

ENSURING A STRONG SAFETY NET FOR THE REMAINING UNINSURED

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MARCH 2015

I. Introduction

For more than 100 years, California’s counties have been charged with providing basic medical care to low-income residually uninsured residents pursuant to a law now codified at Welfare and Institutions Code section 17000 (§ 17000). Over time, Federal and state health programs—including, most recently, expanded Medi-Cal and subsidized private insurance through the California Marketplace, Covered California—have stepped in to provide care for many low-income and vulnerable people in our state. By various estimates, after the full implementation of the Affordable Care Act, there are still anywhere from 2 to 4 Million non-elderly Californians who lack health coverage.¹ For those who are left out of those programs, counties must develop programs to provide care—which we will refer to as § 17000 programs—to ensure that a safety net is available to catch the remaining uninsured. Yet one recent study found that less than 200,000 of the remaining uninsured are enrolled in a county § 17000 program.² Advocacy is needed to ensure that remaining uninsured Californians have access to their county § 17000 programs, and that those programs are strong and robust to meet the needs of residually uninsured residents.

This issue brief will give an overview of the demographics of the remaining uninsured population in California, the legal requirements on California’s counties’ obligation to provide safety net care to the remaining uninsured, and the funding sources for that care. Advocates should use this issue brief as a tool to evaluate whether their county program complies with the legal requirements of § 17000, and also to identify areas where the county can go beyond the minimum requirements to create a strong and coordinated safety net that meets the needs of all residents.³

II. Who are the Remaining Uninsured

Studies suggest that nearly two-thirds of the remaining uninsured population is Latino, and about a quarter is white.⁴ One study found that 37% of the remaining uninsured population

¹ See, e.g., Bianca DiJulio *et al*, Where are California's Uninsured Now? Wave 2 of the Kaiser Family Foundation California Longitudinal Panel Survey (2014) (about 2.4 Million in 2014), <http://kff.org/health-reform/report/where-are-californias-uninsured-now-wave-2-of-the-kaiser-family-foundation-california-longitudinal-panel-survey/>; ANTHONY MENACHO *ET AL.*, HEALTH ACCESS CALIFORNIA, REORIENTING THE SAFETY NET FOR THE REMAINING UNINSURED 3 (2015) (2.7 to 3.4 Million in 2015), available at <http://www.health-access.org/images/pdfs/CountySafetyNetReportSurveyResults3-12-15.pdf>; UCLA CENTER FOR HEALTH POLICY RESEARCH & UC BERKELEY CENTER FOR LABOR RESEARCH AND EDUCATION, CALSIM VERSION 1.91 STATEWIDE DATA BOOK: 2015–2019 at 2 (2014) [hereinafter UCLA & UCB STUDY] (just over 4 Million in 2015), available at <http://healthpolicy.ucla.edu/publications/Documents/PDF/2014/calsimdatabook-may2014.pdf>.

² MENACHO *ET AL.*, *supra* note 1 at 8 (176,534 enrolled in 17000 programs as of late 2014).

³ See generally HEALTH ACCESS CALIFORNIA, CALIFORNIA’S UNEVEN SAFETY NET: A SURVEY OF COUNTY HEALTH CARE (2013) (describing best practices from county Low Income Health Programs), available at http://www.health-access.org/images/pdfs/CAunevenSafetyNet_countysurvey_Nov2013.pdf.

⁴ DiJulio, *supra* note 1 (62% Latino, 24% white; 5% black, 8% other); UCLA & UCB STUDY, *supra* note 1 (66% Latino).

had never had any health coverage.⁵ The remaining uninsured are predominantly middle aged men.⁶ In addition, almost a quarter of the remaining uninsured are age 50 or older.⁷ There are also still nearly half a million uninsured children in California.⁸

The biggest reason that California's remaining uninsured cite for not getting coverage is cost.⁹ This is unsurprising, since the majority of those who remain uninsured are low income.¹⁰ In addition, over one-quarter of the remaining uninsured population is estimated to be undocumented, making them ineligible for free Medi-Cal (except for certain emergencies) or subsidies to purchase private plans.¹¹ One study found that, of those who were uninsured prior to 2014 and gained coverage in 2014, 46% reported that paying for coverage was somewhat difficult or very difficult.¹² This finding suggests that some of those who initially take up coverage may fall off and become uninsured again over the course of the year if they are unable to afford to continue paying premiums.

Another major reason that Californians report remaining uninsured is lack of awareness about new coverage options.¹³ One study estimated that 60% of the remaining uninsured are limited English proficient.¹⁴ LEP individuals may have more difficulty obtaining information about coverage options that they can understand.

Finally, many Californians report they have not yet applied for coverage.¹⁵ And over one-third of the remaining uninsured reported that they attempted to get coverage during open enrollment, but were unsuccessful.¹⁶ But since California law prevents residents from purchasing coverage outside of the annual open enrollment period, unless they experience certain qualifying events, those who wait to get coverage may be out of luck.¹⁷ And while one study estimates that the vast majority of remaining uninsured Californians will be exempt from

⁵ *Id.*

⁶ *Id.* (24% aged 50-64).

⁷ *Id.* (56% of remaining uninsured identified as male; 33% aged 35-49).

⁸ CAROLINE COLEMAN, INSURE THE UNINSURED PROJECT, CHILDREN'S HEALTH COVERAGE UNDER THE ACA 1 (2014), available at <http://itup.org/wp-content/uploads/2014/01/Part-1-Childrens-Health.pdf>.

⁹ DiJulio, *supra* note 1 (34% of those surveyed cite affordability); *id.* (noting that another 15% cited ineligibility for subsidized coverage as a reason for remaining uninsured); *cf.* UCLA & UCB STUDY, *supra* note 1 (estimating that 40% of remaining uninsured cannot afford coverage).

¹⁰ DiJulio, *supra* note 1 (39% have income under 133% FPL, and another 24% have income between 133 and 400% FPL); *cf.* UCLA & UCB STUDY, *supra* note 1 (estimating that 52% of the remaining uninsured have income under 200% FPL).

¹¹ DiJulio, *supra* note 1 (29% undocumented); *cf.* UCLA & UCB STUDY, *supra* note 1 (25% undocumented).

¹² DiJulio, *supra* note 1.

¹³ *Id.* (9% unaware of options).

¹⁴ UCLA & UCB STUDY, *supra* note 1.

¹⁵ DiJulio, *supra* note 1 (9% have not tried to get coverage / too busy).

¹⁶ *Id.* (36% attempted enrollment but were unsuccessful).

¹⁷ See CAL. HEALTH & SAFETY CODE § 1399.849(a); CAL. INS. CODE § 10965.3(a).

the tax penalty, to be assessed against those who are uninsured for more than three months of the year, they will still have no source of coverage if a medical catastrophe hits.¹⁸

III. Counties Legal Obligation to Provide Care to Remaining Uninsured Residents

Counties' obligation to provide health care for low-income residents is set out in statute as follows:

*Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives and friends, by their own means, or by state hospitals or other state or private institutions.*¹⁹

Section 17000 is designed to ensure that low-income Californians who are not eligible for health affordability programs like Medi-Cal or Covered California have access to a minimum safety net to meet their health care needs. Over the years, the courts have interpreted various components of § 17000 to determine the extent of the obligation to indigent residents. Because the statute clearly addresses itself to counties using the word “shall,” their duty is mandatory, and they must offer basic medical services (as described below) to low-income residents.²⁰

A. Financial eligibility criteria

California law gives counties discretion in setting their eligibility criteria to qualify for their § 17000 programs.²¹ A threshold eligibility criterion that merits close scrutiny is the financial eligibility standards set by the county to qualify for care.

Section 17000 requires counties to provide health care to “all indigent” residents. How a county defines indigency for purposes of § 17000 varies. Counties typically identify who is indigent to qualify for their 17000 programs by setting asset or property limits and income criteria.

¹⁸ UCLA & UCB STUDY, *supra* note 1 (estimating that 72% of remaining uninsured will be exempt from penalty).

¹⁹ CAL. WELF. & INST. CODE § 17000; see *Welfare Rights v. Frank*, 25 Cal. App. 4th 415, 420-21 (1994) (describing the legislative history of the statute).

²⁰ *County of San Diego v. State of California*, 15 Cal. 4th 68, 104-05 (1997).

²¹ CAL. WELF. & INST. CODE § 17001 (“The board of supervisors of each county, or the agency authorized by county charter, shall adopt standards of aid and care for the indigent and dependent poor of the county or city and county”). Section 17000 is also interpreted to require counties to pay cash aid, which takes the form of General Assistance or General Relief, to very poor residents. *Mooney v. Pickett*, 4 Cal.3d 669, 671 (1971). The cash aid requirement has been significantly curtailed by statute. See *Welfare Rights*, 25 Cal. App. 4th at 420-21.

Counties may establish their own policies regarding the amount of property a person may have while receiving aid through § 17000.²² Counties have generally adopted all or part of the pre-ACA Medi-Cal asset rules, such as allowing up to \$3,000 in assets for an individual and exempting one car and one's home, but may adopt more restrictive policies.

With regard to income, according to a 2015 statewide survey of county indigent health programs, income eligibility limits for indigent health programs span a wide range.²³ At the low end, three counties limit their programs to persons with income at or below 100% of the Federal Poverty Limit (\$11,770 a year for an individual in 2015), while at the high end one county is reported to have an income eligibility limit of 700% of the Federal Poverty Limit (\$82,390 a year for an individual in 2015).²⁴ The majority of counties—43 of 58—have set their upper income eligibility limits at 200 % of the Federal Poverty Limit, or \$23,540 a year for an individual.²⁵

❖ How does the county define who is medically indigent?

- What are the income limits for someone to qualify for medically indigent services?
 - If the income eligibility limit is a percentage of the Federal Poverty Limit, does the county update the dollar amount equivalent every year on April 1?
- If there is an income eligibility limit, did the county do a study on the cost of basic necessities (housing, utilities, food, transportation, personal care, etc.) to live in the county in setting its income eligibility limit?
 - How current is the data the county used in assessing the cost of basic necessities? And is the data specific to the county?
- Is there an upper income eligibility cap, and if yes what is it?
- Does the county have an assets or resources eligibility requirement? If yes, what is it based on?
- Are there exemptions from any of the program's eligibility requirements? For example, is there a financial hardship exception to offset income that is otherwise over the income eligibility limit?
 - How does the county notify the general public and/or applicants for indigent county health of the availability of this exemption?
- When were the county's financial eligibility requirements last updated?
- How many people is your county serving in its § 17000 program?

²² CAL. WELF. & INST. CODE § 17107; see also *id.* § 17111 (allowing recipients to be permitted to keep tools of his trade necessary to continue employment and a car of "reasonable value" in order to enable the aided person to become self-supporting).

²³ MENACHO ET AL., *supra* note 1 at 7-8; see also CAL. DEPT. OF HEALTH CARE SERVS., COUNTY INDIGENT CARE PROFILE (2014), available at http://www.dhcs.ca.gov/provgovpart/Documents/AB%2085/County_Profiles_ADA.pdf.

²⁴ *Id.* The three counties with income eligibility limits of 100% of the Federal Poverty Limit are Merced, Placer and Santa Cruz; Ventura County reports an income eligibility limit of 700% FPL. See *id.*

²⁵ *Id.* The 43 counties with an income eligibility limit of 200% of the Federal Poverty Limit include eight individual counties - Alameda, Kern, Monterey, Orange, Riverside, San Joaquin, San Mateo, and Santa Barbara - and the 35 rural and/or small counties that make up the County Medical Services Program (CMSP) consortium. See *id.*

Contrary to what these widely disparate income limits indicate, there are boundaries to the discretion a county may exercise in setting income eligibility criteria. First, counties must not set their standards to such low levels that they would leave otherwise qualified residents without subsistence medical care.²⁶ Section 17000's mandate is not limited to assisting only the county's most destitute individuals; the mandate to care for "all indigents" requires counties to provide care for residents who may have greater means, but who nevertheless are unable to pay for the costs of their own medically necessary care.²⁷

A second and related boundary on the counties' discretion in setting income limits centers on a person's ability to pay for care. The California Supreme Court has held that a county's income eligibility standard must take into account an individual's actual ability to pay for the cost of subsistence care in order to be proper.²⁸ A third limit on a county's discretion to establish income criteria requires a county take into account the cost of basic needs to live in the county, such as housing, utilities, food, transportation, etc., in setting income criteria that may be appropriate for residents.²⁹

Another aspect of a county's income eligibility criteria to assess is if the county's income eligibility limits are "hard" income caps, meaning they absolutely bar persons from accessing § 17000 services, regardless of a person's medical need or ability to pay. Such caps have been struck down as improper.³⁰ A county "cannot be considered [a] 'safety net' or place of 'last resort' for subsistence medical care" if persons "suffering from serious injury or illness, but whose income is \$1 over the income cap...and cannot afford or cannot obtain insurance" are unable to access § 17000 care.³¹ There are several options available to counties to address this issue, such as having a § 17000 program that includes a sliding scale fee or share of cost system based on an ability to pay analysis;³² providing reasonable policies and procedures for residents to request hardship exemptions from such limits; or setting their income eligibility criteria at such a level that persons above the level can afford to pay for care. Advocates should work with their counties to ensure that financial eligibility rules are reasonable to ensure access to the remaining uninsured who will not otherwise be able to pay for care.

²⁶ *Hunt v. Superior Court*, 21 Cal.4th 984, 1014 (1999) ("[I]n determining a financial eligibility standard for [17000 county health services], the County must consider whether implementation of the standard would leave some residents incapacitated by age, disease, or accident, and whose condition is not relieved through other means, without subsistence medical care").

²⁷ See, e.g., *Alford v. County of San Diego*, 151 Cal.App.4th 16, 29 (2007) (noting that "medically indigent persons" includes the "working poor"); *Goodall v. Brite*, 11 Cal.App.2d 540, 548 (1936) (holding that a county hospital must accept beyond the "pauper class" and accept persons "who can pay something towards their care and treatment").

²⁸ *Hunt*, 21 Cal.4th at 1015.

²⁹ *Alford*, 151 Cal.App.4th at 35.

³⁰ *Id.* at 35 (striking down San Diego's flat income eligibility cap of \$1,078 a month, or 135% of the Federal Poverty Limit at the time, because the county failed to consider an individual's ability to pay all or part of their subsistence medical care, even if the person was just \$1 over the cap).

³¹ *Id.*

³² Section 17000 programs can include income-tiered categories for care, where services may be available at no cost to persons below a certain income level and some type of cost-sharing arrangement at higher income levels.

B. Cost-Sharing

An issue related to the setting of financial eligibility limits is when counties include cost-sharing in their § 17000 programs. Cost-sharing can take many forms and generally describes anytime a program charges a person for services, such as imposing a fee schedule for services, i.e., \$5 for a primary care visit, \$10 for a specialist and \$20 for ER. Another example of cost-sharing would be if participants who exceed a certain income or asset limit are required to spend the amount of money they have above the limit in order to access services, a practice commonly referred to as share of cost or spending-down.

Including cost-sharing arrangements in Section 17000 programs are permissible, but a county's discretion in imposing cost-sharing has limitations. First, counties are strictly prohibited by statute from charging fees as a condition of receiving § 17000 services. Section 16804.1 of the Welfare and Institutions Code states that “[n]o fee or charge shall be required of any persons before a county renders medically necessary services to persons entitled to services pursuant to § 17000.”³³

- ❖ **Is there cost-sharing?** Examples of cost-sharing include participant fees, co-pays, sliding scale fees, share of cost, or a percentage of the cost of care to receive services.
 - If there is cost-sharing:
 - What are the amounts of these fees?
 - On what basis did the county develop its cost-sharing system?
 - When was the cost-sharing scheme last updated?

And like income eligibility limits, any cost-sharing system must be tied to a person's ability to pay for care.³⁴ What this means is that if a § 17000 program requires participants over 100% of the Federal Poverty Level to pay according to a fee schedule, for example, the county must have a factual basis to assume all persons above that level can afford to pay the fees. Section 16804.1(b) addresses this issue by providing that counties may “implement a reasonable sliding fee schedule based on ability to pay.” Advocates should evaluate their counties' cost-sharing rules to make sure they are up-to-date and reflect the current cost-of-living in the county.

³³ Note that counties may attempt to bill recipients of § 17000 services after the fact. See *infra* section III.F.

³⁴ See, e.g., *Brown v. Crandall*, 198 Cal. App. 4th 1, 10 (2011) (noting that “the ability to pay for private health insurance does not necessarily demonstrate an ability to pay all of a substantial medical bill. . . . [but] whether a person can afford such care is a factual question that should be decided based on evidentiary proof”); *Poverty Resistance Center v. Hart*, 213 Cal.App.3d 295, 304 (1989) (“[F]actual premises which underpin a standard adopted under Section 17001 must be supported by evidence before the Board and by reasonable inference drawn therefrom”).

C. Application Process

Counties have substantial discretion in terms of when they will accept an application for their § 17000 programs. For example, while some counties operate their programs to accept applications at any time, other counties will only accept applications from individuals who have an existing medical need.³⁵ Such requirements are most

❖ Are there timing requirements for application?

Does the county allow for retroactive eligibility or does eligibility begin at application or in that month? Does the county limit eligibility to the time when a person has a medical need?

likely consistent with the statutory mandate to relieve and support residents—those without an existing need are presumed not to require the county’s relief and support.³⁶ Counties may require residents to reapply for help or “renew” enrollment in a § 17000 program on a regular basis.³⁷ Counties may be required to cover bills incurred in the past, but have some discretion to require residents to apply for help within a certain period after the bill was incurred.³⁸ Following their experience with Low Income Health Program funding from 2010-2013, some counties are using “coverage-like” programs to deliver care to indigent residents, which permits them to stay in the § 17000 program for an entire year without a need to reapply or demonstrate medical need.³⁹ Advocates should work with their counties to explore whether this type of program design is feasible to ensure broad access by the remaining uninsured.

D. Residency

The statutory language limits eligibility for health care services under § 17000 to individuals who are residents in the county where they are applying for aid. Residents of an Indian Reservation are considered residents of the county in which the Reservation is located.⁴⁰ Residence is defined in the law as “the place where one remains.”⁴¹ Like the general rules governing residency in California, residence for the purposes of § 17000 programs require both physical location and intent to stay in a place.⁴² Counties may not refuse services to county residents simply because they don’t have a valid address.⁴³ Similarly, a rule requiring applicants

³⁵ See HEALTH ACCESS CALIFORNIA, *supra* note 3, at 4.

³⁶ See Cal. Welf. & Inst. Code § 17000.

³⁷ See HEALTH ACCESS CALIFORNIA, *supra* note 3, at 11.

³⁸ See *McGrath v. Crandall*, No. A127890, 2011 WL 1085112, at *4 (Cal. Ct. App. Mar. 24, 2011) (remanding the question of whether a county is obligated to cover past bills);

³⁹ See HEALTH ACCESS CALIFORNIA, *supra* note 3, at 13. The Low Income Health Programs were part of a federal Medicaid waiver that allowed counties to draw down federal funds to provide health care to certain residents with income under 200% FPL. See generally ABBI COURSOLE, NATIONAL HEALTH LAW PROGRAM, CALIFORNIA’S SAFETY NET LAW AND LOW INCOME HEALTH PROGRAMS (2012), available at <http://www.healthlaw.org/publications/californias-safety-net-law-and-low-income-health-programs>.

⁴⁰ *Acosta v. San Diego Cnty.*, 126 Cal. App. 2d 455, 467 (1954).

⁴¹ Cal. Welf. & Inst. Code § 17101.

⁴² See *Nelson v. San Diego County Bd. Of Supervisors*, 190 Cal. App. 3d 25 (1987). The general residence rules for the state are set forth at Government Code § 244.

⁴³ *Nelson*, 190 Cal. App. 3d 25 at 31.

to reside in the county for a period of time before accessing services through the 17000 program is likely invalid.⁴⁴

The statute limits the county's obligation to support only those who *lawfully* reside. The term "lawfully" has been interpreted to allow counties to limit services to individuals with a satisfactory immigration status.⁴⁵ Counties have the discretion to aid undocumented immigrants and/or non-residents but are not required to do so.⁴⁶ Counties also have some discretion as to which specific immigration statuses they will consider "lawfully resident." At least one court suggests that counties may follow CalWORKS welfare rules with respect to immigration status, which are generally more restrictive than the immigration status rules for Medi-Cal and Covered California.⁴⁷

❖ How does the county define "residency"?

- Does the county require that a person must reside in the county for a certain number of days to be considered a county resident?
- How does the county consider immigration status in its residency definition?
 - Which immigration statuses are eligible for the county's program?
 - Does the county's program provide services to persons who are undocumented?

In Medi-Cal, all immigrants regardless of documentation status may be eligible for restricted-scope Medi-Cal, which provides for emergency care and certain pregnancy-related and long-term care services.⁴⁸ Immigrants who can establish PRUCOL (Permanently Residing Under Color of Law) status are eligible for full-scope Medi-Cal benefits.⁴⁹ In Covered California, immigrants are eligible to purchase a health plan as long as they are "lawfully present."⁵⁰ While there is significant overlap between the groups of immigrants who are eligible for Medi-Cal, and those who are eligible for Covered California, there will be some immigrants whose immigration status qualifies them for full-scope Medi-Cal, but not Covered California, and vice versa.⁵¹ For example, immigrants who hold work permits under the Deferred Action Childhood Arrival (DACA) executive order are potentially eligible for Medi-Cal through PRUCOL, but are not eligible for Covered California. If they are ineligible for Medi-Cal due to income, these DACA

⁴⁴ See *Mem'l Hosp. v. Maricopa Cnty.*, 415 U.S. 250, 269 (1974).

⁴⁵ *Khasminskaya v. Lum*, 47 Cal. App. 4th 537, 543 (1996); *Bay General Community Hospital v. County of San Diego*, 156 Cal. App. 3d 944, 961 (1984).

⁴⁶ Cal. Welf. & Inst. Code § 17003.

⁴⁷ See *Khasminskaya*, 47 Cal. App. 4th at 543.

⁴⁸ CAL. WELF. & INST. CODE § 14007.5(d); *id.* §§ 14007.2, 14011.2(e)(1); see also 42 C.F.R. § 435.407(k).

⁴⁹ CAL. WELF. & INST. CODE § 14007.5(b); *id.* § 11104 (eligibility of immigrants who are PRUCOL); see also CAL. IMM. POLICY CENTER, HEALTH PROGRAM ELIGIBILITY CHART FOR CALIFORNIA IMMIGRANTS 2 n.3 (2013) (explaining PRUCOL), available at <http://www.caimmigrant.org/wp-content/uploads/2014/10/HPEligibilityChartforCAImmigrants.2013.pdf>;

⁵⁰ 45 C.F.R. § 152.2 (defining "lawfully present").

⁵¹ See CAL. IMM. POLICY CENTER, *supra* note 49; NAT'L IMM. LAW CENTER, MAJOR BENEFIT PROGRAMS AVAILABLE TO IMMIGRANTS IN CALIFORNIA 3-4 (2014), available at <http://nilc.org/document.html?id=481>.

may be eligible for help from their county's § 17000 program. Advocates should be aware of their county's rules regarding immigrant eligibility, and consider challenging policies that are overly restrictive.

E. Programmatic Eligibility

Section 17000 limits a county's obligation to provide care to only those individuals who do not have another source of care for the services they request from a county. Practically speaking, this provision is usually used as a legal basis to require applicants for county programs to apply for Medi-Cal, Covered California or other potential sources of health coverage, including other private programs (like COBRA or employer coverage) before the county will cover their health care costs.

❖ **What is the relationship between eligibility for county indigent health services and eligibility for Medi-Cal or subsidized insurance through Covered California?**

- Does the county require applicants to prove ineligibility for these other two programs so that they are eligible for county indigent health services?

A county's obligation to provide additional, but necessary, services to those enrolled in coverage depends on the type of coverage the person has. The statute explicitly relieves counties of any duty to provide health care to those persons who are enrolled in, or who are eligible for, Medi-Cal—even if a needed service has been eliminated from Medi-Cal.⁵² Counties do have to provide health

care to those who have a Medi-Cal application pending; it may recoup the cost of those services provided from the state Medi-Cal program if the Medi-Cal application is ultimately approved. However, a county may be obligated to cover medically necessary services that are not covered by a person's private insurance. For example, in § 17000's counterpart cash assistance program, a Court of Appeal held that a county was prohibited from refusing to aid a person who was enrolled in another welfare program, but who did not actually receive any financial assistance from it.⁵³ Similarly, counties should provide for residents enrolled in coverage that does not provide for a needed service—for example, dental care—when the service is needed to remedy pain and infection and the residents cannot otherwise afford the cost of such care.

The counties' obligations with respect to those remaining uninsured who are eligible for subsidized Covered California plans, but not enrolled, have not yet been tested. Previous cases suggest that if subsidized Covered California plans are inaccessible to low-income Californians due to cost, counties could be required to offer services to this populations.⁵⁴ Alternately, counties might consider subsidizing residents' Covered California plan premiums, which might

⁵² CAL. WELF. & INST. CODE § 17030.

⁵³ See *McCormick. v. County of Alameda*, 193 Cal. App. 4th 201 (2011) (General Assistance, the cash aid counterpart to § 17000 health programs, must pay for services when CalWORKs provides no cash assistance).

⁵⁴ See *id.*

be more cost-effective than providing the services directly at full county cost. For those remaining uninsured individuals who missed the enrollment period to apply for subsidized insurance through Covered California, cases suggest that the county has an obligation to provide care at least until the person next has an opportunity to enroll.⁵⁵ Advocates should work with their counties to explore the best mechanisms to ensure that those eligible for other affordable coverage options are swiftly enrolled, and to provide interim services for those who miss an enrollment period.

F. Recouping expenses

Counties may require residents to repay the cost of care provided to them through a § 17000 program, implemented by a lien on the recipient's property.⁵⁶ In addition,

❖ **Are applicants required to sign a lien as security for the cost of any services provided to them?**

counties may seek repayment from any legally responsible relatives or immigration sponsors of those who receive care from a § 17000 program.⁵⁷ The law contains detailed provisions concerning when a county may enforce such a lien to recoup the cost of care, and protecting consumers from onerous collections.⁵⁸ Other consumer debt collection protections may apply if the county attempts to collect on the lien.⁵⁹ Moreover, the California Supreme Court held that counties may not collect from wages that a recipient earns after receiving aid to the extent that those wages are needed for his support.⁶⁰ Advocates should determine whether their county requires residents to sign a lien before receiving services from its § 17000, and encourage counties that do so to evaluate whether doing so is cost-effective.

G. Scope of Services

The kind of care counties must provide to their low-income residents is derived from the statutory obligation to “relieve and support.” That phrase has not been interpreted to obligate counties to provide their low-income residents with a set benefits package; instead, the cases have required counties to provide “subsistence medical care.”⁶¹ This standard requires counties to provide

❖ **Which services are covered by the county indigent health program?**

- Does the county indigent health program cover more than emergency or urgent care services? If so, which services?
- What is the county's criteria for covering a service?
- Which services does the county expressly refuse to cover?

⁵⁵ See *id.*

⁵⁶ CAL. WELF. & INST. Code § 17109.

⁵⁷ See *id.* § 17300 (responsible relatives); *id.* § 17001.9 (sponsors of immigrants).

⁵⁸ See *id.* §§ 17400-410.

⁵⁹ See, e.g., *Joseph v. J.J. Mac Intyre Companies, L.L.C.*, 238 F. Supp. 2d 1158 (N.D. Cal. 2002).

⁶⁰ *Cnty. of San Diego v. Muniz*, 22 Cal. 3d 29 (1978).

⁶¹ *Hunt*, 21 Cal. 4th at 1012.

“at least...medical services necessary for the treatment of acute life-and-limb threatening conditions and emergency medical services.”⁶² In the case of emergency care, counties must pay for that care even if it is provided out-of-network or out-of-county.⁶³

But the courts have also clearly interpreted the counties’ obligation to extend beyond emergency care. The precise scope of the obligation has not been clearly defined, but courts have held that counties must provide “medically necessary care.”⁶⁴ And such care must be “sufficient to remedy substantial pain and infection.”⁶⁵ Under this standard, counties have been found liable for urgent dental care to address abscesses, for example, but not routine preventive dental care.⁶⁶ While some counties offer only a very limited scope of services in their § 17000 programs, others offer preventive services and broad access to specialty care; some counties have even implemented innovations like medical homes, and integrated delivery for behavioral health services.⁶⁷ Advocates should evaluate whether the services offered by their county are “sufficient to remedy substantial pain and infection.”⁶⁸ Advocates should also look for opportunities to work with their counties to implement cost-effective innovations, including coverage of preventive services, better care coordination through medical homes, and improved integration with county behavioral health delivery systems.

IV. County Indigent Health Program Funding

Since 2014 the counties’ role in providing health care to indigent residents has significantly decreased, with much of the responsibility for the health care for that population shifting to the state as a result of the expansion of Medi-Cal to childless adults and subsidized insurance through Covered California. Recognizing their altered role in providing health care to indigent childless adults and prompted by a 2013-2014 state budget that significantly decreased state financing to counties for health care, counties are recalibrating the financing of their indigent health programs to adjust.

This process of trying to “right-size” a county’s indigent care program to its funding is complicated by many factors: not knowing how many people will continue to rely on counties for their health care; uncertainty over the direction of state and federal policy decisions on coverage options for undocumented persons under the ACA; the discretion under § 17000 for counties to define eligibility criteria for their programs to either expand or constrict the number

⁶² *Id.* at 1014.

⁶³ *Fuchino v. Edwards-Buckley*, 196 Cal. App. 4th 1128 (2011).

⁶⁴ *County of Alameda v. State Bd. of Control*, 14 Cal. App. 4th 1096, 1108 (1993).

⁶⁵ *Cooke v. Superior Court*, 213 Cal. App. 3d 401, 404 (1989).

⁶⁶ *Id.* at 415 (county is not required to ensure “good teeth and a picture-perfect smile in order to succeed in the workplace. . . [but it must provide a] level of care which remedies the pain and infection which petitioners have needlessly endured”); see also *Harris v. Bd. of Supervisors, Los Angeles Cnty.*, 366 F.3d 754, 765 (9th Cir. 2004) (county may not cut services in a way that will “deprive plaintiffs of medically necessary care, will endanger their health, and will lead to their unnecessary suffering”).

⁶⁷ See HEALTH ACCESS CALIFORNIA, *supra* note 3, at 13-14.

⁶⁸ *Cooke*, 213 Cal. App. 3d at 404.

of people served; and a lack of historical data on how much counties spend on their indigent health programs.

What is known is that under the § 17000 mandate, counties continue to serve as the provider of last resort for remaining uninsured indigent residents. While the number of poor uninsured residents may be diminishing, they are still significant, with anywhere from 1.8 million to 2.3 million remaining uninsured Californians estimated to have income at or below 200% of the Federal Poverty Level by 2019.⁶⁹ Ensuring the state and the counties adequately fund county-based indigent health is important to protect the ability of the uninsured to access necessary health care.

This section provides an overview of the historical financing sources for county indigent health programs and the current budgeting challenges facing the counties going forward. It will offer advocates insight into how they can work with their county to help maximize funds available for its § 17000 program, to ensure that the program is designed in a way that is efficient but also provides broad access to the remaining uninsured who rely on the safety net for care.

A. Historical Funding Sources for County Indigent Health

County indigent health programs are funded by a complex combination of state, county, and federal sources. Since 1991, the predominant source of funding for county programs has been largely from the state with what are known as 1991 realignment revenues.

Made up of state sales tax and vehicle license fees, 1991 realignment has been a dedicated state funding stream that helps pay for the costs of indigent health care under the counties' § 17000 obligation, as well as public health activities such as communicable disease control, environmental health, smoking cessation, and childhood exposure to lead.⁷⁰ Historically the state has provided counties with approximately \$1.5 billion per year under 1991 realignment.⁷¹

For counties to receive these 1991 realignment revenues from the state, they must commit to using some county general funds to maintain a minimum level of expenditure—a maintenance-of-effort (MOE)—on their public health and indigent health programs. The collective MOE amount from the counties has averaged approximately \$343 million per year.⁷² In addition to 1991 realignment and county general funds, tobacco settlement monies allocated to the

⁶⁹ LAUREL LUCIA, ET AL., UC BERKELEY CTR. FOR LABOR RESEARCH & EDUCATION & UCLA CTR. FOR HEALTH POLICY RESEARCH, WHICH CALIFORNIANS WILL LACK HEALTH INSURANCE UNDER THE AFFORDABLE CARE ACT? (2015), available at <http://healthpolicy.ucla.edu/publications/Documents/PDF/2015/uninsuredbrief-jan2015.pdf>.

⁷⁰ MAC TAYLOR, CAL. LEGISLATIVE ANALYST, REPORT: THE 2013-2014 BUDGET: EXAMINING THE STATE AND COUNTY ROLES IN THE MEDI-CAL EXPANSION (2013), available at <http://lao.ca.gov/analysis/2013/health/ACA/medi-cal-expansion-021913.pdf>.

⁷¹ CAL. ASSEMBLY BUDGET COMMITTEE, BILL ANALYSIS: AB 85 (2013), available at http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_0051-0100/ab_85_cfa_20130614_132736_sen_floor.html.

⁷² *Id.*

counties under the Master Settlement Agreement between the states is also a common funding source for county health programs.⁷³

Federal dollars have also been an important source of funding for county indigent health services. For example, counties with public hospitals receive federal support for serving the Medi-Cal population and the uninsured through Medicaid Disproportionate Share Hospital payments. But the ACA reduces those funds over the next several years in recognition that more uninsured persons will now have coverage.

California counties also received a boost of federal funds in recent years from the state's two Section 1115 Medicaid Demonstration Waivers in 2005 and 2010. Together those waivers provided federal funding for, among other things, a Safety Net Care Pool to subsidize public hospitals for uncompensated care costs for uninsured persons, and county-based indigent health programs with medical homes.⁷⁴

B. AB 85 and the Redirection of 1991 Realignment Away from County Health

In light of the anticipated savings by counties in their indigent health care programs due to the expansion of Medi-Cal, Governor Jerry Brown dramatically altered the primary funding stream for county indigent care when he signed AB 85 as part of the state budget. AB 85 redirects the estimated county savings from county health to support county social services, specifically a 5% increase in CalWORKs grants, effective March 1, 2014.⁷⁵

For the 2013-2014 budget year, the total amount the state could redirect from 1991 realignment revenue to county social services was capped at \$300 million. But that amount is expected to more than double in the coming years, with the state anticipating county health care savings at an estimated \$724.9 million in 2014-2015 and projected \$698.2 million in 2015-2016.⁷⁶

AB 85 offered counties two basic options for how to determine the amount of funds to be redirected from their health programs. The first option, commonly known as the “60/40 option,” generally redirects 60% of the sum of: (1) the 1991 health realignment funds that

⁷³ TAYLOR, *supra* note 68.

⁷⁴ *Id.* In 2005, the federal government approved the first of two 1115 waivers in California, which created county-operated “Coverage Initiative” programs in ten counties and provided 50% federal funding for care. In November 2010, several months after passage of the ACA, the federal government approved the next waiver—called California’s “Bridge to Reform” waiver—which built upon the previous ten counties Coverage Initiative programs by authorizing county-based “Low Income Health Programs” in every county. See COURSOLE, *supra* note 39.

⁷⁵ CAL. WELF. & INST. CODE § 11450.025(a). To redirect 1991 realignment revenue to county social services, AB 85 created two new subaccounts under the Local Revenue Fund in the state budget: a Family Support Subaccount and a Child Poverty and Family Supplemental Support Subaccount. *Id.* § 17600(b)(5) and (6). The CalWORKs grants increase is paid from these subaccounts. *Id.* §§ 17601.50, 17601.75.

⁷⁶ CAL. OFFICE OF THE GOVERNOR, PROPOSED 2015-2016: BUDGET SUMMARY FOR HEALTH AND HUMAN SERVICES 62 (2015), available at <http://www.ebudget.ca.gov/2015-16/pdf/BudgetSummary/HealthandHumanServices.pdf>.

would have otherwise been allocated to the county, and (2) the county's health MOE, with specified limits.⁷⁷

The second option, known as the “shared savings formula,” or simply “the formula,” is more complex.⁷⁸ Under the formula, a county must provide its revenues and actual costs incurred for its county health services. If the county's revenues exceed its costs, 80% of that excess revenue is redirected to the state. If the county's costs exceed its revenues, no realignment funds are redirected.

For the counties that choose the formula, it is important to note that beginning with the 2014-2015 budget the amount initially redirected each fiscal year is based on *savings estimates* provided by the state.⁷⁹ Under the AB 85 methodology, within two years of the end of each fiscal year, counties must submit documentation of county revenues and expenses that will be used to calculate actual county savings and adjust the redirected amount accordingly.⁸⁰

This opportunity to “true-up” the estimated amounts that had been redirected from a given year means that the formula counties will not have an actual accounting for their indigent health care programs until one and a half years after the fiscal year has ended. For example, for fiscal year 2014-2015, the formula counties and the state will not reconcile those counties' savings until December 2016.

C. County Funding Decisions

A county may choose between these two options as long as it either is a “provider county,” or one that owns and operates a public hospital, or a “payer county,” also known as an Article 13 county, which do not have a public hospital. A County Medical Services Program (CMSP) county, a group of 35 rural and/or small counties that contracts with the state to provide indigent care, is required to follow a version of the 60/40 option.⁸¹

Of the provider counties, all twelve counties opted for the formula, with Los Angeles using a specially designated formula.⁸² Of the twelve payer counties, seven chose the formula option and five opted for the 60/40 option.

⁷⁷ For non-CMSP counties with no designated public hospital, the MOE amount is capped at 14.6% of the county's 2010-2011 allocation. CAL. WELF. & INST. CODE § 17600.50(b)(2)(B).

⁷⁸ CAL. WELF. & INST. CODE §§ 17612.1 - 17612.4 & 17613.1 - 17613.4 (detailing the formulas to be used by public hospital counties and by non-public hospital counties).

⁷⁹ CAL. WELF. & INST. CODE §§ 17612.3(b) & 17613.3(b); see also MAC TAYLOR, CAL. LEGISLATIVE ANALYST, THE 2013-2014 BUDGET: CALIFORNIA SPENDING PLAN, 41 (2013), available at <http://www.lao.ca.gov/reports/2013/bud/spending-plan/spending-plan-073013.pdf>.

⁸⁰ CAL. WELF. & INST. CODE §§ 17612.4 and 17613.4.

⁸¹ *Id.* § 17600.50(a).

⁸² *Id.* § 17612.5.

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	60/40 OPTION	SHARED SAVINGS FORMULA
Article 13 "Payer Counties"	<i>Placer; Sacramento; Santa Barbara; Stanislaus; Yolo</i>	<i>Fresno; Merced; Orange; San Diego; San Luis Obispo; Santa Cruz; Tulare</i>
Public Hospital "Provider Counties"		<i>Alameda; Contra Costa; Kern; Los Angeles; Monterey; Riverside; San Bernardino; San Francisco; San Joaquin; San Mateo; Santa Clara; Ventura</i>

D. AB 85 Timeline for Data Sharing and Redirection

The following is a general timeline regarding the AB 85 redirection process so advocates can track when their counties are scheduled to disclose their financial data to the Department of Health Care Services (DHCS) and DHCS's schedule to disclose its calculations to the counties.

For Fiscal Year 2013-2014*By June 30, 2015*

Counties submit their final revenues and costs data to DHCS

By December 31, 2015

"True-up" for FY 2013-2014. DHCS provides the counties with the final calculations for FY 2013-2014. Counties whose savings are greater than the estimated amount that was withheld in 2014 will pay the state the difference. If a county's savings are under the estimated amount, the state will pay the county the difference.

For Fiscal Year 2014-2015 and beyond

<i>November</i>	Counties that selected the formula option submit their reports on the prior year's revenue and cost data to DHCS, i.e., by November 2015 counties submit their reports on FY 2014-2015 (which ends on June 30, 2015)
<i>January</i>	DHCS completes the interim calculations of estimated county savings for the upcoming fiscal year, using the most current and accurate data available
<i>May</i>	As part state budget May revise, DHCS updates the interim calculation for the upcoming fiscal year
<i>June</i>	By June 30 th , counties submit to DHCS their final data on the previous fiscal year's revenues and costs
<i>July through December</i>	DHCS provides the counties with the final calculation and submits to counties by December 31 st of the fiscal year following the receipt of the final data

These dates may be used as a guide for advocates as key times to engage with their counties on the status of their § 17000 programs. Counties may look to make substantive changes to their § 17000 programs, such as expanding or contracting eligibility criteria or the scope of services provided, based on the estimated and final determinations by DHCS regarding the redirected AB 85 funds and the data the counties will be gathering on the revenues and costs associated with their programs.

V. Conclusion

While far fewer Californians rely on their counties to provide them with subsistence health care services today than before 2014, millions of Californians remain uninsured. Thus, § 17000 remains an important backstop to ensure that the most vulnerable individuals who cannot obtain full coverage through health reform do not fall through the cracks and continue to get the care they need. County realignment has changed the funding available to counties to serve their remaining uninsured residents. To fulfill the requirements of § 17000, counties must continue to invest in their safety net infrastructure using the new funding mechanisms available. The appendix to this issue brief provides advocates with a framework for evaluating their counties' compliance with the legal requirements imposed by § 17000, and for identifying areas where their counties may be able to go beyond the minimum to provide comprehensive care to their remaining uninsured residents.

Appendix

Section 17000 County Indigent Health Program—Advocate Checklist

How does the county define who is medically indigent?

- What are the income limits for someone to qualify for medically indigent services?
 - If the income eligibility limit is a percentage of the Federal Poverty Limit, does the county update the dollar amount equivalent every year on April 1?
 - If there is an income eligibility limit, did the county do a study on the cost of basic necessities (housing, utilities, food, transportation, personal care, etc.) to live in the county in setting its income eligibility limit?
 - How current is the data the county used in assessing the cost of basic necessities? And is the data specific to the county?
 - Is there an upper income eligibility cap, and if yes what is it?
 - Does the county have an assets or resources eligibility requirement? If yes, what is it based on?
 - Are there exemptions from any of the program’s eligibility requirements? For example, is there a financial hardship exception to offset income that is otherwise over the income eligibility limit?
 - How does the county notify the general public and/or applicants for indigent county health of the availability of this exemption?
 - When were the county’s financial eligibility requirements last updated?
 - How many people is your county serving in its 17000 program?
- ❖ ***Is there cost-sharing?*** Examples of cost-sharing include participant fees, co-pays, sliding scale fees, share of cost, or a percentage of the cost of care to receive services.
- If there is cost-sharing:
 - What are the amounts of these fees?
 - On what basis did the county develop its cost-sharing system?
 - When was the cost-sharing scheme last updated?
- ❖ ***Are there timing requirements for application?*** Does the county allow for retroactive eligibility or does eligibility begin at application or in that month? Does the county limit eligibility to the time when a person has a medical need?
- ❖ ***How does the county define “residency”?***
- Does the county require that a person must reside in the county for a certain number of days to be considered a county resident?
 - How does the county consider immigration status in its residency definition?
 - Which immigration statuses are eligible for the county’s program?
 - Does the county’s program provide services to persons who are undocumented?

- ❖ **What is the relationship between eligibility for county indigent health services and eligibility for Medi-Cal or subsidized insurance through Covered California?**
 - Does the county require applicants to prove ineligibility for these other two programs so that they are eligible for county indigent health services?

- ❖ **Are applicants required to sign a lien as security for the cost of any services provided to them?**

- ❖ **Which services are covered by the county indigent health program?**
 - Does the county indigent health program cover more than emergency or urgent care services? If so, which services?
 - What is the county's criteria for covering a service?
 - Which services does the county expressly refuse to cover?