Health Policy for Low-Income People in California

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This report is part of The Urban Institute's *Assessing the New Federalism* project, a multi-year effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director and Anna Kondratas is deputy director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, Inc., the project studies child and family well-being.

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About the Series

Assessing the New Federalism is a multi-year Urban Institute project designed to analyze the devolution of responsibility from the federal government to the states for health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, Inc., the project studies changes in family well-being. The project aims to provide timely nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's Web site. This paper is one in a series of reports on the case studies conducted in the 13 states, home to half of the nation's population. The 13 states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. Two case studies were conducted in each state, one focusing on income support and social services, including employment and training programs, and the other on health programs. These 26 reports describe the policies and programs in place in the base year of this project, 1996. A second set of case studies to be prepared in 1998 or 1999 will describe how states reshape programs and policies in response to increased freedom to design social welfare and health programs to fit the needs of their low-income populations.

The income support and social services studies look at three broad areas. Basic income support for low-income families, which includes cash and near-cash programs such as Aid to Families with Dependent Children and Food Stamps, is one. The second area includes programs designed to lessen the

dependence of families on government-funded income support, such as education and training programs, child care, and child support enforcement. Finally, the reports describe what might be called the last-resort safety net, which includes child welfare, homeless programs, and other emergency services.

The health reports describe the entire context of health care provision for the low-income population. They cover Medicaid and similar programs, state policies regarding insurance, and the role of public hospitals and public health programs.

In a study of the effects of shifting responsibilities from the federal to state governments, one must start with an understanding of where states stand. States have made highly varied decisions about how to structure their programs. In addition, each state is working within its own context of private-sector choices and political attitudes toward the role of government. Future components of *Assessing the New Federalism* will include studies of the variation in policy choices made by different states.

Contents

Highlights of the Report

Overview

California health policymakers face an insurance system in which only 57 percent of the nonelderly population is covered by employer-sponsored insurance. This is among the lowest rates of employer-sponsored coverage in the country. As is the case in other states with similar rates of employer-sponsored coverage, California has a very high rate of uninsurance and associated concerns related to access to care and public health outcomes. Recognizing these concerns, to address the needs of its population California has assembled a set of policies that try to compensate by relying on broad Medi-Cal eligibility (Medicaid is called Medi-Cal in California), private health insurance market reforms, and a county-based system of providing indigent health care. Despite these efforts, one out of five nonelderly Californians lacks health insurance coverage. This has created significant demands on the state's safety net providers.

Meeting these demands is complicated by the large numbers of documented and undocumented (illegal) immigrants in the state. These individuals tend to have lower incomes, on average, and are less likely to have private insurance coverage. Under welfare reform, many immigrants will lose access to income support and food stamp benefits. However, the state has chosen to keep documented immigrants eligible for Medi-Cal under the same rules that existed before welfare reform. Although this decision was affected by the reality that they would still be eligible to receive emergency Medi-Cal benefits in any case, it lessens the potentially adverse consequences of welfare reform on documented immigrants. For undocumented immigrants who can receive emergency Medi-Cal services, there have been efforts to reduce nonemergency, state-funded health programs after welfare reform.

In a state as large and diverse as California, it is not surprising to find this diversity reflected in the design of the state's health policies. Within Medi-Cal, for example, the state is advancing three distinct county-based approaches to managed care that reflect the development of the local health care markets. Similarly, within the indigent care system, counties are free to design their own approaches to meet their obligations to the low-income uninsured. When California has implemented statewide initiatives during the past decade, they have relied on the private market and built on the highly developed nature of managed care in the state. Most recently, when the state decided how it would respond to the federal State Children's Health Insurance Program, it chose to bypass a major Medi-Cal expansion and establish a program—Healthy Families—that provides subsidies to allow families to purchase children's coverage through commercial plans.

Medi-Cal Program

Medi-Cal enrolled 6.8 million Californians at some point during 1995, at a cost of $17 billion. Despite these high aggregate costs and the decision to cover almost all optional services, California is able to cover this many individuals by keeping expenditures per enrollee well below the national average. In 1995, Medi-Cal spent $1,959 per enrollee, 39 percent below the national average of $3,202. While these spending differences hold for all eligibility groups (adults, children, the blind and disabled, and the elderly), spending per enrollee is particularly low for the elderly because of very low spending on long-term care. State officials view these patterns as evidence that Medi-Cal is one of the most cost-efficient Medicaid programs in the country.

Medi-Cal keeps coverage broad by setting relatively generous eligibility standards and by going beyond the minimum federal mandates. The "efficiency" that allows the state to afford broad eligibility is the result of successful efforts at keeping provider payment rates low. The best example of this may be the Selective Provider Contracting Program that has allowed the state to negotiate hospital-specific rates since 1982 under a waiver from the federal government. However, these low hospital payment rates may have been sustainable in recent years only because of the state's ability to supplement them with spending through the Medi-Cal disproportionate share hospital (DSH) program. Medi-Cal DSH has been an attractive way to pay certain safety net hospitals more because it draws federal dollars into the state without outlays from the state general fund.

Medi-Cal is in the process of implementing a major expansion in its mandatory managed care requirements. More than 3 million beneficiaries in most of the major counties will be required to enroll in some type of managed care plan. According to state officials, this policy initiative has been driven by the state's desire to increase access and improve quality, particularly for primary care and preventive services, and not to save money. Some county officials and repre-

sentatives of providers do not share this impression. They believe the state's emphasis on Medicaid managed care is driven by cost as well as access concerns. There are three basic models of managed care in California that will play a significant role in the future of the program. The major new approach that is currently being implemented is the two-plan model, which provides capitated services to Aid to Families with Dependent Children (AFDC), poverty-related, and medically needy beneficiaries in 12 counties and requires that safety net providers be included in at least one of the managed care options.

County Indigent Health Services

California takes a different approach from most other states in financing and delivering medical care to the indigent population. The state provides some funding support for basic medical care to low-income people who are not eligible for Medi-Cal and who cannot pay for their own health care. However, responsibility for additional funding, program administration, and operation rests with the counties. Section 17000 of the California Welfare and Institutions Code establishes that counties are required to be the providers of last resort. Although expenditure data are incomplete, it is estimated that between $2 billion and $2.5 billion is spent annually on services for roughly 1.7 million indigent persons through county programs.

Because each of the counties is responsible for running indigent care programs, there is considerable variability among counties in the size, scope, and design of their indigent health care programs. Instead of providing a detailed picture of all 58 counties in California, this report focuses on three—Los Angeles, Alameda, and San Diego—that contain more than 40 percent of the state's population and represent a range of approaches to delivering services to the medically indigent population. Los Angeles and Alameda operate public systems of hospitals and clinics, but try to partner with private providers in the county. Alameda County, which contains Oakland, has been working with private providers for a longer time than has Los Angeles. San Diego takes a completely different approach, contracting for indigent health care services solely through the University of California hospital—county-owned until the 1970s—and private-sector providers.

Health Insurance Reforms and the Market

California passed comprehensive small-group market reforms in 1992 to make it harder for indemnity and managed care insurers to refuse to sell to firms with 2 to 50 employees. The key provisions of California's small-group reform laws are guaranteed issue, guaranteed renewal, limits on preexisting condition exclusions, and modified community rating. The guaranteed issue provision was particularly significant because it was for all products. Most states at that

time required that only one or two products be made available to all small groups, and thus permitted more market segmentation than California allowed. The law also established a voluntary, publicly sponsored, small-employer health insurance purchasing pool, known as the Health Insurance Plan of California (HIPC). The HIPC will also serve as the model of coverage offered through Healthy Families. Both the HIPC and Healthy Families are administered by the Managed Risk Medical Insurance Board.

California's small-group reforms are widely perceived to have worked well, in part because they helped stabilize the small group insurance market—that is, premiums fell or increased only slightly in the first few years of reforms. Still, the fact that smaller percentages of California's nonelderly population are covered through employer-sponsored health insurance than in the nation as a whole suggests that while premium inflation may have abated, relative premium declines have not been enough to induce significant increases in coverage. Thus, the problems of the uninsured in general and uninsured workers in particular remain, despite the perceived success of the small-group reforms, because of structural economic conditions.

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

Long-Term Care

Long-term care services for the elderly are administered by several different agencies in California, which is the cause of some problems. This fragmentation in responsibility across state departments has resulted—according to a December 1996 report of an independent state oversight agency, the Little Hoover Commission—in the lack of a single point of access for assessment and referral for the continuum of long-term care service options offered by the state. An intergovernmental task force is working to design a standardized admission instrument for all Medi-Cal long-term care, including nursing homes, home care, and personal care. There is considerable concern, however, that this effort toward integration will not be successful.

Long-term care services are also provided to younger persons with disabilities, including mental illness and developmental disabilities. Four different

state departments and the counties have responsibility for different groups and different types of services. For example, while most of the mental health programs are administered by the counties, the state Department of Mental Health directly operates the state hospitals and oversees the county programs. As a result of spreading responsibility and programs across so many departments, California's long-term care system for younger persons with disabilities, like that for the elderly, is not well integrated. Many people express desire for a reorganization that would create a single department for long-term care. However attractive, this does not seem likely in the near term, at least for services for younger persons with disabilities.

Two programs of note in California with respect to long-term care are the Partnership for Long-Term Care and the Long-Term Care Integration Program. California participates in the Partnership for Long-Term Care, which encourages the purchase of private long-term care insurance policies through a state guarantee of asset protection for policy purchasers. The state is also attempting, through implementation of a planned Long-Term Care Integration Project, to combine state-supported long-term care services provided by the Department of Health Services (DHS), the Department of Aging (DOA), and the Department of Social Services (DSS) at the community (county) level.

Overview of California: Thumbnail Sketch of the State

Sociodemographic Portrait of California

In 1995, California had a population of 31 million, making it the largest state in the country. Population growth in California has been slightly greater than that of the U.S. population since 1990 (table 1). One in six Californians—16.2 percent of the state's population—has an income that falls below the federal poverty level (FPL), slightly higher than the rest of the nation; just more than one-fourth of the children live below the FPL. The state is highly urban, with metropolitan areas of more than 1 million accounting for about three-fourths of the total population. The Los Angeles metropolitan area alone accounts for almost one-third of the state's population.

California is one of the most ethnically diverse states in the nation. Approximately 30 percent of California's population is Hispanic, and more than 10 percent of the population is Asian.[1] One in three foreign-born people in the United States resides in California,[2] and one-fourth of California's population was born outside the United States, giving California the highest concentration of immigrants in the nation.[3] Of the state's immigrants, 42 percent are from Mexico.[4]

Economic Indicators

In 1995, California's per capita income was slightly higher than that of the rest of the country, $24,073 versus $23,208 (table 1). But the growth in per

Table 1 *State Characteristics*

	California	United States
Sociodemographic		
Population (1994–95)[a] (in thousands)	31,617	260,202
Percent under 18 (1994–95)[a]	28.7%	26.8%
Percent 65+ (1994–95)[a]	10.6%	12.1%
Percent Hispanic (1994–95)[a]	30.6%	10.7%
Percent Non-Hispanic Black (1994–95)[a]	6.4%	12.5%
Percent Non-Hispanic White (1994–95)[a]	51.0%	72.6%
Percent Non-Hispanic Other (1994–95)[a]	12.1%	4.2%
Percent Noncitizen Immigrant (1994–95)[a]	25.5%	9.3%
Percent Nonmetropolitan (1990)[a]	2.8%	21.8%
Population Growth (1990–95)[b]	6.2%	5.6%
Economic		
Per Capita Income (1995)[c]	$24,073	$23,208
Percent Change in Per Capita Personal Income (1990–95)[c, d]	13.1%	21.2%
Percent Change in Personal Income (1990–95)[c, e]	19.5%	27.7%
Employment Rate (1996)[f, g]	60.8%	63.2%
Unemployment Rate (1996)[f]	7.2%	5.4%
Percent below Poverty (1994)[h]	16.2%	14.3%
Percent Children below Poverty (1994)[h]	25.6%	21.7%
Health		
Percent Uninsured—Nonelderly (1994–95)[a]	19.7%	15.5%
Percent Medicaid—Nonelderly (1994–95)[a]	18.1%	12.2%
Percent Employer Sponsored—Nonelderly (1994–95)[a]	56.9%	66.1%
Percent Other Health Insurance—Nonelderly (1994–95)[a, i]	5.3%	6.2%
Smokers among Adult Population (1993)[j]	18.4%	22.5%
Low Birth-Weight Births (<2,500 g) (1994)[k]	6.2%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995)[l]	6.1	7.6
Premature Death Rate (Years Lost per 1,000) (1993)[m, n]	52.4	54.4
Violent Crimes per 100,000 (1995)[o]	966.0	684.6
AIDS Cases Reported per 100,000 (1995)[j]	35.2	27.8
Political		
Governor's Affiliation (1996)[p]	R	
Party Control of Senate (Upper) (1996)[p]	23D–16R–1I	
Party Control of House (Lower) (1996)[p]	43D–37R	

a. Two-year concatenated March Current Population Survey (CPS) files, 1995 and 1996. These files are edited by the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.

b. U.S. Bureau of the Census, *Statistical Abstract of the United States: 1996*. 116th ed. Washington, D.C. 1996. 1995 population as of July 1. 1990 population as of April 1.

c. *State Personal Income, 1969–1995*. CD-ROM. Washington, D.C.: Regional Economic Measurement Division (BE-55), Bureau of Economic Analysis, Economics and Statistics Administration, U.S. Department of Commerce, October 1996.

d. Computed using mid-year population estimates of the Bureau of the Census.

e. Personal contributions for social insurance are not included in personal income.

f. U.S. Department of Labor. *State and Regional Unemployment, 1996 Annual Averages*. USDL 97-88. Washington, D.C., March 18, 1997.

g. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.

h. CPS three-year average (March 1994–March 1996, where 1994 is the center year) edited using the Urban Institute's TRIM2 microsimulation model.

i. "Other" includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.

j. Normandy Brangen, Danielle Holahan, Amanda H. McCloskey, and Evelyn Yee. *Reforming the Health Care System: State Profiles 1996*. Washington, D.C.: American Association of Retired Persons, 1996.

k. S.J. Ventura, J.A. Martin, T.J. Mathews, and S.C. Clarke. "Advance Report of Final Natality Statistics, 1994." *Monthly Vital Statistics Report*, vol. 44, no. 11, supp. Hyattsville, MD: National Center for Health Statistics, 1996.

l. National Center for Health Statistics. "Births, Marriages, Divorces, and Deaths for 1995." *Monthly Vital Statistics Report*, vol. 44, no. 12. Hyattsville, MD: Public Health Service, 1996.

m. ReliaStar Financial Corporation. *The ReliaStar State Health Rankings: An Analysis of the Relative Healthiness of the Populations in All 50 States*, 1996 edition, Minneapolis, MN: ReliaStar, 1996.

n. Race-adjusted data, National Center for Health Statistics, 1993 data.

o. U.S. Department of Justice, FBI. *Crime in the United States, 1995*. October 13, 1996.

p. National Conference of State Legislatures. *1997 Partisan Composition, May 7 Update*. D indicates Democrat, R indicates Republican, and I indicates Independent.

capita income from 1990 to 1995 was much less in California than in the rest of the nation, 13.1 percent compared with 21.2 percent. California did not experience as much growth because it emerged from the recession of the early 1990s at a much slower pace than did other states. According to the state's analysis, the economy started its recovery in 1995, and since then California has seen steady, moderate economic growth and low inflation.[5] These trends are expected to continue through the decade. By 1996, the state's unemployment rate had declined to 7.2 percent but was still above the national average of 5.4 percent.

The overall poverty rate and the poverty rate among children were higher in California than in the nation as a whole in 1995. Although the nationwide income gap between rich and poor families has widened considerably since the 1970s, it has happened more rapidly in California than in any other part of the country.[6] In California, income has grown very little at the top of the income range, and incomes at the mid- and low levels have dropped significantly.[7]

Health Insurance and Health Care Conditions

Some 19.7 percent of California's nonelderly population was uninsured in 1994–95. This rate was almost 20 percent higher than the national average of 15.5 percent and stems from the low number of people who have employer-sponsored insurance; only 56.9 percent of nonelderly people had employer-sponsored coverage in 1994–95. Because of California's high poverty rate and broad eligibility criteria for Medi-Cal (the state's Medicaid program), a larger percentage of the nonelderly population is covered by this program than is the case nationwide: 18.1 percent in California compared with 12.2 percent for the nation.

Despite high rates of uninsurance, when clinical and public health status performance are examined, California ranks better than most states. An analysis by ReliaStar indicated that in 1997 California ranked 18th[8] among all states in overall health status, a slight improvement from its 1996 ranking of 20th.[9] This improvement is attributed in part to declines in smoking. California's infant mortality rate was the 15th lowest among all states. California is also outperforming many other states in areas such as low prevalence of cancer, support for public health care, and a low rate of occupational fatalities.[10] But southern California is still plagued with high levels of violent crime and infectious disease (e.g., tuberculosis, sexually transmitted disease). AIDS is still a large problem as well, especially in the San Francisco and Los Angeles areas.

Political Overview

Since 1990, California has had a Republican governor, Pete Wilson. During Wilson's term in office, for all but the 1994–96 period, the state legislature has

been Democratically controlled by a small margin. Under the state constitution, Governor Wilson must vacate his position after his second term ends in 1998. As of early 1998, there were 43 Democrats and 37 Republicans in the State Assembly, and 16 Republicans, 23 Democrats, and one Independent in the State Senate. In 1990, California voters approved term limits for state legislators and other statewide officials by a 52 percent majority (Proposition 140), and they have survived a series of legal challenges and court decisions. Term limits have made it difficult to gain consistent leadership in the legislature. In many instances, legislators have had to vacate their positions just as they were gaining sufficient experience and understanding of the lawmaking process.

State Budget Overview

California's fiscal outlook is good. After the recession in the early 1990s, the state has seen moderate, yet steady, economic growth and increased revenues. In state fiscal year (FY) 1995-96, general fund revenues were $46.3 billion. Revenue increased by 5 percent in FY 1996-97 to $48.7 billion.[11] Since this decade's recession, FY 1996-97 is the first year the state has had a small general fund reserve; therefore, the state will still have to be cautious about spending.

The federal Balanced Budget Act of 1997 (BBA) will also affect the state's revenues. The state could receive up to $859 million in 1998 for its Healthy Families program under the federal State Children's Health Insurance Program. (To receive these funds, the state will be required to pay for approximately 35 percent of the program's costs.) The state, however, is expected to lose about 9 percent, approximately $460 million, of its total federal Medi-Cal disproportionate share hospital (DSH) funds over the next five years.[12] By 2002, federal DSH spending through Medi-Cal will be almost 20 percent lower than it was in 1995–96.

State and county flexibility in budgeting decisions is often constrained by the state constitution, legislative rules, or ballot initiatives that have been adopted through the electoral process. For example, a long-standing rule severely restricts the state's ability to raise revenues through the income tax by requiring a two-thirds majority to pass a tax increase through the legislature. After a period of reductions in some marginal tax rates, the rates have now sunsetted back to 1991 levels. Ballot initiatives affect the state budget process by limiting tax options (Proposition 163 prohibited future sales taxes on food), mandating spending requirements (Proposition 98 established funding guarantees for K–12 education and community colleges), or creating dedicated tax sources (Proposition 99 imposed a cigarette tax to fund health education and indigent health programs). Counties have also been affected by these types of initiatives, most visibly by Proposition 13 in 1978, which limited their ability to raise property taxes and transferred the authority to allocate local property taxes to the state. In addition, many counties feel that by directing new revenues that become available to the state toward education programs, Prop-

osition 98 is causing them to lose access to resources required to meet their population's needs. These propositions have played a significant role in shaping the state's health programs, especially those related to the funding available to county indigent health programs (discussed below).

Among California's major budget sectors—Medicaid, corrections, primary and secondary education, higher education, and Aid to Families with Dependent Children (AFDC)—Medicaid was the second largest budget item in 1995, the largest being primary and secondary education. Expenditures from the state general fund for Medicaid in 1995 totaled nearly $6.4 billion, 15 percent of overall state spending (table 2). Over the past several years, spending for Medicaid has been growing at a faster rate than overall state spending. Since 1990, Medicaid spending has grown on average 12.5 percent per year, while overall state expenditures have increased only 1.1 percent per year—a substantial difference. From 1990 to 1995, Medicaid spending also increased more than any other budget sector.

Table 2 *California Spending by Category, 1990 and 1995 ($ in Millions)*

	State General Fund Expenditures[a]			Total Expenditures[b]		
Program	1990	1995	Annual Growth	1990	1995	Annual Growth
Total	$40,473	$42,643	1.1%	$66,051	$87,244	5.7%
Medicaid[c, d]	3,534	6,382	12.5	7,240	16,961	18.6
% of Total	(8.7)	(15.0)	—	(11.0)	(19.4)	—
Corrections	2,451	3,241	5.7	2,468	3,322	6.1
% of Total	(6.1)	(7.6)	—	(3.7)	(3.8)	—
K–12 Education	15,312	15,062	(0.3)	16,924	17,439	0.6
% of Total	(37.8)	(35.3)	—	(25.6)	(20.0)	—
AFDC	2,216	2,815	4.9	4,651	5,751	4.3
% of Total	(5.5)	(6.6)	—	(7.0)	(6.6)	—
Higher Education	5,576	4,910	(2.5)	7,317	6,721	(1.7)
% of Total	(13.8)	(11.5)	—	(11.1)	(7.7)	—
Miscellaneous[e]	11,384	10,233	(2.1)	27,451	37,050	6.2
% of Total	(28.1)	(24.0)	—	(41.6)	(42.5)	—

Source: National Association of State Budget Officers, *1992 State Expenditure Report* (April 1993) and *1996 State Expenditure Report* (April 1997).

a. State spending refers to general fund expenditures plus other state fund spending for K–12 education.

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

c. States are requested by the National Association of State Budget Officers (NASBO) 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, etc., is included in state spending because states cannot separate them. California reported other state funds of $24 million in 1990 and $1.874 billion in 1995, resulting from increased use of provider taxes, fees, donations, and assessments.

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 includes all remaining state expenditures (e.g., transportation; other cash assistance programs; capital expenditures for higher education, corrections, transportation, environmental projects, housing, and other expenditures) not captured in the five listed categories.

When other state and federal expenditures are included, as shown in the second panel of table 2, expenditure patterns are similar but of a different magnitude. Medicaid and primary and secondary education are the largest budget items, each consuming around 20 percent of the total budget in 1995. Medicaid remains the fastest-growing budget sector between 1990 and 1995; it had an average growth rate of about 18.6 percent each year, dramatically outpacing all other budget sectors. Although not reflected in table 2, some of the growth in Medicaid spending represents a shift in funding from other state health programs. As a result, the rapid growth in Medicaid spending should not be viewed as an indicator of the growth in overall health spending by the state.

Roadmap to Rest of Report

The rest of this report introduces the major health care policy issues, initiatives, and challenges that California is facing in 1998. It presents:

- The context of the state's current health policy;
- A review of state health care programs, with a particular focus on the Medi-Cal program;
- A description of the health care financing and delivery systems, highlighting the role of managed care in the state;
- A summary of the role of safety net providers in the state, focusing on Los Angeles, Alameda, and San Diego Counties;
- A description of long-term care for the elderly and disabled populations; and
- A summary of health care policy challenges that California may face in the future.

Health Policy Context

Despite the large numbers of uninsured adults and children in California, state budgets throughout the 1990s have placed a higher priority on programs aimed at improving primary and secondary education and corrections than they have on new public initiatives to expand health insurance coverage. California's health policy efforts have primarily focused on maintaining an already well-developed two-pronged strategy for dealing with the low-income uninsured: broad eligibility for Medi-Cal and support for a county-based indigent health care system. The responsibility placed on counties to care for the uninsured distinguishes California from most other states. It also shapes the debate over many health policies and programs, especially those that affect the funds available to counties to pay for indigent care. Where statewide health policy innovations have occurred, they have tended to result in small programs whose goal is to insure limited numbers of individuals through private health plans or to provide specific types of services (e.g., family planning or immunizations) to specific groups. The most prominent of these innovations have been Access for Infants and Mothers (AIM), the Health Insurance Plan of California Purchasing Cooperative that the state administers for small employers, and a high-risk pool for those individuals with severe medical problems.

Through Medi-Cal, the state covers almost all optional services and has chosen to go beyond the income eligibility levels required under the federally mandated expansions for pregnant women and children. The state is able to afford a Medi-Cal program with generous coverage because its spending per enrollee is well below national averages. The prevalence of private managed care plans and the competitiveness of California's health care market in the face of excess capacity have created an environment in which hospitals, and other providers, are willing to accept the low rates offered by Medi-Cal. Until the

early 1990s, the state was hesitant to have Medi-Cal join with the private-sector managed care explosion that has been dominant in California since the 1980s. This was largely because of the success the state has had in keeping provider payments low and because of lingering concerns related to marketing abuses that occurred in the 1970s, when Medi-Cal tried to use managed care to save costs without adequate state oversight of managed care plans.

Designing health policy in California is complicated because a large portion of the uninsured are immigrants, many of them undocumented (illegal). The state is obligated to cover emergency services for low-income undocumented immigrants through Medi-Cal. However, public opinion tends to support the view that because immigration policy is set at the federal level, the costs of programs for immigrants should be a federal responsibility—a view reflected in voter approval in 1994 of Proposition 187, which attempted to block the provision of a broad range of publicly funded services to undocumented immigrants in California. Despite this tension, the state has been funding a program to provide prenatal care to approximately 70,000 undocumented immigrant women each year. Court intervention has blocked the cuts in the prenatal program proposed by the Wilson administration as part of the state's response to federal welfare reform. However, observers indicate that the program probably will not survive through 1998.

Even with broad Medi-Cal eligibility, there are still many low-income individuals who do not qualify or who have not sought coverage. To serve these people, the state relies on a county-based health care system. Under California law dating back to the 1930s, counties are required to serve as the providers of last resort for the medically indigent population. A variety of approaches to indigent care have emerged throughout the state. Because counties have autonomy in designing programs to fulfill this obligation, some counties (e.g., Los Angeles, San Francisco, and Alameda) have built and maintained large systems of public facilities, while others (e.g., San Diego and Sacramento) have contracted with private providers to serve the indigent population. Although data on this system are incomplete and somewhat out-of-date, approximately 1.7 million people—5 percent of the state's population—receive care through this system at a statewide cost of between $2 billion and $2.5 billion annually.

The state recognizes that counties would be unable to meet these programmatic obligations without some state participation in funding indigent health care services. Over the years, the nature of this financial support, as well as the ultimate responsibility for setting program rules, has shifted. In the early 1970s, the state created a medically indigent adult (MIA) Medi-Cal eligibility category to help counties meet their obligations to provide indigent care. In the face of 1978's Proposition 13, which limited counties' ability to increase taxes and continue funding their obligations for county health programs, California created a block grant program to pay for services to those not eligible through the MIA program. By 1983, the state felt it could no longer continue to fund the MIA program, and so eliminated it. To offset this loss, the state increased block grants to the counties by 70 percent of the state's cost of MIA. To receive these

block grants, counties had to submit reports to document how the money was spent, and they had to maintain the level of spending they had before Proposition 13.

In 1991, a recession was putting fiscal pressure on the state's budget, and the funding levels for the block grants were in question. This led to a fundamental change in the state's approach to funding county indigent health care programs. Funding was "realigned" through a dedicated fund stream that was created from an increase in the sales tax and an earmarked portion of the vehicle license fee. Dedicated funding streams were also created to help the counties fund their obligations for mental health services and social services. The state was no longer obligated to fund the block grants, which had served their purpose for more than a decade. In exchange, the counties were no longer subject to the uncertainties of annual budget decisions (although they still had financial maintenance-of-effort requirements). If the realignment funds fell short of expectations, which they did as the recession deepened immediately after realignment was put in place, counties would have little recourse. Although counties are required to be the providers of last resort for indigents, they have very limited ability to raise additional tax revenues that can be used to offset shortfalls in state funding and thus to fulfill this obligation.

The pressure to change that realignment and the recession put on the counties would have been far worse had it not been for the state's willingness to work with the counties to draw federal dollars into the state through the Medi-Cal program. Specifically, beginning in 1991, the state established a large Medi-Cal disproportionate share hospital (DSH) program (discussed in a later section) that allowed safety net hospitals to receive additional Medi-Cal revenues with no additional net expenditures of state or county funds. Many of these safety net hospitals were county-operated facilities that used these additional federal dollars to offset the costs of meeting their obligations to the medically indigent population, as intended under the DSH program.

However, even the DSH funds have not been stable for public providers. Throughout the 1990s, as the California health care market has become increasingly competitive, private hospitals have become very willing to treat Medi-Cal patients, especially when they also receive DSH payments. This has caused the volume of Medi-Cal patients treated at county facilities to fall while the volume at private hospitals has increased. DSH payments, which are tied to Medi-Cal inpatient stays, have also shifted from county to private providers. This DSH shift, in combination with the movement of dollars into managed care, is viewed as a serious problem by public hospitals, because the private providers treat far fewer indigent patients than do the county hospitals, leaving county hospitals with the indigent patients but less Medi-Cal revenue to help pay for their care.

As in many states, the federal Personal Responsibility and Work Opportunity Reconciliation Act (welfare reform) that was passed in 1996 led California to reassess many of its social programs. In the health care area, the state had to

decide how welfare reform was going to affect Medi-Cal eligibility and whether the state was going to continue covering the large number of legal immigrants who had initially lost categorical eligibility for Medi-Cal. Overall, California has not used the flexibility it received under welfare reform to move away from its generous Medi-Cal eligibility standards. Nonimmigrants that were eligible for Medi-Cal continue to be eligible. Despite the governor's proposal to exclude legal immigrants arriving after August 1996 from full Medi-Cal benefits as federal rules allowed (they still would have been eligible for emergency services), the legislature did not adopt this provision, and all legal immigrants continue to be eligible for Medi-Cal if they meet other eligibility standards. This places California among the more generous states, given the number of immigrants residing in the state. However, there has not been a reaffirmation of the prenatal care program for undocumented immigrants, although, as mentioned above, the program is still being funded, in part as a result of court intervention.

Despite the potential changes that could take place under welfare reform, the state's approach to health policy has not shifted dramatically. The state has worked with existing federal and state programs to try and meet the needs of its residents. Despite an interest in expanding health care coverage for children, the Wilson administration has been reluctant to continue expanding Medi-Cal because of the federal rules attached to the program. There was action, however, after Congress passed the State Children's Health Insurance Program. At that time, the governor proposed and the legislature passed a program that involves a limited expansion of Medi-Cal and the creation of the Healthy Families program, which subsidizes the purchase of private coverage for low-income children through a health insurance purchasing cooperative.

During 1996, when Medicaid block grants were considered by Congress, California policymakers discussed some options without developing formal proposals. The general sense was that the state would move in the direction of combining the various funds it currently uses (e.g., federal Medi-Cal, realignment, and cigarette taxes) to develop programs that were less dependent on categorical eligibility than Medi-Cal. One block grant option that was considered was to replace current programs with one that offered insurance coverage at no cost to all individuals with income up to some threshold. Higher-income individuals could also obtain coverage, but a sliding scale premium related to income would be imposed. Counties remain quite concerned about how block grants and changes in state programs might affect the funds currently available through the Medi-Cal DSH program.

State Health Insurance Programs and Other Initiatives

The Department of Health Services (DHS) is one of the largest departments in the California state government. It is responsible for administering both the Medi-Cal program and a broad range of public health programs. In its role as the Medi-Cal administrator, DHS enters into agreements with other departments to perform specific functions related to Medi-Cal. These departments include the California Medical Assistance Commission and the Departments of Social Services, Aging, Developmental Services, Alcohol and Drug Programs, and Mental Health. The extent of these collaborative efforts has created coordination problems for the state, especially in the area of long-term care (discussed in a later section). As the state's primary public health agency, DHS runs programs that complement and support local health department activities related to controlling environmental hazards, disease prevention, and serving populations with special health needs. In addition, DHS issues licenses to health facilities.

The state also funds the Managed Risk Medical Insurance Board, a voluntary, semi-independent state board, which administers four programs that offer health insurance to selected individuals through commercial health plans. The populations served by these programs are (1) people who are unable to obtain insurance because of a preexisting condition; (2) small employers who have difficulty purchasing coverage for their workers through the private market; (3) pregnant women and infants; and (4) low-income children up to age 18 (through Healthy Families). In addition to these publicly funded health insurance programs, California has implemented health insurance initiatives, such

as small-group and individual insurance reforms, aimed at encouraging more coverage through the private sector by improving access to affordable health insurance. California differs from most states in that more low-income citizens have Medicaid than have private group or individual insurance.[13]

The Medi-Cal Program

During 1995, the Medi-Cal program enrolled 6.8 million people at a cost of almost $17 billion, making it the largest health care purchaser in the state. In terms of eligibility and service coverage, Medi-Cal is one of the most generous programs in the country. The maximum allowed income for AFDC in relation to the federal poverty level (FPL) in 1996 was 56 percent in California, higher than the average for the nation of 39 percent. Through two eligibility expansions, Medi-Cal now covers pregnant women and infants up to age one whose income is below 200 percent of the FPL, regardless of assets. Eligibility generosity is also reflected in the state's medically needy program,[14] which has standards above those of the nation. The income limit for the medically needy in relation to the FPL in 1996 was 86 percent, whereas the average for the nation was only 48 percent.

The comprehensiveness of Medi-Cal's service coverage is reflected in its decision to provide 32 of the 34 optional services for which the federal government provides matching funds. Except for personal care services, including in-home support services (California incorporated its supplemental in-home support services program into the Medi-Cal program for the categorically eligible and called it personal care), medically needy recipients receive the same benefit package as the categorically needy. Although the governor has maintained Medi-Cal's broad eligibility, it is routine for budget proposals to suggest modest reductions in service coverage as a way of meeting fiscal challenges. However, these service reductions generally have not been adopted by the legislature.

Expenditure and Enrollment Trends: 1990–1995

In the early 1990s, Medi-Cal expenditures increased rapidly but at a somewhat lower rate than in the rest of the country: an average increase of 21.6 percent annually in California versus 27.1 percent in the country as a whole from 1990 to 1992 (table 3). From 1992 to 1995, Medi-Cal expenditure growth averaged 11.0 percent each year, a rate that exceeded the national annual average of 9.9 percent. The high growth rate at the beginning of the decade occurred largely because of rapid increases in caseload (table 4); during this period, California's spending, on average, for each enrollee (table 5) grew more slowly than in the rest of the nation. The caseload growth in California was the result of federal and state expansions in Medicaid eligibility and more people needing public assistance because of the recession.

Growth in the Medi-Cal DSH program was another important reason for expenditure increases in the early 1990s. Table 3 documents the development

Table 3 *Medicaid Expenditures by Eligibility Group and Type of Service, California and United States ($ in Millions)*

	California					United States				
	Expenditures			Average Annual Growth		Expenditures			Average Annual Growth	
	1990	1992	1995	1990–92	1992–95	1990	1992	1995	1990–92	1992–95
Total	**$8,412.7**	**$12,439.1**	**$16,993.3**	**21.6%**	**11.0%**	**$73,662.2**	**$118,926.0**	**$157,872.5**	**27.1%**	**9.9%**
Benefits										
Benefits by Service	$7,991.2	$9,740.4	$13,273.1	10.4%	10.9%	$69,168.7	$97,602.4	$133,434.6	18.8%	11.0%
Acute Care	5,303.6	6,769.8	9,176.1	13.0%	10.7%	36,904.5	55,059.9	79,438.5	22.1%	13.0%
Long-Term Care	2,687.6	2,970.5	4,097.0	5.1%	11.3%	32,264.2	42,542.5	53,996.1	14.8%	8.3%
Benefits by Group	$7,991.2	$9,740.4	$13,273.1	10.4%	10.9%	$69,168.7	$97,602.4	$133,434.6	18.8%	11.0%
Elderly	$2,231.5	$2,590.9	$3,195.0	7.8%	7.2%	$23,334.3	$31,757.9	$40,087.4	16.7%	8.1%
Acute Care	666.3	882.4	1,094.3	15.1%	7.4%	4,925.4	6,911.5	9,673.7	18.5%	11.9%
Long-Term Care	1,565.2	1,708.4	2,100.7	4.5%	7.1%	18,408.9	24,846.4	30,413.7	16.2%	7.0%
Blind and Disabled	$2,865.7	$3,412.0	$4,878.7	9.1%	12.7%	$25,771.6	$35,684.6	$51,379.4	17.7%	12.9%
Acute Care	1,867.1	2,291.5	3,146.9	10.8%	11.2%	12,929.2	19,483.6	29,760.7	22.8%	15.2%
Long-Term Care	998.6	1,120.5	1,731.8	5.9%	15.6%	12,842.4	16,201.0	21,618.7	12.3%	10.1%
Adults	$1,410.0	$1,834.1	$2,400.6	14.0%	9.4%	$8,765.0	$12,710.1	$16,556.9	20.4%	9.2%
Children	$1,483.9	$1,903.4	$2,798.7	13.3%	13.7%	$11,297.8	$17,449.8	$25,410.9	24.3%	13.3%
DSH	$11.0	$2,191.5	$2,915.3	1,311.5%	10.0%	$1,340.9	$17,525.6	$18,988.4	261.5%	2.7%
Administration	$410.5	$507.3	$805.0	11.2%	16.6%	$3,152.6	$3,797.9	$5,449.4	9.8%	12.8%

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

Table 4 *Medicaid Enrollment by Eligibility Group, California and United States (Enrollment in Thousands)*

	California					United States				
	Enrollment			Average Annual Growth		Enrollment			Average Annual Growth	
	1990	1992	1995	1990–92	1992–95	1990	1992	1995	1990–92	1992–95
Total	**4,789.0**	**6,060.1**	**6,774.4**	**12.5%**	**3.8%**	**28,856.7**	**35,765.1**	**41,672.0**	**11.3%**	**5.2%**
By Group										
Elderly	501.1	551.4	566.0	4.9%	0.9%	3,412.2	3,771.0	4,116.6	5.1%	3.0%
Cash	345.8	349.9	362.4	0.6%	1.2%	1,713.1	1,739.2	1,789.2	0.8%	1.0%
Noncash	155.2	201.5	203.6	13.9%	0.3%	1,699.1	2,031.8	2,327.3	9.4%	4.6%
Blind and Disabled	623.1	720.4	845.8	7.5%	5.5%	4,040.9	4,875.1	6,405.2	9.8%	9.5%
Cash	571.5	659.3	749.9	7.4%	4.4%	3,236.81	3,853.4	4,973.5	9.1%	8.9%
Noncash	51.6	61.1	95.8	8.8%	16.2%	804.1	1,021.7	1,431.7	12.7%	11.9%
Adults	1,324.5	1,723.7	1,960.1	14.1%	4.4%	6,738.7	8,373.3	9,584.2	11.5%	4.6%
Cash	781.7	866.6	1,042.2	5.3%	6.3%	4,651.6	5,342.5	5,441.4	7.2%	0.6%
Noncash	542.8	857.1	917.9	25.7%	2.3%	2,087.2	3,030.9	4,142.8	20.5%	11.0%
Children	2,340.3	3,064.7	3,402.6	14.4%	3.5%	14,664.9	18,745.7	21,566.0	13.1%	4.8%
Cash	1,430.1	1,656.1	1,841.9	7.6%	3.6%	9,946.2	11,281.8	11,314.6	6.5%	0.1%
Noncash	910.2	1,408.5	1,560.7	24.4%	3.5%	4,718.7	7,463.9	10,251.4	25.8%	11.2%

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

Table 5 *Medicaid Expenditures per Enrollee by Eligibility Group, California and United States*

	California					United States				
	Spending per Enrollee			Average Annual Growth		Spending per Enrollee			Average Annual Growth	
	1990	1992	1995	1990–92	1992–95	1990	1992	1995	1990–92	1992–95
Total	**$1,669**	**$1,607**	**$1,959**	**–1.9%**	**6.8%**	**$2,397**	**$2,729**	**$3,202**	**6.7%**	**5.5%**
By Group										
Elderly	$4,453	$4,699	$5,645	2.7%	6.3%	$6,839	$8,422	$9,738	11.0%	5.0%
Cash	1,895	2,072	2,724	4.6%	9.5%	3,329	4,017	4,818	9.8%	6.2%
Noncash	10,154	9,261	10,846	–4.5%	5.4%	10,377	12,192	13,521	8.4%	3.5%
Blind and Disabled	$4,599	$4,736	$5,769	1.5%	6.8%	$6,378	$7,320	$8,022	7.1%	3.1%
Cash	3,811	3,961	4,991	1.9%	8.0%	4,969	5,927	6,686	9.2%	4.1%
Noncash	13,331	13,105	11,854	–0.9%	–3.3%	12,047	12,574	12,660	2.2%	0.2%
Adults	$1,065	$1,064	$1,225	0.0%	4.8%	$1,301	$1,518	$1,728	8.0%	4.4%
Children	$634	$621	$823	–1.0%	9.8%	$770	$931	$1,178	9.9%	8.2%

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

and size of California's DSH expenditures. Medi-Cal DSH grew from an $11 million program to a $2.2 billion program between 1990 and 1992. This rate of increase far exceeded the national average growth in DSH during this time. By 1992, DSH accounted for almost 18 percent of Medi-Cal spending. From 1992 to 1995, DSH continued to account for a high share of Medi-Cal spending. Average annual DSH growth was 10.0 percent, while the nation overall experienced modest annual growth of 2.7 percent.

The deceleration in Medi-Cal DSH growth during the 1992 to 1995 period played a large role in the overall reduction in Medi-Cal spending growth. Spending on Medi-Cal services, however, grew at a constant rate of roughly 10 percent through the entire period. In contrast, the deceleration in overall spending growth for the nation as a whole was a result of slower growth in both DSH and payments for acute and long-term care services.

Table 3 also highlights that California, compared with other states' Medicaid spending, spends a smaller share of its Medi-Cal budget on long-term care and services for the elderly. In 1990, 32 percent of California's Medi-Cal expenditures went to pay for long-term care services, whereas the national average was 44 percent. Part of the reason is that a smaller share of California's population is older than 65 (table 1) than is the case for the nation overall. By 1995, there was some shift toward greater spending for long-term care within Medi-Cal, but long-term care spending as a share of the total program was still lower in California relative to the national average. In 1995, California spent 24 percent of its Medi-Cal service-related dollars on services for the elderly, whereas the nation as a whole spent 30 percent. In contrast, in 1995 California spent 18 percent of Medi-Cal service dollars on nondisabled, nonelderly adults versus 12 percent for the nation.

Table 4 shows that overall enrollment growth in California over the 1990 to 1995 period was comparable to growth in the nation overall. Between 1990 and 1992, average annual growth in Medi-Cal enrollment was 12.5 percent in California versus the national average of 11.3 percent. This difference is largely the result of higher growth rates among noncash adult and elderly recipients in the Medi-Cal program. Between 1992 and 1995, California experienced 3.8 percent average annual growth in its Medi-Cal enrollment while enrollment growth in the rest of the country was 5.2 percent annually. Data not shown in the tables indicate that since 1994 enrollment in Medi-Cal has been leveling off.[15] State officials forecast that in 1997 and 1998 the number of enrollees will grow by less than 1 percent each year.

As mentioned above, Medi-Cal has a long history of keeping rates paid to providers low relative to other states. The results of this are documented in table 5. In 1995, California spent on average 39 percent less per Medi-Cal enrollee—$1,959 versus $3,202—than the country as a whole. California spent less per enrollee than the nation for all Medi-Cal eligibility groups—elderly, blind and disabled, adults, and children. The greatest differential in spending between Medi-Cal and the nation occurs among expenditures per enrollee for

the elderly, again reflecting the state's low outlays for long-term care. In 1995, California spent 42 percent less than the country as a whole per elderly Medi-Cal person. For other groups, the difference was closer to 30 percent less than the national average. California is sometimes viewed, particularly by state officials, as having one of the nation's "most cost-efficient" Medicaid programs. For example, analyses of American Hospital Association survey data (for both inpatient and outpatient services)[16] indicated that in 1995, Medi-Cal paid hospitals 85 percent of costs, while the national average Medicaid payment was 94 percent. In addition, the average reimbursement rate per day for freestanding nursing facilities in FY 1992–94 was 8.9 percent less than the national average.[17]

Consistent with the state's low spending levels, spending per enrollee in California grew only half as fast as the nation's spending between 1990 and 1995. The differences were particularly dramatic during the 1990 to 1992 period across all eligibility groups. However, the 1.9 percent reduction shown in table 5 is largely a result of the federally mandated eligibility expansions that changed the overall composition of Medi-Cal enrollment. Adults and children—the lowest cost groups—made up a larger share of enrollment in 1992 than they had in 1990, and this caused average spending per enrollee across the program to fall by more than it did for all but one of the eligibility groups shown (noncash elderly). California was not able to achieve the same low growth in spending per enrollee between 1992 and 1995 as it had in the 1990 to 1992 period. Spending per enrollee grew at rates that were much more comparable to nationwide rates. However, growth in Medi-Cal per enrollee costs in 1992 to 1995 was not so high as to offset the lower growth rates that had been achieved over the prior two years.

Recent Medi-Cal Eligibility Policies

California implemented two Medi-Cal optional eligibility expansions during the 1990s. In 1992, it waived asset requirements for pregnant women and infants up to age one with incomes at or below 185 percent of the FPL. In 1994, it expanded Medi-Cal coverage to pregnant women and infants up to age one with incomes up to 200 percent of the FPL, regardless of assets. More recently, asset requirements have been waived for all children eligible for Medi-Cal through the poverty-related expansions. According to state officials, these expansion efforts were undertaken as an attempt to reduce the state's high rate of infant mortality resulting from low birth weight. Data indicate that infant mortality rates declined from 7.9 per 1,000 births in 1990 to 6.1 in 1995.

Welfare reform and Medi-Cal. The federal welfare reform law and subsequent state laws have changed the relationship between Medi-Cal and cash welfare for families, the latter of which has been the path of Medi-Cal eligibility for a majority of adult and child enrollees. As a part of welfare reform, California has decided to maintain Medi-Cal eligibility for all of those who receive benefits under CalWorks (the state's Temporary Assistance for Needy Families program that replaced AFDC). In some areas, CalWorks eligibility is more liberal than AFDC had been. Thus, the substantial increase in earned income disregards under

CalWorks also means that there is a higher income standard for Medi-Cal families who are working. The net effect is that California has expanded its eligibility criteria for Medi-Cal, as it relates to welfare. Even so, cash assistance caseload levels in Medi-Cal probably will still decline.

Legal immigrants. About one quarter of California's Medi-Cal enrollees are noncitizen immigrants, the highest proportion of any state in the country.[18] Thus, the recent federal change in immigrant eligibility for Medicaid will have a substantial impact on California. The federal law stipulates that most legal immigrants entering the country after August 22, 1996, are ineligible for Medicaid, but are still covered for emergency services. Governor Wilson proposed adopting these guidelines, but the state legislature did not enact them, so the state is still providing full coverage to all post-enactment legal immigrants. Presumably, the state will be responsible for funding nonemergency services for those immigrants who are not covered under the federal law.

Essentially, none of the immigrants who participated in Medi-Cal in August 1996 will lose eligibility, provided they meet other income and categorical criteria. At one point, some immigrants on Supplemental Security Income (SSI) were going to lose Medi-Cal eligibility, but the passage of the BBA of 1997 reversed that policy and grandfathered the elderly and disabled who participated as of August 1996 or who were in the country on that date and become disabled later.

Undocumented immigrants. Since 1994, controversy over health care provision to undocumented (illegal) immigrants in California has been highly charged. At that time, California voters enacted Proposition 187, which declares that undocumented immigrants are ineligible for a range of government health and education programs.[19] Governor Wilson has repeatedly sought to reduce state expenditures involved in caring for undocumented aliens, such as the prenatal care program, independent of federal action, and to increase federal aid to cover expenses under the belief that immigration policy and the related costs are a federal responsibility. In FY 1996–97, Congress refused to give the state $216 million of additional federal funds to finance a budget deficit caused by Medi-Cal emergency benefits to undocumented immigrants. For the first time, in FY 1998, the federal budget includes some funds to offset these expenses.

By federal law, undocumented immigrants are eligible for emergency services under Medi-Cal, including labor and delivery, if they otherwise meet current eligibility requirements for Medi-Cal. Undocumented immigrants who do qualify receive a Medi-Cal card indicating that they are eligible for Medi-Cal emergency care only.

The state does not have a comprehensive list of what emergency care services are reimbursed under this benefit. Instead, it relies on the provider to determine initially whether the service is an emergency. Because the scope of

emergency services is not clear, providers complain that they risk having claims denied if the state decides a given service was not an emergency.

Since 1986, California has extended prenatal care to undocumented women through Medi-Cal. These services are supported by state-only funds. Each year, California provides about $84 million in prenatal care to about 70,000 undocumented women. In his budget for 1997–98, Governor Wilson again proposed eliminating this prenatal program and cited federal welfare reform law as justification. (A provision in the federal law mandates that states cannot provide state or locally funded benefits to unqualified immigrants—other than emergency services, immunizations, and tests for communicable disease.) Governor Wilson had proposed eliminating this program in budgets proposed before welfare reform. Termination of the prenatal program has been delayed in response to court challenges brought by advocates, but its future is uncertain.

California also uses state-only money to fund institutional long-term care services for undocumented immigrants. Approximately 200 undocumented immigrants live in nursing homes at a cost of about $10 million per year. Governor Wilson has proposed finding a legislative solution that would allow undocumented immigrants currently receiving long-term care to continue to receive it until other arrangements, such as family- or other community-based alternatives, could be made. Under this proposal, no new recipients would be added to the program.

The Public Health System

The majority of California's public health programs are located in two divisions of the Department of Health Services: (1) Prevention Services and (2) Primary Care and Family Health. The Division of Prevention Services is responsible for communicable diseases, AIDS, chronic disease, injury control, and environmental health issues. The Division of Primary Care and Family Health oversees the Women, Infants, and Children (WIC) Supplemental Nutrition program, maternal and child health (MCH), health services for children with special needs, and family planning. This division is also addressing issues related to the adequacy of public health services within Medi-Cal as the program shifts to managed care.

The governor's 1996–97 budget allocated about $1.7 billion to public health, a sum that included federal and state funds. As a share of total expenditures on health in California, public health accounted for 7.6 percent in 1995–96. Under Governor Wilson, the state has directed spending increases at children's health, emphasizing prevention, despite lack of broad political appeal for these programs. Observers suggested that the weak political support derives from the perception that the programs are targeted only at low-income populations. The major revenue sources for public health activities in the state are federal categorical funds, including the MCH block grant; state and county general funds; dedicated sales tax and vehicle license fees (i.e., realignment, as described earlier); and tobacco tax

revenues. Realignment and tobacco tax revenues both support county responsibilities for indigent health care, including medical services and public health services. The percentage of these dollars spent on public health is not known with certainty and appears to vary by county; estimates range from 15 to 40 percent.

Medi-Cal has also become an increasingly important source of funding for public health activities, particularly MCH services. Many prenatal services that were once provided with MCH block grant dollars are covered by Medi-Cal as a result of eligibility expansions and increases in provider participation in and certification for Medi-Cal.

The state shares legal responsibility with counties to protect and enhance the health of the public. Counties (and three cities) carry out their responsibilities through local health departments; 11 of the smallest counties contract with the state to provide public health services. Some counties operate hospitals and large clinics, and the public health department is often integrated into this larger system. Among the more populous counties, public health expenditures comprised about one-fifth of total county expenditures on health in 1995–96.

A recent trend in at least a few counties, including Los Angeles, is the separation of core public health activities from the delivery of personal health services. Personal health services that have traditionally fallen in the domain of public health include immunizations and family planning. Services such as these, in at least three counties, have been removed from public health clinics and are instead being provided in primary care clinics. One impetus for this change is to allow public health agencies to focus on core activities such as epidemiological studies, community assessment, and monitoring.

In an environment of expanding Medi-Cal managed care, California's public health officials are redefining their role in other ways as well: establishing standards of care for health plans, evaluating the population-based impacts of Medi-Cal managed care, and developing memorandums of understanding (MOUs) with health plans that outline the division of responsibilities for services within the realm of public health. These MOUs are part of a strategy that would allow for contracts in which health plans pay local health departments for public health services (e.g., family planning, HIV testing, sexually transmitted disease services, and immunizations) when they are provided to Medi-Cal managed care plan members. Some state officials felt they had underestimated how difficult it would be for managed care plans to agree to these public health arrangements, suggesting that plans' reluctance to cooperate was a result, in part, of the low capitation rates paid by Medi-Cal.

Other Publicly Funded Health Programs

California sponsors two subsidized health insurance programs, the California Major Risk Medical Insurance Program and the Access for Infants and Mothers

program. In addition, the governor has just signed into law the Healthy Families program in response to the State Children's Health Insurance Program that will be jointly subsidized by the state and federal governments. These programs are administered by the Managed Risk Medical Insurance Board, a voluntary, semi-independent state board. In addition, there are many programs aimed at improving access to specific services for vulnerable subgroups of the population.

Major Risk Medical Insurance Program

The Major Risk Medical Insurance Program (MRMIP), established in 1991, is a program through which individuals who are ineligible for Medicare and Medi-Cal, and who cannot get health insurance because of a preexisting condition, can obtain medical coverage. The program covers a relatively small number of high-risk individuals, having served only 45,000 people since it was established. As of January 1997, MRMIP contracted with seven private health plans throughout the state. The largest plan is Blue Cross of California, with nearly three-quarters of the enrollees. Inpatient and outpatient services are included in the benefit package. The program is supported by tobacco tax revenues collected by the state under Proposition 99 and premiums from subscribers.

Access for Infants and Mothers Program

The Access for Infants and Mothers (AIM) program, started in 1992, provides subsidized health insurance for pregnant women and infants with incomes between 200 and 300 percent of the FPL. The program is supported by about $40 million in state funding from tobacco tax revenues collected under Proposition 99 and premiums from subscribers. This funding level can support 450 enrollees and their infants per month, but only about 300 are enrolled in an average month. Given the size of California's population, this is a small program. To participate, in addition to meeting the income criterion, a woman must not be eligible for Medicare or Medi-Cal (other than those who spend down); must not be more than 30 weeks pregnant; must have lived in California for at least six continuous months; and must not have private insurance that covers maternity care or that has a maternity-only deductible of less than $500. Currently, the state contracts with eight private health insurance plans, one of which is Blue Cross of California, which has about 50 percent of the enrollment. Plans participate as full-risk providers, with a negotiated rate that is neither age- nor risk-adjusted. Participants pay 2 percent of total gross family income adjusted for family size. In 1995, the average subscriber contribution for the basic service package was $630. AIM benefits include prenatal visits, hospital delivery, and full health services during pregnancy and 60 days postpartum. Health services are provided to the infant born from the AIM-covered pregnancy for the first two years of life.

Healthy Families Program

In response to the federal State Children's Health Insurance Program in the BBA of 1997, California will provide medical, dental, and vision cover-

age for all children through age 18 whose family incomes are below 200 percent of the FPL. It will do this through the creation of the Healthy Families program and the expansion of Medi-Cal eligibility. Proposed implementation is July 1998.

The Healthy Families program envisions using two approaches, subject to federal government rules and approval, to ensure maximum enrollment: (1) a purchasing pool in which families select a private health plan, and (2) a purchasing credit component to help families pay the premium for dependent coverage in an employer-sponsored plan. The second component still requires legislative action. In order to be eligible for Healthy Families, a family must have an income of between 100 and 200 percent of the FPL, it must be ineligible for Medi-Cal, and it must not have been insured by an employer-sponsored plan for the previous three months.[20] The only group of children through the age of 18 that would not be covered are those between the ages of 14 and 18 in families whose income is below 100 percent of the FPL, and the Medi-Cal program will be expanded to cover them.

Health Education and Direct Service Programs

As part of its overall strategy to improve preventive services and assure the public's health, California has many programs aimed at health education and direct provision of services. Among the areas these programs address are family planning, immunization, HIV/AIDS, and cancer screening. From a spending standpoint, these programs are small relative to Medicaid, but the outlays for them are greater than those for AIM, for instance, and they are designed to serve larger numbers of people. For example, the Planning, Access, Care and Treatment (PACT) program is designed to address the family planning needs of approximately 500,000 clients by contracting with more than 1,700 providers statewide to provide comprehensive services to low-income men and women. The budget for PACT in FY 1996-97 was about $65 million.

Insurance Reform Initiatives

Private insurance, especially employer-sponsored insurance, is an important source of coverage for the low-income population of California. More than 3.1 million low-income individuals—15.4 percent of the poverty population and 41.1 percent of the near-poor—are covered by private group or individual insurance. In total, this is two-thirds of the number covered by Medi-Cal. Furthermore, 85 percent of the 2.9 million uninsured are in households with at least one working member, so that private insurance remains their most likely route to health coverage. Making private insurance affordable for the low-income population was only part of the reason California pursued insurance reforms. Nonetheless, the state recognized that the low-income nature of California's uninsured made it unlikely that insurance reforms could have any more than a marginal effect on expanding coverage.

The California legislature had two primary motivations for passing comprehensive small-group market reforms in 1992: (1) Health care costs were rising rapidly, and (2) California workers were less likely to have employer-sponsored health insurance offered to them than were workers elsewhere in the country. The purpose of the laws, as implemented in 1993, was to make it harder for insurers to refuse to sell to any particular employment-based group. The laws apply to all health insurance products—indemnity and managed care alike—sold to firms with two to 50 employees. (The group size was originally set at five to 50, and the minimum dropped to four and then to three over the next two years, as part of an established transition, and to two in 1997. The legislature never enacted a proposal to lower the minimum group size to one.) The laws apply to all insurers, be they indemnity carriers regulated by the Department of Insurance (with an elected commissioner) or health care service plans (i.e., health maintenance organizations or HMOs) regulated by the Department of Corporations (headed by a gubernatorial appointee). California passed much less extensive reforms for the individual market, as will be discussed later.

The key provisions of California's small-group reform laws are guaranteed issue, guaranteed renewal, limits on preexisting condition exclusions, and modified community rating. The law also established a statewide voluntary, publicly sponsored small-employer health insurance purchasing pool, known as the Health Insurance Plan of California (HIPC), which is operated by the Managed Risk Medical Insurance Board.

Guaranteed issue in California means that insurers must offer all products to all small groups and to all members of those groups. They can no longer categorically deny (or "redline") particular industries or professions, nor can they offer some insurance products exclusively to preferred groups. Most states with guaranteed-issue rules in the small-group market merely required insurers to offer one or two products on a guaranteed-issue basis. The new federal health insurance reform law, the Health Insurance Portability and Accountability Act (HIPAA, popularly known as Kassebaum-Kennedy, PL 104-191), requires guaranteed issue for all products sold to small groups in all states, as of July 1, 1997.

Guaranteed renewal means that an insurer must offer to continue coverage of a currently insured group—that is, the policy cannot be summarily canceled because of claims experience or a change in the health status of the group members. While insurers can increase the premium charged at renewal, such increases must conform to the prescribed rate band (discussed below). Exclusions from coverage of preexisting conditions were limited to six months (the waiting period), and then allowed only for conditions that were treated or the subject of a medical consultation in the six months before coverage (the look-back period). Alternatively, an HMO may require a 60-day waiting period for any coverage to begin for any new member of an insured group. HMOs were also required to give enrollees credit for prior coverage, although indemnity insurers did not have to do so.

Pure community rating would entail charging all insured persons the same premium. Most states use modified community rating, meaning they allow spe-

cific and limited deviations from identical pricing. California's modified community rating provision has two dimensions. One is the set of factors that insurers use to adjust premiums: six age groups (under 30, 30–39, 40–49, 50–59, 60–64, 65+), four family types (employee only, employee and spouse, employee plus children, employee with spouse plus children), and nine geographic regions. This means that there are potentially 216 premium categories. The other dimension is rate bands, constraints on the amount that premiums may vary within any premium category. The total permissible variation within a category was ±20 percent (0.8 to 1.2 times the standard rate) until July 1, 1996, when it narrowed to ±10 percent. This approach preserves insurers' ability to charge lower premiums to younger subscribers, but reduces the effect of individuals' experience on their specific premiums.

The HIPC has been operating since July 1993. It is governed by the Managed Risk Medical Insurance Board originally created to run the state high-risk pool. As of January 1, 1996, more than 5,000 employer groups and more than 100,000 individuals had enrolled in one or more of the HIPC's 24 participating health plans. The small-group reforms, including the rating restrictions, that are within California's private insurance markets also apply within the HIPC. In addition, HIPC plans feature standard benefit packages and annual open enrollment periods in which subscribers may change health plans. The HIPC uses data on enrollees' health risks (last year's claims) to adjust premiums received by insurers in order to reduce the effect of risk selection on insurer cash flow.[21]

Like most states, California has taken fewer steps to reform the individual health insurance market. The only substantive reform is a limit on preexisting condition exclusions, to 12 months for a condition discovered in the previous 12 months. Twenty-five states have some limits on preexisting condition exclusions for individual policies, most with shorter look-back periods than California has.[22] HIPAA requires group-to-individual portability for certain eligible individuals, and this will be a big change for the California individual market. In part for this reason, California was unable to agree on its own provisions to enforce HIPAA and will therefore accept the default of federal enforcement.

Effects of Reforms on Markets

The state health reform laws passed in 1992 required both the Department of Insurance and the Department of Corporations to do analyses of the effects of the first year of reforms on their licensees—commercial insurers and HMOs, respectively.

Most of the 46 carriers that responded to the Department of Insurance survey reported that base rates were increased to compensate for the added risk that must now be shifted to healthy groups. A majority felt affordability had been adversely affected by the reforms. Overall, indemnity carriers reported losing about 28,000 covered lives in the small-group market in the period of study (June 30, 1993, to June 30, 1994), a loss that was more than made up by HMO enrollment expansions (see below). This represented a loss of about 5 percent of the indemnity small-group enrollment base and about 10 percent

of the small groups that were enrolled. The indemnity plan losses were absolutely and proportionately greater in the Los Angeles County region, where HMO competition is particularly fierce.[23]

The Department of Corporations conducted a survey of its licensees in 1994.[24] Overall, health care service plans reported that enrollment in the small-group market increased by 22 percent (330,000) in the first year of reform, more than enough to compensate for the decline in small-group coverage by indemnity carriers, described above. This suggests that HMO competition had the net effect of lowering average premiums charged. Many carriers were worried that the healthiest groups would drop their insurance when the ±10 percent rate bands went into effect (July 1996). The Department of Corporations concluded that there was too much uncertainty to predict the future direction of "affordability" and "continuity" of coverage in California.[25]

Effects of Reforms on the Small-Group Market

There have been no formal studies of the direct and indirect impacts of the HIPC on insurance markets in California, so this assessment is based on interviewees' opinions. A consensus exists that the HIPC has become a kind of bellwether for many more people than those who buy or sell insurance through it. Because the HIPC's benefit packages are standardized, and because the prices that insurers charge for HIPC enrollees are publicly available, many participants in the small-group market are able to use HIPC premiums as a benchmark. Thus, HIPC premiums are likely to be upper-bound constraints on prices outside the HIPC, because small employers can join the HIPC fairly easily. HIPC premiums fell in the first three years of the plan's existence, and there is considerable evidence that average health insurance premiums for a number of organized groups in California also declined each year in nominal (absolute) terms from 1993 until 1997.[26] HIPC enrollment is expanding steadily, not astronomically, and the plan is still a very small part (less than 2 percent) of the small-group market in California as a whole.

Health Insurance Market Prospects

California's small-group reforms are widely perceived to have worked well, in part because premiums fell or increased only slightly in the first few years of reforms. Whether this is coincidence or the actual result of reforms is not important, politically, as long as premiums are falling. Some, perhaps most, of this favorable premium experience was probably a result of the excess capacity and competitive pressures in health care provider markets, and it could be reversed when that excess capacity finally disappears from the health delivery system. Still, the fact that a smaller percentage of California's nonelderly population is covered through employer-sponsored health insurance than in the nation as a whole suggests that while premium inflation may have abated, relative premium declines have not been enough to induce significant increases in coverage. Thus, the problems of the uninsured in general and uninsured workers in particular remain because of structural economic conditions, despite the perceived success of the small-group reforms (i.e., promoting access to insurance).

Health Care Delivery and Financing System

Health care delivery and financing systems are changing everywhere, but California's may have been the most extensively reorganized (with the possible exception of Minneapolis-St. Paul) of any in the country. Unmanaged indemnity insurance has virtually disappeared,[27] and health plan competition centers around for-profit HMOs, nonprofit HMOs, and preferred provider organization (PPO) products of more traditional insurers. Medi-Cal has recently decided to take advantage of this managed care health plan competition, as will be discussed after the delivery system as a whole is described.

Overview of California's Health Care Markets

Current Health Insurance Markets

Nearly three-fourths of California's insured population is enrolled in managed care, about 46 percent in HMOs.[28] Only nine indemnity carriers still offered purely unmanaged fee-for-service plans. In 1996, there were more than 500 traditional indemnity insurers—18 large ones[29]—and 48 full-service HMOs.[30] In California the latter are legally termed "health care service plans" or Knox-Keene licensees, after the legislation that governs HMOs in the state. A few insurers (notably Blue Cross and Blue Shield) have both kinds of licenses.

California has six large HMOs with more than 1 million enrollees each. Combined, they account for 70 percent of 1996 total health care service plan

enrollment (12.5 million out of 17.9 million as of March 31, 1996).[31] About half of the indemnity carriers offer individual policies, whereas more than two-thirds of HMOs offer individual products.[32]

Overall, the indemnity health insurance market was estimated to be $2.1 billion in 1994, and it seems to be slowly losing market share to HMOs. About 40 percent of the total, $851 million, is accounted for by groups in the size range of three to 50. The top eight carriers account for two-thirds of all indemnity premiums and three-fourths of small group indemnity premiums. The top three products of each firm account for 90 percent of all business written, which implies that the public is buying or being offered relatively few of the many commercial plans.[33]

In response to this financing revolution and the excess provider capacity that changing delivery patterns have created and exposed, provider groups have begun to reorganize themselves to improve their bargaining power and to maintain autonomy in the new health marketplace. To a much greater extent than elsewhere, California physicians have formed large, integrated medical groups that are capable of bearing capitation risk for large numbers of patients. These physician groups are developing complex relationships with hospitals and specialists outside their groups, and they represent the core of an emerging delivery system that is based on capitation.

Mergers among physician groups, hospitals, and health plans have played a significant role in these developments in California, as has the conversion of some health plans and hospitals from nonprofit to for-profit status. Some mergers reduce redundancies, confer economies of scale, increase clinical integration, improve health outcomes, and increase overall efficiency, while others are more likely to simply increase the market power of the merged entities and reduce competitive pressures in the long run. Mergers among hospitals and conversions of nonprofit hospitals to for-profit status, especially amid a system-wide drive toward cost efficiency, also raise questions about continued commitments to community-based uncompensated care. This commitment is especially important in California, given the large number of uninsured (20 percent of the nonelderly population, or 6.2 million people, in 1995).

Competition Policy

To date, California has not granted blanket antitrust immunity to any provider group or specific joint venture. The state prefers to address contested market phenomena (mergers or particular anticompetitive actions) on a case-by-case basis. This policy approach may have contributed to the creation of larger physician organizations and to mergers among them, because mergers permit the kind of "collective bargaining" with managed care plans that providers want, whereas concerted pricing by independent physicians risks running afoul of the antitrust laws. There are also efficiency reasons that large medical groups are more successful than small independent practices in competitive marketplaces: economies of scale; ability to spread capitation risk; reduced transactions costs of negotiating, monitoring, and enforcing agreements with other

components of the delivery system; and the creation of an organizational context for continuous clinical process innovation.[34]

Hospital mergers were the original focus of antitrust activity in California, but with occupancy rates between 50 and 60 percent, it is difficult to argue that most proposed mergers present risks to future competition. The attorney general's office is generally pleased with the level of federal-state cooperation on important cases in recent years (at least since 1989). An example was the Stanford–University of California at San Francisco hospital merger, simultaneously analyzed by the Federal Trade Commission, the California Department of Health, and the state attorney general (AG) and approved on competitive efficiency grounds. Pacificare/FHP, a 1997 merger of two of the largest HMOs in the state that received a similar level of antitrust and press attention, had a combined statewide market share of less than 13 percent. The reality is that most health plan, hospital, and physician service markets in California are extremely competitive at present, and the authorities are watching but letting the players affiliate and consolidate as they see fit. The greatest current policy focus is not in merger analysis but in price-fixing cases among PPOs and physician groups that participate in networks (price fixing is illegal per se, regardless of market share). Experienced observers, both policymakers and local academics, expect considerably more health market shakeout and reorganizations in California.

Nonprofit Conversion Policy

Nonprofit conversion policy matters because uncompensated health care is a crucial community benefit that nonprofit hospitals have traditionally provided. Estimates suggest that nonprofit hospitals provide over half of all uncompensated hospital care in California.[35] Uncompensated care may be provided directly by a hospital or financed with the income from assets transferred from a formerly nonprofit corporation—either a hospital or a health plan—to a foundation that is chartered to use the assets to serve the hospital's community.

Legally, a nonprofit entity is organized for a purpose other than to produce returns to owners; its net earnings may not be distributed but must be used to further its mission. The assets of a nonprofit entity are held "in trust" and are required to be used for these charitable purposes for the benefit of a local community or in a manner consistent with its state charter or enabling statute (as in the case of some Blue Cross and Blue Shield plans). A nonprofit conversion to for-profit status is a transaction in which the new proprietary owners buy the assets that were held in trust. The proceeds of that sale, by law, must be constituted and managed to further a charitable purpose (not necessarily the original one) and may not be diverted to private gain by the nonprofit's trustees, directors, or managers.

Jurisdiction over the conversion of nonprofit health care entities in California was split until very recently. The Department of Corporations had complete jurisdiction over conversions of HMOs and Blue Cross and Blue Shield plans (i.e., Knox-Keene plans), whereas the AG had authority over the conversion of non-

profit hospitals. The 1980s saw a large number of health plan conversions, and it was widely perceived that the Department of Corporations was less effective than the AG in protecting the public's interest by preserving the original charitable purposes of the nonprofit entity. Complaints about the department's oversight performance centered on two facts: Former directors of nonprofit health plans became wealthy as owners of the new for-profit plans, and the purchase price or wealth left behind in the new foundations was considerably lower than the value of the assets that had been held in public trust, as manifested by stock market value soon after conversion.[36]

This dissatisfaction with the Department of Corporations' oversight of nonprofit health plan conversion reached a peak with the Blue Cross/WellPoint conversion process that began in 1991 and culminated in a 1996 law, A.B. 3101, which gave the AG veto power over health plan conversion agreements. It also mandated that public hearings be conducted by the AG's office, that an analysis be done of the transactions' likely impact on the local community, and that the state be reimbursed by the parties proposing a conversion for the expense of hiring experts and doing the proper analyses. Finally, the bill codified the transaction review protocol that the AG's office had been using for years with respect to nonprofit hospital conversions. Eventually, in the Blue Cross case, two foundations were created with a combined net asset value of $3 billion. These foundations are still defining their missions, but they could extend to subsidizing direct patient care as well as clinical and health services research. The original deal approved by the Department of Corporations had allowed Blue Cross to transfer 90 percent of its assets to a for-profit subsidiary and avoid any obligatory transfer of assets to new foundations created to maintain the public benefits once held in trust by Blue Cross.

One important current issue in nonprofit conversion policy in California is what to count as a potential community benefit when calculating a foundation's obligation to maintain the original charitable purposes of the assets held in trust by the nonprofit. The AG's office takes the view that uncompensated care, as the most tangible and measurable community benefit, should be the focus. Some advocates (and health plans and hospitals) argue for a more expansive definition (e.g., educational and outreach services and investments in population-based public health). There has been recent legislative debate on this issue. To date, idiosyncratic accounting systems and definitions have kept this more expansive view off the table in conversion analyses, but the AG's office is open to better measurement of such benefits in the future.

Regulation of Managed Care Plans

The state recently has seen significant political activity on the quality improvement, provider autonomy, and patient protection fronts. Two major ballot initiatives were voted on in 1996 that, among other things, would have banned financial incentives to withhold care and prohibited denials of care without a physical examination. Although the propositions were defeated, the fact that they were on the ballot, that they garnered 40 percent or more of the votes, and that

many of their provisions were substantially reintroduced in the legislature during 1997 indicates that many citizens in California are concerned about access to quality health care in a market dominated by managed care. A Managed Health Care Improvement Task Force, chaired by Alain Enthoven of Stanford University, was created by the legislature in 1996. It was charged to report by the beginning of 1998 on the effects of managed care on costs, quality, access, and medical research in California. Governor Wilson stated, "This task force will advise me and the legislature on how to update California's governance of the managed care industry to preserve its best features with the fewest side-effects."[37] The task force's report, among many specific recommendations, called for the creation of a new consolidated state entity to oversee managed care plans and recommended establishing a third-party review process to appeal denials of claims as well as a risk adjustment process for health plans.[38] One of the biggest ongoing health policy issues in California and the nation continues to be whether and how to regulate managed care to satisfy competing and sometimes contradictory objectives of low-cost, high-quality health care services.

Medi-Cal Managed Care

One of the most important policy areas for Medi-Cal is the implementation of managed care. The first push toward placing Medi-Cal beneficiaries in managed care occurred in the early 1970s. At the time, it was thought that the state might be able to save Medi-Cal dollars. Over time, it became clear that managed care could not improve upon the low amounts being paid under the fee-for-service program. Among other things, the state has been successful in negotiating highly competitive fee-for-service rates through its selective contracting program for hospitals.

The current era of California's thinking about Medi-Cal managed care began in 1991. No longer focused on saving costs, the movement to managed care, as articulated by state officials, is intended to provide Medi-Cal beneficiaries with more than a "shopping card" for services. Officials within California's Department of Health Services stated that the expansion of Medi-Cal managed care since 1991 has been based on a desire to increase access, particularly for primary care and preventive services. Some county officials and representatives of providers do not share this impression. They believe the state's emphasis on Medi-Cal managed care is driven by cost as well as access concerns.

There are five different models of managed care in California, although only the first three play a significant role in the future of the program: (1) The major new approach being implemented is the two-plan model, which will provide capitated services to AFDC, poverty-related, and medically needy beneficiaries in 12 counties. Beneficiaries in other eligibility groups can choose managed care through the two-plan model, but their enrollment is not mandatory. (2) County-Organized Health Systems (COHSs) in five counties provide services to a full range of eligibility groups. (3) Geographic Managed Care (GMC)—

limited to two counties—in which the state Medi-Cal program negotiates capitation rates with multiple plans from which beneficiaries can choose, is mandatory for AFDC beneficiaries and optional for other beneficiaries. The two other models, Prepaid Health Plan (PHP) and Primary Care Case Management (PCCM), are being phased out in counties after one of the other three models has been implemented. PHPs are state-licensed managed health care organizations that typically provide care to privately insured individuals as well as Medi-Cal beneficiaries and enroll AFDC and Supplemental Security Income (SSI) beneficiaries on a voluntary basis. The PCCM program was developed in 1983 to provide a transitional managed care model with limited financial risk. Under PCCM arrangements, primary care providers provide and assume risk for primary care and specialty physicians' services and selected outpatient preventive and treatment services. They are also responsible for arranging and authorizing inpatient services, which are paid for by the fee-for-service fiscal intermediary, and for case managing services provided to their members.

Around 1990, California had planned to implement managed care more widely by expanding the role of private PHP and PCCM models, but counties and other traditional providers strongly voiced their concern about possible exclusion from a managed care Medi-Cal program that was based on PHPs. This gave rise to the two-plan model that guarantees a role for safety net providers but still gives beneficiaries a choice of a commercial HMO.

Although California has the highest overall HMO penetration rate of any state in the country, it has been cautious in shifting its Medi-Cal beneficiaries into managed care. With respect to Medi-Cal managed care penetration in July 1997, 1.9 million of the 5.4 million Medi-Cal beneficiaries, or 35 percent, were in Medicaid managed care. The growth in Medicaid managed care by type of plan from 1988 through 1997 is shown in table 6. As can be seen, 258,124 enrollees were in the PHP model in 1988. By July 1997, enrollment in the PHP and PCCM models had decreased considerably, while enrollment in other models had

Table 6 *Medi-Cal Managed Care Enrollment, 1988–1997, by Plan Type*

Type of Plan	June 1988	June 1990	June 1992	June 1994	June 1996	July 1997
PHP	258,124	237,730	327,856	458,972	537,683	181,749
PCCM	15,710	50,641	151,295	153,364	98,398	11,149
COHS	52,194	59,762	71,300	127,927	415,074	393,989
GMC (Medi-Cal)	N/A	N/A	N/A	101,824	145,359	139,101
Two-Plan Model	N/A	N/A	N/A	N/A	72,163	1,131,561
Total	**326,028**	**348,133**	**550,451**	**842,087**	**1,269,677**	**1,857,549**

Sources:
June 1988–June 1996: California Department of Health Services, 1997, unpublished table entitled "Medi-Cal Managed Care 1988–1997."
July 1997: Managed Care Capitation Report (DHS).
PHP = Prepaid Health Plan
PCCM = Primary Care Case Management
COHS = County-Organized Health System
GMC = Geographic Managed Care

grown. Tremendous growth occurred in the two-plan model between June 1996 and June 1997; it moved from 6 percent of those in managed care to 61 percent.

Different Models of Managed Care

All prepaid health plans are required by the Knox-Keene legislation to be licensed by the Department of Corporations. These prepaid plans must be able to demonstrate their capacity to perform and show relevant prior experience consisting of both medical and administrative ability. They must also demonstrate that they have appropriate financial capacity and expertise to undertake the proposed financing and provision of health care services.

Two-plan model. Under the two-plan model's structure, AFDC, poverty-related, and medically needy beneficiaries choose from two plans: (1) a local initiative, which must contract with all disproportionate share hospitals and traditional providers (e.g., federally qualified health centers, or FQHCs) and (2) a commercial plan. The state believes this structure will enhance recipients' choices, while giving traditional providers a chance to compete for enrollees. Elderly and disabled beneficiaries in the two-plan counties can voluntarily elect to receive services through one of these two plans, or they can remain in fee-for-service Medi-Cal. The state does not plan to make the program mandatory for these population groups in the future.

California is phasing in the two-plan model in 12 of its most populated counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Alameda was the first county to be fully operational, followed by Kern, San Francisco, San Joaquin, and Santa Clara. Tulare is the only county where the date when the plans will be operational is a question. The California Association of Health Plans sees implementation of the two-plan model as a shift away from a Medi-Cal program that offers choice of providers from multiple plans, which it does not consider a positive policy change.

The current implementation dates for the 12 counties are given in table 7. The two-plan model gained a 1915(b) waiver from the Health Care Financing Administration in January 1995. It served 72,000 beneficiaries in June 1996, and 1.13 million beneficiaries (61 percent of those in managed care) were enrolled as of July 1997 (table 6). However, there are now serious concerns in some counties (such as San Francisco) that there may not be enough Medi-Cal enrollees to support two plans, and in several counties implementation may be halted. Many of the counties are now pursuing the COHS strategy. In addition, questions are being raised about the costs of the two-plan administrative structure in, for example, Los Angeles, where each plan is a consortium of other HMOs.

County-organized health systems. Under a COHS, a local agency with representation from providers, beneficiaries, local government, and other interested parties is created by the county Board of Supervisors to contract with the Medi-Cal program. Operating under a federal Medicaid freedom of choice waiver and

Table 7 *California Department of Health Services Medi-Cal Managed Care Division, Two-Plan Model Expansion Counties*

County	Local Initiative Implementation Date	Commercial Plan Implementation Date
Alameda	01/01/96[a]	07/01/96 (Blue Cross)[a]
Contra Costa	02/01/97[a]	03/01/97 (Foundation)[a]
Fresno	None[b]	11/01/96 (Blue Cross)[a] 01/01/97 (Foundation)[a]
Kern	07/01/96[a]	09/01/96 (Blue Cross)[a]
Los Angeles	04/01/97[a]	07/01/97 (Foundation)[a]
Riverside	09/01/96[a] (Inland Empire)	March 1998 (Molina)[c]
San Bernardino	09/01/96[a] (Inland Empire)	March 1998 (Molina)[c]
San Francisco	01/01/97[a]	07/01/96 (Blue Cross)[a]
San Joaquin	02/01/96[a]	02/01/97 (Omni)[a]
Santa Clara	02/01/97[a]	10/01/96 (Blue Cross)[a]
Stanislaus	10/01/97[a]	02/01/97 (Omni)[a]
Tulare	Early 1998[c]	October 1998[c] (Foundation)

Source: California Department of Health Services, unpublished document, December 1997.
a. Already operational.
b. There will be no local initiative in Fresno County. The department has contracted with two commercial plans.
c. This is an estimated date. It is subject to change.

other waivers, a COHS is required to provide, on a capitated at-risk basis, all basic benefits covered by Medi-Cal and to administer a comprehensive managed health care delivery system for all Medi-Cal beneficiaries residing in the county, including the elderly and disabled. Beneficiaries are given a wide choice of providers within the COHS; however, they may not obtain Medi-Cal services under the traditional fee-for-service system.

Five counties are currently operating COHSs. Santa Barbara and San Mateo have been operating them since the 1980s, and Solano, Santa Cruz, and Orange Counties began in the mid-1990s. As of July 1997, 394,000 Medi-Cal beneficiaries were served in COHS counties. In addition to covering all eligibility groups, four of the five COHSs cover or will cover all Medi-Cal services. The exception is San Mateo, which does not cover nursing home care. Of the five COHSs, all but Orange County's have awarded contracts directly to FQHCs. FQHCs contracting with the other four counties are trying to obtain a cost-based reconciliation payment from DHS. However, the San Mateo COHS is suing the state to exclude any of its gains from their risk pool arrangements from the FQHC cost adjustment.

Geographic managed care. GMC has been implemented in Sacramento and will be implemented in San Diego. GMC is designed to provide a choice of managed care plans, all of which are expected to assure access to comprehensive primary care, preventive services, and other necessary health care. Sacramento County began the development of the GMC project in early 1992 and implemented it in April 1994. At that time, the California DHS entered into contracts with 11 managed care plans (7 comprehensive medical plans and 4 prepaid dental plans) to cover Sacramento County's AFDC, poverty-related, and medically

needy populations on a mandatory enrollment basis. Enrollment is voluntary for elderly and disabled beneficiaries. As of July 1997, 139,000 beneficiaries in Sacramento were enrolled. GMC is just being implemented in San Diego County. The start date estimate is July 1998. Six PHP and PCCM contracts in San Diego now serve 119,687 Medi-Cal beneficiaries.

Enrollment

How states enroll beneficiaries into capitated plans is often an issue in Medicaid managed care. States often use enrollment brokers to avoid risk selection, which can increase the state's fee-for-service costs, maximize the number of beneficiaries who make voluntary selections of plans and are not just assigned by the system, and provide appropriate educational and other materials to beneficiaries to help them in the selection process. For the two-plan and GMC models, California decided to work with enrollment brokers. GMC had fairly high voluntary enrollment. DHS officials suggested that the achievement of higher voluntary enrollment rates under GMC was a result of the lack of overlap of physicians within the seven different networks. In the two-plan model, beneficiaries' incentive to make plan choices may be reduced because, according to state officials, many providers will be available through both plans.

Beneficiaries in the two-plan model who do not select between the local initiative and the mainstream HMO will be assigned to the local initiative to a level sufficient to maintain disproportionate share hospital (DSH) funding to the county. After this assignment, beneficiaries are split between the local initiative and the mainstream plan. Auto assignment for COHSs is basically determined by the counties, which are able to make their own rules. Most counties have rules that provide advantages to safety net providers. The COHS counties may auto-assign beneficiaries to either health plans or providers depending on the contractual arrangements a county has used in establishing the COHS.

Setting Capitation Rates

The state sets capitation rates essentially the same way for all of the managed care models, although there are some differences related to the COHS and GMC models (discussed below). Capitation rates are based primarily on fee-for-service equivalent costs adjusted by age, sex, geographic area, Medi-Cal aid category, and eligibility for Medicare. Rates are calculated first for past periods and then projected to the future considering legislative changes and trends. Adjustments are made for services provided under other programs (child health and disability prevention, health insurance recoveries, stop-loss insurance). The costs of mental health services and psychotherapeutic drugs prescribed by psychiatrists are not included in the rates. Medi-Cal DSH payments to eligible hospitals are also made outside of the managed care capitation rates. An administrative allowance by category of eligibility is added to the rate, and if there is dental coverage, an amount for that is also added.[39]

Family rates used for AFDC eligibles, who make up more than 90 percent of the enrollees, ranged from $61 to $97 per month and are shown for the local initiative and the mainstream plans in table 8. As can be seen, the rates for the local initiatives are higher, reflecting the requirement that they contract with the traditionally more expensive providers (FQHCs and hospitals receiving DSH payments). These rates are also much lower than those in other states, reflecting California's historically low Medi-Cal payment rates, in part achieved through selective contracting. DHS reserves the right to redetermine rates annually on an actuarial basis or move to a negotiated rate.

In GMC and COHS models, capitation rates are set through a bid-negotiation process. In GMC, rates differ by capitated entity because different providers actually cover a different range of services. For example, in the Sacramento GMC, Kaiser, one of the participating plans, covers special services otherwise paid through California Children's Services, whereas the other plans do not. In the COHS model, both the county capitation rate from the state and any county capitation payments to providers are determined by a negotiation process.

FQHCs subcontracting with Medi-Cal managed care contractors may elect to be reimbursed on an at-risk basis or a reasonable-cost basis. The California Primary Care Association, which represents these providers, believes that implementation of the two-plan model is problematic, especially in counties where both county-operated FQHCs and FQHCs run by community-based organizations exist. In these cases, the legislation provides that the local-initiative health plans assign beneficiaries who do not make a provider selection to county-based FQHCs, thus minimizing the involvement of other FQHCs. There are also incentives for the mainstream commercial plans to contract with FQHCs. Despite these incentives, the California Primary Care

Table 8 *FY 1996-97 Medi-Cal Capitation Family Rates*

County	Local Initiative ($)	Mainstream HMO ($)
Alameda	85.39	76.46
Contra Costa	85.69	79.61
Fresno	71.85	66.86
Kern	74.56	71.63
Los Angeles	74.61	73.40
Riverside	81.59	77.14
San Bernardino	74.55	72.42
San Francisco	88.13	78.42
San Joaquin	67.53	61.32
Santa Clara	96.89	84.34
Stanislaus	71.78	68.59
Tulare	67.05	61.19
Unweighted Average	**78.30**	**72.64**
% Mainstream Is Lower Than the Local Initiative		–7.2%

Source: California Department of Health Services, September 1997.

Association has expressed concern that community-based FQHCs will experience financial crisis and the possibility of closure. These concerns also apply to the GMC and COHSs. A recent Legislative Analyst's Office study has concluded that rural FQHCs have not been adversely affected by Medi-Cal managed care so far.[40]

Quality Assurance

The process for monitoring quality within managed care plans is still evolving in California. DHS officials said the quality assurance plan in the two-plan model demonstrates the direction of quality assurance activities for all Medi-Cal managed care.

In the two-plan model, contractors must have an ongoing quality improvement program that demonstrates organization commitment. Contractors must perform ongoing studies of both clinical care and health service delivery. Applicants must also show a network capacity to serve 60 percent of the Medi-Cal beneficiaries in the proposed region, and they receive favorable treatment in contracting decisions if they include traditional and safety net providers (county-operated health systems, community health centers, and disproportionate share hospitals) in their service delivery networks. Credentialing and recredentialing at least every two years is required of physicians and other health care providers. Also, contractors must offer second opinions by specialists to their members upon request. Provider network changes must be summarized in a monthly report to DHS.

The Future of Medi-Cal Managed Care

There are no immediate plans for bringing the elderly and disabled into mandatory managed care in the two-plan or GMC models. DHS has not decided whether it wants to include these groups in mandatory managed care. The exception to this is the COHS model, where the elderly and disabled are included in some counties. State officials believe that the experience with the COHSs will help DHS determine what needs to be done to meet the needs of the elderly and disabled populations.

The future of Medi-Cal managed care in California, a state with a high penetration of managed care in its commercial market, will be determined by the state's attitude toward expanding managed care to more rural counties and mandating managed care for the aged and disabled. Because the elderly and disabled beneficiaries are not perceived to have access problems similar to those of other Medi-Cal beneficiaries, there is no urgency to move these population groups into managed care. In addition, some groups (e.g., developmentally and physically disabled persons and chronically ill children) are very suspicious of managed care because of concerns that it would impede their access to care and disrupt established care patterns and relationships with providers.

Medi-Cal Hospital Payment and the Disproportionate Share Hospital Program

California uses a selective contracting program to reimburse hospitals that participate in the state's Medi-Cal program. The selective contracting program, operated by the California Medical Assistance Commission (CMAC), negotiates per diem payment rates with hospitals each year on an individual basis. About 260 of 500 hospitals in the state were under contract with CMAC in 1996, and selective contracting accounted for about 90 percent of total inpatient dollars for Medi-Cal. Through annual contract negotiations, it is entirely possible that two similar hospitals located near each other could have vastly different negotiated rates. The state received a waiver from the Boren amendment when selective contracting was first implemented in the early 1980s.

As a result of excess capacity and intense competition in the California market, selective contracting has achieved inpatient hospital payment rates that are among the lowest in the nation.[41] In combination with other factors, low Medi-Cal payment rates have elevated the importance of California's DSH program (commonly referred to as "855" after the state bill number of the enabling legislation) for funding of the state's health care safety net. The dollars involved are substantial—California's DSH program is the second largest in the country, with annual expenditures of $2.1 billion. Net federal financial participation contributes about $850 to $900 million per year to safety net providers. (Although California's Medi-Cal match rate is 50 percent, less than 50 percent of DSH spending is available to providers because the state retains a portion of the federal match as an "administrative" fee.) The importance of DSH is difficult to overstate, given that estimates show that counties spend from $2 billion to $2.5 billion per year on health services for people who lack insurance, are ineligible for Medi-Cal, and cannot pay for services on their own.[42]

To raise the state share of DSH funds, public entities that operate disproportionate share hospitals—counties, special districts, and the University of California—are required to contribute funds to the state in the form of intergovernmental transfers (IGTs). Total IGTs were approximately $1.3 billion in FY 1994-95 (see table 9). The state government does not return the entire federal match drawn by DSH because of the "administrative fee" it retains. In 1992–93, about $133 million of the federal match for DSH was spent by the state; the amount rose to $239 million in 1994–95 and fell to $153 million in 1996–97.

A salient tension exists between California's public and private hospitals over the current and future distribution of DSH payments. As discussed above, public entities that operate DSH-eligible hospitals are required to transfer money to the state, but both public and private hospitals are eligible to receive DSH funds. Many of the public hospitals considered this "unfair" because they are the only ones paying into the system, but private hospitals that attract Medi-Cal patients are receiving a growing portion of DSH dollars. Even if "unfair,"

under federal law the state cannot use collections from private hospitals as IGTs to generate DSH match. Therefore, possible solutions to this perceived inequity are limited. Table 9 shows the trend in DSH payments from FY 1992-93 to FY 1994-95 and how the "net benefit" (defined as DSH payments less transfers and the state administrative fee) has been steadily increasing for private hospitals. Since FY 1992-93, the share of the net benefit has increased about 10 percentage points a year for private hospitals to the point where they were receiving about 43 percent of the net benefit from DSH in FY 1994-95.

At the core of the public hospitals' concern is the formula used by the state to determine DSH payments to eligible hospitals. Hospitals may qualify for DSH based on either Medi-Cal patient volume or uncompensated care. Almost all of the private hospitals qualify under the Medi-Cal criterion, while a much greater proportion of public hospitals qualify by virtue of uncompensated care levels. The formula for determining individual DSH payments to hospitals, however, is designed to give a greater weight to Medi-Cal volume. This distinction is important, given the large differences in indigent care provided by the public hospitals over private facilities. Private hospitals provide less indigent care than public hospitals but are increasingly serving more Medi-Cal patients. This shift in Medi-Cal patients has been reducing the public hospitals' return on the transfers they provide to finance the DSH program, although the return is still positive. The county governments that operate the hospitals are concerned, because they have less revenue available to subsidize the indigent care that they are required to provide.

The BBA of 1997 granted the state a one-year reprieve from the public/private conflict with a targeted provision that allowed the state to pay individual hospitals DSH payments up to 175 percent of their total Medicaid shortfall (i.e., financial losses for treating Medicaid patients because of low payment rates) and uncompensated care levels. (Under the current law, which restricts pay-

Table 9 *Public/Private Medi-Cal Disproportionate Share Hospital Payments, 1992–1995*

	1992–93		1993–94		1994–95	
	Public	Private	Public	Private	Public	Private
Dollars (thousands)						
Gross Payments*	$1,864,283	$201,591	$1,850,500	$293,508	$1,807,666	$361,993
Intergovernmental Transfers	1,172,332		1,226,549		1,324,587	
Net Benefit	691,951	201,591	623,951	293,508	483,079	361,993
Percent of Total						
Gross Payments*	90.2%	9.8%	86.3%	13.7%	83.3%	16.7%
Intergovernmental Transfers	100.0%		100.0%		100.0%	
Net Benefit	77.4%	22.6%	68.0%	32.0%	57.2%	42.8%

Source: Legislative Analyst's Office, 1995
*Total DSH payments less state "administrative fee."

ments to only 100 percent, public hospitals would have received approximately one-third of the net benefit from the Medi-Cal DSH program and the state would have lost $200 million in federal funds.) The 175 percent exception will enable the state to pay public hospitals about one-half of the net benefit for FY 1997-98. The issue will reemerge and become even more important after the BBA exception expires because the BBA also reduces the amount of federal funds the state can receive through the DSH program. The state is currently reimbursed for 50 percent of DSH spending up to a total of $1 billion in federal spending (i.e., a 50 percent federal match applied to $2.1 billion in total DSH spending); the BBA will reduce the eligible amount by almost 20 percent ($1 billion to $877 million) by the year 2002. The implication of these changes is that the current "competition" over DSH funds—and by definition the pool of funds available to finance the state's safety net—will intensify over the next few years.

The state has another DSH-type program, the Emergency Services and Supplemental Payment Fund (commonly referred to as the "1255" program), that is managed by CMAC and works in conjunction with the 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, which are then redistributed to other public and private hospitals in the form of higher payment rates during the annual negotiations with CMAC. There is no set formula on how much each hospital will receive in 1255 payments, although no hospital has ever lost money in return for the voluntary transfers. The 1255 program, although much smaller than the state's DSH program, has grown substantially in the last few years. Between FYs 1992-93 and 1994-95, 1255 payments almost doubled, from approximately $180 million to $344 million. Los Angeles County hospitals are the primary recipients of 1255 dollars; they received $209 million in FY 1994-95.

Serving the Medically Indigent in California

Given the discretion that counties have in discharging their obligations as the provider of last resort, it is not surprising that there is significant variation across counties in the health care safety net. This report focuses on three of the 58 counties in California—Los Angeles, Alameda, and San Diego. These three counties contain more than 40 percent of the state's population and represent a range of approaches to delivering services to the medically indigent population. Los Angeles has built up a large public system of hospitals and clinics that, until recently, has not tried to partner with private providers in the county. Alameda operates county hospitals and clinics, but also funds services provided at private clinics and hospitals in order to provide adequate access for the indigent population. (Assuring access through private contracts has become more of an issue for the county as the indigent population has become more geographically dispersed. At one time, the indigent population was concentrated in Central Oakland, and now it has moved more toward the eastern part of Alameda County. The county has chosen to contract with providers already located in these areas, as opposed to building new facilities.) San Diego has taken a completely different approach. It sold its public hospital to the University of California in the 1970s and contracts for indigent health care services solely through the university hospital and private-sector providers. These three counties' approaches to serving their indigent populations are discussed in detail in the sections that follow.

Table 10 presents background data on demographic and health system characteristics in each of the three counties. Although Los Angeles is the largest of the

Table 10 *Alameda, Los Angeles, and San Diego Counties, Demographic Comparisons*

	Alameda	Los Angeles	San Diego	California
Total population—1995	**1,323,312**	**9,138,789**	**2,644,132**	**31,589,153**
Population Growth 1980–1990 (Percent)	15.5	18.5	34.2	25.7
Population Growth 1990–1995 (Percent)	3.6	3.1	5.8	6.1
Population Breakdown—1990				
Percent White	59.6	56.8	74.9	69.0
Percent Black	17.9	11.2	6.4	7.4
Percent Other	22.6	32.0	18.6	23.6
Percent Hispanic[a]	14.2	37.8	20.4	25.8
Percent Foreign Born	18.0	32.7	17.2	21.7
Percent below the Federal Poverty Level (1989)	10.6	15.1	11.3	12.5
Health Status/Health System Statistics				
Births/1,000 (Average 1992–1994)	16.7	20.7	18.7	18.8
Infant Deaths/1,000 (Average 1992–1994)	6.6	7.2	6.3	6.9
Physicians/100,000 Residents (1995)[b]	231	233	219	215
Inpatient Beds/100,000 Residents (1994)[b]	196	305	252	258

Source: George E. Hall and Dendra A. Gaquin. *1997 County and City Extra Annual Metropolitan, City, and County Data Book*, Lanham, MD: Bernan Press, 1997.

a. Can be any race.

b. These data are drawn from the 1997 Area Resource File, Bureau of Health Professions, U.S. Department of Health and Human Services.

three by far, the most rapid population growth has been occurring in San Diego. However, population growth in all three counties was below that in the rest of the state between 1990 and 1995. The racial composition of the counties differs as well. San Diego has the largest share of population that is white. The county with the largest share of population that is African American is Alameda, with a share more than twice the state average. Los Angeles has the largest Hispanic population, with more than one-third of the people identifying themselves as Hispanic. The importance of immigrants in Los Angeles is clearly evident by the share of the population not born in the United States. Los Angeles is further differentiated from the other two counties by the high concentration of poverty. The poverty rate in Los Angeles is about one-third higher than that of either Alameda or San Diego.

In terms of provider availability, the three counties are similar with respect to physician-to-population ratios but differ in hospital bed supply. Los Angeles had 305 short-term general hospital beds per 100,000 population in 1994, in comparison with 252 in San Diego and 196 in Alameda. Birth outcome and health indicators vary across the counties as well. Infant mortality rates, AIDS deaths, and rates of violent crime are highest in Los Angeles. Incidence of low birth-weight babies is highest in Alameda.

Los Angeles County

The demands on Los Angeles County to meet the health care needs of its low-income population are enormous. Some estimates suggest that as much as one-third of the county's nonelderly population is uninsured. Another 20 percent is covered by Medi-Cal. Los Angeles meets its obligations to be the provider of last resort by operating an extensive network of hospitals and clinics managed by the Los Angeles County Department of Health Services (LACDHS). This system is particularly crucial for the uninsured, providing more than 95 percent of all inpatient care to the indigent population. The county system is less important to Medi-Cal enrollees, because it accounts for only 31 percent of Medi-Cal inpatient care.[43] Many private hospitals serve Medi-Cal inpatients, and there are more than 70 free and community clinics that serve both Medi-Cal and indigent patients. Historically, the public- and private-sector providers in Los Angeles have worked independently of each other within the county's safety net system. It was not until very recently that public system and private providers started working together as part of a Medicaid Section 1115 waiver granted to LACDHS (discussed below).

Public Safety Net Providers

LACDHS, with a staff of about 24,000 employees, is responsible for monitoring and assuring public health, serving as the provider of last resort for the indigent population, and organizing and managing the trauma care system. In fulfilling these roles, LACDHS operates six hospitals, six comprehensive health centers (CHCs), and 39 health centers (oriented toward public health and preventive care), as well as a federally qualified Knox-Keene licensed HMO, the Community Health Plan (CHP).[44] In FY 1995-96, this system provided approximately 500,000 emergency room visits, 750,000 inpatient days, and 3 million outpatient visits. The total budget for the LACDHS was $2.3 billion in 1996–97 and accounted for about 20 percent of the county's total budget. Medi-Cal provided about 40 percent of the revenues needed to meet the LACDHS budget, and the state provided 25 percent through its indigent care subsidies. The actual direct county contribution to the LACDHS budget was less than 7 percent. The remaining LACDHS revenues came from Medicare, other federal sources (e.g., public health grants), interagency transfers from other county departments, and a variety of small sources. The importance of Medi-Cal to the financing of this system and the large number of immigrants in the county made the state's decision to continue Medi-Cal eligibility to immigrants under the rules that existed before welfare reforms critical to the county.

The county runs two related programs that require patients to contribute to the costs of the services they receive. First, under the ability-to-pay program, patients who cannot document insurance coverage before they receive nonemergency services at a LACDHS provider are screened to determine whether they can contribute to the cost of care, and if so, how much. Payments, along a sliding scale, are expected from people with incomes between 100 and 300 per-

cent of the FPL. Because the county serves large numbers of undocumented immigrants, it recognizes that not all of its clients will submit to the ability-to-pay application process. Therefore, it offers a prepayment program that allows people to bypass financial screening and pay a flat fee of approximately $35 when they receive outpatient services. In 1996–97, only about 2 percent of LACDHS revenues came from these self-pay mechanisms.

Keeping the LACDHS system financed has not been easy, and the county is very concerned about its future stability. For example, of approximately 40 percent of LACDHS revenue provided through Medi-Cal, almost half comes from Medi-Cal DSH payments, a special supplemental Medi-Cal hospital payment program run by the state, and the county's Section 1115 waiver program that started in 1996. The Section 1115 waiver enabled the LACDHS to stabilize its health care system after a financial crisis during the summer of 1995.

Under the waiver, LACDHS is given access to special revenues on the condition that it redesign its approach to providing health care services.[45] The waiver allows the county to receive a federal match for services provided to indigent patients, even though they are not otherwise eligible for Medi-Cal, and provides for supplemental funding that offsets some of the DSH revenue reductions county hospitals have experienced over the past few years. Over the five years of the waiver, the county expects to receive more than $900 million more in revenues than it would have otherwise. Although these waiver funds helped avert a crisis, they will account for less than 10 percent of LACDHS revenues over the five-year period.

In exchange for these new revenues, LACDHS has committed to trying to reduce its inpatient capacity and reengineer its overall system to produce services at lower costs. In addition, it is committed to using some of the waiver revenues to purchase services for its indigent population from existing private clinics. This goal is designed to make indigent persons less dependent on public providers and offer them more places where they can receive services. (At the time of the research team's visit in 1997, there were 107 ambulatory care access points, up from the original 39 sites operated by LACDHS in 1995.) These arrangements are the first broad public-private collaboration of this type within the county, and both public and private providers indicated the arrangements have been beneficial.

The Section 1115 waiver is quite unusual in that county officials were directly involved with the federal government in making initial arrangements for the waiver. Because of the urgency of the LACDHS financial crisis and the sense that the state was unwilling or unable to provide additional resources quickly, LACDHS determined that it was in its interest to approach federal officials directly. As the negotiations progressed, the state joined LACDHS in developing and finalizing various elements of the waiver.

Although the Section 1115 waiver represents a visible new source of funds for LACDHS, in recent years the county has been relying more on state funds,

primarily realignment and Proposition 99 tobacco tax dollars, to cover the costs of its indigent care system. There has also been a substantial increase in the share of LACDHS revenues from the Medicare program, although Medicare still accounted for only 6.5 percent of revenues in 1996–97 (up from 4.5 percent in 1994–95). There has been little, if any, change in the county's ability to generate revenues from private insurers or directly from the patients it serves.

On top of its ongoing struggles to keep the LACDHS system funded through external sources, the county now faces the uncertainties of the shift to Medi-Cal managed care under the two-plan model. Given the system's dependence on Medi-Cal revenues, a significant loss of Medi-Cal patients to private providers will shift financial resources and require public providers to adapt to lower revenues. However, to the extent that the two-plan demonstration remains limited to the AFDC-related population, the fiscal risks to LACDHS are contained, because these individuals account for a relatively small share of LACDHS's Medi-Cal revenues. As is the case for all two-plan model counties, the majority of LACDHS Medi-Cal revenues are earned by treating SSI Medi-Cal enrollees. If the state were to expand managed care to the SSI population, the county's providers could experience a substantial drop in Medi-Cal revenues if the SSI population chose private providers.

Although LACDHS recognizes there are some financial risks associated with the two-plan model, it has not taken the lead role in organizing the local initiative plan—called LA Care. (LA Care is made up of a consortium of health plans, only one of which is the county's HMO [CHP].) This is quite different from the strategy followed by the Alameda County health department, which has been the primary organizer of the local initiative there (discussed below). Instead, LACDHS is following a combination of strategies. First, Medi-Cal patients will be able to select LACDHS's HMO (CHP) through the LA Care local initiative. CHP has historically been a very small HMO, with enrollment of about 35,000, but it is expected to grow to 165,000 when the two-plan model is fully operational. However, in part because CHP did not have a provider network that covered all areas of the county, the Health Care Financing Administration (HCFA) delayed full implementation of the two-plan system in Los Angeles. Second, LACDHS has negotiated contracts with other managed care plans so that its providers can be included in their networks. Through this mechanism, LACDHS will still be able to serve beneficiaries in both LA Care and the commercial plan. It is too early to know how the two-plan model will affect the LACDHS system.

Private Safety Net Providers

Although LACDHS's system currently dominates provision of health care for indigents in the county, private hospitals and clinics also serve as safety net providers, especially for those covered by Medi-Cal. Private clinics may expand their role in serving the indigent population as a result of changes occurring under the Section 1115 waiver. As of spring 1997, approximately 53 private clinics had contracts to provide indigent care services and be paid under the waiver project. Private providers were interested in participating

in the waiver arrangements because they had missions similar to those of public facilities in providing care for the indigent and Medi-Cal populations, and because they would receive reimbursement for some previously uncompensated care.

As discussed earlier, tension over the distribution of DSH funding between public and private providers is a statewide issue. The role of private hospitals within the Los Angeles safety net is thus controversial. The fundamental issue is "who are the safety net providers in Los Angeles County?" Proponents of the public system argue that, although many private hospitals treat large numbers of Medi-Cal inpatients and thus qualify to receive DSH payments, private hospitals are not really safety net providers because they do not provide much uncompensated care. Private hospitals respond that they are part of the safety net and may be the only hospitals providing "truly" uncompensated care because they do not receive any share of the funds the state provides to cover the costs of indigent health care. They claim that they are willing to share some of the indigent care burden with the county if they could be compensated for these services, but that the county has not been willing to enter into these arrangements. The county appears unwilling to go down this road because it is concerned about private providers' long-term commitments to serving the needs of this population.

The research team spoke with administrators of three private hospitals that serve large portions of Medi-Cal patients—White Memorial (47 percent of patients are Medi-Cal), California Hospital Medical Center (54 percent Medi-Cal), and Queen of Angels (51 percent Medi-Cal). All reported that they rely heavily on DSH funding. As a result of Medi-Cal's low reimbursement rates, these hospitals claim that they would be losing money without DSH and their financial viability would be uncertain. For example, in FY 1996 Queen of Angels' operating margin was negative without DSH, –1.5 percent, but with DSH it was from 12 to 15 percent. Hospitals indicated that they used DSH dollars to cover unreimbursed patient care costs, to expand community services, and, sometimes, to revitalize facilities.

Many questions hang over the Los Angeles County safety net. How will the amount of Medi-Cal funding that LACDHS receives be affected by the two-plan model and the DSH provisions in the BBA of 1997? As the major county hospital is downsized (as is currently planned), will private hospitals play a larger role in providing services to the indigent population? Will the restructuring taking place under the county's Section 1115 waiver allow the county to serve the needs of its uninsured population without the special waiver funds after the year 2000 (when the waiver is scheduled to expire)? Will Healthy Families reduce the number of uninsured children in the county and therefore the demands placed on the safety net? Finally, what will happen if a recession hits, especially after the Section 1115 waiver, and the county's ability to pay its share of indigent costs or the state's contribution is reduced?

San Diego County

The County of San Diego is politically conservative, and many in the county pride themselves on its distinctive approach to the provision of health care to the poor and uninsured. San Diego County officials feel strongly that the county should not be in the business of directly providing health services to any population. Beyond the provision of basic public health services, such as immunizations and the control of communicable diseases, the county provides no direct services to county residents. It has no county-run hospitals or primary care clinics. Instead, the county contracts with private-sector, nonprofit groups to provide care to the indigent and fulfill its mandate as a provider of last resort.

Beyond the formal relationship embodied in these contracts, there is an informal, although very real, tradition of collaboration among the various constituencies in the health sector for addressing the problem of health care for the indigent. There seems to be a recognition that further financial support is unlikely to be forthcoming from the County Board of Supervisors as currently constituted and that therefore it is in the interest of all concerned—hospitals, clinics, associations, advocates, and the county Department of Health Services (DHS)—to work together to make the best use of the resources that are available. The county takes the role of catalyst rather than funder in the public-private collaboration. The fact remains that, despite this collaboration, some observers fear that many indigent residents are going without needed care.

The County

Authority for health programs rests with the county DHS, which is responsible for coordinating the flow of federal, state, and other funds. According to its director, a benefit of the absence of public hospitals and clinics in the county is that it gives the health department a high degree of flexibility in negotiating with hospitals, which are generally in excess supply in this market. The county DHS has no public employee labor unions to contend with, nor does it have any hospital or clinic investments to protect. In addition, its independence gives it a greater degree of credibility when dealing with the private sector. The collaborative relationship between the county and the private sector has influenced the county's approach to the state's mandate to implement the GMC model of managed care for Medi-Cal populations, "Healthy San Diego."

Total public expenditures in FY 1995 on medical care for the poor in the county included nearly $700 million for Medi-Cal, of which half was federal and half was state funding; $33 million in health realignment and tobacco tax funds; and $14 million in county-generated funds, including the county contribution to the state categorical program (discussed below). San Diego County's per capita public-funded health care spending is the lowest in the state, after Orange County, among counties with populations over 1 million. While the problem of the uninsured continues to grow in this county, the net county con-

tribution to indigent care financing has declined from $43 million in 1990–91 to $12 million in 1995–96.

The $47 million in state and county financing for indigent care is administered by the County Medical Services program (CMS) (which is distinct from the earlier state-sponsored County Medical Services program that evolved, in California's small counties, from the Medically Indigent Adults [MIA] program). CMS currently contracts with 13 of the 23 acute care hospitals in the county, a network of 18 community health centers, and more than 2,300 physicians and ancillary service providers. Reimbursement to hospitals from all sources under CMS covers on average only 17 percent of charges, less than one-half the Medi-Cal reimbursement rate.[46] Furthermore, the CMS patient caseload is unevenly divided among participating hospitals; the University of California at San Diego (UCSD) Medical Center provided nearly one-third of all CMS hospital services in FY 1995. None of the county's for-profit hospitals has a CMS contract. CMS reimbursement for community health clinics is based on cost, and the clinics generally view CMS reimbursement as adequate. The CMS program explicitly excludes nonresidents of the county and illegal immigrants.

Providers

Two major hospital systems, Sharp (seven hospitals) and Scripps (six hospitals), along with UCSD, accounted for 80 to 90 percent of the $271 million in county indigent care costs in 1995. Indigent care is measured as uncompensated care plus the costs for CMS services not covered by the county's reimbursement. The county's contract with UCSD is different from those with other hospitals and is based on its historical relationship with the UCSD hospital. In 1971, the county sold the hospital to the university under an operating agreement that stipulated that the hospital would continue to function as the provider of last resort for county residents. UCSD is therefore considered by many to be the de facto public hospital, with indigent and Medi-Cal patients representing about 50 percent of its total caseload. The operating agreement, however, did not include a maintenance-of-effort clause for San Diego, and county financial support to UCSD through CMS has declined since 1994. In addition, this county on the Mexican border redefined its responsibility for indigent care to specifically exclude illegal aliens, exacerbating the financial strain caused by the decline in funding. The UCSD hospital has survived financially by receiving special teaching subsidies from the state and supplemental Medi-Cal payments and by reorganizing the facility's management to create efficiencies.

UCSD and other hospitals in the county are facing several threats to their financial health. Although the for-profit hospital presence is small in the county, some financially weak hospitals are reported to have pursued for-profit partners, and there is concern about the potentially increasing presence of for-profit health care in the county. The nonprofit hospitals fear that for-profit entrants to the hospital sector would be less willing to share in the provision of care to the indigent and less willing to participate in the distinctive public-private cooperation that characterizes San Diego's approach to care for the indigent. More of a concern,

given the low levels of other public funding, is the future of Medicaid DSH payments, which are an important source of revenue for San Diego County hospitals. As has been expressed elsewhere, there is concern that reductions in these funds would be devastating for some hospitals, and there is strong concern about federal changes in the DSH program enacted in the Balanced Budget Act of 1997.

There are 21 nonprofit community health centers with more than 60 different sites in San Diego and adjacent Imperial County. One-third of their combined annual budget of about $85 million comes from Medi-Cal, and nearly one-fourth comes from targeted state categorical health programs such as the Child Health and Disability Program, the California Children's Services program, the Early Access to Primary Care program, and other public sources, including federal community and migrant health center grants. Less than 10 percent comes from county sources, an amount comparable to that of Los Angeles.

Nearly one quarter of the care provided at these clinics is uncompensated. The clinics have, in general, developed very efficient operations and are able to use funds received from reimbursable programs to fund care for the uninsured. Given that county-funded indigent care is limited, clinics' indigent care provision is highly dependent on cross-subsidization from Medi-Cal and the state and federal categorical program revenues. Continued funding for these programs is not certain, and cuts would hamper the clinics' ability to provide indigent care. In addition, the potential loss of Medi-Cal funding for prenatal services for immigrant women represents another serious threat to the clinics' charity care provision.

Under the county's Medi-Cal managed care program, Healthy San Diego, HMOs that wanted to qualify for inclusion had to agree to offer contracts to traditional safety net providers under the same terms they offer to other comparable providers. HMOs were also required to auto-assign beneficiaries who did not select a primary care provider to these traditional providers as a way of preserving existing patient/doctor relationships.

Concern is widespread and growing that, while San Diego's safety net may be functioning now, there are numerous threats to its continued viability, many of which are beyond local control. The termination of cost-based reimbursement for FQHCs under managed care and cutbacks in DSH funding may do serious harm to the ability of the clinics and hospitals to provide the services to the medically indigent that the county has decided not to pay for directly. For-profit ownership of hospitals is growing in the county, and this growth raises the question of whether a for-profit concern will have the same commitment to contributing freely to the needy in the community.

Alameda County

Alameda County, which is located in the San Francisco Bay area and is home to the city of Oakland, has a comprehensive health care system to serve

the low-income population. At the heart of the system is the Alameda County Health Service Agency (ACHSA), the local health department. Among other things, ACHSA owns and operates both hospitals and freestanding clinics, making Alameda one of the 17 California counties that continues to run its own health care facilities. Beyond the county system, several private hospitals and clinics located in Alameda are actively involved in caring for the poor. Indeed, some private clinics and hospitals have entered into public-private partnerships with ACHSA (some of which are long-standing while others are fairly new) to render care to low-income persons. The services provided under these arrangements are paid for from a combination of realignment revenues, tobacco taxes, and local funds.

As in other California counties, Alameda's health care safety net must meet the growing demand for health care services in a world of declining revenues. In an effort to deal with this problem, the ACHSA has recently undertaken several initiatives. Most prominently, it took the leadership role in the planning and development of the local initiative managed care plan under California's two-plan program. In addition, the county has recently applied for its own Section 1115 waiver, something akin to Los Angeles County's.

Public Safety Net Providers

ACHSA, the Alameda County health department, operates three departments—Public Health, Behavioral Health, and the Alameda County Medical Center (ACMC). The Public Health department performs traditional public health functions, including communicable disease control, environmental health, and public health nursing. Behavioral Health is a recently created department that combines mental health and alcohol and drug services. The biggest of ACHSA's three departments is the ACMC, which is composed of three public hospitals—two acute care hospitals and an acute psychiatric inpatient hospital—and five freestanding clinics.

Alameda County also runs an indigent health care program that was described as one of the more liberal in the state. Specifically, the indigent program covers persons whose income falls below 200 percent of the federal poverty level (FPL). Those below 100 percent of the FPL have no cost-sharing, and a sliding scale cost-sharing arrangement is imposed on those between 100 and 200 percent of the FPL. The indigent program is strictly a service program; no insurance coverage is extended. It is estimated that the Alameda County network of providers (including county-owned facilities and private facilities operating under county contracts) cares for between 65,000 and 80,000 indigent patients annually.

In 1996–97, the ACHSA had an annual budget of $475 million, about 40 percent of Alameda County's overall budget. As in other California counties, funding for the ACHSA comes from a variety of sources, including state dollars provided through realignment and Proposition 99 funds, state and federal Medicaid and DSH dollars, and county general funds. Also like their counter-

parts in other counties, Alameda health officials have been grappling with budget cutbacks. Between FYs 1992-93 and 1996-97, for example, county health programs had reductions totaling about $150 million. Some of this funding decline, however, has been made up with federal Medicaid DSH funds, which started coming to the county in FY 1991-92.

While federal DSH dollars have helped maintain ACHSA's budget in recent years, DSH funds received by the county have declined in the last couple of years, causing considerable concern among county administrators. Alameda officials were also concerned about the prospect of losing general Medicaid revenues as Medicaid clients are mainstreamed into private managed care plans under the two-plan demonstration. This could also cause further decline in DSH funds. Some of the county's DSH concerns have been temporarily fixed with the DSH provision in the BBA of 1997 that raises the amount of payments that individual facilities can receive (see DSH discussion above). According to respondents, the shift to managed care for AFDC-related populations under the two-plan demonstration has already adversely affected the county-run clinics. Given that Medicaid dollars are estimated to fund about 80 percent of the county's indigent care costs, small decreases in Medicaid revenues have the potential to jeopardize Alameda's health care safety net.

Alameda officials were also worried about the financial impacts of welfare reform on the county system, particularly in the long run. The county's immigrant population is growing rapidly: In 1994 alone, nearly 10,000 new immigrants arrived in Alameda. Administrators were concerned about the ability to finance the health care of newly arriving poor immigrants who would have qualified for Medicaid before welfare reform but now must be cared for under the county indigent program. Another fiscal strain on the county is the result of the end of state-sponsored prenatal care for undocumented women. County estimates suggested that the elimination of this program could affect 2,600 women each year in Alameda and the county would lose up to $2.6 million in state revenues annually.

In response to the demands on its health care safety net, the AHSCA has undertaken a number of initiatives. A key one was to implement several cost-cutting strategies. Over the last few years, for example, the ACHSA has undergone a wholesale restructuring. Six departments were collapsed into three, 550 jobs were eliminated, county physician salaries were reduced, and the number of medical/surgical beds in the ACMC hospitals was reduced.

Beyond cost-containment measures, the county has adopted several revenue-enhancing strategies. A highly important one has been the county's development of the two-plan local initiative called the Alameda Alliance for Health. By developing the alliance, county health facilities hope to retain a large share of the two-plan patient population. They also hope that now the county system will be in a good position to continue serving the SSI population—which is the real financial backbone of the county health care system—if and when managed care is mandated for the group.

Private Safety Net Providers

In addition to the county providers, private hospitals and clinics in Alameda County care for low-income populations. Seven private hospitals participate in the state's Medicaid selective contracting program (described earlier). Among these seven hospitals, only two receive Medicaid DSH funding. For several of the private hospitals, the bulk of their Medicaid business consists of the AFDC-related populations (providing obstetric and pediatric services and the like), whereas the SSI population tends to receive care in county facilities. Private hospitals provide limited indigent care. As in Los Angeles County, the bulk of inpatient indigent care is provided by the ACMC hospitals.

There was some conflict between private hospitals and the county hospital system. County officials maintained that private hospitals have been "skimming" the Medicaid population—that is, caring for less sick patients such as obstetric cases while leaving the county to care for the sicker patients such as the SSI population. Indeed, several respondents stated that, as Alameda's health care market has become increasingly competitive, private hospitals have actively sought out selected Medicaid patients. County officials fear that with the introduction of the two-plan model, Medicaid clients will continue to shift to private hospitals, which could cause financial hardship for county facilities. Not only would the county lose basic payments for hospital services, but the potential effects of the two-plan model would be exacerbated by the state's DSH allocation formula.

Despite some friction between the county and private hospitals, the two groups have recently developed some public-private partnerships. Over the past five years, in an effort to expand access and increase capacity for services, the county has contracted with two private hospitals to provide selected services to different populations.

Alameda has a broad network of private, nonprofit community health centers. According to the National Center for Health Statistics, there were 39 privately licensed community and free clinics in Alameda County in 1994. Through a number of long-standing public-private partnerships, the county has contracted with private clinics to provide care to the uninsured. A big concern among private clinic administrators at present is their financial stability under managed care. While the clinics interviewed by the research team had entered into contracts with both of the two-plan health plans, clinic administrators asserted that the capitation rates under the demonstration are inadequate. Given that Medicaid revenues are a highly important revenue source for community health clinics, a reduction in Medicaid dollars could pose a significant hardship.

The Future

Alameda officials were highly committed to preserving their county health care system. County hospitals have been around for about 100 years and are viewed as part of the community. Union presence is strong, and the public

sector represents a significant job base. Indeed, in 1996 the Alameda County Board of Supervisors voted not to close the county hospitals. At the same time, county officials are fully aware of the many challenges they face in keeping the system working and have implemented a number of strategies to try and keep it functioning.

Long-Term Care

California's spending on Medi-Cal long-term care services is substantially below that of the average state. In 1995, California spent only 55 percent of the average amount spent for long-term care services per aged, blind, or disabled enrollee in the United States ($2,715 compared with $4,945).[47] California's long-term care spending is also relatively low as a percentage of the state's Medicaid budget, 24.1 percent versus 34.2 percent for the nation. Compared with U.S. average spending per enrollee, California spent 48 percent as much for institutional long-term care for the elderly, 41 percent as much for home health care for the elderly, and 63 percent as much for home health care for the blind and disabled. While spending in California is relatively low ($4.1 billion in 1995), it increased faster (11.3 percent per year between 1992 and 1995) than in the United States as a whole (8.3 percent) (table 11).

Long-Term Care for the Elderly

Fragmentation

Long-term care services for the elderly are administered by several different agencies in California, which creates some problems. Nursing home and home care are regulated by the Department of Health Services (DHS). Case management for personal care services and home care services to prevent premature institutionalization are administered through the Department of Social Services and the Department of Aging, respectively. In addition, case management services are provided by the Department of Aging's Multi-Purpose Senior Services Program (MSSP). Because of this separation of responsibility, no single point of access exists for long-term care services where potential beneficiaries can receive assessment and referral. In addition, these different agencies that

Table 11 *Medicaid Long-Term Care Expenditures by Eligibility Group, California and United States (Expenditures in Millions)*

	California					United States				
	Long-Term Care Expenditures			Average Annual Growth		Long-Term Care Expenditures			Average Annual Growth	
	1990	1992	1995	1990–92	1992–95	1990	1992	1995	1990–92	1992–95
Total	**$2,687.6**	**$2,970.5**	**$4,097.0**	**5.1%**	**11.3%**	**$32,264.2**	**$42,542.5**	**$53,996.1**	**14.8%**	**8.3%**
Elderly	$1,565.2	$1,708.4	$2,100.7	4.5%	7.1%	$18,408.9	$24,846.4	$30,413.7	16.2%	7.0%
Nursing Home Care	1,340.4	1,474.1	1,676.0	4.9%	4.4%	15,131.3	20,542.9	25,571.5	16.5%	7.6%
ICFs/MR*	46.9	56.2	70.4	9.4%	7.8%	348.9	452.0	615.8	13.8%	10.9%
Mental Health	98.2	97.3	177.0	–0.4%	22.1%	973.0	1,286.0	1,107.3	15.0%	–4.9%
Home Care	79.7	80.8	177.3	0.7%	30.0%	1,955.7	2,565.6	3,119.1	14.5%	6.7%
Blind and Disabled	$998.6	$1,120.5	$1,731.8	5.9%	15.6%	$12,842.4	$16,201.0	$21,618.7	12.3%	10.1%
Nursing Home Care	357.8	382.6	430.8	3.4%	4.0%	3,161.3	3,968.0	4,813.3	12.0%	6.6%
ICFs/MR*	357.6	417.8	486.1	8.1%	5.2%	7,241.3	8,380.4	9,321.1	7.6%	3.6%
Mental Health	130.0	146.3	269.2	6.1%	22.5%	457.9	682.1	881.3	22.1%	8.9%
Home Care	153.2	173.8	545.7	6.5%	46.4%	1,982.0	3,170.5	6,603.0	26.5%	27.7%
Adults and Children	$123.8	$141.6	$264.5	7.0%	23.2%	$1,012.9	$1,495.1	$1,963.7	21.5%	9.5%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
*Intermediate care facilities for the mentally retarded.

administer separate parts of the long-term care system have different eligibility criteria for the receipt of benefits. Department of Social Services evaluation criteria are oriented toward the social needs of the individual, whereas DHS's nursing home eligibility is based more on medical criteria. An intergovernmental task force is charged with designing collaborative approaches for reducing fragmentation, including such projects as developing a standardized admission instrument for all Medi-Cal long-term care—nursing homes, home care, and personal care.

Cost Containment

Annual Medi-Cal spending on long-term care for the elderly in 1995 was $3,712 per enrollee, compared with $7,388 for the nation. Cost-containment efforts have included reducing the costs of nursing home care and expanding home and community-based care alternatives.

California spends almost 10 times as much on nursing home care as on home care services for the elderly ($1,676.0 million versus $177.3 million). The state has traditionally paid low rates for nursing home care, which limits its options for further savings. The average reimbursement rate in FY 1992-94 was $76.27 per day for freestanding nursing facilities, compared with a national average rate of $83.72. Rates are set prospectively, with payments for nonprescription drugs, medical supplies, and oxygen included. Advocates argue that average Medi-Cal rates support only about three-fourths of the cost of a nursing home day.

Privatization through Encouraging Long-Term Care Insurance

The state has also begun some innovative efforts to reduce state expenditures on long-term care by increasing private contributions. One effort is the California Partnership for Long-Term Care program. Insurers began selling Partnership products in California in 1993. California is one of four states (with Connecticut, Indiana, and New York) to receive grants from the Robert Wood Johnson Foundation to launch public-private partnerships that combine long-term care insurance with Medicaid. The California Partnership for Long-Term Care uses private insurance to cover the initial costs of long-term care. Consumers who purchase qualified insurance policies can become eligible for long-term care services after their private insurance is exhausted without spending all of their assets, as is typically required to meet Medicaid eligibility criteria. The intent is to increase the number of middle-income elderly Californians with private long-term care insurance coverage and thereby keep them from impoverishment. As of December 31, 1997, eight companies were participating in the program, with 6,000 policies in force. One concern with the program is that qualified insurance products are costly and complicated. The program is attempting to redesign the product to make it more competitive and less costly, but officials worry that any product of this type will have a hard time being viewed as a success because its payoff to the state will come well into the future.

California does not seem particularly focused on policies to reduce transfers of assets. The state already had an estate recovery program in place when

Congress mandated that states implement these programs in 1993. California recovered $28 million in 1993, the largest amount of revenue recovered in any state. This was only about 2.0 percent of the Medi-Cal expenditures on nursing home care, but only five states received an amount equal to a larger percentage of their Medicaid expenditures.

Community-Based Care

The state has initiated a number of efforts to expand community-based care. There are several important Medicaid waiver programs for the elderly, but they serve relatively few individuals, given the size of the state, and expenditures are modest. The largest is the MSSP program, which provides case management services to Medi-Cal beneficiaries who are 65 and older and are at risk of institutionalization. There is a 6,000-person cap on the number of clients served at any given time in the year, which has permitted the provision of services to approximately 8,000 frail clients per year.

Personal care services under Medi-Cal are generally provided by the Department of Social Services' In-Home Supportive Services (IHSS) program. This program provides services to approximately 200,000 aged, blind, and disabled persons who are unable to remain safely in their homes without assistance. Among the services are domestic, heavy cleaning, transportation, protective, supervision, and nonmedical personal care. The program has two parts, one financed with federal matching funds through Medi-Cal and the other by state and county funds. Basic program eligibility is linked with SSI, with federal eligibility standards. Approximately 65 percent of IHSS recipients receive care through the Medi-Cal funded program, known as the Personal Care Services Program (PCSP). This component of the IHSS program is 50 percent federally funded, and the balance comes from the state (32.5 percent) and counties (17.5 percent). The second part of IHSS, the residual program, is 65 percent state-funded and 35 percent county-funded. To be eligible for the residual program a person must be 65 years or older, blind, or disabled and need IHSS services; must live in his or her own home; and must meet all Supplemental Security Income/State Supplemental Program (SSI/SSP) criteria. To be eligible for PCSP, individuals must meet the same criteria as for the residual program, but in addition they must have a disability expected to last at least 12 months or until death, require at least one personal care service, and not have a parent or spouse as sole provider.

The state also has three waiver programs to support the provision of home care services: the Program for All-Inclusive Care for the Elderly (PACE), On-Lok, and a Social Health Maintenance Organization (SHMO). PACE and On-Lok integrate long-term and acute care services into one program funded by Medicaid and Medicare, with the provider at financial risk for costs above the agreed-upon capitation rates. There are two PACE sites, Sacramento and Oakland. California enrollment in these programs is about 615 beneficiaries. California has one of the nation's four SHMOs in Long Beach. This program integrates Medicare and Medicaid and member premiums to provide acute care, prescription drugs, and long-term care benefits to about 625 dual-eligible enrollees.

Long-Term Care for Younger Persons with Disabilities

Organization

Long-term care services are also provided to younger persons with disabilities. These include individuals with mental illness, mental retardation, cerebral palsy, epilepsy, and autism. Approximately 140,000 individuals with developmental disabilities are served by the public system in California, about 56 percent of whom are eligible for Medi-Cal. Public mental health services are available in California to low-income persons who experience severe and disabling mental illnesses and to children and adolescents with serious emotional disturbances. According to the California Department of Mental Health, approximately 475,000 Californians received services in the public mental health system in 1995, about 350,000 of whom were Medi-Cal–eligible.

Medi-Cal expenditures (for acute and long-term care) for younger persons with disabilities were $5,769 per enrollee in California versus $8,022 per enrollee nationally in 1995 (table 5). California's long-term care expenditures per enrollee for younger persons with disabilities were also significantly below the national average—$2,048 in California versus $3,375 nationally (based on further analysis of data in table 5). California is generally viewed as a state that generously covers a lot of optional services and eligibility categories but is a parsimonious payer.

The California Department of Developmental Services (DDS) is the main state agency for persons with developmental disabilities. It has an annual budget of more than $1.5 billion. DDS contracts with 21 private nonprofit regional centers operating throughout the state. These centers are responsible for providing a comprehensive community-based system of services to their clients. The California Department of Mental Health (DMH) oversees the state's mental health system and has a budget of almost $2 billion. Most of the mental health programs are administered by the counties, while DMH directly operates the state hospitals and oversees the county programs. The California Department of Social Services provides oversight to the IHSS program, which provides personal care and supportive services to aged, blind, and disabled persons. Finally, the California Department of Rehabilitation offers programs that assist persons with severe disabilities to obtain and retain employment and live independently in their communities.

As a result of spreading responsibility and programs across many departments, California's long-term care system for younger persons with disabilities, like that for the elderly, is highly fractionated. This fractionation is unlikely to change in the future, because the long-term care integration pilot program described above would exclude the developmentally disabled and persons with mental illness, while including other disabled beneficiaries needing long-term care.

Deinstitutionalization

The 1990s have seen decreases in the number of persons in state-operated institutions for the developmentally disabled and the mentally ill. DDS directly

operates developmental centers that provide inpatient care to persons with developmental disabilities. As of January 1997, 4,931 persons were served in six state-operated developmental centers. There has been a gradual depopulation of these large state developmental centers since the 1960s. For example, in 1968, 13,355 Californians were living in state institutions. There are a variety of community options for persons with developmental disabilities as they are moved out of developmental centers. These options include community care facilities, supportive living services, and family home health agencies. As of January 1997, out of the total population of approximately 140,000 persons served by DDS, only 3 percent resided in developmental centers; 66 percent lived in their own homes, 23 percent resided in community care facilities, and 8 percent lived independently.[48]

Pressure to deinstitutionalize persons with developmental disabilities has escalated in recent years because of the 1993 Coffelt settlement. In 1990, a group of parents led by William Coffelt sued the state, charging that the developmental centers provided poor care for their children and demanding new community-based homes and programs. The settlement called for the state to increase the availability of high-quality, stable, and integrated community living arrangements for persons with developmental disabilities.

Considerable controversy has been generated in the state over the recent deinstitutionalization efforts. Some critics charge that there is a high death rate among those moved from the developmental centers to the community and that individuals are being moved from hospital-like state institutions to group homes that are staffed by poorly trained and poorly paid caretakers. In July 1996, the state funded a 3 percent across-the-board increase in rates paid to community care facilities, the first rate increase since 1988. For 1997–98, the governor's budget proposed augmenting for DDS that includes $60 million within Medi-Cal devoted to enhanced services for this population. Critics continue to cite problems with the availability of medical and psychiatric care and lack of state oversight. In March 1997, the California Medical Association called for a moratorium on transfers until health and safety concerns could be resolved. These issues continue to be widely discussed.

Persons with mental illness can receive 24-hour institutional care in state hospitals operated by the Department of Mental Health. As of June 1997, there were 3,781 individuals in state hospitals in California. Before realignment in 1991, the state was financially responsible for all residents in state hospitals. Since realignment, the counties have been financially responsible for all residents except those admitted on criminal grounds. As a result, the counties have an incentive to reduce the number of residents in these hospitals, and they have responded by moving more persons into the community.

Community-Based Care

Home and community-based services for younger persons with disabilities are provided in a patchwork of programs in a number of agencies. The two most

prominent programs are the Medicaid home and community-based waiver program for the developmentally disabled and the IHSS program, which provides personal care and domestic services to a large number of elderly and disabled persons, as discussed above.

Since 1982, California has had a Medicaid home and community-based waiver program for mentally retarded and developmentally disabled persons who are Medi-Cal–eligible and would require the intermediate care facility level of care for the mentally retarded. The number of persons served under that waiver has grown dramatically over the past few years, from 3,360 in 1992 to more than 37,000 in 1997. Services provided under this program include homemaker chores, home health aide and personal care services, environmental accessibility adaptations, skilled nursing, transportation, specialized medical equipment and supplies, assisted living, and physical and occupational therapy. In terms of waiver programs, California ranks first in terms of the number of mentally retarded and developmentally disabled people served, but 16th in participants per 1,000 population. Its costs per participant in 1996 were $10,712, ranking 48th in the nation, which again reflects the pattern of broad coverage and tight controls on benefits and payment rates. DHS also operates an AIDS and AIDS-Related Condition waiver that provided services to 4,550 beneficiaries in 1996. These services are funded through the Medi-Cal program. The state also provides 25,000 AIDS patients with assistance in obtaining their medications through the AIDS drug assistance program.

Managed Mental Health Care

California is in the process of implementing a new Medi-Cal managed mental health program. Historically, more than 80 percent of Medi-Cal mental health services have been provided through California counties. After the managed mental health program is implemented, 100 percent of Medi-Cal mental health services will be provided through the counties. The managed mental health system envisioned will be carved out from the other health services provided by Medi-Cal through managed care plans or fee-for-service. California has traditionally had a bifurcated system for Medi-Cal mental health services—fee-for-service and Short-Doyle. In the fee-for-service Medi-Cal system, the need for outpatient services was determined by the practitioner. Beneficiaries served under the Short-Doyle system were generally more seriously mentally ill than those served under fee-for-service, with statewide standards for medical necessity. Under the Short-Doyle system, the counties have responsibility to develop a comprehensive mental health system for county residents. A total of 474,480 clients were provided mental health services in the Short-Doyle system in FY 1995-96.[49] Of these, 350,963 were Medi-Cal–eligible.

The Short-Doyle Medi-Cal system is at least in part the model for the new managed mental health system. The new program calls for a single managed health care plan in each county, and the county itself will have the right of first refusal to be that plan. The managed care plans will be responsible for offering an array of Medi-Cal mental health services consistent with state-defined stan-

dards. All Medi-Cal beneficiaries will receive services from these plans. The design is the logical extension of current state and county relationships, in which counties provide most of the public mental health services. Whether capitated funding for mental health services will be fully implemented is in question. There is a major issue over the setting of county capitation rates by the state because of the historical disparity between counties; some of the big and more powerful counties have received up to 10 times more per capita than other counties. This issue is likely to be very difficult to resolve.

Future Considerations

As California moves forward, it will be facing the realities that have shaped its health policy choices in the past—large numbers of low-income uninsured individuals, a very competitive market for health care services, and extensive county-level responsibilities for and variation in approaches to providing health care to Medi-Cal beneficiaries and the medically indigent. The state has designed its Medi-Cal program to cover large numbers of people and many services. It has achieved this objective by keeping payment rates for both acute and long-term care services low. The major change currently taking place in Medi-Cal is the expansion of mandatory managed care enrollment for most beneficiaries, other than the elderly and disabled. California has not tried to adopt a single approach to managed care throughout the state. Instead, it has allowed counties to follow models of Medi-Cal managed care that reflect differences in how their health care systems have evolved and how they treat indigent patients. Health plans are participating, but they are concerned that the low capitation payments that follow from the low fee-for-service rates may make it difficult to enhance access for the Medi-Cal population, as the state would like. At this point, it is unclear how well managed care will work for Medi-Cal, especially in the state's largest county, Los Angeles.

The state requires that counties be the providers of last resort for indigents without coverage, and it assists the counties in financing the programs that they develop to meet this obligation. This financing comes from dedicated state realignment revenues and the Medi-Cal DSH program. The DSH component could be reduced as a result of the expansion of Medi-Cal managed care if the local initiatives in the two-plan counties are unsuccessful in attracting or retaining a sufficient share of the Medi-Cal population. Not only could the safety net providers lose a large share of the patients for whom they receive payments that cross-subsidize indigent care, but they could also lose some of their ability

to draw Medi-Cal DSH revenues, which are tied in part to providers' share of Medi-Cal patients. Although some protections will be provided through the auto-assignment mechanism that favors the local initiatives and safety net providers, if beneficiaries feel they will be better served in the commercial plan by a different set of providers they can switch plans and the associated revenues will follow.

Financing of county indigent health programs is further threatened by the uncertain future of the state's Medi-Cal DSH program. The program is financed with intergovernmental transfers from public hospitals, but payments are made to all hospitals that treat large numbers of Medi-Cal and indigent patients. Over time, as more Medi-Cal patients have sought treatment in private hospitals, less revenue has been returning to the public hospitals. The inability to return more money to public hospitals is a problem, because these are the institutions that are providing the majority of care to the indigent population and they rely on DSH as a significant funding source for these services. Ultimately, there is concern that some counties will refuse to participate in the intergovernmental transfer program by privatizing their facilities, making it difficult to finance the state's large DSH program through the remaining counties. The state has tried to delay this prospect through a variety of mechanisms, such as joining in the Los Angeles County Section 1115 waiver process and obtaining limited exemptions to the 1993 Omnibus Budget Reconciliation Act DSH caps through the BBA of 1997. DSH policy is a major issue that warrants close attention in the future.

Some of the burden on safety net providers could be eased by the Healthy Families program that was passed quickly in 1997 in response to the federal State Children's Health Insurance Program. The program will start in July 1998, and many details are still to be worked out. By assigning a limited role to Medi-Cal in the Healthy Families program, the state is showing its commitment to private-sector-oriented policies that build on the state's highly competitive health care marketplace. The success of this program will depend on participating commercial and local health plans' willingness to offer coverage at affordable rates and the eligible population's interest in purchasing coverage, even at subsidized rates.

Whether in Medi-Cal, Healthy Families, or employer-based insurance plans, California is relying heavily on managed care. Up to now, the state has not imposed extreme regulatory requirements on the activities of managed care plans. However, public concerns about access to high-quality health care under managed care are beginning to arise, as reflected in two major ballot initiatives that were defeated in 1996. Together these propositions, among other things, would have banned financial incentives to withhold care, prohibited care denials without a physical examination, imposed new taxes on health care business mergers or restructurings, and imposed new staffing requirements for all health care facilities. The inclusion of these propositions on the ballot and the votes they garnered, more than 40 percent, made politicians take note. A Managed Health Care Improvement Task Force was created, and it submitted many recommendations for improving managed care that are currently being debated.

Although no major changes are planned to the state's approach to its indigent health system, there are doubts that the current combination of realignment funds, tobacco taxes, Medi-Cal DSH, and local property taxes produce an efficient system. Many interviewees within both the private and the public sectors believed that if existing funding streams could be pooled and coordinated, the funds currently available for indigent care could be made to cover a larger proportion of the medically indigent population. With pooled funding streams, both better outcomes and lower costs might be achieved through the application of utilization and cost management principles to the care of a population that, because of the structure of the current system, has had to rely on uncoordinated sources of medical care.

In the area of long-term care for the elderly, a state commission (the Little Hoover Commission) concluded that many of the state's policies favor expensive institutionalization at the expense of home and community-based waiver services preferred by beneficiaries.[50] Much of the emphasis in planning the future long-term care system in California is tied to the Long-Term Care Integration Pilot Program, which the state is attempting to implement in five counties. It is essentially an effort to integrate at the county level long-term care services provided by a variety of agencies. It is hoped that this program will become the basis for the delivery of all long-term care services in the future.

The physically and developmentally disabled are thought to have been historically more successful than the elderly in lobbying for funding and litigating for expanded services in the entitlement programs. Deinstitutionalization of the developmentally disabled is currently receiving a great deal of attention. Many critics of the current deinstitutionalization process are not fundamentally opposed to moving more people into the community, but they would first like to see improvements in the quality of care in community homes, which would require more money. Because this issue involves numerous interested parties, including group homeowners, rehabilitation programs, parents' groups, advocacy groups, state administrators, regional centers, and state legislators, many of whom have been at odds for years, reaching a consensus on how to reform the system is no small task.

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APPENDIX

List of People Interviewed

California Department of Health Services

Peter Abbott
Catherine Camacho
Joseph Kelly
Paul Kimsey
Joseph Klun
Roberto Martinez
Frank S. Martucci
Carolyn Michaels
Darryl Nixon
Sandra Pierce
Doug Porter
Rugmini Shah
Benjamin Thomas

Other State Government

Dixon Arnett	Department of Aging
Randy Baker	Department of Finance
Byron Chell	California Medical Assistance Commission
Diane Cummins	Department of Finance
Thomas Greene	Department of Justice
Phyllis Heath	Department of Aging
Carol Hood	Department of Mental Health
Stephen Mayberg	Department of Mental Health
Donna Mandelstam	Department of Social Services
Fred Miller	Department of Aging
Gary Pettigrew	Department of Mental Health
Pam Rich	Department of Aging
James R. Schwartz	Attorney General's Office
Sandra Shewry	Managed Risk Medical Insurance Board
David Topp	Health and Welfare Agency
Amy Zajac	Department of Insurance

Alameda County Government

Judy Armstrong
Yolanda Baldovinos
Janis Burger
Wilma Chan
Linda Cretz
Irene Ibarra
David Kears

Los Angeles County Government

Michael Bustamante
Steven Escoboza
Mark Fincane
Irene Riley
Rene Santiago
John Schonoff
Toni Yaffe
Zev Yaroslavsky

San Diego County Government

Randy Mecham
Yolanda Partida
Robert Ross
Pam Slater
Joan Zinser

Consumer Advocates

Michael Burgmaier	Children Now
Lark Galloway-Gillian	Community Health Councils Project
Manuel Garcia	Mexican American Legal Defense and Educational Fund
Karen Gill	League of Women Voters
Silvia Hampton	League of Women Voters
Sue Hodges	Public Authority Advisory
Corinne Jan	Oakland Chinese Community Council
Greg Knoll	Legal Aid
Tom Porter	Public Interest Center on Long Term Care
Lucy Quacinella	Western Center on Law and Poverty
Guillermo Rodriguez	Latino Issues Forum

Governor's Office

Jeanne Cain

Hospitals and Health Centers

Melinda Anderson	Olive View Medical Center
Douglas Bagley	LAC/USC Medical Center
Bud Beck	Scripps Health
Terry Bonecutter	Queen of Angels Hospital
Robert Cooper	West Oakland Clinic
Connie Diaz	Ranchos Los Amigos Medical Center
Jack Duffy	Scripps Health
Randy Foster	Martin Luther King Medical Center
Al Greene	Alta Bates Medical Center
Melvin Grussing	High Desert Hospital
Michael Karpf	University of California at Los Angeles (UCLA) Medical Center
Sumiyo Kastelic	University of California at San Diego (UCSD) Hospital
Tecla Mikoseff	Harbor-University of California at Los Angeles (UCLA) Medical Center
Tony Paap	Children's Hospital
Barbara Ryan	Children's Hospital/San Diego
Mike Smart	Alameda County Medical Center
Beth Zachary	White Memorial Medical Center

Others

Catherine Camp	County Supervisors Association
Ann Eowan	Health and Life Insurance of California
James Foley	Managed Care Support Systems
Burt Margolin	Brady & Berliner
Margaret Pena	California State Association of Counties
Dan Rabovsky	Legislative Analyst's Office
Ruth Reidel	Alliance Healthcare Foundation
James Robinson	University of California at Berkeley School of Public Health
John Rodriguez	Formerly with California Department of Health Services
Bob Tranquada	University of Southern California
Lory Wallach	Alliance Healthcare Foundation

Provider and Plan Associations

Marianne Bennett	California Primary Care Association
Micki Beyer	San Diego Council of Community Clinics
Beau Carter	Integrated Healthcare Association
Michael Dimmitt	California Healthcare Association
Catherine Douglas	Private Essential Access Community Hospitals
Jonathan Edwards	Private Essential Access Community Hospitals
Bill Gertin	Alameda County Contra Costa Medical Association
Karma Hartman	Hospital Council of San Diego
Barbara Hood	California Association of Homes and Services for the Aging
Derrel Kelch	California Association of Homes and Services for the Aging
Jim Lott	Health Care Association of Southern California
Denice Martin	California Association of Public Hospitals
Paul Minicucci	California Association of Homes and Services for the Aging
Sean O'Brien	Foundation Health Plan
Maureen O'Haren	California Association of Health Plans
Tony Rodgers	LA Care
Mark Sektan	California Association of Health Plans
Gary Stephany	Hospital Council of San Diego
Steve Thompson	California Medical Association
Judith Yates	Hospital Council of San Diego

State Legislators/Staff

Peter Hansel	Paul Press	Diane Van Maren
David Maxwell-Jolley	Debra Roth	Diane Watson
John Miller		

About the Authors

Stephen Zuckerman is a principal research associate at the Urban Institute's Health Policy Center. His main research interests are insurance coverage and market reforms, physician payment, Medicaid managed care, and access to care for low-income populations. He is currently directing the health care component of *Assessing the New Federalism*'s household survey, the National Survey of America's Families. Prior to joining the Institute, he worked at the American Medical Association's Center for Health Policy Research.

Teresa Coughlin is a senior research associate at the Urban Institute's Health Policy Center, where her research focuses on Medicaid and other health care programs for low-income populations. She is the author of a book on Medicaid and several articles on health care. Most recently, her work has centered on issues of state health care reform, Medicaid managed care, and Medicaid DSH programs.

Len Nichols is a principal research associate in the Urban Institute's Health Policy Center. His recent work includes health insurance reform, Medicare reform, and medical savings accounts. Prior to joining the Health Policy Center, he was senior advisor for health policy at the Office of Management and Budget and chair of the Economics Department at Wellesley College.

David Liska is currently a research associate in the Health Policy Center of the Urban Institute. His work at the Institute focuses on the Medicaid program, state health care reform, and national health care reform legislation. In addition, he maintains the Institute's database on Medicaid enrollments and expenditures.

Barbara Ormond is a research associate with the Health Policy Center of the Urban Institute. Her work there has focused on the impact of health system

change on uninsured and publicly insured populations. Prior to coming to the Urban Institute, she conducted research on hospital provision of uncompensated care in the United States and on the demand for curative care in rural Indonesia. She spent several years working at the U.S. Agency for International Development, where she focused on rural health systems.

Alicia Berkowitz is a former research associate with the Health Policy Center at the Urban Institute. She studied Medicaid reform and managed care efforts in various states, including California. She has also studied issues relating to long-term care, health care markets, and people dually enrolled in Medicare and Medicaid. Since leaving the Urban Institute, she has been on the staff of a private health care management consulting firm conducting health care analyses for public and private clients.

Meghan Dunleavy is a former research associate in the Urban Institute's Health Policy Center. In addition to this study of California, she participated in an evaluation of the Medicaid Section 1115 waiver for Los Angeles County.

Jodi Korb is a senior research associate at Laguna Research Associates. Her current research focuses on the dual eligible populations and on the effect of community health centers on access to care and service use. Other research interests include Medicaid managed care and long-term care insurance. Prior to joining LRA, she worked at the Congressional Budget Office and the Prospective Payment Assessment Commission.

Nelda McCall is president of Laguna Research Associates in San Francisco, California. She has written numerous publications on managed care, long-term care, public and private insurance, and information management. Prior to founding LRA in 1989, she was the director of health policy research at SRI International and held staff positions at the Palo Alto Medical Research Foundation and the Federal Systems Division of IBM.

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