Overview
Health policymakers in California are challenged to meet the needs of a population that has very low rates of employer-sponsored health insurance and, as a result, high rates of uninsurance. After a period of robust economic growth, the declining economy, which has been exacerbated by the events of September 11, 2001, may make some policy options unaffordable. Furthermore, policy choices are complicated by the fact that the state has a large population of immigrants, many of whom are undocumented and therefore not eligible for most publicly funded programs. California’s basic strategy for addressing the needs of its low-income population is to maintain reasonably broad eligibility for its publicly funded health insurance system, while providing support for a county-based system of indigent care for those uninsured and not eligible for public coverage. Historically, the state has kept reimbursement rates in its public programs low relative to national averages as a means of keeping broad eligibility affordable.

Beginning under Governor Wilson, California took a two-pronged approach in response to the State Children’s Health Insurance Program (SCHIP) and the opportunity to improve children’s health insurance coverage. First, the state expanded Medi-Cal eligibility to all children in families earning up to 100 percent of the federal poverty level (FPL). Second, the state created Healthy Families, a separate children’s health insurance program that provides coverage to children ages 1 through 19 with family incomes between 100 and 200 percent of FPL. Healthy Families has been in the spotlight since its implementation in 1998 and is one of the governor’s top health policy priorities—in part due to the program’s potential to cover uninsured children, but also because it is a nonentitlement program and allows for greater administrative flexibility and a better federal matching rate than Medi-Cal.

With the shift in 1998 from Republican Governor Pete Wilson to Democratic Governor Gray Davis, some hoped for swift and progressive health care reform. However, Davis’s preference for fiscally conservative policymaking coupled with his interest in keeping education a top priority has yielded somewhat restrained reforms in spite of substantial growth in state revenues. Since 1998, California’s health policy has embodied moderate eligibility expansions and enrollment simplification, provider and health plan payment rate increases, a number of initiatives aimed at improving quality of care in nursing homes, and the creation of a new state department aimed at improving patient protections for those enrolled in managed care.

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Although initially criticized for low and slow-building enrollment, Healthy Families has been gaining momentum. California has implemented a number of strategies to simplify children’s enrollment
in Healthy Families and Medi-Cal, including shortening the joint Healthy Families/Medi-Cal application, piloting an electronic application (Health-e-App), and implementing 12 months of continuous coverage for children in Medi-Cal to make it consistent with Healthy Families.

Medi-Cal has also been changing under Governor Davis. In 2000, California expanded eligibility for Medi-Cal under a 1931(b) program by making all parents with incomes up to 100 percent of FPL eligible for coverage (the previous limit was roughly 74 percent of FPL). In addition, California increased the Medically Needy eligibility level for the aged, blind, and disabled to 133 percent of the FPL (up from a maintenance need level of 84 to 90 percent of FPL). As part of the federal Ticket to Work and Work Incentives Improvement Act, California has extended Medi-Cal benefits to working individuals with disabilities earning below 250 percent of FPL.

In addition to changes resulting from the recent eligibility expansions, the state’s Medi-Cal managed care program continues to evolve. Although welfare reform and the improving economy resulted in actual Medi-Cal managed care enrollment falling short of projections, approximately 52 percent of Medi-Cal beneficiaries are currently enrolled in managed care and 26 of 58 counties enroll some or all Medi-Cal beneficiaries into managed care. To improve access and quality within the Medi-Cal program, and in part because it is long known for having among the lowest Medicaid payment rates in the country, California adopted a broad package of rate increases for Medi-Cal providers totaling $800 million in the budget for 2000–01. As part of these increases, California increased capitation rates by 9.2 percent for plans participating in the “two-plan” model, a managed care model that includes a county developed plan (e.g., local initiative) and a commercial plan. Also included in this broad rate increase initiative were a 10 percent rate hike for nursing homes and a 7.5 percent wage pass-through for long-term care workers in nursing homes.

The quality of nursing home care has been a pressing issue in California since a 1998 Government Accounting Office audit revealed that nearly a third of California’s nursing homes had serious and often life-threatening violations. The rate increase, along with a series of measures to increase oversight of nursing home facilities, was part of the governor’s Aging with Dignity Initiative—a broad-based senior care proposal targeted at improving the quality of long-term care (LTC). The initiative also included measures to promote community-based care such as a $500 tax credit for taxpayers who are eligible caregivers for individuals with LTC needs.

California has also been moving forward with managed care reform to provide patient protection and education for its 23.5 million citizens enrolled in managed care plans. In 1999, California passed a law that allows patients to hold health plans accountable in court when an HMO causes “substantial harm” to a patient. Another significant development, particularly in light of the national debate on a patients’ bill of rights, is the creation of the California Department of Managed Health Care. Launched in July 2000, the Department has an HMO Help Center where consumers can go 24 hours a day, 7 days a week, for assistance in dealing with their health plan. In addition to the Help Center, the Department of Managed Health Care is responsible for licensing all plans (including SCHIP and Medi-Cal plans), providing an annual HMO report card, and monitoring the financial solvency of the state’s medical groups—in response to recent medical group insolvencies that challenged plans’ abilities to maintain continuity of care.

In light of the slowing economy, Davis feels that his fiscally conservative approach to policymaking has been vindicated. By not having committed to large spending increases and by dedicating the state’s sizable tobacco settlement to health programs, the governor’s 2001 budget revision—which reflected lower revenue projections—avoided major cuts in Health and Human Services spending. Nevertheless, the future course of California health policy is far from certain. The state does not yet know how its supplemental payment program that subsidizes many safety net hospitals will be affected by federal regulations limiting Medicaid payments. In addition, with Medicaid enrollment expected to increase and
an uncertain economy, California is likely to face some difficult policy tradeoffs in the coming year.

This study is part of a series of 13 state reports examining new opportunities in health policy for low-income people over the past five years and how these opportunities have put new pressures on policy formulation. Many developments increased state flexibility, including welfare reform and delinking of Medicaid from cash assistance, new funding for children’s health insurance coverage under SCHIP, repeal of federal minimum standards for nursing home and of hospital reimbursement that had constrained states’ control over Medicaid payments, and federal willingness to grant waivers under Medicaid (and now under SCHIP as well). Fiscal capacity also rose—from booming revenues during the long economic expansion of the 1990s and from new tobacco settlement funds.

However, new pressures on revenues and state policy arose from recent federal economizing under Medicaid and Medicare, notably including cuts in safety net support that was believed to have been abused by some states; political pressures for state tax cuts; and, starting in 2001, an economic slowdown and fears of recession. The terrorist attacks of September 11, 2001, have accelerated the downturn in the economy that was already beginning to affect California. New pressures also arose from the Supreme Court’s *Olmstead* decision that detailed a right to home- and community-based services under the Americans with Disabilities Act, rapid growth in pharmaceutical spending, and the difficulties faced by Medicaid managed care. Political demands for public action arose from developments such as the rise in uninsurance, growth in private and public managed care.
rising pharmaceutical costs, hospital fiscal woes, as well as from events specific to each state.

To examine how states have responded to both federal constraints and state flexibility during the last half decade, this study of California and 12 other states examines state priority setting and program operations in health policy affecting the low-income population.\(^1\) Five major sets of issues are addressed in this set of reports. First, how have the political and fiscal circumstances of the state changed over the last several years? Second, has the state expanded public or private health insurance coverage, through Medicaid, SCHIP, Medicaid research and demonstration waivers, or state-funded programs? Third, how have Medicaid managed care and other acute care issues changed? For example, has access been affected by managed care plan withdrawals from Medicaid or backlash against plans by providers or beneficiaries? How are states coping with federal Disproportionate Share Hospital (DSH) cuts? Fourth, how are states responding to pressures to expand home- and community-based services for disabled persons, their new freedom to set reimbursement rates, and the labor shortage? Fifth, what other issues were prominent?

This report examines the major health policy issues California has dealt with in the period between 1997 and 2001, highlighting Medi-Cal (California’s Medicaid program) enrollment and expenditure trends, policy developments in Medi-Cal and Healthy Families (California’s separate State Children’s Health Insurance Program), and other recent acute and long-term care issues. Information for this report comes primarily from an early 2001 case study. As part of the case study, researchers conducted interviews with a range of health policy stakeholders, including state officials, legislative staff, and industry representatives. This report updates a 1997 study on health policy for low-income people in California.

Background

Demographics and Insurance Coverage

California is the largest state in the country, with about one of every eight Americans living within its borders. The state’s racial and ethnic composition is quite different from that of the country as a whole (see table 1). About one-third of Californians are of Hispanic origin, compared with only 12 percent of the overall U.S. population. California also has a large Asian population, which makes up roughly 12 percent of the state’s population compared with 4 percent nationally. African-Americans make up only 7 percent of California’s population, but account for 13 percent nationally. In terms of economic indicators, although California has a per capita income that is slightly above the U.S. average, it also has poverty rates for adults and children that are above the U.S. average. In addition, poverty rates for California’s children fell at about twice the rate as the rate for children nationally, while poverty rates for adults in California decreased more slowly than for adults nationally.

There are different patterns of insurance coverage among adults and children in California. The overall uninsurance rate for children in the state is not significantly different from the national rate (see table 2). This holds for children in both low- and higher-income families. For children in low-income families (income below 200 percent of FPL), below-average rates of employer-sponsored coverage are offset by above-average rates of public coverage. However, among adults at all income levels, low rates of employer-sponsored coverage are not offset by sufficiently high rates of public coverage and, as a result, California adults are significantly more likely to be uninsured.

Political Developments

In 1998, after California had spent eight years under the administration of Republican Pete Wilson, Democrat Gray Davis took over as governor. This put control of the governor’s office and both houses of the state legislature into Democratic hands. Previously, there had been tension between the Republican governor and the Democratic legislature. The elec-
tion of a Democrat to the State House lessened but did not eliminate the tension, especially not in the area of health policy. This is because Davis is a fiscally conservative Democrat who has been unwilling to make policy changes that could result in future budgetary commitments that might be difficult to meet. In addition, Davis has made clear that his top three spending priorities are “education, education, and education,” a fact that many in California’s health policy community were slow to accept.

Two areas of health policy—adult eligibility for public coverage and generosity of Medi-Cal provider payment rates—can be used to highlight the similarities and differences between Governors Wilson and Davis. Both men favor the separate program created under the State Children’s Health Insurance Program (SCHIP)—Healthy Families—over the Medi-Cal program as the means for expanding coverage. The preference for Healthy Families relates to the fact that Healthy Families is not an entitlement program, it offers more administrative flexibility, and it is less costly to the state because the federal matching rate is higher.

Davis moved ahead with an eligibility expansion for children under Healthy Families and has also applied for a waiver to expand eligibility for parents under the program. However, indicative of Davis’s reluctance to expand Medi-Cal, he has not chosen to include parents with incomes up to 133 percent of the federal poverty level (FPL) in Medi-Cal, even though coverage for their young children (up to age 6) is mandated through Medi-Cal. There is no way to know how Wilson might have chosen to spend the additional revenues available to the state as a result of the improved economy. However, the consensus from the people interviewed for this study was that Davis was more interested in health policy for low-income people than Wilson, although not as proactive as the legisla-

### TABLE 2. Health Insurance Coverage, by Family Income and Type of Insurance, California and the United States, 1999

<table>
<thead>
<tr>
<th></th>
<th>Children (Ages 0–18)&lt;sup&gt;a&lt;/sup&gt; (%)</th>
<th>Adults (Ages 19–64)&lt;sup&gt;b&lt;/sup&gt; (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 200% FPL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer-sponsored</td>
<td>California 29.0</td>
<td>United States 38.7</td>
</tr>
<tr>
<td>Medicaid/SCHIP/state</td>
<td>California 40.8</td>
<td>United States 35.2</td>
</tr>
<tr>
<td>Other coverage</td>
<td>California 5.1</td>
<td>United States 3.8</td>
</tr>
<tr>
<td>Uninsured</td>
<td>California 25.1</td>
<td>United States 22.4</td>
</tr>
<tr>
<td>Above 200% FPL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer-sponsored</td>
<td>California 82.0</td>
<td>United States 85.3</td>
</tr>
<tr>
<td>Medicaid/SCHIP/state</td>
<td>California 4.5</td>
<td>United States 3.8</td>
</tr>
<tr>
<td>Other coverage</td>
<td>California 7.7</td>
<td>United States 4.9</td>
</tr>
<tr>
<td>Uninsured</td>
<td>California 5.8</td>
<td>United States 6.0</td>
</tr>
<tr>
<td>All Incomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer-sponsored</td>
<td>California 59.6</td>
<td>United States 66.7</td>
</tr>
<tr>
<td>Medicaid/SCHIP/state</td>
<td>California 19.8</td>
<td>United States 16.4</td>
</tr>
<tr>
<td>Other coverage</td>
<td>California 6.6</td>
<td>United States 4.5</td>
</tr>
<tr>
<td>Uninsured</td>
<td>California 14.0</td>
<td>United States 12.5</td>
</tr>
</tbody>
</table>

Note: Figures in bold represent values that are statistically significantly different from the national average at the 0.10 confidence level or better.

FPL = federal poverty level
SCHIP = State Children’s Health Insurance Program

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ture or some advocates might have wanted. Neither governor seemed inclined to under-
take major policy shifts that would have had big associated costs.

One area where Davis’s policies have differed substantially from Wilson’s relates to
health care workers. Davis is viewed as more “sympathetic” to the unions than Wilson.
For example, Davis increased the rates paid to nursing homes on the condition that a por-
tion of the increase be targeted to increasing the wages of workers; auditors were assigned
to make sure this happened. Similarly, Davis has committed the state to sharing in the cost
of a series of wage increases and health care benefits for home care workers caring for
Medi-Cal recipients who are employed in a county with a public authority.2 The provision
of the wage increases and health benefits is subject to collective bargaining and the
approval of the county board of supervisors in each county with a public authority. To
accommodate union representation, Davis signed legislation that an employer of record be
designated in each county for Medi-Cal home care workers.3

Market Developments

Despite having a very high share of its insured population enrolled in managed care,
Californians faced significant premium increases in recent years. Between 1998 and 1999,
premiums in the individual insurance market rose between 18 and 36 percent. Even for
California Public Employees Retirement System (CalPERS) enrollees, premiums rose by 12
percent over that same period. As CalPERS moved into 2001, the self-insured plans that it
offered were facing substantial losses and the benefits committee felt it had no choice but
to cut benefits. Although no service coverage changes were adopted, CalPERS decided to
increase family deductibles from $500 to $1,000 and to raise copayments for visits, hospi-
talizations, and prescription drugs.

Some of this pressure on health care premiums could be related to the finding that
provider consolidations, especially among hospitals, put providers in a better position to
charge higher prices for their services.4 However, hospital mergers and the expansion of
hospital systems in California have not been a guaranty of a strong financial position.

One of the more highly publicized hospital mergers in the state took place between
Stanford University Hospital and the University of California–San Francisco (UCSF)
Hospital in 1997. An explicit goal was that the partnership would “give the new corpora-
tion more power to bargain with managed care firms and would reduce costs.” By the
middle of 1999, it became clear that the UCSF Stanford Health Care System was losing
money. Losses of about $170 million were being projected for 2000 and 2001, with reasons
ranging from poor coordination of staffing after the merger to the high costs of treating
low-income patients at one facility in the system to the costs of compliance with seismic
engineering standards. Within months of identification of these projected losses, the merg-
er was dissolved. Similarly, Catholic Healthcare West (CHW)—the largest nonprofit
healthcare provider system in California, blamed low reimbursement rates, seismic
upgrade expenses, rising drug costs, and uncompensated care for operating losses of $317
million in 2001. In response, the CHW system sold one hospital, restructured its organiza-
tion, and eliminated 350 jobs at the administrative and corporate level.

A more disruptive market development occurred when the MedPartners Provider
Network filed for bankruptcy in 1999. MedPartners, an out-of-state physician practice
management company, had organized medical practices into a “virtual provider organiza-
tion” that was marketed to health insurers. Providers were paid on a capitated basis and
were promised that marketing and management services, group purchasing, and other
resources provided by the parent company would allow this network of provider groups
to thrive. However, after building up a substantial patient enrollment, MedPartners
defaulted on many of its payment obligations and sold some member practices to hospi-
tals or other large groups. The southern California part of the network was sold to a rela-
tively new physician organization that was not able to keep things going and ultimately
declared bankruptcy in late 2000.

Although the reasons for this major financial failure are difficult to sort out, and
charges from providers and health plans abound, it is clear that avoidance of another
provider network upheaval became a policy objective for the state.6 In fact, the turmoil
The MedPartners debacle was cited as a reason for the development of the new Department of Managed Health Care (DMHC, discussed below). This new department does not have oversight authority over medical groups, but can influence health plan behavior through its licensing and oversight authority. In June 2001, the DMHC took over day-to-day operations of Maxicare Health Plans, a large Los Angeles-based HMO, when it became apparent that the HMO did not have sufficient reserves to meet minimum solvency requirements. DMHC reports that the Maxicare has continued in operation and has been paying its bills. The final resolution of this problem has not yet been determined.

Certain provisions of the 1996 Health Insurance Portability and Accountability Act (HIPAA) have raised concerns among health plans, especially among programs administered by the state. These provisions relate to administrative simplification and security procedures. The state interprets HIPAA as requiring all health providers and plans that engage in electronic and administrative transactions to meet a national set of standards for coding and tracking medical information and for assuring security of that information and patient privacy. There is a concern that if these standards are not met, some federal funding could be at risk or other financial penalties could be imposed. Across all state agencies, the 2001–02 budget is estimating that the state will need to spend about $37 million from its general fund to pay for HIPAA implementation.

State Fiscal Circumstances
General Fiscal Condition and Budget Priorities

California’s economy was strong in recent years, and state fiscal year expenditures were on target in 2001. In 2000–01, general fund revenues increased by $6.9 billion (9.7 percent), reflecting strong revenue collections attributable to 2000 economic activity. However, California’s budget outlook remains uncertain due to a projected revenue decline and the still-unknown impact that the September 11, 2001, terrorist attacks may have on the economy.

The state budget shows some insight into overall state policy and program priorities (see table 3). Education has been a top policy and budget agenda item for Governor Davis, and not surprisingly, K–12 and higher education made up nearly 50 percent of state general-fund expenditures in 2000. Education was the fastest growing budget item between 1995 and 2000, growing at nearly three times the rate of the state’s Medicaid program and several percentage points higher than the national average. Total state spending over this period grew 4 percentage points higher than the national average annual growth rate, driven primarily by the increased education spending. Medicaid expenditures made up 12 percent of estimated state spending in 2000, making Medicaid the second largest spending item in California’s general fund budget after education—albeit a very distant second.

Currently, the strength of California’s economy is being affected by slowing economic growth and consequently, reduced anticipated tax revenues. In the 2001–02 budget year, revenue growth is projected to decrease by $2.9 billion (a 4 percent decline, compared with a 6.9 percent increase in 2000–01), reflecting the anticipated slower economic activity and a decline in capital gains and stock options-related income in 2001.

In May, the governor issued a revised budget that proposes reducing general fund spending by roughly $3 billion in FY 2001–02. The governor tried to spread the revised reductions across many areas, with the exception of Education and Health and Human Services, which received small increases in funding. Significant cuts were proposed for the Resources Agency and the Business, Transportation, and Housing Agency. California, thus far, has avoided any major budget cuts in Health and Human Services by not having committed to large spending increases and by dedicating the state’s sizeable tobacco settlement to health programs. Nevertheless, the state has adopted a “cost avoidance” strategy for Health and Human Services, which means that efforts are being made to control costs without cutting covered services or eligibility. In the 2001–02 budget, cost avoidance efforts have included freezing provider payments, exploring pharmacy rebate options, and
expanding Medi-Cal anti-fraud initiatives. However, the events of September 11, 2001, which accelerated the downturn in the economy, will likely increase the budget pressure on Medi-Cal and other health programs.

In addition to the slowing economy, it is estimated that California will suffer a net loss of more than $9 billion from power purchases this year due to the financial insolvency of two of the state’s investor-owned utilities. While revenue bonds have been authorized for the purpose of repaying the general fund, the energy crisis contributed to a sense of unease during the summer 2001 budget negotiations.

### Tobacco Settlement Revenue and Priorities

California received $1 billion in three tobacco settlement payments during the past 12 months and will receive another two payments in 2001. California is expected to receive $25 billion over 25 years. The settlement revenue is divided as follows: 50 percent to the state for appropriation; 40 percent to the counties; and 10 percent to Los Angeles, San Diego, San Francisco, and San Jose. The state’s share was deposited in the general fund and was not earmarked; however, the governor advised the legislature that his 2001–02 budget proposal earmarked this settlement entirely for the expansion of services to children, low-income and uninsured adults, cancer treatment (e.g., breast, cervical, and

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**TABLE 3. California Spending by Category, 1995 and 2000 ($ in Millions)**

<table>
<thead>
<tr>
<th>Program</th>
<th>State General-Fund Expenditures&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Total Expenditures&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual 1995</td>
<td>Estimated 2000</td>
</tr>
<tr>
<td></td>
<td>CA</td>
<td>U.S.</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Medicaid&lt;sup&gt;c,d&lt;/sup&gt;</td>
<td>$6,382</td>
<td>$7,639</td>
</tr>
<tr>
<td>% of Total</td>
<td>15%</td>
<td>12%</td>
</tr>
<tr>
<td>K–12 Education</td>
<td>$14,381</td>
<td>$24,629</td>
</tr>
<tr>
<td>% of Total</td>
<td>34%</td>
<td>37%</td>
</tr>
<tr>
<td>Higher Education</td>
<td>$4,910</td>
<td>$7,759</td>
</tr>
<tr>
<td>% of Total</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>Public Assistance</td>
<td>$5,105</td>
<td>$4,861</td>
</tr>
<tr>
<td>% of Total</td>
<td>12%</td>
<td>7%</td>
</tr>
<tr>
<td>AFDC/TANF</td>
<td>$2,815</td>
<td>$1,850</td>
</tr>
<tr>
<td>% of Total</td>
<td>7%</td>
<td>3%</td>
</tr>
<tr>
<td>Corrections</td>
<td>$3,241</td>
<td>$4,521</td>
</tr>
<tr>
<td>% of Total</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Transportation</td>
<td>–38</td>
<td>5%</td>
</tr>
<tr>
<td>% of Total</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>All Other&lt;sup&gt;e&lt;/sup&gt;</td>
<td>$7,943</td>
<td>$16,409</td>
</tr>
<tr>
<td>% of Total</td>
<td>19%</td>
<td>25%</td>
</tr>
</tbody>
</table>

**Source:** National Association of State Budget Officers (NASBO), 1996 State Expenditure Report (April 1997), and 1999 State Expenditure Report (June 2000).

a. State general-fund expenditures exclude other state funds and bond expenditures.

b. Total spending for each category includes the general fund, other state funds, bonds, and federal aid.

c. States are requested by the National Association of State Budget Officers to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as “other state funds.” In some cases, however, a portion of these taxes, fees, and so forth are included in state spending because states cannot separate them.

d. Total Medicaid spending will differ from data reported on the HCFA-64 for three reasons: first, NASBO reports on the state fiscal year and the HCFA-64 on the federal fiscal year; second, states often report some expenditures (e.g., mental health and/or mental retardation) as other health rather than Medicaid; third, local contributions to Medicaid are not included but would be part of Medicaid spending on the HCFA-64.

e. This category could include spending for the State Children’s Health Insurance Program, institutional and community care for mentally ill and developmentally disabled persons, public health programs, employer contributions to pensions and health benefits, economic development, environmental projects, state police, parks and recreation, housing, and general aid to local government.
An Urban Institute Program to Assess Changing Social Policies

Medicaid Trends
As with many state Medicaid programs, Medi-Cal enrollment in the late 1990s underwent a significant decline among adults and children receiving cash assistance because of welfare reform and the strong economy. While this was somewhat offset by gains in enrollment among those not receiving cash assistance, enrollment is still below prewelfare reform levels. Medi-Cal spending per enrollee remains very low compared with other states. California’s low spending per Medi-Cal enrollee is, and has historically been, a means of keeping broad eligibility affordable. Growth in Medi-Cal spending rose in 1999 and 2000 primarily because of increasing prescription drug costs, Medi-Cal expansions, and long-term care wage increases.

Enrollment
Data collected through the Centers for Medicare and Medicaid Services (CMS) show that, between 1995 and 1998, Medi-Cal enrollment fell by about 200,000 people or 1.3 percent annually (see table 4). This overall change is consistent with national trends that showed a 1 percent annual reduction in enrollment. Both nationally and in California, the drop in enrollment was concentrated among adults and children who receive cash assistance (excluding the elderly and the disabled). By 1998, Medi-Cal enrollment among adults who received cash assistance had fallen to 60 percent of 1995 levels. To some extent this was offset by gains in enrollment among California adults not receiving cash assistance, but these offsets were not as great as those observed nationally. For California children who receive cash assistance, the decline in Medi-Cal enrollment was smaller than that observed nationally. In addition, the growth in the number of Medi-Cal children enrolled through poverty-related categories more than offset the drop in the cash assistance eligibility groups. It appears that adults who were no longer receiving cash assistance—many of whom were immigrants in California—were unaware of their opportunity to retain Medi-Cal coverage or were unwilling to apply for the benefits. These immigrant adults may have feared that their own or their children’s use of benefits would render them a “public charge” under immigration laws and would subsequently affect their ability to gain legal permanent residence or to naturalize, or might even lead to deportation. These concerns were fostered by some immigrants who were mistakenly made to repay Medi-Cal benefits in order to gain legal permanent resident status or reenter the country after a trip abroad.10

More recent data reported by the California Department of Health Services suggest that Medi-Cal enrollment rebounded somewhat in 1999, but remains below 1997 levels. These data show that Medi-Cal enrollment fell from 5.2 million in June 1997 to 5.0 million in December 1997, then rose to 5.1 million in June 1999.11 The state’s data indicate that enrollment of “Public Assistance Families” (comparable to the combination of adults and children who receive cash assistance) fell by nearly 337,000 from December 1998 to December 1999, but increases in enrollment of Medicaid-only families completely offset this decline.12 Enrollment of elderly and disabled people grew slowly but steadily from June 1997 to December 1999.

Expenditures
Aggregate Medi-Cal expenditures grew at a rate of 3.8 percent annually between 1995 and 1998, slightly below the national average of 3.9 percent (see table 4). However, expenditures per enrollee in California were $3,207 and this ranked California 50th of the 51 states (including the District of Columbia) in the nation (see table 4). These low spending levels have been a persistent characteristic of the Medi-Cal program.13 Although lagging in the level of spending, the 7.6 percent annual growth in Medi-Cal expenditures per enrollee was slightly above the national average of 6.1 percent.
TABLE 4. Medicaid Enrollment and Expenditures in California, 1998

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Total Expenditures</td>
<td>$19.0</td>
<td>–</td>
</tr>
<tr>
<td>Medical Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>By Eligible Group</td>
<td></td>
<td></td>
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<tr>
<td>Elderly</td>
<td>$15.9 $3.6</td>
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<tr>
<td>Blind and disabled</td>
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<tr>
<td>Adults</td>
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</tr>
<tr>
<td>Cash assistance</td>
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<td>551</td>
</tr>
<tr>
<td>Other enrollees</td>
<td>$1.4 $1.4</td>
<td>563</td>
</tr>
<tr>
<td>Children</td>
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<tr>
<td>Cash assistance</td>
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<td>Other enrollees</td>
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<tr>
<td>By Type of Service</td>
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<td></td>
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<tr>
<td>Acute care</td>
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<td>–</td>
</tr>
<tr>
<td>Long-term care</td>
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<td>–</td>
</tr>
<tr>
<td>DSH</td>
<td>$2.5</td>
<td>–</td>
</tr>
<tr>
<td>Administration</td>
<td>$0.6</td>
<td>–</td>
</tr>
</tbody>
</table>

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports.

Note: Does not include the U.S. Territories. Enrollment data shown are estimates of the average number of people enrolled in Medicaid in any month during the fiscal year. Expenditures per enrollee shown reflect total annual expenditures on medical services for each group, divided by the average monthly enrollment within that group. “Cash assistance” refers to enrollees who receive AFDC/TANF or SSI, or who are eligible under Section 1931 provisions. “Other enrollees” include the medically needy, poverty-related expansion groups, and people eligible under Medicaid Section 1115 waivers. “Acute care” services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, EPSDT, family planning, dental, vision, other practitioners’ care, payments to managed care organizations (MCOs), and payments to Medicare. “Long-term care” services include nursing facilities, intermediate care facilities for the mentally retarded, inpatient mental health services, home health services, and personal care support services. “DSH” stands for disproportionate share hospital payments.
Medicaid expenditures (state and federal combined) accounted for roughly 16 to 17 percent of California’s total expenditures from SFY 1998 through SFY 2000. According to another National Association of State Budget Officers (NASBO) study, California’s Medicaid “costs” grew by 11.1 percent in SFY 1999 and 10.8 percent in SFY 2000, compared with 6.2 percent and 7.7 percent nationally, and 9.3 and 9.9 percent for states in the Far West region. Prescription drug costs, Medi-Cal expansion, and long-term care facilities’ wage increases were the major Medicaid cost drivers in SFY 2000 and SFY 2001.

Expectations for the Future

During fiscal year 2000–01, there were approximately 5.2 million Medi-Cal beneficiaries in any given month. Due to eligibility expansions and simplified enrollment procedures, Medi-Cal enrollment is expected to increase in 2001–02 by 15 percent—to an average monthly caseload of about 6.1 million beneficiaries. The proposed budget anticipates this enrollment increase and allocates funding accordingly. It is unclear to what extent the economic slowdown may increase Medi-Cal enrollment beyond budgeted levels.

Health Insurance Coverage

In recent years, California has furthered its reputation for broad eligibility. California has expanded Medi-Cal by increasing the income limit up to 100 percent of FPL, extending no-cost benefits to the aged, blind, and disabled for those earning up to 133 percent of FPL, and implementing a Medi-Cal buy-in for persons with disabilities earning up to 250 percent of the FPL. Under SCHIP, California also expanded adolescent children’s Medi-Cal coverage to 100 percent of the FPL. The state’s separate SCHIP program, Healthy Families, was expanded under the Davis administration to 250 percent of FPL and the state has submitted a waiver proposal to cover parents in Healthy Families earning up to 200 percent of FPL.

Medi-Cal Coverage Expansions

Section 1931(b). On January 1, 1998, California implemented its Temporary Assistance for Needy Families (TANF) program, California Work Opportunity and Responsibility to Kids (CalWORKS). In the wake of welfare reform, which severed the link between cash benefits and Medicaid, states may implement Section 1931(b) to ensure that welfare recipients remain eligible for Medicaid. California implemented a Section 1931(b) expansion to mandate that CalWORKS recipients remain automatically eligible for Medi-Cal. In March 2000, California increased the income limit for the Section 1931(b) program from roughly prewelfare reform levels of 74 percent to 100 percent of FPL. This expansion essentially meant that Medi-Cal subsumed the families previously in the Medically Needy program. In addition to having a higher income limit and no “share of cost” or spend-down requirement, the 1931(b) program offers families who lose cash assistance access to Transitional Medi-Cal coverage, which the Medically Needy program does not. This Medi-Cal expansion for the working poor is considered to be one of the major drivers in the anticipated enrollment increases. To date, 99,400 adults have taken advantage of this program and an additional 149,400 individuals are expected to enroll in 2001–02.

Medi-Cal Expansions for Low-Income Seniors and Persons with Disabilities. In addition to the Section 1931(b) expansion, California extended no-cost Medi-Cal benefits to aged, blind, and disabled individuals earning below 133 percent of FPL on January 1, 2001. It is anticipated that 52,800 beneficiaries are expected to qualify for this program in 2001–02. California is also one of eight states, at the time of this writing, that have a Medicaid buy-in plan for working persons with disabilities under the federal Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999. As part of TWWIIA, states have the option of creating a Medicaid buy-in, which allows working individuals with disabilities to have access to the Medicaid program in order to reduce the loss of publicly funded benefits that many individuals with disabilities experience when they gain employment. California’s program is extending Medi-Cal benefits to working individuals...
with disabilities who earn below 250 percent of FPL. Individuals in this program pay sliding scale premiums based on their income. As of January 2001, approximately 443 individuals were enrolled in the program.\textsuperscript{24} TWWIIA also requires states to create an employment network, whereby Social Security Insurance or Social Security Disability Insurance beneficiaries receive a choice of places to go for employment training services.\textsuperscript{25} California is currently in the planning phase of establishing an employment network and, like most states, will not implement this component of TWWIIA until 2002–03.

\textit{Simplifying the Eligibility Process}

California’s Medicaid program has traditionally been viewed as having a very complex application and eligibility determination process. According to a Medi-Cal Policy Institute Survey, 78 percent of beneficiaries believe that too much paperwork and documentation are required to enroll.\textsuperscript{26} In January 2000, the state eliminated the requirement for Medi-Cal families to submit quarterly eligibility status reports. Previously, many families were disenrolled because they failed to complete and return the quarterly recertification reports. In addition, in January 2001, the state decided to provide 12-month continuous eligibility to children under age 19. It is anticipated that continuous eligibility for children will result in an approximate increase of 369,000 average monthly eligibles in 2001–02.\textsuperscript{27}

\textit{Healthy Families: Expansion for Children}

Within months of the passage of Title XXI, California submitted a plan to expand health insurance coverage under the new State Children’s Health Insurance Program (SCHIP). Federal law gave states three options for expanding coverage—through Medicaid, the creation of a new or expansion of an existing separate state program, or a combination of the two. California decided to expand coverage through a combination of Medicaid and the creation of a new program, called Healthy Families.\textsuperscript{28} The state received federal approval in March 1998 to expand coverage through:

- Medi-Cal—expanding the Title XIX program through a resource disregard (which allowed families to have more assets) and raising the eligibility threshold to children under age 19 in families earning up to 100 percent of FPL; and

- Healthy Families—creating a separate children’s health insurance program that provides coverage to children ages 1 through 19 with family incomes between 100 and 200 percent of FPL.

California was one of 18 states that decided to use SCHIP funding for a combined program expansion (rather than exclusively through Medicaid or exclusively through a separate program), and like other states that took this approach, the Medicaid portion of the initiative represented a relatively small component of the overall effort.\textsuperscript{29} For example, a recent study showed that Healthy Families’ enrollment totaled 305,759 in June 2000, while enrollment in the Medi-Cal SCHIP expansion totaled 20,827.\textsuperscript{30} In fact, California’s expansion to poverty level coverage for all children up to age 18 was actually an acceleration of already scheduled expansions—federal law would have eventually required this change anyway. As with many other states, California’s decision to focus primarily on an alternative to Medi-Cal related to several factors, including political resistance to expanding a federal entitlement program and experiencing further Medi-Cal growth; concern that the county-run Medi-Cal system would continue to be entrenched in bureaucracy and slow to change; and the belief that a cumbersome eligibility process and difficulties with access to care would continue to plague Medi-Cal recipients.

Since the Medi-Cal expansion is building upon the existing Title XIX program, California implemented this component of SCHIP immediately after receiving federal approval in March 1998. The Healthy Families component of California’s SCHIP program
Healthy Families was implemented several months later in July 1998. Healthy Families is administered by a different agency than Medi-Cal—the Managed Risk Medical Insurance Board (MRMIB).31 To apply for Medi-Cal or Healthy Families, individuals may complete a mail-in application that screens eligibility for both programs. The state contracts with an enrollment broker, EDS, that receives the mailed applications through a single point of entry for program determination. Of note, a three-month period without employer-sponsored insurance (i.e., “waiting period”) prior to enrollment is a condition of eligibility in Healthy Families. Although some advocates have criticized the waiting period as a barrier to enrollment, California is not alone in adopting this strategy as a means to limit the crowd out of private coverage—nationally, approximately two-thirds of SCHIP programs have implemented waiting periods.32

Healthy Families benefits are based on what is offered to public employees through the CalPERS and service is delivered through managed care organizations (primarily HMOs). In the Healthy Families program, enrollees pay premiums ranging between $4 and $27 per month, depending on the number of children in the program, the health plan selected, and their income level. There is a $5 copayment for all services except prenatal, well baby, well child, or immunization services.33 These premium and copayment levels are fairly consistent with other SCHIP programs.

As with most of the SCHIP programs, initial enrollment into Healthy Families and the Medi-Cal expansions was lower than anticipated. Although 1998 estimates indicated there were approximately 400,000 uninsured children eligible for Healthy Families, enrollment in SCHIP was only 55,106 (for both Healthy Families and the Medi-Cal expansion) in December 1998.34 In November 1999, the state received federal approval to expand income eligibility in Healthy Families from 200 to 250 percent of FPL, and to apply Medi-Cal income deductions when determining eligibility for the Healthy Families program. The state anticipated that this eligibility expansion would increase enrollment by an additional 132,000 children.35

According to state estimates, 424,403 children were enrolled in Healthy Families as of April 2001.36 Although this figure may seem large in contrast to other states’ SCHIP programs, it is important to remember that California is challenged with large numbers of uninsured—there were 1.85 million uninsured children in 1999, of whom 39 percent (726,000) were eligible for Medi-Cal, 29 percent (535,000) were eligible for Healthy Families, and 13 percent (245,000) were undocumented and therefore not eligible for either program.37 Advocates point to the millions of dollars of unspent SCHIP funding as evidence of the program’s under-utilization—California spent only 11 percent of its FY 1998–2000 allotment38—and believe that more must be done in terms of outreach and streamlining the enrollment processes for Healthy Families and Medi-Cal.39

California has taken a number of steps to simplify the enrollment process in recent years. Perhaps one of the most significant developments is the inclusion of $1.3 million in the governor’s 2001–02 budget proposal to launch Health-e-App, a new online Healthy Families/Medi-Cal application for children, statewide over the next year. In January 2001, Health-e-App was piloted in San Diego. With the help of certified application assistants, applicants submitted their information electronically, selected a health plan and provider, and received preliminary eligibility notification online.40 Health-e-App reduced the number of application errors by 40 percent and reduced the time between application and final eligibility determination from 18 to 13.5 days. It was anticipated that with several operational fixes (e.g., developing an automated mechanism for applicants to pay the required premium and resolving several issues involving handling and smooth transmission of the supporting documents that accompany the electronic application), processing time could be reduced even further.41 In addition to Health-e-App, California’s enrollment simplification efforts include reducing the application from 28 to 8 pages, allowing applications to be submitted by mail, and not having an asset test or an in-person interview.

Despite efforts to streamline the application process, some advocates and researchers believe that families are still confused about and lacking in awareness of Healthy Families
and Medi-Cal enrollment procedures. According to National Survey of America’s Families (NSAF) tabulations, administrative hassles were cited as a primary concern by the parents of 15.9 percent of all low-income uninsured children in California. Moreover, according to NSAF, only 52 percent of low-income families have heard of Medi-Cal or Healthy Families and understand the basic eligibility rules. In addition, the large number of applications (31 percent) indicating that the family did not want the applicant reviewed for Medi-Cal eligibility has raised concerns that Medi-Cal stigma persists and that immigrants are fearful that Medi-Cal participation will qualify them as a public charge. Like many other SCHIP and Medicaid programs, California is also faced with the challenge of retention—as over half of beneficiaries lose coverage because they fail to recertify annually or pay monthly premiums.

**Healthy Families: Adding Coverage for Parents**

In January 2001, California submitted a SCHIP waiver proposal to expand the Healthy Families program to parents with incomes up to 200 percent of FPL. The proposed expansion would permit deducting allowed expenses from countable income and waiving the asset test, as is the case for the children in Medi-Cal and Healthy Families. Of note, parents earning at or below 100 percent of FPL who would qualify for Medi-Cal are still subject to an asset test, resulting in lower-income parents facing stricter requirements than relatively higher-income parents. Some interviewees felt that such policy disconnects between Healthy Families and Medi-Cal are illustrative of the governor’s preference for the Healthy Families program. The Healthy Families proposal requires parents to pay premiums ranging between $10 and $20 per month, and includes copayments similar to those for state employees.

In summer 2001, the legislature raised the income eligibility to 250 percent of FPL—mirroring the eligibility threshold for children. The state plans to submit an amendment to expand eligibility to 250 percent of FPL. Such an expansion would make an additional 106,000 uninsured parents eligible for Healthy Families. There is also some evidence that equalizing the eligibility level for parents and children may have the additional benefit of increasing children’s enrollment into Healthy Families, as parents seem more likely to enroll children when family coverage is offered. California received federal approval for the Healthy Families expansion in January 2002. Although the state planned to delay implementation until the summer of 2003 due to the economic downturn, it now hopes to begin implementation as early as July 2002. It is estimated that 412,000 uninsured adults would be eligible for Healthy Families under the existing proposal.

**Acute Care Issues**

**Medicaid Managed Care**

California’s Medi-Cal managed care program continues to evolve. Approximately 52 percent of Medi-Cal beneficiaries are currently enrolled in managed care and 26 of 58 counties enroll some or all of Medi-Cal beneficiaries into managed care. In recent years, issues have centered around implications of CalWORKS on Medi-Cal enrollment, the development of the state’s Two-Plan Model, and payment rates for participating plans.

The implementation of Medi-Cal managed care proceeded more slowly than planned. By the end of 1996, California had hoped to enroll 2.8 million beneficiaries, or approximately 50 percent of its beneficiaries, into managed care. However, the state did not meet this goal in 1996 because of welfare reform and the administrative complexity of delinking CalWORKS from Medi-Cal. By July 1997, only 35 percent of Medi-Cal beneficiaries were enrolled in managed care. It took several years before California was able to reach its initial goal of enrolling 50 percent of beneficiaries into managed care.

California’s geographic breadth and diverse population influenced the development and implementation of multiple managed care models as part of an attempt to adapt managed care to each county’s local circumstances. There are three predominant models of Medi-Cal managed care. The largest is the Two-Plan Model whose implementation began
in 1996. Under the Two-Plan Model, Medi-Cal contracts with a commercial plan and a
“Local Initiative” plan in each of the 12 counties designated to participate. The Local
Initiative plan is required to include traditional Medi-Cal providers in its networks (e.g.,
disproportionate share hospitals and county facilities) and, as such, allows for the shift of
large segments of the Medi-Cal population into managed care without necessarily disrupt-
ing patient-provider relationships. In 1995, 12 counties were selected to participate in the
Two-Plan Model. Although implementation proceeded at a slower pace than anticipated,
enrollment in the model grew by roughly 71 percent between 1997 and 1999. The second
largest model of Medi-Cal managed care is the County Organized Health System (COHS).
Under this approach, each of five counties operates a managed care program that requires
mandatory enrollment for almost all Medi-Cal beneficiaries at the time they sign up for
coverage. The third model—Geographic Managed Care (GMC)—is used in two counties
and allows for choices among many plans within each county. Under GMC, the state con-
tacts with commercial plans that get paid on a capitated basis. Under both the Two-Plan
and GMC models, enrollment into managed care is mandatory for cash assistance and
poverty-related beneficiaries and voluntary for other categories of Medi-Cal beneficiaries.
Over 70 percent of Medi-Cal managed care beneficiaries were enrolled in the Two Plan
Model as of October 1999, followed by 16 percent enrolled in COHS and 13 percent in
GMC.

Although administrative complexities and low enrollment in the state’s Two-Plan sys-
tem led two counties—San Francisco and Contra Costa—to voice a preference for moving
to a single-plan approach in 1997, the Two-Plan Model currently seems to be working well
in other counties. Beneficiaries report high satisfaction and the Local Initiative plans, pub-
licly governed initiatives that use county health services and safety net providers, are
doing well financially. Stakeholders believed that the financial health of the Local
Initiatives was in part due to low utilization, carve outs for mental health and for children
with special health care needs, and emergency room deterrence.

In 2000, the Local Initiatives also benefited from a 9.2 percent increase in capitation
rates, as part of a broad package of rate increases for Medi-Cal providers totaling $800 mil-
lon. Although the rate increase was in response to the state’s historically low capitation
rates—California’s Medi-Cal health plan capitation rates were the lowest of any Medicaid
program in the country—California’s Medi-Cal managed care market was deemed finan-
cially stable in 1998 relative to the national Medicaid market and to the private sector mar-
ket in California before the rate increase was implemented. However, little data are avail-
able to determine whether financial success is being achieved at the expense of meeting
patient needs.

Another important development with respect to California’s expansion of Medi-Cal
managed care was the consolidation of specialty mental health services at the county level
in July 1998. This consolidation was prompted by an interest in controlling rising health
care costs, minimizing cost-shifting between state and county programs, and improving
service integration. Under the consolidation, counties now provide mental health services
to Medi-Cal participants through a mental health managed care plan contracting with the
state Department of Mental Health. Counties share in the financial risk. Study respondents
reported little interest in further expanding Medi-Cal managed care to other vulnerable
populations in the GMC or Two-Plan counties.

Medicaid Disproportionate Share Hospitals and Related Payment Programs

California operates one of the largest disproportionate share hospital (DSH) programs in
the country under Medi-Cal, with state and federal expenditures of about $2.5 billion in
1998. Given the state’s 51.7 percent matching rate and the state’s reliance on inter-
governmental transfers to finance its share of Medi-Cal DSH, less than half of this figure
represents federal revenues that are potentially available as supplemental payments to
hospitals. Although the amount of federal money available to hospitals is lowered by the
fact that the state retains some of this money as an “administrative fee,” California has
distributed the bulk of the federal share of Medi-Cal DSH to the designated hospitals since the program started. At its height in 1994–95, the state’s administrative fee was $237 million or about 25 percent of the federal share. Since then, the state fee has fallen to about $110 million in 1998–99 (about 10 percent of the federal share) and dropped to under $30 million in 2001–02.

Despite the net benefits that Medi-Cal DSH has provided to California hospitals and the state, the program has not been without conflicts. During the mid-1990s, public hospitals became increasingly frustrated by the fact that they were financing the program through the inter-governmental transfers (IGTs) they provided, while the amount of net payments they were receiving declined. Between 1991–92 and 1996–97, federal DSH payments to public hospitals fell from about $650 million to $370 million, while private hospital payments rose from about $200 million to almost $400 million. The reasons for this were that the state’s federal allotment of DSH dollars remained fixed, individual hospitals could not receive gross Medi-Cal DSH payments in excess of 100 percent of uncompensated care costs, and the number of private hospitals treating large enough numbers of Medi-Cal patients to qualify for DSH increased. Concern existed that if these trends continued, public hospitals would refuse to participate—although IGTs for Medi-Cal DSH are mandatory—and that the program would collapse.

This politically volatile situation was resolved after the passage of the Balanced Budget Act (BBA) of 1997 that, among other provisions, began a phase-in of lower state DSH allotments. The BBA of 1997 also contained a special exemption that allowed California to make gross DSH payments to its public hospitals up to 175 percent of their uncompensated care levels (including any Medi-Cal losses resulting from treating Medicaid patients at payment rates not sufficient to cover costs). The 175-percent exception enabled the state to pay public hospitals about one-half of the net benefit for SFY 1997–98. The principle that the net federal portion of Medi-Cal DSH funds be distributed on a 50/50 basis between public and private hospitals became state law in fall 1997 and has been reaffirmed in two subsequent actions. This approach offers an ongoing solution to the conflict among hospitals, because the federal government made the 175-percent rule permanent for all public hospitals, not just those in California, with the passage of the Beneficiary Improvement and Protection Act of 1999.

The state also has a supplemental hospital payment program, the Emergency Services and Supplemental Payment Fund (commonly referred to as the “1255” program after the legislative bill that created the program), which works in conjunction with the state’s selective contracting negotiations. While 1255 is technically not a DSH program, its operation uses nearly identical funding and payment mechanisms. Participating public hospitals voluntarily make fund contributions that are federally matched under Medicaid and then redistributed to other public and private hospitals in the form of supplements to the rates that were negotiated through selective contracting. To be eligible for these supplemental payments, hospitals must be a contract hospital, be eligible to receive actual Medi-Cal DSH payments, and provide comprehensive emergency medical services. There is no set formula on how much each hospital will receive in 1255 payments, although no hospital has lost money by making the voluntary transfers.

The 1255 program, although smaller than the state’s Medi-Cal DSH program, grew substantially during the 1990s. Between SFYs 1992–93 and 1997–98, gross 1255 payments quintupled, increasing from approximately $180 million to $910 million. Again, given California’s Medi-Cal matching rate, net federal payments under 1255 were about 50 percent of these levels. Los Angeles County hospitals have been the primary recipients of 1255 dollars. Although the 1255 program was originally designed as a mechanism for assuring that emergency services would be adequately funded, some believe that the state has been using these supplemental payments as a replacement for increases in actual Medi-Cal payment rates. The state does have an incentive to do this, because the state shares of increases in actual rates would most likely need to be funded through the general fund as opposed to the IGT method used to fund the state share of 1255 payments.
As are other states, California is uncertain about how federal regulations that impose an upper payment limit on Medi-Cal rates paid to public hospitals will affect its supplemental payment program. Initially, some in the state had hoped that California would not be affected by these regulations because the state operates under a 20-year-old freedom of choice waiver that allows it to engage in selective hospital contracting. However, since it appears that 1255 payments will count against the federal upper payment limit, there could be actual limits on the total amount of 1255 payments that will be available to be distributed to hospitals. For example, we were told that 1255 payments put Medi-Cal rates paid to Los Angeles county hospitals at about 180 percent of Medicare; current proposed regulations would limit Medicaid payments to 100 percent of Medicare. Moreover, there is concern that federal restrictions may have a “chilling effect” on the willingness of the state to engage in this voluntary program to the extent it has in the past.

**Pharmaceutical Assistance to the Aged**

With rising pharmaceutical costs making it difficult for seniors to afford prescription drugs, a number of states have established programs that offer pharmaceutical assistance to the aged. In February 2000, California implemented a new program to assist seniors with purchasing prescription drugs. Under this program, Medicare recipients can now use any California pharmacy that accepts Medi-Cal and receive prescriptions at the Medi-Cal rate. Potentially, this provides seniors with a 10–24 percent discount from the rates they would otherwise pay. Anyone with a Medicare card is eligible to participate and seniors merely have to show their card to the pharmacist to receive the Medi-Cal prescription rate (there are no forms to fill out). While this form-free access to the program offers seniors convenience, it also means that the state can track inquiries but has little ability to track participation. State officials reported that they received approximately 600,000 cost comparison inquiries per month but did not know how many seniors were taking advantage of the program. Some observers doubted that the program would be able to offer seniors discounts that were substantially better than those offered by large chain drug stores.

**Issues in Long-Term Care for Older People and Younger Persons with Disabilities**

The complexity and fragmentation of California’s long-term care (LTC) system has been well documented. LTC services at the state level are managed by several different agencies: Nursing home care is administered by the Department of Health Services (DHS); developmental services are administered by the Department of Development Services (DDS); the California Department of Aging (CDA) administers the Medi-Cal Adult Day Health Care program and licenses all adult day health care centers in the state; and personal care is administered by the Department of Social Services (DSS). These agencies serve similar target groups, yet run programs with different eligibility rules, need criteria, funding sources, and application procedures. Adding to the complexity, many of the state programs are administered through local government agencies and private nonprofit organizations. While the need for coordination among the state agencies is great, it has been historically lacking.

California has long been characterized for low LTC spending per Medi-Cal beneficiary, which raises concern about access and quality. Indeed, California is ranked 48th in spending per beneficiary age 65 and over, and 50th in state rankings for LTC expenditures as a percentage of total Medicaid expenditures. Of Medi-Cal LTC expenditures, approximately 82 percent were spent on institutional care and 18 percent were used for home- and community-based care in 1999.

Under the Davis administration, there have been a number of recent developments to address the system’s fragmentation, poor nursing home quality, and low provider reimbursement, in addition to furthering more community-based alternatives to institutional care. In response to a need for greater coordination, the Long-Term Care Council was established in January 2000. The council consists of the Directors of the Departments of
Aging, Developmental Services, Health Services, Mental Health, Rehabilitation, Social Services, and Veterans Affairs, and the Office of Statewide Health Planning and Development. In addition to coordinating policy development and program operations across state-level agencies, the Council has also been assigned the central role in Olmstead planning in California. Thus far, the Council has established an agency work group, solicited public input through stakeholder meetings, and developed a proposal for a pilot program to test a new assessment and transition process for nursing home residents seeking placement in other care settings, which was included in the governor’s 2001–02 budget.62

**Nursing Home Care**

California’s nursing home industry includes 1,390 facilities and 132,962 beds, with an occupancy rate of roughly 82 percent, just below the national average of 83 percent. The system has become smaller in recent years with a 5.2 percent decrease in total beds between 1995–99. This trend contrasts sharply with the rest of the nation, which saw a 3.2 percent increase over the same periods.63 In addition, spending growth for nursing facilities in California has been slower than the national average, 0.4 percent average annual growth compared with 4.3 percent between 1995–1998.64 California’s decrease in nursing home beds and slow growth in nursing facility spending was associated with a shift to more community-based health care.

As noted, California spends very little per LTC beneficiary, and a relatively small portion of the Medi-Cal budget is earmarked for LTC expenditures. Medi-Cal is also known for low reimbursement rates: In 1998, California’s freestanding nursing home daily payment rate ranked 36th among all states and was only 68 percent of the average private pay rate in California.65 Despite the potential for rate cuts as a result of the repeal of the Boren Amendment in 1997, concerns over access and quality of care prompted Medi-Cal rate increases for nursing homes, physicians, and home care providers by up to 10 percent in the 2000 Budget Act.66 The Medi-Cal rate increase was part of a broader initiative to improve the quality of long-term care in California, described below.

The quality of LTC health facilities has been a pressing issue in California, as in the rest of the nation. In July 1998, the General Accounting Office (GAO) concluded that nearly a third of California nursing homes had violations that caused death, jeopardized resident health and safety, and involved falsifying medical records.67 In response to these violations, the California legislature enacted several measures in 2000 that fulfilled Governor Davis’s Aging with Dignity Initiative—a broad-based senior care proposal targeted at promoting community-based care and improving the quality of LTC. As part of the Aging with Dignity Initiative, the 2000 Budget Act provided $516 million in total funds to improve the quality of long-term care through a 10 percent Medi-Cal rate increase to nursing homes, a 7.5 percent wage pass-through, increased oversight of nursing home facilities, improved responsiveness to consumer complaints, a new quality assurance process for state surveys, and assistance to facilities to improve programs and services.

Related to the quality of nursing home care is recent pressure to increase the states’ minimum staffing requirements. In spring 2001, a bill passed the Assembly to change the state’s current 1:9 nurse-to-patient ratio to 1:5. However, a recent California Department of Health Services study reported that staffing at one-third of California’s nursing homes already fail to meet the state’s current minimum requirements, suggesting that the new legislation may not be meaningful. The study does not recommend increasing the current ratio, in light of a healthcare workforce shortage.68

**Home- and Community-Based Care**

California’s average annual spending growth for home care between 1995 and 1998 was 18.8 percent, while the nation’s increased by 14.3 percent.69 This suggests that policy changes such as the addition of a Medically Needy program for IHSS recipients (see below) have led to growth in home care spending as opposed to an overall expansion in the population served. Nevertheless, the governor’s Aging with Dignity Initiative and the
development of a new Medicaid Home- and Community-Based Services Waiver program suggest that California is moving toward more noninstitutional alternatives.

**In-Home Supportive Services (IHSS)**

The largest number of California’s long-term care participants receive services from the In-Home Supportive Services (IHSS) program, which helps to pay for personal care and chore services for elderly individuals and people with disabilities who need assistance to remain in their own homes. The IHSS program is administered at the state level by the California Department of Social Services, with counties responsible for establishing and determining eligibility, and authorizing IHSS services. The program is funded by Medi-Cal (through the Personal Care Services Program), the state general fund, and county funds.

IHSS is one of the largest home- and community-based care programs in the country, with a total program cost of more than $1 billion in FY 1998. In 1998, the average monthly IHSS participant caseload was around 214,845 individuals—67 percent of whom were Medi-Cal participants. The number of Medi-Cal participants in IHSS increased substantially in 1998 when the state included IHSS as a Medi-Cal service for their Medically Needy population in order to receive federal funds. A unique program characteristic is that a majority of services are delivered by independent providers, who are hired individually by the IHSS participant. Of note, nearly half of these independent providers are family members, although services provided by a parent or spouse are covered by state and county funds rather than the Medi-Cal Personal Care Services Program.

Medi-Cal costs per beneficiary in the IHSS program are low ($5,722) compared with average nursing home costs ($31,028). The number of hours of service that IHSS will pay for are limited as a means of controlling the program’s budget. However, since these limits do not necessarily take into account the need to prevent institutionalization, some believe that it would be more cost-effective to increase the number of hours for some individuals in order to continue care for them in the home rather than in nursing facilities.

Another key issue related to the IHSS program, as well as other LTC programs, is a high turnover rate among providers. In the IHSS program, turnover has been attributed to low reimbursement (minimum wage) and a lack of health insurance and other benefits. To address these issues, the state passed a law in 1999 mandating that each county establish an entity to serve as an employer of record for independent IHSS providers by January 2003. The intent of this legislation is to provide a mechanism for collective bargaining over wages, hours, and benefits. Counties have various options to establishing an employer of record including creating a public authority, establishing a nonprofit consortium, making independent providers county employees, or contracting with a private agency. Eight counties, thus far, have opted for a public authority structure. Independent providers will also benefit from a $0.50 minimum wage increase, effective January 1, 2001, and an additional $0.50 wage increase effective January 1, 2002. Moreover, for the FY 2000-01 state budget, the governor agreed that the state would share in the cost of IHSS wages up to 103 percent of the state’s minimum wage for providers not employed in a county with a public authority. For this year’s budget the governor agreed to increase the amount in which the state would share in these workers’ wages to 105.31 percent of the state’s minimum wage.

**Home- and Community-Based Service (HCBS) Waivers**

California currently has six Medi-Cal Home- and Community-Based Service Waivers Section 1915(c), which are designed to serve people in a community setting who would otherwise require institutional care. These six waivers are:

- Nursing Facility (NF)—Serves individuals with disabilities and provides case management, skilled nursing, therapy services, and personal care services. Administered by DHS In-Home Operations.
• Model-NF—Serves children with disabilities and provides case management, skilled nursing, therapy services, and personal care services. Administered by DHS In-Home Operations.

• In-Home Medical Care—Serves individuals with disabilities who need acute care and provides case management and therapy services. Administered by DHS In-Home Operations.

• AIDS—Serves individuals with mid- to late-stage HIV/AIDS and provides case management, skilled nursing, attendant care, counseling, home-delivered meals, and transportation. Administered by the DHS Office of AIDS.

• Multipurpose Senior Services Program (MSSP)—Services frail elderly and provides case management and a range of other home- and community-based services and equipment.

• Developmentally Disabled (DD)—Services individuals with developmental disabilities and provides case management, counseling, education, monitoring of care programs, and a full spectrum of treatment and habilitation services.

The HCBS waivers offer a limited number of slots, and in some cases have long waiting lists. The waivers, excluding DD, served 11,022 participants in FY 1997–98, compared with the roughly 214,845 people served in the IHSS program. For example, in December 2000, the NF program had 160 individuals on a waiting list and the Model-NF program had 50 individuals. Even though waiver participants need to meet the need criteria for institutional care, waiver expenditures per person ($5,986) are significantly lower than institutional expenditures per person ($31,028).

Community-based services for the developmentally disabled are administered by the Department of Developmental Services (CDDS) and operated by Regional Centers, which are primarily funded through a HCBS waiver. In 1998, more than 90 percent (133,114) of Medi-Cal beneficiaries served by CDDS received services in community-based settings while 7 percent of Medi-Cal beneficiaries (9,333) were served through institutional programs. As with the other waiver programs, there is a large discrepancy between spending per participant in the community ($12,402/year) than in institutions ($72,731/year), leading to speculations about quality. These speculations prompted CMS to put a freeze on California’s Medi-Cal home- and community-based waiver program in 1998. The freeze barred the state from enrolling any new beneficiaries with mental retardation or developmental disabilities until it corrected deficiencies, including declining enrollee health, poorly staffed and unsanitary facilities, and over-prescription of medications. Moreover, CMS charged that enrollees were shifted in and out of the program without their consent, “churning” the enrollment in such a way that helped California maximize federal Medicaid payments, resulting in $8.7 million in federal overpayments in FY 1996. This resulted in enrollment growth—from several hundred enrollees in 1982 to more than 35,000 in 1997.

Recognizing the need to further develop alternatives to institutional care, particularly in light of the Olmstead decision, the governors’ 2001–02 budget includes $1 million to develop an additional HCBS waiver for assisted living. Specifically, the waiver will test the effectiveness of two service delivery approaches—one that provides an assisted living benefit to residents in licensed residential care facilities and another that provides the benefit to residents in publicly funded senior and disabled housing projects. It is believed that this waiver would allow DHS to offer Medi-Cal recipients more options for LTC in more home-like settings.

The governor’s 2000–01 budget, as part of the Aging with Dignity Initiative, also promotes community-based care by establishing a $500 tax credit for taxpayers who are eligi-
ble caregivers for individuals with certified LTC needs. It also promotes private sector alternatives by strengthening protections for senior citizens who purchase long-term insurance by requiring insurers to disclose certain information to seniors interested in such policies.

**Other Community-Based Programs**

Other community-based programs serving Californians include the Medi-Cal Home Health and Hospice program administered by DHS and the Adult Day Health Care Program administered by the Department of Aging under an agreement with DHS. The majority of hospice and home health services are covered by Medicare (93 percent). The key issue related to these services is the closure of some home health agencies because of changes in Medicare reimbursement and new utilization restrictions. The Adult Day Health Care Program, which provides a variety of health, therapeutic, and social services for frail elderly and impaired adults, has expanded rapidly in recent years and, coupled with a labor shortage, has resulted in an increase in providers who lack the appropriate backgrounds in health care and social services.

In addition to home health and adult day care, it is worth noting that most mental health services are provided at the community level and average Medi-Cal expenditures for noninstitutional county mental health participants were low ($2,027) compared with average Medi-Cal expenditures for state hospital participants ($58,587). The state is interested in expanding more community options for those with mental illness and has included this population in the pilot project, mentioned earlier, to develop an assessment tool for transitioning individuals from institutions to community settings.

**Other Issues**

In addition to being more “union-friendly” and more interested in expanding coverage to the uninsured than the previous administration, Governor Davis has also been more interested in managed health care oversight. In the governor’s first state of the state address in January 1999, he explicitly noted that one of the administration’s goals “is to make sure that the overwhelming number of Californians who rely on HMOs are receiving the quality of care they’re paying for. No one should be exempt from accountability—including HMOs.” In addition, the state needed to implement policies to bring it into compliance with federal HIPAA legislation. While Wilson vetoed numerous bills regarding patients rights, Davis’s openness to this issue reinvigorated legislative efforts. Managed care legislation has been a key development in California health policy in recent years.

**Managed Care Reform**

Perhaps the most significant development in managed care, particularly in light of the national debate on a patients’ bill of rights, was the creation of the California Department of Managed Health Care, the only department of its kind in the nation. Launched in July 2000, the department is responsible for licensing all plans, ensuring HMO accountability, conducting public education initiatives, providing an annual quality of care HMO report card, and monitoring the financial solvency of the state’s medical groups. Previously, the state regulated HMOs through the Department of Corporations, which has the primary responsibility of regulating financial securities and which was relatively unknown to HMO consumers.

The Department of Managed Health Care has been much more visible to consumers than the Department of Corporations through the promotion of their HMO Help Center, where consumers can go 24 hours a day, 7 days a week, for assistance in dealing with their health plan. Staffed by about 75 people, including customer service representatives, nurses, lawyers, and administrators, the Help Center has made notable progress in resolving disputes between consumers and HMOs. In July 2000, when HMO questions were still being handled by the Department of Corporations, 69 percent of calls remained unresolved after 30 days. In December 2000, only six months after the start of the HMO Help
Center, calls unresolved after 30 days were down to 5 percent. Although respondents felt that there was only a modest consumer education budget, the Help Center hotline is still averaging about 18,000 calls per month. Of note, respondents from the department reported that only 5,000 to 6,000 of the total monthly calls required customer assistance (the majority of calls were handled through an auto-response system). Of those calls about half were complaints stemming from patients not understanding their HMO’s rules and the other half were legitimate problems, largely stemming from poor communication between the plan and the patient. As of mid-August 2001, 323 cases have had to go beyond the Help Center to an independent medical review process.

California has also been continuing with managed care initiatives to provide patient protection and education for its 23.5 million citizens enrolled in managed care plans. In 1999, California passed a law that allows patients to hold health plans accountable in court when an HMO causes “substantial harm” to a patient. In addition, managed care organizations are required to provide patients with a second medical opinion at their request and patients may appeal to an independent reviewer when they need to challenge a managed care organization’s decision. There were also a number of insurance mandates passed in 1999 that require insurers to cover prescription contraception methods (if they provide outpatient prescription drug benefits), hospice care, diabetic services and supplies, phenylketonuria (PKU) testing and treatment, and diagnosis and treatment of breast cancer. In 1998, California mandated direct access to OB-GYN care, prostate cancer screening, and physician determination of length of stay for mastectomies or lymph node dissections.

Insurance Market Reform

In addition to reforming the managed care industry, there were several noteworthy developments in the state’s insurance market. In the 2000 legislative session, a bill was enacted to bring California into compliance with HIPAA by requiring each health care plan or disability insurer to offer, market, and sell coverage to federally eligible individuals (those covered under group contract for 18 months) who live within the insurer’s service area. The bill also prohibited health plans from imposing any preexisting condition exclusion with respect to coverage. HIPAA’s provisions relating to administrative simplification and security procedures have raised concerns among state officials and health plan representatives. Both fear the financial ramifications of bringing all health providers and plans that engage in electronic and administrative transactions into compliance with national standards for coding and tracking medical information and assuring patient privacy.

Another significant change in California’s insurance market involves a statewide small employer purchasing pool. Formerly known at the Health Insurance Plan of California (HIPC), the program was administered by the Managed Risk Medical Insurance Board (MRMIB) until July 1999, when management was transferred to a nonprofit organization, the Pacific Business Group on Health. Subsequently, the program’s name was changed to Pacific Health Advantage (PacAdvantage). PacAdvantage provides small businesses (20–50 employees) with the ability to purchase affordable health, dental, and vision coverage by enabling them to buy insurance together as a single large group. PacAdvantage currently has about 160,000 single and dependent individuals receiving coverage through its purchasing pool.

Conclusion

While education has been Governor Davis’s top priority, California has expanded eligibility for its public health insurance programs—Healthy Families and Medi-Cal—and implemented policies to simplify enrollment. Although Medi-Cal payment rates have increased, California’s reimbursement rates still cause the state to rank among the less generous in the country. This strategy of maintaining low payment rates has kept broad eligibility affordable. In contrast to the previous administration, Davis has also demonstrated his interest in managed care reform by supporting “right to sue” legislation and the creation
of the Department of Managed Health Care. Davis has also been supportive of the health care unions through policies that facilitate organizational activities and targeted wage and fringe benefit increases.

Some policymakers and advocates have been disappointed with Davis’s lack of sweeping health care reform. However, the governor believes that his fiscally conservative approach to health policy has been justified in light of the unanticipated costs of California’s energy crisis and the slowing economy. By not having committed to large spending increases and by dedicating the state’s sizeable tobacco settlement to health programs, the governor’s 2001–02 budget revision—which reflects lower revenue projections—was able to avoid proposing major cuts in Health and Human Services spending.

The Healthy Families program remains at the center of the administration’s health policy agenda for 2001–02. As of January 2002, the state expects to implement its healthy Families adult expansions as early as July 2002, which would provide public coverage to over 400,000 parents with incomes up to 200 percent of the federal poverty level. In addition, signing up for Healthy Families, as well as for Medi-Cal, will be made easier as the state expands an online application pilot program—Health-e-App—from a single county to statewide.

The aging of the population puts issues related to long-term care on California’s health policy agenda, as in other states. However, more than most states, California has been hampered in its policy development by the fragmentation in the structure of its long-term care programs. To address this issue, the present administration established the Long-Term Care Council—a work group of the heads of the various agencies with responsibilities in this policy area. At present, the council is attempting to coordinate policy, program, and budget planning. Whether the Long-Term Care Council is successful at integrating agency activities will determine the extent to which the fragmentation in California’s long-term care system is reduced over the next few years.

In addition to improving system coordination, the quality of nursing home care has been a pressing issue in California since a 1998 Government Accounting Office audit revealed that nearly a third of California’s nursing homes had serious and often life-threatening violations. The Medi-Cal rate increase, as well as a series of measures to increase oversight of nursing home facilities, are part of the governor’s Aging with Dignity Initiative—a broad-based senior care proposal targeted at improving the quality of long-term care. The initiative also included measures to promote community-based care such as a $500 tax credit for taxpayers who are eligible caregivers for individuals with LTC needs.

While the health policy agenda, defined in the proposed 2001–02 budget, promises further coverage expansions and improved quality of care, the future course of California health policy is far from certain. The state does not yet know how its Medi-Cal supplemental payment program that subsidizes many safety net hospitals will be affected by federal regulations establishing upper payment limits on Medicaid rates. Although policy changes are expected to increase Medi-Cal enrollment, the uncertain economy suggests, that California may face some difficult policy tradeoffs in the coming years.

Endnotes


2. Public Authorities have been established in eight counties as the employer of record. Approximately 65 percent of the entire In-Home Supportive Services/Personal Care Services Program (IHSS/PCSP) caseload resides in these eight counties.

3. The employer-of-record requirement and the state sharing in increased wages and health benefits applies to IHSS/PCSP funded workers, not all home care workers in the state.


11. Note that the enrollment data from Ellis et al. include people covered during a single month, while the enrollment data in table 1 represent the average number of enrollees in all months during the federal fiscal year (October–September). Ellis, Eileen, Vernon K. Smith, and David M. Rousseau. 2000. “Medicaid Enrollment in 50 States: June 1997 to December 1999.” Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, October.


17. “California Governor’s Budget May Revision 2001–02.”

18. Those who receive Medi-Cal “medically needy” benefits may be eligible with or without a “share of cost.” Share of cost refers to the amount of health care expenses a recipient must incur before Medi-Cal offers assistance.

19. Under the Wilson administration the Healthy Families program had expanded eligibility up to 200 percent of FPL.

20. The state plans to submit an amendment to its current proposal to expand coverage for adults up to 250 percent of FPL.

21. If recipients stop receiving 1931(b) or cash assistance because of increased earnings, they may qualify for Transitional Medi-Cal for up to 24 months.

22. “California Governor’s Budget Summary 2001–02.”

23. “California Governor’s Budget Summary 2001–02.”

24. “California Governor’s Budget Summary 2001–02.”

25. Previously these individuals could only go through the Department of Vocational Rehabilitation for employment training.


27. “California Governor’s Budget Summary 2001–02.”

28. California also used SCHIP funds to expand the state program, Access for Infants and Mothers (AIM) from 200 to 250 percent of FPL. AIM covers infants up to age 1. Like Healthy Families, AIM is administered by MRMIB.


31. The MRMIB is a government agency, created in 1990 with a broad mandate to advise the governor and the legislature on strategies for reducing the number of uninsured persons in the state. The agency runs three programs: Healthy Families, AIM, and the Major Risk Medical Insurance program, which provides health insurance for Californians who are unable to obtain coverage in the individual health insurance market.


33. The amount a family pays in copayments is limited to $250 annually, excluding vision and dental copayments.


44. Ibid. The joint Medi-Cal/Healthy Families application allows people to indicate that they do not want to be reviewed for Medi-Cal eligibility.


46. As of this writing, the proposal is still pending.

47. Premiums may be as low as $7 per month because the state is planning to provide a $3 discount to those parents who enroll in the community provider plan.

48. Ibid.


58. Under the law that restricted payments to only 100 percent, public hospitals would have received approximately one-third of the net benefit from the Medi-Cal DSH program, with the state losing $200 million in its allotment of federal DSH funds.

Table 1 Notes


b. Urban Institute calculations derived from the 1999 National Survey of America’s Families. Note: All calculations only include residents under age 65.


k. In 1996, the threshold represents the state Medicaid threshold for poverty-related eligibility or AFDC-related eligibility. Higher thresholds for separate state-financed programs (such as in New York) are not represented here.

l. The figure for 1998 represents the higher of the state threshold for Medicaid eligibility, or the state threshold for Medicaid expansions or stand-alone programs enacted under the SCHIP legislation.

m. The figure for 2000 represents the higher of Medicaid or SCHIP eligibility. In 2000, all states covered at least some children through SCHIP; certain groups in some states are only eligible through Medicaid.

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