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THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

Health Care Coverage and Financing Issues in California: An October 2005 Update

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Home to more than 35 million residents, California's size, income diversity, and large multicultural population set it apart from all other states in the nation. Each of these factors affects the health care financing and delivery systems in the state. Since 2001, California state officials have confronted annual gaps between revenues and spending in each budget that have consistently been the largest in the nation both in dollar terms and in percent of overall budget. The estimated budget shortfall for FY 2006 is at about 10 percent of general fund spending.[1]

Against the backdrop of persistent budget gaps, this brief provides an overview of key financing and coverage issues in California health care policy today. This issue brief begins with a summary of recent health insurance coverage trends in California and the Medi-Cal program; then turns to an overview of the newly adopted FY 2005-06 budget agreement; followed by a discussion of key issues driving the current health policy agenda including:

- The Potential Cap on State Spending
- The New Hospital Financing Waiver
- Improving Coverage for Children

The brief concludes with a discussion on Medicaid reform actions at the federal level and the potential implications for California. Information included in this brief has been compiled over the past year and will be updated pending the state's special election set for November 8, 2005.

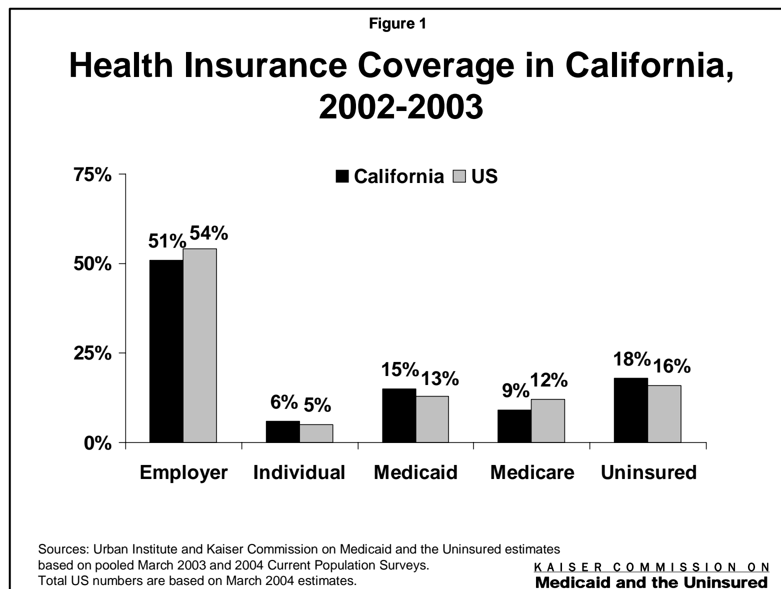
I. BACKGROUND

Meeting the health needs of residents who vary greatly by race, workforce and regional diversity is a challenge for the state's health care system. While all states face challenges in providing health care services to their residents, the California health care system is particularly complex due to a combination of factors. California has more people living in poverty than the national average (19% compared with 17% nationally). Minorities represent over half of California's population and non-citizens account for one out of every six people. California has a large manufacturing industry and a growing services industry, but it continues to be the nation's leading agricultural producer. California also has large regional diversity. Most residents live in a handful of southern counties, and nearly three in ten

[1] National Conference of State Legislatures, "State Budget Update: April 2005," http://www.ncsl.org

residents live in Los Angeles County alone. The next most populous region in the state is the San Francisco Bay area, home to 20 percent of the state's population.

Nearly 29 million Californians had some form of public or private health insurance coverage in 2003, while over 6.4 million remain uninsured. Like most Americans, the majority of Californians were covered by employer-sponsored health insurance (ESI) (51%), although rates of ESI in California are lower than the national average of 54 percent (Figure 1). Nearly a quarter relied on some form of public program coverage such as Medicare and Medicaid, and six percent of Californians purchased coverage through the individual market. Despite both public and private health insurance coverage options, gaps persist in the current system leaving 6.4 million uninsured in California in 2003.[2]



From 2000 to 2003, California experienced a 2.3 percent decline in employer-sponsored health insurance coverage rates among the non-elderly population due to the sluggish economy, rising health care costs, and increasing use of contract workers. California's average monthly unemployment rate rose from 5.4 percent in 2001 to 6.8 percent in 2003, decreasing the proportion of California residents with access to job-based insurance.[3] During the same time period, premiums for employment-based health insurance rose 31.3 percent over 10 times the 3 percent growth in wages, creating a financial strain on both employers and individuals.[4]

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2 Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2003 and 2004 Current Population Surveys. Total US numbers are based on March 2004 estimates.
3 Brown, E. Richard and Shana Alex Lavarreda, "Job-based Coverage Drops for Adults and Children but Public Programs Boost Children's Coverage," UCLA Center for Health Policy Research, February 2005.
4 Kaiser Family Foundation, "California Employer Health Benefits Survey, 2003," March 2004. http://www.kff.org/statepolicy/7039.cfm and US Department of Labor, Bureau of Labor Statistics accessed 6/6/05 at www.bls.gov.

One in five nonelderly Californians were uninsured in 2003 including almost a quarter of adults and 35 percent of those in families with incomes below 200% FPL ($29,360 for a family of three).[5] Job-based insurance declined significantly among all income groups between 2001 and 2003. The percent of adults who were uninsured increased slightly as job-based insurance fell but the uninsured rate for children actually decreased as a result of expanded enrollment in Medi-Cal and Healthy Families, with approximately 321,000 fewer children uninsured in 2003 than in 2001.[6]

Today, more than 10 million low-income Californians – roughly 16 percent of the state's population – rely on Medi-Cal for health care services. Medi-Cal, the state's Medicaid program, provides health insurance coverage for some of California's most vulnerable residents. Medi-Cal is jointly funded by the state and the federal government at a 50 percent match rate. Medi-Cal provides health coverage to a higher proportion of state residents than most other states largely as a result of expanded eligibility for children in the 1990s and an increase in enrollment attributable to increases in California's unemployment rate and a decline in private coverage rates. Medi-Cal covers nearly one in four children, covers the majority of persons living with AIDS, and fills in gaps in Medicare coverage for low-income elderly people and persons with disabilities.

Medi-Cal is also a major financer of California's health care delivery system paying for $1 out of every $6 spent on health care. Medi-Cal pays for two-thirds of all nursing home care and 4 in 10 births in the state. Medi-Cal is the primary funding source for the state's mental health program and system of care for the developmentally disabled. Additionally, Medi-Cal provides significant funding for California's health care safety net, including the public and private hospitals that serve Medi-Cal beneficiaries and the uninsured. About half of all public hospital revenues come from the Medi-Cal program.

Together Medi-Cal and Healthy Families (California's State Children's Health Insurance Program or SCHIP), provide health insurance coverage to children in families with incomes up to 250% of the federal poverty level (FPL) ($39,175 for a family of three in 2004) and parents with incomes up to 100% FPL ($15,670 for a family of three in 2004). As of June 2004, Healthy Families enrollment reached 722,089, a 19 percent increase over a two-year period (Figure 2).[7] These two public programs (Medi-Cal and Healthy Families) play a critical role in ensuring access to health care services to those who are least able to afford the costs of health care in the state.

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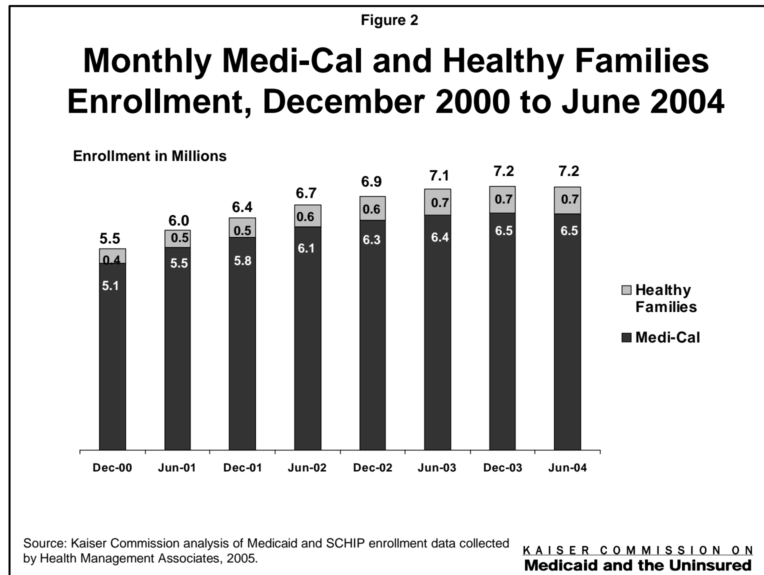
5 Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2003 and 2004 Current Population Surveys. Total US numbers are based on March 2004 estimates.

6 Brown, E. Richard and Shana Alex Lavarreda, "Job-based Coverage Drops for Adults and Children but Public Programs Boost Children's Coverage," UCLA Center for Health Policy Research, February 2005.

7 Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured, "Medicaid Enrollment in 50 States: June 2004 Data Update and SCHIP Enrollment in 50 States: December 2004 Data Update," September 2005.



The state addresses the health care needs of its low-income population by maintaining fairly broad eligibility for Medi-Cal and Healthy Families combined with a county-based system of indigent care for the uninsured that are not eligible for these programs. To keep such broad eligibility affordable, the state has a history of keeping provider payment rates low relative to national averages leading to low per capita spending. Medi-Cal services are delivered either through traditional fee-for-service or managed care arrangements. Over half (51%) of Medi-Cal enrollees are in enrolled in managed care, less than the national average of 60 percent, including all Medi-Cal children, pregnant women, and non-disabled parents. Most elderly and disabled Medi-Cal enrollees, in contrast, get their care in fee-for-service arrangements, with 86 percent of elderly and 79 percent of non-elderly beneficiaries with disabilities in fee-for-service arrangements.[8]

Despite one of the lowest per capita spending of any Medicaid program in the nation, federal and state Medi-Cal spending totaled $30.4 billion in 2003. About $12.3 billion comes from state-only general fund dollars. Spending on the Healthy Families program totaled $869 million in 2003 of which $304 million was state-only general fund dollars. Unlike Medicaid, federal SCHIP law establishes overall Healthy Families funding levels, which are capped each year according to the legislation that created the program in 1997.

In 2003, nearly two-thirds of Medi-Cal spending (63%) was for acute care services, which includes inpatient and outpatient service as well as prescription drugs, and nearly a third of spending was for long-term care services (Figure 3). Sixteen percent of overall spending was for payments to managed care organizations. Payments to hospitals serving a disproportionate share of low-income or uninsured patients (DSH) accounted for 6 percent of spending. In FY 2005, California will receive an estimated $1.03 billion in federal DSH funds.

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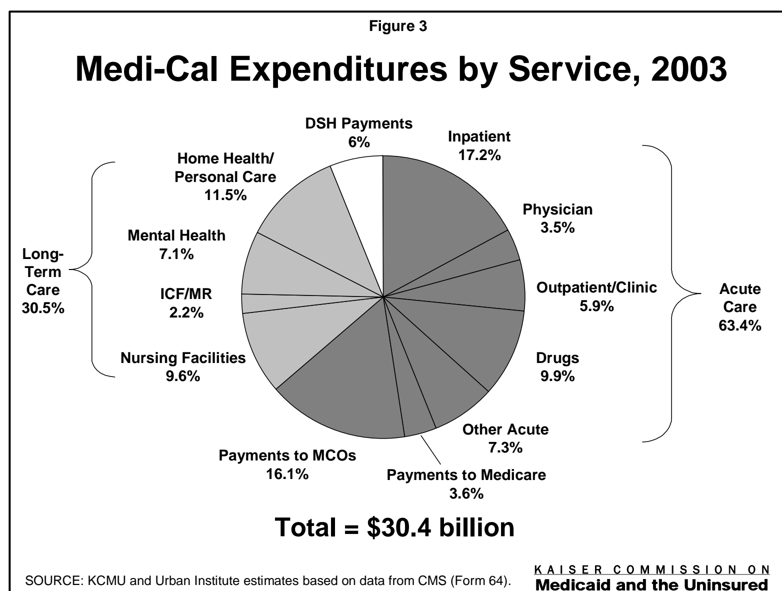
[8] Kaiser Commission on Medicaid and the Uninsured, "The California Medicaid Program at a Glance: Fact Sheet," July 2005, http://www.kff.org/medicaid/7138-02.cfm



II. CALIFORNIA BUDGET BACKDROP

Since 2001, California state officials have confronted persistent gaps between revenues and expenses in each annual budget. These budget gaps developed although state general fund expenditures remained relatively constant over the time period. The initial gap was caused by a dramatic decline in revenues during fiscal 2001-02.[9] The decline in income taxes was particularly serious, as these revenues provide about half of the revenues needed to support general fund programs. California's dependence on the progressive income tax as a source of revenue had grown as capital gains and stock option income surged in the late 1990s and other fees and taxes were cut. Despite the link between the budget shortfalls and the drop in revenues, there has been very little interest in tax increases among Californians as a means of balancing the state's budget. Over the past few years California has been relying on limited cuts in program spending, borrowing against future expected revenues, fund shifts, spending deferrals, and time-limited taxes to produce a balanced budget each year.[10]

California's FY 2005-06 budget agreement relied on a number of spending cuts, borrowing of funds and higher than expected revenues to balance the budget. Significant spending reductions in the budget agreement included: $135.5 million from suspending the cost-of-living adjustment (COLA) for CalWORKs cash assistance payments in 2005-06; $179.9 million from suspending the state COLA for SSI/SSP grants and delaying the pass through of the federal COLA in 2005-06; and $60 million from eliminating the Property Tax Administration grant program. The budget agreement also relied upon bonds,

[9] Hill, Elizabeth G. "California Spending Plan, 2004-05: The Budget Act and Related Legislation," Legislative Analysts' Office, September 2004; California Budget Project, "The 2004-05 Budget Agreement and Beyond," October 2004.

[10] Zuckerman, Stephen. "Medicaid and the 2003-04 Budget Crisis: A Look at How California Responded," Prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, August 2005. http://www.kff.org/medicaid/7324.cfm

fund shifts, and deferrals to balance the budget.[11] In addition, the state assumed higher than expected general fund revenues ($1.035 billion higher for 2005-06 than was originally assumed in January 2005) due to improved economic conditions and a net gain in revenues from the tax amnesty program.

The 2005-06 Medi-Cal budget provides roughly $1.3 billion in new general fund support for the program, reflecting an 11 percent increase over last year's budgeted amount. The increase in expenditures reflects ongoing caseload growth, increases in costs and utilization of medical services, and rate increases for nursing home providers. The California legislature did not adopt most of the Governor's Medi-Cal redesign proposal but it did include some modified components of the redesign – expanding managed care and capping dental benefits – in the final budget agreement. Medi-Cal managed care was expanded in 13 new counties, but without mandatory enrollment of aged and disabled beneficiaries. Dental benefits were capped at an $1,800 annual limit for adults in Medi-Cal beginning January 1, 2006. The final budget plan also included a modest increase in state spending ($5.9 million) to increase enrollment of children in Medi-Cal and Healthy Families and restored funding for certified applicant assistants to assist in the enrollment of eligible children.[12]

The FY 2005-06 Medi-Cal budget acknowledges both savings and increased costs resulting from the shift of prescription drug coverage for certain aged and disabled Medi-Cal beneficiaries ("dual eligibles") to the new Medicare Part D drug benefit scheduled to take effect in January 2006. Savings are expected to be achieved in payments to Medi-Cal managed care plans and Medi-Cal drug costs when dual eligibles begin to receive their drug coverage from Medicare instead of Medi-Cal. However, California will be required to pay an estimated $511 million in "clawback" payments to the federal government under the new Medicare law. Additional state costs could also result from other actions to assist Medi-Cal beneficiaries who may encounter problems in their transition to Medicare Part D drug coverage.[13]

III. HEALTH POLICY ISSUES

Several issues have dominated the health policy agenda in California this year. This section provides a brief overview of those items including the potential cap on state spending, the newly negotiated hospital financing waiver, and the increased efforts to expand health insurance coverage to children.

Potential Cap on State Spending

A potential cap on state spending could have major implications for state programs such as Medi-Cal. Governor Arnold Schwarzenegger called a special election scheduled for

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[11] California Budget Project, "2005-06 Budget Cuts and Human Services Funding – State Will Still Face Gap in 2006-07," August 2005.

[12] Hill, Elizabeth, "Major Features of the 2005 California Budget," Legislative Analyst's Office, July 2005 http://www.lao.ca.gov/2005/major_features/2005-06_major_features.pdf

[13] Ibid

November 8, 2005, for voters to consider several ballot measures, including changes in teacher tenure, redistricting, and a state spending cap.[14] The spending cap – Proposition 76 – would impose a new state spending limit, give the governor broad authority to cut spending if revenues fall below forecast levels, and make changes to the minimum school funding requirement and to transportation funding.[15]

The new cap would limit state spending based on revenue growth in the three prior years for state programs such as Medi-Cal and education. The formula would have the effect of allowing deficit spending during an economic downturn when revenue growth declines, and the same formula would prevent the state from restoring spending reductions made during a downturn when the economy strengthens, since the cap would be based on years when revenue growth was slow or negative.

Since the state spending cap would not be linked to the number of potentially eligible Medi-Cal beneficiaries or to the increase in cost of providing health care services, it could result in increased pressure on the state to further cut provider payments or to reduce the scope of services covered by Medi-Cal in order meet the spending obligations under the cap. While proponents argue that the new cap is designed to "smooth" state spending, others suggest that it would substantially reduce spending over time. Analysis by the California Budget Project found that had Proposition 76 been enacted in 1995, allowable 2005-06 spending would be $5.9 billion below the budgeted amount signed into law by the Governor this year.[16]

The New Hospital Financing Waiver and Pressures on California's Safety Net

CMS recently approved a new hospital financing waiver in California that changes the way in which federal matching funds to the state are determined. In September, the state negotiated and the legislature passed a new 5-year $18 billion Medicaid hospital financing waiver, effective September 1, 2005, that determines the amount of supplemental federal funding the state's safety net hospitals receive for treating a disproportionate share of Medi-Cal beneficiaries and the state's 6.4 million uninsured. In response to CMS concerns about California's method of financing the state share of its Medi-Cal payments to hospitals, the state will shift the source of its share of certain Medi-Cal costs from intergovernmental transfers (IGT) to certified public expenditures (CPE). Under the new waiver, public hospitals (but not private safety-net hospitals) or counties would "certify" expenditures for eligible services provided to Medicaid beneficiaries and the federal government would then match those CPEs.

The new waiver also creates a Safety Net Care Pool (SNCP) that will make a fixed amount of federal matching funds available annually to purchase care and expand coverage for the uninsured.[17] During the first two years of the waiver, $180 million per year in SNCP funding

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[14] Associated Press, "Measures Expected on California Special Ballot," *Washington Post*, June 13, 2005.
[15] California Budget Project, "2005-06 Budget Cuts and Human Services Funding – State Will Still Face Gap in 2006-07," August 2005.
[16] California Budget Project, "Proposition 76's New Spending Cap Could Require Substantial Spending Cuts," Budget Brief, September 2005.
[17] Andy Schneider and Peter Harbage, "Medi-Cal Hospital Waiver Implementation – The 3 Waivers: Medicaid Hospital Financing in California, Iowa, and Massachusetts," The California Endowment. August 23, 2005.

was conditioned upon implementation of "milestone" policies specified in the wavier's special terms and conditions – namely the transferring of roughly 554,000 seniors and persons with disabilities into managed care plans starting in January 2007. The move to managed care for the elderly and persons with disabilities raises significant health concerns due to their high utilization of services. Questions also arise over whether the transition would negatively impact access to doctors and specialists. Because an agreement was not reached by the end of the September 2005 legislative session, a loss of additional federal funding to California occurred when both the Governor and state legislators agreed to postpone until January 2006 discussions over moving this population to managed care.[18] Over the remaining three years of the wavier, $540 million of the SNCP must be used to support a broadly defined "coverage initiative" to expand coverage options for uninsured individuals.[19]

The Schwarzenegger Administration has stated the new financing waiver will provide some $3.3 billion more to the state's hospitals over five years than they would have received under the previous funding system.[20] However, skeptics argue that the federal cap on funding could shift financing risk and burden from the state to the counties, does not keep up with medical inflation, and does not provide the needed funding growth since the federal funds would be capped in the outyears.[21] The issue of adequate future financing is critical because many of California's hospitals are largely dependent upon supplemental financial support from local, state and federal sources. Hospitals in California are a core component of the health care safety net treating millions of medically underserved individuals each year, regardless of insurance coverage, immigration status, or ability to pay for services rendered. Public hospitals make up 6 percent of California hospitals, yet provide more than half the hospital care to the state's 6.4 million uninsured.

The laws governing nurse staffing and seismic retrofitting of public buildings in addition to increased demand for services and workforce are putting a strain on the California safety net system. The new ratio rules call for one nurse per five patients in medical-surgical units by 2005, as well as one nurse per four patients in specialty care and telemetry units and one nurse per three patients in step-down units by 2008. The regulations state that licensed vocational nurses can comprise no more than 50% of the licensed nurses assigned to patient care and that only registered nurses can care for critical trauma patients. The rules also require at least one registered nurse to serve as a triage nurse in emergency departments. The nursing shortage has made these new rules difficult to achieve. A judge recently overturned an emergency order by the Department of Health Services that sought to delay until January 2008 the implementation of the ratio, under which nurses can care for no more than five patients at one time. Under the emergency order, nurses could have cared for no more than six patients at one time. Hospitals claim that they must hire 4,000 additional nurses or close some wards to comply with the new ratio.

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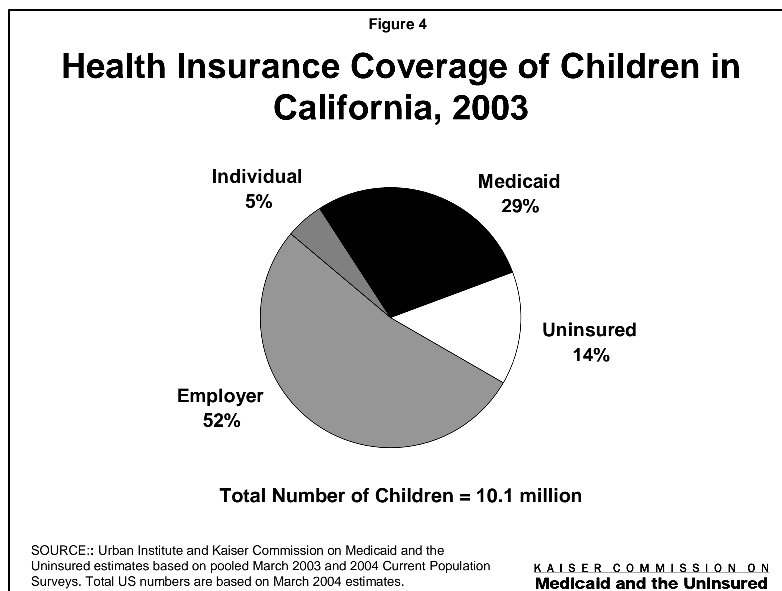
[18] BNA Health Care Policy Report. "State to Delay Mandated Managed Care For 500,000 on Medi-Cal, Losing Federal Aid," Volume 13 Number 36, September 12, 2005.
[19] California Healthline, "State Reaches Agreement with HHS to Increase Medi-Cal Managed Care Enrollment," June 23, 2005. www.californiahealthline.org
[20] BNA Health Care Policy Report: "California Lawmakers Pass Bill to Alter Distribution of Federal Supplemental Funds to Hospitals," Volume 12 Number 37, September 19, 2005.
[21] California State Association of Counties, http://www.csac.counties.org/default.asp?id=881 accessed 8-26-05.

In recent years there have been intense pressures on hospitals, public hospitals in particular, due to increased demand for specific services such as emergency, trauma care and interpreter services; workforce issues such as rising labor costs, shortages of nurses and other health care professionals; difficulties related to investment in capital resources and information technology; and rising pharmaceutical costs.[22] According to the California Department of Health Services, 60 hospitals have closed and 26 have opened in the last 10 years. Some officials contend that the hospital industry could benefit from consolidation, but communities affected by hospital closures cite the loss of emergency care and jobs. Hospital closures are the result of multiple complex factors. Some hospitals, especially those in isolated or rural areas, do not have enough patients to support themselves. Many hospitals have been affected by the migration of certain procedures from hospitals to outpatient clinics, low Medi-Cal and Medicare reimbursements, competitive managed care payment rates, and increasing technology costs. In addition, a separate California law requiring that all hospitals guarantee by 2008 that their buildings would not collapse in a significant earthquake, or by 2013 if the buildings are expected to remain in use 30 years from now, may also lead to increased hospital pressures.

Improving Coverage for Children

There is bipartisan support among policy makers in both the Administration and state legislature to cover all children. Together Medi-Cal and Healthy Families provide coverage to over 3 million low-income children in California; however, about 14 percent of children (or 1.4 million) remain uninsured (Figure 4). Several bills to expand coverage to children, regardless of their immigration status, have been introduced in the state legislature and are being actively considered. Although there is considerable political momentum, very limited state funds are likely to be dedicated to the financing of coverage expansions in the near-term and the ability to raise new revenues is limited due to the ongoing budget deficit. Advocates are developing proposals to phase in coverage expansions over several years.



[22] Regenstein, Marsha and Jennifer Huang, "Stresses to the Safety Net: The Public Hospital Perspective," Kaiser Commission on Medicaid and the Uninsured, June 2005. http://www.kff.org/medicaid/7329.cfm

A coalition of more than 120 organizations including advocates, faith-based organizations, business leaders, educators, health plans, providers, parents, and civic leaders have created Californians for Healthy Kids, which is committed to ensure that every child in California has access to high quality, affordable health care. There is strong public support in favor of covering all children. In a statewide recent poll, California voters identify children not having health insurance as a grave concern. Specifically, nine out of ten voters (89 percent) view uninsured children as a serious problem, with three out of four voters statewide (73 percent) describing it as either extremely or very serious. Voters overwhelmingly support a plan that would "ensure that every child in California has health insurance." Nearly four out of five voters (78 percent) support this plan, with more than half (55 percent) strongly in favor of it.[23]

Over the past five years, local coalitions have created a model to expand health coverage and create systems change for children and families called the Children's Health Initiative (CHI). This program (referred to as *Healthy Kids*) offers health coverage to children in families with incomes up to 300% of the FPL, or $48,270 for a family of three, and those who are ineligible for Medi-Cal and Healthy Families including undocumented children.

Although the state's fiscal situation has adversely affected county health budgets, a growing number of local coalitions have advanced new coverage solutions using CHI model. The first CHI was launched in Santa Clara County in January 2001 with financial support from the County of Santa Clara, the City of San Jose, the local First 5 Commission, the local Medi-Cal managed care plan, and several private foundations.[24] Because the outreach message is simple and because families do not have to navigate through different enrollment entities, the integrated program and single enrollment approach draw additional children into the existing publicly funded programs. In fact, over the past year, Healthy Families enrollment in Santa Clara grew at almost twice (32%) the rate of the state average (17%). In addition to Santa Clara County, nine other counties, including Los Angeles and San Francisco, are currently operating a CHI and another 18 counties throughout the state are in various stages of planning.

IV. FUTURE CHALLENGES

At the same time that state officials in California are seeking ways to control the rising costs of Medicaid spending, policy makers in Washington are also in debate over federal spending on Medicaid. The Administration's FY 2006 budget included major reductions in federal Medicaid spending totaling about $45 billion over 10 years. The Congress passed a budget resolution in April that requires up to $10 billion in reductions in Medicaid spending over the next 5 years. While specific legislative proposals to reach the savings target are still under development, some of the proposals could shift costs to the states at a time when many states

[23] From February 12-20, 2005, Fairbank, Maslin, Maullin & Associates conducted a statewide telephone survey among 1,200 likely voters in California. Interviews were done in both English and Spanish. The margin of error for the entire sample is plus or minus 2.8% at the 95% confidence level.

[24] Wong L, Frazer H, Finocchio L, Winterbauer T, Schroeder G. "Pioneers for Coverage: Local Solution for Insuring All Children in California." San Mateo, CA: Institute for Health Policy Solutions, October 2004.

already face additional responsibility for Medicaid as a result of the implementation of the new Medicare Part D program.

Although state fiscal conditions have improved modestly in California, health care costs continue to rise rapidly, and proposed reductions in federal spending would have an impact on the ability of the Medi-Cal program to provide needed access to health care services. Because of the size of California's Medicaid program, which is second only to that of New York, the state will likely have to contribute significant amounts to any reductions in federal Medicaid spending if Congress is to achieve its savings target. Taken together, plans to reduce Medicaid spending at the federal level and the new hospital financing waiver will affect billions of federal Medicaid dollars for California.[25]

Prompted by significant state budget shortfalls over the last several years, the Governor's health policy agenda includes a restructuring of Medi-Cal financing and delivery with the goal of maintaining coverage for eligible populations while containing program costs. Although revenues have rebounded to some extent, all indications are that California will be confronting annual budget shortfalls for at least the next few years. In addition, the proposed ballot initiative to cap state spending could have significant implications for future Medi-Cal spending as could the hospital financing waiver that includes five-year capped funding of the Safety Net Care Pool.

Federal and state actions, particularly the proposed cap on state spending, could have important implications for low-income Californians and the California safety net system. As California remains under pressure to reduce Medi-Cal costs, health care costs continue to rise and California residents continue to experience a decline in employer-sponsored insurance. Going forward, efforts to address the rising cost of health care spending in private insurance and publicly funded programs as well as maintaining adequate financing of the safety net that now serves over 6 million uninsured are important policy issues driving health policy in California today.

[25] Schneider, Andy. "Congress Considers Medicaid Spending Cuts: Implications for California's Medi-Cal Beneficiaries and Safety Net Providers," The California Budget Project, June 2005.

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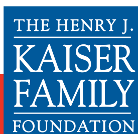

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.