Background Information on the Health Care "Safety Net"

Prepared for
The Assembly Select Committee
on California's Health Care Safety Net

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The Health Care Safety Net

Background—California's Health Care Delivery System

Currently, Californians receive health care services through a variety of mechanisms:

- ***Private Insurance and Medicare.*** For the most part, individuals under the age of 65 receive health insurance through their employer or the employer of a family member. Most persons over 65 and certain disabled persons receive coverage under the federal Medicare program. Most insured individuals pay for a portion of their care out-of-pocket through deductibles (where the individual pays a certain amount each year before the insurance pays benefits) and co-payments (where the individual pays a certain percentage or a fixed fee each time he or she uses services).

- ***Medi-Cal.*** The state, with assistance from the federal government, funds health coverage for certain low-income individuals through the Medi-Cal program. Most of the recipients are members of families with dependent children or are aged, blind, or disabled.

- ***Services for Persons Without Health Coverage.*** Persons who are without health insurance and are ineligible for Medi-Cal or Medicare must buy services on a pay-as-you-go basis. They often cannot afford to pay for the services they receive. For the most part, *private* providers attempt to avoid incurring costs for clients who cannot pay for services by referring them to public programs, if feasible. However, they generally have been able to recoup the costs they incur for providing these services by increasing charges to insured clients. *Public* providers support their costs for providing services to persons who are unable to pay through a variety of governmental programs collectively referred to as the safety net. Some private nonprofit providers, such as community clinics, supplement public services to persons without coverage using funds available from safety net programs and private grants.

What Is the Safety Net?

California's health care safety net represents the health-related services provided through counties for persons who lack health insurance or other coverage, such as Medi-Cal, and cannot pay for health services rendered. Although the state provides a host of health services through its Medi-Cal and various public health programs, counties are ultimately responsible for serving those with no other means of public or private support, as stipulated under Section 17000 of the Welfare and Institutions Code.

Who Uses the Safety Net?

According to hospital discharge data from the Department of Health Services' (DHS) Medically Indigent Care Reporting System (MICRS), the state served roughly 1.7 million medically indigent persons in 1992-93 (latest data available). The data show that a majority of those served: (1) received outpatient services, (2) received services in Los Angeles County, and (3) were identified as Hispanic. Furthermore, those receiving indigent care were categorized into these three age groups: 31 percent below the age of 21, 34 percent between the ages of 21 and 34, and 35 percent age 35 or older.

How Much Does the Safety Net Cost?

Figure 1 shows the amount of state and county expenditures on indigent health care in 1992-93—the latest year in which complete data are available from the DHS. The department indicates, however, that these data may not be reported by the counties on a consistent basis. It is not clear, for example, how the expenditure of federal disproportionate share hospital funds is reported by the counties.

Figure 1

Estimates of Statewide Indigent Health Costs For 1992-93

(In Millions)

	1992-93
State funds	
Proposition 99	$211.6
State General Fund	20.2
Realignment[a]	614.0
County funds	
County General Fund	478.1
Reimbursements[b]	109.0
Total	**$1,432.9**

[a] Estimated as 59.3 percent of realignment revenues for all health services plus the portion of realignment funds CMSP counties receive.

[b] Estimated as roughly equal to 13 percent of realignment revenues for all health services

Source: Department of Health Services Office of County Health Services.

How Has the Safety Net Been Funded?

Funding for the "safety net" has been provided through several different sources over the years. Below, we describe the major funding sources:

- ***County Health Services (AB 8 Program).*** This state program was established in 1979 in the aftermath of Proposition 13. The AB 8 Program provided counties block grants to support public health services and inpatient/outpatient care for low-income persons. In order to receive their full share of state County Health Services funds, counties were required to provide matching funds based on their 1977-78 health care expenditures, adjusted for inflation and population growth. In 1991, realignment legislation replaced state funding from the County Health Services program with funds generated from an increase in vehicle license fees (VLF) and sales taxes.

- ***Medically Indigent Services Program (MISP).*** This state program provided funds to serve the medically indigent adult population for larger counties. The state established MISP along with the County Medical Services Program (CMSP) in 1983, when it transferred responsibility for the medically indigent adult (MIA) population from the state's Medi-Cal program back to the counties. To support this transfer, the state provided MISP and CMSP counties with General Fund support equal to 70 percent of the expected cost of serving the MIA population under Medi-Cal. Eligibility standards and benefit levels varied significantly among MISP counties, with some offering benefits below those previously provided under the Medi-Cal program. Realignment in 1991 repealed the MISP and replaced it with funds generated from an increase in vehicle license fees and sales taxes.

- ***County Medical Services Program .*** This state program provides funds to smaller counties that chose to contract with the state to administer their MIA programs. The realignment legislation in 1991 transferred responsibility for the CMSP from the state to the counties, significantly reducing state General Fund support and replacing it with revenues generated from an increase in vehicle license fees and sales taxes. Prior to realignment, the CMSP offered medical benefits similar to the Medi-Cal program; but shortfalls in revenues required the CMSP counties to reduce provider rates and eliminate certain benefits in 1992.

- ***State Legalization Impact Assistance Grants (SLIAG).*** The federally funded SLIAG reimbursed states for the expenses incurred in assisting newly legalized persons pursuant to the Immigration Reform and Control Act of 1986. A portion of SLIAG funds was allocated to counties for indigent health services from 1988-89 through 1994-95.

- ***Proposition 99.*** The Tobacco Tax and Health Protection Act of 1988 (Proposition 99) allocates a portion of tobacco tax revenues for county health services. In 1989, the Legislature established the California Healthcare for Indigents Program (CHIP) and the Rural Health Services (RHS) Program, which allocate Proposition 99 funds to expand county indigent health services. In order to receive CHIP or RHS monies, however, counties must spend a certain level of general purpose revenues for health services, as specified in statute. Proposition 99 support for counties has been declining, due to decreasing tobacco tax revenues.

- ***Realignment.*** In 1991, the state transferred much of its fiscal responsibility for health services programs to the counties as part of a "realignment" of state and local programs. Specifically, the state eliminated funding for the AB 8 Program and MISP, and significantly reduced its support for CMSP. Realignment legislation replaced those funding sources for counties with revenues derived from an increase in the state sales tax and the VLF, provided counties continued to spend their AB 8 match amounts and dedicate their VLF funds for health services.

- ***County General Funds.*** In order to receive their realignment funds and full share of Proposition 99 revenues, counties are required to maintain a minimum level of county spending on indigent health care, as specified in statute. Some counties, however, spend more on these services than is statutorily required.

- ***Disproportionate Share Hospital (DSH) Supplemental Payment Programs.*** California has established two programs to provide supplemental Medi-Cal payments to certain hospitals that provide services to disproportionate numbers of Medi-Cal and other low-income patients. These programs were established to assist safety net hospitals in meeting the uncompensated care costs associated with the provision of medical services to uninsured and underinsured patients.

  - ***The SB 855 Program.*** Chapter 279, Statutes of 1991 (SB 855, Robbins) established the SB 855 Program. The program, administered by the DHS, provides supplemental payments to hospitals that serve disproportionate numbers of low-income individuals. Under the program, *public* entities that operate disproportionate share hospitals—such as counties, special districts, and the University of California system—are required to transfer funds to the state by means of intergovernmental transfers. These funds are combined with matching federal funds and redistributed as supplemental payments to *all* eligible disproportionate share hospitals, including private hospitals. A hospital may qualify to receive DSH payments if its Medi-Cal inpatient utilization rate exceeds an established threshold or it uses a minimum percentage of its revenues to provide health care to Medi-Cal and uninsured patients. Total

supplemental payments—intergovernmental transfers (county funds) plus matching federal funds—have grown from $1.6 billion in 1991-92 to $2.2 billion in 1994-95 and are capped at that level by federal law.

- ***The SB 1255 Program.*** The California Medical Assistance Commission (CMAC) administers the SB 1255 Program, established by Ch 996/89 (SB 1255, Robbins). The program provides supplemental payments to certain eligible DSH hospitals—generally hospitals that (1) are licensed to provide emergency medical services and (2) contract with CMAC to serve Medi-Cal patients under the Selective Provider Contracting Program. Like the SB 855 Program, intergovernmental transfers are made by public entities, but these transfers are *voluntary* in the SB 1255 Program. These funds are combined with matching federal funds and redistributed by the CMAC as supplemental payments to eligible hospitals (including private hospitals) that demonstrate a need for additional funds.

Major Shifts in Safety Net Funding

Several shifts have occurred within the state's health care safety net over the past five years.

- ***Realignment Revenues Lower Than Projected.*** The 1991 realignment legislation fundamentally changed the state and county fiscal relationship. Although intended to be revenue neutral, realignment resulted in lower than expected funding levels for county indigent health programs. As Figure 2 shows, the level of realignment revenues initially anticipated for 1991-1992 was not achieved until 1994-95.

Figure 2

Realignment Funding For All Health and Indigent Health Services 1991-92 to 1995-96

(In Millions)

Type of Service	1991-92	1992-93	1993-94	1994-95	1995-96
All health services					
Expected	$941.4				
Actual	843.5	$886.3	$886.8	$948.5[a]	$995.8[a]
Difference	97.9				
Indigent health[b]					
Expected	$652.1				
Actual	577.4	$614.0	$614.30	$652.3	$683.3
Difference	74.7				

[a] Department of Finance Projections.

[b] Indigent health portion estimated as 59.3% of total realignment health portion, plus entire realignment portion of County Medical Services Program counties.

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

DSH Supplemental Payments Facing New Federal Cap

- ***The SB 855 Program.*** Figure 3 shows this program's net benefit (supplemental payments less intergovernmental transfers) to public and private hospitals for 1992-1993 through 1994-95. Figure 4 shows the amount of uncompensated care costs attributed to public and private DSH hospitals. The figures show that while the percent of the total hospital net benefit received by public hospitals decreased from 77 percent to 57 percent between 1992-93 and 1994-95, the percent of uncompensated care costs provided by DSH public hospitals increased from 91.6 percent to 93.5 percent.

Figure 3

SB 855 Program

(Dollars in Thousands)

	1992-93			1993-94			1994-95		
	Gross Payments	Transfers	Net Benefit	Gross Payments	Transfers	Net Benefit	Gross Payments	Transfers	Net Benefits
Public	$1,864,283	$1,172,332[a]	$691,951	$1,850,500	$1,226,549[a]	$623,951	$1,807,666	$1,324,587[a]	$483,079
Private	201,591	—	201,591	293,508	—	293,508	361,993	—	361,993
Hospital totals	**$2,065,874**	**$1,172,332**	**$893,542**	**$2,144,008**	**$1,226,549**	**$917,459**	**$2,169,659**	**$1,324,587**	**$845,072**

[a] State fee for Medi-Cal Program: $133,000 in 1992-93, $154,000 in 1993-94, and $239,000 in 1994-95.

Source: Department of Health Services.

Figure 4

Medi-Cal and Uncompensated Care Provided by DSH Hospitals[a] 1992 to 1994

(Dollars in Thousands)

	Medi-Cal Days				Uncompensated Care[b]			
	1992	1993	1994	% Change	1992	1993	1994	% Change
Public DSH hospitals	1417.2	1354.5	1296.1	-8.5%	$1,172,008.4	$1,409,629.7	$1,462,524.7	24.8%
Percent totals	61.2%	60.0%	60.0%		91.6%	92.7%	93.5%	
Private DSH hospitals	899.1	915.2	878.5.	-2.3%	108,119.7	110,909.0	101,802.9	-5.8%
Percent totals	30.8%	40.0%	40.0%		8.4%	7.3%	6.5%	
Totals	**2,316.3**	**2,269.7**	**2,174.6**		**$1,280,128.1**	**$1,520,538.7**	**$1,564,326.7**	
	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	

[a] DSH hospitals are hospitals receiving SB 855 DSH payments in 1994-95.

[b] Represents sum of deductions from revenues for county indigent care and "charity other" care.

Source: Senate Senate Office of Research based on OSHPD Quarterly Data.

- ***The SB 1255 Program.*** Figure 5 shows this program's gross supplemental payments to hospitals, intergovernmental transfers to the state, and net benefit to public and private hospitals for fiscal years 1992-93, 1993-94, and 1994-95. Hospitals will negotiate with the CMAC later this fiscal year to determine the 1995-96 amounts, with the exception of Los Angeles County (see below).

Figure 5

SB 1255 Program

(Dollars in Thousands)

Hospital Type	1992-93 Gross Payments	1992-93 Transfers	1992-93 Net Benefit	1993-94 Gross Payments	1993-94 Transfers	1993-94 Net Benefit	1994-95 Gross Payments	1994-95 Transfers	1994-95 Net Benefit
L.A. County hospitals	$245,000	$130,000	$115,000	$245,000	$130,000	$115,000	$438,000	$229,000	$209,000
Other county hospitals	66,545	33,500	33,045	64,400	32,000	32,400	150,400	79,000	71,400
County subtotals	$311,545	$163,500	$148,045	$309,400	$162,000	$147,400	$588,400	$308,000	$280,400
L.A. community hospitals	$7,650	—	$7,650	$9,550	—	$9,550	$12,000	—	$12,000
Children's hospitals	8,800	—	8,800	10,700	—	10,700	21,515	—	21,515
Other community hospitals	2,925	—	2,925	3,475	—	3,475	9,350	—	9,350
Community subtotals	$19,375	—	$19,375	$23,725	—	$23,725	$42,865	—	$42,865
District hospitals	$500	—	$500	—	—	—	$750	—	$750
University of California hospitals	24,000	$15,000	9,000	$24,500	$15,000	$9,500	50,300	$30,000	20,300
Totals	**$355,420**	**$178,500**	**$176,920**	**$357,625**	**$177,000**	**$180,625**	**$682,315**	**$338,000**	**$344,315**

Source: California Medical Assistance Commission.

- ***Other DSH Considerations.*** The federal Omnibus Budget Reconciliation Act of 1993 placed a cap on how much each hospital can be reimbursed under the DSH Programs. Basically, hospitals cannot receive more than 100 percent of their uncompensated care costs through DSH supplemental payments, beginning in 1995-96. Federal regulations to implement these provisions have not been issued. We note that the DHS has submitted a state plan amendment to the federal Health Care Financing Administration proposing a method for calculating uncompensated care costs for hospitals in California, but no decision has been made on this proposal. Because the regulations have not been adopted and hospital-specific data are not yet available, an estimate of the impact of the hospital caps on California is not available at this time.

- ***Proposition 99 Revenues Declining.*** The decline in tobacco consumption has led to lower tobacco tax revenues for Proposition 99 programs, including county health services, as shown in Figure 6. Between 1991-92 and 1995-96, the amount of tobacco tax revenues counties received is expected to fall from $244.1 million to $177.8 million—a 27 percent decline.

Figure 6

Proposition 99 Funding For County Indigent Health Services 1991-92 to 1995-96

(In Millions)

Program	1991-92	1992-93	1993-94	1994-95	1995-96
California Healthcare for Indigents Program	$228.0	$196.1	$192.5	$162.9	$163.0
Rural Health Services	4.2	3.5	3.4	2.8	2.8
County Medical Services Program	12.0	12.0	12.0	12.0	12.0
Totals	**$244.1**	**$211.6**	**$207.9**	**$177.7**	**$177.8**

Source: Department of Health Services Office of County Health Services.

- ***Los Angeles County.*** As a result of its fiscal problems, Los Angeles County negotiated agreements with the federal government and the state to receive $514 million in federal funds for 1995-96. Most of these funds will flow through the SB 1255 Program:

  - The county and the CMAC negotiated the early receipt of federal funds through the SB 1255 Program for 1995-96. Normally these negotiations would have occurred later in the fiscal year. The county will transfer an additional $170 million to match an equal amount in new federal funds. Of the $340 million, Los Angeles County will receive $320 million in SB 1255 payments. The net benefit to the county, therefore, will be $150 million.

  - Contingent upon approval of a federal Medicaid waiver, the county will transfer an additional $182 million to match an equal amount in federal funds, thereby receiving $364 million in SB 1255 payments. The net benefit to the county, therefore, will be $182 million.

  - In addition, the county will receive another $182 million in federal funds through various programs, pursuant to the waiver.

Uninsured Rates Vary Significantly Across California

The UCLA Center for Health Policy Research report, entitled *Health Insurance Coverage of Californians, 1989-92*, examined recent trends in health insurance in California. Figure 7 compares the percent of the population lacking insurance and those covered by insurance or Medi-Cal in larger regions of the state. The report indicates that Los Angeles County's uninsured rate of 30.9 percent is the highest among the 30 largest metropolitan areas nationwide. Four other regions—Orange, Sonoma, San Diego, and Fresno-Kern Counties—have uninsured rates in excess of 20 percent.

Figure 7

Uninsured, Job-Related Insurance, and Medicaid Coverage by Major Regions In 1992-93

Region	Percent Uninsured	Percent with Job-Related Insurance	Percent with Medicaid Coverage	Other[a]
Los Angeles County	30.9%	45.3%	13.8%	10.0%
Orange County	24.3	59.4	6.6	9.7
Sonoma County	24.0	52.6	9.4	14.0
San Diego County	21.9	48.9	14.5	14.7
Riverside-San Bernardino Counties	19.6	58.7	13.0	8.7
Fresno-Kern Counties	21.0	45.2	22.2	11.6
Santa Barbara-Ventura Counties	17.0	60.3	13.1	9.6
Sacramento-Yolo-El Dorado-Placer-San Joaquin-Stanislaus Counties	15.6	59.7	12.3	12.4
San Francisco-San Mateo-Marin-Alameda-Contra Costa Counties	15.2	62.7	7.6	14.5
Santa Clara County	14.6	68.7	5.8	10.9

[a] Primarily other insurance, including Medicare.

Source: UCLA Center for Health Policy Research analysis of 1992 and 1993 Current Population Survey.

The report further indicates that the majority of uninsured individuals are employed, largely in small firms. Those individuals employed full-time in small firms (less than 25 workers) are less likely to receive health insurance compared to employees in small firms in the rest of the nation—36 percent in the state versus 42 percent nationally. Many of the smaller firms are involved in the agricultural, retail, and service sectors of the economy.

Public-Private Partnerships

We list below some ways the state and counties have worked with private groups to improve health services for indigents or those who otherwise would be indigent.

- ***Lowering Health Insurance Costs for Small Businesses.*** The state Managed Risk Medical Insurance Board (MRMIB) administers the Health Insurance Plan of California (HIPC), which serves as a purchasing pool to leverage lower health insurance rates for small businesses with 3 to 50 employees. By negotiating with health insurance companies, the HIPC helped reduce premium rates by an average of 6.3 percent in 1994-95, and expects to lower them by an additional 5.1 percent in 1995-96. Since its inception in 1993, the HIPC has enrolled over 5,000 small businesses and 97,000 people through 25 different private health plans. Approximately 20 percent of those small businesses enrolled in HIPC did not previously offer health insurance to their employees.

- ***Subsidizing Health Insurance.*** The MRMIB also secures health insurance for individuals through the California Major Risk Medical Insurance Program (MRMIP) and the Access for Infants and Mothers (AIM) Program. The MRMIP has helped secure health insurance for over 19,000 California residents ineligible for Medicare and unable to obtain coverage in the open market because of pre-existing medical conditions. The program supplements premiums (to seven participating health plans) which subscribers pay for comprehensive inpatient and outpatient health care services. The AIM Program contracts with private health insurance plans to provide coverage for low-income women seeking pregnancy-related and neonatal medical care. The program has enrolled over 4,500 women and 11,000 infants through eight private health plans. Both the MRMIP and AIM Program are funded with tobacco tax (Proposition 99) revenues.

- ***Contracting Services.*** Some counties, such as San Diego and Orange, do not operate their own hospitals or primary care clinics, but contract with the University of California and with nonprofit, community based groups to provide their health services. San Diego County has contracts with 21 nonprofit community-based groups to operate primary care clinics. The clinics reportedly keep their costs down by private fund raising, using volunteers, and paying lower salaries on average.

Federal Medicaid Reform

Congress recently passed legislation that would make significant changes to the federal Medicaid Program (Medi-Cal in California).

Changes in Entitlement to Services. States would be required to provide some medical assistance to children under age 13 and pregnant women in families with incomes at or below the federal poverty level and to disabled persons, as defined by the state.

Increased Flexibility in Some Areas. The legislation would increase the states' discretion over several key areas, including eligibility criteria and benefit coverage. States would be authorized to establish the benefit package, with the exception of two mandatory benefits: (1) immunizations for eligible children and (2) pre-pregnancy family planning services and supplies, as determined by the state. In addition, states would no longer be required to: (1) cover specific services; (2) reimburse specific types of health care providers; (3) reimburse at specific rates; (4) provide services on a statewide basis; (5) provide services of the same duration, amount, and scope to all eligible individuals; (6) allow patients "freedom of choice" to select providers; or (7) reimburse noncontract hospitals and nursing facilities on the basis of reported actual costs.

Some Strings Are Still Attached. The legislation includes a state maintenance-of-effort requirement for three population groups: (1) pregnant women and children in families with incomes below 185 percent of poverty, (2) the elderly, and (3) the disabled. Also included is a maintenance-of-effort provision for Medicare premium assistance and payments to Federally Qualified Health Centers and rural health centers.

Payments to States. A federal maximum allotment would be established for each fiscal year beginning with federal fiscal year 1996 (October 1995 to September 1996). States would be required to match federal funds up to the federal cap. Funds would be allotted to states based on a funding formula. The DSH program would be eliminated, with the payments incorporated into the overall funds allotted to states according to the funding formula. In addition to this block grant funding, California would receive an estimated $1.6 billion over five years to partially offset costs for emergency services provided to undocumented persons.

Proposed Waiver for Los Angeles County. We note that this legislation puts at risk Los Angeles County's receipt of the $364 million in federal funds anticipated as a result of the proposed Medicaid waiver.