



Budget Backgrounders: ***Making Dollars Make Sense***

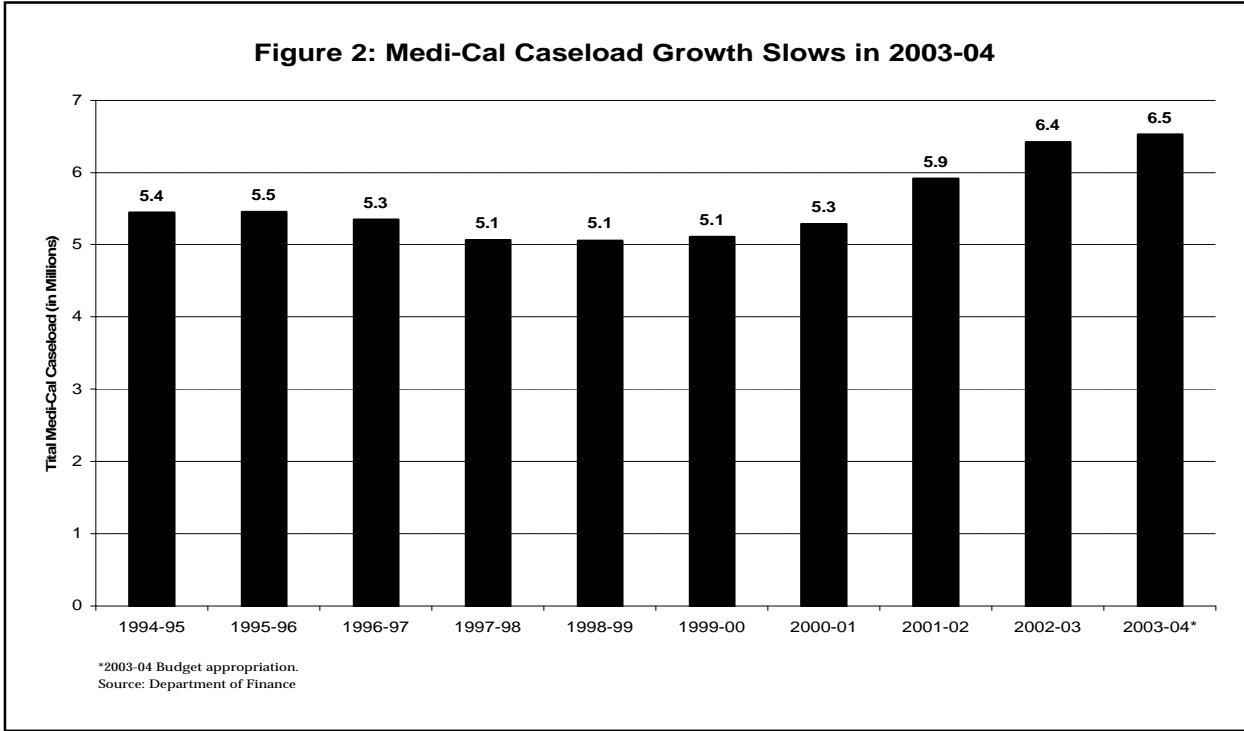
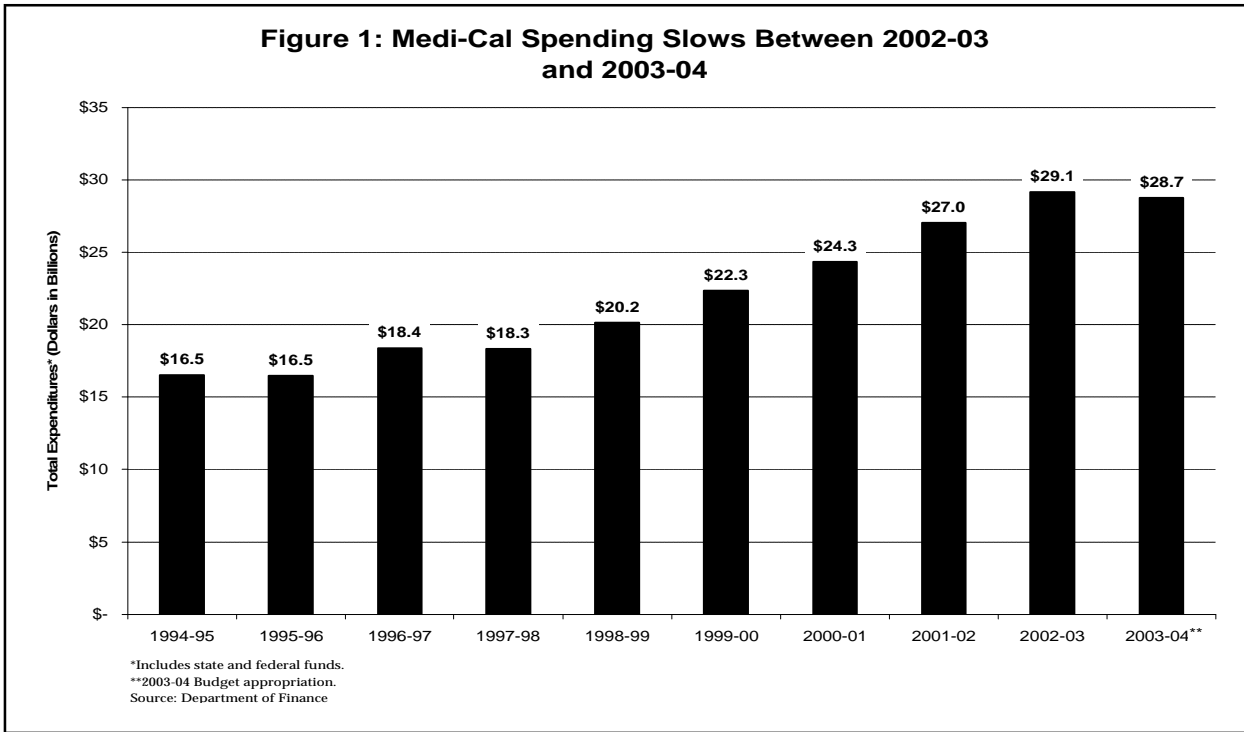
February 2004

MEDI-CAL PROGRAM

California has taken various steps to extend health coverage to the uninsured through the Medi-Cal program. However, many challenges remain in providing coverage to those still uninsured, ensuring access, and promoting quality health care. The Governor's budget proposals could harm beneficiaries' access to services and quality care and would result in the loss of federal funds. These proposals include obtaining a federal waiver to implement cost-saving measures and reducing payments to certain Medi-Cal providers by 10 percent. However, a federal court has blocked the state from implementing a 5 percent provider payment reduction that was scheduled to go into effect January 1, 2004.

The Medi-Cal program provides health insurance for eligible low-income families and individuals.

- Medi-Cal is California's version of Medicaid, a federal-state health insurance program for low-income individuals who can't afford or who don't have access to private coverage. Medi-Cal provides health care services to children; parents; and elderly, blind, and disabled persons who receive public assistance or meet income and other eligibility criteria.
- Nationally, Medicaid programs play a major role in helping states reduce the number of uninsured and respond to losses of private health insurance due to unemployment during economic downturns, increasing premiums, and other factors.
- Medi-Cal insures about one out of four children in California, covers the majority of persons living with AIDS, fills in gaps in Medicare coverage for low-income elderly persons and persons with disabilities, paid for 42 percent of all births in California in 2000, and pays for two-thirds of all nursing home days. Medi-Cal also provides an important support to low-income working families.
- State Medicaid programs are required to offer a core set of benefits, such as doctor visits, hospital care, and laboratory services. California additionally offers more than 30 federally-optional benefits through Medi-Cal, including prescription drugs and dental services for adults.
- The state and federal governments each pay about 50 percent of the costs of the Medi-Cal program. The 2003-04 Budget provides approximately \$28.7 billion (\$10.5 billion General Fund) for Medi-Cal (Figure 1).
- In fiscal year 2003, Medi-Cal brought about \$17 billion in federal funds to California, which was paid to health plans and health care providers.
- Nearly one out of five Californians, 6.5 million individuals, are enrolled in Medi-Cal (Figure 2).



Many eligible Californians are not enrolled in Medi-Cal.

- About 6.3 million Californians experienced a lack of health coverage sometime during 2001, and approximately 820,000 children and adults were eligible for Medi-Cal, but not enrolled, according to the 2001 California Health Interview Survey (CHIS).
- In 2002, 20 percent of non-elderly persons lacked health coverage in California, compared to 17.2 percent in the US overall, according to federal Census data. For more than a decade, California's percentage of uninsured non-elderly persons has remained higher than that of the nation as a whole.

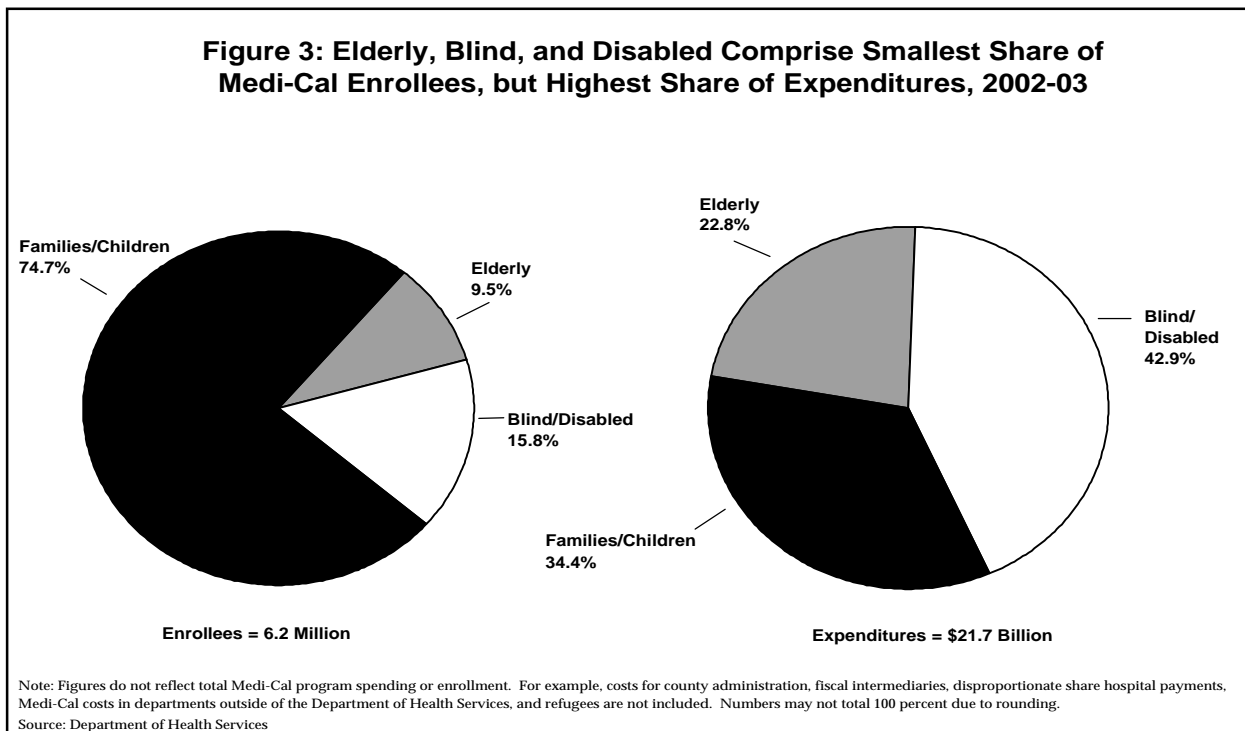
- Based on a three-year average between 2000 and 2002, California had the sixth largest proportion of non-elderly uninsured in the nation.
- In 2002, 68 percent of uninsured children in California were in families where the head of the household was working full time year-round, and 85 percent were in families where the head of the household worked at least part time or part of the year.

Elderly, blind, and disabled individuals make up about 25 percent of the Medi-Cal caseload, but account for about 66 percent of Medi-Cal expenditures (Figure 3).

- In 2002-03, estimated average spending per Medi-Cal enrollee was \$1,614 for children and families, \$8,422 for the elderly, and \$9,547 for disabled individuals.
- For 2003-04, about half (48 percent) of total Medi-Cal expenditures are projected for pharmacies, long-term care facilities (including nursing facilities), and inpatient hospital services.
- The Legislative Analyst’s Office (LAO) estimates that spending for most health services to elderly, blind, and disabled Medi-Cal enrollees will increase at an annual rate of between 5 percent and 7 percent from 2004-05 through 2008-09, due to increased utilization and costs. In contrast, the LAO estimates that the cost of services to children and families will grow more slowly, up to 2.8 percent annually, during the same period.

In 2000, California ranked 50th out of 51 Medicaid programs in spending per enrollee.

- In 2000, California spent an average of \$2,635 per enrollee compared to the national average of \$3,799, and ranked 50th out of 51 Medicaid programs in spending per enrollee. This was partly because California paid providers less than other states and partly because a higher proportion of the state’s caseload consisted of lower-cost enrollees, such as children.



Expenditure growth in Medi-Cal has mainly been due to increases in enrollment and increased spending on prescription drugs, nursing facilities, and inpatient hospital services.

- Nationally, increases in recent Medicaid spending have been partly driven by enrollment increases due to loss of income and private insurance coverage during the economic downturn as well as by increases in hospital and prescription drug costs that have affected the entire health care sector.
- In recent years, California has adopted policies to expand and simplify Medi-Cal eligibility, including expanding eligibility to parents with incomes below the federal poverty level (FPL); extending no-cost benefits to the elderly, blind, and disabled who earn up to 133 percent of the FPL; and providing 12 months of uninterrupted coverage for children from the date they are determined eligible for Medi-Cal.
- Between 1994-95 and 2000-01, pharmacy expenditures accounted for one-third of the total growth in Medi-Cal fee-for-service per capita provider payments, nursing facility payments accounted for more than 20 percent, and inpatient hospital services accounted for 15 percent.

Spending on prescription drugs is one of the fastest growing components of health care in both Medicaid and the private sector.

- Between 2000 and 2001, national spending on prescription drugs increased by 16 percent. Between 1996 and 2001, the annual increase was higher than increases in hospital care or physician services. The federal Centers on Medicare and Medicaid Services (CMS) estimates that prescription drug costs will be the fastest growing component of Medicaid costs between 2002 and 2004.
- Three factors contributed to the increase in national prescription drug spending between 1997 and 2001. Increased utilization of prescriptions accounted for 47 percent of the increase, use of new and higher-priced drugs accounted for 27 percent, and manufacturer price increases for existing drugs accounted for 26 percent.

Despite serving a greater number of elderly and disabled individuals, Medicaid has been more effective in containing health care costs than the private sector.

- While most private insurers do not cover the elderly or many of the severely disabled, these groups represent about one-quarter of Medi-Cal beneficiaries. Therefore, Medi-Cal experiences additional cost pressures that private sector insurers do not.
- Nevertheless, growth in spending per Medicaid enrollee has been lower than growth in private insurance premiums. Nationally, while per enrollee premiums for employer-sponsored insurance increased on average by 12.7 percent between 2001 and 2002, per enrollee Medicaid costs increased by 7.5 percent for non-elderly adults and by 6.7 percent for children over the same period.
- In 2002, the average annual premium for employer-sponsored insurance in California was \$7,471 for a family. The estimated average spending per Medi-Cal enrollee was \$1,614 for children and families in 2002-03.

California has adopted various cost-saving measures due to state fiscal constraints.

- California has adopted a variety of cost-containment strategies in Medi-Cal, including expansion of managed care in the 1990s and the addition of over 250 state staff since 1999 to investigate and deter provider fraud.¹

- In the 2003-04 Budget, California adopted policies that reversed or reduced prior expansions in the Medi-Cal program, including reducing payments to certain providers by 5 percent; requiring adults to submit forms twice per year rather than annually to retain Medi-Cal eligibility; and eliminating the second year of transitional Medi-Cal benefits for former welfare recipients. However, a federal court recently blocked the state from implementing the 5 percent rate reduction for certain Medi-Cal providers, on the basis that it would impact beneficiaries' equal access to quality medical services.²

The Governor's budget proposals would further reduce payments to providers, which could decrease beneficiaries' access to services and quality care.

- Despite the court ruling preventing the state from implementing the 5 percent reduction, the Governor proposes an additional 10 percent rate reduction for specified Medi-Cal providers, including physicians, medical transportation, home health, and other medical providers and services. This would result in General Fund savings of \$160.9 million in 2003-04 and \$462.2 million in 2004-05.
- According to a 2001 study by the Medi-Cal Policy Institute, California's fee-for-service payments to physicians ranked 42nd among 51 Medicaid programs nationwide after adjusting for geographic cost factors and represented 65.2 percent of the amount the federal Medicare program for the elderly pays for the same services.
- In 2001, the average number of available primary care physicians per capita for Medi-Cal beneficiaries was about one-third less than it was for the general population. About one-quarter of primary care physicians accounted for 80 percent of the primary care services provided to Medi-Cal beneficiaries.
- In addition, the Governor proposes to eliminate the Wage Adjustment Rate Program (WARP), which provides supplemental payments to certain long-term care facilities for salaries, wages, or benefits for caregivers of Medi-Cal services, for General Fund savings of \$46 million in 2003-04. According to the Administration, no funds have yet been allocated for the program.

The Governor proposes additional measures for General Fund savings of \$400 million in Medi-Cal.

- According to the Administration, proposals may include: changing eligibility standards; offering different benefit packages and requiring different premium amounts for benefits; requiring co-payments from beneficiaries for various services; changing the basic Medi-Cal optional benefit package; and expanding managed care, including encouraging enrollment of elderly, blind, and disabled persons into managed care plans.
- The Administration intends to obtain a federal Medicaid waiver to implement the proposals and plans to engage stakeholders, constituents, and the Legislature to help inform the design of these efforts.
- The Proposed Budget does not assume Medi-Cal savings in 2004-05 related to these changes due to the time needed to develop and implement the proposals. However, the Administration anticipates General Fund savings of \$400 million in 2005-06.

Proposals would result in a loss of federal funds.

- California would lose approximately one dollar in federal funds for every dollar cut from the state's Medi-Cal program. The 10 percent provider rate reduction and elimination of the WARP would result in a loss of federal funds of \$212.1 million in 2003-04 and \$485.1 million in 2004-05. This would double the impact of the proposed General Fund reduction on local economies and the state's health care system.

Agnes Lee prepared this Background. The California Budget Project (CBP) was founded in 1994 to provide Californians with a source of timely, objective, and accessible expertise on state fiscal and economic policy issues. Funding for this Background comes from a grant from The California Endowment. The CBP engages in independent fiscal and policy analysis and public education with the goal of improving public policies affecting the economic and social well-being of low- and middle-income Californians. Support for the CBP comes from foundation grants, publications, and individual contributions. Please visit the CBP's web site at www.cbp.org.

Endnotes

¹ California provides Medi-Cal managed care services through three models: County Organized Health Systems, Geographic Managed Care, and the Two-Plan Model.

² On December 23, 2003, a federal district court enjoined the state from implementing the 5 percent provider rate reduction that would have gone into effect January 1, 2004. In its ruling, the court stated "because the state failed to consider the effect of a rate reduction on beneficiaries' equal access to quality medical services, in view of provider costs, the pending rate reduction is arbitrary and cannot stand." The preliminary injunction did not apply to rates paid to managed care plans. Court opinion, *James Clayworth, et al. v. Diana M. Bonta, et al./California Medical Association, et al. v. Diana M. Bonta*, downloaded from <http://207.41.18.73/caed/DOCUMENTS/Opinions/Levi/03-2110.pdf> on January 8, 2004.