A Summary of Health Care Financing for Low-Income Individuals in California, 1998 to 2005

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www.itup.org
February 3, 2005

Prepared under grants from:
The California Wellness Foundation
The California Endowment
The Blue Shield of California Foundation

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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 State Fiscal Year (SFY) 2002-03, 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 fourth edition of this report is divided into three sections. It begins with an overview of enrollment and expenditure trends in the major publicly funded health insurance programs available to low-income Californians. By far, Medi-Cal continues to be the largest source of coverage and financing. It is complemented by a number of other health insurance programs that fill in its gaps in coverage. The report then reviews the multiple and overlapping state funding streams that finance health care services for low-income, uninsured individuals. Finally, it presents an overview of the health care delivery systems for these populations, including hospitals, community clinics, and specialized programs for certain sub-populations.

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

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

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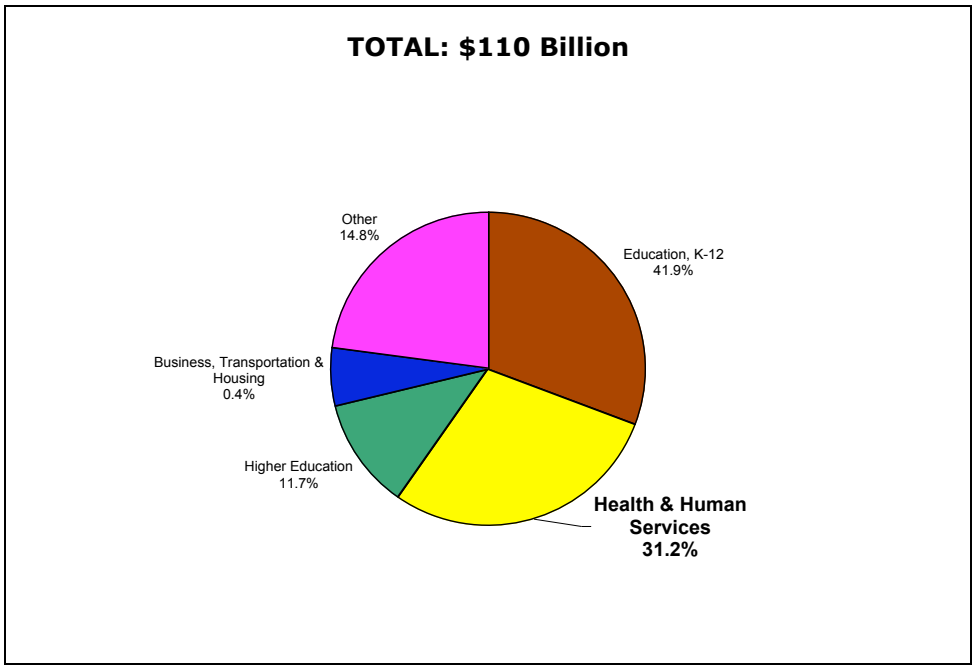
OVERVIEW OF STATE BUDGET

Total state expenditures in the 2005-06 Budget are expected to be $110 billion, which includes $85 million from the State's general fund. Revenues for the State include the State's general fund ($85 billion), and special funds ($24 billion). State General Fund Revenues are projected to grow by 7% in SFY 05-06.

In aggregate, spending for health and human services accounts for 31.2% of the total state budget in SFY 2005-06 (Figure 1). It is the second largest budget category, trailing only spending for primary education from kindergarten through 12th grade.

Figure 1: Expenditures by Department as a Proportion of the Total State Budget, SFY 2005-06*



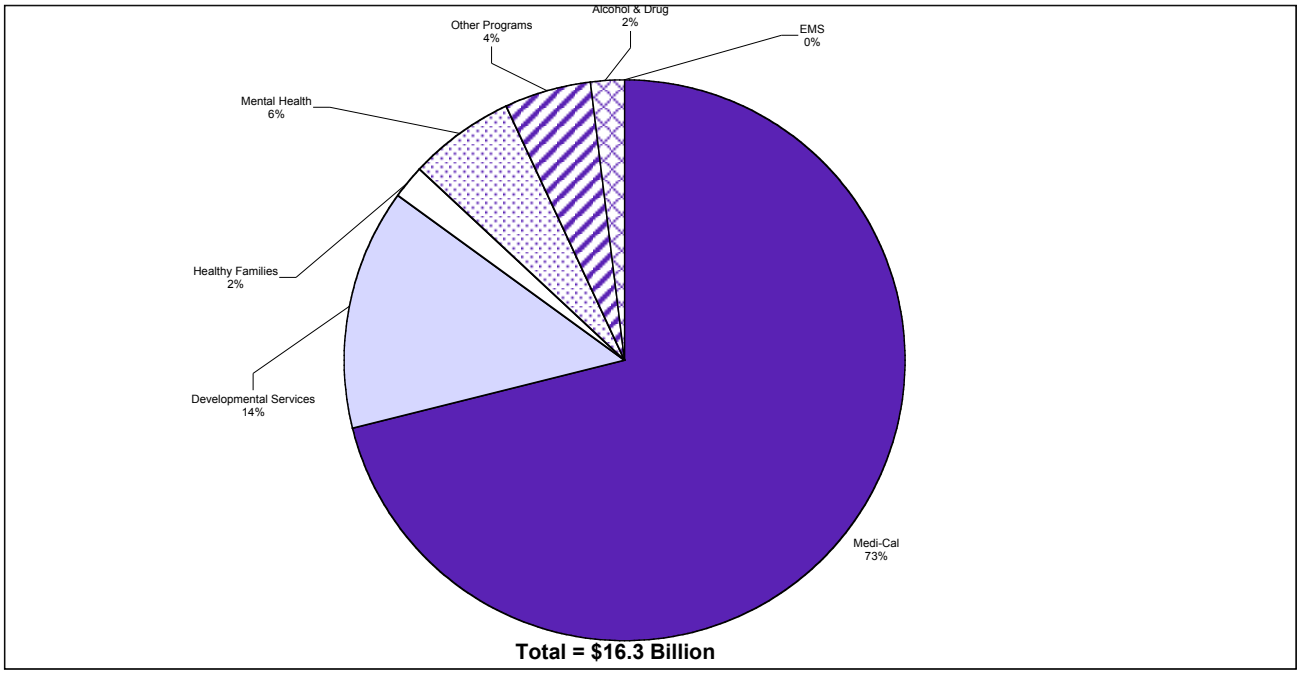
SOURCE: Department of Finance, California State Budget 2005-2006.
*Figure includes revenues from the General Fund and the Economic Recovery Bonds.

General Fund expenditures for state health and social service programs in 2005-06 are proposed to increase 4.6% from the previous year.

HEALTH EXPENDITURES IN STATE BUDGET

Within the state's health and human services budget, Medi-Cal, the health and long-term care financing program for low-income individuals and persons with disabilities, represents the largest share of General Fund spending (Figure 2).

Figure 2: General Fund Expenditures for Health Programs, SFY 2004-05



SOURCE: Legislative Analyst's Office (LAO), California Spending Plan, 2004-2005.

After several years of modest growth, Medi-Cal spending growth accelerated beginning in 2001 and is expected to increase to $34.1 billion in federal and state funds ($12.9 billion General Fund) in SFY 2005-06 (Table 1). Costs per enrollee grew, fueled by growth in pharmaceuticals, nursing facilities, and inpatient hospital services (Medi-Cal Policy Institute, 2002; Governor's Budget Summary 2005-06). Numbers of program participants grew in response to eligibility expansions and a weak private job market.

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 $3.1 billion and $3.7 billion, respectively. The Healthy Families program is projected to spend nearly $895 million in federal and state funds due to enrollment growth that is projected to increase from 713,900 in 2004-05 to 779,400 in 2005-06 -- a 9.2% increase. Realignment allotments for county health, mental health and social service programs are projected to grow from $4.136 billion to $4.363 billion between 2004-05 and 2005-06, of which more than a third is for county health. The Governor's Proposed FY 2005-06 Budget does not separate the allotment for county health from mental health and social services. (Table 1)

Table 1: Major Healthcare Expenditures by the State of California, * SFY 1998-2005

State Fiscal Year	Medi-Cal	In-Home Support Services	Regional Centers for Developmentally Disabled	Realignment Allotments***	Healthy Families
1998-99	$18,494,200,000	$1,397,800,000	$1,400,200,000	$1,159,355,000	$59,379,000
1999-00	$20,492,400,000	$1,628,300,000	$1,617,300,000	$1,239,294,000	$211,800,000
2000-01	$22,589,700,000	$1,875,000,000	$1,888,300,000	$1,415,491,000	$400,078,000
2001-02	$25,053,700,000	$2,378,500,000	$2,075,500,000	$1,420,889,000	$549,600,000
2002-03	$29,769,000,000	$2,784,000,000	$2,315,500,000	$1,458,810,000	$684,423,000
2003-04	$29,532,000,000	$3,181,000,000	$2,571,000,000	$1,485,819,000	$808,422,000
2004-05**	$31,215,700,000	$2,724,000,000	$2,700,000,000	$4,135,638,000	$839,100,000
2005-06**	$34,065,000,000	$3,096,000,000	$3,689,900,000	$4,362,896,000	$894,900,000

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

**Estimated

*** Governor's Proposed FY 05-06 Budget reports realignment for county health, mental health and social services, but does not separately identify the county health allotment, as it had in years prior to 2004-5.

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

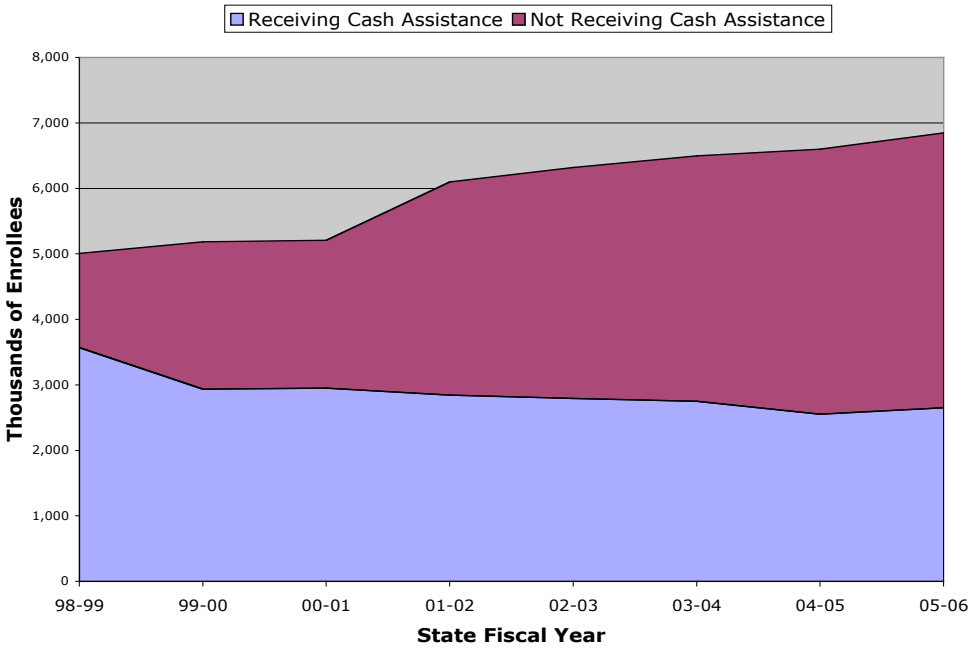
SECTION 1: HEALTH INSURANCE COVERAGE OF LOW-INCOME CALIFORNIANS

THE MEDI-CAL PROGRAM

Medi-Cal Enrollment[1]

Overall, those eligible for Medi-Cal though public assistance has decreased since 1996, however, overall Medi-Cal caseload has increased (Figure 3). Enrollment is projected to grow to 6.8 million in 2005-06. Enrollment growth is due to a slow economy with losses in employment-based health coverage combined with eligibility expansions and simplifications in the enrollment process, such as 12 months of eligibility for children, enacted over the past few years. Most of the enrollment growth has been in working families. The majority of Medi-Cal beneficiaries are families and children. Although the aged and disabled comprise a relatively small percentage of total beneficiaries, they account for the majority of Medi-Cal spending; they are also expected to increase by 3.2% to 1.7 million in 2005-06.

Figure 3: Medi-Cal Enrollment by Eligibility Category, 1998-99 to 2005-06



*Estimated
SOURCE: Department of Finance, Governor's Budget Summary, 2005-06.

In 2003-04, 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 less than 1.4 million in 2003-04 (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 161,000 in 2003-04. The earlier enrollment declines were more than offset by gains in family coverage under

[1] Source: Department of Finance, Governor's Budget Summary, 2005-06.

section 1931(b). Coverage for undocumented immigrants declined between 1998-99 and 2000-01, rebounded in 2001-02, but declined again in 2003-04. Enrollment for long-term care beneficiaries accounts for just over 1% 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	185% Poverty	133% Poverty	100% Poverty	Medically Indigent	UP
1998-99	**5,007**	**3,569**	2,444	1,125	**647**	579	-	68	**575**	142	97	57	279	**216**
1999-00	**5,187**	**2,935**	1,773	1,162	**1,390**	111	1,209	70	**655**	167	127	97	264	**207**
2000-01	**5,209**	**2,950**	1,768	1,182	**1,603**	140	1,394	69	**513**	172	103	83	155	**143**
2001-02	**6,100**	**2,847**	1,647	1,201	**1,918**	254	1,594	70	**524**	170	109	110	135	**226**
2002-03	**6,321**	**2,793**	1,557	1,225	**2,568**	619	1,882	67	**574**	188	118	112	156	**246**
2003-04	**6,463**	**2,664**	1,384	1,280	**2,671**	322	2,280	69	**635**	194	132	148	161	**220**

SOURCES: Department of Health Services, Medi-Cal Beneficiary Profile, 2004; Department of Health Services, Estimated Average Monthly Certified Eligibles, Fiscal Years 2001-04; The Medi-Cal Policy Institute, 2002.

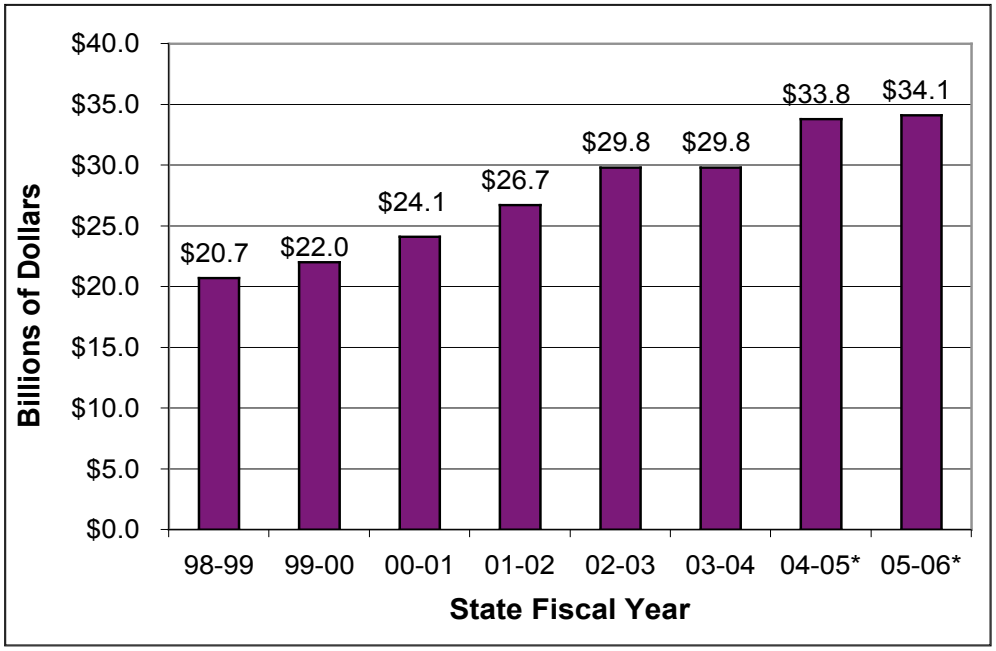
* Abbreviations- "SSI/SSP" – Supplemental Security Income/State Supplementary Payment; "UP" – Undocumented Persons

Due to the categorical and income eligibility requirements for adults, more than half (53%) of Medi-Cal beneficiaries are children under age 20. Reflecting the racial diversity of the state, Medi-Cal beneficiaries are predominantly people of color. More than half (51%) are Latino. Another nearly 11% of beneficiaries are African American. Whites comprise 22% of all Medi-Cal beneficiaries.[2]

Medi-Cal Spending

Total federal and state Medi-Cal expenditures are projected to increase to $34.1 billion in 2005-2006 (Figure 4). This represents almost a 65% increase from 1998-99.

Figure 4: Total Federal and State Medi-Cal Expenditures, 1998-99 to 2005-06



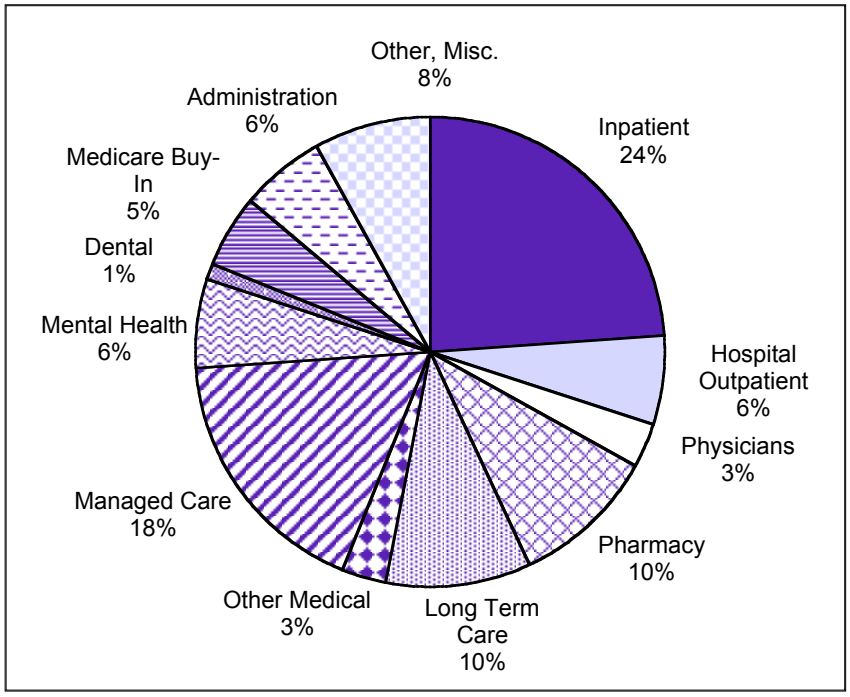
*Estimated

SOURCES: Department of Health Services, Governor's Budget Summary 2005-06.

[2] Department of Health Services, Medi-Cal Beneficiaries by Age and Demographic Status, 2004;

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% of total Medi-Cal spending, of which about half is for county administration of eligibility.

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 growth in program spending 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.[3]

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 four pilot counties. The One-e-App will allow families to determine eligibility and apply for many health and social services programs via the Internet. However, significant barriers remain, such

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

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 goals of attaining citizenship.

Over three quarters of all beneficiaries (77%) remain enrolled in Medi-Cal after one year; retention rates 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.[4]

Managed Care

Between 1997 and 2003, 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 2.4 million in 2003. The number of 2003 enrollees in the geographic managed care (GMC) system increased from 143,000 to 336,000 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 554,000 in 2003. The Governor's Proposed Budget would phase into managed care over 800,000 additional families, seniors and disabled by FY 2008-09.

Table 3: Medi-Cal Enrollment by Type of Managed Care Plan, 1997-2003

(In Thousands)

Year	Total	FFS	Total Managed Care	COHS	GMC	PCCM	PHP	2-PLAN
1997	5,151	3,391	1,760	378	143	22	367	849
1998	4,971	2,826	2,145	352	198	8	87	1,500
1999	5,041	2,527	2,514	377	324	2	7	1,804
2000	5,110	2,590	2,520	402	315	2	1	1,801
2001	5,531	2,704	2,826	459	319	0.1	0.9	2,047
2002	6,286	3,030	3,251	534	338	0	1	2,378
2003	6,412	3,102	3,309	546	338	1	1	2,419

SOURCE: DHS Annual Managed Care Statistical Reports.

Abbreviations: "FFS"- Fee for Service; "COHS"- County Organized Health Systems; "GMC"- Geographic Managed Care; "PCCM"- Primary Care Case Management; "PHP"- Prepaid Health Plan

Access to Care[5]

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 Medi-Cal specialists per 100,000 beneficiaries and five surgical specialists per 100,000 beneficiaries, compared to federal minimum standards of ten and 15 per 100,000 beneficiaries, respectively.

[4]Ibid

[5]Ibid.

Utilization[6]

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

MANAGED RISK MEDICAL INSURANCE BOARD (MRMIB) PROGRAMS[7]

The Managed Risk Medical Insurance Board (MRMIB) administers health coverage programs to individuals who do not have health insurance and also plays a role in health care policy development. Three insurance programs administered by the MRMIB include Healthy Families, Major Risk Medical Insurance Program (MRMIP), and Access for Infants and Mothers (AIM). The Health and Human Services proposed funding for MRMIB in 2005-06 is $1.048 billion.

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 $47,125 for a family of four). The Federal and State governments jointly fund Healthy Families. The federal to state funding match is a 2:1 ratio. From its inception in June 1998, enrollment in Healthy Families grew to approximately 714,000 in 2004-05 with total expenditures of almost $807 million (Table 4). Enrollment among children is expected to grow to more than 779,000 in 2005-06 with expenditures of nearly $895 million.

Table 4: Healthy Families Enrollment and Expenditures, SFY 1998-2005

State Fiscal Year	Enrollment	Expenditures
1998-1999	131,816	$59,379,000
1999-2000	296,538	$211,801,000
2000-2001	444,723	$389,533,000
2001-2002	561,631	$546,261,000
2002-2003	660,316	$692,912,000
2003-2004	661,939	$761,499,000
2004-2005	713,900	$806,778,000
2005-2006*	779,400	$894,948,000

*Projected.

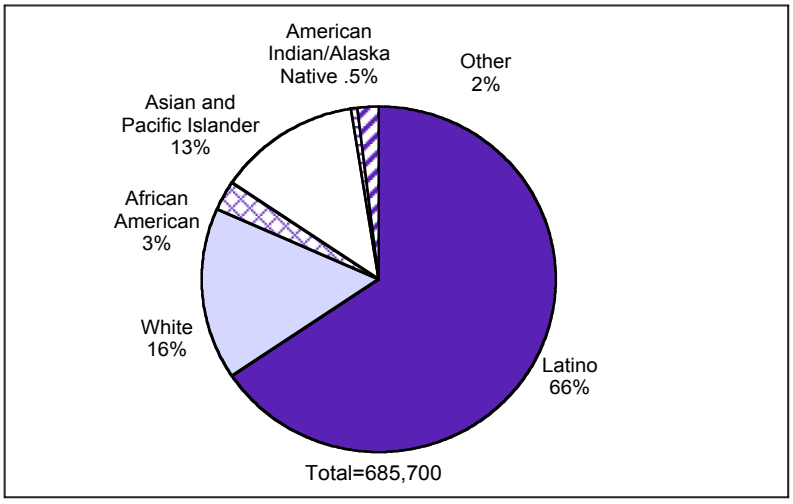
Sources: California Department of Finance, Governor's Budget Summary, 2005-06

Healthy Families is an ethnically diverse program. Approximately three in five (58 percent) beneficiaries are Latino (Figure 6). Approximately one in seven (14 percent) beneficiaries are White, 12% are Asian/Pacific Islander, 3% are African American, and 0.3% are American Indian/Alaska Native. The majority (54%) of Healthy Families beneficiaries reside in one of five Southern California counties: Los Angeles (28%), Orange (10%), San Diego (9%), San Bernardino (7%), and Riverside (7%).

[6] Ibid.

[7] Source: California Department of Finance, Governor's Budget Summary 2004-05, 2005-06

Figure 6: Ethnicity of Healthy Families' Subscribers, November 2004



SOURCE: MRMIB website accessed December 2004

Major Risk Medical Insurance Program (MRMIP*)*

MRMIP offers insurance to individuals with health conditions, who cannot obtain private health insurance. In November 2004, 9,356 people were enrolled in the program (Table 5). The decline in program enrollment and improvements in the waiting list are due to recent legislation, transitioning long time enrollees into health plans without a subsidy for their perceived higher risk.

Thirty-seven percent of MRMIP subscribers are between 50 and 64 years old followed by 30-49 years old (36%) and under 29 years old (26%). Whites comprise a disproportionate share of MRMIP subscribers (65%) compared to their percentage of the total state population. More than half of the subscribers (54%) are enrolled with Blue Cross. Kaiser Permanente and Blue Shield are the other private health plans participating in MRMIP. Projected spending in SFY 05-06 is $40 million.[8]

Table 5: MRMIP Enrollment, By Demographic Characteristics, November 2004

Category	Number Enrolled	Proportion Enrolled
TOTAL	**9,356**	**100.0%**
Subscribers	8,886	95.0%
Dependents	470	5.0%
Health Plans		
Blue Cross	5,061	54.1%
Kaiser (North & South)	3,666	39.2%
Blue Shield HMO	527	5.6%
Contra Costa	102	1.1%
Race/Ethnicity		
White	6,072	64.9%
Asian/Pacific Islander	1,366	14.6%
Latino	1,001	10.7%
Other	646	6.9%
African American	168	1.8%
American Indian	37	0.4%

SOURCE: MRMIB website accessed in December 2004.

[8] Department of Finance, Governor's Budget Summary, 2005-06.

Access for Infants and Mothers (AIM)

AIM provides insurance coverage to pregnant women and infants with incomes between 200 and 300% of the Federal Poverty Level who do not qualify for Medi-Cal or Healthy Families. Before July 2002, approximately 54,000 women and infants had enrolled in the program. Between July 2002 and June 2004, an additional 15,494 women and infants had enrolled in AIM. By November 2004, there were 19,444 enrolled in AIM, thus, nearly 4,000 women and infants had enrolled in a short period of time (July-November 2004).[9]

AIM funding for 2004-05 was $123.2 million, according to the Governor's budget; there is a 19% decrease for SFY 2005-06 ($99.8 million).[10] This decrease in funding is mainly due to AIM infants transitioning into the Healthy Families program, which qualifies for 2/1 federal matching payments. The Governor's proposed Budget forecasts a further decrease in state support for AIM by securing federal financial participation for services to pregnant women.

Table 6: AIM Enrollment, as of November 2004

Category	Proportion Enrolled
TOTAL	**100.0% (n = 19,444)**
Women	30.0% (n = 5,763)
Infants	70.0% (n = 13,681)
Health Plans*	
Blue Cross (CA Care & Prudent Buyer)	55.3%
Health Net	25.6%
Sharp Health Plan	9.6%
Kaiser (North & South)	6.3%
Other	3.2%
Race/Ethnicity*	
Latino	43.2%
White	25.5%
Asian/Pacific Islander	21.0%
Unknown	6.7%
African American	1.6%
American Indian	0.3%
Income**	
$20,000-$25,000	1.0%
$25,000-$30,000	5.1%
$30,000-$35,000	16.3%
$35,000-$40,000	20.9%
$40,000-$45,000	23.1%
$45,000-$50,000	15.0%
$50,000	18.6%

SOURCE: MRMIB website accessed in December 2004.
* Current Mothers only; ** Through June 2004 only

Since July 2002, 43 percent of new (women) beneficiaries have been Latina, 26 percent were White, and 21 percent were Asian/Pacific Islander. Approximately 55% of women subscribed to a Blue Cross health plan and 26% were enrolled in Health Net. Reflecting the higher income limits for this program, 37 percent of women participating in AIM live in families with annual incomes between $30,000 and $45,000 and 34 percent have annual incomes above $45,000.

[9] Source: MRMIB website
[10] Source: California Department of Finance, Governor's Budget Summary 2005-06

There are a high percentage of AIM enrollments (current Mothers only) in certain counties relative to their county population -- such as Monterey (8%) and San Diego (11%). The proportions of enrollment in AIM in other counties include: Los Angeles (25%), Orange (8%), and Riverside (5%).

PRIVATE HEALTH INSURANCE COVERAGE[11]

In 2003, California passed SB 2 (Burton and Speier) requiring larger employers to provide coverage for their employees or pay a fee into a state purchasing pool operated by MRMIB beginning in 2006. It is estimated that up to one million previously uninsured Californians would have been covered by this measure, if fully implemented.[12] The legislation was repealed by a narrow margin via a referendum of the State's voters in November 2004.

Employer-Based Coverage

- Thirteen million Californians received health insurance through their employer in 2001, about 64% of the 18-64 years old population (California Health Interview Survey, 2001).

- Sixty-seven percent of California businesses offered health insurance in 2004, which was similar to 2003. Yet even among firms that offer coverage, not all employees are covered.
  - Eighty percent of workers in firms that offer coverage are eligible for coverage. The workers who were ineligible for coverage are mainly due to waiting periods or minimum work-hour rules.
  - When offered, most (87%) of those eligible accept coverage.
  - Only 1 percent of individuals who decline coverage do so 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, only 20% offer health insurance to part-time employees, and just 5% offer health insurance to temporary workers.

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

- Over half (52%) of California workers who have insurance through their employer are enrolled in an HMO. Nearly thirty percent are enrolled in a PPO.

- Large employers in California with more than 200 employees are very likely to offer employees a choice in health plans, with 93% offering more than one plan. Only 27% of small employers offer workers a choice of plans.

- This is the 4th year in a row that health insurance premiums for CA employees have increased by double digits (11.4% increase in 2004). Forty-four percent of employers stated that they are likely to increase the share of premiums paid by employees.

[11] Unless otherwise noted, information on employer-based health insurance was obtained from the California HealthCare Foundation, Kaiser Family Foundation/Health Research and Educational Trust (HRET) California Employer Health Benefits Survey, March 2004, Kaiser Family Foundation/HRET National Employer Health Benefits Survey, 2004, at www.hret.org.

[12] 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, 2001)

- A recent national study reports that half of those buying individual insurance are self employed, a quarter are unemployed or out of the labor force and a quarter are working, mostly for small employers.[13] Three of eight have incomes below 200% of the federal poverty level and nearly three quarters are between the ages of 35 and 65 (25% between the ages of 55 and 65).

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

- Another recent study reports that nearly one fourth of Americans under the ages of 65 are potential candidates for individual health coverage, and the individual market is reaching less than one fourth of its potential market.[14] The individual market is reaching less and less of its candidates, declining from over a third of its market in 1988 to less than a fourth of its market in 2003, primarily due to the rise in premiums and decline in affordability.

- In California, consumers have less protection in purchasing individual coverage, than small employers do in purchasing coverage – there are fewer restrictions on insurance underwriting practices, less price transparency and thus less ability to compare market prices.

- ITUP reviewed and compared premiums for small employers and individual coverage in 48 of California's 58 counties and found that individual coverage is typically more costly than comparable small employer coverage. Premiums are highest in areas lacking provider and plan price competition and lowest in the large urban areas of Southern California where price competition is strongest.[15]

[13] Ziller et al, Patterns of Individual Health Insurance Coverage 1996-2000, Health Affairs (December 2004).
[14] Buntin, Marquis and Yegian, The Role of the Individual Health Insurance Market and Prospects for Change, Health Affairs (December 2004).
[15] See Hickey, Overview of the Uninsured, California 2003 (Insure the Uninsured Project July 2004) at www.itup.org. Average statewide premium for standard coverage for a fifty-year-old individual was $374 per month in 2003, and premiums for roughly comparable HMO coverage ranged from a low of $266 to a high of $495 per month.

UNINSURED CALIFORNIANS[16]

Despite the presence of public and private health insurance programs, 16% 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 under 20 years old, which constituted approximately 11% of all children under 20 years old; and 3.5 million adults between 20 and 64, which constituted approximately 18% of all adults 20-64 years old.

In the 2003 survey, uninsured children had declined to nearly 783,000 in 2003, less than 8% of all children (CA Health Interview Survey (CHIS), 2003) due to the growth in enrollment of children in the state's Medi-Cal and Healthy Families programs. There is a marked decline in the numbers of children eligible, but not enrolled in the state's Medi-Cal and Healthy Families programs.

Individuals with incomes below 200% of the Federal Poverty Level (FPL) comprise two-thirds (3 million) of the uninsured population. Uninsured rates decline as income increases. Nearly a third (30%) of persons with incomes below poverty are uninsured; over a quarter (26%) of persons with incomes between 100% and 200% of poverty are uninsured. More than one in seven (15%) of persons with incomes between 200 and 300% of poverty are uninsured. (CA Health Interview Survey, 2003) The federal poverty level for a family of three in 2004 was $15,670, equal to about $7.50 an hour for a full time full year worker.

Fifteen percent (more than one in seven) of California's workers are uninsured, overwhelmingly because they are not offered coverage at work. Workers and their family members account for over 80% of uninsured Californians.

The uninsured population is demographically diverse (Table 7). In 2001, 2.5 million Latinos (who were under 65 years old) were uninsured, which comprised 54% of the state's total uninsured and 28% of all Latinos under 65 years old. Another 440,000 Asian/Pacific Islanders had no coverage for their health expenditures. Slightly more than 1.3 million Whites were uninsured.

Table 7: Uninsured Persons (<65 years old) in CA, By Race, 2001

Race	Total Number Uninsured (n = 4,597,000)	Proportion of Total Uninsured	Proportion of Racial Group Uninsured
Latino	2,500,000	54%	28%
White	1,304,000	28%	9%
Asian	440,000	10%	14%
African American	172,000	4%	10%
Other/2 + Races	160,000	3%	16%
American Indian/Alaska Natives	22,000	<1%	19%

SOURCE: California Health Interview Survey, 2001.

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

[16] Source: Unless otherwise indicated, information is based on the CA Health Interview Survey (CHIS), 2001.

Measuring California's Uninsured: CHIS, CPS and SIPP

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 count of Medi-Cal and Healthy Families enrollment, closer to the actual program enrollment at the time of the survey. The 2001 CHIS reports 4.5 million are uninsured at a point in time and a total of 6.2 million uninsured at some point 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 data of uninsured over the course of a year. The CPS survey data on the numbers of persons reporting enrollment in Medi-Cal and Healthy Families is very substantially below the actual enrollment in those two programs. The most recent CPS data from October 2004 shows a slight decline in the percentages of Californians who are uninsured. Forty-eight of the fifty states in the U.S. showed increasing rates of uninsured over the past two years. The CPS data shows a decline in employment-based coverage and an increase in enrollment in public programs. The percentage growth in the uninsured was largest among young adults (1.5% increase), workers (0.7% increase) and individuals living alone (0.7% increase).[17]

The 2003 CHIS report is now available. It shows a decline in employment-based coverage and increases in public coverage, particularly for children.

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

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

[17] US Census Bureau, Comparison of Uninsured Rates Between States Using Three Year Averages 2001-2003 at www.census.gov

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

Background

In California, counties are responsible for provision of health care to indigent uninsured individuals. Counties receive a mix of state and federal revenues to fund public health services and medical care for the indigent. In return, counties are required to comply with a financial Maintenance of Effort (MOE) for indigent care.[18] Counties can be grouped into four broad categories based on their size, location, and delivery system: 1) small, rural counties, 2) large counties with public hospitals, 3) large counties without public hospitals and 4) hybrid counties with public clinics and private hospitals.

Historically, counties relied on property taxes to pay for a portion of health services for the uninsured. After the passage of Proposition 13, the legislature enacted a series of laws to shift responsibility and funding for indigent populations from the state to counties. In 1991, they combined multiple state funding streams into realignment funds that are financed through a portion of state sales taxes and vehicle license fees.[19] The principal funding streams supporting county care to the uninsured are realignment, tobacco funds, net county disproportionate share hospital (DSH) funding and county match.

Between 1997-98 and 2004-05, realignment payments to counties increased by nearly one-third from $1.11 billion to $1.48 billion (Table 8). All 58 counties and three cities (Berkeley, Long Beach, and Pasadena) receive realignment funds. During this period, all 58 counties and three cities experienced modest increases in their realignment funds. Allotments are based on historical funding patterns under predecessor programs with equity adjustments for counties that are disadvantaged by the historical formulas. In 2003-04, Los Angeles County received $485.3 million, nearly 33% of all realignment funds distributed statewide.

Table 8: 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	$1,352,672	$55,646	$444,646	$79,160	$50,811	$14,413
2003-04*†	$1,475,853	$60,724	$485,253	$86,240	$55,379	$15,712

* Estimated.

† Total for SFY 2003-04 does not include funds for city health departments (Berkeley, Pasadena, Long Beach)
SOURCE: Office of County Health Services, Maintenance of Effort Calculation.

[18] This MOE requirement is tied to the receipt of Proposition 99 funds discussed later in this report. Essentially MOE requires counties to spend some of their General Purpose revenues for health programs.
[19] For more information about the financing of health care for the uninsured in California, please see Wulsin and Janice Frates. "California's Uninsured: Programs, Funding, and Policy Options." Insure the Uninsured Project. July 1997 at www.itup.org.

County Indigent Health Care Programs: Medically Indigent Services Program (MISP)

County indigent health care programs finance inpatient, outpatient, and emergency Medi-Cal services for uninsured residents and vary by county. In the 24 large counties the program is known as Medically Indigent Services Program (MISP). In these counties, Latinos comprised more than one-half (53 percent) of all indigent patients. In 2001-02, MISP counties spent a total of $1.5 billion to provide services to 1.4 million patients (Table 9). Los Angeles County alone accounted for more than half of all indigent patients served and total indigent care expenditures for all MISP counties. Counties that operated a county hospital based delivery system had significantly higher costs and revenues and delivered more care to the uninsured than counties without a public delivery system. Payor counties had much lower revenues, smaller expenditures and paid for less care to the uninsured.

Table 9: County Indigent Healthcare Clients and Expenditures for Selected Services in Selected Counties, SFY 2001-02

County	Unduplicated Patients	Expenditure per Patient	Expenditure per Inpatient Day	Expenditure per Outpatient Visit	Expenditure per Emergency Visit	Total Expenditures
All Counties	1,446,919	$1,082	$2,047	$173	$250	$1,566,172,565
Los Angeles	763,098	$1,049	$2,360	$161	$268	$801,068,780
San Francisco	61,123	$1,389	$2,434	$184	$326	$84,882,067
Santa Clara	79,151	$803	$1,900	$179	$548	$63,635,990
Orange	121,586	$435	$801	$68	$117	$52,925,586
San Diego	49,299	$1,149	$1,096	$184	$152	$56,658,017
Kern	8,078	$2,493	$1,895	$206	$364	$20,141,239
Fresno	18,358	$982	$1,090	$122	$172	$18,037,148
Tulare	5,369	$1,272	$1,138	$254	$123	$6,828,348

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

The four different models of county health systems are: counties with public hospitals (provider counties), counties with private providers (payor counties), counties with a hybrid of county clinics and private hospitals (hybrid counties) and small counties which collaborate in a Medi-Cal like system for indigent adults (small counties). There are enormously wide variations in eligibility, funding and access to services in these very different delivery systems.[20] Each county makes its own decisions as to how much relative emphasis to place on care for the uninsured as opposed to other county health priorities, on inpatient and emergency services versus primary care and outpatient services and the mix of public and private providers to deliver services.

Table 10: County Delivery System by County Type

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

[20] For your county and comparisons to other counties and regions around the state please see ITUP's county reports at www.itup.org.

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

Table 11: Financing by County Type

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

County Indigent Health Care Programs: County Medical Services Program (CMSP)

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

Between 1997-98 and 2004-05, total funding for the CMSP increased from $183 million to $236 million, and individual revenue sources changed considerably (Table 12). During this period, realignment funds increased as a percentage of total funds from 67% in 1997-98 to 79% 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[21] also have been phased out. County fund and third party-payer information was unavailable.

Table 12: Sources of Revenue for County Medical Services Program (CMSP), 1997-98 to 2004-05

(In Thousands)

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

* Approved budget.

SOURCE: Legislative Analyst's Office, CMSP Governing Board Budget, 2004-05.

In 2002, CMSP paid for 576,500 outpatient visits and 53,703 inpatient days. Hospital spending accounted for nearly 80% of total CMSP expenditures.

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

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

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

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

State payments to counties under CHIP declined significantly from approximately $165 million in 1997-98 to $25.2 million in 2003-04 as an increasing portion of Proposition 99 funds were shifted to other health programs (Table 13). All counties experienced sizeable reductions in CHIP funding. Wide variation in CHIP allocations persist with counties that operate publicly funded hospitals receiving relatively larger allocations proportionate to their population size and number of uninsured.

Table 13: California Healthcare for Indigent Program (CHIP) Allotments to Selected Counties, SFY 1998-99 to 2003-04

(In Thousands)

State Fiscal Year	Total	Alameda	Los Angeles	Orange	San Bernardino	Tulare
1998-99	$148,730	$7,185	$66,320	$7,181	$5,782	$1,924
1999-00	$74,621	$3,719	$34,578	$3,085	$3,013	$827
2000-01	$84,819	$4,101	$39,033	$3,618	$3,438	$969
2001-02	$71,947	$3,550	$33,714	$2,902	$2,861	$777
2002-03	$55,690	$2,734	$26,379	$2,094	$2,328	$561
2003-04	$25,213	$1,367	$13,294	$459	$1,115	$123

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

County Indigent Health Care Programs: Rural Health Services (RHS) Program

Thirty-four small counties receive RHS appropriations, also funded by Proposition 99. RHS reimburses providers who submit claims for covered services to the indigent uninsured who are not covered by any other program. After a substantial augmentation in SFY 1998-99, total funding for RHS declined to $2 million in 2003-04 (Table 14). All counties experienced reductions in funding during this period. In 2003-04, the five most populated rural counties (Butte, Marin, Shasta, Solano and Sonoma) received more than half (53 percent) of total RHS funding. The remaining rural counties received very modest payments under the program, with Alpine County receiving less than $1,000 annually.

Small counties are allowed to contract back with the state to administer RHS on their behalf; the program administrator is the DHS Office of County Health Services. For FY 2003-4, only one small county elected to administer its own RHS program.

Table 14: Rural Health Services (RHS) Allocations to Selected Counties, SFY 1998-99 to 2003-04

(In Thousands)

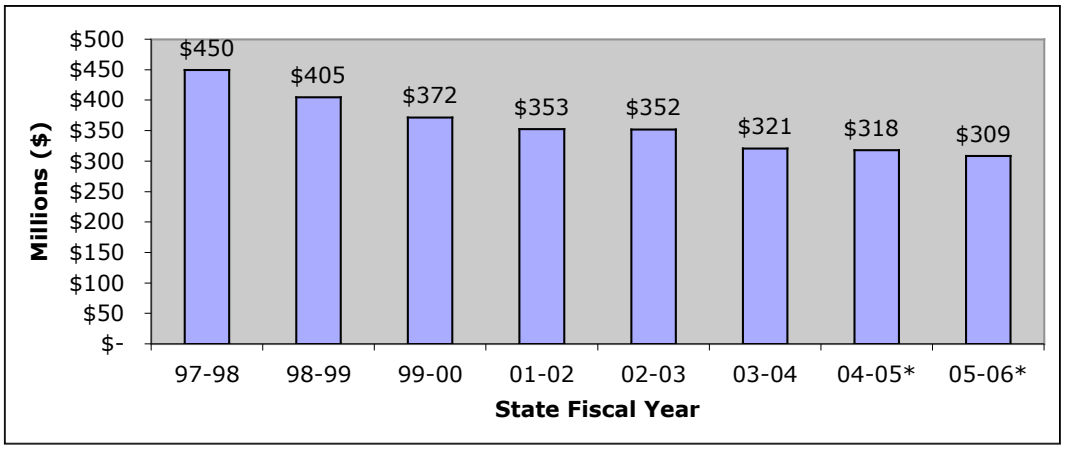
Year	Total	Butte	Humboldt	Imperial	Shasta	Solano	Sonoma
1998-99	$6,484	$503	$328	$297	$481	$780	$943
1999-00	$2,456	$190	$143	$124	$238	$263	$427
2000-01	$2,977	$217	$143	$147	$201	$370	$466
2001-02	$2,525	$190	$117	$124	$172	$311	$394
2002-03	$2,123	$162	$97	$99	$158	$260	$338
2003-04	$2,009	$172	$93	$91	$174	$248	$328

SOURCE: Department of Health Services, Office of County 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 $309 million in special funds in 2005-06 (Figure 7).

Figure 7: Proposition 99 Revenues, State Fiscal Year (SFY) 1998-99 to 2005-06



*Estimated

SOURCE: Governor's Budget Summary 2005-06.

Proposition 99 revenues are used for a variety of health programs serving low-income adults and children. These include: Breast Cancer Early Detection Program (BCEDP), grants to community clinics, the Children's Health and Disability Prevention (CHDP) program, CHIP, and RHS. In addition, Proposition 99 funds are used to subsidize two health insurance products: Major Risk Medical Insurance Program (MRMIP) and the Access to Infants and Mothers (AIM). Finally, Proposition 99 funds the activities of the Office of Statewide Health Planning and Development (OSHPD) (Table 15). The accounts dedicated to counties (CHIP and RHS) have declined precipitously. The account dedicated to AIM steadily grew until the Proposed Fiscal Year 2005-6 Budget when the state proposes to secure federal matching funds for AIM services to pregnant women. According to the state's Legislative Analyst, the Governor's Proposed Budget does not allocate the AIM savings to an increase in funding for county health programs for the uninsured.

Table 15: Proposition 99 Allotments for Select Health Programs, 1998-99 to 2005-06
(In Thousands)

State Fiscal Year	Total Spending	BCEDP	CHDP	CHIP	RHS	MRMIP	AIM	OSHPD
1998-99	$493,018	$0	$49,291	$148,730	$6,484	$46,033	$37,499	$1,837
1999-00	$496,825	$11,660	$55,160	$74,621	$2,621	$42,764	$45,796	$1,047
2000-01	$428,454	$9,000	$59,882	$84,819	$2,973	$45,000	$56,218	$998
2001-02	$397,759	$11,200	$63,300	$74,947	$2,525	$40,000	$38,613	$1,032
2002-03	$361,598	$12,700	$17,500	$55,690	$2,123	$40,000	$75,764	$1,047
2003-04*	$341,682	$15,648	$0	$25,213	$2,009	$40,000	$91,300	$1,047
2004-05*	$314,273	$9,548	$4,200	$21,013	$1,047	$40,000	$93,764	--
2005-06*	$319,742	$12,800	NA	NA	$1,047	$40,000	$13,670	NA

*Estimated

Source: Legislative Analyst's Office, Department of Finance, Budget Summary 1998-2005; Governor's Budget Summary 2005-06.
Abbreviations: "BCEDP"- Breast Cancer Early Detection Program; "CHDP" – Children's Health and Disability Prevention; "CHIP"- California Healthcare for Indigent Program; "RHS"- Rural Health Services; "MRMIP" – Managed Risk Medi-Cal Insurance Program; "AIM" – Access to Infants and Mothers; OSHPD"- Office of Statewide Health Planning and Development

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 the state of California annually as a result of the settlement (Table 16). The national tobacco settlement roughly doubles the amount of tobacco-related funds available to the state for the next 25 years.

Table 16: 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.

Counties and cities throughout the state are receiving additional revenue directly as a condition of the settlement (Table 17). Many counties use their tobacco settlements for health care to the uninsured; some do not. There is no legal obligation as a part of the settlement for counties to spend their tobacco settlement funds on health care to the uninsured, and there is no statewide reporting on how counties spend their settlement funds.

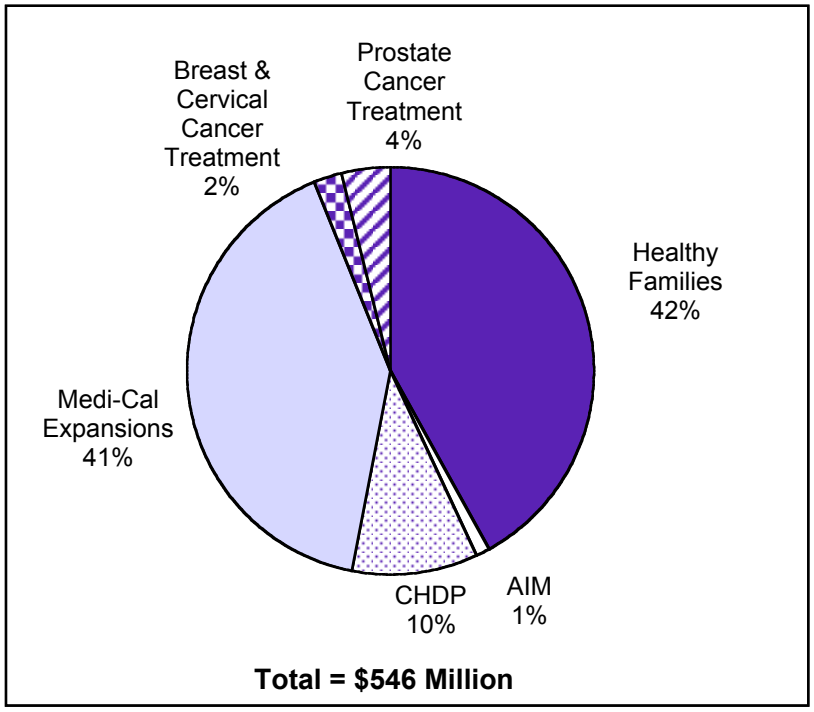
Table 17: Projected Tobacco Settlement Payments to Selected Counties, 2005

Counties	Total Payment: 2005 (In Millions)
Alameda	$15.5
Los Angeles	$102.3
Orange	$30.6
San Bernardino	$18.4
Tulare	$4.0
TOTAL: California Counties	**$404.5**

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

In 2002-03, $546 million in state Tobacco Settlement Funds was allocated for health programs. This figure included $72 million carried over from the previous year. Forty-two percent of the funds supported the Healthy Families program. An approximately equal amount (41%) funded Section 1931 (b) coverage expansions and breast and cervical cancer treatment under Medi-Cal (Figure 8). Funds were also allocated for state-funded breast and cervical cancer treatment and prostate cancer treatment programs, CHDP and AIM.[22]

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



SOURCE: LAO, State Spending Plan, 2002-03

State and local First Five Commissions receive Proposition 10 funding through a 50 cent per pack increase in the state's tobacco tax to improve the early childhood development of children 0-5. Some of this funding ($700 million annually) is being used in some counties to support coverage of uninsured young children in local Healthy Kids programs also known as Children's Health Initiatives. The funds are used both for coverage and for outreach to uninsured children.

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

Funding for County Health Programs for the Uninsured

Insure the Uninsured Project (ITUP) compiled state, county and federal funding for county health programs. Included were state realignment, state Prop 99 funds to counties, federal net county DSH and required county match.[23] Excluded were sources of funding such as county overmatch, county tobacco settlement, private hospital DSH and net SB 1255 for public and private hospitals.[24] From these combined sources, counties receive on average $500 per uninsured resident for the costs of all county health programs, including public health services.[25]

- County Health programs for the uninsured are under-funded when compared to costs of providing public or commercial coverage. ITUP compared funding for county health to the cost of coverage for an average adult, using costs for an essential benefits package as computed by Milliman Inc. for the Blue Shield Foundation of California. Funding for county health was less than 1/6 the cost of coverage through a well-managed commercial HMO with providers reimbursed at commercial rates and 1/4 the cost of coverage through a well-managed HMO with providers reimbursed at Medi-Cal rates (See Figure 4 from ITUP Report on Counties).

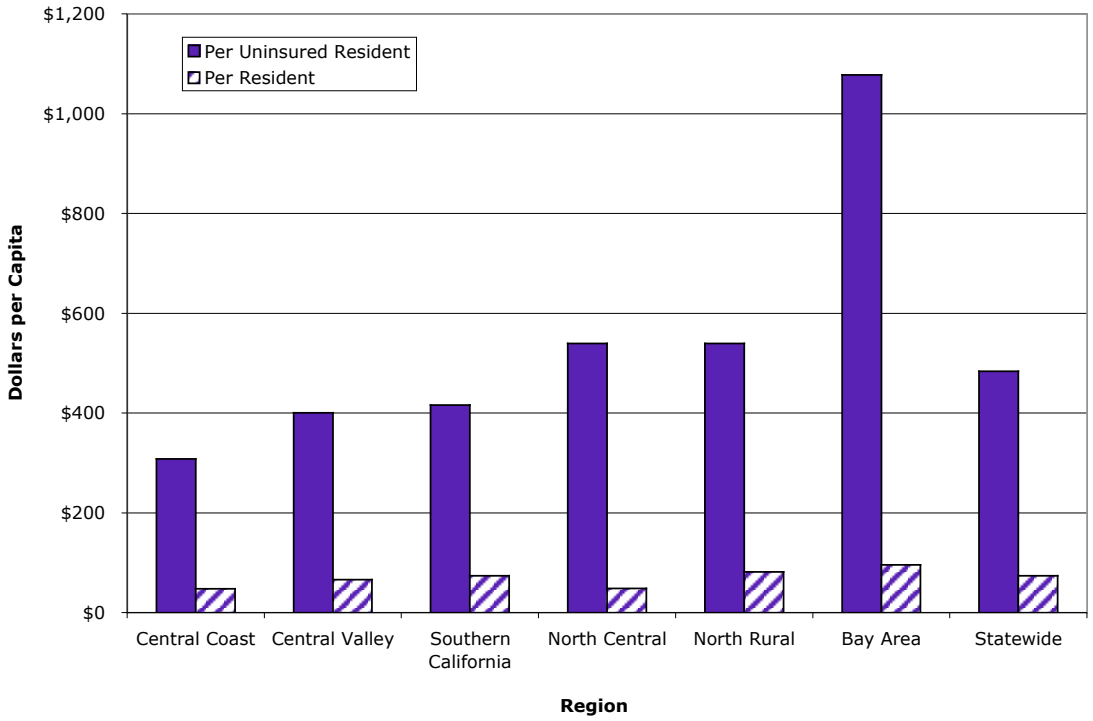
Figure 4. Public Funding* Per Uninsured Resident (MICRS 2002, CMSP Governing Board 2002) Vs. Commercial Spending Per Insured Person (Millman USA 2003)

* Public funding includes Realignment, Prop 99, Net County DSH and County Match
\# Physician Reimbursement at 100% San Francisco Medicare
~ Medi-Cal Reimbursement

[23] Counties may choose to spend their realignment funds on programs such as public health services to all county residents and on county care to the uninsured, but counties must spend their Prop 99 funds on care to the uninsured.
[24] ITUP's rationale for excluding net SB 1255 (about $800 million) is that we lack data on its distribution by county or by region. Our rationale for excluding tobacco settlement is that counties are not required to spend these funds on County Health; many do, some do not. We excluded county overmatch (some counties do and others do not), as counties are not required to spend these funds on county health. We excluded private DSH as this funding goes directly to private hospitals for their uncompensated care to the uninsured; it is not distributed through county health programs although counties may choose to take this funding into account in their program funding decisions.
[25] We divided county health funding by the numbers of uninsured as reported in the 2001 CHIS report.

- Funding for county health per uninsured county resident is highly variable between regions and counties. Funding per uninsured county resident was lowest in the Central Coast region at roughly $300 per uninsured, county resident and highest in the Bay Area region. (Figure 5 from ITUP Report on Counties and the Uninsured, 2003).

Figure 5. Total Funding* Per Capita in California, 2002 (OCHS)



There is also wide variation in funding for county health within the regions. In the Southern California, Central Coast and Central Valley regions, counties with higher funding had twice as much funding per uninsured as those counties with the lowest funding. In the Bay Area, the county with the highest funding had three times as much funding per uninsured as the counties with the lowest funding in the same region. In the Northern Rural region, counties with the most funding had nearly 250% more funding per uninsured than counties with the lowest funding. Inter-county variations in the North Central region were less than two to one from low to high.

California counties pay annually for about 100 inpatient days and 100 emergency room visits per 1000 uninsured;[26] this is a hospital use rate less than half that of an insured adult in California. Counties pay for about one outpatient visit per uninsured;[27] this is a physician use rate of about one fourth that of an insured adult in California. These figures are highly variable by county with those counties with the most funding per uninsured paying for more services and those counties with the least funding per uninsured paying for well below these averages.

[26] We averaged the hospital's OSHPD reports on county funded visits and days and the MICRS and CMSP county reports on county funded visits and days and divided by California's uninsured as reported in CHIS, 2001.
[27] We used the MICRS and CMSP reports on county funded visits and divided by California's uninsured as reported in CHIS, 2001.

OTHER STATE HEALTHCARE PROGRAMS

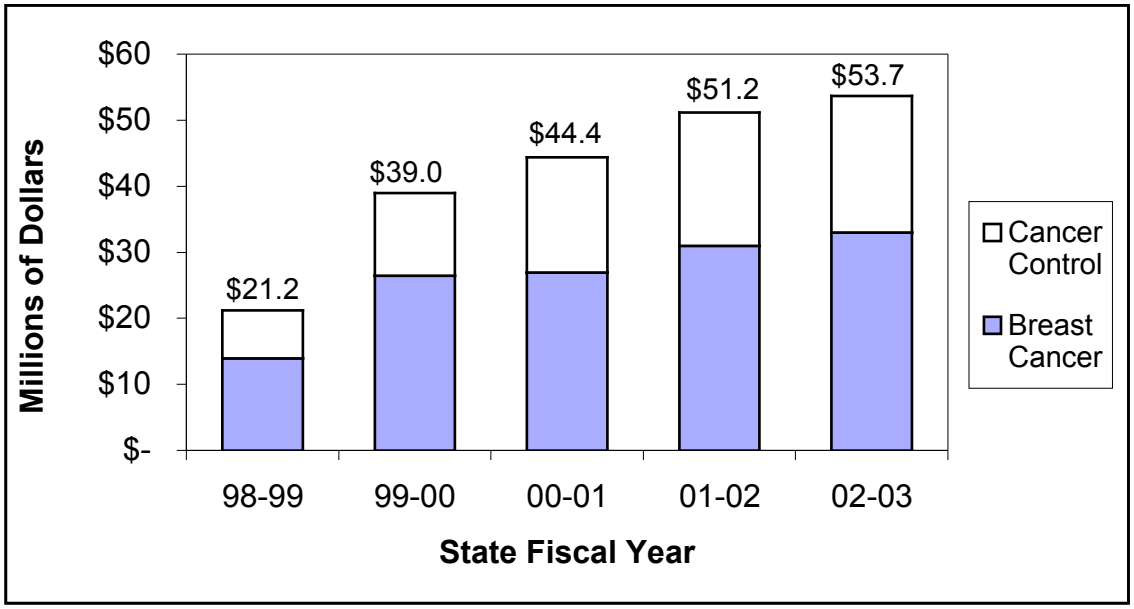
Cancer Control

Although they pale in comparison to Medi-Cal in terms of the number of beneficiaries and expenditures, many other state-funded programs address specific health needs of particular uninsured populations. State spending for cancer control programs expanded dramatically between 1997-98 and 2002-03. Appropriations for the Breast Cancer Preventive Health Services program increased from $14 million to $33 million in 2001-2 (Figure 9). Likewise funding for the cancer control program increased from $7 million to $18 million during this period.

There are three main sources of federal and state funding for breast and cervical cancer:[28]

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

Figure 9: State Expenditures for Breast Cancer Prevention and Cancer Control, SFY 1998-99 to 2002-03



SOURCE: Department of Finance, California State Budget, 2002-03.

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 18). Women are eligible to receive free breast cancer screening services if they are 40 years old or older, earn less than 200% FPL, and have limited or no health insurance to pay for necessary treatment.[29] The same eligibility requirements apply for women to receive free cervical cancer screening except the age requirement is 25 years old or older. Men are eligible to receive prostate cancer screening and treatment services as needed under a similar state program (IMPACT) established in 2000.

[28] Source: California Department of Health Services, Cancer Detection Section, September 2002.
[29] Source: California Department of Health Services, Cancer Detection Section, September 2002.

Table 18: Low-Income Women Receiving Breast and Cervical Cancer Screening in California, 2000-01

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[30]

Created in 1996-7, Family PACT (Planning, Access, Care, Treatment) provides no-cost, comprehensive family planning services to eligible low-income men and women. Individuals are eligible if they are at or below the 200% federal poverty level and do not have another source of health care. Family PACT was initially funded by the State, but since 1999, it has mostly been federally financed through a Medicaid 1115 waiver (which provides 90% of the funding).

In FY 2002-03, Family PACT provided services to 1.57 million clients. The program's expenditure in FY 2003-04 was $414 million.

Immunization and Tuberculosis Control

Between 1998-99 and 2002-03, funding for the immunization assistance program increased from $38 million to $49 million (Table 19). 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 19). In 2002, tuberculosis case rates in California were an average of more than 8.9 per 100,000 compared to the national average of less than 5.2 per 100,000.[31]

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

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

SOURCE: Legislative Analyst's Office.

[30] Source: Department of Health Services. Family PACT Overview.
[31] Source: Department of Health Services. Report on Tuberculosis in CA, 2002.

CHILDREN'S MEDICAL SERVICES PROGRAMS[32]

The 2005-06 State Budget had allocated approximately $243.7 million, which is an increase of $22.7 million (about 10%) from the 2004-05 Budget. The following main programs fall within the Children's Medical Services Programs: Children's Health and Disability Prevention Program, California's Children's Services, and Genetically Handicapped Persons Program.

Children's Health and Disability Prevention (CHDP) Program

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

The initial 2002-03 budget created the "CHDP Gateway" to enroll all eligible, uninsured children into Medi-Cal and Healthy Families. The CHDP Gateway Budget has grown to $101 million for an estimated 173,000 children for the 2004-05 Budget. Program funding for the residual CHDP was reduced as Medi-Cal and Healthy Families financed more services. Thus, in 2003-04 only about $17 million was allocated for approximately 300,000 CHDP health screens (Table 20). The Governor's proposed budget for 2004-05 has continued to decrease this amount by 76% to an estimated $4.2 million for approximately 71,000 CHDP health screens.

Table 20: State Expenditures for the Child Health and Disability Prevention Program, 1998-99 to 2004-05

State Fiscal Year	Expenditures	CHDP Gateway
1998-99	$83,876,000	
1999-00	$84,596,000	
2000-01	$118,251,000	
2001-02	$129,122,000	
2002-03	$99,000,000	
2003-04*	$17,000,000	
2004-05*	$4,200,000	$101,000,000

*Estimated

SOURCE: Legislative Analyst's Office, Analysis of the 2003-04, 2004-05 Budget Bill, and Department of Finance.

California Children's Services (CCS)[33]

The California Children's Services (CCS) program provides comprehensive case management, health care, and therapy to financially eligible children under 21 with special health care needs due to designated physical limitations and chronic diseases. The majority of care provided to these children is funded through the Medi-Cal and Healthy Families programs. Table 21 reveals that the users of CCS grew slightly in 2004-05.

[32] Source: Governor's Budget Highlights, 2005-06.

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

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

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

*Estimated

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

Eighty-eight percent of CCS beneficiaries are eligible for Medi-Cal or Healthy Families. The state and counties contribute equally to CCS for children ineligible for Medi-Cal or Healthy Families. Contributions for the state-only program (for beneficiaries who do not qualify for Medi-Cal or Healthy Families) were projected to decrease approximately 3% between 2003-04 and 2004-05 (Table 22).

Table 22: 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*	$146,260,000
2004-05*	$142,000,000

* Estimated

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

Genetically Handicapped Persons Program (GHPP)[34]

The Genetically Handicapped Persons Program (GHPP) provides health coverage for Californians 21 years old and older with specific genetic diseases including cystic fibrosis, hemophilia, sickle cell disease, and certain neurological and metabolic diseases. GHPP also serves children under 21 years old with GHPP-eligible Medi-Cal conditions who are not financially eligible for CCS. There is no maximum income requirement for GHPP, however, families with incomes greater than the 200% FPL pay based on their family size and income.

Funding for GHPP in 2004-05 is expected to be $49.5 million, which is a 13% decrease from 2003-04. An estimated 1,679 clients would benefit from the service in 2004-05.

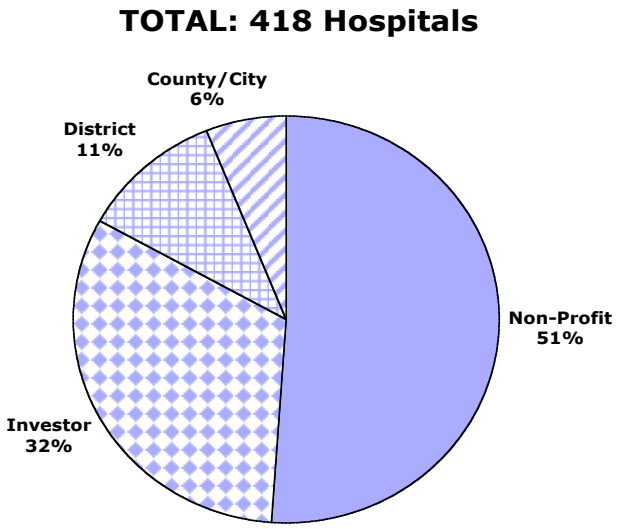
[34] Governor's Budget Summary, 2004-05; Legislative Analyst's Office, Analysis of the 2004-05 Budget.

SECTION 3: THE HEALTHCARE 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 418 comparable hospitals[35] in California, more than half (51%) are non-profit, approximately one-third (32%) are investor-owned, and the remaining are county/city (6%) or district (11%) hospitals (Figure 10). The number of investor-owned hospitals declined from 159 to 115 between 1997 and 2002, but increased to 133 in 2003.

Figure 10: Distribution of Hospitals in California by Type of Control, 2003



SOURCE: Office of Statewide Health Planning and Development, 2003

In 2003, hospitals in California had approximately 17.7 million inpatient days (Table 23), which is an increase of more than one million from the previous year. Medicare paid for 42% of all inpatient days and Medi-Cal covered 21% of days. Third party payers accounted for one-third of all days. While Medicare accounted for the largest percentage of all inpatient days in the state in 2003, private insurance accounted for the most outpatient and emergency room visits (40%). About 7% of hospital services represent care to the uninsured – more than half are reimbursed by counties and less than half are bad debt and charity care. Overall, county indigent programs accounted for 3% of inpatient days, 5% of outpatient visits and 7% of emergency room visits.

In 2003, Medi-Cal patients had the longest average length of stay among payers at 6.5 days, reflecting skilled nursing facility use in hospitals. Medicare and Medi-Cal managed care payers had substantially shorter hospital lengths of stay (4.9 and 4.1 days respectively) in 2003 than fee for service Medicare, fee for service Medi-Cal or county indigent (5.8 days) programs.

[35] 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.

Table 23: Hospital Use, By Payment Source, 2003

Source of Payment	Inpatient Days	Average Length of Stay (Inpatient)	Outpatient Visits (Including ER)	ER Visits*
Total	17,673,686	5.7	43,839,861	9,426,008
Medicare	40%	6.3	26%	16%
Medi-Cal	28%	6.5	21%	25%
County Indigent	3%	5.8	5%	6%
Private Insurance	24%	4.4	40%	38%
All Other Payers	5%	6.0	8 %	14%

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

The payer mix is different for the four types of hospitals. At city and county hospitals, 72% of inpatient days were reimbursed by Medi-Cal or county indigent (about 21%) programs in 2003 (Table 24). In contrast, either Medicare or private insurance covered 69% of the patient days at investor-owned hospitals. Non-profit hospitals mirror the distribution of payers for all hospitals in the state. California hospitals provided 43.8 million outpatient visits, of which 9.4 million occurred in emergency departments.

Table 24: Hospital Utilization* by Payer and Type of Control, 2003

Type of Utilization	All Hospitals	Non-Profit	Investor	City/County	District
Total Inpatient Days	17,673,686	10,940,601	3,852,136	1,588,247	1,292,702
Medicare	7,042,876	4,518,715	1,826,187	201,837	496,137
Medi-Cal	4,987,729	2,637,974	1,035,869	817,121	496,765
County Indigent	600,693	208,937	39,083	330,802	21,871
Private Insurance	4,314,607	3,120,632	846,599	122,095	205,265
All Other	727,781	454,343	104,398	25,790	72,664
Outpatient Visits					
Total Outpatient Visits	43,839,861	29,591,903	5,537,731	5,830,251	2,879,976
Emergency Room Visits	9,426,008	5,767,821	1,854,267	996,664	807,256

*Analysis only includes comparable general acute care hospitals.
SOURCE: Office of Statewide Health Planning and Development, 2003.

In 2003, hospitals generated $42.5 billion in net patient revenues and spent $42.1 billion (Table 25). Among all hospitals, private insurance payments (39%) and Medicare (33%) represent the largest source of payments followed by Medi-Cal (22%). County indigent funded care represents 4% 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. More than 76% of the net revenues of investor-owned hospitals come from Medicare and third-party payers.

Table 25: Net Hospital Revenues, * by Type of Hospital and Revenue Source, 2003

Net Revenues	All Hospitals	Non-Profit	Investor	City/County	District
Medicare	$14,001,303,869	$9,541,863,070	$3,126,289,192	$447,586,730	$885,564,877
Medi-Cal	$9,480,122,630	$4,053,986,530	$1,242,347,912	$3,873,939,516	$309,848,672
County Indigent	$1,523,696,302	$299,374,316	$54,858,433	$1,150,156,106	$19,307,447
Private Insurance	$16,470,366,917	$12,589,341,426	$2,631,174,437	$425,385,687	$824,465,367
Other	$1,910,456,624	$1,149,887,817	$544,944,070	$74,058,017	$141,566,720
Net Patient Revenue	**$43,385,946,342**	**$27,634,453,159**	**$7,599,614,044**	**$5,971,126,056**	**$2,180,753,083**
Total Operating Expenses	**$42,107,909,789**	**$28,064,514,585**	**$6,887,226,309**	**$4,932,856,383**	**$2,223,312,512**

*Analysis includes comparable general acute care medical hospitals.
SOURCE: Office of Statewide Health Planning and Development, 2003.

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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 2003, hospitals in the state reported receiving $1.8 billion in DSH gross payments although they only net about half of this total (Table 26). 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 $4.1 billion in bad debt and charity care charges; the actual cost of bad debt and charity care (charges multiplied by the hospital cost to charge ratio) was $1.2 billion or 2.9 percent of hospitals' net operating expenses.

Table 26: Hospital Utilization and Supplemental Payment, By Type of Control, 2003

Category	All Hospitals	Non-Profit	Investor	City/County	District
Bad Debt	$2,421,819,299	$1,542,326,661	$503,675,604	$194,668,586	$181,148,448
Charity Care	$1,671,543,777	$893,593,165	$532,937,774	$223,238,879	$28,419,834
DSH Funds Received	$1,785,202,291	$401,721,935	$175,916,489	$1,203,906,548	$3,657,319
Net DSH Funds Received	$892,202,291				

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

Federal DSH payments to California hospitals declined to a projected $1.0 billion in 2005 (Table 27). California uses local funds known as Intergovernmental Transfers (IGTs) as the match for federal DSH payments. Federal officials are challenging the use of Intergovernmental Transfers (IGTs) to fund DSH programs in California and other states, putting federal DSH funding for California's hospitals at risk.

Table 27: DSH Payments in California, 1999-2005

Year	Total	Federal	Public net	Private net	County/Public IGT
1999	$2,094,117,647	$1,068,000,000	$617,165,976	$551,467,927	$1,026,117,647
2000	$1,898,039,216	$968,000,000	$503,265,859	$486,993,451	$930,039,216
2001	$2,040,034,000	$1,020,017,000	$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 Department of Health Services, California Association of Public Hospitals and Governor's Budget 2005-06.

Beyond DSH, California provides supplemental state funds to hospitals through a number of mechanisms. In total, these additional supplemental payments accounted for $1.4 billion in 1999-00 and grew to nearly $2 billion in 2003-04 (Table 28). 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. SB 1732 (additional fund to DSH for capital construction costs) declined from $123.7 million in 2002-03 to $107.2 million in 2003-04. The Medical Education Program funds a hospital's medical education costs related to health care services provided to Medi-Cal beneficiaries; this amount was similar in 2003-04 from the previous three fiscal years. AB 761, which is supplemental reimbursement to small and rural hospitals with standby emergency rooms that are not eligible for SB 1255, funded $75,000 for small rural California hospitals in 2003-04.

Table 28: State Supplemental Payments to California Hospitals, 1999/00-2004/05

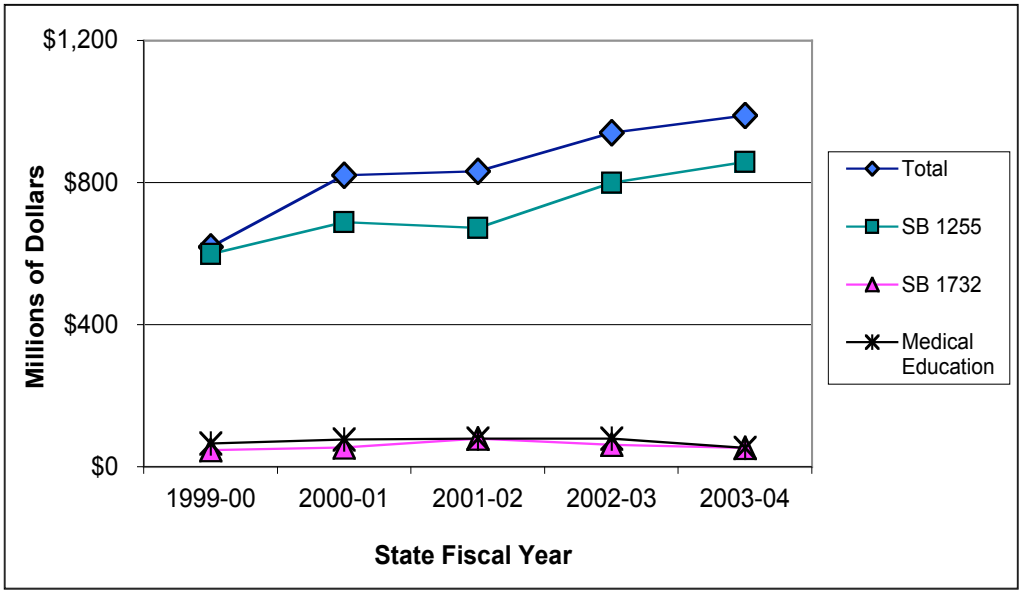
Year	Total Payments	SB 1255	SB 1732	Medical Education	AB 761
1999-00	$1,427,300,000	$1,200,000,000	$94,900,000	$132,400,000	$0
2000-01	$1,641,798,000	$1,377,555,000	$108,943,000	$154,650,000	$650,000
2001-02	$1,663,419,000	$1,344,715,000	$159,354,000	$159,350,000	$0
2002-03	$1,882,400,000	$1,600,000,000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

* Estimated

SOURCE: California Medi-Cal 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 11).

Figure 11: Net Supplemental Payments to California Hospitals, 1999/00-2003/04



SOURCE: California Medi-Cal Assistance Commission Annual Reports.

FREE AND COMMUNITY CLINICS

The 768 licensed primary care clinics reporting to OSHPD represent another important component of the health care safety net in California. In 2003, they provided health care services to more than 3 million patients, about 9% of the total state population (Table 29). According to data from the Office of Statewide Health Planning and Development (OSHPD), 63% of patients were adults over age 20 while 37% were children under 19 in 2002. 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 29: Unduplicated Patients in Private Primary Care Clinics, * By Age, 1997-2003

(In Thousands)

Year	Total Patients	Ages 0-1	Ages 1-19	Ages 20-44	Ages 45-64	Ages 65+
1997	2,431	100	832	1,125	266	107
1998	2,691	107	925	1,212	327	121
1999	2,770	115	979	1,211	338	127
2000	2,828	111	975	1,229	377	136
2002	3,022	110	1,003	1,344	425	140
2003	3,263	Not available	Not available	Not available	Not available	Not available

* Includes both community and free clinics, but not dental clinics.

SOURCE: Office of State Health Planning and Development, Annual Report of Primary Care Clinics 1997-2003.

The total number of patient visits increased 10% between 2002 and 2003, by approximately 1 million (Table 30). In 2003, Medi-Cal beneficiaries accounted for 34% of all encounters while encounters by patients who paid for care out of pocket or who did not pay for care accounted for 10% of all visits. The number of encounters under Medicare, Medi-Cal, and other payers all increased during this period. Between 2002 and 2003, clinics experienced a decrease in the number of CHDP and private insurance patient visits.

Table 30: Visits at Private Primary Care Clinics, * By Payment Source, 1997-2003

(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[36]	650	282	474	1, 250	301	613	625	331
2003	10,182	3,486	1,625	NA[23]	727	246	523	1,470	310	614	561	420

*Includes both community and free clinics, but not dental clinics.

SOURCE: Office of State Health Planning and Development, Annual Report of Primary Care Clinics 1997-2003

In 2003, free and community clinics received revenues totaling almost $1.5 billion (Table 31) – an increase of nearly 16%. Clinics receive funds through grants, contracts, health insurance, and direct payments for services. Grants and contracts accounted for 36% of total clinic revenues while Medi-Cal accounted for 29%. Grant funding increased from $302.1 million in 1997 to $534.1 million in 2003. Medi-Cal increased from $350 million in 2002 to $421 million in 2003.

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

Table 31: Total Revenues at Private Primary Care Clinics, * By Payment Source, 1997-2003

(In Thousands)

Year	Total Revenues	Grants	Medi-Cal	Total Other State+	Total County	Self-Pay	Donations	Medicare	Private Insurance	HMOs
1997	$795,257	$302,059	$196,523	$72,808	$43,621	$48,219	$40,295	$29,310	$26,399	$22,702
1998	$842,286	$304,550	$211,427	$83,323	$48,001	$52,112	$43,755	$33,518	$25,763	$27,001
1999	$920,163	$355,303	$223,902	$95,616	$50,492	$49,235	$47,230	$33,616	$29,135	$22,457
2000	$1,008,996	$401,480	$226,885	$101,157	$55,287	$64,745	$43,556	$34,878	$36,313	$33,047
2002	$1,260,655	$406,537	$349,767	$160,022	$82,621	$54,037	$46,666	$89,433	$55,236	-
2003	$1,462,037	$534,117	$420,772	$159,943	$77,534	$58,989	$65,126	$92,018	$53,538	-

*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 1991-2003.

Patients used community clinics for an average of 3.1 visits in 2003 (Table 32). Medicare patients visited clinics on average 5.5 times in 2003, while uninsured patients averaged 3.9 visits. Payments for the uninsured and Medi-Cal represented the vast majority of net patient revenues.

Table 32: Clinic Use and Patient Revenues, 2003

Payment Source	Patients	Visits	Average Annual Visits per Patient	Net Patient Revenues*
Total	3,263,398	10,182,968	3.1	$910,484,000
Uninsured	1,215,629	4,789,223	3.9	$301,902,403
Medi-Cal	1,023,108	3,485,804	3.4	$420,771,717
Healthy Families	69,838	199,166	2.9	$14,242,606
Medicare	132,551	727,423	5.5	$92.017,595
Private Insurance	200,654	560,638	2.8	$53,537,801
Other Coverage	621,618	420,714	0.7	$28,011,878

* Net patient revenue does not include grants and contracts.

SOURCE: OSHPD, Annual Report of Primary Care Clinics, 2003.

The average payment for each encounter differs considerably across payers. Reflecting the cost-based reimbursement received by Federally Qualified Health Centers (FQHCs), Medicare and Medi-Cal produced the highest average revenue per visit at $126 and $121 respectively in 2003 (Table 33). 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 2003. The categories of county, self-pay and the state Family PACT program are the largest components of clinics' revenues for uninsured patient visits.

Table 33: Average Revenues Per Visit at Private Primary Care Clinics, By Payment Source, 1997-2003

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[37]		$68	$78	$89	$52
2003	$89	$126	$121	$64	$116[24]		$68	$64	$95	$52

* Includes both community and free clinics, and does not include dental clinics.
* Other State includes Free, Breast Cancer, Family PACT, and Healthy Families
SOURCE: OSHPD, Annual Report of Primary Care Clinics 1997-2003.

The uninsured account for nearly 47% of free and community clinic patient visits – about 1.0 annual visits per California uninsured. County payments amount to nearly 30% of clinics' net patient revenues for uninsured patients; a number of counties, however, do not reimburse clinics for their care to the uninsured. In 2003, free and community clinics' uncompensated care for the uninsured (cost of uninsured visits minus uninsured revenues) was $126 million or 14% of clinics' net patient revenues.[38]

Table 34: Clinics Uninsured Revenues, 2003

Total Uninsured Revenues	County	Self Pay	Family PACT	EAPC	CHDP	Breast Cancer
$301,902,403	$84,464,021	$58,989,355	$108,532,800	$32,133,546	$16,868,600	$5,033,584

SOURCE: OSHPD, Annual Report of Primary Care Clinics, 2003.

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

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

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