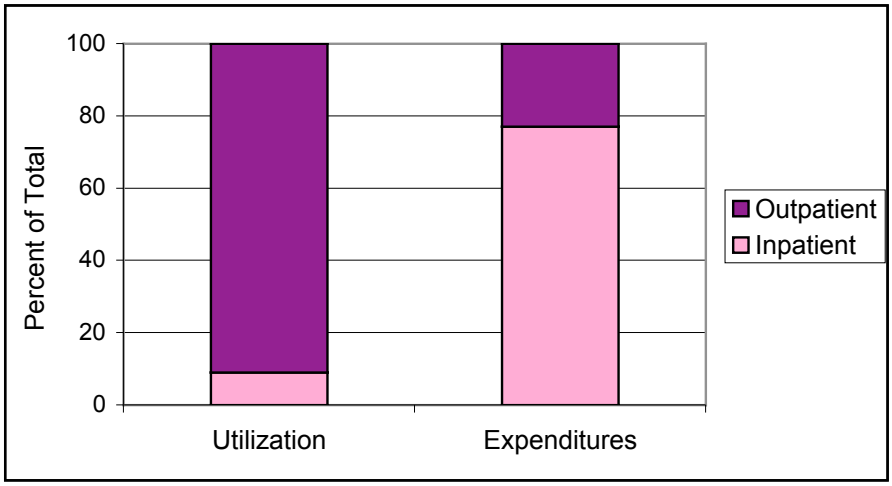
Table 9: Sources of Revenue for County Medical Services Program (CMSP), 1997-98 to 2003-04
(In Thousands)

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
2003-04*	$221,184	$175,000	$0	20,000	$0	NA	NA

* Approved budget.
SOURCE: Legislative Analyst's Office, CMSP Governing Board Budget, 2003-04.

In 2002, CMSP provided 576,500 outpatient visits and 53,703 inpatient days with a total in and outpatient expenditures of $148.6 million (Figure 9). Total CMSP expenditures of $221.4 million include spending for pharmacy and hospital physician claims. Inpatient spending accounted for more than one-half of total CMSP expenditures.

Figure 9: County Medical Services Program (CMSP) Inpatient and Outpatient Utilization and Expenditures, 2002



SOURCE: CMSP Governing Board 2002.

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 34 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 $55.7 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 and number of uninsured.

Table 10: California Healthcare for Indigent Program (CHIP) Allotments to Selected Counties, SFY 1998-99 to 2002-03

(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

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 (Butte, Marin, Shasta, Solano and Sonoma) received more than half (51 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.

Table 11: Rural Health Services (RHS) Allocations to Selected Counties, SFY 1998-99 to 2002-03

(In Thousands)

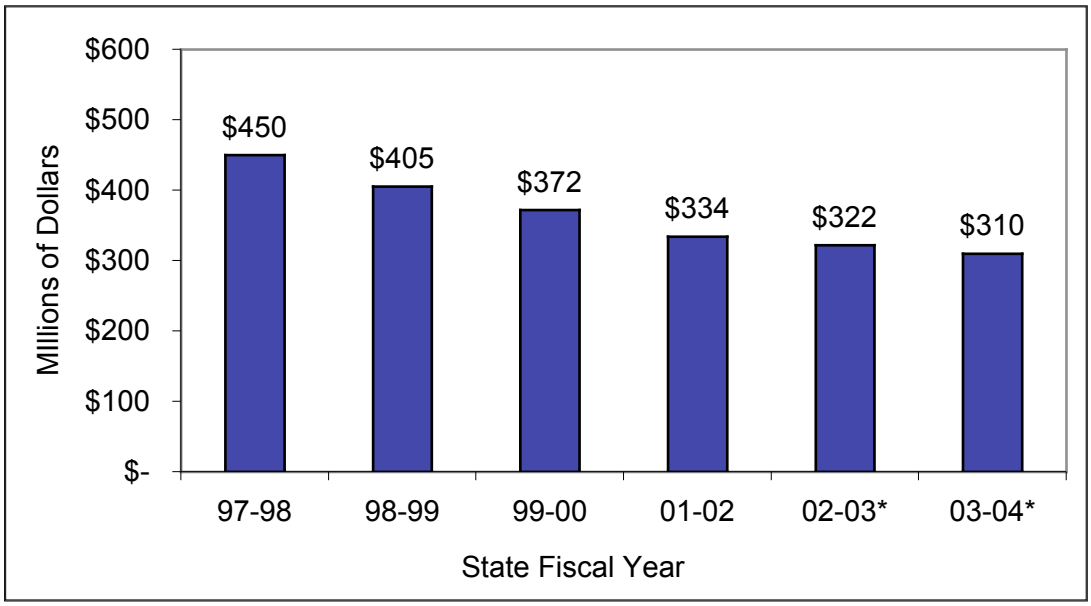
Year	Total	Butte	Humboldt	Imperial	Shasta	Solano	Sonoma
1998-99	$6,484	$503	$328	$297	$481	$780	$943
1999-00	$2,456	$190	$143	$124	$238	$263	$427
2000-01	$2,977	$217	$143	$147	$201	$370	$466
2001-02	$2,525	$190	$117	$124	$172	$311	$394
2002-03	$2,123	$162	$97	$99	$158	$260	$338

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 $310.0 million in special funds in 2003-04 (Figure 10).

Figure 10: Proposition 99 Revenues, SFY 1998-99 to 2003-04



*Estimated

SOURCE: Governor's Budget Summary 2003-2004.

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 (Table 12). The accounts dedicated to counties (CHIP and RHS) have been steadily declining, while the account dedicated to AIM has been steadily growing.

Table 12: Proposition 99 Allotments for Select Health Programs, 1998-99 to 2003-04
(In Thousands)

State Fiscal Year	Total Spending	BCEDP	CHDP	CHIP	RHS	MRMIP	AIM	OSHPD
1998-99	$493,018	$0	$49,291	$146,387	$6,484	$46,033	$37,499	$1,837
1999-00	$496,825	$11,660	$55,160	$83,483	$2,456	$42,764	$45,796	$1,047
2000-01	$428,454	$9,000	$59,882	$84,819	$4,935	$45,000	$56,218	$998
2001-02	$397,759	$11,200	$63,300	$74,917	$4,935	$40,000	$38,613	$1,032
2002-03*	$359,302	$12,700	$17,500	$67,596	$4,935	$40,000	$70,682	$1,047
2003-04*	$339,295	$15,648	$0	$46,591	$4,487	$40,000	$81,300	$1,047

*Estimated
Source: LAO, Dept. of Finance, Budget Summary 1998-2004, DHS, Cigarette and Tobacco Products Surtax Fun Expenditures and Available Revenues 2003-04.

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

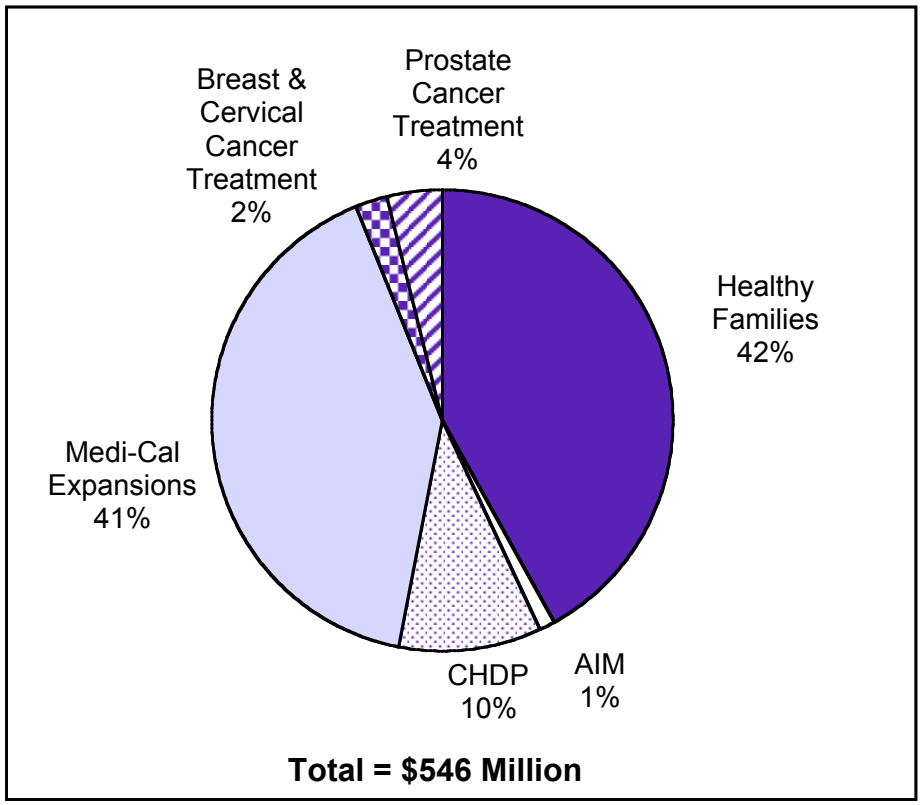
Year	Revenue
1998	$153,000,000
1999	$0
2000	$409,000,000
2001	$373,000,000
2002	$445,000,000
2003	$446,000,000
2004-07*	$386,000,000
2007-18*	$369,000,000
2018-25*	$441,000,000

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

In 2002-03, $546 million in Tobacco Settlement Funds was allocated for health programs. This figure includes $72 million carried over from the previous year. Forty-two percent of the funds supported the Healthy Families program. An approximately equal amount (41 percent) funded Section 1931 (b) coverage expansions and breast and cervical cancer treatment under Medi-Cal (Figure 11). Funds were also allocated for state-funded breast and cervical cancer treatment and prostate cancer treatment programs, CHDP and AIM. These funds were not expected to be available for these health programs in SFY 2003-04. As a part of the 2003-02 budget plan, future revenue from the settlement was to be sold to support state operations. A small roll-over amount from 2002-03 was available for prostate cancer treatment ($3.2 million) in 2003-04.[11]

[11] LAO, State Spending Pan 2002-03.

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



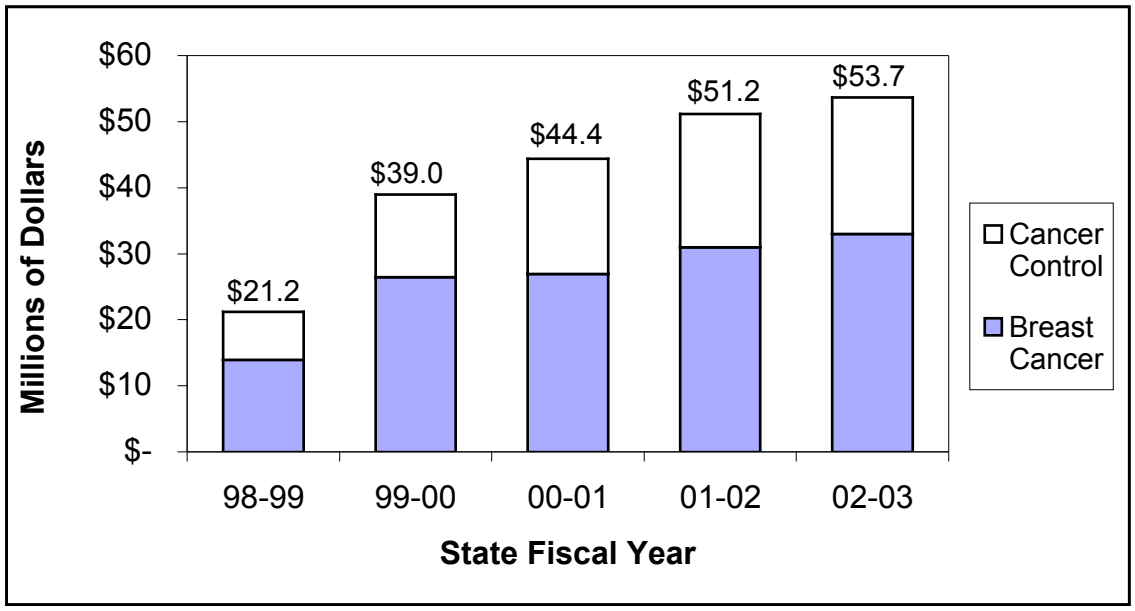
SOURCE: LAO, State Spending Plan, 2002-03

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 2002-03



SOURCE: Dept. 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). In 2002-03, CHDP financed an estimated 1.7 million screenings at an average cost of $58 per screening.

The initial 2002-03 budget created the "CHDP Gateway" to enroll all eligible, uninsured children into Medi-Cal and Healthy Families. Program funding was consequently reduced as more services were expected to be financed by Medi-Cal and Healthy Families.

Table 16: State Expenditures for the Child Health and Disability Prevention Program, 1998-99 to 2003-04

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	$99,000,000
2003-04*	$16,000,000

*Estimated
SOURCE: LAO, Analysis of the 2003-04 Budget Bill, 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 slightly (4 percent) between 2002-03 and 2003-04 (Table 17).

Table 17: Users and Total Expenditures for California Children's Services, 2002-2004

SFY	Users	Expenditures	Cost Per User
2002-03	172,340	$1,261,256,000	$7,318
2003-04*	178,380	$1,416,067,000	$7,939
2004-05*	177,374	$1,414,167,000	$7,973

*Estimated
SOURCES: Governor's Budget Summary 2003-04, LAO Analysis of the 2003-04 Budget, and Governor's Budget 2004-05.

Eighty-eight percent of 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-only program (for beneficiaries who do not qualify for Medi-Cal or Healthy Families) are projected to decrease slightly between 2002-03 and 2004-05 (Table 18).

Table 18: State-Only Program Expenditures for California Children's Services, 2002-2003 to 2004-05

State Fiscal Year	Expenditures
2002-03	$142,486,000
2003-04*	$141,425,000
2004-05*	$139,525,000

* Estimated
SOURCE: LAO, Analysis of the 2003-2004 Budget, Governor's Budget 2004-05.

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 in 2002-2003 was approximately $40 million. Estimated 2003-2004 funding represents a 7% decrease to $36 million. General fund support is estimated to decrease by $770,000 in 2004-05.[12]

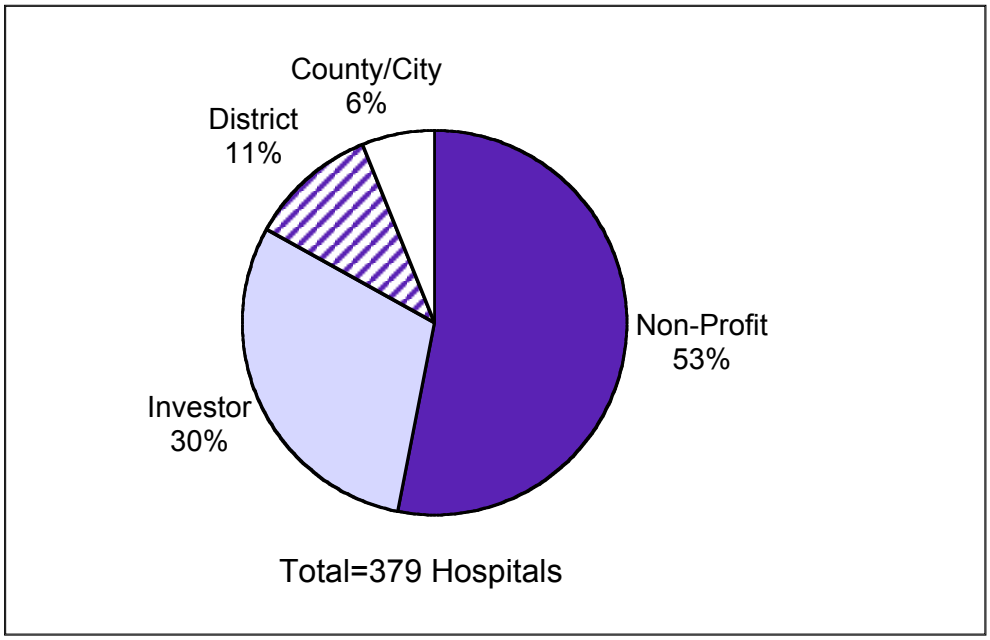
[12] Governor's Budget, 2003-04, 2004-05.

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 379 comparable hospitals[13] in California, more than half (53 percent) are non-profit, approximately one-third (30 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 115 between 1997 and 2002.

Figure 13: Distribution of Hospitals in California by Type of Control, 2002



SOURCE: Office of Statewide Health Planning and Development

In 2002, hospitals in California had nearly 16.6 million inpatient days (Table 19). Medicare paid for 40 percent of all inpatient days and Medi-Cal covered 28 percent of days. Third party payers accounted for 25 percent 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 2002, private insurance accounted for the most outpatient and emergency room visits. Medi-Cal patients had the longest average length of stay among payers at 6.7 days, reflecting skilled nursing facility use in hospitals. Managed care programs report shorter lengths of stay.

Table 19: Hospital Use, By Payment Source, 2002

Source of Payment	Inpatient Days	Average Length of Stay	Outpatient Visits (Including ER)	ER Visits
Total	16,552,225	5.7	43,137,148	7,331,205
Medicare	40%	6.2	26%	16%
Medi-Cal	28%	6.7	20%	24%
County Indigent	3%	5.2	5%	6%
Private Insurance	25%	4.3	40%	40%
All Other Payers	4%	6.2	8%	14%

SOURCE: Office of Statewide Health Planning and Development 2002.

[13] 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

The payer mix, however, is different for the four types of hospitals. At city and county hospitals, 70 percent of inpatient days were reimbursed by Medi-Cal or county indigent programs (Table 20). In contrast, 70 percent of the patient days at investor-owned hospitals were covered by either Medicare or third-party, private insurance coverage. Non-profit hospitals mirror the distribution of payers for all hospitals in the state. California hospitals also provided 43.2 million outpatient visits, of which 9.1 million occurred in emergency departments.

Table 20: Hospital Utilization,* by Payer and Type of Control, 2002

Type of Utilization	All Hospitals	Non-Profit	Investor	City/County	District
Total Inpatient Days	16,552,225	10,286,363	3,461,421	1,586,957	12,174,484
Medicare	6,640,317	4,282,316	1,678,146	201,628	478,227
Medi-Cal	4,598,037	2,417,340	930,207	802,771	447,719
County Indigent	491,874	116,329	26,177	327,561	21,807
Private Insurance	4,107,317	3,023,860	730,641	155,465	197,351
All Other	714,680	446,518	96,250	99,532	72,380
Outpatient Visits					
Total Outpatient Visits	43,137,148	29,354,828	5,300,628	5,973,182	2,508,510
Emergency Room Visits	9,101,937	5,634,795	1,772,353	963,291	731,498

*Analysis only includes comparable general acute care medical hospitals.
SOURCE: Office of Statewide Health Planning and Development 2002.

In 2002, hospitals generated $37.9 billion in net patient revenues and spent $37.5 billion (Table 21). Among all hospitals, private insurance payments (38 percent) and Medicare (34 percent) represent the largest source of payments followed by Medi-Cal (23 percent). County indigent care represents only 2 percent of hospitals' net revenues.

The relative importance of funding sources varies considerably across different types of hospital. Non-profit hospitals rely on a mixture of private insurance, Medicare, and Medi-Cal revenues while city and county hospitals rely heavily on Medi-Cal and county indigent revenues. In contrast, more than 78% 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, 2002

Net Revenues	All Hospitals	Non-Profit	Investor	City/County	District
Medicare	$12,795,529,595	$8,764,856,074	$2,837,729,689	$407,860,098	$785,083,734
Medi-Cal	$8,544,936,262	$3,598,940,399	$1,081,547,415	$3,604,849,582	$259,598,866
County Indigent	$708,821,266	$275,154,891	$84,236,454	$329,254,964	$20,174,956
Private Insurance	$14,200,769,707	$10,597,988,002	$2,251,276,858	$359,451,737	$722,053,110
Other	$1,600,416,758	$1,033,901,382	$386,732,454	$85,437,788	$94,345,134
Net Patient Revenue	**$37,850,473,588**	**$24,270,840,748**	**$6,911,522,871**	**$4,786,854,169**	**$1,881,255,800**
Total Operating Expenses	**$37,523,074,539**	**$24,828,991,405**	**$6,148,079,186**	**$4,619,708,238**	**$1,926,295,710**

*Analysis includes comparable general acute care medical hospitals.
SOURCE: Office of Statewide Health Planning and Development 2002.

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 2002, 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 $3.5 billion in bad debt and charity care charges; the actual cost of bad debt and charity care was $1.1 billion or 3.0 percent of hospitals' net operating expenses.

Table 22: Hospital Utilization and Supplemental Payment, by Type of Control, 2002

Category	All Hospitals	Non-Profit	Investor	City/County	District
Bad Debt	$2,065,169,950	$1,247,999,721	$466,770,019	$207,954,497	$142,445,713
Charity Care	$1,440,070,200	$840,136,073	$416,648,870	$160,062,198	$23,223,059
DSH Funds Received	$1,935,674,502	$492,574,608	$168,678,845	$1,272,513,366	$1,907,683
Net DSH Funds Received	$967,837,251	$246,287,304	$84,339,423	$636,256,683	$953,842

SOURCE: Office of Statewide Health Planning and Development 2002.

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 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
2004	$2,478,178,000	$1,239,089,000	NA	NA	$1,239,089,000
2005	$2,001,530,000	$1.000.765.000	NA	NA	$1.000.765.000

SOURCES: California Association of Hospitals and California Association of Public Hospitals and Governor's Budget 2004-05.

Beyond DSH, California provides supplemental state funds to hospitals through a number of mechanisms. In total, these supplemental payments accounted for $1.2 billion in 1999-00. They grew to $1.9 billion in 2002-03 (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.

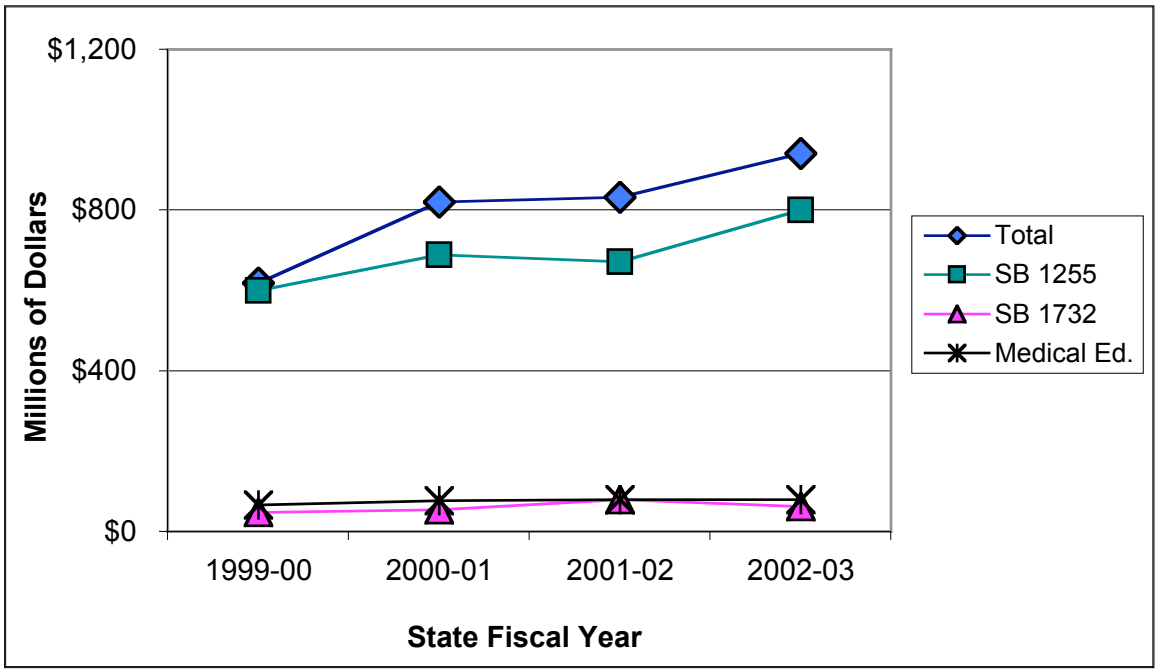
Table 24: State Supplemental Payments to California Hospitals, 1999/00-2002/03

Year	Total Payments	SB 1255	SB 1732	Medical Education	AB 761
1999-00	$1,237,500,000	$1,200,000,000	$94,900,000	$132,400,000	$0
2000-01	$1,641,148,000	$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*	NA	$1,718,714,000	NA	NA	NA
2004-05*	NA	$1,611,286,000	NA	NA	NA

SOURCE: California Medical Assistance Commission Annual Reports, and Governor's Budget 2004-05.

Because of the local public matching requirements in these programs, hospitals net only half of the payments (Figure 14).

Figure 14: Net Supplemental Payments to California Hospitals, 1999/00-2002/03



SOURCE: California Medical Assistance Commission Annual Reports.

FREE AND COMMUNITY CLINICS

The 689 licensed primary care clinics reporting to OSHPD represent another important component of the health care safety net in California. In 2002, they provided health care services to more than 3 million patients, about 9 percent of the total state population (Table 25). According to data from Office of Statewide Health Planning Development (OSHPD), 63 percent of patients were adults over age 20 while 37 percent were children under 19. Seventy percent of patients were women in 2002. An increasing number of middle-aged adult patients between 45 and 64 visited community clinics between 1997 and 2002.

Table 25: Unduplicated Patients in Private Primary Care Clinics,* By Age, 1997-2002
(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

* Includes both community and free clinics, but not dental clinics.
SOURCE: Office of State Health Planning and Development, Annual Report of Primary Care Clinics 1997-2002.

Between 1997 and 2002, the total number of patient visits decreased slightly between 2000 and 2002, by approximately 1 million (Table 26). In 2002, Medi-Cal beneficiaries accounted for one-third (33 percent) of all encounters while encounters by patients who paid for care out of pocket or who did not pay for care accounted for 16 percent of all visits. The number of encounters under Medicare, Medi-Cal, the EAPC program, MISP and CMSP programs, private insurance, and other payers all increased during this period. Between 2000 and 2002, clinics experienced a decrease in the number of visits of self-paying, non-pay, CHDP and "other payer" patients.

Table 26: Visits at Private Primary Care Clinics,* By Payment Source, 1997-2002
(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[14]	650	282	474	1, 250	301	613	625	331

*Includes both community and free clinics, but not dental clinics.
SOURCE: Office of State Health Planning and Development, Annual Report of Primary Care Clinics 1997-2002

In 2002, free and community clinics received revenues totaling $1.3 billion, a 59 percent increase from 1997 (Table 27). Clinics receive funds through grants, contracts, health insurance, and direct payments for services. Grants and contracts accounted for 32 percent of total clinic revenues while Medi-Cal accounted for 28 percent. Grant funding increased from $302.1 million in 1997 to $406.5 million in 2002 and Medi-Cal revenues increased by 78 percent during that period. Clinics also received substantially more revenue from their patients in 2002, $634.5 million up from $416.9 million in 1997.

[14] Managed care is included in the Medicare, Medi-Cal and Private insurance categories in the 2002 OSHPD report.

Table 27: Revenues at Private Primary Care Clinics,* By Payment Source, 1997-2002
(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	-

*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 1991-2002.

Users of community clinics received an average of 3.1 visits in 2002 (Table 28). Medicare patients visited a clinic 5.2 times in 2002 while the uninsured had 3.9 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 was $243.7 million (30% of total patient fees, 19% of total clinic revenue).

Table 28: Clinic Use and Patient Revenues, 2002

Payment Source	Patients	Visits	Average Annual Visits per Patient	Net Patient Revenues*
Total	3,022,067	9,245,733	3.1	$807,452,408
Uninsured	1,138,103	4.424.312	3.9	$282,836,458
Medi-Cal	881,374	3.031266	3.4	$349,767,224
Healthy Families	66,288	185,285	2.8	$12,193,508
Medicare	124,182	649,792	5.2	$89,433,366
Private Insurance	218,860	624,449	2.9	$55,235,823

* Net patient revenue does not include grants and contracts.
SOURCE: OSHPD, Annual Report of Primary Care Clinics, 2002.

The average payment for each encounter differs considerably across payers. Reflecting the cost-based reimbursement received by Federally Qualified Health Centers (FQHCs), Medicare produced the highest average revenue per visit at $137 in 2002 (Table 29). Programs such as EAPC and CHDP only paid between $64 and $68 per encounter. Each CMSP and MISP visit generated $116 for clinics. Clinics experienced a substantial increase in payment rates from private insurance between 1997 and 2002. 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, 1997-2002

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[15]		$68	$78	$89	$52

* Includes both community and free clinics, and does not include dental clinics.
SOURCE: OSHPD, Annual Report of Primary Care Clinics 1997-2002.

[15] CMSP and MISP data were reported in one combined category in the 2002 OSHPD report.

Sources

E.R. Brown, N. Ponce, T.Rice, S.A. Lavarreda. *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey (CHIS)*. UCLA Center of Health Policy Research, June 2002. www.healthpolicy.ucla.edu

California Association of Public Hospitals and Health Systems. *Policy Report: Medi-Cal Disproportionate Share Hospital Program.* Berkeley, CA. 2000.

California HealthCare Foundation. *The Health Insurance Act of 2003: An Overview of SB 2*, November 2003. www.chfc.org

California HealthCare Foundation. *Medi-Cal Fact and Figures: A Look at California's Medicaid Program*. January 2004. www.chfc.org

California Medical Assistance Commission. *Annual Reports*. www.cmac.ca.gov/annual.html

County Medical Services Program (CMSP) Governing Board. *CMSP FY 2003-2004 Budget,* www.cmspcounties.org/about/abt_pgm_dsgn_cmsp_bdgt.htm

County Medical Services Program (CMSP) Governing Board. *Summary of Expenditures of by Service Type and County; Total Inpatient Days and Claims by County; Outpatient Visits by County,* 2002.

Department of Finance. *California State Budget 2003-2004 and 2004-2005*, www.dof.ca.gov /HTML/BUD_DOCS/Bud_link.htm

Department of Finance. *California State Budget 2003-2004 and 2004-2005: Governor's Summary,* www.dof.ca.gov /HTML/BUD_DOCS/Bud_link.htm

Department of Health Services. *Annual Managed Care Statistical Reports*, 1995-2002.

Department of Health Services. *Cigarette and Tobacco Products Surtax Fund Expenditures Available Revenues 2004-05 Governor's Budget (2003-04) FY 2003-04 as of 2004-05 Governor's Budget*, January 2004.

Department of Health Services, *Medi-Cal Beneficiaries by Managed Care Plan for January 1996-2002.* www.dhs.ca.gov/admin/ffdmb/mcss/RequestedData/Beneficiary%20files.htm

Department of Health Services, *Medi-Cal Beneficiary Counts for January 2001-2003.* www.dhs.ca.gov/admin/ffdmb/mcss/RequestedData/Beneficiary%20files.htm

Department of Health Services. *November Estimate Medi-Cal Expenditures by Service Category, FY 2003-04*, December 2002. www.dhs.cahwnet.gov/admin/ffdmb/estimate/Nov_2002/2003_04_expenditures_service_category.pdf

Institute of Medicine. *Series on the Uninsured,* 2001-2004. www.iom.edu/project.asp?id=4660

Kaiser Family Foundation and Health Research and Educational Trust. *California Employer Health Benefits Survey*, February 2003. www.kff.org

Kaiser Family Foundation and Health Research and Educational Trust. *National Employer Health Benefits Survey*, September 2003. www.kff.org

Legislative Analyst's Office. *Analysis of the 2003-04 Budget Bill,* February 2003. www.lao.ca.gov/analysis_2003/health_ss/health_ss_toc_anl2003.html

Legislative Analyst's Office. *California's Spending Plan, 2002-03,* September 2002. www.lao.ca.gov/2002/spend_plan_02/0902_spend_plan_toc.html

Legislative Analyst's Office. *California's Spending Plan, 2003-04,* October 2003. www.lao.ca.gov/2003/spend_plan_03/1003_spend_plan_toc.html

Legislative Analyst's Office. *The Tobacco Settlement: What Will it Mean for California?* January 1999.

Managed Risk Medical Insurance Board. *Access for Infants and Mothers (AIM) Subscriber and Health Plan Data Summary*, January 2004. www.mrmib.ca.gov/MRMIB/AIMReports.shtml.

Managed Risk Medical Insurance Board. *Healthy Families Program Monthly Enrollment Reports*, November 2003. www.mrmib.ca.gov/MRMIB/HFP/HFPReports.shtml

Managed Risk Medical Insurance Board. *Managed Risk Medical Insurance Program (MRMIP) Subscriber and Health Plan Data Summary,* September 2003. www.mrmib.ca.gov/index.shtml

Medically Indigent Care Reporting Systems (MICRS). *County Health Care Program Expenditures for Medically Indigent FY2000-2001*.

Medically Indigent Care Reporting Systems (MICRS). *County Indigent Patients Counts and Utilization FY2000-2001*.

Office of County Health Services. *CHIP and RHS Allocations*. www.dhs.ca.gov/hisp/ochs/chsu/CHIP_RHS_TABLES_FOR_WEB.XLS

Office of County Health Services. *Maintenance of Effort Calculation FY 1997-1998 through FY 2003-04*, www.dhs.ca.gov/hisp/ochs/chsu/MOE_Allocation_Tables_for_Web.xls

Office of Statewide Health Planning and Development. *Annual Utilization Report of Primary Care Clinics*, 2002. www.oshpd.cawhnet.gov

Office of Statewide Health Planning and Development. *Hospital Annual Financial Data,* 2002. www.oshpd.cawhnet.gov

Office of Statewide Health Planning and Development. *Primary Care Clinic Utilization Trend Data, 1991-2000*, 2000. www.oshpd.cawhnet.gov

Lucien Wulsin, Janice Frates. *California's Uninsured: Programs, Funding and Policy Options.* Oakland, CA: California Health Care Foundation, July 1997. www.work-and-health.org.