California's Prisons

How Can the Legislature Minimize the Cost of an Ever-Expanding System?

Summary

- *California is in the midst of the largest prison construction effort ever undertaken in the United States.*
- *The Legislature in this decade has appropriated $3 billion to plan and build prison facilities at 21 locations throughout the state. Based on overcrowding guidelines chosen by the California Department of Corrections (CDC) and the department's latest projection of inmate population growth, the state will need to spend an additional $1.6 billion on prison facilities. At the end of this construction effort, prisons will be more overcrowded than when the construction program began.*
- *The annual cost of running the prison system will increase from $1.6 billion to $3.1 billion between now and 1994-95, a 90 percent increase. This growth will come at the expense of other state programs subject to the appropriations limit since the limit is expected to grow by roughly 50 percent during this time period.*
- *The Legislature has options to significantly reduce the additional costs of building and operating an expanded prison system. These options include: selective reductions of prison sentences, changes in parole supervision, expansion of the conservation camp system, and overcrowding facilities more intensively than currently planned by CDC.*
- *We recommend that the Legislature consider all available options to minimize costs before appropriating funds for additional prison facility construction.*
- *We recommend that the Legislature direct CDC to improve its Facilities Master Plan to assist the Legislature in this process. We further recommend that the Legislature consider CDC's Facilities Master Plan and all CDC capital outlay funding requests during the annual budget process.*

In response to a burgeoning prison population, the Legislature in the past eight years has appropriated approximately $3 billion to plan and build new prison facilities throughout the state. The California Department of Corrections (CDC), however, projects additional capital needs of almost $1 billion through the year 1993. Even at the end of that period, the state's prisons would be overcrowded by an average of 134 percent. In addition, by 1994-95 the state would be spending at least $3.1 billion

annually (in 1994 dollars) to operate these correctional facilities. This is a 700 percent increase in the cost of operations since 1980, with inflation accounting for only one-seventh of the increase.

Given the increasing share of the General Fund budget absorbed by the prison system, the Legislature may wish to examine ways to control these future costs. In this analysis, we: provide background on the state prison system and CDC's current five-year facilities plan, examine the future costs associated with that plan, and suggest several ways available to the Legislature to reduce — or at least minimize — the costs of housing state prisoners.

Background

In mid-1980 California's inmate population was approximately 23,500, which was roughly equal to the prison system's design capacity. Between that time and June 30, 1988, the inmate population more than tripled, growing from 23,500 to 72,100. Looking ahead, CDC now projects an inmate population of 110,200 by mid-1994.

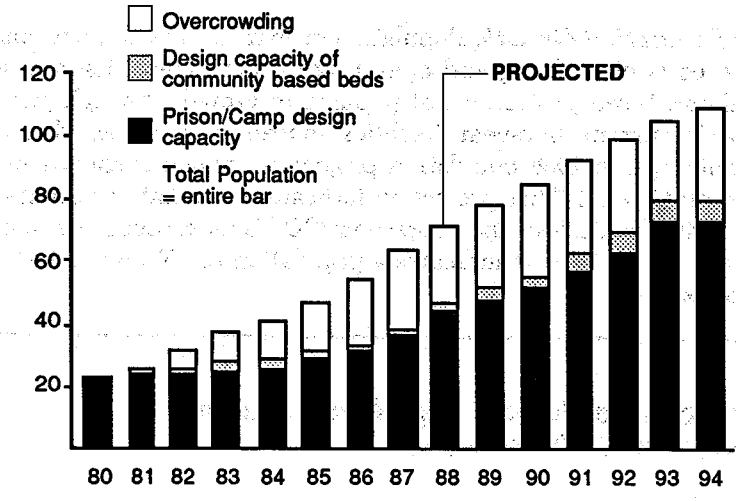
In response to this burgeoning population, California initiated — and is now in the midst of — the largest prison construction effort ever undertaken in the United States. Since 1980, the Legislature has authorized construction of more than 40,000 new prison beds. As of June 30, 1988, about 21,100 of these beds were completed and occupied. The remainder were under either construction or design. The completion of these beds will increase the prison system's design capacity by nearly three times, to 63,900 beds.

Chart 1 shows past and projected increases in the state's prison population and design capacity. The chart also includes the design capacity of community-based beds—locally operated facilities housing parole violators and/or inmates on work furlough programs. These community-based beds, while outside the prison system per se, do provide housing for some inmates. As Chart 1 shows, prison system overcrowding is the difference between the actual or projected population and the design capacities of the prison system and community-based facilities.

The CDC has been able to overcrowd its facilities by placing two inmates in cells designed for one and converting gymnasiums and other activity areas into dormitories. Prison system overcrowding peaked in March 1987 at 178 percent of design capacity before beds added by new construction began to outpace population increases. Today, overcrowding stands at 158 percent of design capacity.

Chart 1

State Prison Population and Capacity[a]
1980 through 1994 (Inmates in thousands)



[a] Data as of June 30 for each year. Population is based on CDC's fall 1988 projections. Projected design capacity is based on CDC's five-year facilities master plan.

CDC's Five-Year Facilities Master Plan

The CDC annually submits to the Legislature a five-year master plan for new facility construction. In addition, supplemental report language adopted in the 1987 Budget Act directs CDC to submit this plan by December of each year so that the Legislature may review it in conjunction with the Governor's annual budget. The most recent plan available to the Legislature at the time this analysis was prepared was the plan submitted for the 1988-89 Budget and updated in May 1988. The plan calls for construction by 1993 of 9,800 beds that as yet have not been authorized by the Legislature.

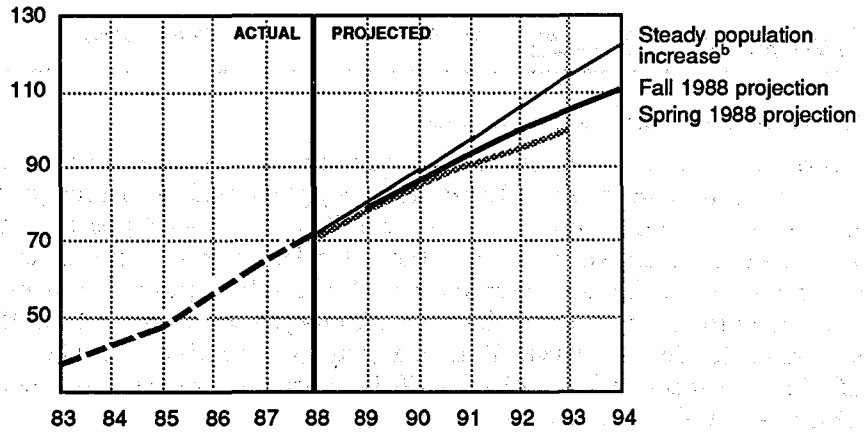
This plan is based on two fundamental factors—projected increases in inmate population and a policy of deliberate overcrowding (with overcrowding guidelines varying by inmate security classification levels). We have concerns with the adequacy of the plan with regard to both of these factors. First, the plan is based on a population projection that now is outdated. The latest CDC projection, released in the fall of 1988, indicates that the prison system will have to accommodate 5,500 more inmates by 1993 than was assumed in the plan. Second, even under the earlier population assumption, the plan did not call for the construction of enough beds to meet the plan's stated overcrowding objectives. This situation is exacerbated by the latest population projection.

According to CDC staff, the department intends to release a new five-year facilities master plan (for 1989-90 through 1993-94) prior to budget hearings. The new plan will be based on CDC's fall 1988 population projection. Presumably, it will call for construction of more beds.

Future Population Growth. Population growth is a key determinant of the future costs of building and operating an expanded prison system. Chart 2 shows three projections of population growth through June 30, 1993. CDC's current five-year facilities master plan is based on the department's spring 1988 population projection, which is shown by the lower line on Chart 2. That projection indicates an inmate population of 99,800 in 1993. The middle line represents CDC's most recent projection, made in the fall of 1988. It indicates a population of 105,300 in 1993 and 110,200 in 1994.

Chart 2

Alternative Projections of Inmate Populations
1983 through 1994 (in thousands)[a]

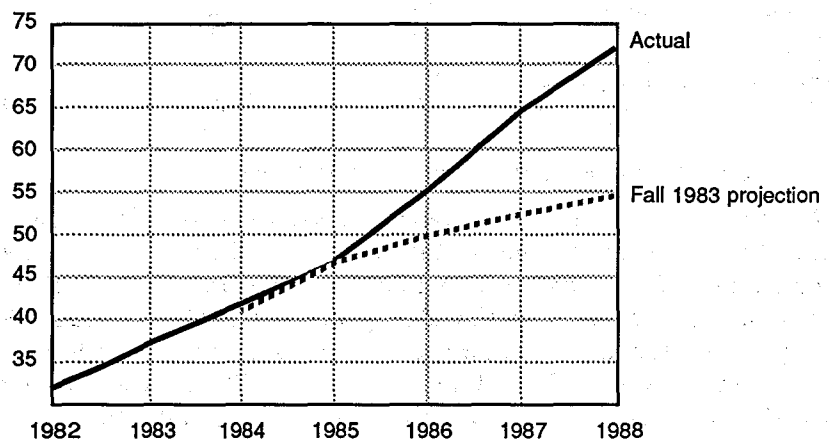


[a] Data as of June 30 for each year.
[b] Projection assumes population increases by 8,300 inmates per year (the average annual increase between 1985 and 1988).

Although growth is higher in the fall 1988 projection, both estimates assume that annual population increases will be smaller than in recent years. Prior CDC projections have made the same assumption, however, and have consistently fallen short of the mark. For example, as Chart 3 illustrates, in fall 1983 CDC projected that the inmate population would increase by 17,500 from June 30, 1983 to June 30, 1988. Instead, the population increased by twice that amount.

Chart 3

Comparison of Previous Population Projection with Actual Population
1982 through 1988 (in thousands)[a]



[a] Data as of June 30 for each year.

CDC's current projections may still underestimate eventual population growth. In view of the above, and for purposes of estimating a potential *range* of future capital and operating costs, we have estimated a continuation of recent population trends. Under this "steady population increase" scenario (see Chart 2), 8,300 inmates would be added each year (the average increase over the last three years), reaching 121,900 in 1994.

The Plan's Overcrowding Targets. CDC's master plan states the department's intent to limit overcrowding to "manageable" levels. CDC would accomplish this by setting guidelines for maximum overcrowding, varying from 100 percent of design capacity (for medical/psychiatric facilities) to 130 percent (for maximum security facilities and reception centers). According to the plan, completion of authorized and planned facilities would result in an average overcrowding level of 126 percent of design capacity in 1993.

It should be noted, however, that with the prisons proposed in CDC's construction plan, overcrowding for some inmate categories would *exceed* CDC's guidelines. As Table 1 shows, the overcrowding guideline for minimum security beds is 120 percent of design capacity. Yet CDC's planned construction would result in overcrowding of 143 percent of design capacity for minimum security beds.

Table 1
CDC Overcrowding Guidelines and Outcome of Current Master Plan

	Percent of Design Capacity		
Classification	*Overcrowding Guidelines*	*Outcome of Master Plan* [a]	*Difference*
Reception Centers	130%	127%	−3%
Level I (minimum security)	120	143	23
Level II	120	119	−1
Level III	130	118	−12
Level IV (maximum security)	130	136	6
Women	120	129	9
Medical/psychiatric	100	107	7

[a] Based on spring 1988 population projection and planned construction.

Moreover, the average overcrowding ratio cited in the plan is based on population projections made in the spring of 1988. CDC's most recent projections (fall of 1988) assume 5,500 *more* inmates by 1993 than the spring projections. Based on the latest population projection, completion of currently planned and authorized construction would result in average prison/camp overcrowding of 134 percent in 1993, with overcrowding exceeding the guidelines in five of the seven bed classifications.

The plan also assumes that the number of community-based beds will increase from 1,970 to 6,370 by 1993. This assumption appears to be optimistic, given that the number of these community beds increased by only 670 (from 1,300 to 1,970) between 1982 and 1988. If the assumed increase in available community-based beds is not realized, further overcrowding of minimum security, women's prisons and camps would result.

Bed Shortfall in Facilities Master Plan. CDC's five-year master plan is divided between "Stage 1" and "Stage 2" projects. The Legislature already has authorized construction of all Stage 1 projects and has appropriated funds for various advance planning activities for all Stage 2 projects. The Legislature, however, has not yet authorized the specific Stage 2 projects. The nature of these projects will have major implications for future capital outlay and support expenditures.

Under Stage 2, CDC proposes to increase prison capacity by 9,800 beds, consisting of: (1) 4,500 minimum security (Level I) beds, (2) 2,900 reception center beds (the point of entry for the system, where new inmates are evaluated and assigned to prisons of appropriate security levels), and (3) 2,400 medical/psychiatric beds (no distinction is made in the plan between medical and psychiatric beds). As noted above, this plan is based on (1) a population projection that is now outdated and (2) overcrowding levels for some inmate categories in excess of CDC's guidelines.

Table 2 shows the numbers of beds (beyond those already authorized) that would have to be constructed by 1994, based on CDC's overcrowding guidelines and more recent inmate population estimates. The middle column of Table 2 shows, for instance, that based on CDC's fall 1988 population projection, the state would need to build 19,900 beds by 1994. On the other hand, if the "steady population increase" scenario were used, the state would need to build 27,800 beds, a difference of 7,900 beds.

Table 2
Additional Beds Needed to Meet Overcrowding Guidelines Under Alternative Population Projections

Bed Classification	*Authorized Bed Capacity*	*Additional Beds Needed (Fall '88 pop. proj.)*	*Additional Beds Needed (Steady population increase scenario)*
Reception Centers	6,480	4,100	5,100
I (minimum security)	11,003	9,500	13,500
II	15,507	2,200	4,000
Women	4,442	1,000	1,600
Medical/psychiatric	1,535	3,100	3,600
Totals	38,967	19,900	27,800

FUTURE COSTS

Future prison system costs consist of capital and operating costs. Approximately 95 percent of the state's prison capital outlay expenditures in this decade have been funded through either general obligation or lease-purchase revenue bonds (both types of bonds are ultimately repaid from the General Fund). About 95 percent of CDC's annual operating costs are met through the General Fund. In this section we review the costs the Legislature will face in the coming years as a result of its construction program—past and proposed.

Capital Costs

According to the CDC's current master plan, the Legislature will need to appropriate approximately $1 billion over the next five years: $900 million to carry out Stage 2 projects and construct the Imperial County prison (authorized as a Stage 1 project), and $116 million to renovate /modify older prison facilities.

These costs, however, are much higher if CDC overcrowding guidelines are met, and alternative population estimates are used. For instance, we estimate a capital outlay cost of approximately $1.6 billion under CDC's most recent population estimate, and a cost of about $2.0 billion under an assumption of steady population growth.

General Obligation Bonds. Of the funds appropriated in the 1980s for prison construction, about 60 percent has come from general obligation bonds. This financing source is the least expensive form of debt financing available to the state. If the $1.6 billion of capital outlay expenditures

required under CDC's latest population estimate were funded by general obligation bonds sold at an interest rate of 7.5 percent, the principal and interest payments would cost the General Fund about $2.9 billion over the next 20 years. This would be equivalent to approximately $2.0 billion in 1989 dollars (which adjusts for the effect of anticipated inflation on payments made in the future).

Lease-Purchase Revenue Bonds. Over one-third of the funds appropriated in this decade for new prison construction have come from lease-purchase "revenue" bonds. These bonds, which do *not* require voter approval, entail higher financing costs than general obligation bonds. In the context of prison facilities, the term "revenue" is a misnomer. This is because prison facilities do not generate any revenues that can be used to repay the bonds. Revenue bonds for prisons are repaid from the General Fund. For example, the Governor's 1989-90 Budget includes $55.3 million from the General Fund for payments on existing prison revenue bonds.

If the $1.6 billion program needed under CDC's overcrowding guidelines and latest population estimate were funded entirely by lease-purchase revenue bonds, we estimate the principal, interest and other financial payments would cost the General Fund approximately $3.1 billion over the next 20 years (or $2.2 billion in 1989 dollars).

Thus, we estimate the state would pay a premium of about $175 million in 1989 dollars from the General Fund by using lease-purchase revenue rather than general obligation bonds.

Operating Costs

Since 1980-81, CDC's annual support budget has quadrupled, from $400 million to $1.6 billion in 1988-89. Table 3 provides an indication of what two population projections mean for future General Fund costs to operate/maintain an expanded prison system. The cost projections are based on the 1988-89 estimated per inmate operating cost ($19,355), adjusted for an assumed 5 percent annual inflation rate. (We also have made allowances for different per capita costs experienced in the department's parole and community bed programs.) Under CDC's current population projection, the department's annual support budget would increase from $1.6 billion in 1988-89 to $3.1 billion in 1994-95. If, however, inmate populations continue to increase each year as they have during the last three years, the annual cost would rise to $3.4 billion in 1994-95. *This increase in operating costs (between 93 percent and 112 percent) over the next six years far exceeds the increase of roughly 50 percent that we expect in the state appropriations limit during the same period.* Growth of this magnitude in the CDC support budget must therefore come increasingly at the expense of other state programs subject to the appropriations limit.

Table 3
Annual CDC Support Costs
Based on Alternative Population Projections

	Support Costs (billions)	*Percent of General Fund Budget*
1988-89 cost	$1.6	4.2%
1994-95 costs based on CDC's fall 1988 population projection [a]	3.1	5.7
Based on steady population increase scenario [a,b]	3.4	6.3

[a] Based on 1988-89 inmate costs adjusted by 5 percent per year for projected inflation. Assumes per inmate costs will not increase as degree of prison overcrowding declines.

[b] Assumes population increases by 8,300 inmates per year, which was the average annual increase experienced during the last three years.

The above projections probably *understate* the eventual costs because we have not adjusted per capita costs to account for increases that should be expected as more prisons become operational and overcrowding ratios decline relative to current overcrowding ratios. As a prison becomes less overcrowded, *per inmate costs increase* because the fixed costs of operating the prison are spread among fewer inmates. The higher, per inmate cost related to these factors should be available to the Legislature so that cost implications of the various options in meeting prison needs are known. Data on these factors, however, are not currently available.

The Special Case of Medical and Psychiatric Beds

CDC's facilities plan calls for the addition of 2,400 medical/psychiatric beds at an estimated cost of $240 million. The plan does not indicate how many medical and psychiatric facilities should be built or where they should be built. The plan also does not indicate how CDC determined its needs for medical/psychiatric beds. At the time this analysis was written, CDC staff were unable to provide data substantiating the basis for this estimate. Clearly, a rapidly expanding inmate population requires an increase in medical/psychiatric services. Whether or not this requires more psychiatric and acute care medical beds *located in correctional facilities* depends, however, on the extent to which CDC (1) uses existing prison system medical/psychiatric beds and (2) contracts for medical/psychiatric services at outside hospitals.

In the *Supplemental Report of the 1987 Budget Act,* the Legislature directed CDC to develop and submit (1) a definitive systemwide plan addressing CDC's short-term and long-range plans for providing health care services to inmates and (2) a report on its use of contracted and in-house medical services. The language specified that CDC submit the systemwide plan to the Legislature by October 1, 1987 and submit the report on contracted and in-house services by November 1, 1987. CDC

submitted the report on contracted and in-house services on April 27, 1988. To date CDC has not submitted the requested systemwide plan.

Contracted and In-House Services. The Legislature requested that the report on contracted and in-house services include "a review of the criteria and guidelines used to determine whether medical services will be provided in-house or on a contractual basis." The CDC's report lists current guidelines for determining whether patients will be treated in-house or outside the institution. These guidelines state that patients will be treated outside the institution when needed "specialized" equipment, diagnostic procedures or physician services are not available in-house. This, however, does not help the Legislature address the main issue in planning for medical/psychiatric facilities: Which services *should* CDC provide in-house?

Systemwide Plan. The Legislature needs the plan it requested in 1987 to assure that the state is effectively addressing inmate medical needs and doing so in a cost-effective manner. To be useful, the plan must—at a minimum—clearly assess current and projected needs, distinguishing between acute care and psychiatric needs, emergency and elective surgery needs, and the growing problem of AIDS. The plan should include cost-benefit analyses to address the issue of which services should be provided in-house and on a contracted basis. In evaluating *where* facilities should be built, the plan also needs to address fully the availability of medical specialists to work within the specific correctional facilities.

OPTIONS TO MINIMIZE THE COST OF THE STATE'S PRISON SYSTEM

We recommend that the Legislature consider all available options to minimize capital and support costs of the prison system before appropriating funds for additional facility construction.

As described above, the prison system will continue to place heavy fiscal demands on the state. At the same time the Legislature responds to these demands, it is reasonable to examine ways to minimize the projected costs of building and operating prisons. We have reviewed several options to control spending that can be grouped into three categories: (1) methods of reducing the rate of growth of inmate populations, (2) measures to reduce per capita costs of constructing and operating facilities, and (3) steps to improve the process of reviewing CDC capital outlay plans and projects, including an option to reduce the cost of financing capital outlay projects.

Several of these options involve difficult policy choices, in which the cost implications must be weighed against the interests of public safety. These options, however, could result in major reductions in General Fund costs for the prison system.

Options to Reduce Inmate Population

Three significant options fall under this category: (1) selective reduction of prison terms, (2) early release and (3) changes in parole supervision.

Selectively Reduce Prison Terms. The simplest way to reduce the ongoing cost of the state prison system is to reduce prison terms for selected offenses, thus incarcerating inmates for shorter periods of time. For instance, if sentencing laws were modified to reduce the prison terms of all newly admitted inmates by an average of 30 days per inmate, there would be an eventual, ongoing reduction in the inmate population of roughly 1,600. The resulting savings would be an estimated: $80 million in capital outlay expenditures (by not having to build as many new prison beds), and $37 million in annual operating costs by 1992-93. These savings would increase in out-years as the reduced prison terms applied to a larger prison population.

Early Release. Another option that has been used effectively in other states to reduce the number of inmates in the prison system and limit overcrowding is to release *some* inmates a *short* time prior to the end of their terms. Such a program could, for example, allow CDC to release on parole certain nonviolent inmates 30, 60, or 90 days in advance of their scheduled parole dates. For instance, if all property offenders admitted in 1986 were released an average of 30 days before their sentences were completed, the state would reduce inmate-years by 720. As a result, the state would save about $7.5 million in one-time operating costs. As this option does *not* reduce the prison population on an ongoing basis, it would not achieve savings in *capital* costs. Early release could be tied to overcrowding levels and could be used under limited circumstances—such as when the prison system reaches a certain level of overcrowding or when the release is authorized by emergency proclamation of the Governor or resolution by the Legislature.

Changes in Parole Supervision. The fastest-growing segment of the inmate population consists of parolees who have been returned to custody for (1) offenses that probably would not have been prosecuted, or (2) violating parole conditions in some way—such as failing urine tests for marijuana usage or failing to report to a parole officer as required. The CDC could reduce the number of technical violators returned to custody by modifying the conditions it imposes on parolees or developing additional resources for supervising technical violators in the community, rather than returning them to the institutions.

For instance, if 10 percent fewer parolees were returned to custody for technical violations of their parole, the department would eventually achieve a reduction in inmate population of approximately 1,800. This would result in capital savings of about $120 million and savings in annual

incarceration costs, by 1991-92, of about $40 million. It is likely that the operational savings would be offset to some extent by additional expenditures in parole supervision and programming that would be necessary to achieve the 10 percent revocation reduction.

Options to Reduce Construction/Operating Costs

In addition to reducing the inmate population, there are at least four significant ways the state can minimize construction and operating costs of its prisons: (1) modify overcrowding levels, (2) meet minimum security bed needs by expanding the conservation camp system, (3) meet additional minimum security bed needs by expanding housing at *existing* prisons and (4) determine the optimum mix of in-house and contracted medical/psychiatric services.

Modifying Overcrowding Levels. Design bed capacity represents the number of inmates a prison is designed to house under ideal conditions. Design bed capacity can be exceeded on a long-term basis, however, through double-celling and multiple shift operations of educational/vocational programs and other activities. In fact, CDC's plan is to overcrowd by as much as 130 percent of design capacity in maximum security prisons and reception centers.

As described in the "Background" section, CDC has established overcrowding guidelines for all of its bed classifications. The department has not, however, provided information identifying the implications of or the bases for these overcrowding ratios. The Legislature needs the above information because overcrowding at a greater intensity than outlined in CDC's master plan could significantly reduce construction needs as well as the department's operating costs. On the other hand, overcrowding at any level raises questions concerning staff and inmate safety, humane treatment, and availability of programs and services for the inmates. *These questions need to be addressed regardless of the amount of overcrowding.* To assist the Legislature in evaluating overcrowding levels, CDC needs to provide construction and operating cost information, and programmatic and security implications of various overcrowding assumptions. With this information, the Legislature (and CDC) can choose among overcrowding alternatives, knowing what each implies for CDC's future capital and support costs.

Expanding the Conservation Camp System. CDC operates 39 camps statewide, including 30 jointly operated with the Department of Forestry and Fire Protection and five with the Los Angeles County Fire Department. Qualified Level I (minimum security) inmates are selected and trained for work in the camps, which are designed to accommodate from 80 to 160 inmates. (Level I inmates who do not qualify for camp work—escape risks or those unable to engage in vigorous physical activity—are

housed in conventional minimum security prisons.) Camp inmates provide firefighting services as well as conservation work (such as tree planting, repairing levees and clearing logging debris from streams).

Camps are less costly to build and operate than conventional prisons, due largely to less stringent security requirements. CDC's master plan indicates a per-bed construction cost of $35,000 for *all* types of Level I beds, but does not show a cost for camps versus Level I beds in a prison setting. According to CDC staff, the department does not have reliable estimates of the relative per capita costs to operate camps and Level I prisons. The department's five-year plan also does not indicate what portion of the proposed 4,500 Level I beds can or will be met through the camp program. The plan simply indicates that "the department is also considering expansion of the camp program." CDC needs to provide this information to the Legislature so that it can be considered along with other factors in determining the extent to which Level I bed needs should be met through camps.

Expanding Level I Facilities at Existing Prisons. The state's maximum and medium security prisons include separate housing for some minimum security (Level I) inmates. The Level I inmates perform a variety of tasks that are needed for the operation of the prisons and which take place outside the security perimeters established for other inmates. Many existing prisons have sufficient land and infrastructure to accommodate additional Level I housing. This approach has potentially significant cost advantages compared to constructing new Level I prisons since there would be no need to acquire land, install major new utilities and/or build administrative and support facilities.

Determining the Proper Mix of In-House and Contracted Medical/Psychiatric Services. The cost of providing inmates with adequate medical, dental and psychiatric care is significant. CDC's 1988-89 budget for these services, including pro-rata facilities operations costs, exceeds $200 million, or almost $2,900 per inmate throughout the prison system. The cost of constructing new medical and psychiatric beds is also significant, an estimated average cost of $100,000 per bed according to CDC's five-year facilities plan.

In addition to infirmaries and clinics at each prison, CDC operates three acute care hospitals and, in cooperation with the Department of Mental Health, psychiatric care facilities at the California Medical Facility in Vacaville. CDC contracts with outside hospitals for specialized medical services not available in CDC facilities.

To the extent CDC contracts for medical/psychiatric services, it can reduce the need to construct new medical/psychiatric beds, for savings of roughly $100,000 per bed. There also may be potential operating savings from an increased use of contracted medical services. The Legislature,

however, does not have the detailed data and cost benefit analyses it needs to evaluate these alternatives and to determine the optimum mix of contracted and in-house services. This, essentially, is the information the Legislature requested in 1987 and still has not received.

Options to Improve Review/Financing of Capital Outlay Plans and Projects

We recommend that the Legislature implement the options discussed below to improve the review/financing of capital outlay plans and projects.

The Legislature can better assess and control future prison costs by receiving more meaningful and timely information on CDC's capital outlay plan and by reviewing the plan and funding needs in the annual budget process.

Needed Improvements in Facilities Master Plan. CDC's current Facilities Master Plan needs to be improved in many ways in order to become a useful guide for the Legislature (and the department). Such improvements would include:

- Assessing in detail *needs for medical and psychiatric beds.*
- Identifying the *number, nature and location* of facilities proposed to meet overall bed needs.
- Specifying a *time frame* for authorization, planning and construction of facilities.
- Assessing projects/actions that would be needed in the event underlying *assumptions*, such as projected population, change over time.
- Including *operating cost estimates* for each type of facility, and assessing how operating costs would be affected by different levels of overcrowding.
- Assessing the efficacy of *alternative courses of action*, including alternatives to incarceration and options to minimize construction costs.

To obtain the information the Legislature needs in making decisions with significant long-range policy/fiscal impacts, and to assure that the most cost effective financing option is available, we recommend that the Legislature adopt supplemental report language directing CDC to incorporate the above improvements into its facilities master plan.

The submittal of such an improved plan will assist the Legislature in assessing the needs, options and costs of the prison system. Moreover, through careful planning and *timely* submittal of information to the Legislature, the most cost-effective method of financing the capital needs could be determined.

General Obligation Bonds More Cost-Effective Than Revenue Bonds. So far, the state has relied almost exclusively on bonds to finance new prison construction. Of approximately $3 billion in construction costs in this decade, the state has used about $1.7 billion in general obligation bonds, almost $1.2 billion in lease-purchase revenue bonds and about $100 million from the General Fund and the Special Account for Capital Outlay (SAFCO). The magnitude of prison capital outlay needs relative to available resources (that is General Fund and tidelands oil revenue) makes the choice of funding alternatives, as a practical matter, between general obligation bonds and lease-purchase revenue bonds.

As discussed in the "Future Costs" section, the state pays a "premium" (in the form of higher financing costs) to use revenue bonds instead of general obligation bonds to finance prison construction. We estimate that the state would pay added costs of approximately $175 million (1989 dollars) from the General Fund over the next 20 years if the estimated cost for CDC's capital outlay needs were funded through lease-purchase revenue bonds rather than general obligation bonds. Moreover, revenue bond payments are subject to the appropriations limit and therefore limit the Legislature's ability to fund competing needs. In view of this, the use of these revenue bonds should be used only under the most urgent circumstances. In most cases, such circumstances can be avoided through proper and timely planning.

On several occasions, however, CDC has placed the Legislature in the untenable position of either approving proposals for lease-purchase revenue financing or having needed prison projects delayed. With proper planning on CDC's part and timely submittal of the plans to the Legislature, further use of lease-purchase revenue financing could be avoided, with significant savings to the state.

Evaluation of Prison Facility Needs Should Be Part of the Budget Process. In addition to a more useful five-year facilities master plan, the Legislature also needs the opportunity to review CDC's master plan and construction requests during the annual budget process in the context of overall CDC and state funding needs. In recent years CDC has not presented its plans and funding requests for new prison construction in the Budget Bill. Instead, it has presented its funding requests for new facilities in separate legislation, generally late in the legislative session. This places the Legislature in the untenable position of attempting to meet the prison overcrowding problem without benefit of the context of an overall approach to the state's prison needs and the opportunity to evaluate the impact on other state programs. This process is neither beneficial to the state nor necessary. The process could be improved substantially through proper planning on the department's part, and by presenting capital outlay plans and funding requests in the annual

budget. Therefore, we recommend that the Legislature consider CDC's facilities master plan and all capital outlay funding requests in the annual budget process along with other statewide spending needs.

Blue Ribbon Commission May Develop Additional Options

The Blue Ribbon Commission on Inmate Population Management, established by Chapter 1255, Statutes of 1987, is composed of leaders of the California criminal justice system, representatives of the judiciary and law enforcement, and various other experts. It is charged with the mission to review the state's system for dealing with prisoner and parolee populations, and examine whether there are viable alternatives and solutions to the problems of overcrowding and rising costs. The commission's first report to the Governor and the Legislature is due in September 1989, with a final report due by the end of the year. In these reports, the commission may recommend other options (in addition to the ones discussed here) that would reduce the growth of the inmate population or that would reduce the costs of housing inmates once they are in prison.

CONCLUSION

Faced with an ever-increasing inmate population, the state for most of this decade has attempted to build its way out of a prison overcrowding situation. Following the appropriation of approximately $3 billion for new prison construction, overcrowding today (158 percent of capacity) is worse than it was when the construction program began (100 percent of capacity). Even if the Legislature spends another $1 billion (per CDC's current plan) over the next five years, overcrowding will be about 141 percent at the end of that period. Moreover, annual CDC support costs have climbed from $400 million in 1980-81 to an estimated $1.6 billion in 1988-89. Under CDC's current population projections these costs will rise to at least $3.1 billion by 1994-95. Thus, in 14 years, CDC's annual support budget will have increased by $2.7 billion or almost eight-fold.

Under the current appropriations limit, the increased annual cost of the state's prison system will necessitate significant reductions in the share of General Fund resources available for other state programs. This is because the rate of increase in the cost of the prison system will dramatically outpace both anticipated General Fund revenue growth and inflationary increases for other state programs.

The Legislature has options for minimizing the projected costs of building and operating/maintaining prisons. These options include—but are not limited to—selective reductions of prison terms, early release programs, changes in parole supervision, expansion of the conservation camp system, adding minimum security housing at existing prisons and

improving the legislative review/financing process for capital outlay plans and projects.

Many of the options considered in this review involve minimum security inmates, a category where trade-offs between significant cost reductions and public safety considerations are most favorable.

Federal Immigration Reform: An Update

What Is the Status of the Expenditure of Funds Provided under the Federal Immigration Reform and Control Act (IRCA)?

Summary

- *More than 1.3 million persons have applied for legal status in California under IRCA, a substantial increase over last year's projection of 900,000.*
- *The budget year will be a critical one for thousands of newly legalized persons seeking to meet the educational requirements of IRCA.*
- *The administration has substantially revised its five-year expenditure plan for federal State Legalization Impact Assistance Grants (SLIAG) due to revised estimates of (1) program utilization and (2) federal funds available to the state.*
- *There have been very few claims for SLIAG funding in the current year. Although the reasons for the lack of claims are not clear, the administration believes that the newly legalized population may not need the level of health and welfare services originally projected and that some may fear disqualification from legalization because of federal rules regarding the use of public assistance by this population.*
- *The SLIAG expenditure plan offers a number of issues for consideration by the Legislature, including: the reliability of the program cost estimates, the reliability of SLIAG as a funding source, the problems of data collection, funding uncertainties at the federal level, and the use of SLIAG to fund other services.*

In 1986, Congress approved legislation amending federal law governing legal and illegal immigration into the United States. This legislation, known as the Immigration Reform and Control Act (IRCA), authorized general amnesty for certain groups of illegal aliens already in the United States, holding out eventual citizenship to these individuals. In addition, the legislation created employer sanctions in hopes of discouraging future illegal immigration.

The IRCA legislation included $4 billion in federal funds to pay for the costs of certain state and federal services that would be available to legal aliens, as well as the costs of registering, reviewing, and approving individuals applying for legal alien status. These funds—known as State Legalization Impact Assistance Grants (SLIAG)—are generally available to the states from 1987-88 through 1991-92.

In this section we review SLIAG expenditures in the current year and the administration's revised allocation plan for SLIAG for 1989-90 through 1991-92. We discuss several issues related to SLIAG in more detail in our individual department reviews included in the *Analysis of the 1989-90 Budget Bill.*

The Legalization Process

The IRCA recognizes two new groups that may lawfully gain citizenship in the United States.

Pre-82s. Undocumented aliens who have lived in this country continuously since January 1982 may become legal residents if they applied to the federal Immigration and Naturalization Service (INS) between May 1987 and May 1988 (the Governor's Budget refers to these individuals as "pre-82s"). After reviewing an application for legalization, the INS grants eligible individuals *temporary* resident status. Each applicant then must submit an application for permanent residency status within a one-year period beginning with the 19th month after the person was granted temporary residency. Consequently, these newly legalized persons must submit applications for permanent residency status to the INS between November 1988 and November 1990.

Special Agricultural Workers. The IRCA permits undocumented immigrants to apply for temporary resident status if they worked in U.S. agriculture for a minimum of 90 days between May 1985 and May 1986. These individuals are known as "special agricultural workers" (SAWs). The deadline for SAWs to apply to the INS for temporary status was November 30, 1988.

Number of Persons Seeking Legal Status Greater than Expected

Last year, the Department of Finance (DOF) estimated that 900,000 individuals would seek legalization in California. Based on the latest figures from the INS, the department now estimates that approximately *1.3 million* individuals have applied for legal status. This includes approximately 945,000 persons who were in the United States prior to 1982, and 370,000 SAWs. According to the DOF, newly legalized persons represent approximately 4.5 percent of the state's total population. More than half of all applicants for legalization in the nation live in California.

Budget Year Is Critical for Legalization Process. Newly legalized persons must meet specified criteria in order to convert to permanent residency. One of the most important criteria is that each person must show progress toward attaining minimum competency in English, history, and civics. INS regulations indicate that individuals can meet these requirements by either passing a short INS exam or by attending English-as-a-second-language (ESL) and civics classes for at least 40

instructional hours in an approved 60-hour course. These educational requirements make the budget year a critical time period for providing adult educational services in order to ensure that all newly legalized persons have the opportunity to convert to permanent residency status.

The Administration's Proposal for the Use of SLIAG Funds

As discussed above, the IRCA appropriates $4 billion to reimburse state and local governments for the costs of health, welfare, and education expenses incurred in assisting newly legalized persons. These monies, minus the federal costs of Medi-Cal, Supplemental Security Income/State Supplementary Program (SSI/SSP), and food stamps that are provided to eligible persons (known as the federal offset), will be allocated to states based on a specified formula.

Five-Year Expenditure Plan. Table 1 displays the amount of SLIAG funds estimated to be available to California and the expenditures of these funds from 1987-88 through 1991-92 as proposed in the Governor's Budget. These estimates were compiled by the Health and Welfare Agency (HWA), which has been designated the lead agency for IRCA implementation. Of the total funds available to the states (after adjusting for the federal offset), the agency estimates that approximately 58 percent will be allocated to California, for a total of $1.8 billion over the four-year period. This amount is $64 million *higher* than the amount estimated last year, based on the state's latest application for funding to the federal government.

Although the IRCA allocates funds to states over a four-year period, the Governor's Budget proposes to spend these funds over a five-year period, from 1987-88 through 1991-92. Federal regulations allow states to carry over SLIAG funds from year to year. Consequently, by carrying surpluses over each year, the budget proposes to make sufficient funds available to support program costs in the fifth year, 1991-92.

Substantially Revised Expenditure Plan. The five-year expenditure plan shown in Table 1 has been substantially revised from the plan presented to the Legislature last year as well as the plan ultimately included in the 1988 Budget Act. According to the HWA, the revisions have resulted because of revised estimates of program utilization in the prior and current fiscal years and because of the revised estimate of the total funds that will be available to the state.

In conjunction with the revised five-year expenditure plan, the Director of Finance notified the Legislature on January 19, 1989 of his intent to substantially revise the expenditure plan for the current year from the one approved by the Legislature in Control Section 23.50 of the 1988 Budget Act. The control section provides limited authority to the

Table 1
Federal SLIAG Funds
Availability and Proposed Expenditures
1987-88 through 1991-92
(dollars in millions) [a]

	State Fiscal Year					
	1987-88	*1988-89*	*1989-90*	*1990-91*	*1991-92*	*Total*
Funds available						
Federal allocation to California [b]	$427.8	$423.2	$416.5	$425.8	$106.1	$1,799.4
Carryover from previous year	—	286.0	393.4	257.6	284.3	n/a
Totals, funds available	$427.8	$709.2	$809.9	$683.4	$390.4	$1,799.4
Proposed expenditures						
Public assistance						
Health:						
Medically Indigent Services program	$68.4	$130.6	$238.9	$238.9	$238.9	$915.6
Medi-Cal	6.3	22.6	46.6	56.9	61.7	194.0
Primary care clinics	10.0	11.6	23.1	23.1	23.1	91.0
County medical services	—	4.9	18.0	18.0	18.0	58.8
California Children's Services	0.6	1.6	2.5	2.5	2.5	9.6
Subtotals, health	($85.3)	($171.2)	($329.0)	($339.4)	($344.1)	($1,269.0)
Mental health	—	$3.0	$3.0	$3.0	$3.0	$12.0
Welfare:						
General assistance	0.1	1.1	4.7	5.7	5.7	17.3
Foster care	—	2.6	2.7	2.3	2.1	9.6
AFDC-FG&U	0.1	0.5	2.1	5.1	5.2	13.0
SSI/SSP	0.1	1.5	2.9	3.7	3.1	11.4
Food stamps	0.1	0.5	0.7	0.7	0.7	2.7
IHSS	—	0.1	0.2	0.2	0.2	0.7
Subtotals, welfare	($0.4)	($6.2)	($13.2)	($17.7)	($17.0)	($54.6)
Housing	—	$2.5	$4.0	$4.0	$4.0	$14.6
Administration, public assistance	0.2	5.6	5.0	3.8	3.8	18.4
Totals, public assistance	$85.9	$188.5	$354.3	$367.9	$371.9	$1,368.6
Education						
Adult education	$30.0	$100.0	$180.0	$20.0	$10.0	$340.0
K-12 supplemental	4.2	2.8	1.4	—	—	8.4
Administration, education	0.1	1.8	2.3	1.0	0.5	5.7
Totals, education	$34.3	$104.6	$183.7	$21.0	$10.5	$354.1
Public health						
Health:						
TB/leprosy control	$5.0	$8.1	$0.6	$0.5	$0.3	$14.5
IRCA subvention	8.6	3.5	6.6	3.4	2.2	24.3
Sexually transmitted diseases	4.0	1.7	1.0	0.5	—	7.2
Laboratory support	—	0.3	—	—	—	0.3
Immunizations	0.6	0.5	0.2	0.1	0.1	1.5
Perinatal services	1.3	2.8	1.1	1.2	1.2	7.6
Family planning	1.0	3.2	1.6	1.7	1.7	9.2
Child health and disability prevention	0.7	—	—	—	—	0.7
Adolescent family life	0.2	0.5	1.0	1.1	1.1	3.9
Administration, public health	0.3	2.1	2.1	1.7	1.4	7.5
Totals, public health	$21.6	$22.7	$14.3	$10.2	$8.0	$76.7
Grand totals, proposed expenditures	$141.9	$315.8	$552.3	$399.1	$390.4	$1,799.4
Carryover to subsequent year	286.0	393.4	257.6	284.3	—	—

[a] Source: 1989-90 Governor's Budget. Details may not add to totals due to rounding.
[b] Based on estimates by the Health and Welfare Agency.

Director to move funds between the items scheduled in the section after notifying the Legislature of his intent to do so. Table 2 shows the revised expenditure plans for the current year compared to the 1988 Budget Act and for the budget year compared to the original expenditure plan included in the 1988-89 Governor's Budget. As the table shows, the administration proposes to reduce the amount of SLIAG funds allocated to welfare programs by 90 percent and substantially increase the amounts for medically indigent services and education programs.

Few Claims in the Current Year. As indicated above, the primary reasons the administration proposes to revise the SLIAG expenditure plan is to reflect its revised estimates of program utilization. In fact, at the time this analysis was prepared, *many programs had not spent any of their SLIAG funds.* Specifically:

- ***Health.*** The Department of Health Services advises that it is still processing claims for 1987-88 and has processed *no claims* for the current year in the county medical services and medically indigent services programs and less than $100,000 in claims in the Medi-Cal program. The department expects to begin processing 1988-89 claims for county health services beginning in March 1989. In addition, the Department of Mental Health has yet to process any claims in the current year.
- ***Welfare.*** The Department of Social Services advises that it has received *no claims* for SLIAG funds for welfare programs in the current year, including General Assistance, Aid to Families with Dependent Children, and SSI/SSP.
- ***Housing.*** The Department of Housing and Community Development (HCD) advises that it has not established a mechanism to determine which program recipients are eligible for SLIAG reimbursement. Consequently, the department has not processed any claims.

The reasons for the lack of claims are not clear. The HWA, however, advises that there are probably two reasons for the lack of health and welfare claims. First, the agency believes that the newly legalized population is a working population (although often in low-paying jobs) that can provide basic food, clothing, and shelter needs for themselves and their families. Second, the agency believes that many have a fear of government assistance programs, heightened by the fear of disqualification from legalization on "public charge" grounds. This is because under IRCA if newly legalized persons are found to have been a "public charge" (that is, receiving welfare or health benefits during specified periods), they may have difficulty qualifying for permanent residency. This fear may keep many newly legalized persons from seeking assistance through these programs.

Table 2
Federal SLIAG Funds
Changes in Expenditure Plans
1988-89 and 1989-90
(dollars in millions) [a]

	1988-89			1989-90		
	Original Plan (1988 Budget Act)	*Revised Plan (1989-90 Budget)*	*Percent Change*	*Original Plan (1988-89 Budget)*	*Revised Plan (1989-90 Budget)*	*Percent Change*
Public assistance						
Health:						
Medically Indigent Services program	$67.6	$130.6	93.2%	$94.0	$238.9	154.1%
Medi-Cal	26.9	22.6	−16.0	47.5	46.6	−1.9
Primary care clinics	11.6	11.6	—	14.7	23.1	57.1
County medical services	4.9	4.9	—	6.7	18.0	168.7
California Children's Services	1.7	1.6	−5.9	1.7	2.5	47.1
Subtotals, health	($112.7)	($171.2)	(51.9%)	($164.6)	($329.0)	(99.9%)
Mental health	$3.0	$3.0	—	—	$3.0	—[b]
Welfare:						
General assistance	41.4	1.1	−97.3%	$88.1	4.7	−94.7%
Foster care	2.5	2.5	—	2.7	2.7	—
AFDC—FG&U	7.4	0.5	−93.2	14.3	2.1	−85.3
SSI/SSP	12.9	1.5	−88.4	21.4	2.9	−86.4
Food stamps	0.3	0.5	66.7	0.3	0.7	133.3
IHSS	0.2	0.1	−50.0	—	0.2	—[b]
Subtotals, welfare	($64.7)	($6.2)	(−90.4%)	($126.8)	($13.2)	(−89.6%)
Housing	$2.5	$2.5	—	—	$4.0	—[b]
Administration, public assistance	4.1	5.6	36.6%	$3.5	5.0	42.9%
Totals, public assistance	$187.0	$188.5	0.8%	$294.9	$354.3	20.1%
Education						
Adult education	$80.0	$100.0	25.0%	$110.0	$180.0	63.6%
K-12 supplemental	2.8	2.8	—	1.4	1.4	—
Administration, education	1.3	1.8	38.5	1.7	2.3	35.3
Totals, education	$84.1	$104.6	24.4%	$113.1	$183.7	62.4%
Public health						
Health:						
TB/Leprosy control	$8.1	$8.1	—	$1.5	$0.6	−60.0%
IRCA subvention	3.5	3.5	—	1.2	6.6	450.0
Sexually transmitted diseases	1.7	1.7	—	—	1.0	—[b]
Laboratory support	0.3	0.3	—	—	—	—
Immunizations	0.5	0.5	—	0.1	0.2	100.0
Perinatal services	2.8	2.8	—	2.3	1.1	−52.2
Family planning	3.2	3.2	—	3.2	1.6	−50.0
Child health and disability prevention	—	—	—	—	—	—
Adolescent family life	0.5	0.5	—	0.5	1.0	100.0
Administration, public health	1.0	2.1	110.0%	0.6	2.1	250.0
Totals, public health	$21.6	$22.7	5.1%	$9.4	$14.3	52.1%
Grand totals, expenditures	$292.7	$315.8	7.9%	$417.4	$552.3	32.3%

[a] Details may not add to totals due to rounding.
[b] Not a meaningful figure.

Education Claims. As of December 31, 1988, the State Department of Education had spent approximately $34 million, or about 43 percent, of its current-year appropriation of $80 million for adult education. As Table 2 shows, the administration proposes to allocate an additional $20 million for adult education in the current year in anticipation of additional claims being processed during the year. The HWA indicates that newly legalized persons appear to be seeking adult education services in advance of when they have to apply to INS for permanent residency status and appear to be staying in ESL and civics classes beyond the minimum number of instructional hours that INS requires.

Issues for Legislative Consideration

Our analysis indicates that the administration's proposed expenditure plan for SLIAG presents the Legislature with a number of questions and issues to consider. Specifically:

Questionable Estimates. Many of the estimates used to develop the five-year plan are questionable. Given the lack of actual claims in the current year and the very limited data available, many of the estimates are little more than educated guesses.

SLIAG Is a Temporary Funding Source. Much of what is proposed in the expenditure plan will fund *existing*, rather than *new*, programs and services. That is, SLIAG funds are proposed to *replace existing General Fund expenditures*. This has a serious drawback. When SLIAG funds are exhausted in 1991-92, the General Fund monies that they replaced will likely have been committed to other uses.

Uncertainty at the Federal Level. President Reagan's budget for federal fiscal year 1990 proposed a 30 percent reduction in SLIAG funding. According to the HWA, if such a reduction is enacted (which would require Congress to rescind its prior appropriation), California could lose $174 million in its estimated remaining SLIAG funding.

Data Collection. The SLIAG expenditure plan in the Governor's Budget has changed substantially from the plan submitted to the Legislature last year. In large measure, this is because so little data were available last year with which to estimate program costs. Given the lack of claims in the current year, we believe the estimating problem is likely to persist in the budget year. This is partially due to the difficulty in (1) determining what services newly legalized persons need from state and local governments and (2) identifying which costs are eligible for SLIAG funding.

Other Services Could Be Funded with SLIAG Funds. Although the budget proposes to support many different programs with SLIAG funds, our analysis indicates that the Legislature could elect to support IRCA-related costs incurred in other programs. These programs include various

environmental health programs in the Department of Health Services and substance abuse programs in the Department of Alcohol and Drug Programs.

We discuss a number of these issues in our *Analysis of the 1989-90 Budget Bill.* Specifically, in the analysis of the Department of Health Services (Item 4260), we review the policy issues regarding the Governor's proposal to substantially increase SLIAG funding for the Medically Indigent Services program. We also address questions regarding the estimates for the perinatal, adolescent family life, and California Children's Services programs, and we discuss a court injunction that limits the department's ability to claim SLIAG funds for some Medi-Cal services. In the analysis of the State Department of Education (Item 6110), we address policy questions regarding the administration's proposals to target SLIAG funding to critical educational services.

State Child Care Services

What Options Are Available to the Legislature for Better Targeting Existing Child Care Funds to Those Most in Need?

Summary

- *Currently, 13 state agencies administer 49 child care programs funded at approximately $747 million—$614 million from the General Fund and $133 million from federal funds. In addition, federal agencies administer four programs funded at an estimated $623 million in 1988-89.*
- *The two programs which provide almost three-fourths of state funding for child care are: (1) the subsidized Child Development program administered by the State Department of Education and (2) the child care tax credit program administered by the Franchise Tax Board.*
- *The Legislature has three major options for modifying child care programs in order to expand the number of low-income children served: (1) modify existing staff to children ratios (which we recommend enactment of legislation to achieve); (2) change the mix of programs currently provided; and (3) raise family fee levels.*
- *The current child care tax credit provides benefits primarily to middle- and high-income families. The Legislature has three primary options for modifying the credit to better target state child care resources: (1) phase out or reduce the credit for families with higher incomes; (2) make the credit refundable; or (3) repeal the credit.*

The Legislature faces important decisions regarding how to target available child care funds to those most in need of affordable care. For instance, with regard to the two existing state programs that provide the majority of funding for child care and related services:

- Should the state-subsidized child development programs administered by the State Department of Education (SDE) be modified as the Legislature considers whether or not to extend the programs beyond their scheduled June 30, 1989 sunset date?
- How can the state child care tax credit administered by the Franchise Tax Board (FTB) be modified to better target subsidies to those most in need of this assistance?

In addition, to the extent that the federal government enacts one or more of the child care programs that are currently being considered in Congress (including those that provide services directly and those that provide tax credits), the Legislature may also need to address issues related to these programs' implementation.

To assist the Legislature in determining how to target existing state resources to those most in need of child care, this analysis first provides background information on the cost and affordability of child care in California. We then discuss existing state and federal child care programs. Finally, we examine options available to the Legislature for better targeting state funds to those most in need of affordable child care.

What Types of Child Care Are Available in the State?

There is a wide diversity of child care programs available in California, both in terms of the services provided and in the role the state plays in monitoring and funding them. There are part-day and full-day programs, summer and year-round programs, and programs targeted to specific groups (such as the disabled, children of teenage parents, and abused and neglected children). Some programs receive state or federal funds (we identify these programs in a subsequent section) and some do not.

Generally, all child care programs are required to be licensed by the Department of Social Services (DSS), except for the following which are specifically exempted: (1) programs where child care providers care only for their children and the children of one other family in the provider's home, (2) care provided to children in their own homes, (3) programs, such as after-school recreational programs, in which activities are provided only on a drop-in basis, and (4) programs operated by school districts in which all staff employed are regular district employees and all children served are students enrolled in the district. In addition to the licensed and license-exempt providers, there are an unknown—but presumably large—number of unlicensed child care arrangements.

All the programs vary considerably in cost, though the greatest variation probably occurs in license-exempt care. For example, some license-exempt care, such as care by relatives, may be provided free. Other types, such as care for one family's children in their own home, may be more expensive than many other forms of child care.

There is almost no information available on the cost of *non*licensed (that is, license-exempt and unlicensed) child care; thus, our analysis in the next section deals only with licensed child care. This is not to imply that parents only use licensed care. Clearly, this is not the case. In fact, many child care experts estimate that the number of children enrolled in nonlicensed programs may *equal or exceed* the number of children enrolled in licensed programs.

Is Child Care Affordable?

There is evidence to support a common perception about child care—that many families in which both parents (or the single parent) work cannot afford to purchase child care at private market rates. Child

care policy experts estimate that families can usually afford to pay approximately 10 percent of their incomes for child care services. Table 1 shows the percentage of family income (at various income levels) needed in 1986-87 to purchase licensed child care (at the state's median market rate) in centers or family day care homes *for one child.* (Child care centers are generally licensed to care for more than 12 children and are usually operated at sites other than families' primary residences. Family day care homes are generally licensed to care for up to either six or 12 children and are usually operated in families' primary residences.)

Table 1
Portion of Family Income Needed to Pay Average Child Care Costs
1986-87

Type of Child Care	*Annual Costs*[a]	*Family Income: Selected Percentages of State Median Income—$33,200* 50.0%	84.0%	100.0%	120.0%	180.0%
Infant Care:						
Child Care Center	$4,194	25.3%	15.0%	12.6%	10.5%	7.0%
Family Day Care	3,298	19.9	11.8	9.9	8.3	5.5
Preschool Care:						
Child Care Center	3,130	18.9	11.2	9.4	7.9	5.2
Family Day Care	3,149	19.0	11.3	9.5	7.9	5.3

[a] The annual costs are the median rates charged statewide by child care providers (simple average of all providers, not weighted by the number of children served). The costs include both subsidized and nonsubsidized funding rates.

Source: California Child Care Resource and Referral Network, *California Inventory of Child Care Facilities,* February 1987 with June 1988 update, San Francisco, California. The statewide median income ($33,200 in 1986-87) was obtained from the Department of Finance.

Using 10 percent of income as a measure of affordability, the table shows that families earning the state median income—$33,200 in 1986-87—could afford to pay for licensed child care, unless they needed child care for infants or for children with special needs (because care for these children is often more expensive that other types of care), or they had more than one child needing child care.

The table also shows that families with incomes at 84 percent of the state median—$27,888 in 1986-87—paid, on average, between 11 percent and 15 percent of their incomes for licensed child care in that year, unless they received subsidies. In general, the children from families with incomes *below* this level are eligible for subsidized child development programs administered by the SDE. Many of the children who are eligible for the child development programs, however, are not served by them. (We discuss the potential unmet demand for the programs in a subsequent section.) While the child care arrangements for an unknown number of the children from these low-income families may be subsidized through employers, nonprofit organizations, and local governments, it is likely that many families in this income range either (1) pay

the full cost of child care or (2) obtain child care informally at less cost.

Families with incomes of 50 percent of the state median—$16,600 in 1986-87—paid between 19 percent to 25 percent of their incomes for licensed care in that year—a proportion that generally made such care unaffordable for this group, unless they received subsidies. While many of these families were probably eligible to receive Aid to Families with Dependent Children (AFDC), there are no data on the number of these families that received child care through AFDC or the Greater Avenues for Independence (GAIN) program. Among other things, GAIN provides child care to AFDC recipients so that they may work or receive job training.

The next section discusses programs in California that receive state and/or federal funds to provide affordable child care to low-income families, as well as other child care and related programs.

STATE CHILD CARE PROGRAMS

Our review indicates that 16 agencies (13 state agencies and three federal agencies) administer 53 separate programs that provide child care and related services in California. Chart 1 identifies these agencies (and their acronyms, which are used in Table 2).

Chart 1

State and Federal Agencies That Provide Child Care and Related Services in California

STATE AGENCIES	
California Community Colleges	CCC
California Department of Corrections	CDC
California State University	CSU
Department of Developmental Services	DDS
Department of Housing and Community Development	HCD
Department of Motor Vehicles	DMV
Department of Personnel Administration	DPA
Department of Social Services	DSS
Department of Transportation	Caltrans
Employment Development Department	EDD
Franchise Tax Board	FTB
State Department of Education	SDE
State Water Resources Control Board	SWRCB

FEDERAL AGENCIES	
Internal Revenue Service	IRS
Department of Education	DOE
Department of Housing and Urban Development	HUD

Chart 2 shows the percentage of funds administered by state agencies in the current year (total of $747 million) that are provided for the major types of child care. As the chart indicates, 48 percent of these funds is used to support child care for low-income families, 17 percent provides support for child care expenses through tax benefit programs, 17 percent is targeted to particular groups of children (such as those who are disabled, abused and neglected, or the children of high school or college students), and 18 percent is used to support services related to child care (such as capital outlay, state administration of child care programs, and child care referral programs for parents.)

Chart 2

Child Care Funds Administered by State Agencies By Type of Program
1988-89

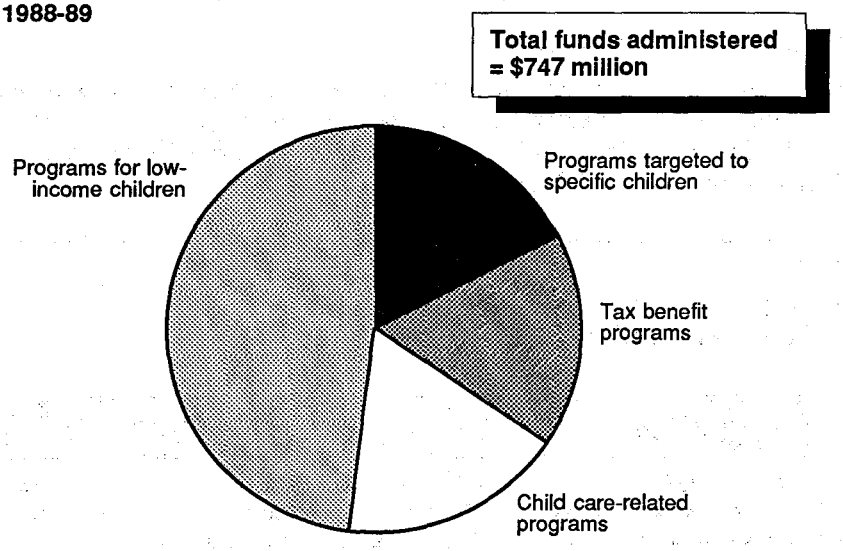


Table 2 lists all the state and federal child care programs operating in California that we were able to identify. The chart provides for each program summary information on eligibility requirements, caseloads, and current-year estimated costs. All the identified programs were funded at a total of $1.4 billion in the current year. The General Fund financed about $614 million (45 percent) of these expenditures and the federal government funded about $756 million (55 percent).

The table displays separately the expenditures of the federal government where the state plays no administrative or policy role. Generally, the programs provide child care and related services through grants or tax credits. While the Legislature cannot directly influence these programs, it may wish to take these expenditures into account when making decisions about the amount of state funds to provide for child care services.

Due to lack of available data, Table 2 excludes programs supported by one-time federal grants not allocated by state agencies, and programs provided through local governments, school districts, private nonprofit agencies and employers, *unless the programs are funded through the state and federal funds we identify.* For example, many school districts operate subsidized child care programs for school-age children. If a district's program is funded through the SDE, it is included in Table 2; if it is funded through general district revenues, it is not included.

Below we discuss in greater detail the two programs that provide the majority of state funding for child care.

Child Development Programs

The SDE administers nine programs which provide direct child care services and nine programs (including two one-time programs) which provide child care services indirectly. In 1988-89, the ongoing child development programs are budgeted at $337.0 million ($334.3 million from the General Fund and $2.7 million from federal funds). The major direct service programs serve families (including AFDC recipients) earning less than 84 percent of the state median income (adjusted for family size), in which both parents or the single parent is in the labor force. Other direct service programs are targeted at specific groups, such as abused and neglected children, migrant children, or the children of teenage parents. The indirect service programs primarily fund capital outlay, child care referrals to parents, training for providers, and special projects.

The direct service programs provided services, usually on a sliding fee scale, to approximately 110,000 children in 1985-86 (the last year for which detailed enrollment data are available). Almost two-thirds of these children were from families headed by single women. Most of the children served were aged 3 through 5 (61 percent), and 98 percent were under 11 years of age. Almost all children (93 percent) were enrolled in child care centers, which are usually licensed to care for more than 12 children.

Our review indicates that the 55,000 children from low-income working families served in 1985-86 through SDE child development programs represent anywhere from 12 percent to 26 percent of the demand for

Table 2

Programs in California That Provide Child Care and Related Services[a]

1988-89 (dollars in thousands)

PROGRAMS[b]	TARGET GROUP	ESTIMATED NUMBER OF CHILDREN SERVED 1988-89	ESTIMATED 1988-89 STATE	ESTIMATED 1988-89 FEDERAL	ESTIMATED 1988-89 TOTAL[c]	COMMENTS
PROGRAMS FOR LOW-INCOME CHILDREN						
General child care (SDE)	Standard[d]	52,453	$208,576	—	$208,576	
Child care for GAIN[e] participants (DSS)	Children of GAIN participants	—[f]	25,931	$4,027	29,958	
State Preschool (SDE)	Low-income, ages 3-5	21,241	35,529[g]	—	35,529[g]	Programs operate part-day only.
Alternative Payment (SDE)	Standard[d]	5,881	33,315	—	33,315	
Dependant Care Disregard (DSS)	Employed AFDC[h] recipients; primarily female heads of households	—[f]	9,794[i]	10,649[i]	20,443[i]	In effect, increases AFDC benefits for employed AFDC recipients with specified child care costs.
Extended day (Latchkey) care (SDE)	Standard[d], ages 5-14	14,953	16,111	—	16,111	Requires participation by nonsubsidized children.
Migrant child care (SDE)	Standard[d], migrant children	2,330	7,326	2,140	9,466	
Child care for employed GAIN participants/transitional child care (DSS)	Children of employed GAIN participants	—[f]	1,776	—	1,766	Provides 90 days of child care for GAIN participants beginning the day they become employed.
Child care for JTPA[j] participants (EDD)	Children of parents receiving training through JTPA	—[f]	—	—[f]	—[f]	Local Service Delivery Areas can spend up to 15 percent of their grants for child care and other support services for JTPA participants.
SUBTOTALS		(96,858)	($338,358)	($16,816)	($355,164)	
PROGRAMS TARGETED TO SPECIFIC CHILDREN						
PROGRAMS FOR CHILDREN OF COLLEGE STUDENTS:						
Child care centers (CSU)	Priority: low-income students, students, faculty and staff, public.	—[f]	$190	—	$190	Funding shown here is divided equally among the 18 campuses (of 19) with child care centers. Total licensed capacity in 1987-88 was 1,197 spaces.

Child care centers (CCC)	Primarily children of students	—[f]	—[f]	—	—[f]	An unknown amount of district funds support centers at 86 of the 106 campuses. Centers served 12,823 children in 1987-88.
Cooperative Agencies Resources for Education (CARE) (CCC)	Children of students on AFDC[h]. Priority: children under age 6.	—[f]	700	—	700	In 1988-89, 39 of the 106 campuses participated. About 50 percent of the total CARE funds support financial assistance for child care.
Campus children's centers (SDE)	Standard[d], primarily campus students	3,775	6,459	—	6,459	
Campus Child Care Tax Ballout (SDE)	Specified community college campus child care centers.	—[f]	4,191	—	4,191	
SUBTOTALS		(3,775)	($11,540)	(—)	($11,540)	
PROGRAMS FOR CHILDREN OF SCHOOL-AGED PARENTS:						
Vocational education—Carl Perkins funds Title II, part A, single-parent (SDE)	Children of school-aged parents	—[f]	—	$8,000	$8,000	50 percent of program funds targeted to low-income areas.
School-Age Parenting and Infant Development (SDE)	Parents enrolled in secondary school and their children	1,300	$6,941	—	6,941	
SUBTOTALS		(1,300)	($6,941)	($8,000)	($14,941)	
PROGRAMS FOR ABUSED AND NEGLECTED CHILDREN:						
Protective Services (SDE)	Abused, neglected or exploited children	2,307	$1,069	—	$1,069	These children also receive first priority for enrollment in other SDE child development programs.
Child Abuse Prevention Program (Ch 1398/82) (DSS)	Abused, neglected or at risk children and families regardless of income	—[f]	—[f]	—	—[f]	An unknown number of counties choose to provide child care as part of this program.
Out-Of-Home Respite Care (DSS)	Abused, neglected or at risk children	—[f]	—[f]	—	—[f]	Respite care is an allowable service in the Child Welfare Services program; an unknown number of counties provide such care.
SUBTOTALS		(2,307)	($1,069)	(—)	($1,069)	

PROGRAMS[b]	TARGET GROUP	ESTIMATED NUMBER OF CHILDREN SERVED 1988-89	ESTIMATED 1988-89 STATE	FEDERAL	TOTAL[c]	COMMENTS
PROGRAMS FOR DISABLED CHILDREN:						
Preschool and infant development (DDS)	Infants 0-36 months (1) identified by regional center as at risk or developmentally disabled and (2) required to receive services in their IDPs[k]	—[f]	$4,200	—	$4,200	5,800 children are eligible.
Day care, recreation and other development programs (DDS)	Regional center clients required to receive such services in their IDPs[k]	—[f]	300	—	300	Estimate based on percentage of children under age 14. 24,000 children are eligible.
Respite (DDS)	Regional center clients required to receive such services in their IDPs[k]	—[f]	1,300	—	1,300	Estimate based on percentage of children under age 14. 24,000 children are eligible.
Severely Handicapped (SDE)	Disabled children in the San Francisco Bay area	197	740	—	740	An additional number of disabled children are served in other SDE-administered child development programs.
Special education infant/preschool program (SDE)	Handicapped children ages 0-5	15,000	81,000	$13,000	94,000	Excludes funds for individual instruction and other designated services.
SUBTOTALS		(15,197)	($87,540)	($13,000)	($100,540)	
PROGRAMS THAT GIVE PRIORITY TO CHILDREN OF STATE EMPLOYEES:						
State Employee Child Care Program (DPA)	Children of state employees	—[f]	$350	—	$350	Provides grants to state employee groups to develop child care services.
Child care center—Sacramento (FTB)	Preschool aged children; Priority given to children of FTB employees	60	36	—	36	Funding covers the program's fixed costs, such as rent.
State developmental centers (SCDs) on-site child care (DDS)	Children of state employees and community members	380	—[f]	—	—[f]	Five of the seven SDCs have child care centers. SDCs may subsidize centers in exchange for priority or reduced-rate child care services for SDC employees.
Child care center—Sacramento (DMV)	Ages 2-6, open to state employees and the public in the Sacramento area. Priority: (1) DMV employees, (2) state employees, and (3) the public.	54	88	—	88	The DMV center building is state-owned; thus, no funds are spent on rent. Budget includes a maintenance and rent subsidy.

DOT TOT child day care center—Sacramento (Caltrans)	Ages infant-5; open to Caltrans staff and other state employees in the Sacramento area. Priority: (1) Caltrans; (2) state employees.	60	—[f]	—	—[f]	The benefit to the state in terms of increased employee productivity is considered when determining the center's rent.
Child care center—Sacramento (SWRCB)	Priority given to children of state employees	60	14	—	14	Center is located in a state building and pays rent to the state at a subsidized rate.
Child care center—Vacaville (CDC)	Priority given to children of CDC employees	—[f]	—[f]	—	—[f]	Center is located at a correctional facility. Subsidized rent of $1 per year charged.
SUBTOTALS		(614)	($488)	(—)	($488)	
PROGRAMS THAT PROVIDE OTHER CHILD CARE SERVICES:						
Centerforce Inmate Visitation Program (CDC)	Children of inmates	—[f]	$79	—	$79	Provides child care while spouses visit inmates. Funds will pay for 23,808 service contacts (defined as one child care meeting regardless of length) in 1988-89.
School desegregation—child care component (SDE)	Children enrolled in specified school desegregation programs	360	510[l]	—	510[l]	Child care provided as an incentive for minority and white families to participate in desegragation plans at targeted schools.
SUBTOTALS		(360)	($589)	(—)	($589)	
TAX BENEFIT PROGRAMS						
Tax credit for child and dependent care (FTB)	Tax-filers claiming child care expenses	950,000[m]	$121,000	—	$121,000	Allows taxpayers to deduct a portion of their child care expenses from their taxable income.
Dependent care assistance program (FTB)	Employees of participating employers	—[f]	8,000	—	8,000	Authorizes employees to place up to $5,000 of their pre-tax income in a child care expense fund.
SUBTOTALS		(950,000)	($129,000)	(—)	($129,000)	
CHILD CARE RELATED PROGRAMS						
PROGRAMS FOR CAPITAL OUTLAY:						
Child care capital outlay (SDE)	Subsidized child care programs	—	—	$19,700	$19,700	Established by Ch 1140/85 and Ch 1026/85 for portable facilities and loans. One-time funds totalled $44 million. Remaining amount will be allocated in 1988-89.

PROGRAMS[b]	TARGET GROUP	ESTIMATED NUMBER OF CHILDREN SERVED 1988-89	ESTIMATED 1988-89 STATE	FEDERAL	TOTAL[c]	COMMENTS
Child care centers capital outlay (CCC)	Community college child care programs	—	110	—	110	One-time equipment funds for a new child care center at Mendocino Community College.
SUBTOTALS		(—)	($110)	($19,700)	($19,810)	
OTHER RELATED PROGRAMS:						
Resource and Referral (SDE)	Parents, regardless of income	—	$7,636	—	$7,636	Provides child care referrals and information to parents and child care providers.
Preschool Scholarship Incentive Program (SDE)	Prospective preschool teachers	—	288	—	288	Provides Early Childhood Education scholarships to those working in the SDE-administered child development programs.
Special projects (carryover) (SDE)	Providers of child care and related services	—	3,895	—	3,895	Funds allocated but not spent in previous years (carryover funds) are used for special projects and child care.
California Child Care Initiative (SDE)	Potential child care providers	—	250	—	250	Primarily funds recruitment and training of new child care providers. Private funds also provide $1 million.
Before and after school program incentives (SDE)	Potential providers of school-age child care	—	—	$336	336	One-time start-up grants.
School age child care (SDE)	Potential providers of school-age child care	—	—	259	259	One-time start-up grants.
Self-care projects (DSS)	Latchkey children, regardless of income	—[n]	253	—	253	Three projects, each with a phone hot-line system, provide training on after-school self-care.
State administration of child development programs (SDE)	Providers of SDE-administered child development programs	—	4,607	—	4,607	Funds used to administer and monitor child development programs serving about 110,000 children.
State administration of child care licensing (DSS)	All licensed child care facilities	—	15,576	—	15,576	Funds are used to license and monitor child care providers. Total licensed capacity of providers is 746,864 in 1988-89.
Special allowance for rent (SDE)	Certain subsidized child care programs	—	441	—	441	Provides rent subsidies.

Community Development Block Grant—Small Cities (HCD)	Low-income families	—[f]	—	68	68	Can be used for operating expenses and capital outlay.
Child Care Food Program (SDE)	Low-income children in preschool and child care programs	—[f]	5,100	74,970	80,070	Provides subsidies for meals and snacks.
Subtotals		(—)	($38,046)	($75,633)	($113,679)	
PROGRAMS FUNDED AND ADMINISTERED BY THE FEDERAL GOVERNMENT						
Tax credit for child and dependant care (IRS)	Tax-filers claiming child care expenses	—[o]	—	$500,000[p]	$500,000[p]	Allows taxpayers to deduct a portion of their child care expenses from their taxable income.
Head Start (DOE)	Low-income, ages 3-5	34,000	—	98,200	98,200	Part-day only.
Dependant care assistance program (IRS)	Employees of participating employers	—[f]	—	25,000[q]	25,000[q]	Authorizes employees to place up to $5,000 of their pre-tax income in a child care expense fund.
Community Development Block Grant—Entitlement Program (HUD)	Low-income families	—[f]	—	—[f]	—[f]	Funds (probably less than $9 million) are generally used for capital outlay.
SUBTOTALS		(34,000)	(—)	($623,200)	($623,200)	
TOTALS		1,104,411	$613,681	$756,349	$1,370,020	

[a] This table does not provide an unduplicated count of services provided because such information is not available. The table most likely underestimates the total amount of state resources provided for child care services, because data are generally not available on the extent to which state agencies, institutions of higher education, and school districts provide in-kind resources (such as facility space and administrative services) for child care programs. The table also underestimates the total amount of resources used to care for the children identified because such information is not available. Specifically, most programs charge parent fees and some programs may receive funding from other sources.

[b] Agency acronyms were identified previously in Chart 1. The programs provide direct child care services unless noted otherwise.

[c] Details may not add to totals due to rounding.

[d] Children served must meet at least one standard eligibility criterion and one standard need criterion as follows: Eligibility: (1) child is actually or potentially abused, neglected, exploited, or homeless; (2) the family receives public assistance; or (3) income is not greater than 84 percent of state median income, based on family size. Need: (1) parents are employed, seeking employment, or in training; (2) parents or child have a medical or psychiatric special need and need child care; or (3) the child is actually or potentially abused, neglected, exploited or homeless.

[e] GAIN: Greater Avenues for Independence.

[f] Figures not available.

[g] The State Preschool and Preschool Scholarship Incentive programs are not budgeted separately. Separate funding estimates are based on SDE information.

[h] AFDC: Aid to Families with Dependent Children.

[i] Does not include GAIN or the effects of federal welfare reform.

[j] JTPA: Job Training Partnership Act.

[k] An Individual Development Plan (IDP) is developed for all regional center clients to determine their individual service needs.

[l] The state expenditure is an estimate of the portion of the budgets for Los Angeles and San Diego programs which is reimbursed by the state.

[m] Estimated number of children served assumes one child per filer.

[n] Although the number of children served is currently unknown, estimates will be contained in the DSS forthcoming report, "Year Two Report on Effectiveness and Cost Effectiveness of AB 1562."

[o] The estimated number of children served was reflected previously for the state tax credit; it is not included here to avoid a known duplication.

[p] Estimate for federal tax credit revenue loss derived by multiplying the U.S. Congressional Joint Committee on Taxation estimate for national revenue loss ($4 billion), by 12.5 percent, an estimate of the proportion of the credits claimed by Californians.

[q] Estimate for federal dependent care revenue loss derived by multiplying the U.S. Congressional Committee on Taxation estimate for national revenue loss ($200 million), by 12.5 percent, an estimate of the proportion of the exclusion which relates to California taxpayers.

subsidized care. Thus, the potential unmet demand for subsidized care for low-income working families in that year ranged from about 155,000 to 405,000 children. Our estimate assumes *current subsidy rates and eligibility standards* and includes adjustments to reflect the fact that many families would use informal child care arrangements (such as care by relatives) even if subsidized care were available. (The effect of these adjustments *may* be to understate the potential "unmet demand" for these programs. We discuss this issue in greater detail in our report, *The Child Development Program: A Sunset Review*, Report No. 89-5, February 1989).

It is not possible to estimate *total* demand for subsidized child care, because data are not available on the demand for child care for specific groups, such as abused and neglected children and the children of high school students.

Child Care Tax Credit

The Franchise Tax Board (FTB) estimates that the tax credit for child and dependent care expenses will result in General Fund revenue losses of about $121 million in 1988-89. This tax credit allows taxpayers to claim a tax credit for a portion of the "out-of-pocket" expenses they incur in providing care for their children, and for certain other dependents who are disabled. The credit may only be claimed by persons who incur the eligible expenses because they are working or looking for work. Child care costs are eligible for the credit whether or not the child care provider receiving payments is licensed. The credit is nonrefundable, and unused credit amounts may not be carried forward into succeeding tax years.

The allowable *state* credit amount equals 30 percent of the taxpayer's corresponding *federal* child care credit. The current federal credit ranges from 20 percent to 30 percent of qualifying expenses, depending on a taxpayer's adjusted gross income (AGI). The federal credit is equal to 30 percent of qualifying expenses for taxpayers with AGIs of $10,000 or less. The credit amount is then reduced by one percentage point for each $2,000 of AGI income over $10,000, until it decreases to 20 percent for taxpayers with AGIs greater than $28,000. The maximum amount of qualifying expenses to which the federal credit may be applied is $2,400 if one qualifying child is involved, and $4,800 if two or more children are eligible.

Thus, the maximum federal credit ranges from $480 to $720 annually for taxpayers with one eligible child, and from $960 to $1,440 for taxpayers with two or more eligible children. The corresponding maximum state credit is equal to 30 percent of these amounts, or $144 to $216 for one child, and $288 to $432 for two or more children. However, California's

tax rate structure is designed so that taxpayers with AGIs low enough to generate the maximum credit amounts generally do *not* have a large enough tax liability to realize the full benefit of the credit. As a result, the effective maximum credit a taxpayer with one child can receive is generally $166, while the effective maximum credit for taxpayers with two or more children is generally $302.

As mentioned, the child care tax credit program provides tax relief to individuals who obtain child care services in order to be able to work or look for jobs. By partially tying the amount of the credit to the taxpayer's AGI, both state and federal law attempt to provide greater tax relief to low-income taxpayers. In addition to providing tax relief, the credit also generally provides an incentive for increased labor force participation by increasing the potential after-tax incomes of eligible taxpayers. At the same time, the tax credit has a structural bias against married couples with one earner, as the program provides no benefits to a parent who elects to stay at home with his or her children.

In the next section, we discuss the Legislature's options for better targeting funds provided through these two child care programs.

POLICY OPTIONS FOR THE LEGISLATURE

The Legislature has several options both for better targeting existing state funds to those most in need of affordable child care and for expanding child care programs to meet more demand. In general, these options involve policy—rather than analytical—decisions about the state's role in providing various types of child care. Thus, we have no analytical basis for making recommendations on *most* of these issues. Rather, we point out the potential trade-offs that exist within the various options.

In the discussion which follows, we limit our review to areas in which data are available to illustrate the possible trade-offs that would occur if various policies were adopted. Specifically, we discuss the following options for the SDE-administered Child Development program:

- Modify existing staff to children ratios;
- Change the mix of programs currently provided; and
- Raise family fee levels.

We also discuss the following options for the FTB-administered tax credit program:

- Phase out or reduce the credit for families with higher incomes;
- Make the credit refundable; or
- Repeal the credit.

Generally, the options discussed below are not mutually exclusive. Thus, the Legislature may consider adopting more than one of the policies we review.

Modify Existing Staff to Children Ratios for Preschool-Aged Children in Child Development Programs

We recommend the enactment of legislation to phase in a change in staff to child ratios for preschool-aged children served through subsidized child development programs from 1:8 to 1:10, on an enrollment basis. A 1:10 ratio would maintain high-quality programs while still providing a richer staff to child ratio than that required by the Department of Social Services for nonsubsidized child care programs. This change would result in annual savings of up to $19 million, which could be used to serve up to 4,300 additional children.

Most subsidized child development programs must maintain higher adult to child ratios than nonsubsidized programs. For example, nonsubsidized programs are required by DSS licensing standards to place one adult in charge of no more than 12 preschoolers, for a 1:12 staff ratio. The SDE, however, requires that subsidized programs meet a 1:8 staff ratio for this age group.

Historically, subsidized programs have been required to meet higher staff ratio requirements because they serve low-income children and children with special needs, such as abused and neglected children. Based on the results of the comprehensive National Day Care Study, however, we find that current staff ratios for preschool children enrolled in subsidized care could be liberalized, while still maintaining high-quality programs. The higher ratio would still be richer than the ratio required by the DSS for nonsubsidized child care programs. Further, the 1:10 ratio would equal or be stricter than those used in 44 of the other 49 states. (This issue is discussed in much greater detail in our recently issued report, *The Child Development Program: A Sunset Review.*)

Recommendation. Accordingly, we recommend the enactment of legislation to change staff ratios for children aged 3 to 5 from 1:8 to 1:10, on an enrollment basis. We further recommend that (1) the staff ratio change be phased in, to allow child care providers to adjust to the changes through normal staff attrition or reassignment and (2) the SDE be required to capture the savings resulting from implementation of the new staff ratios. We estimate that full implementation of this recommendation would result in General Fund savings of up to $19 million annually, which could be used to serve up to 4,300 additional children.

Target Savings to Specific Areas. Historically, the Legislature has almost always acted to use savings in subsidized child care programs to provide additional child care services (rather than have the monies revert to the General Fund). In addition, the Legislature most recently has required certain child care funds to be distributed to each of the state's counties based on need. *To the extent the Legislature wishes to maintain these practices,* we recommend that it give priority to allocating

the savings (of up to $19 million annually from the General Fund) available through modification of existing staff ratios for subsidized child care programs to counties that are relatively underserved by child development funds.

Change the Mix of Child Development Programs Currently Provided

Another option for the Legislature is to change the relative funding amounts provided to two existing child development programs administered by the SDE. These programs—the Alternative Payment (AP) program and the General Child Care program—serve primarily the children of low-income parents who are working or receiving job training. The programs are somewhat different in structure, cost, and program content.

In the current year, the AP program is budgeted $33.3 million and the General Child Care program is budgeted $208.6 million. In 1985-86, the AP program provided services to approximately 8,500 children and the General Child Care program served approximately 52,000 children.

The Alternative Payment Program. The AP program allows each parent to choose the type of child care to be provided, as long as it is either licensed or license-exempt. The program then reimburses the child care program selected by the parent. (Thus, it is often referred to as a "vendor-voucher" program.) The local AP agencies determine each child's eligibility, refer the parents to available child care spaces, and provide social services to parents and children as needed. An existing supply of licensed and/or license-exempt child care is necessary in order for an AP program to be effective, since the program does not create new child care spaces directly.

In 1987-88, it cost approximately $4,000 to serve one child for a year in the AP program. Of this amount, approximately $1,000 (or 25 percent) went to AP agencies, and about $3,000 (or 75 percent) went directly to child care providers.

The child care providers reimbursed through the AP program that are not license-exempt must have staff to children ratios of at least 1:12. While this is the minimum staff ratio that providers must meet, there are no data available on the *average* standards met by providers.

The General Child Care Program. The General Child Care program provides services to children directly, primarily in child care centers (which are generally licensed for more than 12 children). Typically, the SDE contracts with each center to provide child care for a specified number of children.

The centers funded through the program are required to meet the SDE's standards. Thus, for preschool-aged children, the centers must

have staff to children ratios of at least 1:8 and must use teachers that have completed roughly a two-year college degree course in Early Childhood Education. Finally, the centers are subject to the SDE's periodic quality review process, which assesses the extent to which they provide developmentally appropriate and high-quality care to children.

In 1987-88, it cost approximately $4,850 to serve one child for a year in the General Child Care program. Of this amount, about $250 to $750 (5 percent to 15 percent) was used to pay for administrative costs and the remainder—$4,100 to $4,600 (85 percent to 95 percent)—was used to provide direct child care services.

Conclusion. Currently, the AP program is less costly (by about $850 per year for each child served) than the General Child Care program. There are no data comparing the average quality levels of each type of program.

Given existing cost differences between the programs, approximately 440 additional children could be served each year for every $10 million that was shifted from General Child Care to the AP program. (If the Legislature first adopted our previous recommendation to modify staff to children ratios for children aged 3 through 5 and then shifted monies to the AP program, the number of additional preschool-aged children that would be served would be lower—about 190. This is because about half of the current price difference between General Child Care and the AP program for this age group is attributable to the costs of maintaining different staff ratios.)

Based on our discussions with the SDE, we find that there are many areas of the state where either the AP program or the General Child Care program could operate effectively. In some instances, however, one program or the other may better meet the needs of particular areas. For example, the AP program may be particularly suited to some rural areas, where the number of children eligible for subsidized care might be too low to support the General Child Care program, which generally provides funding for several children in one child care center. On the other hand, the General Child Care program may be more appropriate in areas where it is sometimes difficult for AP programs to operate—that is, in some urban low-income areas that do not have much existing licensed or license-exempt child care.

Raise Family Fee Levels for Child Development Programs

Currently, most families served through the Child Development program are required to pay fees on a sliding fee schedule. The SDE indicates that approximately $10 million in fees are collected each year. Many families pay no fees, usually because (1) their incomes are below 50 percent of the state median income (the income level at which families

begin to pay fees), or (2) their children are enrolled in programs that do not charge any fees (such as the State Preschool program). The SDE requires that family fees be used primarily to provide additional children with subsidized child care services.

There are several options for raising family fees that the Legislature may wish to consider (each $1 million raised could be used to serve up to 230 additional children):

- ***Increase fees for all families by some flat amount,*** such as 10 percent or 15 percent. Each 10 percent general fee increase would yield approximately $1 million annually in additional revenues.
- ***Raise fees for families that earn higher incomes,*** such as those who earn at least 70 percent or 80 percent of the statewide median income. Unfortunately, the SDE does not collect information that is detailed enough to determine the amount that would be raised by selectively increasing fees.
- ***Charge a minimum fee for each child.*** Currently, families that earn less than 50 percent of the statewide median income ($12,599 for a family of three in the current year) are not charged any fees. The SDE estimates that there were *at a minimum* 19,500 children from such families enrolled in subsidized child care in 1985-86. Based on enrollment levels in that year, charging the current minimum fee level (about $120 per year or $10 per month) for these children would yield at least $2.3 million in additional fee revenues.
- ***Charge fees for children enrolled in the programs that do not currently require fee payments.*** Several child development programs are free to all participants. These programs are: State Preschool, the School-Age Parenting and Infant Development (SAPID) program (which serves the children of high school students), the Severely Handicapped program, and the Protective Services program (which primarily serves abused or neglected children). In 1985-86, approximately 25,000 children were enrolled in these programs. Assuming that at least one-half of the children came from families with incomes high enough to pay the minimum fee, charging the current minimum fee level for children enrolled in these programs would yield at least $1.5 million in additional revenues.
- ***Charge fees for siblings.*** Currently, families with more than one child enrolled in a subsidized child development program pay a fee only for one child. According to the SDE, there were approximately 17,360 children with at least one brother or sister also enrolled in subsidized care in 1985-86. Approximately 7,000 of these children would have been required to pay fees in that year (because their family incomes were sufficiently high), if they had not been exempt because they were the siblings of other enrolled children. Based on 1985-86 sibling enrollment levels, charging the current minimum fee

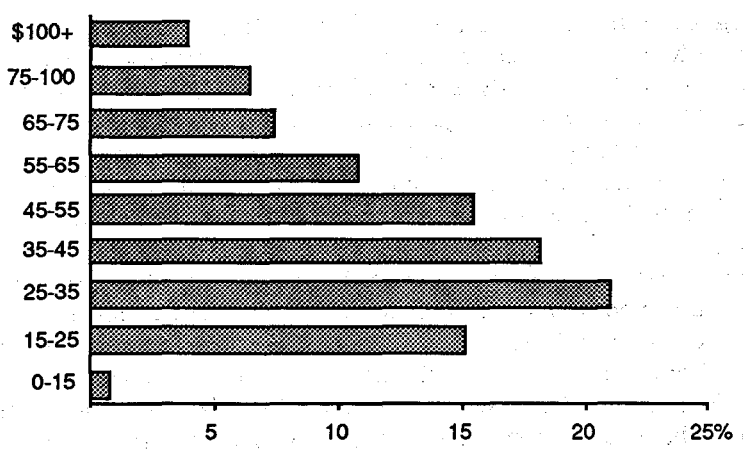
level for each sibling would yield approximately $840,000 in additional fee revenues. Charging fees at levels higher than the current minimum fee level would, of course, generate additional revenues to the extent that siblings remain enrolled in subsidized programs.

All of these options would increase the *total* number of children served in child development programs (assuming the additional fee revenues were used to expand the existing program). However, because some families might not be able to afford to pay higher fees, the options also could result in some *currently served* children dropping out of the program.

Change the Tax Credit for Child and Dependent Care Expenses

Who Is Using California's Child Care Credit? According to preliminary data from the FTB, taxpayers claimed nearly $110 million in child and dependent care credits for 1987. The board estimates that this revenue loss will increase to $121 million in the current year and $133 million by 1989-90. Chart 3 illustrates the percentage distribution of 1987 child care credits by taxpayer AGI. As the chart demonstrates, approximately 84 percent of these credit amounts benefited taxpayers with AGIs greater than $25,000, while less than 1 percent of the credits benefited taxpayers with AGIs less than $15,000.

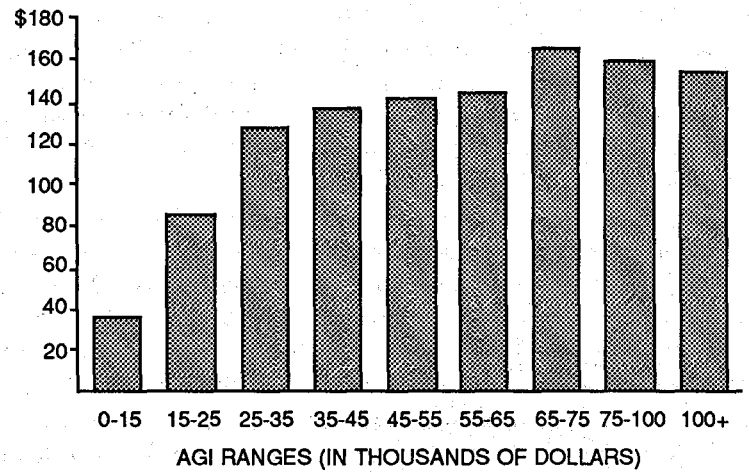
Chart 3
1987 State Child Care Credit Distribution By Adjusted Gross Income Range
(dollars in thousands)



The average credit amount used by taxpayers in different income ranges is displayed in Chart 4. The chart illustrates that the average credit amount used by taxpayers tends to increase with income, despite the provisions of the credit which decrease the maximum allowable credit as income rises. For example, the average credit for taxpayers with AGIs of $15,000 to $25,000 is $87, while the average credit for taxpayers in the $65,000 to $75,000 AGI range is $166. This is primarily the result of: (1) the tendency for taxpayer expenditures on child care services to increase with income and (2) the limited ability of taxpayers in lower income ranges to make use of their available credits (for instance, taxpayers with AGIs less than $16,000 essentially receive no benefit from this program because they generally do not have a tax liability to claim the credit against.)

Chart 4

Average 1987 Child Care Credit Per Taxpayer By Adjusted Gross Income (AGI) Range



Is the Child Care Credit "Targeted" Appropriately? The child care credit provides tax relief to taxpayers who use child care services because they are working or looking for work. However, *over half the tax benefits provided by this program are used by taxpayers with AGIs greater than $40,000 (which corresponds roughly to 120 percent of the statewide median income). In addition, the average benefit provided by this program is greatest for taxpayers with AGIs greater than $65,000 (which*

is roughly equal to 180 percent of the statewide median income). As Table 1 (shown earlier) suggests, many of these taxpayers can afford child care without state subsidies.

This distribution of credit resources may not be consistent with the Legislature's policy intentions. Currently, the state's credit program is tied directly to the federal child care credit. The federal credit program provides, over a limited income range, that the maximum allowable credit decreases as income rises. Tying the state credit to a program structured in this way suggests that legislative intent is *not* to provide a tax relief program where the average benefit level provided tends to increase with income.

Accordingly, the Legislature may wish to consider three basic options for modifying this General Fund program. These options are (1) phase out the credit over a specified income range, (2) make the credit refundable, or (3) repeal the credit.

Phase Out the Credit. Phasing out the credit could enable the Legislature to direct this program's resources towards a taxpayer group with lower average income. For instance, if the child care credit were phased out for taxpayers with AGIs of $35,000 (which roughly corresponds with the state's median income) to $45,000, the state would realize annual revenue gains of approximately $60 million. These additional revenues could be used to finance new or existing direct expenditure child care programs, to increase the credit amount for taxpayers below the specified phase out level, or to fund other direct expenditure programs of higher legislative priority.

However, phasing out the credit will leave the basic structure of this program intact. As has been discussed, the basic structure of the credit limits the program's ability to assist low-income individuals. Low-income taxpayers can only receive assistance from this program to the extent they generate a tax liability. As noted above, taxpayers with AGIs less than approximately $16,000 receive no benefit from the credit.

Make the Credit Refundable. Alternatively, the provisions of the program could be altered to make the tax credit refundable. Allowing a refundable child care credit would provide assistance to taxpayers in lower AGI ranges, regardless of their income tax liability. The FTB estimates that making the current child care credit refundable would require an appropriation in the range of $8 million annually. It should be noted that any appropriation made for credit refunds would be subject to the state's constitutional appropriations limit.

However, even making the credit refundable does not eliminate potential "cash flow" problems for low-income individuals. For taxpayers with minimal monthly cash resources, an annual refund related to

monthly child care expenses which have *already been incurred* may be of little assistance. These taxpayers simply may be unable to afford the "up front" costs of child care, while awaiting annual reimbursement for a portion of these expenses. In addition, making the credit refundable creates certain compliance problems for the FTB, and thus would require additional FTB enforcement expenditures.

Repeal the Credit. The current distribution of benefits provided by the child care credit is skewed significantly toward taxpayers with AGIs above the state median. As described above, the option of phasing out the credit has significant limitations in its ability to effectively shift this benefit distribution towards low-income individuals. Moreover, making the credit refundable enhances the program's capacity to assist lower-income taxpayers, but it also has certain inefficiencies in addressing the problems of these taxpayers. Therefore, the most efficient policy option for the Legislature may be to repeal the child care tax credit program and devote the resources generated to direct expenditure programs.

For example, the revenues generated by repeal could be dedicated to SDE's Child Development program or to increasing the number of months of transitional child care provided to GAIN participants. Devoting these resources to existing direct expenditure programs could improve significantly the targeting of these General Fund resources, minimize concerns regarding the cash resources of low-income individuals, and take advantage of program administration efforts which are already in place. Again, however, converting the tax credit to a direct expenditure could involve a significant increase in expenditures which are subject to the state's constitutional appropriations limit.

Summary

Many families in which both parents (or the single parent) work—particularly those earning less than 84 percent of the state median income—cannot afford to purchase licensed child care at market rates. While the state subsidizes care for a significant portion of these low-income families, a large unserved population remains. Our review of the state's two primary child care programs indicates that the Legislature has several options for modifying both programs to (1) better target state funds to those most in need of affordable child care and (2) expand child care programs to meet demand.

Substance-Exposed Infants

What Are the Problems Associated with Pregnant Women Abusing Alcohol and Drugs? What Options Are Available to the Legislature for Addressing Them?

Summary

- *Maternal substance abuse results in a variety of different direct and indirect medical and social problems, including low birthweight, prematurity, congenital deformities, and risk of child abuse.*
- *There are no comprehensive data on the prevalence of infant substance exposure, but it appears to be a significant and increasing proportion of all births.*
- *Infant substance exposure appears to result in high costs to a number of state and local programs, including Medi-Cal, child welfare services, developmental programs, and special education programs.*
- *There are a number of issues raised by the current configuration of services: (1) resources are concentrated on addressing the results of the problem rather than preventing it, (2) there are limited drug treatment slots available to pregnant women, (3) programs fail to provide outreach or consistent methods of identification and case management, (4) licensing requirements make it difficult to place certain substance-exposed children in foster care, and (5) substance abuse reporting requirements by health care providers are unclear.*
- *To help the Legislature address these concerns, we make several recommendations on how to improve existing services to substance-abusing pregnant women and substance-exposed children. In general, we recommend that the Legislature give priority to options that prevent maternal substance abuse and its effects.*

There have been many reports from medical and social service providers and others regarding the increasing numbers of women who abuse alcohol and drugs during their pregnancies and the problems that result with their substance-exposed infants. The reports indicate that these women and their babies are placing burdens on existing services and resulting in long-term costs to society.

In this analysis, we outline (1) what we know about pregnant substance abusers and their infants, (2) how available state programs serve them, (3) issues raised by the existing service system, and (4) options available to the Legislature for better serving these populations.

In preparing this analysis, we found no statewide consistent data on either substance-abusing pregnant women or substance-exposed infants. To better understand the prevalence of, and the problems related to,

substance abuse during pregnancy, we visited a number of counties and local providers. As a result, our analysis relies on county- or hospital-specific data and anecdotal reports from service providers.

BACKGROUND

Maternal Substance Abuse Causes Harm to Infants

When women use alcohol or illicit drugs while they are pregnant (or breast-feeding), their infants may develop a variety of short- and long-term medical, developmental, and behavioral problems. The short-term problems include prematurity, low birthweight, strokes, irritability, and withdrawal symptoms. The longer-term problems include mental retardation, congenital disorders and deformities, growth retardation, hyperactivity, poor motor coordination, and speech and language difficulties. In addition, substance-exposed infants are at significantly increased risk of dying from Sudden Infant Death Syndrome and AIDS. The specific effect of the exposure on the infant depends on a variety of factors, including: what kind of substance the woman used, when during her pregnancy she used it, and how much—if any—prenatal care she received.

These medical and developmental problems may result directly from exposure to the substance or may be indirectly related. For example, many substance-abusing women receive insufficient prenatal care and have poor nutrition. These factors contribute to prematurity. In addition, a woman's intravenous (IV) drug use may lead to infection with HIV (the virus that causes AIDS), which in turn can be passed on to the infant.

A woman's substance abuse can result in social problems for infants, as well as medical and developmental problems. Specifically, data on substance-exposed children who are enrolled in regional center prevention programs funded by the Department of Developmental Services (DDS) indicate that substance-exposed infants frequently have psychological and social problems, including poor attachment with a parent and family histories of abuse or neglect.

In some cases, the medical problems may result in social problems. For example, a substance-exposed infant's medical problems may make the infant extremely irritable and difficult to care for. This, in turn, may lead to poor attachment, abuse, or neglect.

Prevalence of Substance Exposure Among Infants

There are no comprehensive data available on the prevalence of substance exposure among infants. However, the Department of Health Services (DHS) and the Department of Alcohol and Drug Programs (DADP) estimate the prevalence of substance exposure as follows:

- ***Drugs.*** The DHS estimates that 2 percent to 5 percent of all newborn infants—or between 10,000 and 25,000 in California in 1987-88—are exposed to illicit drugs. In August 1988, the DHS estimated that an average of 13 percent of all infants admitted to neonatal intensive care units statewide were drug-exposed.
- ***Alcohol.*** The DADP estimates that approximately 4,500 infants are born annually in California with either Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE), medical and developmental conditions that are directly related to alcohol abuse. FAS and FAE occur in as many as 69 percent of infants born to mothers who were heavy drinkers during pregnancy.

There are at least three reasons why these prevalence estimates may be low. First, hospitals may be underreporting the number of drug-exposed infants because they do not universally screen all mothers and all infants. For example, when the University of California Davis (UCD) Medical Center tested only those women in labor it believed were at high risk for drug abuse, it reported that 11 percent of the women tested had positive drug screens. Once the center initiated *universal* screening, the level jumped to 22 percent.

Second, hospitals rarely test for alcohol abuse. They generally rely on the infant's physical appearance as an indication that the mother has been using alcohol. Thus, only the most severe cases of exposure, the ones that result in FAS or FAE, come to the attention of hospital personnel.

Third, because available data on infant substance exposure tends to be limited to those infants requiring special care, it does not reflect the number of infants born to substance-abusing mothers who did not come to the attention of medical authorities through their care in neonatal intensive care units (NICUs) or elsewhere. Research suggests that even though these infants may appear normal at birth, they may be developmentally delayed and may require special education or other services in later years.

The Prevalence of Substance Exposure Among Infants Appears to be Increasing

Without comprehensive data on substance exposure among infants, it is impossible to provide a complete picture of the problem. However, some county health facilities and child welfare programs have maintained data which show that the prevalence of substance exposure is increasing. To some degree, these data may reflect a growing awareness of the problem by health care providers, as well as increasing prevalence.

Data from Health Facilities. Some county hospitals have documented increases in the prevalence of substance abuse among pregnant women and substance exposure among infants whom they serve. For example:

- Harbor-UCLA Medical Center reports that it found cocaine intoxication among 6 of every 10,000 live births in 1983 compared with 231 of every 10,000 live births in 1987.
- Alameda County's Highland Hospital reports that among mothers delivering at the facility, the proportion that admitted to drug use during pregnancy jumped from between 2 percent and 3 percent in 1985 to 12 percent in 1987.
- San Francisco General Hospital reports that the number of substance-exposed infants delivered at its facility jumped from 50 in 1983 to 240 during 1987.

Data from County Child Welfare Services Programs. The following data reflect the extent to which substance-exposed infants and children constitute an increasing proportion of children referred to county Child Welfare Services (CWS) programs due to a suspicion of abuse and neglect:

- Los Angeles County Health Department's Child Abuse Prevention program reports that the number of neonatal withdrawal incidents reported to it as suspected abuse increased from 538 in 1985 to 1,335 in 1987, an increase of 148 percent over two years.
- CWS programs in San Francisco, Sacramento, and Orange Counties report significant increases in the number of substance-exposed infants taken into protective custody. Most dramatically, Sacramento County reports that between the first calendar quarter of 1987 and the first calendar quarter of 1988, the number of substance-exposed infants taken into protective custody increased from 35 per month to 115 per month.

Data on Foster Care Placements. The Department of Social Services (DSS) does not collect data on the number of substance-exposed infants who are placed in foster care. However, the Orange County Social Services Agency estimates that approximately one-fifth of the children in its foster care program were substance-exposed as infants. Each of the three counties we spoke with—Sacramento, San Francisco, and Orange—indicated that substance-exposed children constitute an increasing proportion of those who are placed in foster care.

WHAT IS THE IMPACT OF MATERNAL SUBSTANCE ABUSE ON STATE AND LOCAL SERVICES?

Substance abuse among pregnant women and substance exposure among infants have a significant impact on a number of state programs. The largest impacts in terms of costs are probably on health care services (Medi-Cal, California Children's Services, and county health services), child welfare services, developmental services, and special education

programs. While there are limited data on the fiscal effect on these programs, we summarize the available information below.

Impact on Health Care Services

The Medi-Cal, California Children's Services (CCS), and county health services programs pay for health care services to pregnant substance abusers and their infants. Medi-Cal pays for a wide variety of medical care services for low-income persons, including those medical services needed by pregnant women and their infants. The CCS program pays for medical treatment and therapy services needed by children with specified medical conditions. County health services programs pay for public health and medical care services, including medical care provided to persons who are not eligible for other state programs.

Hospital Services for Women. Because substance-abusing pregnant women are reluctant to seek services during their pregnancies, they more frequently show up in emergency rooms to deliver their babies having had little or no prenatal care. This makes a woman's delivery far more risky and thus more difficult and expensive for the hospital she chooses for her delivery and subsequent care. The higher costs that may result from these deliveries may be borne by Medi-Cal, CCS, or counties. Table 1 shows data from four hospitals, which indicate that in all four facilities, substance-abusing women were at least twice as likely to receive insufficient prenatal care than all women delivering in those facilities.

Table 1
Pregnant Substance Abusers Avoid Seeking Prenatal Care
Percentage of Women Delivering with Insufficient or No Prenatal Care in 1987

Hospital	*Substance-Abusing Women*	*All Women*
Highland Hospital (Alameda County)	60%	37%
Martin Luther King–Drew Medical Center (Los Angeles County)	90	33
UCD Medical Center (Sacramento County)	60	23
San Francisco General Hospital	55	12

Health Care Costs for Infants. Women who receive little or no prenatal care are more likely to give birth to infants who are premature, low-birthweight, and have other medical problems. In August 1988, the DHS estimated that an average of 13 percent of all infants admitted to NICUs statewide were drug-exposed. The DHS estimates that the additional *annual* health care costs of these drug-exposed infants is *$178 million.* Approximately three-quarters of these costs are paid by the Medi-Cal and CCS programs. These infants may also require costly ongoing medical care through these programs.

Impact on Developmental Programs

The extent to which drug-exposed infants will eventually develop developmental disabilities is unknown. However, FAS is among the top three known causes of mental retardation (and the only one that is totally preventable). The DADP reports that the *annual* costs associated with caring for persons born with FAS are approximately $214 million. Of these costs, only $2 million is attributed to infants born in any year while the remainder is attributed to the ongoing costs of children and adults born in previous years.

To the extent that drug-exposed infants later manifest developmental disabilities, state costs for case management and other support services provided by regional centers and state developmental centers can be considerable. Specifically, total costs for caring for the average client in the state developmental centers are $70,000 annually. The average cost incurred for each regional center community client is $5,500 annually.

Impact on Child Welfare Services Programs

County CWS programs respond to allegations of child abuse and neglect, deliver time-limited services to abused children and their families, and provide case management services to children in foster care.

Substance-exposed infants may be referred to county CWS programs in two ways. First, medical or social services providers may identify an infant at birth (or shortly thereafter) as being substance-exposed and report the infant to CWS as in danger of being abused. Second, the infant or child may be reported later to CWS because he or she is suspected of being abused. In either case, CWS evaluates the family situation. The infant or child may be left in the care of the family (sometimes on the condition that the family use certain services, such as drug treatment), be placed in protective custody (such as an emergency shelter or foster care), or be recommended for adoptive placement.

To the extent that county CWS programs either (1) investigate allegations of child abuse and neglect due to substance exposure that otherwise would not have been reported or (2) place a substance-exposed child into foster care, program costs are substantially increased. Specifically, the average cost to county CWS programs in responding to and investigating each allegation of child abuse and neglect, and providing time-limited services to abused children and their families, is over $11,000 annually per child. In addition, the average cost of foster care placement is over $13,000 annually.

Impact on Special Education Services

Research suggests that substance-exposed children may exhibit behavioral and learning difficulties. However, the State Department of Edu-

cation (SDE) does not maintain data on the number of children served in special education programs who were substance-exposed at birth. Furthermore, none of the representatives of the three Special Education Local Plan Areas (SELPAs) we spoke with could estimate the number or proportion of their pupils who were substance-exposed at birth. Because school districts do not track these children, we do not know the extent to which substance-exposed children differ from other children with respect to their needs for special education services.

The state pays for special education services needed from infancy through age 22. With the exception of services needed by infants, SELPAs are capped at the number of children they can serve. The additional cost of providing special education services to a substance-exposed infant or child who would not otherwise enroll in these programs ranges from $2,100 to $6,900 annually. In SELPAs that have reached their caps, a substance-exposed child with a severe handicap might displace another child with a less severe handicap. In these instances, the costs of serving a substance-exposed child would be less.

WHAT PROGRAMS ARE AVAILABLE FOR SERVING SUBSTANCE-ABUSING WOMEN AND THEIR CHILDREN?

Programs Generally Serving Substance-Abusing Women and Their Children

Our review indicates that the state does not currently administer any programs *exclusively* addressing the needs of pregnant substance abusers or substance-exposed infants. The 1989-90 Governor's Budget proposes increases to address some of the problems related to maternal substance exposure. For a detailed analysis of the administration's specific proposals, please see the *Analysis of the 1989-90 Budget Bill*, Items 4200, 4260, and 5180.

However, the state administers a number of programs that serve substance-abusing women and their children along with other women and their children. We discuss three types of programs below.

Prenatal Care and Case Management Programs. In addition to Medi-Cal, the DHS administers four programs designed to provide perinatal care—including nutrition counseling, case management, and other support services—to low-income women.

The Comprehensive Perinatal Services (CPS) and Prenatal Care Guidance programs are available to Medi-Cal-eligible women, the Community-Based Perinatal Services (CBPS) program is available to other low-income women, and the Adolescent Family Life program (AFLP) is available to pregnant and parenting teens. The DHS could not tell us the extent to which these programs are serving pregnant substance abusers.

Drug and Alcohol Treatment Programs. The state provides block grant funds to counties for alcohol and drug treatment programs. Counties may use these funds to provide a wide array of alcohol, methadone, and drug-free treatment programs—in both outpatient and residential settings—to members of the general public having problems with substance abuse. Generally, counties use these publicly funded treatment slots for low-income persons. Persons with private insurance covering substance abuse treatment often seek treatment from other providers.

The DADP does not keep data on the number of pregnant women served in county drug and alcohol treatment programs. However, our visits with these treatment programs indicate that they find it difficult to serve pregnant women because they believe they cannot deliver the special services these women require (for instance, coordination with prenatal care). County drug and alcohol administrators indicate that this sometimes results in pregnant women not receiving drug and alcohol treatment.

High-Risk Infant Follow-Up Programs. The DHS High-Risk Infant Follow-Up (HRIF) and the DDS prevention programs follow infants who are at high risk of developmental disability or delay to ensure they are receiving needed medical and social services. Substance-exposed infants who are also premature, low-birthweight, or have other problems may be eligible for these programs.

Both the HRIF and DDS prevention programs report that substance-exposed infants are an increasing proportion of their program caseloads. The HRIF program reports that substance-exposed infants represented about 7 percent of infants it followed in 1986 and almost 10 percent in 1987. The proportion of infants served in the DDS prevention program who are substance-exposed has increased from 10 percent in 1985-86 to 20 percent in 1987-88.

Local Programs Designed Specifically for Substance-Abusing Women and Their Infants

Local agencies have developed a variety of approaches to serve the comprehensive needs of pregnant substance abusers and their infants. We briefly summarize a few of these local programs below:

Comprehensive Programs. San Francisco and Los Angeles Counties use funds they receive from the DADP to support the delivery of comprehensive services (including prenatal care, drug abuse treatment and parenting education) to pregnant drug abusers and their infants. After two years of providing these services, these programs report some success. Specifically, San Francisco County reports that about three-fourths of the births to program participants were drug-free. Los Angeles

County reports that the program has significantly lowered the incidence of complications at birth, increased birthweight, and reduced the length of stay in NICUs. These results appear especially promising in view of the DADP estimate that only about one-third of persons normally receiving drug treatment remain drug-free six months after treatment.

Outreach and Referral Programs. Alameda County has established a case management program for all identified substance-abusing mothers delivering at Highland Hospital. The county Child Health and Disability Prevention (CHDP) program visits the family at home within 10 days of delivery and follows the infant for one year. The county reports that the percentage of substance-abusing mothers consistently bringing their children in for medical care increased from 10 percent to 67 percent within six months after it implemented the program.

Jail Health Programs. In order to deliver comprehensive prenatal care and substance abuse treatment services to pregnant substance abusers who are incarcerated, Alameda County coordinated services provided separately through Highland Hospital, the county jail, and alcohol and drugs programs from 1985 through 1988. These services are now administered through one agency—the private contractor responsible for delivering health services to jail inmates. County staff estimate that approximately 50 percent of the pregnant women they begin seeing in jail continue to receive services from the agency after being released.

Foster Care Programs. A number of counties have tried to increase the foster care placement options for substance-exposed infants. For example:

- The San Francisco County Department of Social Services combines CWS funds, Aid to Families with Dependent Children-Foster Care (AFDC-FC) funds, and charitable contributions in order to encourage foster parents to accept substance-exposed infants with special needs. San Francisco uses these funds to provide monthly care rates that are up to $1,400 more per child per month than the basic statewide foster family home rate. Once these infants are placed in the foster homes, the foster parents receive additional support services, such as respite care.
- The Orange County Social Services Agency uses AFDC-FC and CWS funds to operate a foster care program for children with special medical needs, 80 percent of whom are substance-exposed. The local welfare department conducts outreach, establishes reporting protocols with local hospitals, locates and trains foster parents, and refers infants to other appropriate programs, including regional center programs.

"Incentive" Programs. Butte County has recently begun to provide mothers of identified substance-exposed infants with a choice: be prose-

cuted for using illegal drugs or enter a program that includes probation, health, mental health, and social services. If the mother chooses to enter the program, she is allowed to maintain custody of her child as long as the the county CWS program does not believe that the infant is at risk of abuse or neglect. Probation staff also follow her case to determine whether or not she returns to drug use. County staff could not provide us with data on (1) the number of substance-abusing mothers for whom prosecution is necessary due to their refusal to enter available treatment or (2) the program's success.

Coordination and Data Collection Programs. Recently, San Francisco County declared the increasing prevalence of substance-exposed infants to be a "public health emergency," thereby making the county eligible for special state funding for one-time county projects. The DHS awarded the county a one-time grant in order to assist it in (1) coordinating services, (2) collecting data to assist it in defining its problem, and (3) developing protocols for identifying, assessing, treating, and referring substance-exposed infants.

Education Programs. Los Angeles Unified School District established a pilot project in March 1988 in order to identify effective educational strategies for preschoolers and kindergartners who were substance-exposed at birth. The children selected for this pilot must meet two specific criteria: (1) cognitive abilities within the average range and (2) no medical/developmental complications or abnormalities. The project has not yet reached any conclusive findings.

WHAT IS THE IDEAL SYSTEM FOR SERVING SUBSTANCE-ABUSING PREGNANT WOMEN AND THEIR INFANTS?

National experts, the providers we met with, and available research indicate that the most effective way to address the complex needs of these populations is through a comprehensive and multidisciplinary system of service delivery and case management. Specifically, an "ideal" system would include:

- Outreach and preventive education.
- Early identification of pregnant substance abusers.
- Interagency case management of pregnant substance abusers and their substance-exposed infants to ensure they receive available services.
- Uniform screening protocols for substance exposure in labor and delivery in order to provide quality maternity care and to identify infants at risk.
- Consistent reporting of substance-exposed infants to local CWS staff in order to determine whether or not the infant is at risk for abuse.
- Family education, parenting services, and other support services.

- Referral to half-way houses or other residential substance abuse treatment programs.
- Training for foster care families who accept substance-exposed infants.

In order to identify problems with the existing system and recommend ways to improve it, in the following sections we compare the components contained in this "ideal" service system to the existing system.

WHAT ISSUES ARE RAISED REGARDING THE WAY SERVICES ARE CURRENTLY DELIVERED?

Existing Resources Are Concentrated at Addressing the Results of the Problem and Not at Prevention

Existing state and local programs tend to treat the *results* of maternal substance abuse and its effect on infants, whether the results are incarceration, hospitalization, family separation, or developmental and educational delay. Relatively fewer public resources are invested earlier in the delivery process when outreach, prevention, education, and rehabilitation can reduce likely dependence on government resources.

Even though preventing many of these women from using drugs and alcohol while they are pregnant is not an easy task, some limited data from local programs suggest that comprehensive prenatal and substance abuse programs can be successful in reducing a woman's substance use during her pregnancy and, thus, significantly improve the health of her infant at birth. As a result, even if the mother abuses drugs or alcohol again, remaining "clean" during pregnancy will lessen the chances that the infant will require additional long-term health and other services.

Limited Drug Treatment Slots for Pregnant Substance Abusers

Based on our visits to several counties, it appears that pregnant women and women with children are frequently unable to find drug treatment slots. This problem appears especially acute in rural areas and for users of drugs like cocaine. For example, we were repeatedly told of women who want to get off drugs while they are pregnant or are ordered by the court to enter drug treatment as a condition of releasing their children from protective custody, but who cannot find a program to accept them. If these women do not get treatment, they are in danger of having a substance-exposed infant or losing their children to protective custody.

The number of slots available for IV drug users may increase as a result of the availability of new federal funds. However, we do not know the extent to which these funds will be used for pregnant women.

Programs Neither Systematically Provide Outreach Nor Adequately Serve Pregnant Substance Abusers

Outreach. Only one state program of which we are aware (Prenatal Care Guidance) provides funds specifically for outreach activities to pregnant women. The DHS could not tell us the extent to which counties use their outreach funds specifically for substance-abusing women. Few of the local providers we visited conduct these activities on their own. Our review indicates that outreach activities are very important for this population because they are reluctant to seek services on their own.

Identification. Our review indicates that local prenatal care, substance abuse treatment, and corrections programs do not consistently identify pregnant substance abusers. For example, prenatal care providers we visited and spoke with in San Francisco, Fresno, Alameda, Sacramento, and Los Angeles Counties differ in (1) the type and extent of questions asked of women to determine substance abuse during pregnancy, (2) what substances they screen for, and (3) if and when they will use a urine toxicology test to verify substance use among women they suspect use illegal substances.

In addition, of the 16 drug treatment providers we visited in four counties (Mendocino, San Francisco, Los Angeles, and San Joaquin), we found that only a few of the drug treatment programs routinely ask if a woman is pregnant when she comes in for treatment. We also found differences in the way county corrections staff seek to identify if a woman is pregnant and/or a substance abuser. A significant proportion of women arrested or incarcerated are substance abusers of child-bearing age.

Referral and Case Management. We found a lack of consistent referral and follow-up among local programs serving substance-abusing pregnant women and their infants. For example, only two of the four county jails we contacted—Alameda and Contra Costa—make formal efforts to link pregnant women to county health services upon their release. Of the 16 drug treatment programs we visited, only the three programs designed specifically for pregnant substance abusers consistently referred women to prenatal care providers and followed up to ensure that they kept their appointments.

We found similar inconsistencies in (1) medical providers' procedures for reporting substance-exposed infants to child welfare and regional center prevention programs and (2) acceptance of these infants by regional centers.

Licensing Requirements Make it Difficult to Place Certain Substance-Exposed Children in Foster Care

Current law and DSS licensing regulations prohibit foster family homes from providing more than incidental medical services to children in their

care (with the exception of in-home medical services for ventilator-dependent children). "Incidental" services do not include the special medical needs that substance-exposed children may have. Therefore, the practical effect of the existing licensing requirements is to prevent placing children with special medical needs, including many substance-exposed children, in foster care.

The DHS indicates that it has secured two federal waivers that permit using Medi-Cal funds to pay for support services for foster families who keep children with special medical needs at home, thereby avoiding more costly institutional care. This funding source cannot be used, however, as long as the current licensing requirements related to incidental medical services are in place.

Uncertainty about Testing for and Reporting Substance Abuse and Exposure May Impair the Delivery of Comprehensive Services

We found that providers have different understandings about which mothers and infants they can test or report and under what justification. For example, public and private hospitals in Los Angeles County have developed written protocols regarding who they can test for substance abuse and under what conditions. However, the UCD Medical Center routinely tests *all* women delivering at its facility.

Similarly, current law makes no mention of infant substance exposure as a reason to report a child being abused or in danger of being abused. As a result, some hospitals report substance-exposed infants to county CWS programs and others do not because they are unsure whether current law requires them to do so.

WHAT OPTIONS ARE AVAILABLE TO THE LEGISLATURE FOR BETTER SERVING THESE WOMEN AND THEIR CHILDREN?

Our review indicates that the Legislature has several options for improving the delivery of services to pregnant substance abusers and their substance-exposed infants. Of the available options, some involve *increasing* the resources allocated to these populations; while others target, coordinate, and remove barriers from *existing* resources in order to enhance the delivery of comprehensive services. In general, we recommend that the Legislature give priority to those options which will increase the delivery of services aimed at preventing substance abuse and its effects.

More Information Needed on Maternal Substance Abuse

We recommend that the Legislature adopt supplemental report language that directs the DADP and the DHS to improve the information available regarding substance-abusing pregnant women and substance-exposed infants. We further recommend that the DHS report

to the fiscal committees during budget hearings on the costs, benefits, and possible funding sources for obtaining information from a one-time survey of hospital births.

Our review of the problems associated with maternal substance abuse was severely limited by the lack of comprehensive data. There are, however, at least two ways to improve the information available on substance-abusing pregnant women and their infants. First, the state could require drug treatment providers that receive state funding to request information on pregnancy status and to include this with the information it currently reports to the DADP. Second, the DHS could obtain additional information on substance-exposed infants by conducting a one-time survey of all hospital births in order to better estimate the extent of the problem. The DHS recently contracted for a similar study in order to gain more information about the extent to which women delivering in California received prenatal care. Also, we believe that federal funds might be available to fund this type of study.

Obtaining better information about maternal substance abuse and infant substance exposure would make it easier for the Legislature to address the problems we discuss in this analysis. Accordingly, we recommend the adoption of the following supplemental report language:

1. Item 4200-001-001. The department shall require all drug treatment providers who report through the California Drug Abuse Data System (CALDADS) to include information on pregnancy status of women served in their programs.

2. Item 4260-001-001. The department shall conduct a one-time sample survey of hospital births in order to determine the extent of maternal substance abuse and infant substance exposure.

We further recommend that the DHS report to the fiscal committees during budget hearings on the costs and benefits of such a survey, as well as possible funding sources.

Clarifying Infant Substance Exposure Reporting Would Improve Treatment of Substance-Exposed Infants

We recommend enactment of legislation that would clarify whether substance exposure is a reportable condition that places an infant in danger of abuse and neglect.

Our review indicates that different hospitals have different policies for reporting substance-exposed infants to county CWS programs for evaluation. Some of the hospital staff we spoke with felt that reporting all substance-exposed infants to CWS programs is the best way to ensure the safety of these children because CWS is the appropriate program to monitor these children and their families after they leave the hospital. Other providers, however, were concerned that a policy of reporting all

substance-exposed infants to CWS could result in more women delivering at home, rather than at a hospital, thereby placing the infants at higher risk during delivery.

In general, the Legislature has *not* left the question of which children should be reported to county CWS programs to the discretion of those involved. For example, health care professionals are *required* to report injuries that they have reason to believe could have been the result of abuse. Once the injury is reported, local CWS programs and the courts decide whether to monitor the family, provide services, take the child into foster care, or dismiss the case. In the case of substance exposure, existing law is unclear as to whether exposure itself is reportable as placing a child in danger of being abused, which is why different hospitals have different policies regarding reporting these cases.

We have no analytical basis for determining whether substance exposure in itself puts a child in danger of being abused. This is a policy question that the Legislature will have to decide based on the advice it receives from health care professionals and child abuse experts regarding what is in the best interests of substance-exposed children. In our view, however, there should be a consistent statewide policy on this issue. This is because the current uncertainty regarding what the law requires in these cases (1) exposes health care providers to prosecution if they wrongfully fail to report a substance-exposed infant and (2) provides an incentive for substance-abusing pregnant women to "shop around" for hospitals that do not consistently report substance exposure. We therefore recommend the enactment of legislation to clarify whether substance exposure is reportable.

Standardized Reporting and Screening Protocols Could Reduce Problems Related to Substance Abuse During Pregnancy

We recommend that the DHS submit to the fiscal committees, prior to budget hearings, a plan for developing model protocols for prenatal screening and testing for substance use and exposure.

Our review indicates that health and social service providers have practices for screening or testing pregnant women or infants for substance use, or referring them to other services, that vary widely in their effectiveness. For example, prenatal care providers may not ask appropriate questions to best elicit information from pregnant women about their substance use during pregnancy. Not having this information makes it difficult for providers to most effectively handle the woman's or infant's problems related to substance abuse.

We believe that the DHS should provide guidance to providers regarding the most effective screening, testing, and referral practices so that (1) substance-abusing women are provided effective pregnancy-

related care and (2) substance-exposed infants are provided appropriate health and social services. To make this information directly usable to providers, we recommend that the DHS do this by issuing model protocols. These protocols should be developed in conjunction with medical and social service providers.

Accordingly, we recommend that the DHS submit to the fiscal committees, prior to budget hearings, a plan for developing model screening, testing and referral protocols related to substance-abusing women and substance-exposed infants. The plan should include an estimate of costs for developing the protocols and a discussion of funding options.

Changing Licensing Restrictions Would Facilitate Placement of Substance-Exposed Infants in Foster Care Homes

We recommend approval of the administration's proposal to amend current law to allow foster families to provide treatment for infants with specialized care needs. (Please see the **Analysis of the 1989-90 Budget Bill,** ***Item 4200, for our additional recommendations regarding this proposal.)***

Our review indicates that current law restricting foster families from providing more than incidental medical treatment for infants may impede placement of substance-exposed infants in foster family homes. In the budget, the administration proposes to fund four pilot projects to encourage care of substance-exposed children in foster family homes rather than in more expensive settings. As part of this proposal, the administration indicates that it will seek legislation that would amend current law to allow foster families to provide treatment for infants with specialized care needs. Relaxing this restriction would also allow the DHS to use state and federal Medi-Cal funds to pay for needed support services.

We recommend approval of this proposal, although we have additional recommendations regarding the expenditure of funds. Please see the *Analysis*, Item 4200, for a more detailed explanation of this proposal.

Ensuring Drug Treatment to Substance-Abusing Pregnant Women May Reduce the Number of Substance-Exposed Infants

We recommend that the Legislature adopt Budget Bill language requiring the DADP to require drug and alcohol treatment providers to (1) ask women whether they are pregnant and (2) give priority to pregnant women.

Our visits with local drug and alcohol treatment providers indicated that they have different policies for identifying and giving priority treatment to pregnant women. Our review suggests that requiring drug

and alcohol treatment providers to (1) ask all women seeking services whether they are pregnant and (2) give pregnant women priority for receiving services could reduce the number of substance-exposed infants.

For these reasons, we recommend that the Legislature adopt Budget Bill language in Item 4200-101-001 requiring the DADP to require all programs receiving DADP funds to give priority to pregnant women. The following language is consistent with this recommendation:

> The Department of Alcohol and Drug Programs shall require all local drug and alcohol treatment providers to (1) ask women whether they are pregnant and (2) give priority to pregnant women in providing treatment services.

The Legislature Should Provide Additional Treatment Slots, Case Management, and Outreach Services for Substance-Abusing Pregnant Women

We recommend approval of the administration's proposals to (1) provide additional drug and alcohol treatment slots for pregnant women and (2) provide additional case management services. (Please see the* Analysis of the 1989-90 Budget Bill, *Items 4200 and 4260, for our additional recommendations regarding this proposal.)

Our review indicates that there are insufficient outreach, substance abuse treatment, and case management resources available for pregnant substance-abusing women. In the budget, the administration has a number of specific proposals designed to provide additional resources for case management and treatment services. In general, we recommend approval of these proposals. However, we have additional recommendations regarding the specific expenditure of these funds. For our more detailed analysis, please see the *Analysis*, Items 4200 and 4260.

State Programs for Older Californians

What Guidelines Can the Legislature Follow When Allocating Funds for Senior Programs?

Summary

- *The continued rapid growth of the elderly population will affect the demand for state programs. The fastest growing age subgroup in the next decade, those 85 and over, is the elderly group most likely to use state services. However, older people belong to a variety of subgroups, with differences in financial, health, and marital status, as well as in ethnicity and age.*
- *The poverty rate for elderly Californians has declined substantially since 1970. Older Californians have a lower rate of poverty than national figures for the elderly or the general population. However, poverty levels are disproportionately high for certain groups, most notably women, minorities, and those living alone.*
- *Most elderly people are relatively healthy and free of any major disability, although the incidence of disability rises with advancing age.*
- *The Governor's Budget proposes expenditures for senior programs of $4 billion from all funding sources in 1989-90, with 83 percent of the total for income support (primarily Supplemental Security Income/State Supplementary Program (SSI/SSP)) and health services (primarily Medi-Cal) to low-income elderly persons.*
- *In recent years, many issues regarding "unmet need" for senior programs have been brought to the Legislature's attention. Our review of three of these programs indicates that the term "unmet need" can have several meanings. It also indicates that filling the unmet need for these programs would involve major fiscal and/or program trade-offs.*
- *Our review of senior programs suggests several guidelines for legislative planning: (1) give high priority to services targeted at subgroups of the elderly most in need of government services, (2) give priority to funding programs in underserved areas, (3) set clear program goals to reflect spending priorities, and (4) minimize program duplication and encourage local cooperation.*

The rapid growth of the elderly population continues to be one of the most important demographic changes affecting California. In 1980, there were 2.4 million Californians 65 years of age and over, or approximately 10 percent, of the state's total population. The Department of Finance

(DOF) estimates that by the year 2000, the number of older Californians will increase by 157 percent, to 6.2 million, or 12 percent of the state's total population.

In this section, we provide a profile of California's older population and the state's expenditures for senior programs, present an overview of "unmet need" for three selected programs, and suggest guidelines for legislative decisionmaking in responding to the increasing demand for senior services.

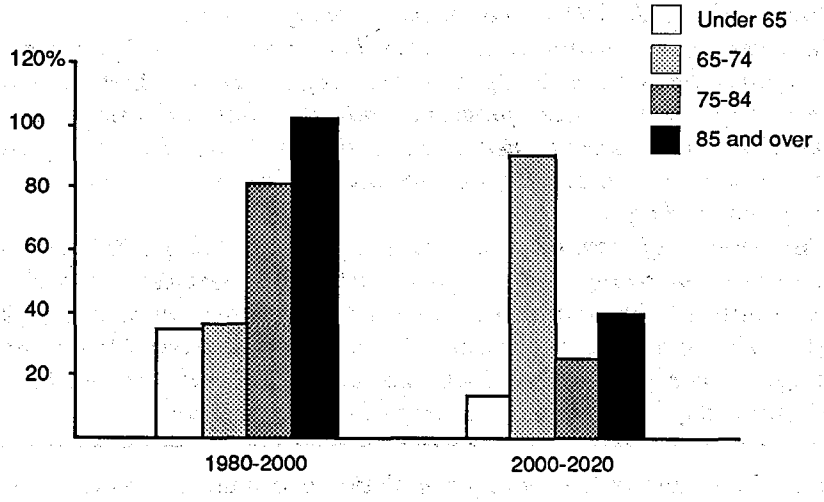
Profile of Older Californians

Older Californians belong to a variety of subgroups, with a range of differences with respect to age, sex, income, health status, marital status, and ethnicity. An understanding of these subgroups can help the Legislature in setting priorities for state services and programs.

Age. Chart 1 displays the DOF's projection of population growth for four different age groups over the periods 1980 to 2000 and 2000 to 2020. The chart illustrates that between 1980 and the year 2000 there will be significant growth in the age 75 and over population. Then during the period 2000 to 2020, the fastest growing age category will be the 65-74 age group, as the "baby boom" generation reaches old age.

Chart 1

Percentage Growth in California's Population By Age Group
1980-2000 and 2000-2020



Sex. As the population ages, the ratio of men to women declines. In the 60-64 age group, for example, men represent 47 percent of the total, but the number of men declines to *29 percent* of persons age 85 and over. Thus, given the increase in the over-85 age group anticipated over the two decades, women will make up an increasing percentage of the aged population.

Financial Status. As Table 1 shows, the percent of older persons whose incomes are below the poverty level in California has declined dramatically since 1970. Between 1970 and 1980, the percent of older Californians below the poverty level, as defined by the U.S. Bureau of the Census, declined from 18.2 percent to 8.3 percent, and has declined further—to 6.1 percent—in this decade.

Table 1
Percent of Population Below Poverty Line

	California			*Nation* [a]		
	1970	*1980*	*1988* [b]	*1970*	*1980*	*1988*
All persons	11.1%	11.4%	12.4%	12.6%	13.0%	14.4%
Persons 65+	18.2	8.3	6.1	24.5	15.7	12.4

[a] Source: U.S. Census Bureau.
[b] Source: California State Census Data Center, from the U.S. Census Bureau Current Population Survey.

Table 1 also compares the poverty rates in California with those for the nation as a whole. It shows that for all time periods shown, the poverty rates in California were lower than for the nation as a whole. In addition, the table indicates that the 1988 poverty rate for older persons in California was significantly lower than the poverty rates for the general population in California and the nation.

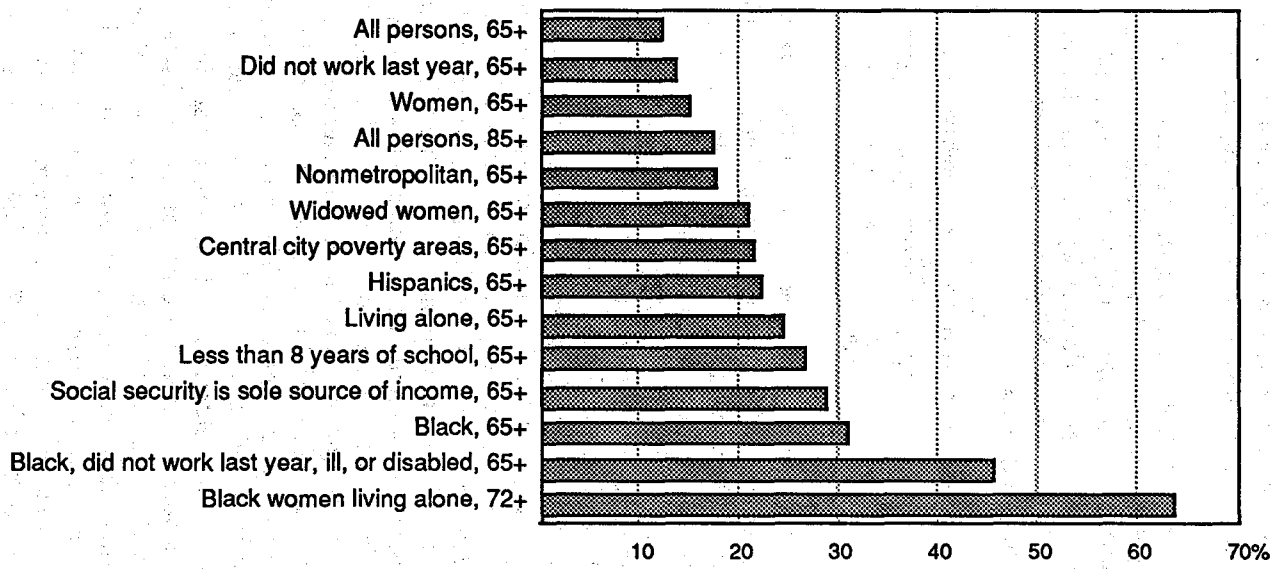
Although the percent of all elderly persons below poverty has declined since the 1970s, poverty levels are disproportionately high for certain groups of older people, most notably, women, minorities, and those living alone. Chart 2 illustrates these large differences among elderly subgroups in the incidence of poverty nationally. The chart shows that, among all people over age 65, 12 percent had incomes below the poverty level. The other categories shown on the chart are all subgroups of the over 65 population. For example, the chart shows that among those over age 65, individuals who did not work in the previous year had a slightly higher incidence of poverty (14 percent). The subgroups shown in the chart overlap, because an individual may fit into more than one category.

Health Status. Most elderly people are relatively healthy and free of any major disability. National studies of major disability among the elderly—defined as daily inability to perform some or all of personal care activities (eating, bathing, dressing, toileting, and mobility)—have estimated that approximately 22 percent of persons over 65 are disabled. The incidence of disability rises with advancing age—14 percent of those aged 65-74, 28 percent of those between 75 and 84, and 58 percent of those over age 85 are disabled. These studies have also shown that the prevalence of disability and illness is disproportionately high among the poorer elderly population.

Chart 2

Percent of Elderly People Below the Poverty Level By Selected Characteristics[a]

1986



[a] Source: U.S. Senate Special Committee on Aging in Conjunction with the American Association of Retired Persons, Federal Council on the Aging, and the U.S. Administration on Aging, *Aging America: Trends and Projections*, 1987-88 edition (based on data from the U.S. Bureau of the Census).

The elderly are the heaviest users of health care services. Individuals over 65 represent 25 percent of hospital discharges, and 86 percent of all patients in nursing facilities, even though they represent only 11 percent of the total population. In addition, they account for 25 percent of all Medi-Cal expenditures, even though they represent only 13 percent of all Medi-Cal eligibles.

The U.S. Bureau of Labor Statistics reports that out-of-pocket health care costs represent 3 percent of income for individuals under 25, 4 percent for individuals between 35 and 44, 9 percent for those between 65 and 74, and 12 percent of the incomes of persons over 75.

Marital Status. Because there are so many more elderly women than men, men are more likely to be married in old age than women. While 70 percent of men over age 75 are married and only 22 percent are widowed, only 24 percent of women over 75 are married and 67 percent are widowed. The California Department of Aging (CDA) estimates that 19 percent of Californians over the age of 60 live alone.

Ethnicity. California's elderly population will become increasingly nonwhite, reflecting the state's changing racial and ethnic make up. The U.S. Census Bureau estimates that in 1988 California's 65 and over population was 82 percent white, 5 percent black, 9 percent Hispanic, and 5 percent Asians and others. The DOF estimates that by the year 2020, the 65 and over population will be 60 percent white, 4 percent black, 20 percent Hispanic, and 16 percent Asian and others.

STATE PROGRAMS SERVING OLDER CALIFORNIANS

In California, 18 state agencies currently administer 40 separate programs that provide services and benefits to older individuals. These agencies are displayed in Chart 3. (The chart also shows the acronyms for these agencies, which are used in Chart 4, below.)

Chart 4 lists state programs for seniors and provides summary information on their eligibility requirements, caseloads, and costs in the current and budget years. The chart shows that the budget proposes to spend $4 billion on these programs in 1989-90, which represents approximately 6 percent of total state spending (General Fund, federal funds, special funds). The General Fund will finance about $2 billion, or 50 percent, of expenditures for senior programs, and the federal government will fund $1.9 billion, or 48 percent. The remaining $100 million, or 2 percent, is supported by state special funds or local funds. (Expenditures from local funds are included in the totals columns, but are not separately displayed in the chart.)

Chart 3

State Agencies That Provide Services and Benefits to Older Californians[a]

Income Support	
Department of Social Services	DSS
Franchise Tax Board	FTB
Department of Economic Opportunity	DEO

Health Services	
Department of Health Services	DHS
California Department of Aging	CDA

Employment, Supportive Social, and Other Services	
Department of Rehabilitation	DOR
Department of Housing and Community Development	HCD
Employment Development Department	EDD
Department of Transportation	Caltrans
Department of Justice	DOJ
State Department of Education	SDE
Department of Veterans Affairs	DVA

Discount Programs	
Department of Food and Agriculture	DFA
California State University	CSU
Department of Consumer Affairs	DCA
Department of Motor Vehicles	DMV
Department of Parks and Recreaction	DPR
Department of Fish and Game	DFG

The budget-year total represents an increase of $123 million, or 3.2 percent, above estimated current-year spending levels. The increase is primarily due to (1) an $83 million increase in SSI/SSP costs related to increased caseloads and the full-year costs of state and federal cost-of-living adjustments (COLAs), which took effect on January 1, 1989, and (2) a $49 million increase in Medi-Cal costs due in part to long-term care rate increases granted in 1988-89, projected caseload increases, and increased costs of Medicare premiums (for seniors who are eligible for Medi-Cal, the state covers the costs of the Medicare part B premium so that the recipient can receive Medicare coverage for such nonhospital costs as doctor's office visits).

The chart groups senior programs into the following three categories, based on the programs' eligibility criteria:

- ***Programs Available to Low-Income Seniors.*** These programs account for 93 percent of all spending on seniors.
- ***Programs Available to All Seniors.*** These programs account for approximately 4 percent of all spending on seniors.
- ***Programs That Have No Age Requirement, But Which Predominantly Serve Seniors.*** These programs represent 3 percent of all state spending on older Californians.

Table 2 summarizes expenditures for senior programs by the type of benefit or service provided. As the table indicates, income support programs and health services programs account for $3.4 billion, or 83 percent, of expenditures for the benefits and services that the state will provide to older individuals in 1989-90.

Table 2
Summary of Services Available to Older Californians
by Program Type
1988-89 and 1989-90
(dollars in millions)

	1988-89			*1989-90*		
	State	*Federal*	*Total*[a]	*State*	*Federal*	*Total*[a]
Type of program or service						
Income support	$957	$746	$1,702	$974	$817	$1,787
Health services	763	747	1,522	786	772	1,568
Supportive social services	195	282	555	190	284	551
Employment	—	14	14	—	11	11
Other services	77	14	105	75	15	104
Discount programs	2	—	2	2	—	2
Totals[b]	$1,993	$1,804	$3,900	$2,027	$1,898	$4,023

[a] Local expenditures are not shown separately, but are included in the totals.
[b] Detail may not add to totals due to rounding.

Who is Served by These Programs?

Chart 4 groups programs for older Californians primarily according to their age and/or income eligibility criteria. As the chart also shows, however, there are a wide variety of state programs designed to serve different subgroups of the elderly. Below, we discuss three categories of programs for the elderly; and where client profile data are available, further identify the elderly subgroups served by the programs in each category.

Programs for the Well Elderly. Some programs designed to provide entertainment, community involvement, or disease prevention focus services primarily on older people who are in relatively good health. These programs include: Preventive Health Care for the Aging, employment services, the Volunteer Service Credit and Foster Grandparents programs, and some of the adult education courses for the elderly.

Programs for the Disabled Elderly. A number of senior programs are targeted at elderly persons with restricted "self-care" abilities. These are often referred to as long-term care programs. Table 3 shows a selected list of programs for the disabled and the participation, by sex and age, in these programs. The table shows that women and the very old generally have the highest participation rates in these programs.

Chart 4

Programs Available to Older Californians By Eligibility Type

1988-89 and 1989-90 (dollars in thousands)

	Services Provided	Requirement to Qualify	Estimated Number of Clients 1988-89	1988-89 State	1988-89 Federal	1988-89 Total[a]	1989-90 State	1989-90 Federal	1989-90 Total[a]
PROGRAMS AVAILABLE TO LOW-INCOME SENIORS									
INCOME SUPPORT									
Supplemental Security Income/State Supplementary Program (DSS)	Cash grants	Age 65 with (1) limited resources and (2) "countable" income that does not exceed the maximum grant	399,081	$926,757	$728,167	$1,654,924	$938,720	$799,651	$1,738,371
Senior Citizens Property Tax Assessment Program (FTB)	Annual grant based on property tax equivalent	Renter age 62 or older and low-income (less than $12,000) or disabled (all ages)	180,000	17,560	—	17,560	18,600	—	18,600
Senior Citizens Property Tax Assistance (FTB)	Direct reimbursements for portion of property taxes	Age 62 or older, or disabled; must own and occupy home; income less than $12,000	51,000	4,040	—	4,040	4,300	—	4,300
Senior Citizens Property Tax Deferral (FTB)	Postponement of property tax payments	Age 62 or older; must own and occupy residence; income less than $24,000	9,735	7,500	—	7,500	7,600	—	7,600
Foster Grandparents program (CDA)	Stipends for seniors who provide supportive services to children with special needs	Age 60 or older and income less than the poverty level	152 volunteers	366	7	373	366	7	373
Senior Companion program (CDA)	Stipends for seniors who provide supportive services to adults with special needs	Age 60 and older and income less than the poverty level	113 volunteers	319	4	343	319	4	343
HEALTH SERVICES									
Medi-Cal (DHS)[b]	Inpatient/outpatient acute medical services, long-term care, ancillary health services	Age 65 and older, and public assistance recipients or meet age, disability, and income requirements	400,900 (average per month)	$747,243	$747,243	$1,494,486	$771,539	$771,539	$1,543,078

Multipurpose Senior Services Program (CDA)	Case management to link clients to various health and social services	Age 65 or older, Medi-Cal eligible and certifiable for placement in nursing homes	8,941	10,659	—[c]	21,037	10,515	—[c]	20,749
SUPPORTIVE SOCIAL SERVICES									
Brown Bag (CDA)	Foodstuffs distributed to older persons	Age 60 or older and SSI/SSP eligible	37,551	723	—	723	723	—	723
In-Home Supportive Services (DSS)	Domestic and nonmedical services provided at home	SSI/SSP eligible	91,663	172,956	208,311	394,941	168,181	209,106	390,961
EMPLOYMENT									
Senior Community Employment Services (CDA)	Subsidized part-time jobs	Age 55 or older and income less than 125 percent of poverty level	1,048	—	5,120	5,120	—	5,175	5,175
DISCOUNT PROGRAMS									
Golden Bear Passes (DPR)	Reduce price on annual state park pass	Age 65 and older and below specified income level	3,700	150	—	150	185	—	185
Discount Fishing Licenses (DFG)	Reduced price on fishing license	Age 65 and older and receiving SSI/SSP or with specified income	17,801	298	—	298	311	—	311
SUBTOTALS, PROGRAMS AVAILABLE TO LOW-INCOME SENIORS				$1,888,571	$1,688,852	$3,601,495	$1,921,359	$1,785,482	$3,730,769
PROGRAMS AVAILABLE TO ALL SENIORS									
HEALTH SERVICES									
Preventive Health Care for Aging (DHS)	RNs provide health appraisals, counseling, referrals, education	Older adults (age 55 and older) in congregate settings who are well	20,643	$1,303	—	$2,606	$527	—	$1,054
SUPPORTIVE SOCIAL SERVICES									
Nutrition (CDA)	Meals provided at community centers or delivered at home	Age 60 or older (and spouses regardless of age)	259,762	12,301	$49,448	100,617	11,970	$49,676	100,514
Supportive Services and Centers (CDA)	Include in-home, transportation, and case management services	Age 60 or older	882,810	2,904	24,672	53,007	2,904	24,775	53,008

	Services Provided	Requirement to Qualify	Estimated Number of Clients 1988-89	1988-89 State	1988-89 Federal	1988-89 Total[a]	1989-90 State	1989-90 Federal	1989-90 Total[a]
EMPLOYMENT									
Job Training Partnership Act/Older Workers (EDD)	Employment and training services	Age 55 and older	Unknown	—	9,123[d]	9,123	—	5,433	5,433
OTHER SERVICES									
Senior Citizens' Shared Housing (HCD)	Grants to nonprofit entities to assist seniors in finding a roommate	Age 60 or older	Unknown	500	—	500	—	—	—
Volunteer Service Credit program (CDA)[e]	Service credits for seniors who provide supportive services to other seniors	Age 60 or older	4,250	50	—	50	50	—	50
Mobilehome Park Assistance Program (HCD)	Technical assistance/loans to residents who wish to buy their mobilehome park	Age 60 or older	566	5,595	—	5,595	1,836	—	1,836
Health Insurance Counseling and Advocacy program (CDA)	Assistance in understanding coverage and provided through Medicare and private insurance	Medicare beneficiaries	80,000	—	—	1,544	—	—	2,646
DISCOUNT PROGRAMS[e]									
Golden State Senior Discount program (DCA/CDA)	Cards issued for purchase of discounted goods and services from volunteer merchants	Age 60 or older	75,000	84	—	84	87	—	87
California Exposition and State Fair (DFA)	Reduced State Fair admission	Seniors	25,858	26	—	26	30	—	30
California State University (CSU)	Student fee waivers	Age 60 or older	1,500	800	—	800	820	—	820

Identification cards (DMV)	Reduced price and extended period of validity on identification cards	Age 62 or older	89,200	444	—	444	456	—	456
SUBTOTALS, PROGRAMS AVAILABLE TO ALL SENIORS				$24,007	$83,243	$174,396	$18,680	$79,884	$165,934
PROGRAMS PREDOMINATELY SERVING SENIORS									
INCOME SUPPORT									
Low-Income Weatherization program (DEO)[f]	Low-cost home weatherization	Income less than 150 percent of poverty level	Unknown	—	$4,030	$4,030	$4,030	$4,030	$3,563
Low-Income Home Energy Assistance program (DEO)[f]	Heating assistance grants	Income less than 150 percent of poverty level	Unknown	—	11,354	11,354	—	11,354	11,354
Emergency Crisis Intervention program (DEO)[f]	Emergency assistance to households unable to pay utility bills	Income less than 130 percent of poverty level	Unknown	—	2,362	2,362	—	2,362	2,362
HEALTH SERVICES									
Alzheimer's Research, Diagnostic, and Treatment centers (DHS)	Research, diagnostic, and treatment services provided to patients and families	Symptoms or indications of Alzheimer's disease	Unknown	$3,564	—	3,564	3,564	—	3,546
Adult Day Health Care (CDA)[g]	Health and social services provided in nonresidential centers	Frail elderly and other disabled adults	3,538	111	—	111	—	—	—
SUPPORTIVE SOCIAL SERVICES									
Alzheimer's Day Care-Resource Centers (CDA)	Supportive services provided to patients and caregivers	Symptoms of Alzheimer's disease or related disorders	1,116	1,550	—	1,550	1,550	—	1,550
Linkages (CDA)	Case management to link clients to various social services	Adults who are not certifiable for placement in nursing homes	4,126	3,900	—	3,900	3,900	—	3,900
Respite Care program (CDA)	Referral of clients and families to respite care providers	Health of caregiver at risk; client at risk of institutionalization	770	60	—	60	30	—	30
Senior Self-Reliance program (DOR)	Assistance in overcoming barriers to mobility	Age 55 or older with limited visual acuity	Unknown	102	—	102	102	—	102

	Services Provided	Requirement to Qualify	Estimated Number of Clients 1988-89	1988-89 State	1988-89 Federal	1988-89 Total[a]	1989-90 State	1989-90 Federal	1989-90 Total[a]
Counselor/Teacher program (DOR)	Mobility orientation and other habilitation services	Client of DOR	Unknown	283	—	283	236	—	285
OTHER SERVICES									
Urban Mass Transportation Act 16b(2) program (Caltrans)[h]	Capital assistance to private nonprofit agencies to purchase specialized vehicles	Elderly and/or handicapped	Unknown	486	2,794	3,280	488	2,777	3,265
Adult Protective Services (DSS)	Investigation and prevention of abuse/neglect of elders	Not applicable	Unknown	17,230	—	21,767	16,654	—	21,009
Prevention of Crimes Against the Elderly (DOJ)	Information and technical assistance	Not applicable	Unknown	1,099	—	1,099	900	—	900
Adult Education Courses for the Elderly (SDE)	Educational courses	Elgibility criteria established by local officials	173,577	27,000	—	27,000	29,000	—	29,000
California Veterans Home (DVA)	Residential nursing and medical services	Veteran and qualifying resident	1,345	24,659	11,086	43,717	26,247	11,807	45,524
SUBTOTALS, PROGRAMS PREDOMINATELY SERVING SENIORS				$80,044	$31,626	$124,179	$86,701	$32,330	$126,390
TOTALS, ALL PROGRAMS				$1,992,622	$1,803,721	$3,900,070	$2,026,740	$1,897,696	$4,023,093

[a] Local expenditures not shown separately, but are included in the totals.
[b] Figures do not include amounts for recipients age 65 or older who receive aid to the blind or disabled.
[c] Federal funds totaling $10.4 million in 1987-88 and $10.3 million in 1988-89 are included in Medi-Cal figures.
[d] Includes $3.7 million in federal funds carried over from prior fiscal years.
[e] Estimated revenue loss, assuming older persons receiving discounts otherwise would have purchased full priced services (except for the Golden State program).
[f] Expenditures for clients age 60 or older. Budget year figures for the Weatherization program do not include $5.3 million in federal funds that can be drawn at any time between 1989-90 and 1991-92.
[g] Except for $111,000 in start-up grants, the amounts expended on this program ($13.8 million in 1987-88 and $15.7 million in 1988-89) are included in Medi-Cal figures.
h Figures include amounts for handicapped as well as elderly.

Table 3
Selected Programs Serving the Disabled
Participation by Sex and Age
1987-88

Program	*Men*	*Women*	*Under Age 65*	*Age 65-74*	*Age 75+*
Multipurpose Senior Services Program....	23%	77%	0%	31%	69%
Linkages.....	31	69	31	22	47
Adult Day Health Care	30	70	22	25	53
Alzheimer's Day Care.....	37	63	12	25	63
In-Home Supportive Services.....	29	71	33	39 [a]	28 [a]
Nursing facilities.....	25	75	13	15	72

[a] These figures are for slightly different age categories.

The profile of clients in two of these programs, In-Home Supportive Services (IHSS) and Medi-Cal, illustrates the subgroups of the elderly that are most likely to use long-term care services. As Chart 4 indicates, the budget proposes almost $2 billion for these two programs ($390 million for IHSS and $1.5 billion for Medi-Cal), or 48 percent of total expenditures for senior programs. Of the total amount proposed for Medi-Cal, $831 million, or 55 percent, is for nursing facility care for persons age 65 and over.

Table 3 shows that three-quarters of nursing facility residents are women and nearly three-quarters are over 75 years old. In addition, national studies have shown that widows and widowers, whites, and persons with few children are disproportionately represented among nursing facility residents. Table 3 also shows that women are the majority of IHSS recipients. The Department of Social Services (DSS) data on IHSS further show that 76 percent of the recipients do not have a spouse available to provide care and that 48 percent are minorities.

Although nursing facility costs represent over half of all Medi-Cal expenditures for the elderly, only 2.9 percent of California's population 65 and over is in nursing facilities, as compared to the national average of 5 percent. This may be attributable to several factors including (1) the limited number of nursing facility beds available in the state, (2) California's relatively heavy use of nonmedical residential care facilities, and (3) the availability of alternative community services in California, most notably IHSS.

California's low nursing facility utilization rate may demonstrate that, in many cases, the programs shown on Table 3 are *alternatives* for each other. Thus, the availability or lack of one service can have an impact on the demand and utilization of other services.

While for some individuals the programs in Table 3 may serve as alternatives to each other, other individuals may need the services of several of the programs. For example, the Multipurpose Senior Services Program (MSSP) provides a multidisciplinary assessment of its clients to

help them remain at home. The assessment often calls for the individual to receive IHSS services and to participate in an Adult Day Health Care (ADHC) program. In addition to receiving other long-term care services, the same MSSP client could receive meals and transportation through an Older Americans Act provider, medical coverage through Medi-Cal, and cash assistance through SSI/SSP.

Currently, programs within and across departments are unable to report on all the services that individual clients receive. The lack of unduplicated client data makes it difficult to identify the various packages of services that different subgroups of the elderly population may require, or the total number of individuals currently being served by the programs.

Finally, Table 3 illustrates that most of the programs that serve the disabled elderly also serve a younger disabled client population. In the future, the Legislature will be faced with the increasing demands of a growing number of individuals under 65 with similar disabilities and service needs. Two major factors in this regard are (1) improvements in medical technology that prolong the lives of persons of all ages with chronic diseases or disabilities and (2) the increasing number of persons with AIDS who may require long-term care services. Although this section focuses on senior programs, it is important to remember that many of the programs that serve seniors have a broader pool of potential recipients, and changes in the under 65 population will also affect the demand for the programs.

Older Americans Act (OAA) Programs. Chart 4 includes expenditures for two programs—nutrition ($101 million) and supportive services and centers ($53 million)—which are funded by the OAA. Enacted in 1965, the OAA provides funding for a range of services for persons 60 and over. The OAA prohibits the use of a means test for these programs but requires that they be targeted at persons in greatest social and economic need.

The CDA, based on federal guidelines, defines individuals as having the greatest social need if they have at least two of the following characteristics: a language/communication barrier, a handicap, they live alone, or they are 75 or over. Individuals are classified as having greatest economic need if their incomes are at or below the SSI/SSP grant levels.

Although available to any person over 60, the programs currently serve primarily those in greatest social or economic need. The CDA reports that in 1987-88, 47 percent of participants in congregate nutrition programs (meals served at a nutrition site) met the criterion of greatest economic need, and 27 percent met the criterion for greatest social need. Of the CDA's clients who received home-delivered meals, 54 percent were categorized as being in greatest economic need and 64 percent

were categorized as being in greatest social need (the two percentages exceed 100 percent because some people are counted in both categories). In the supportive services and centers category, 54 percent of transportation recipients were in greatest economic need and 53 percent were in greatest social need. Among in-home service recipients, 44 percent were in greatest economic need and 58 percent were in greatest social need.

WHAT IS THE "UNMET NEED" FOR SENIOR PROGRAMS?

The Legislature has focused greater attention in recent years on the "unmet needs" of the elderly population. "Unmet need" has also been a concern at the federal level. For example, the 1987 amendments to the OAA require the U.S. Commissioner on Aging to submit to Congress by September 30, 1989, the *national* unmet need for all OAA programs. The CDA is required to submit data on California's unmet needs by June 30, 1989.

Obviously, decisionmakers need information on the needs of the elderly population in order to design senior services and programs and to guide them in allocating resources to and among the various programs. Assessments of "unmet need" are potentially useful in both respects. There are, however, two significant problems that arise in assessing unmet need. First, the term "need" itself is subjective. Specifically, a service that one policymaker regards as a necessity may not be seen in the same light by a policymaker with a different set of priorities.

Second, the available data on seniors and on their use of existing services are limited. As Table 3 illustrates, many of these programs serve clients within the same subgroups. A person could choose one or more of several services to meet his or her needs. For example, an elderly disabled person could use ADHC and/or IHSS. Estimates of unmet need for any one program are, therefore, limited by the lack of data on how older people use services, or what the trade-offs are between programs.

To help bring the question of unmet need into sharper focus for the Legislature, we have selected three programs for further review: one entitlement program—the IHSS program—and two programs that are currently available only in certain parts of the state—the ADHC and the Alzheimer's Day Care Resource Centers (ADCRC) programs.

The In-Home Supportive Services (IHSS) Program

The IHSS program is an entitlement program—that is, any individual in the state is entitled to receive program benefits if he or she meets the eligibility criteria. These criteria consist of income and resource criteria (the individual must be "poor" enough to qualify for SSI/SSP) and need criteria (the individual must be aged, blind, or disabled and be assessed by a county social worker as needing the care provided by the program

to remain safely at home). Like other entitlement programs for the elderly—such as the SSI/SSP, Medi-Cal, and property tax assistance programs—the availability of IHSS is *not* limited by the appropriation levels in the budget.

Thus, at one level the program could be considered to have *no* unmet needs, as all eligible persons who seek these services are provided them. Even though IHSS is an entitlement program, the Legislature is still frequently confronted with issues regarding unmet need for IHSS, which usually fall into one or more of the following categories.

Administrative Issues. The IHSS program is administered by 58 different counties. There are, consequently, practical differences with respect to how each county assesses need and makes arrangements to deliver services. These differences can have a significant effect on the level of service actually provided to recipients. For example, the average IHSS hours per case in 1988-89 ranges from a high of 116 to a low of 22, depending on the county. Individuals in low-hour counties could argue that they have unmet needs because their county is providing fewer hours than they might get in another county.

Cost Control Issues. Benefit levels in the IHSS program have been partially influenced by the Legislature's decision to control program costs. Currently, the major cost control measure in the IHSS program is the statutory limit on the number of hours per month that an individual can receive (283 hours for severely impaired and 195 hours for non-severely impaired clients). The DSS estimates that 1.2 percent of IHSS recipients, or approximately 16,000 recipients in 1988-89, have been assessed by county social workers as needing more hours than the statutory limit allows. Therefore, the limit on hours results in "unmet needs" for some recipients.

The 1989-90 Budget proposes a $64 million General Fund savings due to proposed new IHSS cost control measures that could have a significant impact on the extent to which the program meets the needs of recipients. We discuss the proposed new cost control measures in more detail in our *Analysis of the 1989-90 Budget Bill* (please see Item 5180-151-001).

Eligibility Issues. Under the current IHSS program, it is possible for an older person to "need" IHSS services but not receive them. Specifically, the existing IHSS eligibility criteria target services at individuals who are poor enough to qualify for SSI/SSP. People with more income than SSI/SSP recipients can receive the services, but they are required to pay for them out of their own pockets, at least until they "spend down" their incomes to welfare levels. Thus, individuals may have "unmet needs" because they require IHSS services to remain safely at home, yet the income and resource limits are too low for them to qualify for the services without charge.

Program Flexibility Issues. The IHSS program provides assistance to recipients with the goal of helping them to remain safely at home. Some individuals may receive IHSS hours when some other kind of service that the IHSS program cannot provide could meet their needs. For example, a person who has difficulty walking can receive IHSS hours for shopping and meal preparation. However, under current IHSS guidelines, the program cannot purchase a walker or wheelchair ramp to help the recipient perform these tasks more independently, and thereby reduce the amount of IHSS hours needed. Individuals who want to be more independent could have "unmet needs" because, under current law, the IHSS program does not have the flexibility to purchase the needed equipment.

Program Awareness Issues. Finally, the Legislature often hears of individuals who need IHSS and who meet the eligibility requirements of the program, but who do not receive services because they are not aware that the services are available.

The Legislature has a great deal of flexibility in how it addresses each of the kinds of unmet needs issues that arise with respect to the IHSS program. Unlike many entitlement programs, there are few federal constraints on how the Legislature can structure the IHSS program. On the other hand, dealing with any of these unmet need issues would involve major fiscal or programmatic trade-offs. For example, the Legislature could eliminate the statutory limit on the maximum hours of service that individual recipients can receive, but to do so would either entail major new costs or the implementation of an alternative cost control mechanism. Similarly, the Legislature could raise the IHSS income and resource limits so that individuals with higher incomes could receive IHSS, but to do so would also entail major new costs. Raising the financial need standard for IHSS would also raise the issue of increasing similar limits for SSI/SSP and Medi-Cal eligibility.

The Adult Day Health Care (ADHC) Program

The ADHC program provides health, therapeutic, and social support services to persons 18 and over whose disability places them at risk of institutionalization. There are 63 ADHC centers in 24 counties, and we estimate that the average center serves approximately 70 elderly and 20 nonelderly clients per month. ADHC is a Medi-Cal benefit for eligible beneficiaries and the CDA estimates that almost two-thirds of ADHC clients are Medi-Cal recipients. The remainder are private clients who pay on a sliding fee basis. Currently, only private nonprofit organizations can be licensed as ADHC centers and receive Medi-Cal funding.

Since ADHC is available in only 24 counties and to only a limited extent in those counties, it is reasonable to assume that there is an "unmet need"

for this service. That is, if the service were available statewide, more people would use it. One way to estimate this need is by using research estimates which have shown that (1) 5 percent of those over age 65 and *not in nursing facilities* are disabled enough to qualify for ADHC and (2) in communities where ADHC is available, 25 percent of those eligible would actually use the service, while the remaining 75 percent would use other alternatives such as in-home services or family caregivers. Applying these figures to California's elderly population, we estimate that 37,000 individuals who are not now in nursing facilities would use ADHC if it were available statewide. This represents an increase of 33,000 clients over the number currently served by ADHC centers. In addition, some unknown portion of the state's nursing facility population would also probably use ADHC centers if more were available.

Assuming a caseload of 70 elderly clients per center, the state would need 530 centers to serve 37,000 elderly ADHC clients. Thus, according to this methodology, *it would take an increase of at least 467 centers, or roughly 700 percent, to provide enough slots for all potential elderly ADHC users in the state.*

In the past, the Legislature has encouraged the opening of new centers by providing one-time "start-up" grants of up to $50,000 per center. One way to meet the "unmet need" for ADHC identified above would be to provide more of these start-up grants. Using this approach, it would cost up to $23 million General Fund to create 467 new centers.

In addition to the start-up costs, the expanded ADHC capacity would result in potential ongoing costs to the Medi-Cal program. For example, if the new centers served 11 percent Medi-Cal clients (the approximate ratio of Medi-Cal beneficiaries in California's over-65, nonnursing facility population), the costs of their care to the Medi-Cal program, assuming the current rate of reimbursement, would be about $22 million ($11 million General Fund) annually.

These costs, however, would be offset to an unknown extent by savings associated with increased ADHC use. First, it could reduce costs for IHSS, Medi-Cal (for services such as hospitalization and home health services), and other community services now being used by these clients. Second, to the extent that the increase resulted in an overall reduction in nursing facility use by all Medi-Cal clients, the Medi-Cal program would experience savings. This is because the Medi-Cal rate for nursing homes is more than the rate for ADHC. However, the current demand for nursing facility beds outstrips the supply in California. It would therefore take a substantial increase in ADHC use to reduce the actual Medi-Cal use of nursing facility beds in the state.

Given the magnitude of the "unmet need" for ADHC, it is important to consider why there are currently so few centers in California. One

explanation may be that providers are discouraged from starting new centers because the fees that they receive are low, relative to their operating costs. Thus, in addition to the option of providing more start-up grants, the Legislature has two options for increasing the supply of ADHC: (1) increase the Medi-Cal rate (which would result in new General Fund costs) and (2) review the existing ADHC licensing requirements in order to identify ways of reducing providers' costs.

Alzheimer's Day Care Resource Centers (ADCRCs)

ADCRCs offer a day program of nursing, activities, and supervision to persons who are suffering from moderate to severe Alzheimer's disease or a related dementia disorder such as Parkinson's disease. The CDA advises that 26 ADCRCs will serve approximately 1,500 clients in 1989-90. These centers receive annual General Fund grants of approximately $60,000 and are required to provide a 25 percent match from county, Area Agency on Aging (AAA), or other local funds. In addition to state and local resources, the centers receive some of their funding from revenues generated by a fee, which is based on a sliding scale tied to client income.

National estimates on the prevalence of dementia vary. In the past, the CDA has used the estimate of the Congressional Office of Technology Assessment (OTA) that severe dementia affects 1 percent of those age 65 to 74, 7 percent age 75 to 84, and 25 percent over the age of 85. In addition, the OTA estimates that there are one to three persons with moderate dementia for every person with severe dementia.

Using a conservative estimate of a one-to-one ratio for moderate to severe dementia, we estimate that in 1988, up to 300,000 persons 65 and over are eligible for the ADCRC program. Assuming the same 25 percent utilization rate that we applied for ADHCs, this would mean that approximately 75,000 persons might use ADCRCs if these centers were available statewide. To serve a clientele of this magnitude would require approximately 1,300 new centers. At the current General Fund cost of $60,000 per center, *this would result in a new ongoing General Fund cost of $78 million per year.* Increasing the number of ADCRCs could also reduce costs for alternative services (such as IHSS and ADHCs) to the extent that individuals choose ADCRCs over those programs. Nevertheless, our analysis indicates that it would require a major new General Fund commitment to expand the ADCRC program statewide.

WHAT GUIDELINES SHOULD GOVERN LEGISLATIVE DECISIONMAKING?

In developing a strategy for responding to the increasing demands for services for the elderly, there is no "right" or "best" approach. The strategy selected by the Legislature will depend on its spending priorities, available state resources, and policy decisions about the types of

programs and benefits to provide for older people. Our review of programs for seniors, however, suggests that there are several guidelines which deserve high priority in the Legislature's planning process.

Give High Priority to Funding Services Targeted at Elderly Subgroups Most in Need of Government Services. Older people are members of a variety of subgroups, each with different needs, rather than a homogeneous population, all with the same needs. To a large extent, the Legislature's priorities for serving these subgroups are reflected in the way existing programs are set up. That is, most of the money the state now spends on seniors goes to serve the poorest and the most disabled. In directing resources to programs for seniors, the Legislature may have to further target limited state resources on the most needy subgroups. For example, our review of senior nutrition programs shows that a higher percent of home-delivered meals participants are in "greatest economic need" (54 percent) than those served at a congregate nutrition site (47 percent). In addition, home delivered meal participants are homebound by reason of illness or disability, or are otherwise isolated. Moreover, 64 percent of home-delivered meal recipients are in "greatest social need," compared to 27 percent in the congregate program. Therefore, in allocating resources for senior nutrition, the Legislature may wish to give priority to the home-delivered meals program because it is targeted at one of the neediest subgroups of the elderly population.

Give Priority to Funding Programs in Underserved Areas. The Legislature has established a number of programs for seniors in recent years, particularly in the area of long-term care, that are not available statewide. Given the limited resources available for increasing the availability of these programs, we think the Legislature should consider expanding first into underserved areas that have demonstrated needs but that currently have few programs or have not benefitted from the recent expansion of long-term care programs.

One way that the Legislature could accomplish the goal of expanding services to underserved areas would be to establish funding criteria for programs that are flexible enough to permit the selection of communities with few existing programs. Currently, new applicants are often required to show that they have previous experience in providing the service, or that there are services available in their communities that will enhance their ability to respond to client needs. While these requirements are intended to ensure program quality, they also have the unintended effect of limiting the ability of providers in underserved areas, who are likely to have limited program experience and few available community services to submit successful applications.

Evaluate Program Goals. There are a variety of goals that may be appropriate for senior services—preventing institutional placement, pro-

moting independence, assisting family caregivers, reducing poverty, or preventing illness. The particular goal of a program can significantly affect its costs and its ability to meet needs.

Under current law, for example, the IHSS program currently has a stated goal of keeping individuals "safe" in their own homes. For this reason, IHSS provides domestic and personal care services to recipients who are not at risk of nursing facility placement. If, however, the IHSS program's goal were to prevent or delay institutional placement, the program would probably not serve most of these clients at all. Instead, it would offer a relatively high level of services, potentially including hours above the current maximum, to a reduced recipient population—those at risk of being placed in a nursing facility—to prevent their institutionalization. Alternatively, if the goal were to promote independence, it might provide services such as walkers or wheelchair ramps that are currently not available. We think it is important for the Legislature to evaluate the cost implications and client impacts of alternative goals for senior programs.

Minimize Program Duplication and Encourage Local Cooperation. Current programs within and across departments are unable to report an unduplicated count of the clients they serve or to identify all the services that individuals receive. This lack of program data makes it impossible to determine the extent to which current programs duplicate and overlap each other. Nevertheless, it is clear that a number of local agencies—county welfare departments, AAAs, Medi-Cal field offices, long-term care programs, and private agencies—provide services to the same clients. Each program incurs costs to keep client records, report to state departments, perform assessments of client needs, and monitor the services provided. To minimize the potential for duplication and inefficiency that exists when so many agencies serve the same or similar individuals, the Legislature could require local agencies to consolidate administrative functions, or it could provide funding incentives to encourage local agencies to work together or to consolidate.

In addition, in order to better identify overlap and duplication, the Legislature could encourage the CDA to improve its data collection systems. We discuss the department's data collection systems in more detail in our *Analysis of the 1989-90 Budget Bill* (please see Item 4170).

CONCLUSION

For purposes of determining the demand for senior programs, the elderly should be viewed as members of a variety of subgroups, some of which may not require government assistance. Currently, the majority of state spending for older people is on income support and health services primarily for the elderly poor.

Departments that currently serve the elderly cannot provide an unduplicated client count of their clientele across programs, and there is limited information about patterns of service utilization by this population group. Using current program definitions, eligibility criteria, and demographic data, it is possible to estimate the potential demand for some programs that serve the elderly. However, these estimates do not account for the individual choices and preferences that would ultimately determine how clients would use the services.

There are two significant problems that arise in assessing unmet need for senior services for purposes of legislative decisionmaking. First, "need" is a subjective term meaning different things to different policymakers. Second, existing data on program use is limited. Therefore, the Legislature may wish to allocate resources for senior programs using priority guidelines, and to continually review existing programs and eligibility criteria to ensure that programs serve priority subgroups of the elderly in the most cost-effective manner.

Insurance Reform

What Effects Will Proposition 103 Have on Buyers and Sellers of Automobile Insurance in California?

Summary

- *Proposition 103, which the voters approved in November 1988, provides for insurance premium rate rollbacks, the approval of future rate increases, and measures intended to make California's insurance industry more competitive. While the measure affects auto, fire and liability insurance, this analysis focuses solely on auto insurance because it is the largest segment affected by the measure.*
- *The insurance industry's current problems are traceable to a variety of factors. Consequently, there is no one simple solution to them.*
- *The effects of Proposition 103 on buyers and sellers of insurance are difficult to predict, and will not be known until the measure becomes fully implemented and operational.*
- *The most important determinants of Proposition 103's effects will be how regulatory decisions are made, and whether the insurance industry's premium rates have been due to excessively high profits or simply the high costs of providing insurance coverage. If regulatory decisions under Proposition 103 take proper consideration of economic factors, and the rate review process itself is not overly burdensome, the measure could help ensure that rates are consistent with the underlying costs of providing insurance coverage.*
- *The insurance industry has certain competitive elements, such as many firms and ease of entry into the business. However, little reliable data exist as to whether or not the insurance industry's current profits are excessive. This is due both to data limitations and disagreements about how to measure such profits.*
- *In order for the rate regulation process to work properly and create a minimum of economic inefficiencies and distortions, it is imperative that the immediate and longer-term regulatory decisions relating to premium rate rollbacks and future premium increases be based on such factors as actual costs and reasonable rates of return on investment.*
- *Standards must immediately be established both for measuring the profitability of individual firms, allocating their costs to different lines of insurance, and designating what level of profitability is "acceptable" for the purpose of approving premium increase requests. The Legislature should closely monitor this process to ensure that it is done properly.*

- *Regardless of whether or not the industry's premium rates and profits are excessive, much of its current problems appear related to the rising underlying costs of providing insurance coverage. Proposition 103 does not address this factor, and, to do so, other approaches will be needed. There are a number of different options which the Legislature can consider for influencing costs.*

INTRODUCTION

On November 8, 1988 California voters approved Proposition 103, one of five different insurance reform measures that were on the statewide ballot. Proposition 103 provides for significant reductions in premium rates for certain types of insurance (auto, fire and liability) and makes various changes regarding how the insurance industry is to be regulated in California. The primary impetus behind passage of the measure appears to have been the rapid rise in insurance premium rates in recent years, combined with uncertainty as to whether these premium increases are fully justifiable on the basis of the actual costs of providing insurance coverage.

The full implications of Proposition 103 for buyers and sellers of insurance in California are not yet known, and will only become apparent over time, after its provisions are fully implemented. Nevertheless, many questions have already been raised regarding what the likely effects of the measure will be. This analysis discusses the various possible outcomes which might occur under Proposition 103 and the factors that will influence exactly which ones ultimately prevail. The analysis focuses on private automobile liability and property-damage insurance coverage, because it is the largest segment affected by Proposition 103 and the segment which has received the most attention from both the Legislature and the public.

WHAT DOES PROPOSITION 103 DO?

Table 1 summarizes the provisions of Proposition 103. Four types of provisions are especially significant.

Premium Rate Rollbacks. Proposition 103 requires that premium rates for all policies written or renewed after November 8, 1988 be *reduced by 20 percent* from the levels in effect as of November 8, 1987 (one year prior to the election). Premium rates are then frozen until November 8, 1989, at which time *a further 20 percent rate reduction* is required for "good drivers." The measure allows individual insurance companies to file for a full or partial exemption from the rate rollbacks if they are threatened by "insolvency" (a term which the measure does not specifically define).

Table 1
Provisions of Proposition 103 [a]

Category	*Key Provisions*
Rate changes:	
Initial rollback	• 20% below rates in effect on November 8, 1987 for all policies written or renewed after November 8, 1988
Additional changes	• Rate freeze until November 8, 1989 • Additional 20% reduction in auto insurance rates for all "good drivers" beginning November 8, 1989
Rate regulation:	
Filing and justification	• Effective November 8, 1989, prior review and approval of all rate changes • Justification for all rate changes
Basis for rate	• Rates must reflect investment earnings • No consideration given to "competitive conditions"
Factors for establishing rate classes	• Primary consideration given to driving record and miles driven • Secondary consideration given to years of driving experience and other factors as determined by commissioner
Antitrust	• Removes current exemption from antitrust and unfair business practice laws
Consumer Assistance	• Establishes a nonprofit corporation to assist consumers and intervene in rate proceedings • Requires Department of Insurance to provide comparative rate information for consumers upon request
Other Features	• Permits sale of insurance by state-chartered banks • Permits discounts and rebates by insurance agents • Requires election of Insurance Commissioner • Increases gross premiums tax and regulatory assessments to offset administrative costs and state revenue losses due to insurance rate reductions

[a] These provisions generally apply to all lines of insurance covered by Proposition 103 (including auto, fire and liability).

Rate Regulation. Prior to Proposition 103, insurance companies were not required to file rate changes with the Insurance Commissioner. The Commissioner, however, had the authority to investigate rate changes and require modifications in rates if they were found to be unjustified. (This authority, however, was seldom exercised.) In contrast, Proposition 103 establishes a *prior approval* process whereby any premium rate change must be filed with the Department of Insurance and cannot go into effect until approved by the Commissioner. All proposed rate changes that exceed 7 percent for personal lines and 15 percent for commercial lines *must* be reviewed by the Commissioner. The Commissioner can *choose* whether or not to review smaller rate changes. If the Commissioner declines to undertake this review, these rate changes automatically go into effect after 60 days.

Antitrust and Unfair Business Practices. Proposition 103 eliminates exemption of the insurance industry to the state's antitrust and unfair business practices (such as price discrimination) laws. Removing these exemptions allows the Attorney General to pursue investigations and bring civil or criminal prosecutions where violations of law are found.

Other Measures to Enhance Competition. Proposition 103 removed several provisions that may have restricted competition between insurance companies. These provisions include (1) restrictions on group insurance, (2) prohibitions on agent commission rebates, and (3) restrictions on entry into the insurance business by commercial banks. Additionally, Proposition 103 requires the Department of Insurance to make available to consumers premium rate comparisons. These provisions are intended to improve the performance of the insurance industry by enhancing competition.

Proposition 103 also provides for election of the California Insurance Commissioner and establishment of nonprofit consumer-intervenor groups.

THE EFFECTS OF PROPOSITION 103—WHAT ARE THE KEY ISSUES?

Many different questions have been raised regarding the possible effects that Proposition 103, once fully implemented, will have on the buyers and sellers of insurance in California. The most frequently asked questions are:

- What will happen to insurance premium rates?
- How will the measure affect the ability of Californians to obtain insurance coverage?
- What will the measure do to the ability of insurance companies to operate profitably in California (including the industry's competitiveness, profitability, and, ultimately, its overall financial health)?

How the Regulatory Process Functions Will Be Critical. As noted earlier, complete answers to these questions will only become apparent once Proposition 103 has been fully implemented and its effects have had time to surface. One thing, however, is clear—the final outcome will depend, to a large degree, on *how the regulatory process established by Proposition 103 functions*, including the specific criteria that will be used to make decisions regarding premium rates. That is, the effects of Proposition 103 on California buyers and sellers of insurance will depend on how the performance of the insurance industry under the rate regulation authority of Proposition 103 differs from how the industry has performed in the past. Proposition 103's effects also will depend on the impacts of the measure's pro-competitive enforcement powers—antitrust investigations and prosecutions under the unfair business practice laws.

Given this, we next review what is known about the insurance industry's characteristics and past performance, followed by a discussion of the different types of outcomes that could result under Proposition 103, depending on exactly the how the regulatory process works.

CHARACTERISTICS AND PAST PERFORMANCE OF THE INSURANCE INDUSTRY

The key issues of interest here are—*Why have insurance rates been increasing so rapidly in recent years, and why has it become hard to obtain affordable insurance coverage in certain areas of the state?* Two main explanations have been suggested. The first is that the insurance industry has simply been responding to such factors as increased numbers of claims and higher settlement costs. The second is that the insurance industry itself is uncompetitive, and has been charging higher rates in order to earn excessive profits. In considering these theories, the basic question to ask is: *To what extent has California's insurance industry been performing in a competitive fashion in recent years?*

Why Does the Degree of Competitiveness Matter?

It is important to ask whether the insurance industry is "competitive" because price levels in competitive industries generally are not out of line with costs, nor do firms earn excessive profits over the long term. In contrast, "noncompetitive" industries often are able to earn excessive profits and charge consumers higher prices than their costs alone can justify. Thus, for example, if the insurance industry *has* in the past been competitive in its pricing and profitability, Proposition 103's rate rollbacks would not be sustainable in the long run and could cause significant disruptions in the short run, including cutbacks in insurance availability. If, on the other hand, the industry *has not* been performing competitively, then these rollbacks could be absorbed from excess profits and sustained in the long run. (Even in this event, however, there could be near-term disruptions as firms adjust to this new environment.)

Is the Insurance Industry Competitive?

Considerable disagreement exists regarding whether insurance premiums and profits generally are greater than those which a competitive environment would produce. Past studies examining this issue seem to suggest that, at least on a *broad industry-wide basis*, the profits earned on private automobile insurance lines of coverage have not been excessive compared either to other financial or to manufacturing industries. However, only a couple of these studies have focused specifically on the profits of California auto insurance companies during the mid- to late-1980s. Thus, at present, the evidence is not very conclusive as to exactly how profitable insurance companies are, including whether their profits are "excessive" compared to those which a competitive environment would produce.

Measuring Profitability Poses Problems. The main reason for this disagreement involves the problem of measuring insurance company profits, including obtaining the necessary data and determining the

precise methodology for calculating profits. The earnings of insurance companies are the net result of two factors: (1) their net underwriting profits or losses and (2) the investment income from the reserve balances they maintain. Depending upon the accounting assumptions used to treat this investment income, a variety of different profit measures can be computed, and no consensus appears to exist regarding which measure is correct as an indicator of overall competitiveness.

What Do Other Indicators of Competitiveness Show? Given the problems of relying on profit data to determine if the insurance industry is performing competitively, an alternative approach is to ask whether the general structure of the industry is suggestive of a competitive environment. This involves looking at factors which economists have found usually correlate with competitive markets, such as the number of firms competing in an industry and the ability of new firms to successfully enter the industry. Our analysis indicates that:

- ***Many Insurance Firms Compete With One Another.*** Currently, there are about 300 firms that compete against one another in California selling automobile insurance, 54 of which each have sales exceeding $20 million. Table 2 lists the market share and total premiums earned for the 30 largest companies selling private auto insurance in California. While it is true that eight firms account for nearly two-thirds of all insurance sales, other measures of market share indicate levels of market concentration lower than federal antitrust authorities usually consider as being potentially anticompetitive.
- ***New Firms Constantly Enter the Market.*** Over the 10-year period 1977 through 1987, 106 companies entered the private passenger automobile insurance market in California, whereas 89 left the market. Thus, the number of competing firms actually has increased somewhat over time.

Conclusion—Competitive Elements Are Present. The available data suggest that certain competitive elements are at work in California's insurance industry. Given this, *it is not at all clear that California's high insurance rates are due to an uncompetitive insurance industry that charges too much and earns excessive profits.*

What Other Factors Might Be Causing Insurance-Related Problems?

To the extent that uncompetitive performance is not the main cause behind high and rising insurance premiums and difficulties in obtaining insurance coverage in certain regions of the state, the main alternative explanation for these problems is that they primarily reflect *the increasing costs of providing insurance coverage to consumers.* If this is true, insurance companies are simply "passing through" to consumers the increased costs of providing insurance and are no different from the

Table 2
30 Largest Private Automobile Insurers in California Market Share in 1977, 1982 and 1987

Company[a]	*Total Premiums 1987 (in millions)*	*Market Share* 1977	1982	1987
State Farm Mutual	$1,427.1	15.8%	16.7%	15.4%
Farmers Insurance Exchange	893.7	9.9	11.5	9.6
CSAA Inter-Exchange Bureau	863.0	7.8	8.8	9.3
Allstate Insurance	851.8	10.2	10.3	9.2
Auto Club of Southern California	767.9	11.5	11.8	8.3
Twentieth Century Insurance	446.5	1.2	2.4	4.8
Mid-Century Insurance	322.0	3.6	2.8	3.5
Mercury Casualty	242.7	2.0	1.1	2.6
USAA	230.4	2.1	2.4	2.5
State Farm Fire & Casualty	157.3	1.1	0.8	1.7
Government Employees Insurance	120.6	1.2	1.1	1.3
Safeco Insurance of America	105.7	1.6	1.5	1.1
Progressive Casualty Insurance	103.8	0.1	0.6	1.1
New York Underwriters	88.6	0.0	0.0	1.0
California Casualty Indemnity Exchange	86.1	1.0	0.9	0.9
Century-National	85.0	0.5	0.5	0.9
West American Insurance	74.3	1.1	1.2	0.8
Liberty Mutual Fire	73.5	0.7	0.7	0.8
Nationwide Mutual	66.4	0.1	0.2	0.7
Aetna Casualty & Surety	64.7	1.5	0.6	0.7
USAA Casualty Insurance	64.5	0.2	0.3	0.7
Mercury Insurance	62.7	0.0	0.1	0.7
Calfarm Insurance	57.9	0.6	0.5	0.6
Allstate Indemnity	56.4	0.3	0.1	0.6
California Casualty Insurance	54.8	0.6	0.6	0.6
Progressive Specialty Insurance	54.3	0.0	0.1	0.6
Dairyland Insurance	50.3	0.2	0.5	0.5
Colonial Penn Insurance	49.5	0.7	0.6	0.5
Financial Indemnity	47.8	0.4	0.3	0.5
All West Insurance	46.1	0.0	0.3	0.5

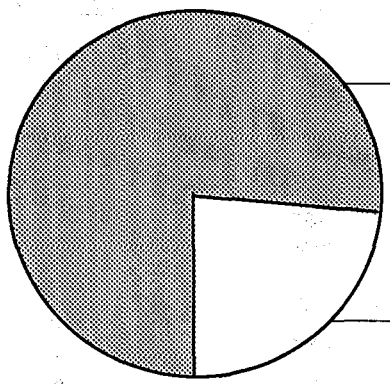
[a] Certain companies in the list have common ownership.
Source: *Underwriter's Report, Annual Statistical Edition* (1978, 1983, and 1988).

sellers of other goods who incorporate their costs into the prices they charge their customers. This, in turn, would imply that the "solution" to problems like high premium rates is not to regulate rates in hopes of lowering them, *but rather to try to reduce the underlying cost pressures that insurers face.*

What Types of Costs Do Insurers Face? Chart 1 summarizes the major cost components of providing automobile coverage. (These data represent average costs for the insurance market generally. Significant cost differences for providing insurance to consumers exist between urban and rural areas, within urban areas themselves and from company to company.) Chart 1 indicates that:

Chart 1

Where The Insurance Dollar Goes[a]



Claims-Related Expenses	
Type	Share
Collision and comprehensive	20%
Property damage liability	13
Wage loss and other economic damages	10
Medical costs	9
Plaintiff attorneys	8
Company attorneys	6
Pain and suffering	5
Other claims-handling expenses	6
Total	77%

Other Expenses	
Type	Share
Commissions and selling expenses	13%
General expenses and surplus (or profits)	6
Taxes and license fees	3
Dividends to policy holders	1
Total	23%

[a] Source: Insurance Information Institute. These estimates include both premiums and investment earnings based on 1986 revenues and costs.

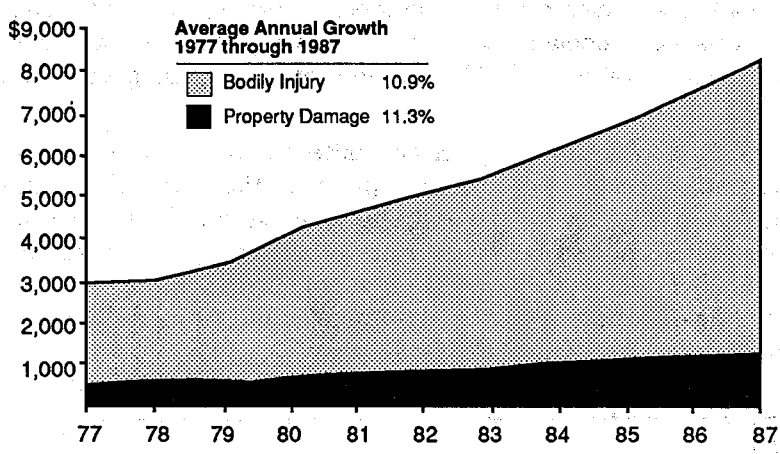
- About 77 percent of each dollar of premium and investment income is either directly or indirectly associated with paying insurance claims.
- Of the remaining 23 percent, 13 percent is for insurance commissions and selling expenses, 6 percent is for general expenses and surplus (surplus represents the funds available to the company to support expansion), 3 percent is for taxes and license fees, and 1 percent is for dividends to policyholders.

Thus, most of the gross income earned by insurers goes for paying claims, marketing insurance products, and paying general business expenses. It is only natural that premium rates will reflect increases in these and other cost components.

What Has Been Happening to Costs? The evidence indicates that many of the cost components of providing automobile insurance coverage *have been experiencing significant increases in recent years.* This certainly comes as no surprise to anyone who has recently visited an automobile body shop to have collision damage repaired, or spent time in a hospital to receive medical treatment for accident-related bodily injuries. Charts 2 and 3 show the statewide trend of average loss payments by major loss category paid by insurance companies from 1977 through 1987. The different loss measures shown all indicate that rates have grown in excess of 10 percent annually over the last 10 years.

Chart 2

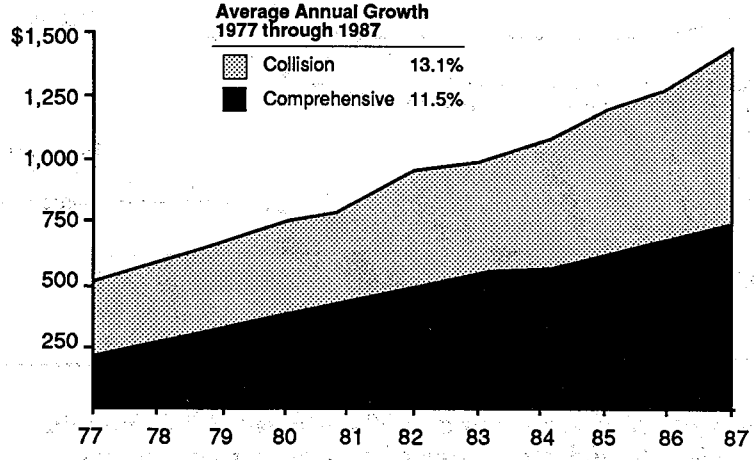
Bodily Injury and Property Damage Average Cost per Claim for Cars in California 1977 through 1987[a]



[a] Source: Fast Track Monitoring System, National Association of Independent Insurers.

Chart 3

Comprehensive and Collision Damage Average Cost per Claim for Cars in California 1977 through 1987[a]



[a] Source: Fast Track Monitoring System, National Association of Independent Insurers.

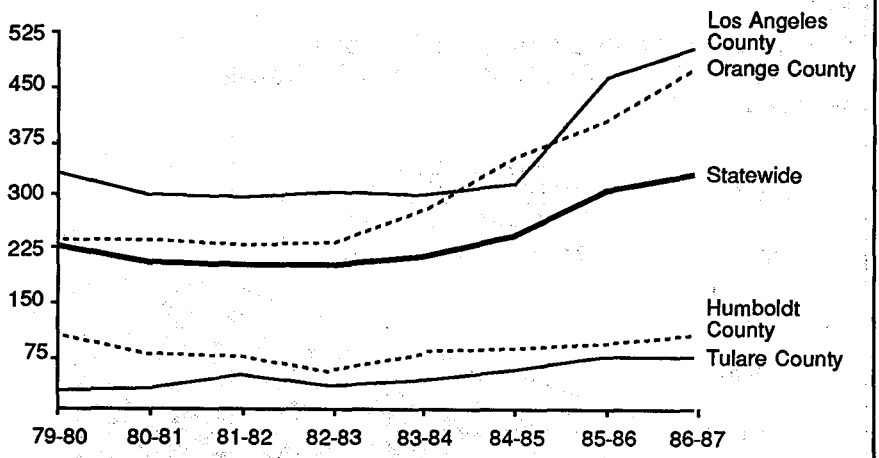
California Has Especially High Costs. Insurance industry data indicate that California has higher insurance premiums than all but a few states. This appears to be the combined effect of a variety of factors, including: (1) the relatively high percentage of the population that lives in urban areas, (2) congested freeways in large urban areas, (3) relatively more small cars (which can result in more severe injuries), (4) relatively more sports and specialty cars (which have higher repair bills), (5) higher litigation rates, and (6) relatively high and rising vehicle theft rates.

California also exhibits significant differences in claims costs and frequencies of claims for different parts of the state. For example, average claim costs are 98 percent above the statewide average in Los Angeles and 17 percent below the statewide average for Sacramento. In addition, Chart 4 shows that accident victims with injuries are far more likely to litigate claims in court in Los Angeles and Orange Counties than in rural areas such as Humboldt and Tulare Counties.

Chart 4

Automobile-Related Lawsuit Rates Statewide and Selected Counties

1979-80 through 1986-87 (lawsuits per 100,000 population)



What Has Been Happening to Premiums? Rising premiums have accompanied the industry's costs of providing insurance coverage. This can be seen by looking at premium data (available from an industry

rating bureau) for several large California insurers over the period 1980 through 1988. Although these data have significant shortcomings, they seem to suggest that premium rate increases during this period *generally* were in line with claims cost increases. These data also show significant differences in premium rates between rural and urban areas of the state (for example, rates in central Los Angeles were about three times as high as in Humboldt County in 1988).

Conclusion—Costs Are a Key Factor. Given the significant rates of increase in insurance cost components in recent years and the increased propensity for claims to be filed, it is reasonable to conclude that high and rising costs of providing insurance coverage are key contributors to the problems of high premium rates and restricted availability of insurance in certain geographic areas. This, in turn, suggests that addressing these problems requires devising means of reducing these costs or at least slowing their increase in the future. Given that many different factors affect the cost to insurers of providing automobile insurance coverage, a variety of approaches will be needed.

Summary Regarding Industry Performance

The insurance industry has a relatively small number of firms accounting for a majority of sales and undoubtedly has certain other attributes suggesting potential performance problems. However, it also appears to have a market structure which is consistent with a reasonable degree of competition. It also is the case that the costs of providing insurance coverage seem to have increased significantly in recent years, due to factors like rising automobile repair costs, medical expenses, and liability claims and settlements. Thus, while competitive shortcomings may explain part of California's current insurance-related problems, it seems doubtful that these problems can be addressed without also dealing with the fundamental underlying cost problem—namely, *insurance coverage is becoming increasingly expensive to provide.*

THE IMPACTS OF PROPOSITION 103 ON INSURANCE BUYERS AND SELLERS

As noted earlier, the key questions regarding how Proposition 103 will affect buyers and sellers of insurance relate to how its basic provisions will affect insurance premium rates, availability of insurance coverage, and the ability of insurers to operate profitably in the state. As discussed below, these effects will depend primarily on three factors:

- The extent to which the industry has already been performing in a *reasonably competitive manner*, minimizing costs and earning adequate profits.
- The degree to which the *underlying costs* of providing insurance will be reduced by the measure's provisions.

- The exact manner in which *regulatory decisions* regarding premium rates and other factors are made once Proposition 103 is fully operational.

What Will Be the Effects of the Premium Rate Rollbacks?

Several basic outcomes are possible regarding the rate rollbacks. For example:

- One possibility is that the rollbacks will result in *permanently reduced premium rates with no adverse effects on consumers.* This would occur, however, *only* if insurers have consistently been earning excessive profits that are not justified by their costs.
- Alternatively, if premium rates have generally reflected the increased costs of providing insurance (as opposed to simply reflecting industry attempts to earn excessively high profits), *the rollbacks may not result in permanently reduced premiums without some other types of offsetting adjustments, such as stricter underwriting standards.* Under this second scenario, insurers initially might be able to absorb at least some of these rollbacks by reducing their reserves; however, this would only be a temporary solution, and probably could not finance rollbacks of the 15 percent to 40 percent range that might be required (the actual size of the rollback for any given company depends on that company's specific premium history since November 8, 1987). Thus, some insurers might request full or partial exemption from the rollbacks during the "rate freeze" period, while others eventually would have to request permission to raise their rates back up into alignment with their costs. In either case, *the industry would experience near-term disruptions.*

Which Outcome Will Prevail? The actual outcome probably will be somewhere in between these two cases. Given the data problems involved, it is not possible to predict exactly what the final outcome will be and how it might differ from company to company. It must be remembered, however, that even economically justifiable upward premium-rate adjustments under the second scenario will occur only if the regulatory process permits them. Failure to do so would force the industry to compensate somehow for undercharging customers, such as through tighter underwriting standards or the exclusion of certain types of coverage altogether. *In order to avoid such distortions, it will be imperative that the immediate and longer-term regulatory decisions relating to the premium rate rollbacks be based on such factors as actual costs and reasonable rates of return on investment.*

A typical example of where the regulatory process regarding rate rollbacks may encounter a problem involves Proposition 103's provision that insurers may seek relief from the rollbacks on the grounds of being

"substantially threatened with insolvency." While the measure does not define this term, it is commonly understood to imply severe financial difficulty. Premium rates, however, should be set not at a level that forestalls "insolvency," but rather one which allows insurers to both cover their costs and earn an adequate profit margin over the long term. Thus, although the rollbacks may not make a particular insurer immediately vulnerable to "insolvency," they may preclude its long-term economic viability. The regulatory process will somehow have to deal with what Proposition 103 literally provides and what actually makes sense from an economic perspective.

What Will Be the Effects of Ongoing Rate Regulation?

One can never say how regulation will work until it actually is tried. However, the actual history of how rate regulation has worked in different industries—especially industries that exhibit some competitive characteristics—*is not very impressive.* The reasons for this are varied. In some cases, regulators have not correctly understood the basic economic forces affecting an industry, and therefore have set rates that are either too high (thereby causing excessive profits and harm to consumers) or too low (thereby destroying the economic health of the industry). In other cases, regulatory decisions have shown biases, either in favor of consumers or the industry being regulated. This has resulted in such problems as reduced industry innovation and subsidies to certain categories of consumers at the expense of others. This history does not imply that rate regulation under Proposition 103 cannot be effective and consistent with competitive performance. It does, however, emphasize that ***if regulation is to "work," it must be neither pro-industry nor pro-consumer. It must proceed from neutral ground and focus on the underlying economic realities of the insurance industry.***

Exactly How Will Rates Be Set? One issue that will have to be confronted immediately is the specific criteria which should be used for approving and disapproving premium rate increases. For example, Proposition 103 states that, in reviewing rate requests, "no consideration shall be given to the degree of competition." Exactly how this provision is interpreted and rate requests are evaluated in relation to it remains to be seen. If rates do not take into account "competition," there could be a potential conflict with the measure's antitrust provisions.

Steps That Need to be Taken. *Before Proposition 103's rate regulation process can begin, we believe that several difficult tasks must be undertaken and completed.* Specifically:

- ***Standards for Measuring Profits.*** Accounting standards must be developed for measuring the profits of insurers, since this should be the single most important criterion used in approving rate requests.

Standards are also needed for reporting costs, allocating operating costs between lines of insurance, and allocating both assets in reserves and general overhead among lines of insurance and between states.

- ***Determination of Acceptable Profit Rates.*** Once profits are defined and measured, an "acceptable" level of profits must be identified which can serve as the standard for justifying the approval of rate requests.

Developing these standards involves difficult and complex decisions. However, the rate regulation process is unlikely to succeed without these standards. There are several alternative approaches that can be taken to develop the required standards, such as (1) administrative proceedings at the Department of Insurance or (2) enactment of legislation. Regardless of the specific approach used, however, *it is imperative that these standards be correctly developed. Thus, the Legislature should closely monitor implementation of the regulatory process to ensure that this happens.*

The Effects of Other Provisions

The other, generally pro-competitive, features of Proposition 103 *clearly offer opportunities for improving the functioning of local insurance markets.* For example:

- Making the industry subject to the same business practice statutes as other businesses should provide both the public and the state Attorney General with incentives to pursue allegations of anticompetitive behavior or unfair business practices (including discriminatory underwriting practices).
- Removing other restraints on competition could have some positive effects on industry performance. For example, those with group coverage could be in a better position to bargain with insurers, and entry by banks could stimulate additional competition within the industry.
- Providing comparative premium-rate data to consumers upon request should make comparison shopping less costly and place greater pressure on insurers to reduce premium costs due to rate competition.

Summary Regarding Effects of Proposition 103—Only Time Will Tell

Given the above, *it is impossible to predict exactly what will be the full range of effects of Proposition 103 on the buyers and sellers of insurance in California. This will be known only after the measure is fully implemented and operational.* Certain provisions in the measure that tend to increase competition clearly will benefit consumers. The effect of

rate regulation on premium rates and insurance availability, however, is much less certain and will depend in large part upon the way in which regulatory decisions are made.

One thing, however, does seem clear—*the insurance industry's current problems are traceable not just to one but to a variety of different factors. Consequently, there is no one simple solution to them. If* regulatory decisions under Proposition 103 take proper consideration of economic factors and the rate review process itself is not overly burdensome, the measure could help ensure that premium rates are consistent with the underlying costs of providing insurance coverage. However, Proposition 103 does not directly address the industry's other difficulties, especially the underlying problem of the rising costs of providing insurance coverage—a problem which seems to be at the center of the industry's difficulties. *In order to deal with this very fundamental issue, other steps and approaches are needed.*

Given that many different factors affect the cost to insurers of providing automobile insurance coverage, there are a variety of different approaches that can be explored for influencing costs. Some of the possible options include: (1) reviewing the underwriting practices of insurers, (2) antitrust and unfair business practices enforcement actions, (3) improved reporting of consumer complaints and complaint resolution, (4) no-fault insurance, and (5) modification of the collateral source rule. The combined use of these and other approaches offers the greatest potential for influencing the costs of providing automobile insurance coverage.

Local Mental Health Programs

What is the Status of the State's Local Mental Health Systems? What Options Does the Legislature Have for Improving It?

Summary

- *Our review of the state's local mental health system reveals a patchwork of services established over time in response to perceived needs for services and available funding sources.*
- *Total expenditures (all funds) for "Short-Doyle" mental health services kept up with inflation and population growth between 1980-81 and 1986-87—the most recent year for which expenditure data are available. Our review indicates that these expenditures have kept up with population growth and inflation primarily because county and federal Medicaid funding have grown.*
- *General Fund appropriations for "Short-Doyle" services, however, have not kept up with inflation and population growth since 1980-81. Specifically, if appropriations had been adjusted for inflation and population growth since 1980-81, the appropriation in 1988-89 would have been $630 million, or $132 million more.*
- *The amount of county funds (match and "overmatch") devoted to mental health services increased from $8.4 million in 1980-81 to $102 million in 1986-87. This growth is partially due to changes in matching requirements.*
- *There are no data available that allow the Legislature to review whether counties use funding allocated to them in the most effective and efficient manner.*
- *The Legislature has augmented local mental health services with categorical funding and through pilot programs. We discuss three other approaches to restructuring the local mental health system: (1) open-ended entitlement, (2) case management entitlement, and (3) funding increases based on inflation and population growth.*

During the last few years, the Legislature has considered numerous requests for additional funding for mental health services provided under the Short-Doyle Act. For example, during legislative hearings on the 1988-89 budget, a coalition of various mental health advocacy groups requested that the Legislature provide $229 million in additional funds for Short-Doyle mental health services. In addition, over the past several years, counties have reported severe program constraints because funding increases have not been sufficient to accommodate rising costs and the growing numbers of persons in need of mental health services.

In this analysis, we (1) provide background on the current Short-Doyle mental health system, (2) review non-Short-Doyle mental health programs, (3) review expenditure and appropriation data for Short-Doyle mental health services, (4) identify issues raised by these data, and (5) provide options for system reform.

Background

Until 1957, California coped with mentally disabled people by placing them in one of 11 state hospitals for indeterminate periods of time with little or no treatment. This was similar to practices in other states.

Consistent with a national trend for deinstitutionalizing the mentally disabled, in 1957 the Legislature significantly reformed the mental health system by passing the Short-Doyle Act. The intent of the Short-Doyle Act was to create a cost-effective alternative to state hospitalization by encouraging counties, under state guidance, to initiate or expand community mental health services. The state provided funds to offset 50 percent of county costs. At that time, it was estimated that 17 percent of the state hospital population could be treated at the local level at a savings to the state.

In 1968 the Legislature again enacted major legislation that (1) established the civil commitment process for patients (the Lanterman-Petris-Short Act) and (2) revised the Short-Doyle Act. This legislation is the basis for the current Short-Doyle system.

The Lanterman-Petris-Short (LPS) Act. The LPS Act provides the legal basis for treating patients in the mental health system. It authorizes commitment for the evaluation and involuntary treatment of persons with mental disorders who are dangerous to themselves or to others, or who are gravely disabled. The act contains procedural safeguards to protect individuals from erroneous commitment. The act represents the state's effort to strike an appropriate balance among treatment needs, individuals' rights, and public safety.

Short-Doyle Act Amendments. In order to assist counties in providing services under the LPS Act, the Legislature also amended the Short-Doyle Act. The amendments required the counties to share responsibility for delivering mental health services and established new funding ratios so that approximately 85 percent to 90 percent of Short-Doyle mental health costs would be funded by the state.

In addition to the Short-Doyle and LPS Acts, there have been other significant events that have shaped the development of local mental health programs:

- 1955-60—Major advancements occurred in the development and use of psychotropic medications to alleviate some of the symptoms of mental illness, allowing more individuals to be treated in the community.
- 1962—Amendments to the Social Security Act allowed mentally disabled persons who had been previously employed to receive social security payments. These payments made it possible for many mentally disabled persons to live in community board and care facilities.
- 1964—The federal Community Mental Health Centers Construction Act stimulated the construction of public and private mental health treatment centers for the specific purpose of utilizing community centers as an alternative to state hospitalization.
- 1965—The Medicare and Medicaid programs were established, making federal funding available to pay for mental health services for persons meeting the eligibility requirements.
- 1974—The Supplemental Security Income/State Supplementary Program (SSI/SSP) allowed indigent mentally disabled persons to receive grants. These amendments allowed additional mentally disabled persons to live in community facilities.

How the Short-Doyle System Works Today

Under the Short-Doyle Act, counties are responsible for planning local mental health programs and providing services, and the state Department of Mental Health (DMH) is responsible for overseeing the system. It requires state and county agencies to fulfill their respective responsibilities in consultation with statutory advisory groups.

All persons in the state are eligible to receive Short-Doyle services. Counties generally provide mental health services to individuals based on the severity and acuity of the person's mental illness. For example, an individual suffering from a severe depressive suicidal episode would take precedence over an individual in need of counseling due to job stress.

State Responsibilities. The Short-Doyle Act requires the DMH to provide leadership in administering, planning, developing, financing, and overseeing local mental health services. The DMH also operates state hospitals that care for the most severely disabled county clients. Specifically, DMH responsibilities include:

- Providing treatment and care for mentally ill persons placed by counties in the state hospitals under the LPS Act.
- Reviewing and approving county mental health service plans.
- Allocating state General Fund appropriations to counties according to specified sharing ratios.
- Assuring that county programs meet specified standards.

- Establishing, monitoring, and evaluating statewide research and prevention programs.

County Responsibilities. Counties are responsible for establishing and maintaining a community-based mental health system. Counties provide services through programs they operate, programs operated by private providers, and state-operated hospitals. The type and amount of services provided to an individual depends on his or her level of mental disability. Services include:

- ***24-hour care*** in local facilities or state hospitals.
- ***Day treatment care***—a range of services that assist individuals with daily living and other skills that help them avoid inpatient care.
- ***Outpatient care***—short- or long-term counseling for individuals who are acutely and/or chronically mentally ill.
- ***Outreach***—services designed to bring special population groups into mental health treatment and to make human services agencies aware of available mental health services.
- ***Continuing care*** for the chronically mentally ill. These services include conservatorships and case management, which supplement direct services.

In addition, counties are responsible for:

- Submitting a county Short-Doyle plan for DMH approval. The plan identifies (1) the county's budget for mental health services and funding sources, (2) the types of mental health services to be offered, (3) the estimated number of persons to be served, and (4) the priority populations to be served.
- Operating a quality assurance (QA) system that covers all county-operated and contracted mental health facilities and programs. QA systems are designed to promote and maintain efficient, effective, and appropriate mental health services.
- Meeting specified program standards.

Funding Arrangements for Short-Doyle Services

Short-Doyle mental health services are funded primarily from state funds (General Fund) and county matching funds. Inpatient hospital services, including state hospital services, generally are funded 85 percent state/15 percent county. Other services generally are funded 90 percent state/10 percent county.

Counties are responsible for managing their programs to ensure that expenditures of state funds do not exceed the amount allocated to the county by the state. Counties do not control state funds appropriated for their state hospital patients. Instead, counties are allocated a specific number of state hospital bed-days for use by their county clients.

Short-Doyle mental health services are supported from a variety of other funding sources as well, including federal grants, county overmatch, fees collected from patients who are able to pay them, payments made on behalf of particular clients—for example, by Medicare, Medi-Cal, and insurance—and other sources.

Table 1 provides an overview of spending for Short-Doyle programs in 1986-87, the most recent year for which actual expenditure data are available. The table shows that the General Fund accounts for 68 percent of all funding for Short-Doyle mental health services, with counties contributing approximately 11 percent through the required match and any "overmatch."

Table 1
Short-Doyle Mental Health Services
Expenditures by Funding Source
1986-87
(dollars in millions)

	Local Programs	*State Hospitals*	*Total*	*Percent of Total*
General Fund	$472.1	$190.2	$662.3	67.9%
County match	42.9	26.8	69.8	7.2
County "overmatch"	32.3	—	32.3	3.3
Federal Medi-Cal	75.8	10.6	86.4	8.9
Medicare	21.9	3.7	25.6	2.6
Other sources	79.2	19.3	98.5	10.1
Totals	$724.2	$250.7	$974.9	100.0%

Allocations to Counties. The level of state funding allocated to counties varies greatly. For example, in 1986-87, General Fund per-capita allocations to counties ranged from $31 in San Francisco to $12 in Orange County. The variation is due in large part to when the county chose to begin participating in the Short-Doyle system. That is, counties that opted into the program earlier have more funding per capita compared to counties that started later.

In recent years, General Fund augmentations to county mental health programs have been allocated to achieve a more equitable allocation of resources among counties. To do this, the DMH has chosen a model that assigns equal weight to (1) a county's total population and (2) the number of residents in the county receiving AFDC and SSI/SSP payments. Therefore, a county with 10 percent of the state's population and 20 percent of its "poverty" population would be entitled to 15 percent of the funds.

As with allocations of General Fund monies, the allocations of state hospital bed-days are based on historical utilization patterns.

Categorical Funding. During the last few years, the Legislature has appropriated funds to serve particular populations with special needs. These "categorical" funds are allocated to counties in the same way as

other funds; that is, counties must provide a 10 percent match. Specifically, these funds are allocated to counties for:

- Homeless persons.
- Children receiving special education.
- Residential care rate supplements.
- Community residential treatment programs.
- Programs to divert mentally disabled persons from placement in jail.
- Specified priority populations such as mentally ill requiring secure facilities, juvenile sex offenders, the elderly and veterans.

Non-Short-Doyle Mental Health Programs

Only a portion of the mental health services available in the state are provided through the Short-Doyle system. In order to place the Short-Doyle system in context with other services, we have identified other mental health programs and funding sources below:

- The DMH is responsible for providing treatment for individuals who are committed by the judicial system. This care is provided in the state hospitals and in community programs. In 1988-89, $141 million was allocated from the General Fund to serve these individuals.
- Institutions for Mental Diseases (IMDs) are skilled nursing facilities with special mental health treatment programs. IMDs are funded through a combination of General Fund, SSI/SSP reimbursements, and third-party revenues. In 1988-89 there were 3,400 IMD beds statewide at a total cost of $65 million ($55 million General Fund). Before 1987-88, IMD services were funded by Medi-Cal.
- Board and care homes for the mentally ill are paid for primarily through SSI/SSP funds.
- Private mental health treatment services are paid through Medi-Cal, Medicare, and private insurance.
- The DMH contracts directly with providers for services in three programs: (1) the Brain-Damaged Adult program ($5.3 million General Fund in 1988-89), (2) AIDS-related services ($1.5 million General Fund in 1988-89), and (3) primary prevention programs ($954,000 from the Primary Prevention Fund in 1988-89).

Even though these programs and funding sources are not considered to be part of the Short-Doyle system, county Short-Doyle programs may depend on their availability. For example, counties frequently place clients in IMDs and Medi-Cal-funded skilled nursing facilities.

Short-Doyle and Other Mental Health Programs—A Fragmented System

Our review of California's current array of mental health programs indicates that, since 1968, these programs have been patched together in response to perceived service needs and availability of funding. This has

resulted in a fragmented system where it is not clear which level of government has overall responsibility. For example, although the Short-Doyle Act placed primary responsibility with the counties to plan local mental health priorities, categorical funding has been added over time for specific populations. These augmentations were made in response to a perception that counties were not able to meet all the mental health service needs of their communities. In another example, the availability of federal funds for Medi-Cal services has resulted in the provision of a large volume of services outside the purview of county Short-Doyle systems.

Spending Trends—Short-Doyle Programs

We examined a number of different measures of the level of resources devoted to Short-Doyle mental health services to determine whether these resources have kept pace with population growth and inflation. In this section, we discuss the following specific measures: expenditures from all funds, General Fund expenditures, General Fund appropriations for local programs, General Fund appropriations for state hospitals, and state hospital bed-days. The most recent *actual expenditure* data is for 1986-87. The most recent *actual appropriation* data is for 1988-89.

We chose 1980-81 as the base year for comparison because it was the first year after Proposition 13 in which programs were relatively stable. However, there is no analytical way to determine what the most appropriate base year would be. This is because our review indicates that there has not been any particular year which could be used as a "model" for the most appropriate level of expenditures.

Base Year Selection Affects Fiscal Analysis. In fact, conclusions regarding whether resources have kept pace with inflation and population growth vary significantly depending on the base year chosen. For example, total General Fund expenditures for local programs and county clients in state hospitals were $662 million in 1986-87. Expenditures would have been $698 million if they had been based on 1980-81 expenditures adjusted for inflation and population growth. Thus, spending in 1986-87 was $36 million *lower* than adjusted 1980-81 spending. These results vary depending on the base year. Spending in 1986-87 was $26 million *higher* than adjusted 1978-79 spending and $72 million *higher* than adjusted 1982-83 spending.

Expenditures From All Funds. Chart 1 shows that total expenditures from *all funds* in 1985-86 and 1986-87—the most recent years for which data are available—exceeded what these amounts would have been had they been increased by inflation and population growth since 1980-81. "All funds" include General Fund, all county funds (both match and overmatch), federal Medicaid and Medicare, and other sources, such as

patient insurance and fees. Total expenditures were $975 million in 1986-87. If expenditures had been adjusted for inflation and population growth each year since 1980-81, the expenditures in 1986-87 would have been $882 million, or $93 million less.

In contrast, Chart 2 shows that total *General Fund* expenditures (combined local programs and state hospitals) were lower than adjusted 1980-81 expenditures in all of the fiscal years since 1980-81 for which data are available. The discrepancy between actual 1986-87 expenditures and adjusted 1980-81 expenditures was $36 million, or approximately 5 percent of actual General Fund expenditures.

County and Medicaid Funds Maintain Programs. The difference between expenditures from all funds and General Fund expenditures is a result of counties increasing sources of funding other than the General Fund in order to maintain Short-Doyle programs. The two largest increases have been in county funds and federal Medicaid funds. County funds (match and overmatch) devoted to mental health services increased from $8.4 million in 1980-81 to $102 million in 1986-87. One reason for the growth of county funds devoted to mental health services is changes in match requirements. In 1980-81, counties were required to provide a match for hospital services, while in 1986-87, counties were required to provide a match for both local programs and hospital services. Federal Medicaid funds have increased from $46 million to $86 million over the same period.

General Fund Appropriations for Local Programs. Chart 3 shows General Fund appropriations for local programs from 1980-81 through 1988-89, compared to 1980-81 appropriations adjusted for inflation and population growth.

The data indicate that General Fund appropriations have been considerably below 1980-81 appropriations adjusted for inflation and population growth. General Fund appropriations for local programs totaled $498 million in 1988-89. *If appropriations had been adjusted for inflation and population growth since 1980-81, the appropriation in 1988-89 would have been $630 million, or $132 million more.* Actual 1988-89 appropriations for local programs were 79 percent of adjusted 1980-81 appropriations.

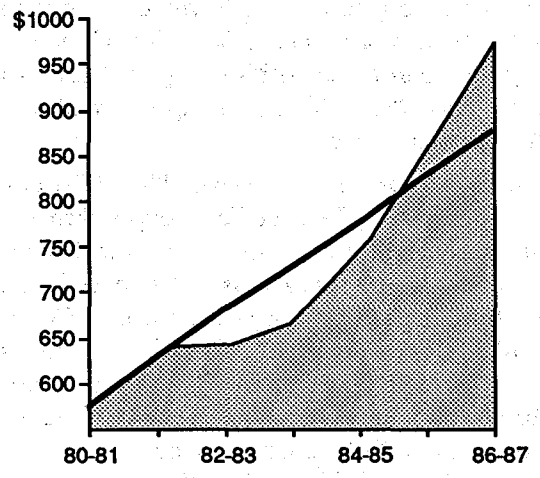
General Fund Appropriations for County Clients in State Hospitals. Chart 4 shows General Fund appropriations for county clients in state hospitals from 1980-81 through 1988-89, compared to 1980-81 appropriations adjusted for inflation and population growth.

Similar to General Fund appropriations for local programs, the data indicate that General Fund appropriations for county clients in state

Chart 1

Total Expenditures for Short-Doyle Mental Health Services

1980-81 through 1986-87 (dollars in millions)



Year	Actual As a Percent of Adjusted
1980-81	--
1981-82	101%
1982-83	95
1983-84	92
1984-85	96
1985-86	104
1986-87	111

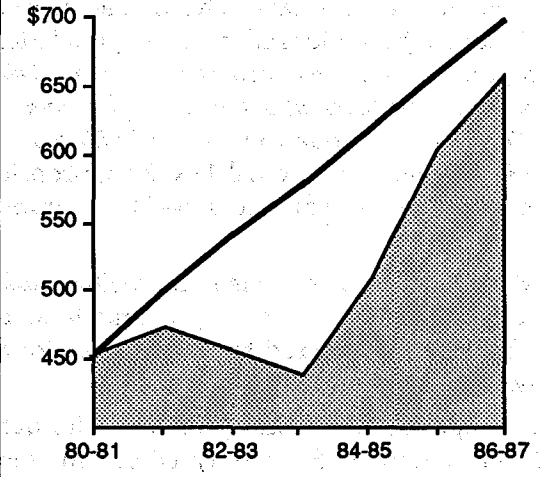
Actual expenditures

1980-81 expenditures adjusted for inflation and population growth

Chart 2

General Fund Expenditures for Short-Doyle Mental Health Services

1980-81 through 1986-87 (dollars in millions)



Year	Actual As a Percent of Adjusted
1980-81	--
1981-82	95%
1982-83	85
1983-84	76
1984-85	82
1985-86	92
1986-87	95

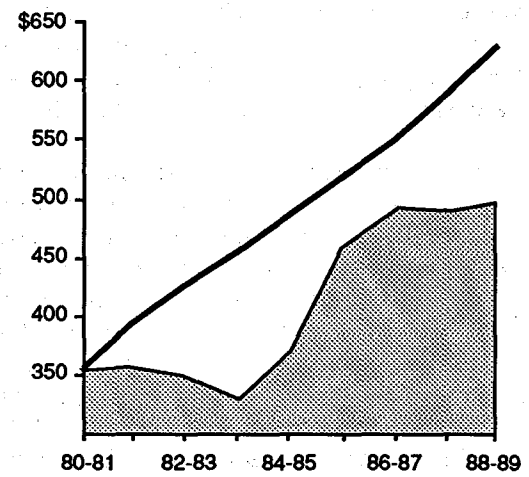
Actual expenditures

1980-81 expenditures adjusted for inflation and population growth

Chart 3

General Fund Appropriations for County Mental Health Programs

1980-81 through 1988-89 (dollars in millions)



Year	*Actual As a Percent of Adjusted*
1980-81	--
1981-82	91%
1982-83	82
1983-84	72
1984-85	77
1985-86	89
1986-87	90
1987-88 (Est.)	83
1988-89 (Prop.)	79

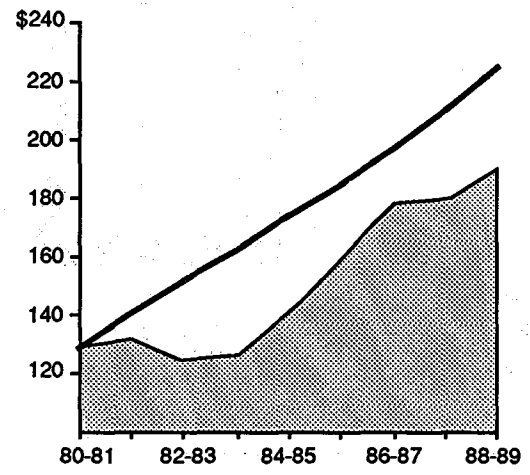
Actual appropriations

1980-81 appropriations adjusted for inflation and population growth

Chart 4

General Fund Appropriations for County Clients in State Hospitals

1980-81 through 1988-89 (dollars in millions)



Year	*Actual As a Percent of Adjusted*
1980-81	--
1981-82	94%
1982-83	82
1983-84	78
1984-85	82
1985-86	86
1986-87	91
1987-88 (Est.)	86
1988-89 (Prop.)	85

Actual appropriations

1980-81 appropriations adjusted for inflation and population growth

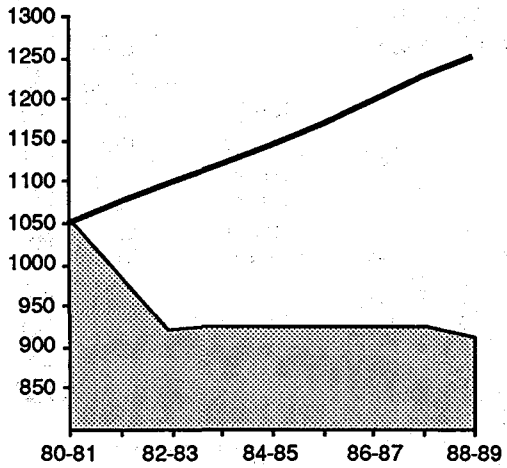
hospitals have been below 1980-81 appropriations adjusted for inflation and population growth. General Fund appropriations for county clients in state hospitals were $191 million in 1988-89. *If appropriations had been adjusted for inflation and population growth since 1980-81, the appropriation in 1988-89 would have been $225 million, or $34 million more.*

The General Fund appropriation for county clients in state hospitals has not lagged as far behind the adjusted 1980-81 appropriation as the General Fund appropriation for local programs. In 1988-89 the appropriation for county clients in state hospitals was 85 percent of the adjusted 1980-81 appropriation.

State Hospital Bed-Days. Chart 5 shows actual state hospital bed-days allocated for county clients since 1980-81, and the number adjusted annually for growth in the state's population. These data indicate that the number of state hospital bed-days for county clients declined sharply in 1981-82 and 1982-83, and have remained relatively constant since then. The sharp decline was due to agreements in which some counties reduced their use of state hospital bed-days in exchange for additional local assistance funds. State hospital bed-days have remained relatively constant since 1982-83 due to budgetary controls. Specifically, the state, through the Budget Act and administrative actions, has encouraged

Chart 5

State Hospital Bed-Days Allocated to County Clients
1980-81 through 1988-89 (bed-days in thousands)



Year	Actual As a Percent of Adjusted
1980-81	--
1981-82	91%
1982-83	84
1983-84	82
1984-85	81
1985-86	79
1986-87	77
1987-88	75
1988-89	73

Actual allocation

1980-81 allocation adjusted for population growth

counties not to use more than the number of state hospital days allocated to them. Counties that exceed their allocations of state hospital days risk having to pay for the excess use themselves.

State hospital bed-days have remained constant during a period of rapid cost increases (shown in Chart 4). The increased costs are due primarily to adding treatment positions in the state hospitals in order to achieve accreditation from the Joint Commission on the Accreditation of Hospitals.

Conclusions. Our review of these data indicates that:

- Total expenditures in 1986-87 exceeded 1980-81 expenditures adjusted for inflation and population growth. Our review indicates that these expenditures have kept up with population growth and inflation primarily because county and federal Medicaid funding have grown.
- General Fund expenditures have lagged behind adjusted expenditures since 1980-81 in every year for which data are available.
- General Fund appropriations in 1988-89 for both county programs and county clients in state hospitals were lower than 1980-81 appropriations adjusted for inflation and population growth.
- Although appropriations for county clients in state hospitals have gone up, the number of bed-days allocated to counties have declined. The decrease in bed-days is due to state policies encouraging the use of community programs instead of state hospitals. The appropriations have increased due to enhancing the number of treatment positions in order to meet accreditation standards.

Our conclusions regarding whether the Short-Doyle mental health system is underfunded relative to previous years and the level of underfunding is limited by the difficulty of determining an appropriate base year.

There are no data available that allow the Legislature to review whether counties use the funding allocated to them in the most efficient and effective manner. Although the DMH collects data from counties on the types of services provided, the number of persons served, and the costs of specific services provided, the data are not comparable between counties and the information does not measure the effectiveness of treatment provided to the mentally ill.

Access to Mental Health Services

In our examination of Short-Doyle mental health services, we attempted to evaluate "access" to mental health services. By this, we generally mean the availability of services to meet needs. Based on our visits to various counties over a period of several years, we conclude that there are significant problems with access to mental health services in

some areas. For example, we observed overcrowding in psychiatric emergency room waiting areas resulting from a lack of available beds for placement of patients. According to mental health providers, the lack of beds has also resulted in releasing many patients without sufficient treatment to prevent additional episodes.

The situation appears to be getting worse; in the current year, due to budget constraints, the counties of Monterey, El Dorado, and San Diego all implemented significant cutbacks in the amount of outpatient service they would be able to provide. In addition, all counties that we visited reported increased waiting times for services. For example, waits of four to six weeks for outpatient services are not uncommon. These lengthy waiting times can potentially discourage individuals needing mental health services from seeking services. They can also increase county costs. This is because without services, some individuals' crises may be exacerbated to the point that they require more costly inpatient services.

How Has the Legislature Responded to Concerns About Local Mental Health Services?

In the past, the Legislature has utilized two strategies for enhancing Short-Doyle mental health services given the constraints of inadequate data: establishing categorical programs and pilot programs.

Categorical Programs. Categorical programs target services and funding to specific mentally ill populations, such as children. The majority of categorical programs were developed and funded in 1985-86. The largest categorical program is a $20 million program for treatment and support services for homeless mentally ill persons.

Categorical programs are attractive because they target specific populations with specific levels of funding. However, categorical programs also have the effect of preempting county responsibility for identifying treatment and funding priorities as required by the Short-Doyle Act. In doing so, *categorical program funding has contributed to the fragmented nature of the mental health system.*

Pilot Programs. Chapter 982, Statutes of 1988 (AB 3777, Wright), established two four-year pilot programs to test how communities can more effectively and economically coordinate a comprehensive array of services for the seriously mentally ill. The pilot programs are designed to provide more structure and accountability in the provision of mental health treatment and support services.

As part of the pilot programs, the state and contractors are developing methods for measuring client outcomes, services, and costs. The development of these methods should assist the Legislature in answering some of the unanswered questions about the adequacy of services provided to individuals, and whether services can be targeted or managed more

effectively. However, the lessons from the pilot programs may not apply to other communities if they have a different mix of currently available services. Moreover, it could take up to six years before definitive conclusions may be reached regarding the statewide feasibility of expanding the pilot.

What Other Options Does the Legislature Have for Restructuring the Short-Doyle System?

Categorical programs and pilot programs are two approaches the Legislature has used in the past for improving the Short-Doyle mental health system. The Legislature has a number of other options for restructuring the system as well. These options include:

- ***Existing system with funding increases and, possibly, improved county accountability.*** Under this approach, the current system would remain intact but counties would receive consistent funding increases to account for population growth and inflation. In conjunction with funding increases, the Legislature could also impose standards and data collection requirements on county mental health services in order to measure access to and costs of services. Also in conjunction with funding increases, the Legislature could make the system less fragmented by giving counties responsibility for all services affecting county clients—including IMD services and services that are currently mandated through categorical programs. This approach is likely to be the least expensive of the three, depending on the level of funding provided. It would not address "unmet need" in the same way that an entitlement program would.
- ***A case management entitlement system***, similar to the Department of Developmental Services regional center system. Like the Medi-Cal model, the state would issue regulations, establish a benefit package, and provide funding based on caseload and cost increases. This approach, however, would require that a case manager be assigned to each individual entering the system to ensure that the individual (1) has access to all treatment and services necessary and (2) is utilizing the services according to a comprehensive treatment and support services plan. Counties or regional entities and private providers would supply case management, treatment, and services. The costs of this system would depend on the package of services offered and the number of eligible clients. This system is likely to be very expensive. In addition, this approach would limit the Legislature's fiscal flexibility in the annual budget process.
- ***An open-ended entitlement system***, similar to the Medi-Cal program. The state would establish a specified set of benefits to all persons meeting eligibility criteria, and fund the system based on caseload and cost increases. Counties would determine eligibility and

could provide services as well. Depending on the eligibility criteria and information system established, this system could potentially address the problems of unmet need and accountability. We have no basis for estimating the fiscal impact of providing services under this option, as this would depend on the benefit package provided and how many persons utilize the services. However, this option is also likely to be very expensive because it allows service utilization with little control once an individual is determined eligible for services. In so doing, it also would limit the Legislature's fiscal flexibility.

In our view, whatever approach the Legislature wishes to take, *it must first decide the following*:

- What level of control should the state exert over county mental health programs and expenditures? For example, should the state attempt to ensure statewide consistency in access to mental health services?
- Who should bear the costs of providing mental health services?
- How much is the state willing to pay for mental health services?