Connecting the Dots on Financing
An ITUP Op-ED for the New Year
Insure the Uninsured Project
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This paper seeks to explain and connect the dots of the budget, the waiver, federal reform and the short and long term financing reforms required to restore our state's greatness.

The Budget
The release of the Governor's 2010-11 state budget should cause us all to take a moment to reflect upon the state of financing for our state's government, and for health care. This year's $20 billion budget deficit reflects the state's inability to finance a hugely increased need for public services[1], driven up by the recession, with an unstable, narrow base of revenue streams that were driven sharply down by the recession.[2] This combines with a political system that requires two-thirds votes to pass the budget, increase revenues and appropriate necessary program funding and a wide and deep political chasm between the two parties that severely inhibits and often quite effectively precludes bi-partisan and indeed any solutions. Sizable deficits are projected out as far as the state can predict.[3]

In many ways, this structure until repaired is a down escalator for health and educational programs and ultimately our state's citizenry and economic growth since a state population that is both poorly educated and in poor health is doomed to failure.[4] This is not a new problem; it has been festering and growing since the early 80's with boom-bust budget cycles and rapidly changing state demographics and economics.

The Governor is right to call upon the federal government for immediate help by extending ARRA stimulus and increasing the Medicaid FMAP (federal Medicaid match); they can and must continue to deficit spend to speed states' economic recovery and job creation and protect state programs for those suffering job, income and health losses.[5] The Governor's proposals to completely decimate Healthy Families for uninsured children and IHSS and Adult Day Health Care for the disabled elderly and CalWorks temporary financial assistance for poor unemployed (previously working) families are the wrong medicine; however they highlight indeed sharply spotlight the need for all of us to convince Congress to extend the stimulus programs long enough to allow state revenues to recover.[6] Maybe your favorite program escaped the hit list for the moment, but its time on the chopping block is not far distant unless we act for both interim financing and a longer-term comprehensive resolution.[7]

The longer-term solution requires in my opinion a state constitutional convention to modernize state and local government decision-making, an overhaul of state taxing

and spending and of course passage and effective state implementation of comprehensive federal health reform -- issues we will discuss later in this memo.

Our short-term actions to solve the state's budget crisis will also require greater reliance on fees, more enlightened self-interest on the part of stakeholders, consolidation of programs and greater use of state/local revenues as state match. We cannot re-balance the state budget with $20 billion in General Fund revenue cuts to state programs.[8] That is nearly twice as much as the entire state General Fund contribution to the Medi-Cal program and almost a quarter of the state's entire General Fund (it fell by nearly $15 billion from its peak in 2007 to its trough in 2008).

Fees can be passed with a majority vote; they must have the right nexus to the program being funded and must not exceed the cost of the service.[9] For example, the fee you pay to enter a state park must be used to support the costs of the state parks and cannot exceed the costs of operating the parks (N.B. it is far less). Tuition at state colleges and universities is a fee, albeit too rapidly increasing for many middle-income families. Gas taxes used to maintain the roads could be classified as fees as well, as long as they do not exceed the costs of road building and maintenance. In the health arena, taxes on cigarettes, alcohol and additives to food that result in obesity and consequently diabetes may also be fees if they have the right nexus, program dedication[10] and do not exceed the directly consequential costs.

Last year, three groups acted out of enlightened self-interest – hospitals, health plans, and state First 5 – to save Healthy Families and Medi-Cal by agreeing to new taxes and/or transfers.[11] We need to properly appreciate their statesmanship and leadership and look to continue and expand this list for the coming year. That may mean Prop 65, medical device manufacturers and medical supplies, health plans and other providers could/should participate. This may mean a short-term tax/fee on some health industry services that goes into a special fund that supports Medi-Cal and Healthy Families for fixed period of time, then sunsets; it must be constructed with some care to comply with federal restrictions.[12]

Waivers

The Governor and the Legislature in last year's budget agreed on the need for a large Medi-Cal reform and financing waiver; this has promise for salvaging state and local programs and building a bridge to federal reform (if it happens and it must). Some are already referring to the waiver as the public hospital waiver or the hospital waiver, possibly in the expectation of pre-determining its shape and outcome, so I'll call it the "Medi-Cal and Uninsured Stepping Stones to Federal Reform" for the same reason.[13]

To make the waiver work, California will need to use unmatched local revenues that are being spent on care to the uninsured medically indigent adults, who would be eligible for federal match under the waiver.[14] For the most part, these are realignment revenues (health and to a lesser degree mental health) that are a share

of the state's sales tax, vehicle license fee and General Fund revenues, all of which have declined over the past year and half, some quite steeply, and will not recover 'til the economy does.[15]

How would the match work? It could be a straight match, for example a 50/50 federal/county match up to a cap of what the county now spends on MIAs.[16] It could be Certified Public Expenditures (CPEs), where the federal government reimburses the county for half of what it already spends on MIAs; I think this approach brings in the least funding.[17] Or it could be IGTs (Intergovernmental Transfers) in which the county writes a check and receives a return check for twice as much with the proviso that all the local and federal matching funds can only be spent on care to the target MIA population.[18] Counties need to decide which mechanism works best for them and why. The waiver could be set at a higher match rate (e.g. 57%, the national average) if California is able to persuade Congress to adjust our FMAP (federal matching rate) to reflect our high percentages of uninsured and low income Californians[19], but the waiver cannot change California's match, only Congress can, and it should.

How much could be matched? It's all the county health and mental health spending on the uninsured MIAs, with a couple of limitations.[20] First you cannot match a federal dollar with a federal dollar and second you cannot match a state or local dollar twice. In most California counties, all of their county indigent spending is on the MIAs, and very little of it is matched with federal funds.[21] In most counties with public hospitals, some of their funds are already matched as part of DSH (Disproportionate Share Hospital) and SNCP (Safety Net Care Program) and most of these counties serve a broader population than just the MIAs, since their medical facilities treat all uninsured county residents who are unable to pay.[22]

What's the catch? There are two from my perspective. The first is that county health safety net systems for the MIAs will need to rapidly evolve to become effective participants in the federal reforms.[23] The new systems need to be primary care centered, rather than based on emergency rooms and hospitals.[24] They need to be a system of care – i.e. the pieces need to fit together, and reinforce each other, and funds need to shift as patterns of care shift – funds must follow patients.[25] The second is we need the same incentives and organized delivery system for all patients – the uninsured, the disabled and families.[26] So to summarize my views, community clinics, public and some private hospitals and local managed care plans need to see themselves and actually be in the same boat – an organized delivery system, and not all may be ready to go there, yet even if counties take no action under the waiver, this may well be the new reality in 3-4 years, if not sooner.[27]

Federal reform

How does this fit into federal reform (when it passes)? Federal reform consists of both interim steps and long-term expanded coverage. For example, the MIAs will be covered as part of federal reform in 2013 under the House bill and 2014 in the Senate version with a 100% federal match for two years and a 90/10 (House) or

83/17 (Senate) federal match thereafter. In the interim, both the House (offering an 80/20 match) and Senate (50/50 match) would give states the latitude for an early start on reform, including coverage for the MIAs in 2011, if the state chooses.[28]

Once fully implemented, federal reform will add an estimated $8-9 billion annually in federal Medicaid funding for care to California's uninsured (House version); under the Senate version it is slightly less (a bit under $7 billion annually).[29] Most of these funds come with a 100% federal match for two years, declining to a 90/10 or 83/17 match.

It will add another very large sum in the form of the federal premium subsidies of the uninsured and individually insured with incomes above the Medi-Cal income thresholds (133% of FPL, Senate; 150%, House) and up to 400% of FPL.[30] Assuming that California with over 15% of the uninsured receives 15% of the Exchange subsidies, that amounts to $11.5 billion annually under the Senate bill and $13.5 billion annually under the House bill. Let's not count any of these chickens before they hatch, but it does give a sense of the magnitude of the benefit of reform for California.

The Medicaid aspects of the federal reforms will add new costs to the state budget -- match for new eligible categories, match for eligible but not enrolled[31], and it will duplicate existing state programs – portions of Medi-Cal, MRMIP, AIM, Family PACT, GHPP, portions of CCS, Breast Cervical and Prostate Cancer treatment.[32] This funding could be redirected, with legislative and gubernatorial agreement. Most county health program expenditures for the MIAs will then be covered by Medi-Cal managed care and another significant portion by the Exchange.[33] State and county dollars for the cost of safety net programs and care to the MIAs could be redirected as well.[34] The Governor has identified one very important priority, increasing Medi-Cal reimbursement rates for outpatient services. There are doubtless others as well since some will certainly argue for higher premium subsidies or restoration and enhancement of benefit packages such as dental and vision care, while others will argue for a stronger local commitment to public health or increased state commitment to education, and others will make the case for balancing the state and local budgets with any savings.

Bottom lines – the money

The Commission on the Economy for the 21st Century correctly identified the need to update state and local financing of government services.[35] While all may disagree with one or more aspects of their recommendations, they raise many good points; the points that stood out most for me are the narrow sales tax base, changing consumption patterns, the high marginal rates and the changing economy; for others it may well be their analysis of tax rates on personal or corporate incomes.

In my view, the sales tax should be expanded to most services, and the marginal sales tax rates should be lowered quite dramatically. The Commission ducked the "third rail" issue of revisions to Prop 13; Prop 13 needs to be fixed to equalize the

tax burdens on new and long standing homeowners and on new and established businesses. We all receive the same educational, police and fire services from our local governments and should not be paying such widely different rates; it is both inequitable and discourages new investment and innovation, new businesses, and new development in our state to freeze property tax valuations and thus tax revenues at 1976 levels for those who owned property in 1978 while the rest of us pay our own taxes and the share of local taxes for the fortunate few. This particular inequity and favoritism for those whose property ownership predates 1978 is more reminiscent of the favored status of the French and English aristocracies than anything one could even begin to imagine as the policies of a vibrant democracy. I am not arguing here with the premise of capping property taxes and their growth, but rather with the division between old timers and new comers; this is not only fundamentally unfair, but its bad for the long term dynamism of our state. We need to agree on long-term solutions rather than band-aids and budget gimmicks that merely shift money around and make the budget even worse for the coming years.[36]

Bottom lines – better governance, better decisions

We need a Constitutional Convention to fix the dysfunctional aspects of state and local governments.[37] We all have our own priorities. Mine would include longer term limits for state legislators so they can better develop the necessary programmatic expertise, regional governance to better reflect the interconnected economic realities, replacement of the two-thirds vote requirements that assure minority rule by simple majority vote requirements, repairing the initiative process that has now become the dominion of the special interests that it initially sought to check, local financing authority that is independent, and state tax, spending and rainy day reserve reforms. Inaction, standing still, waiting for others to fix it will assure further deterioration, it is time for California to come together for a better future.

Prepared by Lucien Wulsin January 22, 2010

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[1] For example Medi-Cal enrollment has grown from about 6.7 million in 2008 to 7.3 million in 2009 and is projected to grow to 7.5 million in 2010 due to the recession. See California Health and Human Services Agency Budget Facts, Governor's Proposed Budget for FY 2010-11 (January 2010).

[2] State personal income tax receipts fell from a high of $55.7 billion in 2007 to $44.3 in 2008 (a drop of 20-25%) and are only projected to recover to $47.8 billion in 2010. State sales tax receipts fell from a high of $32.6 billion in 2006 to a low of $29.4 billion in 2010. California Department of Finance, Governor's Proposed Budget 2010-2011, Revenue Estimates, Schedule 3.

[3] The state's Legislative Analyst predicts $20 billion in structural deficits for each of the next 5 years. Legislative Analyst's Office, California's Fiscal Forecast: 2010-11 Budget (November 2009)

[4] We may all have a sense that we are over-taxed in California for state services – we do pay on average about 6% of personal income in state taxes, but this fluctuates

quite a bit (from a high of 6.78 in 1979 to a low of 4.95 in 2008). Looking historically, we paid an average of 5.5% of personal income for state taxes into the General Fund over the past 4 years as compared to a high of about 6.5% of income during the time frame from 1976 to 1984. California Department of Finance, Governor's Proposed Budget 2010-2011, Revenue Estimates, Schedule 2 (Summary of State Tax Collections).
California's combined state and local taxes average about 11.5% of income as compared to a national average of 11% (we are now less than 5% above the national average) whereas during the '70's California was about 20% over the national average. Averages conceal anomalies -- such as California has very personal income tax rates for those with top incomes and very low tax rates for lower income earners; we have a very progressive state income tax that in part reflects the enormous run-up in the share of the economy inuring to the benefit of the very top earners. See Center for the Continuing Study of the California Economy; Is California a High Tax State? (Oct. 2007) at www.ccsce.com/pdf/Numbers-oct07-HighTaxState.pdf See also Report of the Commission on the 21st Century Economy (September, 2009) at www.catce.ca.org
California's national ranks on education spending and education results have been steadily dropping. See EdSource, How Does California's Education Spending Compare With That Of Other States (June, 2009) at www.edsource.org/iss_fin_FAQ_cacompares.html. We have fallen from the top to the bottom in percent of adults with a high school education and from first to thirteenth in the percent of adults with a college BA, and this will do long term damage to our economy. Pia Lopez, California Education Not What It Used to be, (Sacramento Bee, March 3, 2009) at www.modbee.com/opinion/state/v-print/story/561924.html
Our health ranking on a nationwide average is 23rd. In California, we rank particularly poorly in infectious disease, lack of health insurance, health status and days of work lost to poor mental health. On other health indicators, we do well with high rates of consumption of fruits and vegetables, low rates of infant mortality and cancer death, low rates of smoking and occupational fatalities. Our overall rank has fluctuated between the high and low 20's for the last 20 years. See America's Health Rankings (2009) http://www.americashealthrankings.org/yearcompare/2008/2009/CA.aspx
Our state's overall spending is inordinately high on corrections and public safety and very low on transportation and highways compared to other states. Blue Sky Consulting Group, California's Budget Crisis (October 2009) at http://www.blueshieldcafoundation.org/resources/reports-and-publications.cfm
[5] The Governor is requesting nearly $7 billion in assistance from the federal government: ARRA extension of the enhanced FMAP ($2 billion), and increase in California's FMAP from 50/50 to 57/43 ($1.8 billion). See Dougherty, ITUP Summary of Governor's Proposed Budget for 2010-11 (January 11, 2009) at www.itup.org Because California has such a high unemployment rate (12.3%, one of the highest in the nation) and a high and increasing poverty rate (14.6% in 2008 and headed up, already higher than states with traditionally high poverty rates, such as Alabama, South Carolina, West Virginia and one of the nation's largest increases

in poverty rates). These requests make good sense. See comparative poverty rates at http://www.statehealthfacts.org/comparemaptable.jsp?ind=16&cat=1 The Legislative Analyst's Office cautions that the state should seek but not rely on these federal revenues as not all of this funding will materialize. LAO, The 2010-11 Budget: Overview of the Governor's Budget (January 12, 2010). http://www.lao.ca.gov/laoapp/PubDetails.aspx?id=2160
The most important change that the federal government could make for all states is to allow the FMAP to fluctuate or float based on economic conditions so that California and all states that must balance their budgets could be protected from the lethal combination of increasing need for program services during the sharp drop in their revenues in recessions.

[6] The doomsday scenarios include: elimination of Cal Works ($1 billion), elimination of the remains of the IHSS program for home care to disabled seniors ($495 million) and elimination of the rest of the Healthy Families program ($126 million). See 2010-11 Budget: Overview of the Governor's Budget (January 12, 2010) and ITUP Summary of Governor's Proposed Budget for 2010-11 (January 11, 2009)

[7] For example, K-12 education funding was reduced by $7.5 billion (15%) between the 2007-08 budget and the '08-09 budget; it grows imperceptibly (0.2%) in this year's Governor's Proposed Budget. LAO, 2010-11 Budget: Overview of the Governor's Budget

[8] Last year's budget negotiations resolved nearly $60 billion in budget shortfalls over a two year period with a combination of terribly severe cuts (e.g. elimination of Medi-Cal dental, hearing and vision services for adults), significant tax increases and accelerations and the federal stimulus package for states. Some changes were for one year only (e.g., Prop 10 Commission and Medi-Cal managed care plans' gross premium tax for Healthy Families) and some for two years only (income, sales and VLF tax and fee increases). This year's proposals to eliminate adult day health care for seniors and the disabled ($104 million), cut In Home Support Services for most of the frail elderly ($950 million), cut 240,000 uninsured children from the Healthy Families program ($99 million) are the sort of proposals that neither Democratic nor Republican legislators would countenance, yet even if enacted, they would achieve only 12% of the budget cuts necessary to balance the budget. The LAO acknowledges that a fragile recovery is not the right time to be increasing tax rates, yet points out that modifications of tax expenditures (special credits, exemptions and deductions) that are not achieving their intended purposes should be on the table

[9] Sinclair Paint Company v. State Board of Equalization 15 Cal.4th 866, 937 P.2d 1350 64 Cal. Rpt. 2d 447 (1997).

[10] See for example, AB 1019 (Beall) of 2009, defeated in Assembly Revenue and Tax Committee. Tobacco and alcohol taxes and their associated revenues have lagged very far behind any of the other major state revenue streams. See Governor's Proposed Budget 2010-2011, Revenue Estimates, Schedule 2 (Summary of State Tax Collections). For example, corporate income taxes produced $532 million in state revenues in 1970 and $10 billion in 2010 (2000% growth in revenues over 40 years) while tobacco taxes produced $240 million in state revenues in 1970 and

$929 million in 2010 (500% growth) and alcohol taxes produced $107 million in 1970 and $354 million in 2010 (300% growth). The comparisons of the slow growth in tobacco and alcohol tax revenues to the sales (2000%) and personal income (4000%) tax revenues are extreme as well. To put it differently, alcohol taxes comprised 2% of the state General Fund in 1970 and 0.3% today; tobacco taxes comprise 0.9% today while they were 4% of the state General Fund today. You may ask why and the reason is that the excise taxes on consumption of these products are not adjusted for either economic growth or price inflation; whereas sales and income taxes make these adjustments quasi automatically.
California could achieve a better balance; heavy smokers and drinkers could pay more or drink and smoke less. Alcohol abuse costs California state and local government an estimated $8 billion annually in the costs of its health and criminal justice programs. Assembly Revenue and Tax Committee Analysis of AB 1019 (Beall) at www.leginfo.ca.gov The potential advantages from increasing these particular fees/taxes are: better health status, increased worker productivity, reduced health costs and spending and an improved economy as smoking and alcohol abuse decline and the enhanced revenues are used for more productive uses, such as better educating and caring for our state's children.
[11] AB 1383 (Jones) and AB 1422 (Bass). AB 1383 is the hospital fee under which hospitals pay into a fund to support the Medi-Cal program. The projected $2.3 billion in federal matching funds are used to assure children's Medi-Cal eligibility ($320 million) and increase hospitals' Medi-Cal rates to a point closer to the Medicare levels of reimbursement, based on a series of calculations specified in the bill. This bill received a 52/22 vote on the Assembly Floor and will need federal approval.
AB 1422 (Bass) authorized multiple funding enhancements to remove the enrollment cap and anticipated eligibility reductions in the Healthy Families program and repair the hole in program funding that the state budget agreement and Governor's vetoes had created. These included a one-time grant from the state Prop 10 Commission, increases in subscriber premiums and a gross premium tax on Medi-Cal managed care plans. The taxes sunset on January 1, 2011. This measure received a 62/5 vote on the Assembly Floor.
Provider fees and taxes are quite common as they exist in 43 other states; California's hospitals agreed to change their long standing opposition to such taxes, given the severity of the state's fiscal crisis. The fee sunsets on January 1, 2011.
[12] The federal restrictions are summarized in the recent publication for the California HealthCare Foundation by Management Associates, Financing Medi-Cal's Future: the Growing Role of Provider Fees and Taxes (November 2009) at www.chcf.org. In essence, the federal regulations require the tax be uniform (within a class of providers), broad based and not guarantee that the providers are held harmless (i.e. there must be winners and non-winners). There are some clearly designated provisions for exemptions and waivers. There are 19 designated classes of providers who can pay taxes/fees, including a catch all for any state licensed or certified provider. See 42 CFR 433.55-.74. CMS (the Center for Medicaid and Medicare Services has raised questions about California's latest fees and taxes'

compliance with federal rules. Most of the fees in other states (as in California) apply to institutional providers and managed care organizations, as opposed to doctors, dentists, podiatrists and nurses, who are also among the classes mentioned under the federal regulations.

[13] See ITUP, Open Letter on the §1115 Waiver (January 4, 2010) at www.itup.org/reports

[14] An 1115 waiver can provide coverage for the uninsured medically indigent adults (MIAs) in California as at least 10 other states already have. In California, the MIAs were on Medi-Cal until 1983 when responsibility for their care was shifted back to the counties with 70% of the funds that the state spent. Eventually in the early 90's counties and the state negotiated realignment (a share of the state sales tax and vehicle license fees and eventually the state General Fund) as a more stable funding stream.

Counties report spending at least $1.8 billion on care to the uninsured. Not all that spending is for care to the MIAs as some counties also pay for care to some immigrants who are not eligible for federal matching funds, except potentially for emergency services. Counties (most of California's counties) that only cover the MIAs are paying for care with a mix of realignment, county match, Prop 99 and tobacco litigation settlement, all of which can be used as local match for federal funding.

Counties with public hospitals (many large California counties) also have access to federal DSH and Safety Net Care Pool funds to pay for care to the uninsured. This adds certain complications: 1) they cannot match a federal dollar with a federal dollar, 2) they cannot match a federal dollar with a state/local dollar that is already matched, 3) they must be able to distinguish between care for the MIAs that would be eligible for the match and non-emergency care to the undocumented that is not eligible for the match. These complications are not insuperable as these counties already make these distinctions with their Safety Net Care Pool and Coverage Expansion Initiative funds.

[15] Sales tax revenues fell about 13-14% before recovering somewhat when the sales tax increase was applied; VLF revenues increased 30% when the state increased the VLF fee back to its historic levels. The state General Fund fell more than 15%; LAO projects that the state's General Fund will not recover to its 2007 levels until 2013-14. Legislative Analyst's Office, California's Fiscal Forecast: 2010-11 Budget and Governor's Proposed Budget 2010-2011, Revenue Estimates, Schedule 2.

[16] Counties and other local government provider entities' (includes District Hospital and UC hospitals) contributions are governed by 42 CFR 433.51, which permits a local appropriation (match), a local intergovernmental transfer (IGT) and a certified public expenditure (CPE). New York for example had an equal 25/25 match between the state and the counties and a 50% federal match on care to the MIAs under its waiver. Prior to its waiver, the New York state/county match was 50/50 for the costs of care to county MIAs through the state's Medicaid program.

[17] Ibid. For example, if a county certified that it spent $60 million on care to the MIAs (CPE) last year; it could recover $30 million in federal match.

[18] Ibid. Under this scenario, if I understand correctly, a county could write a check for $60 million (IGT) and receive a return check of $120 million to care for its MIAs. The full $120 million must be spent on the program; it cannot be diverted to other important county purposes, such as jail health or preservation of public libraries.
[19] See n. 5. 42 USC 1396d(b) governs state matching rates, and it is based on a state's per capita income, with a minimum match of 50/50 and a maximum match of 83/17. California is somewhat anomalous as a state with high per capita income combined with a high poverty rate and high rate of uninsured and a high rate of unemployment; these are typically inversely related so that states with high per capita incomes have low rates of poverty, uninsured and unemployment as well. New York also has a high poverty rate and high per capita income; however its rate of uninsured is lower than California in part due to its broader Medicaid eligibility.
[20] As discussed earlier, counties report spending at least $1.8 billion on physical health care to the uninsured, with no breakout for the dollars spent on the MIAs. There is no comparable figure for county mental health services. Counties receive in excess of $1.2 billion in mental health realignment and $700 million in Prop 63 funds. There is no up to date report on how those funds are spent and how much is used for mental health services to MIAs and how much on county mental health care to Medi-Cal patients. County mental health departments operate local managed care plans for the severely mentally ill.
[21] We computed a three-year average spending between 2001 and 2004 of $1.8 billion, of which only $468 million was associated with the 46 counties without public hospitals. See ITUP, Safety Nets and Coverage Expansions: ITUP Recommendations (July 2007) at www.itup.org/reports.
[22] We computed a three-year average spending between 2001 and 2004 of $1.8 billion, of which over $1.3 billion was associated with the 12 counties with public hospitals and more than 43% of all county spending on the uninsured occurred in Los Angeles County. Ibid. Since then, other counties have increased their spending while Los Angeles' share of spending on the uninsured has fallen. Public hospitals typically see all patients regardless of immigration status and bill and collect payments from patients with an ability to pay; Medi-Cal is their best payor and public hospitals are typically very thorough and successful in identifying Medi-Cal inpatient eligibility, but less so on the outpatient side. They are able to identify their MIA patients but do not now do so, as there is no financial reason to add this task to their other administrative burdens.
[23] The county systems for the MIAs are not, except in a few counties, managed care programs and are not operated with the same incentives and delivery structures as a managed care system. In many of these counties, there is a parallel managed care program for Medi-Cal families that can be adapted to add the MIAs quite readily; however delivery system issues, such as the central role of primary care, integrated delivery systems, the vital role of prevention and competitive incentives are typically absent in county care of the MIAs. In the "Exchange" model, county safety net systems would need to compete on price, quality and customer satisfaction and service with commercial plans and delivery networks; the model is similar to California's Healthy Families program, in which some but not all safety nets are

highly successful competitors. While their advantages of familiar long-standing patient relationships, language and location provide real advantages to those safety nets willing to compete on a level playing field, not all safety nets are ready or willing to compete, and if so, they may not survive.

[24] California has a strong base of over 800 free and community clinics that provide a large volume of care to the uninsured; they provide on average 1 visit per uninsured – representing on average half the outpatient visits for California's uninsured. Unfortunately in some counties, they are not integrated with the county hospitals and strategic private hospitals into a managed care network; in fact they are often viewed as unwelcome competitors, rather than the focal point of the delivery system that they would become under Medi-Cal managed care and under federal health reform. In counties such as Alameda the relationship between the county and the clinics is longstanding and exemplary. Other counties are on the spectrum between these poles. Federal reform builds on these clinics, at least those with FQHC (Federally Qualified Health Center) status. It invests heavily in them during the interim period of the reforms and continues to build that investment after the reforms are fully implemented. See n. 27.

Due to both history and the incentives of federal funding streams, the institutional side, the hospital and its emergency room, typically dominates county hospital systems. This is slowly evolving towards more outpatient care and spending, but with very different starting points and progress in each county and too often built on a comparatively quite costly institutional base. See Tuttle and Wulsin, California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured (October 2008) at www.itup.org/reports and Crall and Wulsin, Counties, Clinics, Managed Care and the Uninsured in Eight California Counties: a Ten Year Trend Report (1996-2006) at www.itup.org/reports

[25] Ideally, the safety net system would evolve into an integrated delivery network with many of the virtues of the Kaiser system, combining the managed care entity, the hospitals, the clinics and staff physicians. With this configuration, the safety nets would be well positioned to improve quality, increase price competitiveness and compete in the managed care markets. This may be a long evolution for some systems and a quicker one in others. In the interim, they need to align incentives and coordinate their delivery systems. Developing common access to interoperable electronic medical records is the necessary first step. Providers need to establish mutual accountability to improve patient outcomes through team approaches to caring for their chronically ill patients. The safety net needs to make quality improvement, and the capacity to adapt to and implement rapid change their organizational imperatives. Wulsin, The Safety Net And Transition To Coverage For California's Uninsured (ITUP, September 28, 2010) at www.itup.org/reports

[26] Most Medi-Cal and Healthy Families eligibles are in managed care, but most Medi-Cal spending is in fee for service, this sends radically inconsistent messages to providers and this ends up as no message at all due to their conflict. Some of the uninsured have different silo programs that pay for parts of their care, such as Family PACT, EAPC. DSH, SNCP, portions of Medi-Cal, Breast Cancer Treatment and county payments. Each program has reimbursement methodologies with different

incentives. If we want to improve care, quality and cost efficiency, we need to have programs with consistent and reinforcing incentives, rather than conflicting ones.

[27] The Senate version of reform starts in 2014; the House Version begins in 2013, and each gives states the options to begin coverage for the MIAs in 2011 with an 80/20 match in the House version and a 50/50 match in the Senate version.

[28] Ibid. There are a series of incremental steps towards reform in 2010, 2011 and 2012, including investments of at least $12 Billion for community clinics in the House version and $8.5 Billion in the Senate over the next five years. Some of the most prominent for care to and coverage of the uninsured are listed in ITUP's Interim Building Blocks (November 23, 2009) at www.itup.org/reports

[29] California Department of Health Care Services, Health Care Reform Cost and Savings Estimate: Full Implementation (December 4, 2009), HR 3590 Patient Protection and Affordable Coverage Act (November 23, 2009) and HR 3962 Affordable Health Care for America Act (November 6, 2009)

[30] See CBO Analysis of HR 3590, Letter to Senator Harry Reid, November 18, 2009 and CBO Analysis of HR 3962, Letter to Representative John Dingell. November 6, 2009. The letter to Senator Reid projects a cost for the premium subsidies through the Exchange at $76.6 billion annually over the three fiscal years 2017-2019. The letter to Rep. Dingell projects a cost of $90.6 billion annually over the three fiscal years 2015-17 ($107 for the comparable period 2017-19 as the Senate bill). For each bill, we averaged the first three years of 100% implementation.

[31] The California Department of Health Care Services analysis found that the eligibility expansions for the MIAs and parents would cost California a match of $895 million in 2018-19 under the House version and $1.34 billion in the Senate version. California Department of Health Care Services, Health Care Reform Cost and Savings Estimate: Full Implementation. This assumed 100% enrollment. DHCS found that the coverage of the eligible but not enrolled (in response to the individual mandate) would cost California a match of $735 million in 2018-19 under the House version and $700 million in the Senate version

[32] DHCS projects that the Senate version of federal reform would save the Healthy Families program $489 million in 2018 and would save other state programs run by the Department of Health Care Services $760 million in 2018. The House version would save Healthy Families $678 million and other state programs run by DHCS $760 million. California Department of Health Care Services, Health Care Reform Cost and Savings Estimate: Full Implementation, HR 3590 Patient Protection and Affordable Coverage Act and HR 3962 Affordable Health Care for America Act. The Healthy Families savings are partially offset by a switch of some program eligibles to Medi-Cal from Healthy Families at a General Fund cost to Medi-Cal of $324 million (Senate version) or $317 million (House version).

[33] See n. 21 and 22. As discussed, many counties' indigent care programs (at least $1.8 billion in spending) would be wholly subsumed by federal reform; however some counties do provide care for new legal immigrants and the undocumented who are not covered by federal reform, and they will need to retain those funds for that purpose. There is no break out that separates these costs, but for starters 20% of California's uninsured will not be covered due to immigration status. When

California stakeholders negotiated these issues in the final moments of California's reform efforts, there was agreement that MIA funds should follow the patient up to a cap. That cap was not more than $1 billion in toto and not more than counties now spend on a county-by-county basis on care to the covered population. See AB X1 1 (Nunez) of 2007-08. That would leave counties with some significant "windfall" funding that could be diverted from care to the indigent to improvements in public health services and the state with some ability to divert some of the "windfall" funding to pay for the state's cost of coverage.

[34] Ibid. If reform happens, some of the local coverage dividend could be used to increase in whole or in part Medi-Cal outpatient reimbursement rates to Medicare levels ($1.9 billion) as was indicated a high priority for the Schwarzenegger Administration. DHCS, Health Care Reform Cost and Savings Estimate: Full Implementation

[35] Commission on the 21st Century Economy Report (September 2009) at www.cotce.gov The California economy has shifted from an agricultural and manufacturing economy to a technology and service driven economy and consumption has shifted from goods to services, furthermore income growth has been highly concentrated at the top end while stagnating at middle and lower income levels so we have more very wealthy and more very poor. In the Commission's view California's tax system produces highly volatile revenues and impairs innovation and competitiveness. They recommended reforms that would lower marginal tax rates and broaden the tax base – particularly by applying taxes to services. They did discuss but did not recommend applying an oil severance tax.

[36] See Robert Wassmer, California's State and Local Revenue Structure after Proposition 13: Is Denial an Appropriate Way to Cope (May 14, 2008) www.csus.edu/indiv/w/**wassmer**r/**denial**.pdf for an excellent discussion of the options to repair California's broken tax system; he ends by throwing an interesting "Hail Mary" idea of using the carbon tax or cap and trade auction revenues to repair/replace California's dysfunctional revenues.

[37] Some of the groups talking and taking action on this include: California Forward, Repair California and California Action Network. Repair California emerged from the call for a Constitutional Convention by the Bay Area Council during the recent budget stalemates. It is preparing an initiative to call a *limited* Constitutional Convention that would authorize a designated set of topics for the convention's consideration (governance, spending and budgeting, elections and initiatives and governmental effectiveness) but restrict the convention from discussing and trying to resolve other "hot button" topics as the death penalty, increases or decreases in taxes, property assessments, civil rights (e.g. Prop 8), abortion and the 2/3rds majority rules for taxes. www.repaircalifornia.org. The bi-partisan California Forward proposes a series of voter initiatives to repair California's governance; these include a majority vote budget, performance review of programs, transparency, outcomes based budgeting and accountability, pay as you go and a marked preference for local governments, their independence from Sacramento and local majority vote rules. www.caforward.org. A grass roots citizen's group, called

the California Action Network is developing an initiative that calls for an open convention. http://californiaactionnetwork.com.

Personally, what I think voters are looking for is a government that works, they are sick and tired of excuses, such as I'm not paid enough or it's the computer's fault, the bureaucracies' fault, the union's fault, the parent's fault, the other party's fault, the patient's fault and especially they the taxpayer's fault. They are tired of the "fear mongerers" as they have looked into the abyss in the recent severe recession. They can see government that works well, such as the Los Angeles Police Department under Chief Bratton, some public charter schools, some clinics, some cities and some counties and they do know where government works poorly and against their best interests. They are both angry and apathetic about the failures of their government. It's up to all of us to meet and exceed voters/taxpayer's expectations if we expect to succeed.