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Health Policy for Low-Income People in California

*Stephen Zuckerman, Teresa Coughlin,
Len Nichols, David Liska, Barbara Ormond,
Alicia Berkowitz, Meghan Dunleavy,
Jodi Korb, and Nelda McCall*

California health policymakers face an insurance system in which only 57 percent of the nonelderly population is covered by employer-sponsored insurance—one of the lowest rates in the country. As a result, California has a high overall rate of uninsurance and associated concerns related to access to care and health outcomes. In response to these concerns, California has assembled a set of policies that include broad eligibility for Medi-Cal (the state's Medicaid program), private health insurance reforms, and a county-based system of indigent health care. Despite these efforts, one out of five non-elderly Californians lacks health insurance coverage. This situation has placed significant demands on the state's safety net providers.

In a state as large and diverse as California, it is not surprising to find diversity in the design of the state's health policies. Within Medi-Cal, for example, the state is advancing three distinct county-based approaches to managed care that take into account the local health care markets. Similarly, within the indigent care system, counties are free to design their own approaches to meet their obligations to the low-income uninsured.

When California has implemented state-wide initiatives during the past decade, it has relied on the private market and built on the highly developed nature of managed care in the state. Most recently, the state responded to the federal Children's Health Insurance Program (CHIP) by choosing to bypass a major Medi-Cal expansion and establishing a program—Healthy Families—that provides subsidies to allow families to purchase coverage for their children through commercial plans.

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State Characteristics

In 1995, California had a population of 31.6 million, making it the most populous state in the country (table 1). The state is highly urban, with metropolitan areas of more than 1 million people accounting for about three-fourths of the total population. California is also one of the most ethnically diverse states in the nation: Approximately 30 percent of its population is Hispanic, and more than 10 percent is Asian. One-fourth of California's population was born outside the U.S., giving California the highest concentration of immigrants in the nation. This is significant in that documented and undocumented immigrants tend to have

Table 1
State Characteristics

	California	U. S.
Sociodemographic		
Population (1994–95) (in thousands)	31,617	260,202
Percent under 18 (1994–95)	28.7%	26.8%
Percent 65+ (1994–95)	10.6%	12.1%
Percent Hispanic (1994–95)	30.6%	10.7%
Percent Non-Hispanic Black (1994–95)	6.4%	12.5%
Percent Non-Hispanic White (1994–95)	51.0%	72.6%
Percent Non-Hispanic Other (1994–95)	12.1%	4.2%
Percent Noncitizen Immigrant (1996)	18.8%	6.4%
Percent Nonmetropolitan (1994–95)	2.8%	21.8%
Population Growth (1990–95)	6.2%	5.6%
Economic		
Per Capita Income (1995)	\$24,073	\$23,208
Percent Change in Per Capita Personal Income (1990–95)	13.1%	21.2%
Unemployment Rate (1996)	7.2%	5.4%
Percent below Poverty (1994)	16.2%	14.3%
Percent Children below Poverty (1994)	25.6%	21.7%
Health		
Percent Uninsured—Nonelderly (1994–95)	19.7%	15.5%
Percent Medicaid—Nonelderly (1994–95)	18.1%	12.2%
Percent Employer-Sponsored—Nonelderly (1994–95)	56.9%	66.1%
Percent Other Health Insurance—Nonelderly (1994–95)	5.3%	6.2%
Smokers among Adult Population (1993)	18.4%	22.5%
Low Birth-Weight Births (<2,500 g) (1994)	6.2%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995)	6.1	7.6
Premature Death Rate (Years Lost per 1,000) (1993)	52.4	54.4
Violent Crimes per 100,000 (1995)	966.0	684.6
AIDS Cases Reported per 100,000 (1995)	35.2	27.8

Source: Complete list of sources is available in *Health Policy for Low-Income People in California* (The Urban Institute, 1998).

lower incomes and are less likely to have private insurance coverage.

In 1995, California's per capita income was slightly higher than the country's as a whole, \$24,073 versus \$23,208 (table 1). But per capita income growth in California between 1990 and 1995 was lower than in the rest of the nation—13.1 percent compared with 21.2 percent. California did not experience as much growth because it emerged from the recession of the early 1990s at a much slower pace than did other states. One in six Californians—16.2 percent of the state's population—had an income that fell below the federal poverty level (FPL) in 1994, slightly higher than the nation overall. About one-quarter of children lived below the FPL, also higher than the national average.

Some 19.7 percent of California's nonelderly population lacked health insurance in 1994–95. This uninsurance rate was almost 20 percent higher than the national average of 15.5 percent and can be attributed to the relatively low proportion of people with employer-sponsored insurance. Because of California's high poverty rate and broad Medi-Cal eligibility criteria, a larger percentage of the nonelderly population was covered by Medi-Cal than is the case nationwide: 18.1 percent in California compared with 12.2 percent for the nation.

Despite its high rate of uninsurance, California ranks in the top half of states in terms of health status. In 1997 California ranked 18th among all states on a composite measure of health status,¹ and its infant mortality rate was the 15th lowest among all

states. But California continues to be plagued with high levels of infectious disease (e.g., AIDS and tuberculosis).

Political and Budgetary Overview

Pete Wilson, a Republican, has been governor of California since 1990. During Governor Wilson's time in office, for all but the 1994–96 period, Democrats have controlled the state legislature by a small margin.

California's fiscal outlook is good. After the recession in the early 1990s, the state has seen steady economic growth. Revenue increased by 5 percent in state fiscal year (SFY) 1996–97 to \$48.7 billion, generating a small reserve for the first time since this decade's recession.

State and county flexibility in budget decisions is often constrained by the state constitution, legislative rules, or ballot initiatives adopted through the electoral process. Ballot initiatives affect the state budget process by limiting tax options, mandating spending requirements, or creating dedicated tax sources (for example, Proposition 99 in 1988 imposed a cigarette tax to fund health education and indigent health programs). Counties have also been affected by these types of initiatives, most visibly by Proposition 13 in 1978, which limited their ability to raise property taxes and transferred the authority to allocate local property taxes to the state. These propositions have played a significant role in shaping state and county health programs.

Medi-Cal was California's second-largest budget item in 1995, the largest being primary and secondary education. Expenditures from the state general fund for Medi-Cal totaled \$6.3 billion in 1995, 15 percent of overall state spending. Over the past several years, general-fund spending for Medi-Cal has been growing faster than overall state spending. From 1990 to 1995, Medi-Cal spending grew 12.5 percent per year on average, whereas overall state expenditures increased only 1.1 percent per year. When other state and federal expenditures are included, Medi-Cal consumed nearly 20 percent of the total budget in 1995

Table 2
Medicaid Expenditures
by Eligibility Group and Type of Service,
California and United States
 (Expenditures in Millions)

	California			United States		
	Expenditures	Average Annual Growth		Expenditures	Average Annual Growth	
	1995	1990-92	1992-95	1995	1990-92	1992-95
Total	\$16,993.3	21.6%	11.0%	\$157,872.5	27.1%	9.9%
Benefits						
Benefits by Service	\$13,273.1	10.4%	10.9%	\$133,434.6	18.8%	11.0%
Acute Care	9,176.1	13.0%	10.7%	79,438.5	22.1%	13.0%
Long-Term Care	4,097.0	5.1%	11.3%	53,996.1	14.8%	8.3%
Benefits by Group	\$13,273.1	10.4%	10.9%	\$133,434.6	18.8%	11.0%
Elderly	\$3,195.0	7.8%	7.2%	\$40,087.4	16.7%	8.1%
Acute Care	1,094.3	15.1%	7.4%	9,673.7	18.5%	11.9%
Long-Term Care	2,100.7	4.5%	7.1%	30,413.7	16.2%	7.0%
Blind and Disabled	\$4,878.7	9.1%	12.7%	\$51,379.4	17.7%	12.9%
Acute Care	3,146.9	10.8%	11.2%	29,760.7	22.8%	15.2%
Long-Term Care	1,731.8	5.9%	15.6%	21,618.7	12.3%	10.1%
Adults	\$2,400.6	14.0%	9.4%	\$16,556.9	20.4%	9.2%
Children	\$2,798.7	13.3%	13.7%	\$25,410.9	24.3%	13.3%
Disproportionate Share Hospital Administration	\$2,915.3	1311.5%	10.0%	\$18,988.4	261.5%	2.7%
	\$805.0	11.2%	16.6%	\$5,449.4	9.8%	12.8%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

and grew faster than all other budget sectors between 1990 and 1995, at an average of 18.6 percent each year.

Medi-Cal Expenditure Trends

Medi-Cal enrolled 6.8 million Californians at some point during 1995, at a cost of \$17 billion. Despite these high aggregate costs, expenditures on benefits per enrollee were only \$1,959, almost 40 percent below the national average of \$3,202. Of all enrollee categories, spending per elderly enrollee departed most from the national average because of low spending on long-term care. Modest provider payments are credited with making Medi-Cal "cost efficient." The prevalence of private managed care plans and the competitiveness of California's health care market in the face of excess capacity has created an environment in which hospitals and other providers are willing to accept the low rates offered by Medi-Cal.

In terms of eligibility rules and covered services, Medi-Cal is one of the most generous programs in the country. Medi-Cal is available to pregnant women and infants up to age one whose income is below 200 percent of

the FPL, regardless of assets. The state's medically needy program set eligibility at 86 percent of the FPL in 1996, whereas the average for the nation was only 48 percent.² In addition, California has chosen to continue Medi-Cal eligibility for documented immigrants under the same rules that existed before welfare reform. (For undocumented immigrants, who can receive emergency Medi-Cal services, there have been efforts to reduce non-emergency, state-funded health programs, such as prenatal care.) The comprehensiveness of Medi-Cal's service coverage is reflected in its decision to provide 32 of the 34 optional services for which the federal government provides matching funds.

In the early 1990s, Medi-Cal expenditures increased rapidly, although at a somewhat lower rate than the country as a whole: an average increase of 21.6 percent annually in California, versus 27.1 percent in the country from 1990 to 1992 (table 2). From 1992 to 1995, Medi-Cal expenditure growth averaged 11.0 percent each year, a rate that exceeded the national average of 9.9 percent. The growth rate was high at the beginning of the decade largely because of rapid increases in caseload, whereas spend-

ing per enrollee was a larger contributor to aggregate spending increases from 1992 to 1995 (table 3).

Growth in the Medi-Cal disproportionate share hospital (DSH) program was another important reason for expenditure increases. Medi-Cal DSH spending grew from \$11 million to \$2.2 billion between 1990 and 1992 and continued to grow at above-average rates through 1995. Low hospital payment rates may have been sustainable in recent years because of the state's ability to supplement them with DSH payments. However, by 2002, the Balanced Budget Act of 1997 will reduce federal Medi-Cal DSH spending to a level almost 20 percent lower than it was in 1995.³

Medi-Cal Managed Care

Medi-Cal is implementing a major expansion in mandatory managed care. More than 3 million beneficiaries in most of the largest counties will be required to enroll in some type of managed care plan. There are three basic models of managed care in California that will play a significant role in the program. The most widely implemented approach is the two-plan model, which provides capitated services to

Table 3
Medicaid Enrollment and Expenditures
per Enrollee: Contributions to Total Expenditure Growth

	California			United States		
	Average			Average		
	1995	Annual Growth		1995	Annual Growth	
	1990-92	1992-95		1990-92	1992-95	
Elderly						
Total expenditures on benefits (millions)	\$3,195.0	7.8%	7.2%	\$40,087.4	16.7%	8.1%
Enrollment (thousands)	566.0	4.9%	0.9%	4,116.6	5.1%	3.0%
Expenditures per enrollee	\$5,645	2.7%	6.3%	\$9,738	11.0%	5.0%
Blind and Disabled						
Total expenditures on benefits (millions)	\$4,878.7	9.1%	12.7%	\$51,379.4	17.7%	12.9%
Enrollment (thousands)	845.8	7.5%	5.5%	6,405.2	9.8%	9.5%
Expenditures per enrollee	\$5,769	1.5%	6.8%	\$8,022	7.1%	3.1%
Adults						
Total expenditures on benefits (millions)	\$2,400.6	14.0%	9.4%	\$16,556.9	20.4%	9.2%
Enrollment (thousands)	1960.1	14.1%	4.4%	9,584.2	11.5%	4.6%
Expenditures per enrollee	\$1,225	0.0%	4.8%	\$1,728	8.0%	4.4%
Children						
Total expenditures on benefits (millions)	\$2,798.7	13.3%	13.7%	\$25,410.9	24.3%	13.3%
Enrollment (thousands)	3402.6	14.4%	3.5%	21,566.0	13.1%	4.8%
Expenditures per enrollee	\$823	-1.0%	9.8%	\$1,178	9.9%	8.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

Temporary Assistance for Needy Families (TANF), poverty-related, and medically needy beneficiaries in 12 counties and requires that safety net providers be included in at least one of the managed care options. Around 1990, California had planned to expand Medi-Cal managed care through the existing prepaid health plan (PHP) and primary care case management (PCCM) models, but counties and other traditional providers strongly voiced their concern about possible exclusion from a managed care program based on PHPs. This gave rise to the two-plan model, which guarantees a role for safety net providers but gives beneficiaries a choice of a commercial HMO. The other two models are the county-organized health system, in which the county establishes an agency to administer a managed care plan for Medi-Cal recipients, and geographic managed care, in which multiple commercial plans are available to Medi-Cal recipients. The PHP and PCCM models are phased out in counties after one of the three new models is implemented.

Healthy Families Program

Under the Children's Health Insurance Program enacted in the federal

Balanced Budget Act of 1997, California will provide health care coverage for all children through age 18 whose family income is below 200 percent of the FPL. It plans to do this by creating the Healthy Families program and expanding Medi-Cal eligibility. The Healthy Families program envisions using two approaches to ensure maximum enrollment: (1) a purchasing pool in which families select a private health plan and (2) a credit to help families pay the premium for dependent coverage in an employer-sponsored plan, pending legislative action and federal approval. The Medi-Cal program will be expanded to cover low-income children between the ages of 14 and 18 in families whose income is below 100 percent of the FPL. California could receive up to \$859 million in 1998 under CHIP; the state must contribute a 35 percent match on the federal funds it receives.

County Indigent Health Services

California's approach to financing and delivering medical care to the indigent population requires that counties be the providers of last resort. Responsibility for program operations

and funding beyond that provided by federal and state monies rests mainly with the counties. Between \$2 billion and \$2.5 billion are spent annually on services for roughly 1.7 million indigent persons through county programs.

The size, scope, and design of county indigent health care programs vary considerably. This study focused on three counties—Los Angeles, Alameda, and San Diego—that contain more than 40 percent of the state's population and represent different approaches to delivering services to the medically indigent population. Los Angeles and Alameda (which contains Oakland) have built and operate large public systems of hospitals and clinics but are also partnering with private providers in the county. San Diego contracts for indigent health care through the University of California hospital and private sector providers.

The state recognizes that counties would be unable to meet their obligation to the medically indigent without some state participation in funding, particularly after the passage of Proposition 13, which limited counties' ability to increase taxes. Over the years, the nature of state financial support has shifted. Most recently, in 1991, the

state “realigned” funding by replacing block grants with a dedicated fund stream from an increased sales tax and an earmarked portion of the vehicle license fee.

DSH payments to safety net hospitals, many of which are operated by the counties, have been an important supplement to realignment funds. However, DSH funds have not been stable for public providers. As the California health care market has become increasingly competitive, private hospitals have become more willing to treat Medi-Cal patients, especially when the hospitals also receive DSH payments. As a result, the volume of Medi-Cal patients treated at county facilities has fallen while the volume at private hospitals has increased. DSH payments, which are tied to Medi-Cal inpatient stays, have also shifted from county to private providers. Public hospitals are left with the indigent patients but less Medi-Cal support to help pay for their care.

Health Insurance Reforms and the Market

California passed comprehensive small-group insurance reforms in 1992 to make it more difficult for indemnity and managed care insurers to refuse to sell to firms with 2 to 50 employees. The key provisions of California’s small-group reform laws are guaranteed issue, guaranteed renewal, limits on preexisting condition exclusions, and modified community rating. The law also established a voluntary, publicly sponsored, small-employer health insurance purchasing pool, known as the Health Insurance Plan of California (HIPC). As of January 1, 1996, more than 5,000 employer groups and more than 100,000 individuals had enrolled in one or more of the HIPC’s 24 participating health plans.

California’s small-group reforms are widely perceived to have worked well, partly because they helped stabilize the small-group insurance market—premiums fell or increased only slightly in the first few years of reforms. But relative premium declines have not been enough to induce significant increases in coverage. Because of structural economic conditions in the state, the problems

of the uninsured in general and uninsured workers in particular remain.

Health delivery and financing systems are changing everywhere, but California’s system may have been the most extensively reorganized of any in the country. Traditional indemnity insurance has virtually disappeared, and health plan competition now centers around health maintenance organizations and preferred provider organizations. In response to this financing revolution and the excess provider capacity created by changing delivery patterns, provider groups have begun to reorganize themselves to improve their bargaining power and maintain autonomy. Mergers among physician groups, hospitals, and health plans have played a significant role in these developments, as has the conversion of some health plans and hospitals from nonprofit to for-profit status.

Long-Term Care

Long-term care services for the elderly are administered by several different agencies in California, leaving the state without a single point of assessment and referral for the continuum of long-term care services it offers. An intergovernmental task force is working to design a standardized admission instrument for all Medi-Cal long-term care.

California’s long-term care system for younger persons with disabilities, like that for the elderly, is not well integrated. Four different state departments and the counties have responsibility for different groups and different types of services. Although creation of a single department for long-term care has been proposed, it is not likely in the near term, at least for younger persons with disabilities.

Like other states, California has made efforts to control its expenditures on long-term care. Initiatives include the integration of acute and long-term care under a single capitation payment; incentives to purchase private long-term care insurance (6,000 policies are in force); and deinstitutionalization of persons with developmental disabilities and mental illness. Finally, California is in the process of implementing a Medi-Cal

managed care program for mental health. The program calls for a single mental health plan in each county; counties, which have been the traditional providers of public mental health services, will have the right of first refusal to be that plan.

Challenges for the Future

As California moves forward, it will face the realities that have shaped its health policy choices in the past—a large number of low-income uninsured individuals, a very competitive market for health care services, and extensive county-level responsibilities for and variation in approaches to providing health care for low-income persons. The major change currently taking place in Medi-Cal is the expansion of mandatory managed care. The two-plan model has been implemented in 12 counties; however, there are now serious concerns in some of these counties (such as San Francisco) that there may not be enough Medi-Cal enrollees to support two plans. Implementation may be halted in several of these counties. For those ineligible for Medi-Cal, counties are the providers of last resort in California and depend in large part on the Medi-Cal DSH program to fulfill this obligation. The reduction of DSH monies to public providers as a result of Medi-Cal managed care and federal DSH cuts has serious implications for the traditional safety net.

Notes

1. ReliaStar Financial Corporation. “ReliaStar State Health Rankings.” Minneapolis, MN, 1996.

2. The medically needy program is an optional Medi-Cal eligibility category. It permits people with incomes just over the AFDC level to get medical assistance. People may spend down into eligibility because their medical expenses reduce their income or assets to the medically needy levels.

3. “DSH Cuts Will Reduce Federal Funds to Seven States by 20 Percent or More.” *BNA Medicare Report*. Bureau of National Affairs, October 3, 1997.

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Author Affiliations

The Urban Institute

Stephen Zuckerman
Teresa Coughlin
Len Nichols
David Liska
Barbara Ormond
Alicia Berkowitz
Meghan Dunleavy

Laguna Research Associates

Jodi Korb
Nelda McCall

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There are two *Highlights* for each state. The *Highlights* that focus on health cover Medicaid, other public insurance programs, the health care marketplace, and the role of public providers. The income support and social services *Highlights* look at basic income support programs, employment and training programs, child care, child support enforcement, and the last-resort safety net. The *Highlights* capture policies in place and planned in 1996 and early 1997. To receive the full-length reports on which the *Highlights* are based, contact the Urban Institute.

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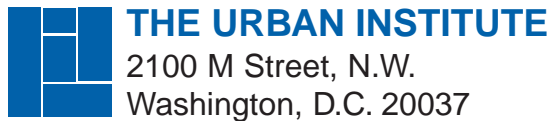
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Telephone: (202) 833-7200 ■ Fax: (202) 429-0687 ■ E-Mail: paffairs@ui.urban.org ■ Web Site: <http://www.urban.org>



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