kaiser commission on medicaid and the uninsured

KEY FACTS

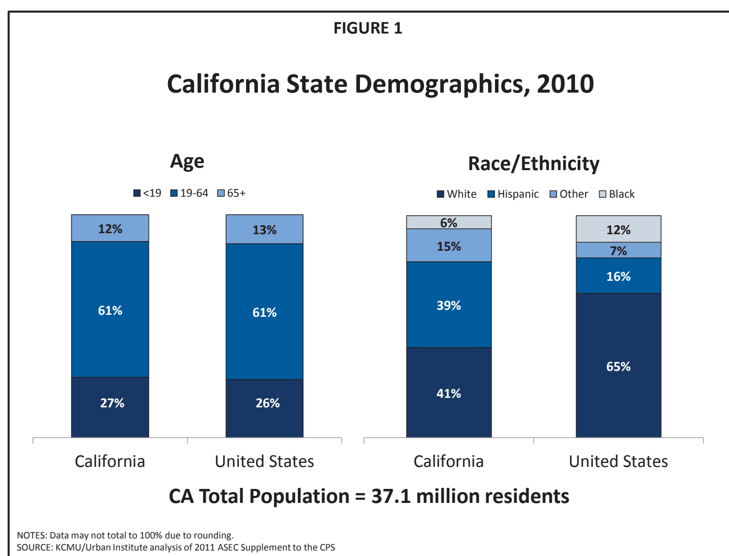
THE HENRY J. KAISER FAMILY FOUNDATION

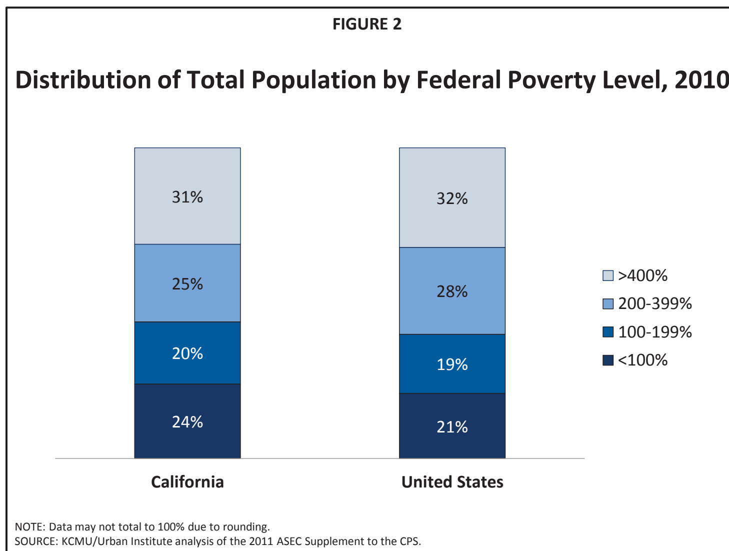
December 2011

The California Health Care Landscape

Demographics

Home to over 37 million residents in 2010, California has the largest population of any state in the U.S.[1] California is a majority minority state: 41% of the state's population identified as White, 39% as Hispanic, 12% as Asian, and 6% as Black (Figure 1).[2] California has a higher share of immigrants than any other state, reaching 27%, or nearly 10 million people, in 2009.[3] As of 2010, 24% of the state's population, or nearly 9 million people, were living in poverty (Figure 2), compared to a national poverty rate of 21%. Poverty in California is not equally distributed by race. Fourteen percent of those living in poverty identified as White, while 34% identified as Black and 56% identified as Hispanic.[4] As of October 2011, California's unemployment rate was just under 12%, the second highest rate in the country.[5]





Population Health

The general health of Californians is slightly above the national average. In the United Health Care Foundation's report, *America's Health Rankings 2011*, California ranked 24th among the 50 states, two places higher than its rank in 2010.[6] California has a low rate of smoking, high rates of early prenatal care, a low infant mortality rate, and low rates of deaths from cancer, compared to other states. California has slightly lower than national rates of asthma, overweight/obesity, and deaths due to heart disease, and a slightly higher rate of diabetes.[7] The state has much lower rates of immunizations than the nation overall and a higher rate of air pollution.[8]

California, like other states, has health disparities. In 2010, 18% of White nonelderly adults had no health care provider, compared to 25% of Blacks and 45% of Hispanics. Over 21% of Hispanics and 19% of Whites had not seen a doctor in the past two years, compared to 11% of Blacks. Nearly 27% of Hispanics and 18% of Blacks reported being in fair or poor health, compared to 9% of Whites; and a greater percentage of Hispanics (11%) and Blacks (10%) had self-reported diabetes than Whites (6%). Similarly, more Blacks (65%) and Hispanics (64%) were overweight or obese than Whites (56%) in 2010.[9]

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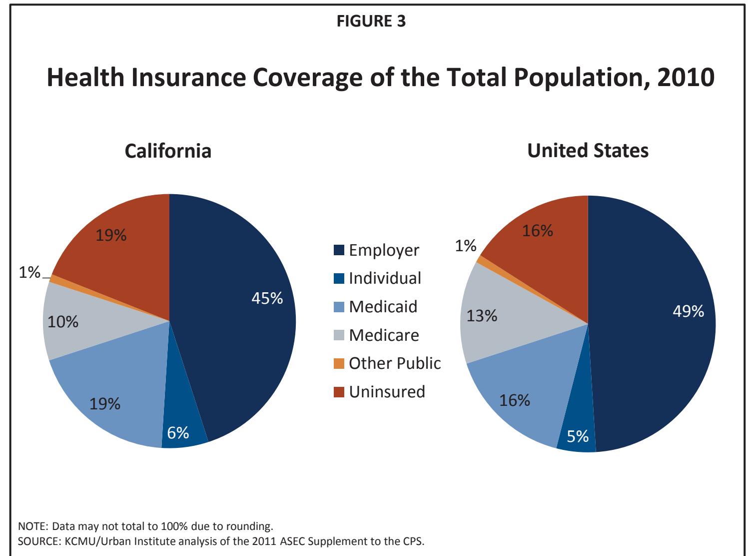
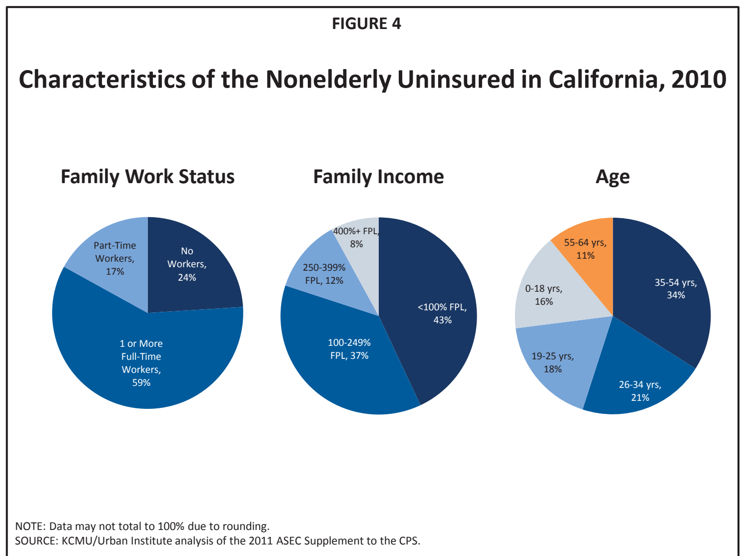
Population health varies across California's 58 counties, with rural counties, especially those in the Central Valley, faring worse than urban ones. A 2007 report by the Central Valley Health Policy Institute found that rural residents had higher rates of overweight and obesity, substance abuse, sexually transmitted infections, and mental illness than their urban counterparts.[10] Older adults who live in rural areas are also more likely to be in poor health and have a higher risk of developing heart disease and diabetes than their urban counterparts. Geographical isolation, lack of proximity to health care providers, language barriers, and food insecurity were observed risk factors for poor health for rural individuals and the ethnically diverse demographic population of the Central Valley.[11,12]

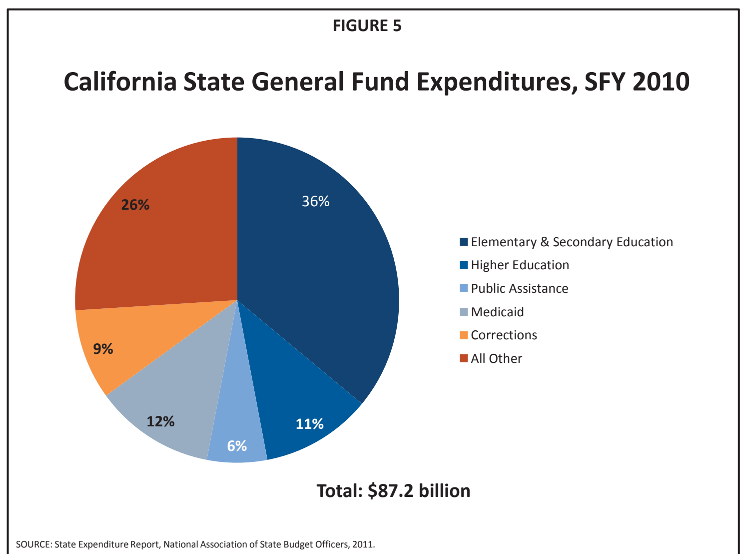
Coverage

Over 7 million people, or 19% of the state's population, were uninsured in 2010 (Figure 3). This is the sixth highest uninsured rate of any state and it exceeds the U.S. average uninsured rate of 16%. As shown in Figure 13 (Appendix) the nonelderly uninsured are not distributed equally among counties (See Figure 12 in the Appendix for the distribution of the nonelderly population by county). As in other states across the U.S., the majority of nonelderly uninsured in California have at least one full-time worker in their households, have income below 250% of the Federal Poverty Level (FPL), and are under age 55 (Figure 4).

Among the 80% of Californians with health insurance, the largest segment was insured through employer-sponsored coverage (45%), followed by Medi-Cal (the state's Medicaid program) (19%), Medicare (10%), and individual insurance (6%).[13]

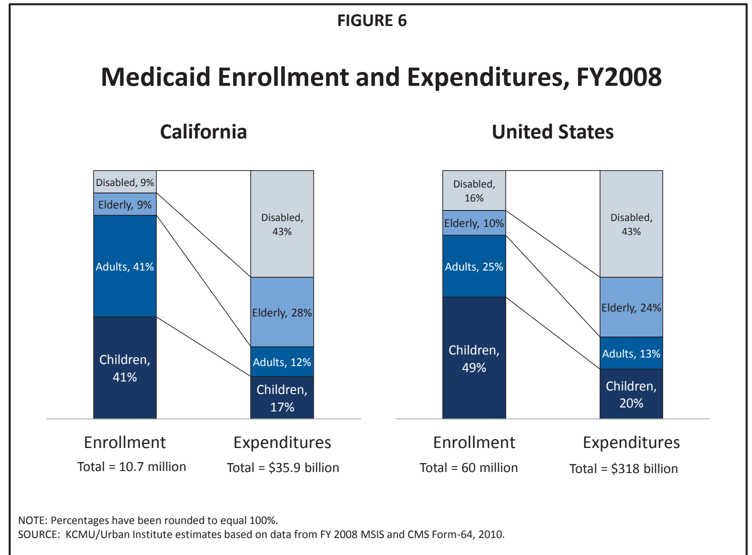


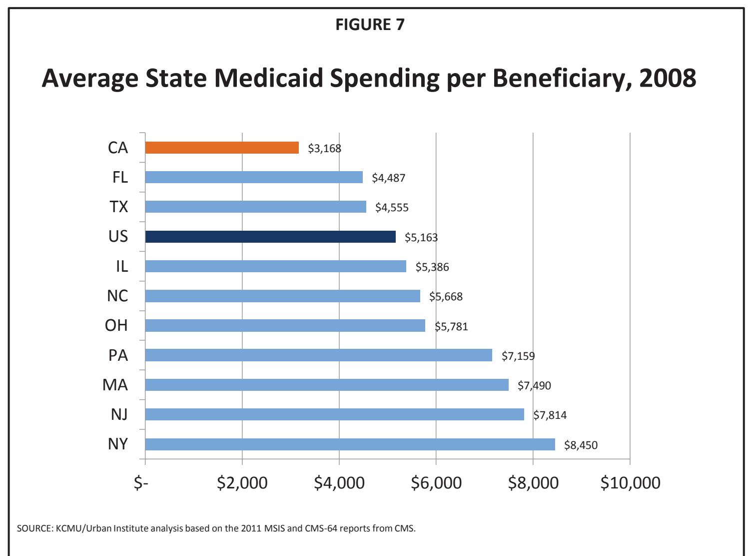




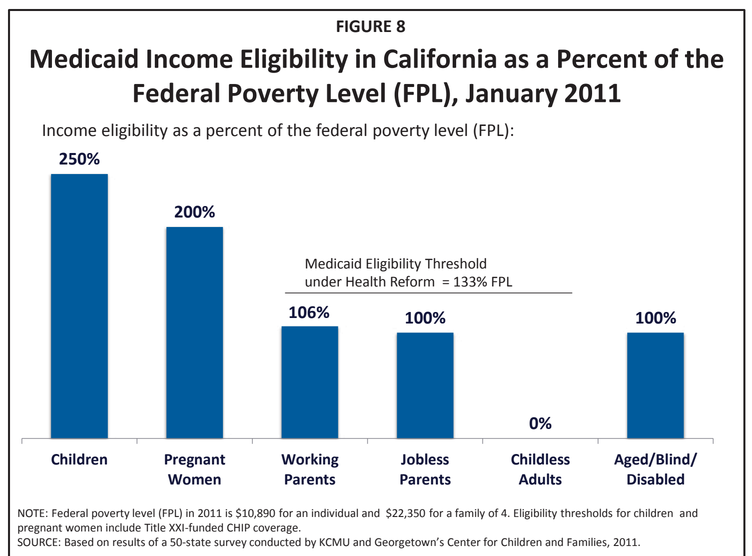
Medicaid

California's Medicaid program, known as Medi-Cal, covers over 6.5 million low-income Californians for whom the state spent 12% of its general revenue funds, an estimated $10.3 billion, in 2010 (Figure 5, previous page).[14] Of those enrolled in 2008, over 40% were children, who accounted for 17% of expenditures. Only 18% of Medi-Cal enrollees were elderly and disabled, but they accounted for over 70% of total Medi-Cal costs (Figure 6).[15] Medi-Cal eligibility levels for different beneficiary categories were above the corresponding national median levels in 2010 (Figure 8).[16] As of October 2010, 55% of California's Medicaid beneficiaries were enrolled in some form of managed care.[17] In 2008, Medi-Cal payment rates to physicians for primary care services were 47% of Medicare rates (the national average was 66%)[18]. On a per-enrollee basis, California's Medicaid spending is the lowest in the nation and is far below the overall national level (Figure 7).[19]





The combined federal and state costs of Medi-Cal for all covered populations were $41.7 billion in FY 2009. This fiscal year, the federal government will pay 50% of the cost of Medicaid in California; for every $1.00 that the state (or its counties) spends, the federal government will send $1.00 to the state in matching funds.[20] California, like many other states, reports that it will be taking cost containment actions in FY 2012, including reductions in provider payments, pharmacy controls, reductions in benefits, and increased copayments.[21] California is also implementing a number of policies designed to improve quality in managed care, including a 5 percent quality factor in capitation payments.[22]

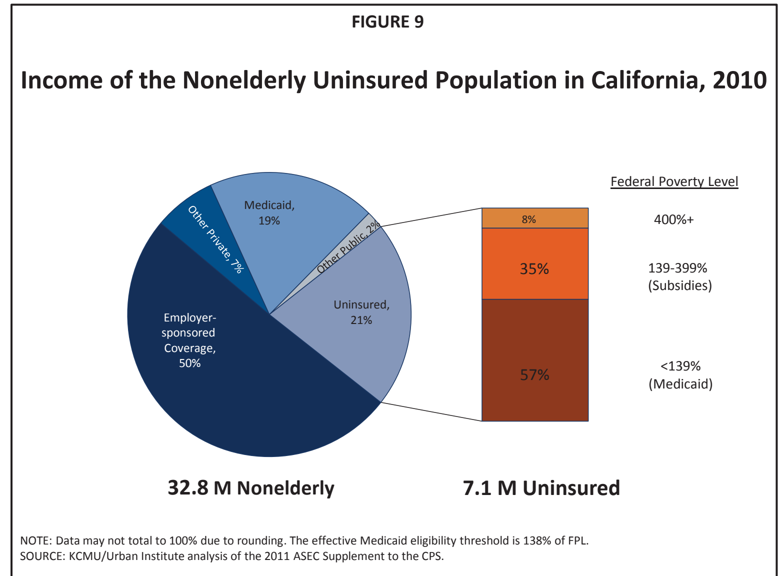


In November 2010, the Centers for Medicare & Medicaid Services (CMS) approved a section 1115 Medicaid Demonstration Waiver for California to assist the state and its counties in preparing for the implementation of the Affordable Care Act (ACA)

coverage expansions in 2014. Under California's "Bridge to Reform" waiver, up to $8 billion in federal Medicaid funds will be available over a five-year period to (1) allow counties to extend coverage to low-income uninsured "childless" adults not eligible for Medi-Cal (See Figure 8), (2) enable county and University of California hospitals and clinics to expand their capacity to provide quality primary and specialty care, and (3) permit the state to require some 380,000 low-income seniors and persons with disabilities (SPDs) to enroll in Medicaid managed care organizations.[23]

FIGURE 9

Income of the Nonelderly Uninsured Population in California, 2010



NOTE: Data may not total to 100% due to rounding. The effective Medicaid eligibility threshold is 138% of FPL.
SOURCE: KCMU/Urban Institute analysis of the 2011 ASEC Supplement to the CPS.

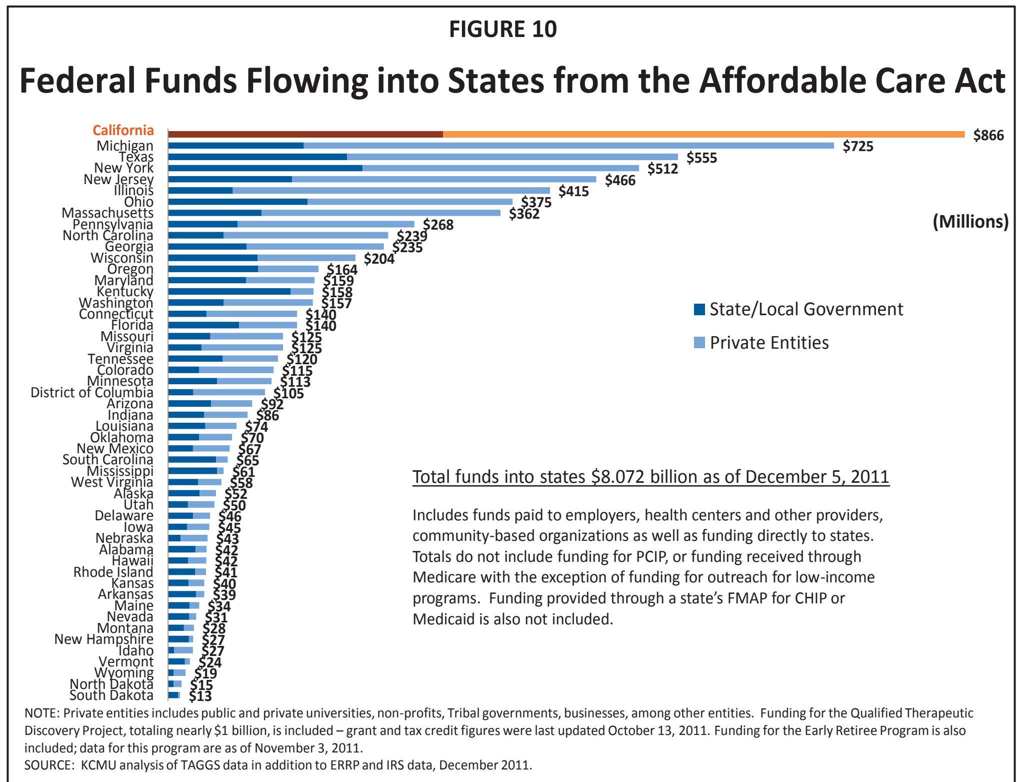
Health Reform

Under the ACA, California, like all other states, will be required to extend Medicaid coverage to all citizens with incomes under 133% of the federal poverty level ($14,500 for an individual and $29,700 for a family of 4 in 2011). KCMU and the Urban Institute estimate that this will add between 2 million and 3 million new enrollees to Medi-Cal by 2019, depending on whether one assumes low or high rates of participation. Under a low participation scenario, the cost of this expansion would be $47.7 billion, of which the federal government would pay $44.6 billion, or 94%. Under a high participation scenario, the total cost would be $61.5 billion, with the federal government paying $54.9 billion, or 89%.[24] An additional 4 million people are expected to enroll in health insurance through the state's health insurance exchange.[25]

On September 30, 2010, California became the first state in the country to pass legislation to create a Health Benefit Exchange (HBEX).[26] A five-member governing Board has been appointed and the HBEX is up and running, funded by a one-year, $39 million Level I Exchange Establishment grant received from the federal government in August 2011.[27] The California HBEX is a quasi-governmental body that follows the "active purchaser" model of benefits exchanges – that is, it will selectively contract with only some qualified health plans in order to achieve goals relating to plan choice, quality, or value.[28]

FIGURE 10

Federal Funds Flowing into States from the Affordable Care Act



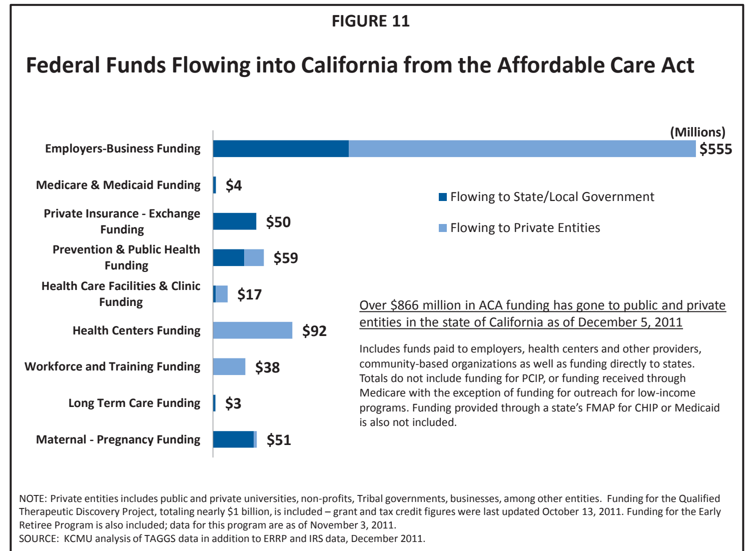
NOTE: Private entities includes public and private universities, non-profits, Tribal governments, businesses, among other entities. Funding for the Qualified Therapeutic Discovery Project, totaling nearly $1 billion, is included – grant and tax credit figures were last updated October 13, 2011. Funding for the Early Retiree Program is also included; data for this program are as of November 3, 2011.
SOURCE: KCMU analysis of TAGGS data in addition to ERRP and IRS data, December 2011.

The Level I grant is only a small portion of the federal ACA funds in California. As of December 2011, $866 million in federal ACA funds have already flowed into California, the largest amount received by any state (Figure 10, previous page). It is important to note that, of those funds, nearly $119 million has gone to private entities through the Early Retiree Reinsurance Program, including employers, community health organizations, and other community-based organizations. The remaining funds have flowed to the state and county governments (Figure 11).[29]

The ACA's Medicaid coverage expansion, combined with its tax credit subsidies for coverage premiums through qualified health plans in the HBEX, will dramatically change the financing of health care for low-income Californians. Under current state law, California's 58 counties have responsibility for the provision of health services to medically indigent adults (MIAs)—i.e., uninsured, low-income adults who are not eligible for Medi-Cal or other public programs.[30] Counties currently use a mix of federal, state, and local funds to finance this care; variations in county fiscal capacity and policy priorities have resulted in significant differences in the organization and administration of health services from county to county. Some counties deliver care through their own hospitals and clinics, while others contract with private hospitals and physicians for this purpose. Under the ACA expansions, many low-income, currently uninsured Californians will be covered through Medi-Cal or through qualified health plans in the HBEX, largely at federal expense. This change will have major implications for county finances, county-operated delivery systems, and access to care.

FIGURE 11

Federal Funds Flowing into California from the Affordable Care Act



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This fact sheet was prepared by Rachel Arguello of the Kaiser Commission on Medicaid and the Uninsured and Andy Schneider, a consultant to the Kaiser Commission on Medicaid and the Uninsured.

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[1] U.S. Census Bureau. *American Community Survey 2010.*
[2] U.S. Census Bureau. *American Community Survey 2010.*
[3] Johnson, H. *Public Policy Institute of California*. Just the Facts: Immigrants in California, April 2011. Available at: (http://www.ppic.org/content/pubs/jtf/JTF_ImmigrantsJTF.pdf).
[4] KCMU/Urban Institute analysis of 2011 ASEC Supplement to the CPS.
[5] Bureau of Labor Statistics. *Regional and State Employment and Unemployment: October 2011, and Unemployment rates by State, seasonally adjusted: October 2010 and 2011.* Available at: (http://www.bls.gov/news.release/laus.t03.htm).
[6] United Health Care Foundation. America's Health Rankings: State Rankings Overview, 2011. Available at: (http://www.americashealthrankings.org/Rankings). Full report available at: (http://www.americashealthrankings.org/SiteFiles/Reports/AHR%202011Edition.pdf).
[7] In 2010, 12.1% of Californians smoked, compared to the national average of 17.2%; in 2006, 85.9% of pregnant women in California received prenatal care in the first trimester, compared to a national average of 83.2%; the 2005-2007 infant mortality rate for California is 5.2 per 1,000 live births, compared to a national average of 6.8 per 1,000 live births, California had 161.7 deaths due to cancer per 100,000 people in 2007, compared to a national average of 178.4 deaths per 100,000. In 2009, 7.8% of Californians had asthma, compared to the national average of

8.4%; in 2007, California had 177.9 deaths per 100,000 due to heart disease, compared to the national average of 190.9; in 2007, 30.5% of children ages 10-17 were overweight or obese in California, compared to 31.5% nationally and in 2010 61.6% of adults were overweight or obese in California, compared to 63.8% nationally; in 2005, 7% of adults had diabetes, compared to 5.5% of adults nationally. All data is available on California's page at www.statehealthfacts.org.

[8] United Health Care Foundation. *America's Health Rankings: California*, 2011. Available at: (http://www.americashealthrankings.org/SiteFiles/Statesummary/CA.pdf).

[9] This data is from a two year merge (2009 and 2010), but is referred to by the second year, 2010, in this report. Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data*, 2009-2010.

[10] This analysis was based on data collected from individuals living in the San Joaquin Valley, a large rural area in Central California. This information is representative of other rural areas throughout the state. Bengiamin, M., Capitman, J.A., and Chang, X. *California State University, Fresno.* Healthy people 2010: A 2007 profile of health status in the San Joaquin Valley, Fresno, CA, 2008.

[11] Durazo, E., et al. *UCLA Center for Health Policy* Research. The Health Status and Unique Health Challenges of Rural Older Adults in California, June 2011. Available at: (http://www.healthpolicy.ucla.edu/pubs/files/ruralolderadultspb.pdf).

[12] Bengiamin, M., Capitman, J.A., and Chang, X. *California State University, Fresno.* Healthy people 2010: A 2007 profile of health status in the San Joaquin Valley, Fresno, CA, 2008.

[13] KCMU/Urban Institute analysis of 2011 ASEC Supplement to the CPS.

[14] National Association of State Budget Officers. *2009 State Expenditure Report*: Tables 1 (All expenditures), Table 7 (Elementary and Secondary Education), Table 12 (Higher Education), Table 18 (Public Assistance), Table 24 (Other Cash Assistance), Table 28 (Medicaid), Table 32 (Corrections), Table 38 (Transportation), Table 43 (All Other), 2010. Available at: (http://www.nasbo.org/Publications/StateExpenditureReport/tabid/79/Default.aspx).

[15] KCMU/Urban Institute estimates based on data from FY2008 MSIS and CMS From-64, 2010.

[16] KCMU/Georgetown's Center for Children and Families. *Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011*, January 2011. Available at: (http://www.kff.org/medicaid/upload/8130.pdf).

[17] HMA/KCMU. *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*, September 2011. Available at: (http://www.kff.org/medicaid/upload/8220.pdf).

[18] In October 2011, CMS approved California's 10% reduction in payments to physicians and other providers, combined with the implementation of a plan for monitoring beneficiary access to services. A legal challenge by providers and beneficiaries to the rate reductions, *Douglas v. Independent Living Center*, is pending before the U.S. Supreme Court. KCMU, *Explaining Douglas v. Independent Living Center: Questions about the Upcoming United States Supreme Court Case Regarding Medicaid Beneficiaries and Providers' Ability to Enforce the Medicaid Act*, September 2011, http://www.kff.org/medicaid/upload/8240-2.pdf

[19] KCMU/Urban Institute estimates based MSIS and CMS 64 reports from CMS, 2011.

[20] State Health Facts. *Texas: Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*. Available at: (http://www.statehealthfacts.org/profileind.jsp?ind=184&cat=4&rgn=45&cmprgn=1).

[21] HMA/KCMU. Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends, October 2011, Appendix A-2. Available at: (http://www.kff.org/medicaid/upload/8248.pdf).

[22] HMA/KCMU. *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends*, October 2011, p.65. Available at: (http://www.kff.org/medicaid/upload/8248.pdf).

[23] KCMU. *Key Facts on California's "Bridge to Reform" Medicaid Demonstration Waiver*, October 2011 Update. Available at: (http://www.kff.org/medicaid/upload/8197-FS.pdf).

[24] Holahan, J., Headen, I. *The Urban Institute*. Medicaid Coverage and Spending in Health Reform, May 2011, Tables 5-12. Available at: (http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf).

[25] Long, P and Gruber, J. *Health Affairs.* Projecting the Impact of the Affordable Care Act on California, January 2011, 1(30): 63-70.

[26] State of California. *California Health Benefit Exchange*. Available at: (http://www.healthexchange.ca.gov/Pages/Default.aspx)

[27] Cohen, A. *Insure the Uninsured Project (ITUP)*. Creating the California Health Benefit Exchange: Progress to Date, December 2011. Available at: (http://itup.org/insurance-exchange/2011/12/07/creating-the-california-health-benefit-exchange-progress-to-date/).

[28] Kaiser Family Foundation, Focus on Health Reform. *Establishing Health Insurance Exchanges: An Update on State Efforts,* July 2011, Table 2. Available at: (http://www.kff.org/healthreform/upload/8213.pdf).

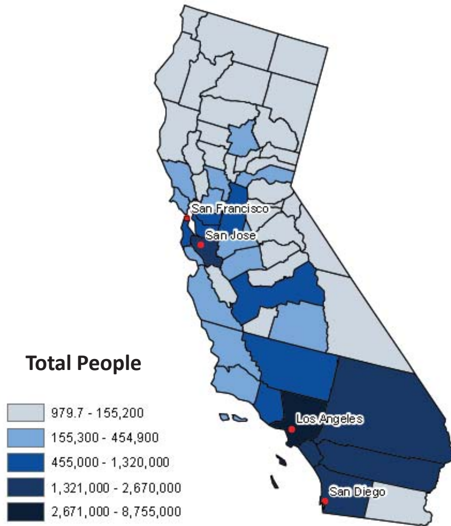
[29] The largest private entity amount is going to The Regents of The University of California ($12,399,087.32) and $131,427,842.85 is going to the California Public Employees' Retirement System. Internal KCMU analysis; report to follow shortly. It is important to note that ERRP funds reported are from data released November 3, 2011. Updated information was released December 2, 2011.

[30] Dam, K. and Wulsin, L. *Insure the Uninsured Project (ITUP)*. A Summary of Health Care Financing for Low-income Individuals in California, 1998 – 2008, August 2008, p. 21. Available at: (http://www.itup.org/Reports/Coverage%20and%20Financing%20for%20Low%20Income%20CA-ins%27/FINAL_HCF%20REPORT%202008.pdf).

Appendix: California Population and Health Coverage Levels by County, 2009

FIGURE 12

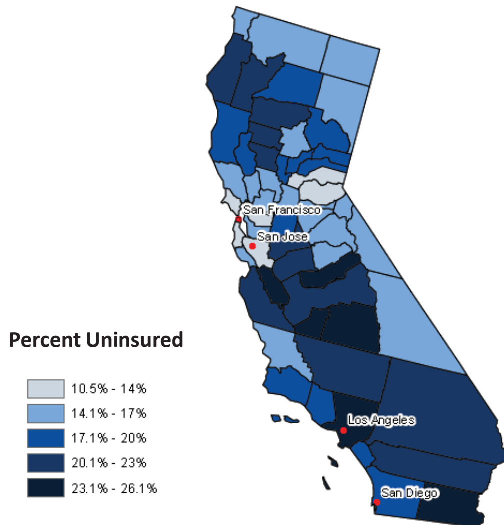
California Nonelderly Population by County, 2009



SOURCE: KCMU and Urban Institute analysis of American Community Survey (ACS) 2009 data.

FIGURE 13

California Nonelderly Uninsured by County, 2009



SOURCE: KCMU and Urban Institute analysis of American Community Survey (ACS) 2009 data.

This publication (#8268) is available on the Kaiser Family Foundation's website at www.kff.org.

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 bipartisan group of national leaders and experts in health care and public policy.