State Oil Spill Preparedness and Response

How Can the State Better Address the Problem of Small, Chronic Oil Spills?

Summary

A major offshore oil spill near the California coast is a very real possibility. Historically, however, few such events have occurred since the 1969 Santa Barbara platform blowout. Even so, the environmental and economic consequences of just one "catastrophic" spill likely would be very severe, so steps have been taken to help prevent offshore oil spills and to improve response capability to contain and clean up a major spill. New proposals at the state and federal level aim to strengthen prevention and response in this area even more.

A related but lower profile problem also needs attention from the state. Available information indicates that there are a substantial number of small oil spills that occur frequently throughout California, mostly in onshore areas. As a whole, these spills also result in significant environmental damage. The state's current system to deal with this problem may not be adequate, either for prevention or response. There are several factors the Legislature needs to consider in attempting to address the problem, including reporting systems, preventive measures (such as regulation and law enforcement), increased or redirected state resources for response and the role of local agencies in response efforts.

Since the accidental release of a large quantity of oil from the tanker *Exxon Valdez* in March 1989, much attention has been focused on the possibility of another major offshore oil spill near the United States coastline. Although California has not experienced a spill of this magnitude, the extensive amount of oil development and transport off the state coast certainly raises the question of whether such an event could happen here and what its

consequences would be. The potential environmental and economic effects of this kind of accident clearly warrant serious concern and require substantial preventive and preparedness efforts.

Even before the Alaskan mishap, however, the state, local governments and private industry had begun to put significant effort into improving systems for major oil spill prevention, preparation and response. Since the consequences of a "catastrophic" spill would be quite large, this problem appears to have overshadowed a related, but less visible one: the chronic, sometimes undetected discharge of much smaller quantities of oil, often in onshore areas. Given that these smaller spills are known to occur more frequently and, in the aggregate, pose significant problems to the environment, the Legislature should consider ways to better address this problem.

In this analysis, we review the history of major *offshore* oil spills near California and the efforts to ensure a reasonable level of safety and environmental protection in this area. We then contrast this with the current system to handle smaller, mostly *onshore* oil spills in the state. Finally, we present some alternatives to consider in attempting to improve this system.

MAJOR OFFSHORE OIL SPILLS HAVE BEEN RELATIVELY FEW

Although each incident received substantial notoriety at the time, historically there have been only a few oil spills in the Pacific Ocean that can be considered "major." Apart from the *Valdez* spill, involving the release of over 11 million gallons of crude oil, the largest and most infamous was the platform blowout in the Santa Barbara Channel in 1969. Although the actual amount is uncertain, according to some estimates this accident released about 3 million gallons of crude oil into ocean waters, resulting in significant environmental damage.

Since 1969, however, there have not been any spills of this magnitude off the California coast. The next largest spill occurred in 1971, when two tankers collided in dense fog just outside of San Francisco Bay, spilling a total of 800,000 gallons of crude oil. This accident led to the use of radar as part of the onshore Vessel Tracking System. In 1984, the tanker *Puerto Rican* exploded 12 miles west of the Golden Gate Bridge, spilling 1.3 million gallons of fuel oil at sea. Although considered a major spill, its environmental impact was considered minimal, relative to its size, because there was relatively little impact on wildlife or the coastal area.

In 1987, two cargo ships collided in the Santa Barbara channel, with one of them, the *Pacbaroness*, spilling about 150,000

gallons of its own fuel oil before sinking. In 1988, a barge collided with its tug off the Washington state coast, leaking about 230,000 gallons of fuel oil into the water, much of which eventually washed up on hundreds of miles of beaches in Washington and Canada.

Most recently, the tanker *American Trader* spilled an estimated 400,000 gallons of crude oil in attempting to unload at a marine terminal near Huntington Beach in February 1990. At the time of our review, the effects of this spill had not yet been determined.

MEASURES HAVE BEEN TAKEN TO ADDRESS MAJOR SPILLS

As the preceding brief history indicates, large offshore oil spills—while posing a very real threat to the coastline—have not been common. Nevertheless, it is clear that, under certain conditions, even *one* major spill could be disastrous for the marine and coastal environments, fishing, tourism and the oil industry itself.

Recognizing this situation, governments and industry have taken steps since 1969 to (1) improve operational safety in offshore oil development and transport and (2) establish adequate preparedness and response plans aimed at cleaning up a major oil spill. For example, the State Lands Commission (SLC), which manages oil and gas leases in state waters (zero to three miles offshore), has an extensive regulatory program designed to prevent spills at platforms, marine terminals, processing facilities and pipelines within this jurisdiction. Various state and federal agencies also conduct surprise "spill drills" to test the adequacy of the industry operators' spill containment and cleanup plans. In addition, new technologies have been put into place to improve the safety of platform drilling and tanker transport.

Although it is difficult to determine how much of the safety record for offshore oil in recent years is attributable to these measures or simply to good luck, the vast majority of offshore spill incidents during this time have been very small. The SLC indicates that, during the past three years, only 21 such incidents were reported at oil facilities leased in state waters, totaling 267 gallons of oil, primarily from routine offshore oil operations. The federal Minerals Management Service, which manages oil and gas leases in Outer Continental Shelf (OCS) waters (3 to 12 miles offshore), reports that over the past 10 years, about 90 percent of oil spills from these operations in the OCS region were less than one barrel (42 gallons), averaging about five gallons each. The largest single recorded spill during this period was about 700 gallons. These amounts seem even less significant when compared to *natural* seepage of oil, occurring along fault lines under coastal waters, at an estimated rate of 2,500 to 25,000 gallons per

day in Southern California alone. (There is, however, a difference ecologically between oil seeping through the ocean floor and oil spilled on surface waters.)

State Oil Spill Response Measures

A 1972 amendment to the California Emergency Services Act of 1970 allows the Governor to establish a state oil spill contingency plan. Pursuant to this authority, the State Interagency Oil Spill Committee (SIOSC) was created during the 1970s, with the aim of developing a coordinated state plan for responding to oil spills, both onshore and offshore, but primarily those from offshore oil platforms, pipelines or tankers. As described in the state's Oil Spill Contingency Plan, the SIOSC consists of representatives of 13 state agencies that are responsible for various aspects of oil spill response in the state. The SIOSC itself is responsible for: (1) establishing and maintaining liaison with federal and local agencies and with public and private organizations engaged in oil pollution prevention and control and (2) coordinating day-to-day procedures between state agencies and other organizations regarding prevention and mitigation of oil pollution.

The committee meets formally at least once a year, in part to ensure that the contingency plan is up to date. The plan was last officially revised in May 1983, and a new revision is now under way.

The SIOSC made the administrative decision to make the Department of Fish and Game (DFG) the lead state agency for oil spills, mainly because of the threat spills pose to the state's natural resources. As such, the DFG is responsible for directing the overall operations of all state agencies engaged in combating an oil spill. In addition to day-to-day response coordination, the DFG has contracted on behalf of the SIOSC for a study evaluating current oil spill response plans and technology to deal with *offshore* oil spills, as required by Government Code Section 8574.6 (Ch 1251/86—SB 2495, Marks). The DFG expects to present this study to the Legislature in March 1990.

Other Response Plans

The DFG is also the state's representative on the federal Regional Response Team (RRT), established to provide a coordinated federal response to major oil spills. The RRT also includes the U.S. Coast Guard and the U.S. Environmental Protection Agency. The Coast Guard usually is on the scene of a major offshore spill, even if it occurs in state waters.

In addition, members of the oil industry have created several privately funded cleanup cooperatives located along the California coastline, due in part to state agency requirements. Each has personnel and equipment available around the clock to respond to a major offshore spill in certain coastal areas.

Legislative Proposals

One reaction to the *Exxon Valdez* accident has been a number of state and federal proposals to address the risk of a major oil spill, in the hopes of preventing another such accident and minimizing the problems experienced with the cleanup efforts in Alaska. These are summarized in Figure 1.

SOME POSSIBILITY OF MAJOR OFFSHORE OIL SPILL WILL REMAIN

Many of those involved in spill prevention planning agree that steps such as the ones described here can and will help to lessen the risks presented by everyday oil production and transport. Despite all these efforts, however, it is also accepted that, short of halting all coastal oil activities—including drilling, extraction and transport—it would be virtually impossible to eliminate *completely* the possibility of an accidental discharge of a large amount of oil into California coastal waters.

In addition, state officials involved in oil spill response planning indicate that, if a major offshore spill does occur (that is, a release greater than 100,000 gallons), no reasonable level of preparedness would prevent at least some of the oil from reaching the beaches or other shoreline, especially given the complex variables of oil trajectory, weather and geography. As a recent California Coastal Commission staff report states, "Although improvements have been made [since its 1979 study], the Commission has found repeatedly that effective prevention of spills, or containment and cleanup of spills that do occur, cannot be provided with existing technology... [S]horeline impacts from a large spill heading toward shore cannot be eliminated."

RELATED ISSUE OF SMALL SPILLS NEEDS ATTENTION

Because several significant accidents in the past 20 years resulted in the release of oil into state coastal waters and the possibility of another such event remains, the state and other entities appropriately have taken steps to address the issue of "catastrophic" or major offshore oil spills. However, a related but less visible problem has not received the same kind of scrutiny: that is, the chronic discharge in *onshore* areas of *smaller* quanti-

Figure 1

State and Federal Measures Would Address Major Oil Spill Issue

MEASURE	STATUS (as of February 1, 1990)	MAJOR PROVISIONS
State Proposals		
AB 2603 (Lempert)	Pending (A) Natural Resources Committee	Expands the SLC's regulatory and inspection authority to improve prevention of offshore oil spills; creates a specific Office of Oil Spill Response within the DFG to direct cleanup operations and training; establishes an oil transport fee to fund $500 million oil spill "Superfund" as potential source for cleanup costs; and adds civil fines and potential criminal penalties for oil spills.[a]
SB 1194 (Marks)	(A) Inactive file	Prohibits large oil tankers from entering state bays and harbors unless accompanied by tugboat.
AB 893 (O'Connell)	Pending (S) Governmental Organization Committee	Adds areas in state waters off the Santa Barbara Coast to an existing sanctuary.
AB 36 (Hauser)	Pending (S) Governmental Organization Committee	Adds state waters off the coasts of Mendocino and Humboldt Counties to existing sanctuaries.
Environmental Protection Act of 1990—Initiative Statute	In circulation for Nov. 1990 statewide ballot	Oil spill prevention and response provisions similar to AB 2603. Also creates a Marine Resources Sanctuary in all state waters along the coast, in which any new oil or gas leasing would be prohibited.[b]
Federal Proposals		
HR 1465 (Jones)	Conference (with S 686)	Oil spill liability and compensation legislation: creates a $1 billion oil spill cleanup fund from oil fees; requires double hulls on oil tankers; and continues to allow states to set their own liability standards.
S 686 (Mitchell)	Conference (with HR 1465)	Contains many provisions similar to those in HR 1465.

[a] A virtually identical bill, SB 1482 (Keene), failed to clear the Senate before the first-house deadline. The author's office indicates that he will introduce a modified version of the bill by the end of February 1990.

[b] In December 1989, the SLC *administratively* established such a sanctuary zone, covering all state coastal waters not currently leased or already within existing sanctuary zones. In addition, the President now is considering a recent federal task force report on options for a possible leasing moratorium in *federal* coastal waters.

ties of oil, much of which is not contained or cleaned up and which can end up in the state's streams, rivers, and eventually coastal waters. These small spills result in water and air pollution, death of fish and wildlife, damage to natural habitat, and human health and safety problems. Neglect of such spills leads to continual, incremental damage to the environment. These spills are not just isolated incidents; they occur on a daily basis, throughout the state.

Extent of Small Oil Spills

Although the nature of these small spills makes it difficult to get a precise picture of the extent of the problem, the available data from two main sources suggest the general magnitude of the problem.

OES Warning Center. First, the state's Office of Emergency Services (OES) operates an emergency warning center, which receives notification of—among other things—hazardous material incidents in the state. Most of these notifications are telephoned in by the parties responsible for hazardous material discharges, as required under existing law, or by local response agencies such as fire departments. During calendar year 1988, the warning center received over 4,000 such calls. Of these, approximately one-half involved petroleum and related products (mostly diesel fuel, gasoline, or petroleum oil lubricants).

These numbers, however, understate the total number of spills. OES staff believe that many other small hazardous material spills were *not* reported to the warning center by responsible parties or local agencies. In addition, state and federal agencies that respond to such incidents, often the DFG and the Coast Guard, are not required to contact the OES warning center about these spills.

Hazardous Incident Reporting. In addition to the immediate OES spill notification required of the responsible party, a designated "administering agency" within local government is required to send a detailed form to the OES after each spill in the agency's jurisdiction. The OES compiles this data in its California Hazardous Material Incident Reporting System (CHMIRS). The draft of the latest CHMIRS summary cites 2,756 such forms filed during calendar year 1988. Although many incidents conveyed to the OES warning center clearly are not being reported through the CHMIRS, the draft report does provide revealing information on common types of conditions under which hazardous materials, including oils, are spilled. According to the summary report, about two-thirds of all the reported incidents involved a spill in one of the following circumstances: unauthorized dumping or abandonment; motor vehicle accident; in storage; normal manufacturing

or end use; or loading and unloading. Assuming petroleum product incidents occur in the same proportions as other hazardous materials, it would appear that most small, onshore oil spills occur under fairly routine conditions.

The DFG, which is the state agency charged with responding specifically to petroleum product discharges (both onshore and offshore), received notification from the OES on all the over 4,000 hazardous material spills reported to the warning center in 1988. DFG staff estimate that about one-half of these incidents involved petroleum products. One hundred or so of these were large (over 1,000 gallons), and about one-half of the remainder were less than one barrel (42 gallons). The largest onshore oil spill in the state in recent years took place at a Shell Oil storage tank in Martinez in April 1988. The spill involved over 200,000 gallons of crude oil that drained into a nearby slough and then the Carquinez Strait, near San Francisco Bay.

Small, Chronic Spills Are a Serious Problem

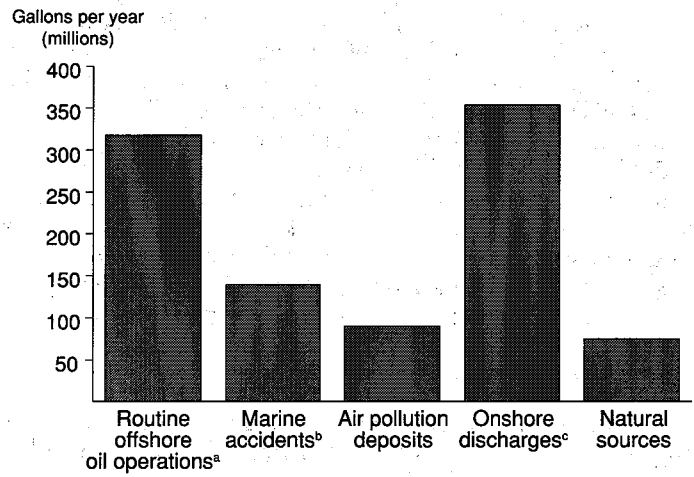
Even if small quantities of oil are spilled in most of the reported (and unreported) incidents, the sheer number of spills inevitably means that a substantial amount of harmful materials is released into the environment every year. While data are not available for California or the United States specifically, *worldwide* data largely extrapolated from United States sources illustrate the seriousness of the problem. Figure 2 shows the total average annual amounts of petroleum products that end up in the worldwide marine environment from various sources. The single largest contribution is from onshore discharges (including municipal and industrial wastes, and urban and river runoff), followed by routine offshore operations (including oil production and transport).

Based on this data, it appears that in an average year, the aggregate amount of petroleum products that make their way to the state's coastal waters from onshore discharges probably is comparable to the total amount from routine offshore oil production and transportation.

In addition, it is safe to assume that at least some of the oil that is spilled onshore remains on land or in inland waters (as opposed to ending up in state coastal waters). In these cases, the long-term environmental damage could be greater than from an offshore spill, since the oil is less likely to be diluted, dispersed, or evaporated than in the ocean. If an onshore oil spill is not contained or cleaned up, the possible results include pollution of surface water and groundwater. Unfortunately, information on these sorts of onshore spills is very incomplete at present.

Figure 2

Chronic Onshore Oil Spills Are a Significant Marine Pollution Source



Source of Petroleum in Ocean Waters (Worldwide)

[a] Includes: offshore oil production (platform drilling and extraction); tanker operations; marine terminals; and bilge and fuel oils.

[b] Includes: oil platform, marine terminal, tanker and other offshore accidents.

[c] Includes: municipal wastes; refineries; other industrial wastes; urban and river runoff including spills; and dumping of wastewater sludge.

Source: Oil In The Sea (National Research Council, 1985). Amounts are for worldwide sources, but largely were extrapolated from data for United States only.

The overall hazards posed by these ongoing small oil spills can have serious effects in many areas: contamination of water and air; loss of fish and other wildlife; and even threats to human health and safety, especially on land.

CONCERNS WITH THE CURRENT SYSTEM'S ABILITY TO DEAL WITH THIS PROBLEM

Our review of the state's current process to respond to small spills indicates several problem areas.

Communication and Reporting Shortcomings

As noted above, the state's current system to gain knowledge of small oil spills has some significant gaps. The OES warning center is not informed of every spill by the responsible party, as required by law, or by local, state or federal agencies (which are currently exempt from this reporting requirement). In addition, the affected local response agencies that eventually will have to respond at the scene of the spill (such as a fire department) often are not immediately notified of the incident. Furthermore, in some—perhaps many—cases, local agencies do not file the required CHMIRS forms with the OES after a spill, which makes later statistical analysis incomplete. Finally, while records exist in its field offices, the DFG does not keep a central record and summary of its reactions to OES warning center notifications—what was the nature of the spill, to what extent did the field staff respond, and so on. This makes it difficult to determine accurately the magnitude of the small spill problem and the overall level of state resources required for an adequate statewide response.

Lead Agency Has Few Resources

Although small onshore oil spills are a problem which is considered in the state's official Oil Spill Contingency Plan, in practice the state has allocated few resources to respond to them. As indicated earlier, the DFG is the state's lead agency for response to oil spills threatening to affect *any* waters of the state. However, the department currently has only two permanent positions dedicated to this responsibility—one for northern California and one for southern California. These two staff members rely on DFG wardens and other field personnel for most on-the-scene activities, such as the initial investigation and coordination of cleanup efforts by other entities. (Currently, the department also has one temporary position which primarily is involved in specific projects such as the contract for the oil spill report required by Chapter 1251. The department has requested in the 1990-91 budget that this position be made permanent and that two additional positions be provided to help manage oil spill response, specifically for small onshore spills.)

Because of the number of reported oil spills—again, more than 2,000 in 1988—and the other ongoing workload demands on the field staff, the DFG is able to respond only to the larger or more environmentally hazardous spills. Consequently, they must leave many "minor" spills to take care of themselves. Finally, DFG staff also believe that a number of small oil spills are not discovered at all.

Difficulty in Funding Cleanup Costs

The DFG mainly attempts to make the party responsible for a spill clean it up. Under existing law, the principle of strict liability requires the responsible party to pay for cleanup, even if another entity has done the actual work. However, in many situations, the responsible party is not always known or is not financially able to pay. In this event, the DFG may draw upon its Fish and Wildlife Pollution Cleanup and Abatement Account, funded from any recovered cleanup payments and civil penalties and continuously appropriated to the department. At the end of 1988-89, the account held about $600,000, an amount which could be depleted in cleaning up one major spill.

Other State Agencies Have Limited Involvement

In relation to the DFG, other departments currently have limited roles in responding to the small spills problem.

State Water Resources Control Board (SWRCB). The SWRCB and the regional water boards provide technical assistance on the potential impact of an oil spill on water resources, and may provide cleanup funding from several special funds under SWRCB control if surface or ground waters are threatened.

Department of Health Services (DHS). The DHS may become involved in the response to an incident if it poses an immediate threat to public health, and may contribute cleanup funds from the state Hazardous Substance Account if the oil is contaminated with a state-designated hazardous substance.

California Highway Patrol (CHP) and Department of Transportation (Caltrans). The CHP acts as the state's on-scene coordinator for oil spills on freeways, state highways, and on roadways in most unincorporated areas of the state. In addition, the CHP provides traffic control at these spills. Caltrans is responsible for ensuring spill cleanup on state roadways and their rights-of-way.

Other Agencies. Other state agencies, such as the SLC, the Division of Oil and Gas (DOG), or the Attorney General's Office, provide advice or legal assistance to the DFG in the event of a spill.

Lack of Emphasis on Prevention

Looking at the problem from the other end, it appears that the state has made relatively little effort to increase *prevention* of these kinds of oil spills. The DFG's responsibility is effectively limited to assessing a spill *after the fact* and coordinating the cleanup work of others if it deems this work necessary. Other state agencies involved in oil and gas industry safety regulation, such

as the SLC, DOG or Coastal Commission, do not have the resources (or often the jurisdiction) to monitor a large number of potential sources of small oil spills. There are also a large number of potential sources that are not directly related to the oil and gas industry, such as manufacturing plants, trucking, and small storage tanks. Finally, since a sizeable portion of actual spills appear to be intentional but surreptitious, much of the burden of prevention falls on local and state law enforcement, which may not have sufficient resources to adequately serve as a deterrent.

Local Agencies Not Always Adequately Involved

Small local governments usually do not have the personnel or technical resources that would enable them to help prevent or respond effectively to small oil spills and minimize environmental damage. Additionally, local agencies do not commonly have their own specific oil spill response plans (as part of their overall emergency planning), nor do they often participate with state and federal agencies in oil spill response planning drills that can help improve interagency coordination in actual spills where this becomes necessary. Furthermore, in cases where the local response agency is not the first to learn of a spill, it sometimes is not informed of the incident until a significant amount of time has lapsed.

HOW CAN THE STATE IMPROVE SMALL OIL SPILL PREVENTION AND RESPONSE?

In addition to measures to address the possibility of another major offshore oil spill, the Legislature should give some attention to the more common, but less visible problem of chronic, relatively small oil spills. In so doing, the Legislature first needs to address the following questions:

- Is the *current* system essentially sound, needing only marginal changes to improve the state's role in preventing and responding to this problem; *or*
- Is the current system ineffective, warranting a closer look at alternative systems for small spill prevention and response?

In either case, the Legislature has options to improve small oil spill prevention and response.

Changes to the Current System

If the current system is retained, the Legislature may wish to consider the following possible changes to address the system's shortcomings.

More Emphasis on Small Spill Prevention. As in the area of major offshore oil spills, one focus of state activity should be lessening the number of actual spills to which the state needs to respond by strengthening ways to prevent small oil spills from occurring. Toward this end, it is critical that individuals and firms face strong incentives to prevent spills. This could be achieved through various means: tougher enforcement by various state agencies (such as the DFG and the SWRCB) of existing regulations and statutes concerning oil discharges; more field patrol and surveillance; and the active use of existing state liability laws to prosecute for damages when a responsible party can be identified.

Improved Communication and Reporting. As described above, complete information on the extent and magnitude of the small oil spill problem is not available under the current system. In part, this could be improved by: (1) more publicity about and enforcement of existing law requiring responsible parties to report spills immediately to the OES warning center; and (2) requiring all state agencies involved in oil spill response to report incidents to the OES, since the OES already is set up to act as a communications center. These steps would provide more timely notice of spills.

In addition, efforts to (1) increase local agency understanding of and compliance with the CHMIRS reporting requirements and (2) ensure that all DFG field reports on spills are forwarded to DFG headquarters for summation would provide better data on which to base decisions to adjust the state's response systems. Finally, for those cases where a local agency is not the first on the scene, the OES should contact the proper local agency as quickly as possible to inform it of the incident.

More Resources for Response. Although the DFG is the lead state agency for oil spill response, it lacks sufficient resources to perform this function effectively. Additional field staff would give the the DFG the ability to require the cleanup of many spills that it now must trust nature alone to take care of, and to discover spills that now go undetected. Funding for this staff could come from increased penalty revenues to the DFG's Pollution Cleanup and Abatement Account or from assessments on producers, transporters and users of specified kinds of oil. Regardless of the methods used, however, any proposals to improve the DFG's response to oil spills should include specifically the *small* spill issue as part of the plan, so that, in addition to resources to address the possibility of major offshore oil spills, resources can be focused on *this* issue.

Alternatives to the Current System

If, on the other hand, the Legislature concludes that the current system is inadequate, it may wish to consider the following alternatives.

Change in Lead Response Agency. The current organizational structure, designed primarily to cope with large coastal spills, may not be the appropriate one for coordinating a statewide response to daily small spills. The State Interagency Oil Spill Committee (SIOSC) made an administrative decision to select the DFG as the lead agency for both purposes. The Legislature, however, has not expressed its preferences. In our view, the DFG may not be the most fitting lead agency for this purpose, since fish and wildlife and their habitat is only one concern out of many. (In addition, in our review of the DFG in the *Analysis of the 1990-91 Budget Bill,* we note that the department is having some severe fiscal problems. These problems are likely to affect the department's ability to direct resources to small spill response.) Other possible lead agencies include the SLC, the OES, the SWRCB, or the Environmental Affairs Agency. Alternatively, the SIOSC could be charged with developing a new, more effective state organizational structure to improve response to small spills.

Increased Local Response Efforts. The local level may be the most appropriate one for many small oil spill prevention and response activities, since most incidents of this type begin in and often are confined to a relatively small area, and do not cross jurisdictional boundaries. The state could provide increased training and technical assistance to local agencies to help improve their efforts in the areas of prevention and response preparedness. In addition, it may be appropriate to require local governments to (1) incorporate a specific *oil* spill response plan into their local contingency planning and (2) participate in oil spill response planning drills with state agencies, to help ensure timely and suitable measures in the event of a spill. Such requirements potentially would constitute state-reimbursable mandates.

SUMMARY

Major offshore oil spills are a very real concern in California, and steps can be and are being taken to address this issue. However, the less visible issue of chronic, small oil spills, many of which occur onshore, also warrants attention because of the cumulative environmental consequences. There are several alternatives for the Legislature to consider that would improve the state's role in preventing and responding to these small spills.

Health Care in Rural California

How Can the Legislature Improve Health Care Services in Rural California?

Summary

Access to health care in rural areas is limited, in part due to long distances between isolated communities, rough weather conditions, and depressed economies. Over the years, access has been further restricted by the closure of rural facilities and the failure of rural communities to attract and retain health personnel. Existing reimbursement and regulatory policies also play a role in limiting the number of providers, and thereby restrict access to health care.

Currently, there are various state programs designed to address some of these issues. However, our review suggests that these programs have limited success in improving access to health care in rural areas, partly because these programs are not coordinated. To address this concern, we recommend that the Legislature strengthen the state's leadership role and designate a lead agency on rural health issues. In addition, we recommend that the lead agency develop a systematic approach to assisting rural health care providers and that state agencies evaluate adjustments to the regulatory and reimbursement systems affecting rural health providers.

INTRODUCTION

Over the past several years, the Legislature has taken numerous actions to address problems with rural health services. Primarily, these actions have been in response to rural hospital closures, continued financial distress of current facilities, and difficulties in recruiting and retaining health professionals. Our review indicates that, despite these legislative efforts, current state programs do not address these problems in a comprehensive way.

In the following pages, we examine health care services in rural areas within the state. Specifically, we (1) review the characteristics of rural areas and health care services in these areas, (2) discuss current state programs, (3) highlight specific problems we identified within the existing services, and (4) suggest ways the Legislature could improve the provision of health care services to rural areas.

WHAT ARE THE CHARACTERISTICS OF RURAL AREAS?

Defining "Rural"

There are numerous inconsistent definitions of "rural" in use by different state and federal programs. For this analysis, we have chosen to focus on counties that (1) are not classified as a Metropolitan Statistical Area (MSA), (2) are not part of a Consolidated Metropolitan Statistical Area (CMSA), and (3) have a total population of 200,000 or less. Under this definition, 25 of the 58 counties in California are considered rural. Figure 1 lists these counties and displays data on the population and the number of hospitals and clinics in each county.

This definition has the limitation of excluding rural areas *within* urban counties. We did not include these areas because most of the data are available only by county. We recognize that these areas within urban counties share many of the characteristics and problems of rural counties.

Low Population Density

Rural counties in California are sparsely populated. The average population density for these 25 counties is 29 persons per square mile with a range of 1 (Alpine) to 99 (Colusa) persons per square mile. In comparison, the density is 2,131 persons per square mile in Los Angeles, 568 in Sacramento, and 16,251 in San Francisco. The total permanent population living in rural counties is 4 percent of the state's population.

Population Swings

Some rural areas experience large swings in their population. Seasonal workers, for example, contribute to temporary population growth in counties where agriculture is a major economic activity. Counties with national and state parks and other resort areas also host significant numbers of seasonal tourists and workers.

Figure 1

Rural Counties in California Population and Number of Health Facilities

County	Population[a]	Number of Hospitals[b]	Number of Clinics[c]
Alpine	1,190	—	—
Amador	29,150	1	2
Calaveras	32,400	1	—
Colusa	15,500	1	—
Del Norte	20,400	1	—
Glenn	23,600	1	1
Humboldt	116,800	6	4
Imperial	115,700	3	4
Inyo	18,200	2	1
Kings	96,000	4	—
Lake	52,100	2	1
Lassen	28,800	1	4
Madera	83,800	2	3
Mariposa	14,800	1	—
Mendocino	76,900	5	5
Modoc	9,375	2	1
Mono	9,800	2	—
Nevada	78,800	2	—
Plumas	20,050	4	2
San Benito	35,250	1	1
Sierra	3,600	1	1
Siskiyou	43,750	2	3
Tehama	47,250	3	—
Trinity	14,000	1	1
Tuolumne	49,000	3	1

a Source: Department of Finance 1989 population estimates.

b Source: Office of Statewide Health Planning and Development (OSHPD) Licensed Services and Utilization Profiles, 1988.

c Source: OSHPD 1985 Annual Report of Clinics as reported in Community Clinic Fact Book, 1987.

Most rural hospitals are small. All but two of the 51 hospitals in rural counties have fewer than 100 beds; and one-half have fewer than 50 beds. The occupancy rate for acute care beds in these hospitals is low, averaging 33 percent in 1988. In comparison, the statewide occupancy rate was 53 percent. The occupancy rate for rural hospitals varies significantly from day to day, and many facilities experience seasonal fluctuations associated with the influx of tourists and workers. Rural hospitals generally focus on primary care and emergency services. For instance, 63 percent of these hospitals have licensed intensive care units, and 55 percent have designated obstetrical beds. These hospitals generally do not have extensive specialty departments.

Many Rural Hospitals Are Financially Distressed. In 1988, 29 out of 42 rural hospitals (data were not available on the other 9) had negative operating margins. In other words, patient service revenue did not cover operating expenses. On the average, patient service revenues for 28 of the 29 hospitals were 7.3 percent below operating expenses. (We excluded Mono General Hospital because it had one-time revenue problems that gave it an extremely low operating margin.)

Generally, this gap is made up with nonpatient revenue such as district tax revenue (for district hospitals), private contributions, and county contributions (for county hospitals). Over time, operating shortfalls mean that the hospitals are unable to maintain the physical plant, replace equipment, and make other capital improvements. For some hospitals, it leads to closure. (Ten rural hospitals have closed during the last 13 years.)

The reasons for this financial distress appear to be:

- ***Difficulty in Covering Fixed Costs.*** Hospitals cannot cover their fixed costs due to low patient volume. Fixed costs are those incurred by the hospital regardless of how many patients they have.
- ***Costly Supplemental Services.*** Hospitals that are unable to cover their fixed costs may further contribute to their financial distress by adding costly supplemental services. This is in response to community demands for a full range of services, and the hospitals' attempts to attract and retain health professionals. For example, some hospitals purchase sophisticated medical equipment, such as computerized tomography (CT) scanners. In some cases, however, these hospitals do not have the patient volume to support such expenditures or services.
- ***Cash-Flow Problems.*** Rural hospitals have relatively small budgets that cannot easily absorb fluctuations in

Isolated Communities and Sparse Services

Rural counties characteristically have sparse services, and their communities are relatively isolated from one another in terms of miles and physical terrain. Travel along a limited network of roads is made even more difficult by rain, fog, or snow. For example, winter conditions in Modoc County can close the roads into Cedarville, leaving that community isolated for days at a time.

Weak Economies

Rural counties generally have weaker economies than the rest of the state. Economic growth in California has occurred in industries that, for the most part, are not located in rural counties. For example, the statewide job growth rate during the 1980s was 18 percent. Eighty percent of this growth occurred in the service (primarily business and financial services), trade, and finance industries. These sectors account for a very small part of the economic activity in rural areas. The economic base in most rural counties includes manufacturing, agriculture, tourist ser-vices, mining, and government. In the past decade, manufacturing employment grew by only 5 percent, employment in both agriculture and mining actually fell, and government employment increased only modestly.

In a large number of the 25 rural counties, the unemployment rate and the percentage of the population living below the poverty level are higher than the statewide average. Based on 1988 Employment Development Department data, 23 of the 25 rural counties had an unemployment rate higher than the statewide average. In 1987-88, 17 of the 25 rural counties had higher monthly average AFDC caseloads per capita than the statewide average.

WHAT ARE THE CHARACTERISTICS OF RURAL HEALTH SERVICES?

Our review of rural health services is based on visits to 30 facilities in 16 counties; discussions with local providers, program administrators, and other interested parties; and examination of data on rural health services. We discuss our findings below.

Inpatient Care

There are 51 hospitals in the 25 rural counties. All of the counties except Alpine have at least one hospital. Distances between hospitals can be as great as 100 miles.

revenues. These fluctuations are due to swings in occupancy and delays in Medi-Cal and Medicare reimbursements. These revenue fluctuations create cash-flow problems for many of these hospitals.

- ***High Personnel Costs.*** Rural hospitals are affected by the statewide nursing shortage. As a result, many of them hire "registry" nurses provided by personnel agencies on a temporary basis at a *higher* cost than permanent nursing staff.
- ***Difficulty Attracting Personnel.*** Hospitals have difficulty in attracting health professionals and administrators due to geographic isolation and limited resources to offer competitive wages. Without sufficient personnel, a hospital can lose patients and, therefore, revenue.
- ***Variations in Administrative Effectiveness.*** Hospital administrators have varying levels of sophistication and knowledge of state programs which, in turn, determine the extent to which they are successful in securing technical assistance and funding. Administrators also vary in their ability to deal with regulatory and reimbursement requirements, as well as the day-to-day operation of the hospital.

Emergency Medical Services

There are two components of emergency medical services: pre-hospital emergency care and hospital emergency room care. Pre-hospital emergency care includes ambulance services and emergency medical personnel. Because of the distances between hospitals in rural areas, pre-hospital emergency care is critical.

One of the primary functions of the rural hospitals is to provide emergency services. All rural hospitals have emergency rooms where patients can be stabilized prior to their transfer to a facility with comprehensive medical services.

The Availability of Emergency Vehicles and Their Staffing Vary Among the Counties. In some counties, emergency vehicles are staffed with paramedics, who are able to provide advanced life support services. In other counties, emergency vehicles are staffed with emergency medical technician-IIs (EMT-IIs), who can provide "limited" life support services, or EMT-Is, who can provide "basic" life support services only.

Outpatient Services

Rural counties have high population-to-physician ratios. The average ratio is 1,034 persons per physician in rural counties,

with a range of 371 persons per physician in Inyo to 3,371 in Glenn. By comparison, the ratio is 381 in Los Angeles, 497 in Sacramento, and 161 in San Francisco. According to the Office of Statewide Health Planning and Development's (OSHPD's) 1987 California State Health Plan, 20 of the rural counties do not meet the OSHPD's standard of adequacy for primary care physicians—no more than 1,205 persons per primary care physician. (Note: These ratios do not reflect the availability of other professionals who practice in conjunction with physicians.)

Outpatient services are also provided by community clinics. As Figure 1 shows, there were 35 such clinics in 16 of the 25 rural counties in 1985. Nine of the counties did not have a clinic.

Certain Outpatient Services Are Difficult to Find. Access to specialty services such as orthopedics and obstetrics often is particularly limited. For example, during our visit to Mendocino County, we found that there are *no* practicing obstetricians providing prenatal services.

Access problems are even more difficult for Medi-Cal recipients. In Needles, for example, none of the three local physicians accept new Medi-Cal patients, nor does the hospital provide outpatient services. In this case, a new Medi-Cal patient has to travel long distances to see a physician who accepts Medi-Cal.

WHAT PROGRAMS CURRENTLY AFFECT RURAL HEALTH SERVICES?

Figure 2 provides specific information on state programs that affect rural health services. Below we discuss some of these programs.

Department of Health Services

Licensing and Certification. The Licensing and Certification Division licenses health facilities and performs certification reviews on behalf of the federal government at facilities that seek to qualify for Medicare or Medi-Cal funding.

In addition to its licensing and certification functions, the division conducts other programs that benefit rural facilities. Under the "swing bed" program, rural hospitals with up to 50 beds designate certain licensed general acute care beds that may be used as skilled nursing beds. For rural hospitals that have a low acute care patient load, the program allows filling a bed that would have been empty otherwise. According to 1988 data, the state has 202 designated swing beds located in 14 rural facilities.

The division has also had for many years the authority to allow facilities to use alternate approaches and techniques to

Figure 2

State Programs Affecting Rural Health Services

Division	Specific Programs or Activities Affecting Rural Providers	Amount of Funding 1989-90
Department of Health Services		
Licensing and certification	"Swing bed" program	—
Medical care services	1. Provides reimbursement for medical services	Unknown amount for rural areas
	2. Supplementary rates for outpatient services provided by rural hospitals	$4 million
	3. Distinct-part skilled nursing facility and swing bed reimbursement programs	Unknown amount for rural areas
Rural and community health	1. County Medical Services Program	$60 million General Fund; $10 million from AB 75 (Proposition 99) funds; $4 million from Immigration Reform and Control Act (IRCA) funds
	2. Other AB 75 provisions	Share of $82 million for county capital outlay; $7 million for hospital uncompensated care
	3. Rural Health, Indian Health, Farmworker Health, and Clinics Programs	$9 million General Fund; $23 million from IRCA funds; share of $20 million from AB 75
	4. Hospital and medical standards program	—
Family health services	Various	Unknown amount for rural areas
Office of Statewide Health Planning and Development		
	1. "Program flexibility"	—
	2. Review of state regulations applicable to small and rural hospitals	—
	3. Alternative Rural Hospital Demonstration Project	—
	4. Health professions development	—
	5. Song-Brown Family Physician Training Program	$2.9 million
	6. Rural Hospital Grant Program	Depends on amount of excess Cal-Mortgage reserves; not implemented yet

Program	Specific Programs or Activities Affecting Rural Providers	Amount of Funding 1989-90
Emergency Medical Services Authority		
	Financial support for rural regional emergency medical services agencies	$1.2 million
California Health Facilities Financing Authority		
	1. County Health Facilities Financing Assistance Fund	$10 million one-time funds
	2. Hospital Equipment Loan Program	$3.9 million one-time funds
	3. Short-term adjustable-rate taxable securities	Not fixed—depends on loan applications; started 1989
	4. Pilot program providing loans for capital expenditures required by state regulations	Total of $3 million over four years; started 1989

meet statutory requirements or regulations. Chapter 67, Statutes of 1988 (AB 1458, Jones), transferred the responsibility for reviewing "program flexibility" requests by small and rural hospitals to the OSHPD.

Medi-Cal. Medi-Cal reimburses necessary health care services provided to public assistance recipients and to other individuals who meet the program's income requirements. Medi-Cal is an important source of revenue for many rural providers. For example, on average, Medi-Cal represents 17 percent of patient revenues for the 42 rural hospitals for which data were available. Generally, Medi-Cal reimburses inpatient services in rural hospitals based on facility-specific costs. Outpatient services, including physician and clinical services, are reimbursed on a flat-rate fee-for-service basis.

In addition to these general reimbursements, the Medi-Cal Program has two provisions directed specifically towards rural providers. First, Medi-Cal currently provides supplementary rates for outpatient services provided by small and rural hospitals. Chapter 1476, Statutes of 1987 (SB 1458, Keene), established the program with a one-time appropriation of $4 million ($2 million General Fund). Each of the eligible hospitals received rate augmentations based on their share of paid outpatient services claims. This augmentation has been continued in later Budget Acts and the 1990 Budget Bill.

In addition to hospital, physician, and clinical services, the Medi-Cal Program reimburses skilled nursing services. Some rural hospitals have converted a wing to a "distinct-part skilled nursing facility" (DP/SNF). Because skilled nursing patients generally stay longer than acute care patients, DP/SNFs provide

the hospital with a more stable patient base. Other rural hospitals participate in the swing bed program (discussed above).

Rural and Community Health. The Rural and Community Health (RCH) Division distributes funds to counties and local providers through various programs.

The Medically Indigent Services Program (MISP) funds counties to provide health care for indigents. Through the County Medical Services Program (CMSP), the state provides these services in counties with populations of less than 300,000 (based on the 1980 census) that wish to participate. All but two (Lake and Mendocino) of the 25 rural counties we identified for this analysis are participants in the CMSP. Funding for the CMSP in 1989-90 is $60.4 million from the General Fund and $4 million from Immigration Reform and Control Act (IRCA) funds for services to newly legalized persons.

The CMSP has been expanded in the current year under Ch 1331/89 (AB 75, Isenberg), which implemented the Tobacco Tax and Health Protection Act of 1988 (Proposition 99) and established a variety of programs. For 1989-90, AB 75 includes $10 million to expand the scope of benefits covered under CMSP and reimburse health care providers in CMSP counties for emergency services provided to out-of-county indigent patients. Some of these funds are being used to encourage innovative approaches to providing rural health services, such as rotating dentists through multi-county areas.

Assembly Bill 75 also includes $82 million for county capital outlay, a portion of which will go to rural counties, and $7 million to reimburse CMSP counties and providers for uncompensated care.

The Rural Health, Indian Health, Farmworker Health, and Clinics Programs provide grants to counties, clinics, and other providers for services to special populations primarily in rural areas. General Fund support for these programs had remained virtually unchanged for the past five years at $9.5 million, with essentially the same providers receiving grants each year. In the current year, this funding was reduced to $8.5 million due to the availability of IRCA funds. In addition to receiving a share of IRCA funds, rural clinics receive a share of AB 75 funds.

In addition to distributing funds to counties and health care providers, the RCH Division provides technical assistance to counties and facilities. Some of this assistance is provided by RCH staff in the course of administering the various grant programs. Chapter 1209, Statutes of 1988 (SB 2549, Keene), required the department to (1) establish a process for identifying strategically

located, high-risk rural hospitals and (2) provide expert technical assistance for those hospitals. Although this program, called the Hospital and Medical Standards Program, provides technical assistance to rural hospitals in distress, a specific listing of strategically located, high-risk rural hospitals has not yet been developed.

Family Health. The Family Health Services Division addresses the special needs of women and children through various programs. Although funds are not targeted specifically at rural providers, they provide a major source of funds for many rural community clinics.

"Safety Net Policy." The Department of Health Services (DHS) established a "safety net" policy in 1988, under which county facilities, providers serving a disproportionate share of Medi-Cal patients, community clinics, and other "safety net" providers have priority for obtaining financial and technical assistance and flexibility in the application of licensing statutes and regulations. Under this policy, a number of financially distressed rural facilities have been assisted by licensing and certification, Medi-Cal, and public health program staff.

Office of Statewide Health Planning and Development

Demonstration Projects. In addition to transferring responsibility for reviewing "program flexibility" requests from the DHS to the OSHPD, Ch 67/88 required the OSHPD to:

- Undertake a comprehensive evaluation of small and rural hospital licensing and building regulations.
- Adopt emergency regulations waiving or modifying unnecessary or unduly burdensome requirements for small and rural hospitals.
- Report to the Legislature on whether or not alternative standards for small and rural hospitals should be adopted permanently.

Pursuant to Chapter 67, the OSHPD is also designing an alternative rural hospital model pilot project. The model would emphasize regulatory relief rather than increased reimbursement. Under this project, participating hospitals would be subject to a different set of state requirements. For example, they would provide five "core" services deemed minimally necessary to ensure basic health services in rural areas. In addition, they would employ a new health profession category. In connection with developing the model, the OSHPD is reviewing licensing requirements that apply to small and rural hospitals.

Health Professions Development. The office administers various health occupations pilot projects, some of which are specifically oriented to address rural needs. For example, 1980 pilot projects demonstrated that it was safe for ambulance drivers to perform selected medical and nursing procedures on trauma and heart attack patients before they reached the hospital. This resulted in a 1981 statute recognizing emergency medical technician IIs. Other pilot projects resulted in the recognition of nurse practitioners and nurse midwives, as well as regulations allowing appropriately trained physician assistants to furnish and dispense drugs.

The office also administers programs designed to increase and improve the recruitment and retention of health professionals. The largest program is the Song-Brown Family Physician Training Program. In the current year, the program has $2.9 million from the General Fund to support the training of approximately 300 family physicians, family physician assistants, and family nurse practitioners. The Song-Brown program is not specifically designed for rural areas. Rather, it helps rural areas to the extent that it supports the training of family practitioners. Based on our visits and 1987 OSHPD data, family practitioners provide most of the physician care in rural counties.

Facilities Development. The office reviews health facilities construction projects to assure that they conform with federal, state, and local building requirements, including seismic safety requirements. Facilities may seek "program flexibility" on building requirements from the office.

The office also administers the California Health Facilities Construction Loan Insurance (Cal-Mortgage) Program, which insures facility loans. The program is funded by annual premiums paid by insured health facility projects. Under Ch 898/89 (SB 1293, Maddy), any excess Cal-Mortgage reserve funds are available to support the Rural Hospital Grant Program. Small and rural hospital projects meeting specified criteria would be eligible for grants of up to $250,000 from this program, when, and if, it becomes operational.

Emergency Medical Services Authority

The Emergency Medical Services (EMS) Authority reviews local emergency medical services programs and establishes statewide standards for emergency personnel. The authority also administers General Fund support for certain rural regional EMS agencies. The 1989 Budget Act includes $1.2 million for five rural regional EMS agencies. Each agency may receive up to one-half of the total cost of operating a minimal EMS system for that region, as defined by the authority.

California Health Facilities Financing Authority

The California Health Facilities Financing Authority (CHFFA) issues revenue bonds to assist nonprofit agencies, counties, and hospital districts in financing the construction and renovation of health facilities. Because of its ability to issue tax-exempt bonds, the CHFFA provides lower-cost financing to qualified institutions than they would be able to secure on the open market.

In the past, some rural counties and providers have found it hard to take advantage of this source of funds due to their difficulty in proving they can repay the bonds. In some cases, the Cal-Mortgage Program has guaranteed repayment of covered facility loans in the event of a default. In addition, the CHFFA has initiated several special programs targeted at county facilities and small and rural hospitals (detailed in Figure 2). The Legislature has also passed legislation to assist rural facilities in obtaining CHFFA funding. Through these efforts, many rural facilities have received limited financial assistance.

The Federal Government

In this section, we briefly highlight four federal programs and policies that affect rural health care: the Medicare Program, the National Health Service Corps, the Rural Health Clinic Act, and the Office of Rural Health Policy.

The Medicare Program. The Medicare Program is a major revenue source for rural providers. Medicare represents, on the average, 34 percent of patient revenues for the 42 rural hospitals for which data were available. In 1983, Medicare established a fixed payment schedule for hospitals based on a patient classification system known as Diagnostic Related Groups (DRGs). This system assumes that, on average, actual costs will be covered by DRG reimbursement levels. However, low-volume providers (including most rural hospitals) face a higher degree of financial risk than high-volume providers because they see a relatively small number of Medicare patients and they experience dramatic fluctuations in patient volume. As a result, their chances of offsetting high-cost cases with profits from lower-cost cases over a given time period are diminished.

In addition, rural hospitals receive a lower reimbursement rate for the same diagnosis than urban hospitals. Overall, average Medicare payments to rural hospitals are *40 percent less* than those to urban hospitals. Rural providers and others have argued that this reimbursement differential does not reflect actual costs of providing health care in rural areas. In response to this, Congress has taken steps to narrow the differential between urban and rural reimbursement rates.

Different reimbursement formulas apply to hospitals designated as Sole Community Hospitals (SCHs) or Rural Referral Centers (RRCs). SCHs receive a partially cost-based reimbursement rate and additional payment protections. Currently, 40 hospitals in California are designated SCHs (not all of them are rural). Being designated an SCH is not always an advantage, however; a hospital with relatively low costs may get a higher level of reimbursement under the DRG system.

Hospitals qualifying as RRCs are reimbursed at the higher urban rate. However, in order to qualify, a facility must have at least 275 beds. This requirement precludes rural facilities in California from obtaining RRC status, because all have fewer than 275 beds.

Medicare is currently administering a two-year Rural Health Care Transition Grant Program to assist small rural hospitals in modifying their services to adjust for changes in service population, clinical practice patterns, and other factors. Each hospital may receive a grant of up to $50,000 a year. Four California hospitals have received grants to date, three of which are in rural counties.

For physician services, Medicare generally determines a "reasonable charge" and reimburses physicians 80 percent of this amount. To the extent that physicians' charges for the same services vary both across and within communities, Medicare reimbursements vary.

National Health Service Corps (NHSC). The NHSC was designed to provide health personnel to designated health manpower shortage areas. The NHSC consists of two programs. The scholarship program pays tuition for medical, dental, and other allied health students in return for a minimum two years of service in a designated shortage area after completion of training. The second program provides up to $20,000 a year to practitioners at the end of their training to pay off school loans. In exchange, they commit to serve a minimum of two years in a designated shortage area.

Although the NHSC has played a significant role in providing personnel to rural areas, this role has been declining dramatically in recent years because overall funding for the program has declined, the scholarship program is being phased out, and the loan repayment program is limited.

Rural Health Clinic Act (Public Law 95-210). The Rural Health Clinic Act of 1977 (Public Law 95-210) increased the Medicare and Medicaid reimbursement rates for clinics that provide services in rural, medically underserved areas and employ

a nurse practitioner or physician assistant. Currently, there are 47 designated "95-210 clinics" in 39 medically underserved rural areas in California. One obstacle to expanding the number of designated clinics is the limited information about the program at both the local and state levels. Apparently, the paperwork required for qualification also discourages many clinics from pursuing this option.

Office of Rural Health Policy (ORHP). The ORHP was established in 1988 to (1) advise the Department of Health and Human Services (DHHS) on the effects that Medicare and Medicaid programs have on access to health care for rural populations; (2) coordinate rural health research within DHHS and administer a grant program; (3) provide staff support to the National Advisory Committee on Rural Health, which was established in September 1988 to advise the Secretary of DHHS on rural health issues; and (4) develop a national clearinghouse for the collection and dissemination of rural health information.

The office maintains contact with state agencies on an "ad hoc" basis.

Counties

Under Section 17000 of the Welfare and Institutions Code, counties are considered the "providers of last resort" for health services to indigent residents. The funds provided to counties through the MISP, CMSP, and other state programs assist counties in meeting this obligation. Most state program funds allocated to counties may be distributed at county discretion. Urban counties generally play a major role in providing health services to indigent persons. Although the level of involvement varies among rural counties, most of them play a more limited role in health care service delivery.

WHAT ARE THE OUTSTANDING ISSUES IN CURRENT STATE PROGRAMS?

As described above, there are many governmental programs designed to improve access to health care services in rural areas. In the following discussion, we identify problems that limit the effectiveness of these programs. We frame our discussion within the four main roles of the state: leadership, support, regulation, and reimbursement.

Leadership Role

Our review indicates that there are several problems with the way the state currently implements existing programs.

State Programs Are Not Coordinated. Current state programs intended to improve access to health services in rural areas do so in a piecemeal and fragmented fashion. As described above, there are several divisions within several state departments, all providing services to rural areas. However, the various programs are not coordinated by a lead agency, thereby resulting in duplication of certain services and gaps in others. For example, there are several programs that are aimed at rural hospitals in distress but no existing program providing ongoing funding for hospitals. Additionally, multiple definitions of the term "rural" contribute to inconsistencies in eligibility requirements between programs. As a consequence, providers have difficulties determining what programs exist and whether they are eligible for assistance.

The State Provides Limited Assistance. Providers cannot take full advantage of existing programs because, in addition to the lack of coordination and varying eligibility requirements, information regarding these programs is not readily available. From our field visits, we found that many rural health care providers were not aware of state programs designed to assist them. Currently, for example, although the RCH Division has implemented several programs for assisting rural clinics and hospitals, it provides technical assistance primarily *in response to* specific requests from facilities. Thus, facilities that are not aware that technical assistance is available from RCH may go without it. Moreover, the state has not assisted providers by making available information on federal programs. For example, no agency has taken an active role in assisting clinics to qualify for designation under federal Public Law 95-210.

The State Has Not Provided Certain Key Central Services. Certain activities, such as designing data collection systems, evaluating services, and providing technical assistance, are more efficient and effective if carried out centrally. However, the state has not done this. For example, statewide evaluation of the adequacy of emergency medical services is very difficult because the state has not yet developed a uniform, standardized data collection system for the availability and utilization of emergency medical services. As a result, although the local EMS agencies maintain some data, these data cannot be used to draw conclusions about the status of the state's EMS system.

The State Could Foster More Innovation. Various departments are currently implementing innovative programs and policies to improve health care services in rural areas, such as the DHS "safety net" policy, the OSHPD's alternative rural hospital demonstration project, and AB 75 rural health projects. Of these programs, the OSHPD's alternative rural hospital demonstration project appears to be the most promising because of its potential

to permanently address some of the regulatory problems of small and rural hospitals. The future of AB 75 projects, on the other hand, will be uncertain unless funding is extended at the end of the budget year. Despite these creative steps, there are many other ways the state could help foster innovation. For instance, the state could encourage the development of third-party billing, rotating specialists, and risk pools.

Support Role

Band-Aid Approach to Assisting Hospitals. State efforts to assist hospitals through routine or emergency funding have been haphazard. The state has taken a "band-aid" approach by providing funding to hospitals on a reactive, emergency basis, as opposed to "stepping back" to assess such issues as whether the facility is critical to health care access and whether financial assistance is the solution to the facility's problem. For example, the Hospital and Medical Standards Program has not identified strategically located, high-risk rural hospitals as required by Ch 1209/88.

Problems in Program Implementation. At times, program implementation limits the impact state assistance programs could have on rural health services. For example, the clinics programs have continued to fund the same providers year after year without reexamining the need for the subsidy. There are also state programs that, for various reasons, have not been implemented. For example, the RCH Division never implemented the California Health Services Corps, authorized in 1976. This was because of limited funding and problems with the program design (that is, implementing the program through state civil service).

Some Program Requirements Preclude Participation by Rural Providers. Rural facilities have difficulties in obtaining funding under some programs due, in part, to specific program requirements. For example, some loan programs sponsored by the CHFFA have minimum loan amount requirements that rural facilities cannot meet. Although the CHFFA has taken steps to allow small and rural hospitals to take advantage of certain loan programs, these programs are generally limited in scope.

Regulatory Role

Licensing Regulations Do Not Recognize Unique Characteristics of Rural Providers. Current DHS licensing regulations make no distinction between rural and urban facilities. Given that rural facilities are a small percentage of total hospitals in California (the 51 rural hospitals in the 25 counties we exam-

ined account for only 10 percent of California's general acute care hospitals), regulations do not distinguish between urban and rural facilities. In some cases, these regulations may not address the circumstances in which rural providers find themselves. For example, by regulation, a general acute care hospital must include surgery as a basic service. However, some rural hospitals cannot economically equip and staff the number of operating rooms required by regulations because of their low occupancy rate. In addition, the hospitals may have trouble recruiting qualified surgical staff. One of the hospitals we visited has operating rooms that have not been used in years because it does not have the required staff to perform surgery. The OSHPD is currently reviewing regulations that apply to small and rural hospitals in view of this conflict.

Inconsistent Interpretation of Regulations. A number of rural hospital administrators we interviewed cited inconsistent interpretation and enforcement of regulations as a major problem. They also expressed frustration with the lack of assistance provided by inspectors in addressing regulatory problems. We have no basis for determining how widespread these concerns are. Licensing and certification staff acknowledged, however, that there have been some problems. The department indicated it is taking steps to assure consistent interpretation and enforcement of regulations.

Information Flow to Rural Providers Insufficient. Although there are a variety of programs designed to address regulatory problems of rural providers, we found that administrators are not always well informed of state regulatory changes, new legislation, and special policies like "program flexibility." Hospitals receive most of their information from organizations and associations, which require membership fees of thousands of dollars. There is minimal information that comes directly from the state.

Reimbursement Role

Reimbursement Procedures Are Complex and Technical Assistance Is Limited. Reimbursement procedures for state programs—primarily Medi-Cal—continue to be complex and burdensome for some rural providers. Billing errors result in payment delays, which contribute to the cash-flow problems of many rural providers. We found that many rural health care providers felt they had no recourse at the state level to address billing problems. They could not determine whom to call to resolve questions or billing problems in a timely fashion.

Medi-Cal Reimbursements May Not Cover Current Costs. Although the Medi-Cal reimbursement rate for most rural provid-

ers is cost-based, payments to facilities may not cover the current costs for Medi-Cal patients. This is because of two reasons. First, the payment formula includes adjustments for previous years' disallowed claims. Second, facilities' actual costs may not be covered because the maximum inpatient reimbursement level (MIRL) caps Medi-Cal reimbursements. The MIRL caps the level of increase in a facility's reimbursement rate based on a complex formula involving case mix and other factors. While these adjustments may be justified, a rural hospital may not have sufficient reserves to cover shortfalls in payments.

HOW CAN THE LEGISLATURE IMPROVE DELIVERY OF RURAL HEALTH CARE SERVICES?

Our review indicates that rural areas share common characteristics. Generally, rural areas tend to be geographically isolated, sparsely populated, and have relatively weak economies. These areas also share common problems with respect to the delivery of health care services. Specifically, they have a limited number of health care providers, hospitals are financially distressed, emergency medical services and specialty care are limited, and it is difficult to attract health professionals.

There is a strong state interest, as shown by the plethora of existing programs, in maintaining and improving access to health care in rural areas. In order to address the problem areas described above, we believe there are several steps the Legislature can take to improve health service delivery in rural areas.

Major Legislative Decisions

As a first step to improving access to health care in rural areas, the Legislature should explicitly address the following issues:

- ***Rural Areas and Rural Health Facilities.*** The existing variation in definitions of rural counties and areas and rural health facilities leads to confusing and overlapping categories. The state needs to develop a statewide definition of rural areas and rural health facilities.
- ***Adequate Access to Health Services.*** The state needs to define the *minimum level* of health services it is willing to ensure in rural areas. Adequate access needs to be defined in terms that take into account the isolation, weather, and road conditions that characterize rural areas.
- ***Distinctions Among Rural Providers.*** The state also needs to determine if all rural providers should be treated

equally. It may be that certain rural providers (for example, geographically isolated ones) should be given priority in state assistance programs.

- ***Funding Commitment.*** Finally, the state must decide the level of funding dedicated to rural health services.

Strengthen the State's Leadership Role

We recommend that the Legislature designate a lead agency to coordinate the state's rural health programs.

The state needs to exercise a greater coordinating role to ensure that existing and future programs improve health care in rural areas without duplicating services. Accordingly, we recommend that the Legislature designate a lead agency to coordinate these programs. The lead agency's mission should be to implement the major legislative decisions discussed above with respect to rural health care.

In addition, the lead agency should be responsible for overseeing technical assistance, coordinating state programs, providing information on rural health assistance programs, and ranking providers for purposes of targeting state assistance programs. Specifically, the functions of the lead agency should include, but not be limited to, the following:

- ***Provide Information on State and Federal Programs Available to Assist Rural Providers.*** For example, the lead agency could assist interested rural facilities in qualifying for programs that allow them to receive higher reimbursement rates or regulatory relief.
- ***Establish Standards for EMS Adequacy.*** To assure availability and access to EMS services, the lead agency could direct the EMS Authority to (1) establish standards of adequacy for EMS services, (2) identify "unmet" EMS needs, and (3) evaluate alternatives to address these needs.
- ***Lead in the Development of More Efficient Service Delivery Mechanisms.*** In light of the shortage of health professionals in rural areas and the limited resources available to rural facilities, it is critical that rural providers deliver services as efficiently as possible. The lead agency could identify better ways to make use of existing resources through such means as: the development of cooperative ventures to purchase equipment, the rotation of practitioners among counties, and the establishment of a referral system among providers. In addition to the self-

insurance program for clinics currently supported by the state, the lead agency could promote and support self-insurance programs for other types of providers.

- ***Develop More Alternative Service Delivery Models.*** In addition to expanding the implementation of existing pilots, the lead agency could develop pilot models for other components of health care, like rotating specialists or new licensure categories.

Improve Support to Rural Health Care Providers

We recommend that the lead agency develop a systematic approach to assisting rural providers.

In order to address the diverse needs of rural providers, we recommend that the lead agency implement existing legislation by identifying strategically located, high-risk rural hospitals. In addition, we recommend the agency develop a similar system for ranking other rural providers. This ranking would enable the state to systematically target its assistance programs.

Review of Regulatory and Reimbursement Systems

We recommend that state agencies evaluate adjustments to the regulatory and reimbursement systems.

As discussed above, some regulatory and reimbursement procedures and requirements do not take into account the unique characteristics and needs of rural health care providers. A review and adjustment of existing regulations could ease the burden for rural providers of complying with inapplicable regulations. Adjustments to existing reimbursement rates and procedures could help relieve hospitals in financial distress. The OSHPD's review of regulations that apply to rural providers is illustrative of state efforts to make adjustments in its regulatory system. Other state efforts could include:

- ***A Review of Medi-Cal Regulations That Apply to Rural Providers.*** Similar to what is currently being done by the OSHPD, Medi-Cal regulations could be reviewed to take into account existing problems and needs of rural providers. For example, rural hospitals with distinct-part skilled nursing facilities (SNFs) could be exempt from the Medi-Cal patient transfer requirements to freestanding SNFs. Distinct-part SNFs help rural hospitals maintain a more stable revenue stream and occupancy rate. This option would result in net costs to the Medi-Cal Program since Medi-Cal reimbursement rates are higher for distinct-part SNFs than freestanding SNFs.

- ***Encouraging Providers to Use Centralized Billing Services.*** To reduce the burden of cumbersome billing procedures, the state could encourage providers to use privately operated billing services or even assist rural providers in establishing contracts with a centralized billing service. This option would be an efficient billing strategy for rural providers at minimal cost to the state. Another option is for the state to expand technical assistance on billing matters. This would require additional funds.

Long-Term Health Care

What Issues Will the Legislature Face in Promoting Adequate Access to Nursing Facility Services Over the Next Decade?

Summary

One of the Legislature's challenges over the next decade is to promote adequate access to nursing facility beds for the state's population. Our review suggests that it is possible that there will be a disparity between the need for nursing facility services and the growth of bed supply over the next decade. Furthermore, the current Medi-Cal reimbursement system may be (1) contributing to low supply growth, (2) causing access problems to nursing facility beds for Medi-Cal clients, and (3) providing incentives that encourage expansion of facilities that are more costly to operate.

There are several options from which the Legislature can choose to address these issues. These options include changes in the Medi-Cal reimbursement system, expansions of community-based services that are alternatives to nursing facility services, and increased availability of long-term care insurance.

Long-term care in nursing facilities will continue to be one of the Legislature's major challenges over the next decade. The primary issue before the Legislature is how it can promote access to long-term care services in nursing facilities for the state's population. Our review indicates that the need for these services will increase in California due to a growing aged population and a growing population with long-term disabling diseases like AIDS. Growth in the supply of nursing facility beds is highly dependent on reimbursement policies of the Medi-Cal system, which provides about three-fifths of the revenues to the nursing facilities industry. Should it decide to do so, the Legislature has a good

opportunity to make changes in the Medi-Cal rate-setting system in 1990-91. This is because on October 1, 1990, new federal requirements (resulting from the Omnibus Budget Reconciliation Act of 1987) that affect the Medi-Cal rate-setting methodology must be implemented.

In this section, we provide a perspective on long-term care services in nursing facilities. Specifically, we discuss (1) the state's role in long-term health care delivery, (2) the characteristics of nursing facilities, (3) the economics of the nursing facility industry, and (4) legislative options for promoting adequate access to nursing facility services over the next decade.

BACKGROUND

Long-term care refers to various social, medical, and support services provided over an extended period of time to persons who depend on others for care. These persons include those with chronic illness or disability. According to Section 9390.1(c) of the Welfare and Institutions Code, long-term care means:

> *...a coordinated continuum of preventive, diagnostic, therapeutic, rehabilitative, supportive, and maintenance services that address the health, social, and personal needs of individuals who have restricted self-care capabilities.*

Long-term care may be provided by *formal* and *informal* support systems. The more visible long-term care providers—like nursing facilities and residential care facilities—are part of formal support systems. Essentially, formal systems are those which receive payments for the services they provide. Services provided by family members, friends, and relatives are usually not paid, and are part of informal support systems.

Although long-term care has both health and social aspects, the following discussion will be limited to services that emphasize health, specifically nursing facility services, rather than social services. Hence, we will not cover social service models like in-home supportive services, residential care, foster care, and others.

WHAT IS THE STATE'S ROLE IN THE DELIVERY OF NURSING FACILITY SERVICES?

The state plays three main roles in the delivery of nursing facility services: regulation, certification, and reimbursement.

Regulation

The Department of Health Services (DHS) licenses nursing facilities that operate in the state and ensures that the facilities

are adhering to regulations. The regulations cover such items as staffing, medical records maintenance, and infection control.

Nursing facilities also have to meet minimum earthquake, fire, and life safety standards established under state building standards. To assure compliance with these standards, the Office of Statewide Health Planning and Development (OSHPD) reviews all plans for construction. These reviews take a few weeks to several months, depending on the quality of the plan and the size of the project.

The state also regulates nursing facility personnel. The DHS certifies nurse aides' compliance with state training requirements. Certified nurse aides (CNAs) are the primary caregivers in long-term health care facilities. In addition, the Department of Consumer Affairs licenses nursing facility administrators, nurses, and physicians.

Certification

All health facilities that seek funding under Title XVIII (Medicare) and Title XIX (Medi-Cal) must be certified by the federal government. The DHS conducts the certification reviews to evaluate the facilities' compliance with Medicare and Medi-Cal "conditions of participation" on behalf of the federal government. Under the Omnibus Budget Reconciliation Act (OBRA) of 1987, the DHS may conduct certification reviews only for non-state-operated facilities. The federal government conducts certification reviews for state hospitals and developmental centers.

Medi-Cal Reimbursement

The California Medical Assistance program (Medi-Cal) is a joint federal-state program intended to assure the provision of necessary health care services to public assistance recipients and to other individuals who cannot afford to pay for these services themselves. Medi-Cal reimburses nursing facilities on a per diem basis. This reimbursement covers the services the facilities provide, such as nursing care, food, laundry, etc. Physician services, drugs, and acute care hospital services are reimbursed separately.

Medi-Cal is a major payor of nursing facility services in the state. According to data from a one-day census conducted in December 1988 by the OSHPD, Medi-Cal funded the stay of 62 percent of the residents in nursing facilities in the state. The DHS estimates that Medi-Cal expenditures for nursing facility services will be $1.9 billion in 1990-91. (This amount does not include the rate increases due to the facilities starting August 1990.) Nursing

facility residents account for a disproportionately large share of the Medi-Cal budget relative to their numbers. They account for 25 percent of the total Medi-Cal budget for health services and 2 percent of the total Medi-Cal caseload.

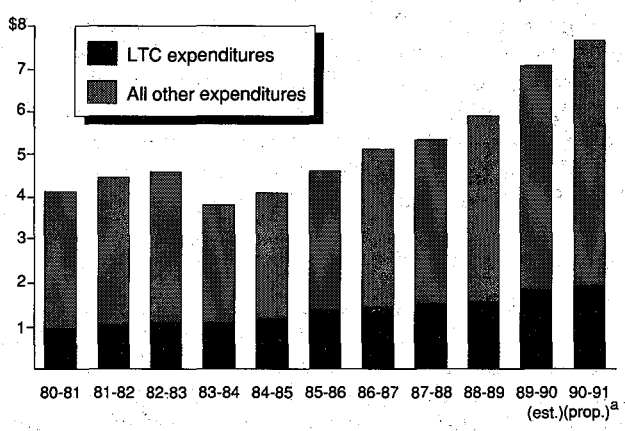
Long-term care expenditures are not only a large portion of the Medi-Cal budget, they are growing rapidly, as is the budget as a whole.

Figure 1 shows Medi-Cal expenditures for long-term care services over the past decade.

Figure 1

Medi-Cal Long-Term Expenditures and Expenditures for All Services

1980-81 through 1990-91
All Funds (dollars in billions)



[a] The budget does not reflect the cost of long-term increases that will be effective August 1990.

WHO PROVIDES LONG-TERM HEALTH CARE SERVICES IN CALIFORNIA?

Long-term health care services are available in various settings, ranging from institutions to the client's home. Nursing facilities, however, provide a majority of long-term health care. Nursing facilities include *skilled nursing facilities* and *intermediate care facilities.* According to 1988 OSHPD data, about 72

percent of the residents in these facilities are aged 75 and over. Nursing facilities admit 76 percent of their residents from hospitals. From there they go home (23 percent), go to the hospital (40 percent), or die (23 percent). (No discharge data are available on the remaining 14 percent of residents.) Seventy-one percent of those admitted stay at these facilities for six months or less.

In this section, we describe the various categories of formal long-term health care services. First, we describe 24-hour care facilities, the main providers of long-term care. Figure 2 summarizes these services and shows the number of beds licensed under each category. We then describe certain community-based services, which provide alternatives to 24-hour care.

Skilled Nursing Facilities (SNFs)

SNFs provide "continuous skilled nursing and supportive care to patients with primary need of skilled nursing services on an extended basis." Licensing regulations require SNFs to provide an average of at least three nursing hours per patient-day. Typical SNF patients include those who are incontinent, in need of tube feedings or wound dressings, and have other conditions that require 24-hour observation and constant availability of skilled nursing services. There are two general classifications of SNFs: "freestanding" and hospital-based.

Freestanding SNFs. As the name implies, freestanding SNFs are those which are not attached to a hospital from a licensing perspective. According to the OSHPD, 91 percent of the state's skilled nursing beds in 1988 were located in freestanding SNFs. During that year, there were 1,137 freestanding SNFs in the state, representing a total of 104,185 licensed beds. These facilities had a 90 percent occupancy rate.

In order to accommodate the skilled nursing needs of mentally ill individuals, the state developed a category known as *skilled nursing facility / special treatment programs* (SNF/STPs). These are freestanding facilities that provide programs designed to meet special treatment needs of mentally ill individuals. Instead of the minimum requirement of three nursing hours per patient-day, SNF/STPs are only required to provide 2.3 nursing hours per patient-day in addition to the staffing requirements of the special treatment program. SNF/STPs account for an additional 4,295 freestanding SNF beds.

Hospital-Based SNFs. Hospital-based skilled nursing services may be provided through *distinct-part skilled nursing facilities (DP / SNFs)* or *swing beds.* The DP/SNFs are those which are located in an identifiable area of an acute hospital with a set

Figure 2

Nursing Facility Characteristics

Category	Description	Staffing	Number of Facilities[a]	Number of Licensed Beds[a]
SKILLED NURSING FACILITIES (SNFs)				
Freestanding	Continuous 24-hour nursing care	Registered nurse (RN) or licensed vocational nurse (LVN) on duty 24 hours, 7 days per week, average 3 nursing hours per client-day	1,137	104,185
SNF/special treatment programs (SNF/STP)	Continuous 24-hour nursing care for mentally ill clients	RN or LVN on duty 24 hours, 7 days per week, average 2.3 nursing hours per client-day, plus STP staffing	41	4,295
Distinct-part (excluding state institutions)	Same as SNF	Same as SNF	131	7,061
Swing bed	Same as SNF	Same as SNF	14	202
INTERMEDIATE CARE FACILITIES (ICFs)				
Freestanding	Intermittent 24-hour nursing care	RN or LVN on duty 8 hours per day, 7 days per week, average 1.1 nursing hours per client-day	140	3,796
Distinct-part (excluding state institutions)	Same as free-standing ICF	Same as free-standing ICF	3	25
ICF for the developmentally disabled (ICF/DD)	Intermittent 24-hour nursing care for DD clients	RN or LVN on duty 8 hours per day, 7 days per week, average 2.7 nursing hours per client-day	33	2,730
Distinct-part ICF/DD (excluding state institutions)	Same as ICF/DD	Same as ICF/DD	1	49

MORE...

number of beds licensed for SNF services. Although most hospital-based SNF services are delivered in DP/SNFs, some hospitals that do not have DP/SNFs may provide these services through swing beds. Small and rural hospitals located in areas with a shortage

Figure 2 CONTINUED

Category	Description	Staffing	Number of Facilities[a]	Number of Licensed Beds[a]
INTERMEDIATE CARE FACILITIES (ICFs) CONTINUED				
ICF/DD-habilitative	Intermittent habilitative and nursing care for 4 to 15 DD clients	Qualified mental retardation professionals 1.5 hours per client-week; direct care hours vary from 4 to 8.5 per client-day	329	2,450
ICF/DD-nursing	Intermittent developmental and nursing care for 4 to 15 DD clients	Direct care hours vary from 5 to 7 hours per client-day[b]	—[b]	—[b]
STATE INSTITUTIONS				
Distinct-part SNF	Same as free-standing SNF	Same as free-standing SNF	10	2,911
Distinct-part ICF	Same as free-standing ICF	Same as free-standing ICF	5	3,686
Distinct-part ICF/DD	Same as ICF/DD	Same as ICF/DD	7	5,263
CONGREGATE LIVING HEALTH FACILITY				
Congregate living health facility	Continuous or intermittent nursing care for up to 6 clients; residential setting	RN or LVN 24 hours, 7 days per week, average 8 to 12 nursing hours per client day[b]	5	49

[a] As of December 31, 1988.
[b] The Department of Health Services has not yet developed permanent regulations.

of skilled nursing beds and a surplus of acute care beds may designate a certain number of their acute beds to "swing" to skilled nursing when the need arises. There were 7,061 DP/SNF beds in the state (excluding state institutions) and 202 swing beds in 1988, according to OSHPD statistics.

Intermediate Care Facilities (ICFs)

ICFs provide "inpatient care to clients who need skilled nursing supervision and supportive care needs but do not require continuous nursing care." Thus, ICF services differ from SNF services in that ICFs provide intermittent, instead of continuous,

nursing care. The state requires ICFs to provide an average of at least 1.1 nursing hours per patient-day. The needs of the residents in ICFs are typically less than those in SNFs.

ICFs may be freestanding or a distinct-part (DP/ICF) of a hospital or a SNF. In 1988 there were 3,796 freestanding and 25 DP/ICF beds (excluding state institutions) in the state, with a 99 percent occupancy rate.

The state also licenses ICFs in one of three other categories.

ICFs for the Developmentally Disabled (ICF/DDs). These facilities provide 24-hour care, habilitation, developmental, and support health services to developmentally disabled residents whose primary need is for developmental services and who have a recurring, but intermittent, need for skilled nursing services. In addition to intermittent nursing care, ICF/DD services include a developmental program. On the average, these facilities provide at least 2.7 nursing hours per client-day. Patients in these facilities typically need specialized developmental and training services. In 1988 there were 2,730 freestanding and 49 DP/ICF/DD beds (excluding state institutions).

ICFs for the Developmentally Disabled-Habilitative (ICF/DD-Hs). These facilities provide habilitation, developmental, and supportive health services to 15 or fewer developmentally disabled persons who have intermittent recurring needs for nursing services but do not require continuous skilled nursing care. These facilities also provide active treatment programs. Minimum direct-care staffing requirements vary from four hours per client-day for facilities with four clients to 8.5 hours per client-day for facilities with 15 clients. The residents in these facilities typically have two or more developmental disabilities. Clients with serious aggressive or self injurious behavior or serious nursing needs are not accepted in ICF/DD-Hs.

ICFs for the Developmentally Disabled-Nursing (ICF/DD-Ns). This is the most recently established ICF category. These facilities provide 24-hour personal care, developmental services, and nursing supervision to 15 or fewer developmentally disabled persons who have intermittent recurring needs for nursing services but do not require continuous skilled nursing care. Minimum direct-care staffing requirements vary from five hours to seven hours per client-day. Typical ICF/DD-N residents include those who have two or more developmental disabilities and a need for nursing services, such as colostomy care or gastrostomy feeding, on an intermittent basis.

State Institutions

State hospitals and developmental centers provide both SNF and ICF services. In 1988, 11 institutions had a total of 2,911 SNF, 3,686 ICF, and 5,263 ICF/DD beds. They had an average occupancy rate of 84 percent. All 11 state institutions are licensed as acute hospitals because they have acute medical/surgical wards.

Congregate Living Health Facilities (CLHFs)

CLHFs provide services to six or fewer residents who need skilled nursing care on a recurring, intermittent, extended, or continuous basis. These facilities are distinct from the SNFs and ICFs in that each CLHF must specialize in serving ventilator dependent, terminally ill, or catastrophically or severely disabled persons. Presumably, the level of care provided by CLHFs is more intense than an SNF but less intense than an acute care hospital. However, Ch 1393/89 (AB 68, Polanco) redefined this category, and the DHS has not yet developed regulations in response to these statutory changes.

Community-Based Long-Term Care

All the above services are provided in around-the-clock facilities. There are other types of long-term care providers, however, serving as alternatives to 24-hour facilities. Most of these alternatives are "community-based," which means that they provide services to clients who live in their homes. These community-based alternatives evolved in recognition that some clients can avoid, or at least delay, nursing facility admission if alternatives are available.

Adult Day Health Centers (ADHCs). ADHCs provide an alternative to institutionalization for older impaired persons or those with functional impairments who are capable of living at home with the help of health care or rehabilitative or social services. ADHC services include planned recreational and social activities and rehabilitation, medical, nursing, nutrition, psychiatric or psychological, social work, and transportation services. According to the DHS, there are currently 63 licensed ADHCs in the state.

Home Health Agencies (HHAs). HHAs also fill the skilled nursing needs of those who wish to remain in the community but cannot go to ADHCs. In addition to skilled nursing services, HHAs may provide physical, speech, or occupational therapy; medical social services; and home health aide services. There are currently 449 licensed HHAs in the state. However, the DHS advises that this number may increase dramatically in the next year because

of the HHA licensing requirement revisions under Ch 856/89 (AB 2266, Connelly). Under Chapter 856, additional HHAs are subject to licensure.

Licensing and Reimbursement Categories

The services discussed above are licensed by the DHS. Virtually all of them are also Medi-Cal reimbursement categories. The only exception is the CLHF, which is currently not considered a Medi-Cal benefit. Other differences include institutions for mental diseases (IMDs) and hospice services, both of which are Medi-Cal reimbursement categories but are not licensing categories. IMDs are SNF/STPs that have been designated as IMDs by the federal Health Care Financing Administration. Federal law prohibits Medi-Cal from reimbursing for IMD services provided to beneficiaries between the ages of 21 and 65. Hospice services are nursing, medical, and counseling services provided to terminally ill clients. Hospice services may be provided by hospitals, nursing facilities, HHAs, or other providers certified to provide hospice services by Medicare.

WHAT FACTORS AFFECT THE DEMAND FOR NURSING FACILITY BEDS?

There are three major factors affecting demand for nursing facility beds. Two of these involve the users of nursing facility services, while the other deals with the availability of other alternatives.

With regard to the users, the need for long-term health care services is measured by a person's dependence on others in performing activities of daily living (ADL) and the frequency of required medical and nursing attention. Activities of daily living include bathing, dressing, using the toilet, getting in or out of a bed or chair, continence, and eating. Two groups of people tend to have high ADL dependencies and require higher frequencies of medical and nursing services: the elderly and people with long-term impairments.

The Elderly

The most obvious and the greatest source of demand is the elderly population. This is primarily because more chronic problems set in as people grow older. Hence, the bigger the elderly population, the higher the demand for long-term care services.

Statistics show that the state's elderly population has been growing rapidly and this growth is projected to continue over the next decade. According to Department of Finance (DOF) estimates, the state's 75-and-older population (which accounts for

almost three-fourths of the nursing facilities population) was 1.3 million in 1988, an increase of 300,000 persons, or 32 percent since 1980. The DOF projects that the 75-and-older population will grow to 1.8 million by 2000, an increase of 520,000 persons (42 percent).

The elderly population has grown and is projected to grow faster than the state's population as a whole. The 75-and-older group constituted 4 percent of the total population in 1980, 4.5 percent in 1988, and the DOF projects that the figure will reach 5.4 percent in 2000.

People With Long-Term Impairments

The other group of people who have high ADL dependencies and require frequent medical and nursing attention are those with long-term impairments. These clients may be younger. They include people in advanced stages of AIDS and Alzheimer's disease, among others. An increasing population of people with these and other chronic diseases, combined with improvements in medical technology to prolong life, will increase the demand for nursing facility services.

Availability of Alternatives

The other factor that affects demand for 24-hour nursing facility services is the availability of community-based alternatives. As we have noted in an earlier analysis of state programs for older Californians (please see *The 1989-90 Budget: Perspectives and Issues,* page 279), the availability of formal community-based alternatives may be a factor in explaining why California has a relatively low institutionalization rate among the state's elderly population. Only 2.8 percent of the state's 65-and-older population resided in nursing facilities in December 1988, compared to 5 percent nationwide. We note, however, that while community-based alternatives delay institutional placement in many cases, they do not totally eliminate the need for institutional long-term care services.

WHAT FACTORS AFFECT THE SUPPLY OF NURSING FACILITY BEDS?

In the nursing facility industry, 84 percent of the facilities are investor-owned. Consequently, as in any private market, the most important factor affecting the supply of nursing facility beds is profitability. The OSHPD reports profitability data on nursing facilities. That information indicates that, based on statewide rate-of-return figures, the industry has experienced very low levels of profitability. Unfortunately, the OSHPD data have serious shortcomings (for example, it is *unaudited* data and

presented in a way that makes it difficult to assess the financial health of the company providing the nursing facility services). Consequently, we are unable to draw conclusions from the OSHPD data about the profitability of the industry.

The key factors affecting profitability are the costs the industry faces in providing nursing care services and the source of revenues (or reimbursements) to facilities.

Industry Costs

The industry incurs two types of costs: entry costs and operating costs. The industry's entry costs are affected by the direct costs of construction and construction delays resulting from extended regulatory reviews, plus uncertainties associated with regulatory processes, including zoning. Entry costs have been reduced somewhat since 1987, when certificate-of-need requirements were eliminated. Previously, health facility construction could not proceed until the OSHPD certified that the facility was needed.

The industry's operating costs are mainly a function of labor costs, its biggest operating cost component. In fact, according to the OSHPD, labor costs for nursing services alone account for 45 percent of operating expenses in nursing facilities.

Industry Revenues

There are two primary sources of nursing facility revenues in the state. The first, and by far the larger of the two, is Medi-Cal. As discussed earlier, Medi-Cal covers about 60 percent of nursing facility residents. The other is private sources, which cover about 30 percent of nursing facility residents. Medicare, the Veteran's Administration, Lifecare, private insurance, and others cover the remainder. The combined influence of the two main payor sources drives the revenue picture of the industry.

Medi-Cal Reimbursement Methodology. Medi-Cal currently reimburses nursing facility costs on a prospective, flat-rate basis. The DHS classifies nursing facilities into certain peer groups based on their category (SNF, DP/SNF, ICF, state hospital), size, and geographic location and annually sets each group's rate at the adjusted median cost of the facilities in that group.

For example, to set the reimbursement rate of peer group A, which has 75 facilities, Medi-Cal would array the adjusted costs of the 75 facilities from lowest to highest. The adjusted costs for each facility are derived from cost report data submitted by the facility, adjusted to reflect disallowed costs (based on audits of a sample of all facilities) and inflationary factors. The adjusted cost of the 38th (median) facility, say $60.00 per day, would be the

Medi-Cal reimbursement for the 75 facilities in that group, regardless of the amount each facility actually spends.

Under this reimbursement system, profitability of a given facility depends on many factors:

- The relationship of that facility's adjusted costs to the median adjusted costs (by definition, Medi-Cal reimburses about half of the facilities in a given peer group above their adjusted costs and the other half at or below their adjusted costs).
- The relationship of actual cost increases to the inflationary adjustments used in rate development (for example, a facility may not have provided staff salary increases in the amount assumed in the inflation adjustment).
- The mix of patients by type of patient (a facility with a greater proportion of "heavy-care" patients will have a more difficult time making ends meet than a facility with a lighter-care caseload due to staffing requirements).

Figure 3 shows the average Medi-Cal reimbursement rates for various nursing facility categories for the prior and current years. It shows that the reimbursement rate for freestanding

Figure 3

Medi-Cal Daily Reimbursement Rates by Service Category Weighted Averages for 1988-89 and 1989-90

Category	1988-89	1989-90
SKILLED NURSING FACILITIES (SNFs)		
Freestanding SNF	$51.84	$60.26
Distinct-part SNF	128.37	147.25
Swing bed	124.60	133.71
Distinct-part SNF (state institution)	156.76	183.75
INTERMEDIATE CARE FACILITIES (ICFs)		
Freestanding or distinct-part ICF	38.62	44.22
ICF or distinct-part ICF for the developmentally disabled (ICF/DD)	59.42	66.16
ICF/DD-habilitative	78.45	91.83
ICF/DD-nursing	—	116.01
Distinct-part ICF/DD (state institution)	164.07	179.51
OTHER		
Congregate living health facility	—	NA[a]

[a] These facilities are not eligible for Medi-Cal reimbursement.

SNFs (which account for the vast majority of beds) is $60 per day. By comparison, the rates for hospital-based SNFs are two and three times as much.

Comparison of Costs and Revenues

According to 1988 OSHPD data, freestanding nursing facilities spent an average of $57.35 daily (for all patients—Medi-Cal, private-pay, etc.) on nursing services, while Medi-Cal paid an average of only $48.32 daily. Although these averages imply that facilities which accept Medi-Cal clients operate at a loss, a 1987 study by the Auditor General on the state's Medi-Cal reimbursement system showed that the industry earned a positive margin on about two-thirds of the Medi-Cal patient-days in 1985. The study indicates that Medi-Cal patients tend to be concentrated in facilities that earn a positive margin on Medi-Cal patients. This suggests that these facilities are either more efficient (that is, lower-cost) than the average or provide fewer services than the average.

Private sources also funded a large portion of nursing facility services. On the average, reimbursements from private sources are higher than Medi-Cal reimbursements and average facility costs. While Medi-Cal paid only $48.32 per day to cover nursing services costs of $57.35 per day, private sources paid an average of $71.23 per day. If private-pay and Medi-Cal patients have similar needs and receive similar services, then the higher the ratio of private-pay residents a facility has, the greater the profit margin.

WHAT ISSUES WILL THE LEGISLATURE FACE OVER THE NEXT DECADE?

In this section, we discuss issues that the Legislature will likely face over the next decade.

Nursing Facility Bed Supply

The adequacy of the state's nursing facility bed supply will depend on the interaction of the factors discussed above. It is difficult to project the actual supply and demand dynamics over the next decade because of the lack of reliable data. However, the common perception is that the nursing bed supply has been, and is expected to remain, extremely tight. This appears to have been the case throughout the early 1980s, when statewide occupancy rates reached 94 percent.

Since that time, occupancy rates have declined, dropping to about 90 percent in 1988. OSHPD data suggest that this decline was a result of no growth in total patient-days in combination with

an increase in the number of beds (between 1980 and 1988, about 20,000 beds were added to supply). One factor in this lack of growth in patient-days may have been increased availability of community-based alternatives. Despite the decline in the statewide occupancy rate, regional shortages may exist.

State agency projections of the number of new nursing facility beds needed by the year 2000 range from almost 34,000 (OSHPD, 1989) to almost 51,000 (Health and Welfare Agency, 1988). Given these demand estimates (especially at the high end), and the actual increase in bed supply between 1980 and 1988 (20,000), it is possible that the state could face a shortage of beds by the year 2000. We note, however, that certificate-of-need requirements that regulated health facility construction in the state until 1987 may have limited the growth of bed supply during most of the 1980-through-1988 period.

Access to Nursing Facility Beds for Medi-Cal Clients

The current Medi-Cal reimbursement system may be a barrier to access to nursing facility beds for Medi-Cal clients. Nursing facilities tend to favor private-pay and Medicare patients over Medi-Cal clients because of their higher reimbursement rates. Hence, Medi-Cal clients have more difficulty in finding a bed than these other two groups.

Access problems may even be more acute for heavy-care Medi-Cal clients. Heavy-care patients generally have nasal gastric tubes or decubiti (bed sores), or are incontinent or ventilator-dependent. Because Medi-Cal's flat-rate reimbursement system does not recognize various levels of care, facilities prefer to accept lighter-care patients as their care is less costly. Heavy-care clients usually remain in hospitals until Medi-Cal staff or the hospital's discharge planning staff arrange nursing facility placements.

There are no readily available data that quantify Medi-Cal clients' access problems. However, two factors suggest that these problems exist.

Relative Decline in Medi-Cal Share of Clients. First, Medi-Cal clients make up a diminishing proportion of the population in nursing facilities. In a 1980 one-day census, 71 percent of nursing facility clients were Medi-Cal clients. By 1988, this number had decreased to 62 percent. On the one hand, this decline could mean that more Medi-Cal clients are using community-based alternatives instead of entering a nursing facility. On the other hand, it could suggest that nursing facilities are filling whatever increase in bed supply there was during this period with privately sponsored patients. We believe that the decline was a result of a combination of the two factors. While more Medi-Cal

clients may be taking advantage of community-based alternatives, the disparity in reimbursement rates between Medi-Cal and private sources in a predominantly for-profit industry suggests that there are significant incentives for nursing facilities to favor privately sponsored clients over Medi-Cal clients. The study by the Auditor General corroborated this hypothesis when it found that hospital discharge planners ranked Medi-Cal clients as considerably harder to place than privately sponsored clients.

High Use of Administrative Days. The second factor that suggests access problems for Medi-Cal clients is the state's high utilization of acute "administrative days." Clients are placed on "administrative status" when they stay in a facility that provides a higher level of care than the client needs. Generally, Medi-Cal places clients on administrative status in acute care hospitals when the client is awaiting nursing facility placement. In 1988-89, Medi-Cal authorized 84,000 administrative days (the equivalent of about 230 beds). These stays vary from a few days to months, depending on how difficult it is to place a client.

To address this problem, the DHS established a "subacute" reimbursement category under Medi-Cal. The subacute level of care is more intensive than skilled nursing care but not as intensive as hospital acute care. To date, only a few providers have participated in this program. The most frequently cited reason for this low participation rate is that the criteria for determining whether a facility can receive a subacute rate for a particular patient were too narrowly defined. The DHS has taken steps to revise these criteria.

Perverse Incentives in the Medi-Cal Reimbursement System

The current Medi-Cal long-term care rate reimbursement system offers perverse incentives to providers. In this section, we discuss some of the effects of the system on patient care, access, and costs.

In his 1987 study, the Auditor General found that Medi-Cal's prospective flat-rate reimbursement system, while effective at controlling costs, has several weaknesses. The system is a good cost control mechanism in that it encourages nursing facilities to spend below the reimbursement rate: the system rewards operators who run their facilities efficiently. However, a flat-rate system also rewards operators who provide minimal patient care and penalizes operators who provide additional services. The rates have no direct relationship to the level of service actually provided.

An example of the effects of the current flat-rate reimbursement system is demonstrated by the rate differential between DP/SNFs and freestanding SNFs. As Figure 3 shows, there is a wide disparity in reimbursement rates between DP/SNFs and freestanding SNFs. The average DP/SNF reimbursement in the current year is $147 per patient-day, while the average reimbursement rate for freestanding facilities is $60.

The rate differential is associated with two problems. First, the higher rates result in significantly higher Medi-Cal costs, without any requirement for a greater level of services. The differential in rates reflects differences in costs of operating the two types of facilities. On the average, in DP/SNFs patients receive a higher level of services and staff receive higher wages than in freestanding SNFs. However, DP/SNFs are subject to the same regulations as freestanding SNFs; they do not *have* to provide any additional services or to accept heavier-care patients to justify receiving a higher rate.

Second, this disparity in reimbursement rates is a problem because it provides an incentive for freestanding SNFs to become DP/SNFs by licensing in association with an acute care hospital. (We note that until recently, Medi-Cal tried to control DP/SNF utilization through a policy to approve DP/SNF stays only when a client could not be placed in freestanding facilities within a certain radius or travel time. Medi-Cal recently suspended this policy in response to a suit challenging this transfer policy.)

Without changes in the Medi-Cal reimbursement system, these problems will likely continue, and perhaps get worse, in the future.

WHAT OPTIONS DOES THE LEGISLATURE HAVE TO PROMOTE ADEQUATE ACCESS TO NURSING FACILITY SERVICES OVER THE NEXT DECADE?

The Legislature has several options to address the issues discussed in the earlier section. The Legislature could promote adequacy of nursing facility beds by either reducing demand and/or increasing supply. In this section, we provide a brief overview of some of the alternatives available to the Legislature to promote adequate access to nursing facility beds over the next decade.

Changes in the Medi-Cal Reimbursement System

The current Medi-Cal reimbursement system is primarily designed to control costs. It is not designed to ensure an adequate supply of Medi-Cal beds. In addition, the current reimbursement system (1) does not relate the level of reimbursements to the level

of services facilities provide, (2) may contribute to access problems for Medi-Cal clients, and (3) creates incentives for building the more expensive distinct-part facilities.

The Auditor General study identified three alternatives to the current reimbursement system: a case-mix system, an outcome-oriented system, and a facility-specific system.

A case-mix reimbursement system sets reimbursement rates based on the level of services required by each patient. An outcome-oriented reimbursement system ties the rates to certain "outcomes," or quality of care. A facility-specific system, on the other hand, reimburses a facility based on its own costs, not on the median of its peer group. Of the three, the study recommended that the state adopt a facility-specific system. The study also recommended a supplementary rate for heavy-care Medi-Cal clients. The facility-specific system would tie reimbursement more directly to the facility's spending and provide more nursing facility bed access to heavy-care clients. A similar system is proposed by SB 1087 (Mello), which was in conference committee at the time this analysis was prepared.

The actual cost of such a system would depend on how it is structured. However, the system could cost significantly more than the current flat-rate system because (1) facilities would have incentives to spend more on care, (2) facilities would have incentives to classify clients as heavy-care in order to receive the higher reimbursement rate, and (3) this system is more complicated and, therefore, more difficult to administer.

The Legislature has a good opportunity to effect major changes in the reimbursement methodology in the budget year, should it decide to do so. This is because effective October 1, 1990, the Omnibus Budget Reconciliation Act (OBRA) of 1987 requires a consolidation of the SNF and ICF reimbursement categories into one. As Figure 3 shows, average SNF and ICF rates currently differ by about $16 daily. Under the OBRA, ICF staffing and physical plant standards would be upgraded to the SNF level. These new standards would require the DHS to make changes in its rate-setting system, as SNF and ICF rates are currently devised separately. These changes could vary from minor adjustments to an overhaul of the whole system. The Legislature has demonstrated interest in changing the whole system through the advancement of SB 1087. The Medi-Cal reimbursement methodology eventually adopted in conjunction with the OBRA-mandated changes will have a significant influence on the supply of, and access to, nursing facility beds in the state over the next decade.

Expand Community-Based Programs

In order to reduce demand for nursing facilities, the Legislature also could expand community-based alternatives to avoid or at least delay entry into nursing facilities. For example, the Legislature has encouraged such expansion in the past by providing "start-up" grants of $50,000 for each new adult day health center. We note that community-based programs are not necessarily less expensive than nursing facility services. However, to the extent that they prevent or delay institutionalization, they help reduce the pressure on nursing facility bed supply.

Expand the Availability of Long-Term Care Insurance

Another option for increasing bed supply is to expand the availability of long-term care insurance, thereby increasing the proportion of patients who are funded from non-Medi-Cal sources. Currently, private funding comes primarily from clients' own savings and other resources. Many privately funded clients become eligible for Medi-Cal within a matter of months after entering a facility because the high cost of nursing facility services depletes their resources. According to a 1987 report by the House of Representatives Select Committee on Aging, 47 percent of single Californians age 65 and older who live alone are at risk of impoverishment after 13 weeks of nursing facility stay. A long-term care insurance program would be effective only to the extent that (1) it covers the target population and (2) the premiums are affordable. Hence, financing of such a program becomes an important issue. The extent of the state's involvement in an insurance program is a policy decision that the Legislature would have to make if it chooses to pursue this option further.

Proposition 99: An Update

What Is the Status of Proposition 99 Implementation?

Summary

Proposition 99 established a new surtax on cigarettes and tobacco products, thereby generating almost $1.5 billion in new revenues available for expenditure in 1989-90 and 1990-91. Assembly Bill 75 (Ch 1331/89, Isenberg) allocated the vast majority of these funds. Our review indicates that the three major departments responsible for the implementation of AB 75 have made good progress in implementing the programs the act established in the current year.

The Legislature will face several major issues related to Proposition 99 in the coming year. Among these are (1) AB 75 will sunset in June 1991, requiring choices regarding the allocation of Proposition 99 funds beginning in 1991-92 and (2) the Governor has proposed augmentations in 1990-91 for local mental health programs and the California Healthcare for Indigents Program (CHIP) that compete with the funding necessary to implement the Major Medical Insurance Program established by Ch 1168/89 (AB 60, Isenberg).

In November 1988, the voters approved Proposition 99, the Tobacco Tax and Health Protection Act, which established a surtax of 25 cents per package on cigarettes and an equivalent amount on all other tobacco products sold in California. Proposition 99 provides a major new funding source—over $550 million annually—for health services, health education, and resources programs.

In this analysis, we (1) provide background on the provisions of Proposition 99 and the Legislature's actions in implementing it; (2) review the 1990-91 budget proposal for Proposition 99 funds;

(3) provide a status report on programs established by AB 75 (Ch 1331/89, Isenberg), which allocated 90 percent of Proposition 99 funds; and (4) identify outstanding issues facing the Legislature in 1990 regarding Proposition 99.

BACKGROUND

Proposition 99 required that revenues from the surtax be deposited in the Cigarette and Tobacco Products Surtax Fund (C&T Fund) established by the act, and allocated specified percentages of the fund to six accounts. The act further required that revenues allocated to the six accounts be expended for specified purposes. Figure 1 identifies the six accounts, the percent of surtax revenues allocated to each, and the specified purposes for each account.

Figure 1

Proposition 99 Accounts

Account	Percent of Surtax Revenues	Purposes
Health Education	20	Prevention and reduction of tobacco use, primarily among children, through school and community health education programs
Hospital Services	35	To pay hospitals for the treatment of patients who cannot afford to pay, and for whom payment will not be made through private coverage or federally funded programs
Physician Services	10	To pay physicians for medical care services provided to patients who cannot afford to pay, and for whom payment will not be made through private coverage or federally funded programs
Public Resources	5	To be equally divided between programs that (1) protect, restore, enhance, or maintain fish, waterfowl, and other wildlife habitat areas and (2) improve state and local park land recreation resources
Research	5	To fund tobacco-related disease research
Unallocated	25	May be used for any of the specific purposes described above

The surtax went into effect on January 1, 1989. However, none of the revenues raised in the last half of 1988-89 (almost $330 million) were spent in 1988-89.

During 1989 the Legislature took the following actions to provide for the expenditure of Proposition 99 funds:

- ***Assembly Bill 75*** allocated revenues from 1988-89, 1989-90, and 1990-91 from the Unallocated, Physician Services, Hospital Services, and Health Education Accounts. The act appropriated $1.2 billion ($703 million for expenditure in 1989-90 and $510 million for expenditure in 1990-91) to establish a variety of new health programs and expand existing programs.
- ***The 1989 Budget Act*** allocated funds available in the Research Account and the Public Resources Account to various programs. The Budget Act also allocated $25.3 million from the Unallocated Account.
- ***Chapter 1168, Statutes of 1989 (AB 60, Isenberg),*** established the California Major Medical Insurance Program and transferred $250,000 from the Unallocated Account to begin developing rules and regulations and to carry out other activities necessary to implement the program. Chapter 1168 also specifies that the program shall be funded by transferring $30 million first from interest accrued on unspent funds and, if necessary, from the unspent balances in the Hospital Services, Physician Services, and Unallocated Accounts. Chapter 1168 also continuously appropriates $30 million annually from the Unallocated Account, beginning in 1991-92, to fund the program.

BUDGET OVERVIEW

Overall, the budget proposes expenditures of $630 million, a reduction of $182 million, or 22 percent, from the current year. The proposed reduction results primarily from the artificially high current-year total, which included one-time funds carried over from 1988-89.

Figure 2 displays the distribution of Proposition 99 funds in 1989-90 and proposed for 1990-91. The Governor's Budget and Budget Summary contain detailed schedules for the individual accounts.

In the following sections, we discuss in greater detail the revenue outlook and outline the spending plan for Proposition 99 funds proposed in the budget.

Figure 2

Proposition 99 Revenues and Expenditures

(dollars in thousands)

	Estimated 1989-90	Proposed 1990-91
Resources		
Revenues from surtax	$576,000	$561,000
Interest income	26,100	14,900
Carry-over from previous year	329,168	118,098
Totals	$931,268	$693,998
Expenditures		
AB 75 programs		
Department of Health Services:		
California Healthcare for Indigents Program	$336,716	$350,404
County capital outlay	82,288	—
Uncompensated care assistance	61,931	—
County data systems	10,000	—
Clinics	19,719	18,265
Children's hospitals	2,000	1,896
Rural health services	6,972	6,542
County Medical Services Program expansion	9,954	9,918
Child Health and Disability Prevention Program expansion	19,696	19,445
Health education programs	91,538	61,146
Expansion of Medi-Cal perinatal services	19,894	19,788
Administration	7,455	7,579
Subtotals	($668,163)	($494,983)
Department of Mental Health	25,000	35,000
Office of Statewide Health Planning and Development administration	225	450
State Department of Education:		
Local assistance	35,100	35,100
Administration	900	900
Other programs		
Board of Equalization	554	463
Major Medical Insurance Board	250	—
Resources programs	42,019	31,202
University of California	40,923	31,949
Employee compensation	36	—
Totals	$813,170	$630,047
Carry-over to next fiscal year	118,098	63,951
Five percent reserve		*34,677*
Other reserves:		
Health Education Account		*28,879*
Physician Services Account		*232*
Public Resources Account		*163*

Revenue Outlook

Surtax Revenues. The budget estimates that surtax revenues will total $576 million for the current year. This represents a reduction of $27 million, or 4.5 percent, below the amount projected last May. Revenues are lower than anticipated because per-capita cigarette sales have diminished more quickly than anticipated since imposition of the surtax in January 1989. (Revenue from the sale of cigarettes accounts for more than 95 percent of surtax revenue.)

Data provided by the State Board of Equalization indicate that per-capita cigarette sales fell by 11 percent in 1988-89. The budget's revenue estimate for the current year is based on a decrease of 6.8 percent for 1989-90. These figures represent a substantially sharper rate of decline than the 3.6 percent average annual decrease that occurred over the period from 1982-83 through 1987-88. The primary reason for these large declines in smoking is the effect of the price increases associated with the imposition of the surtax.

The budget estimates that surtax revenue for 1990-91 will total $561 million, based on a projected decline of 4.5 percent in per-capita cigarette sales. The projected decline in smoking for 1990-91 is less than the declines in the past year and the current year because the *one-time* effect of the surtax price increases on people's behavior will have passed. Nevertheless, the 4.5 percent decline in smoking assumed in the budget estimate still represents a greater rate of decline than the pre-surtax annual decline rate of 3.6 percent. The major reasons for the anticipated faster decline in smoking include increased educational efforts to reduce smoking and additional restrictions on smoking in public places and work areas. (Because the budget expects population growth to partially offset reduced per-capita sales, the projection for surtax revenues of $561 million represents a decrease of only 2.6 percent for 1990-91.)

Over the longer term, surtax revenues are expected to gradually diminish. Based on the Department of Finance's estimates for current-year revenue, its projections for population growth, and assuming that the decline in per-capita cigarette sales it expects for 1990-91 continues at the same rate, we estimate surtax revenues would be on the order of $500 million in 1994-95 (a 12 percent reduction).

Interest Income. The budget reflects interest income of $439,000 in 1988-89, $26.1 million in the current year, and $14.9 million in 1990-91. Actual interest income on surtax revenues was much higher in 1988-89 ($4.7 million) than the $439,000

reflected in the budget. However, the General Fund received $4.3 million of the interest earnings because the administrative actions necessary for the C&T Fund subaccounts to retain interest earnings did not occur until July 1989.

Comparison to AB 75 Revenue Assumptions. The spending plan included in AB 75 assumed that available revenues for the three-year period 1988-89 through 1990-91 would total $1.5 billion ($294 million in 1988-89, $603 million in 1989-90, and $572.9 million in 1990-91), *all from surtax collections.* The AB 75 spending plan did not reflect *any* interest income.

The current projection of *surtax* revenues for the three-year period is about $4 million less—actual revenues of $329 million in 1988-89 and projected revenues of $576 million in 1989-90 and $561 million in 1990-91. The significant reductions in anticipated current-year and 1990-91 surtax revenues due to declining consumption are offset by an increase of $35 million in 1988-89 collections above the amount anticipated. This increase was due to a one-time accrual adjustment.

The budget's estimate of *total* revenues available in the three-year period is $37 million above the amount anticipated when the Legislature enacted AB 75. This is the net effect of (1) interest income of $41 million, offset by the reduction of $4 million in surtax revenue.

Expenditures

Figure 2 (above) displays the budget's spending plan for Proposition 99 funds for 1989-90 and 1990-91.

Assembly Bill 75 Programs. Assembly Bill 75 established the spending plan for funds in the Health Services, Physician Services, Health Education, and Unallocated Accounts for both the current and budget years. (Below we describe the implementation of programs supported by these funds.) The 1990 Budget Bill includes funds for administration in the Office of Statewide Health Planning and Development, the Department of Health Services (DHS), State Department of Education, and county boards of education. The Governor's Budget proposes augmentations of $10 million for local mental health programs and $34.6 million for the California Healthcare for Indigents Program (CHIP) in the DHS.

Public Resources Programs. The 1989 Budget Act appropriated $42 million from the Public Resources Account for a variety of *one-time* projects and some continuing support costs in various state agencies. The 1990 Budget Bill proposes $31.2 million for similar purposes. The proposed allocation of Public Resources Account funds in the 1990 Budget Bill is consis-

tent with the Proposition 99 requirement that 50 percent of the funds be allocated to wildlife habitat and 50 percent to state and local park and recreation resources.

Research Programs. The 1989 Budget Act appropriated $42.6 million from the Research Account to expand the cancer registry in the DHS and support research at the University of California. The 1990 Budget Bill proposes $31.9 million to continue these expenditures.

Reserves. The budget proposes carrying over into 1991-92 a 5 percent reserve in all accounts plus $29.3 million in additional reserves. Of these additional reserves, $28.9 million are in the Health Education Account.

STATUS REPORT ON AB 75 PROGRAMS

Below we describe each program established by AB 75 and provide a status report. Generally, the three agencies involved are making good progress in implementing AB 75.

California Healthcare for Indigents Program (CHIP)

Assembly Bill 75 appropriated $336.7 million in 1989-90 and $315.8 million in 1990-91 to support the CHIP. In addition, the 1990 Budget Bill proposes an augmentation of $34.6 million for the program. Assembly Bill 75 requires that CHIP funds be distributed to counties operating MISPs based on specified percentage shares. The department reports that it is implementing the program and that approximately one-half (or about $170 million) of funds appropriated for the current year have been distributed. The department released guidelines for expenditure of program funds to counties in December 1989.

The *Hospital Services Account* funds ($200 million in 1989-90 and $188.8 million in 1990-91) are to be divided into county hospital and noncounty hospital portions within each county based on each group's share of uncompensated care costs. The county hospital portion may be used for county hospital services or noncounty hospital services, as determined by the county. Fifty percent of the noncounty hospital portion are to be allocated directly to those hospitals based on uncompensated care data. The remaining 50 percent is available to maintain access to emergency care and to purchase other necessary hospital services for medically indigent persons.

The *Physician Services Account* funds ($41.1 million in 1989-90, and $38.4 million in 1990-91) will pay for unreimbursed physician services. Counties must use at least 50 percent of the available funds to pay for unreimbursed emergency services. The

measure caps these reimbursements at 50 percent of the physician's losses. Counties may use the remaining funds to pay for new contracts with physicians to provide emergency, obstetric, and pediatric services in noncounty facilities where service access is limited.

The *Unallocated Account* funds ($95.3 million in 1989-90 and $88.7 million in 1990-91) are available at the county's discretion to provide health services for patients unable to pay and services that are not covered by private insurance or by fully or partially federal-funded programs.

County Capital Outlay

The act allocated $82.3 million in 1989-90 to fund capital outlay at county health facilities. Ninety percent of the available funds goes to Medically Indigent Services Program (MISP) counties; the remaining 10 percent goes to County Medical Services Program (CMSP) counties. The act permits counties to use a portion of their allocations to replenish specified reserve funds.

The DHS reports that expenditure applications and guidelines currently are being developed but that no funds have yet been distributed.

Uncompensated Care Assistance

The act provided $37 million in 1989-90 for uncompensated care at county and noncounty hospitals, to be allocated to hospitals based on financial data reported to the Office of Statewide Health Planning and Development (OSHPD). In addition, AB 75 allocated $24.9 million in 1989-90 to MISP counties for uncompensated physician services. Counties must use at least 50 percent of their allocation for unreimbursed emergency services. The measure caps these reimbursements at 50 percent of the physician's losses. Up to 50 percent of each county's allocation may be used for new contracts with private physicians to provide emergency, obstetric, and pediatric services in noncounty facilities where service access is limited.

The DHS and the OSHPD report that all funds for uncompensated care assistance have been distributed.

County Data Systems

The act allocated $10 million in 1989-90 to develop and implement county medically indigent care reporting systems. To receive funding, counties must submit applications to the DHS. The department reports that it is currently developing criteria for distributing the funds. The department indicates it plans to disburse all funds on May 1.

Clinics

The measure appropriated $19.7 million in 1989-90 and $18.3 million in 1990-91 for medical services and preventive services, including smoking prevention and cessation health education, rendered by primary care clinics to persons with incomes at or below 200 percent of the federal poverty level. Clinics serving medically underserved areas or populations have priority for funds. Up to $10 million of the 1989-90 funds may support clinic capital outlay grants.

The department reports that all staff budgeted to implement the program in the current year have been hired. The department has issued requests for application to counties for funds appropriated by the act. However, no funds have yet been distributed.

Children's Hospitals

Assembly Bill 75 appropriated $2 million in 1989-90 and $1.9 million in 1990-91 for distribution to seven children's hospitals based on their share of the uncompensated care costs of all children's hospitals in the state. The department has issued applications to the hospitals for their use in requesting current-year funds, and expects to disburse the funds in February.

Rural Health Services

Assembly Bill 75 provided $7 million in 1989-90 and $6.5 million in 1990-91 for services in CMSP counties. Funds from the Hospital Services Account are to be distributed to hospitals based on their share of the county's uncompensated care costs. Funds from the Physician Services Account are to support unreimbursed medically necessary emergency, obstetric, and pediatric physician services. Funds from the Unallocated Account are to support expanded emergency medical transportation and public health services.

The department has set up claiming procedures and is holding workshops to assist providers in claiming additional funds. The department indicates it will begin distributing these funds in early February.

County Medical Services Program (CMSP) Expansion

The act allocated $10 million in 1989-90 and $9.9 million in 1990-91 to expand the scope of services under CMSP and to compensate hospitals and other emergency providers for emergency services rendered to out-of-county indigent patients. The department reports that in both 1989-90 and 1990-91, it is using $5 million of the funds to expand services (particularly dental

services) covered under the CMSP and the remaining $5 million to reimburse providers for out-of-county care. The expanded scope of services took effect January 1, 1990. The department has set up claiming procedures for out-of-county care costs and is holding workshops to assist providers in claiming these funds.

Child Health and Disability Prevention (CHDP) Program Expansion

The act allocated $19.7 million in 1989-90 and $19.4 million in 1990-91 to extend CHDP Program eligibility to additional children. This program provides medical examinations to children. The act also adds an anti-tobacco education component in the CHDP medical examination.

The department reports that it has (1) hired five of the six positions provided for program implementation, (2) developed its revised plan requirements for county plans and provider billing, and (3) received revised plans for some counties requesting Proposition 99 funds. The department also reports that it is working with local nonprofit agencies to determine how these agencies can provide smoking education materials to local health departments in order to prevent the departments from having to develop duplicative materials.

Health Education Programs

Oversight, Data, Analysis. The act created the Tobacco Education Oversight Committee to advise the DHS and the State Department of Education on C&T-funded tobacco education programs. The act requires the committee to develop a comprehensive master plan for statewide tobacco education programs. To fund the committee's expenses, the act appropriated $2.3 million in 1989-90.

The DHS reports that it has selected a contractor to conduct a baseline survey that will be used to evaluate the effectiveness of the education programs.

Media Campaign. The act provided $14.3 million in both 1989-90 and 1990-91 for a public information campaign. The measure specifies that programs directed at children ages 6 to 14 have priority for funding and that the media used for the campaigns shall be effective in reaching this target population. The department reports that it will begin contract negotiations in February.

Competitive Grants. The act provided $41.6 million in 1989-90 and $11.4 million in 1990-91 for a grant program administered by the DHS to fund health education and promotion

activities designed to reduce tobacco use and tobacco-related diseases among target groups. The act allows nonprofit organizations, including school districts, to receive grants under this program for efforts to reduce tobacco use. In school districts, these must be nonclassroom, district-wide programs. The department indicates it intends to issue requests for proposals by March, but it does not expect to encumber these funds until June.

High-Risk Programs. The act appropriated $35.6 million in 1989-90 and $35.4 million in 1990-91 for allocation to designated local lead agencies for tobacco use prevention and reduction programs for high-risk population groups. To receive funds, local lead agencies must submit local program plans to the DHS for review and approval.

The department reports that it has issued guidelines required by the act and has begun holding workshops to assist counties in developing their plans.

School Programs. The act provided $32.6 million in 1989-90 and another $32.6 million in 1990-91 for a grants program administered by the State Department of Education (SDE) to fund health education and tobacco information activities designed to reduce tobacco use among school children. (This annual amount does not include $2.5 million for local assistance to county boards of education provided in the 1989 Budget Act and proposed in the 1990 Budget Bill.) The SDE has indicated that these funds—which it expects to allocate to districts in February—will be used for *both* program planning and program implementation purposes.

Assembly Bill 75 also directed the SDE to prepare guidelines on the use of these funds that require districts to select one or more model program designs. The SDE issued guidelines in November 1989; however, the guidelines do not require the use of model programs. This situation may have resulted because of the SDE's inability to fill several staff positions. The SDE indicates that once these positions are filled, it will proceed to develop a list of model program designs. It is unclear whether the SDE intends to revise these guidelines to (1) make the use of these models mandatory—as envisioned by the legislation—or (2) otherwise include reference to these models when district plans are reviewed by county offices of education.

Expansion of Medi-Cal Perinatal Services

Assembly Bill 75 allocated $19.9 million in 1989-90 and $19.8 million in 1990-91 to extend coverage for perinatal services under the Medi-Cal Program to pregnant women with family incomes between 185 percent and 200 percent of the federal poverty level

and their infants up to one year of age. The act required the DHS to conduct outreach activities to increase participation and access to these services.

The department reports that it implemented expanded eligibility for pregnancy-related services beginning October 1, 1989. The department's plan to use C&T funds for perinatal outreach has two components. First, it plans to use funds appropriated by AB 75 to permit counties to station eligibility workers at locations other than welfare offices. Second, the department is developing a request for proposals to hire a public relations contractor to (1) develop a campaign to encourage providers to participate in Medi-Cal and (2) develop and implement a statewide campaign to inform women about Medi-Cal coverage of perinatal services and to encourage them to receive early prenatal care.

Mental Health

The act appropriated $25 million in 1990-91 for local mental health services. In addition, the 1990 Budget Bill proposes an augmentation of $10 million for this purpose. The 1989 Budget Act included a $25 million appropriation from the C&T Fund for mental health services in 1989-90. In the current year, $12.5 million was allocated to counties on the basis of the poverty/population formula and $12.5 million was allocated to counties as a cost-of-living adjustment. Assembly Bill 75 does not specify how the funds will be allocated in 1990-91.

OUTSTANDING ISSUES

Assembly Bill 75 Will Sunset in June 1991

Assembly Bill 75 sunsets in June 1991. Consequently, the Legislature faces decisions regarding how to allocate Proposition 99 funds from the four accounts affected by AB 75 beginning in 1991-92. One option is to use the funds to provide health coverage to uninsured Californians. Both the Governor and legislative leaders have expressed their intent to develop legislation implementing such a program.

Proposed Budget Augmentations Compete With Health Insurance Program for Interest Funds

As indicated earlier, the amount of funds currently projected to be available for expenditure in 1989-90 and 1990-91 exceeds by $37.2 million the amount anticipated when the Legislature enacted AB 75, due to the net effect of reductions in surtax revenues and accounting for interest income.

The Governor's Budget projects that as a result of these changes, $30.5 million in additional funds will be available in the four accounts affected by AB 75. The Governor's Budget also identifies an additional $14.1 million available as a result of (1) spending $12.3 million that was not allocated by AB 75 (that is, reducing the carry-over reserve) and (2) reducing anticipated funding for administration. Thus, the budget identifies a total of $44.6 million in additional funds available for expenditure in the four accounts affected by AB 75.

The budget proposes to use these monies to fund augmentations to local mental health programs ($10 million) and the CHIP ($34.6 million). The budget does not propose to fund the Major Medical Insurance Program established by Ch 1168/89 (AB 60, Isenberg). Chapter 1168 specified that the program should be funded first by transferring $30 million from accrued interest earnings and, if necessary, from unspent balances in the Physician Services, Hospital Services, and Unallocated Accounts. However, the act did not explicitly require a transfer of interest earnings to occur in 1988-89, 1989-90, or 1990-91. Beginning in 1991-92, the act requires the transfer of $30 million annually from the Unallocated Account to the Major Medical Insurance Fund for the purpose of funding the program.

Accordingly, the Legislature faces some choices. It must decide whether it will fund the Major Medical Insurance Program at the intended level, agree to the augmentations proposed by the Governor, or use the funds available for different purposes entirely.

No Justification Submitted for Department Support Funding

The budget proposes $7.4 million from various accounts of the C&T Fund for support costs in the departments associated with implementing AB 75. Of this amount, the budget proposes $5.9 million for the DHS, $900,000 for the SDE, and $450,000 for the OSHPD.

At the time we prepared our analysis, the DHS and the OSHPD had not submitted justification for their proposed support expenditures. Specifically, the departments had not provided (1) fiscal details of their proposals, (2) information on activities proposed, or (3) estimated workload. Therefore, we have withheld recommendation on the budget proposals until the departments submit the necessary information. (Please see Items 4140 and 4260 in the *Analysis of the 1990-91 Budget Bill.*)

Allocation Method Not Specified for Mental Health and CHIP Funds

The budget proposes an augmentation of $10 million from the C&T Fund for these mental health programs. This brings total C&T funding for local programs to $35 million for 1990-91. However, AB 75 does not specify and the Department of Mental Health has not specified how these funds would be allocated to counties. Similarly, the budget proposes an additional $34.6 million for the CHIP. Assembly Bill 75 does not specify and the DHS has not specified how these funds will be allocated. (Please see Items 4260 and 4440 in the *Analysis* for additional discussion of these issues.)

Concerns Over Clinics Program Implementation

In the process of implementing AB 75, the department has established a statewide uniform reimbursement rate for outpatient visits ($65) and case management services ($6.50). It has also issued a request for application (RFA) to over 500 clinics in late December. The RFA consists of two parts: part I for funding expanded services and part II for funding clinic modernization or capacity expansion.

We are concerned that the implementation activities currently underway by the department may reduce program effectiveness. Specifically:

- The department has not established specific funding priorities.
- The department has not provided any documentation supporting the statewide uniform rates it has developed.
- The RFA specifies that a clinic may only receive as much in modernization or capacity expansion funds as it receives in expanded services funds. This precludes clinics from submitting proposals that would expand access but do not comply with this criterion.

(Please see Item 4260 in the *Analysis* for further discussion of this issue.)

Variations In County Fiscal Capacity

How and Why Does Fiscal Capacity Vary Among the State's Counties? What Options Does the Legislature Have for Improving It?

Summary

The fiscal capacity of California's 58 counties varies considerably. While all of the counties are subject to many of the same sources of fiscal pressure, our analysis indicates that the fiscal capacity of a number of counties is low and declining. As a result, their ability to deal with ongoing fiscal pressures is worsening.

Contrary to widespread belief, low fiscal capacity is not confined to the small rural counties; a number of larger counties also are characterized by low or declining fiscal capacity. While the specific contributing factors vary from county to county, low capacity counties generally experience some combination of limited revenue, low growth in revenue, and/or high or increasing costs for state-required programs. In addition, the state may aggravate the differences in fiscal capacity to the extent that the assistance it provides does not reflect the current county populations in need of services.

In 1987-88, state grants for fiscal relief had a positive impact on county fiscal capacities, particularly with regard to the smaller counties. However, given that the state has not provided a similar amount of targeted fiscal relief in subsequent years, it is likely that some counties have continued to experience a decline in fiscal capacity.

If the Legislature wishes to avert future declines in county fiscal capacity, it can provide short-term fiscal relief to counties by increasing the funding provided under the County Revenue Stabilization program. In the longer term, the Legislature may wish to examine more permanent solutions to the county fiscal dilemma, such as the reallocation of state program funding or property tax revenues, the creation of additional county revenue sources, or the realignment of county program responsibilities.

In September 1989, Butte County officials announced that the county could not balance its 1989-90 budget, and therefore planned to seek bankruptcy protection in federal court. While subsequent state relief and budgetary reductions by the county allowed it to finance projected 1989-90 expenditures, these actions did not provide a long-term solution to the county's fiscal dilemma. Butte County officials currently are projecting an $8 million deficit for 1990-91. (Please see our recent Policy Brief *County Fiscal Distress: A Look at Butte County* for more information.)

While it is tempting to isolate Butte County as a lone example of a California county in fiscal straits, our analysis indicates that many other counties are experiencing serious fiscal difficulties. Furthermore, our review indicates that this is not merely a *rural* county problem.

The state has a clear interest in maintaining the fiscal viability of county governments. They are the entities which serve all Californians through programs of statewide interest (such as health, corrections, and welfare programs). In addition, they provide to residents of unincorporated areas such local services as sheriff and library services. In this piece, we examine county fiscal capacity—the ability of counties to respond to these needs.

First, we describe the county-state relationship and discuss our framework for identifying variations in county fiscal capacity. Second, we provide our findings regarding the fiscal capacity of counties, and discuss some of the counties which rate below average in this regard. Third, we identify the primary factors that contribute to low fiscal capacity. Finally, we offer several alternatives that the Legislature may wish to use to improve the fiscal capacity of California's counties.

BACKGROUND: A FRAMEWORK FOR COMPARING COUNTY FISCAL CAPACITY

For the purposes of this analysis, we define county fiscal capacity broadly as the ability of a county to meet whatever public service needs may arise in its community with the resources it has available to it. Low fiscal capacity leads to fiscal *distress* when the imbalance between resources and responsibilities leads the county to have severe difficulty addressing service needs.

The Dual Role of Counties

Counties in California play a dual role in providing services to their residents. First, counties are charged with the responsibility to administer a variety of programs required by state law. These

state-required programs include welfare (such as Aid to Families with Dependent Children—AFDC—and general assistance), county health services, In-Home Supportive Services (IHSS), community mental health, corrections and the trial courts. Second, the counties administer a variety of *local* programs. These include some programs of state interest, such as public health and social services, and others of primarily local import, such as the municipal-type services provided to residents of unincorporated areas (for example, fire and sheriff services).

The state provides substantial funding for many, but not all, of its required programs. In many cases, specific county contributions are also required. Such programs include AFDC, county health services, community mental health, IHSS and the trial courts. The counties bear the primary fiscal responsibility for other state-required programs, because the state in these cases does not provide funding specifically for these purposes. Such programs include general relief, probation, indigent legal defense, and corrections.

County Revenue Sources

Counties pay for their share of state-required program costs and for local programs out of the revenue they have available for general county purposes. County general purpose revenue (GPR) comes from a variety of sources, including the property tax, state general purpose subventions (such as vehicle license fees), and the sales tax. Due to the constraints imposed by Proposition 13, *counties have very limited power to increase GPR.* For example, counties cannot increase their property tax rate, and must get voter approval to increase other taxes.

As service demands or costs grow over time, state-required programs and local programs compete for the growth in the existing GPR base. Because counties have relatively limited control over the costs of state-required programs, these programs may absorb an increasing share of GPR over time. Thus, the GPR available for local purposes may decline over time, requiring counties to restrict spending on local programs.

Fiscal Capacity Indicators

Based upon our review of county financial data, we have identified three useful indicators of the fiscal capacity of counties:

- ***Local Purpose Revenues (LPR).*** The first indicator is the total GPR available for *local purposes,* after expenditures on state-required programs are accounted for. We refer to this residual as local purpose revenue, or LPR.

This measure shows the residual fiscal capacity of counties to meet local needs after meeting state requirements.

- ***Change in LPR.*** Another important indicator is the *change* in LPR over time. A decline in LPR shows that a county's revenues are not growing at the same pace as the costs of state-required programs, and suggests that the county may be faced with difficult trade-offs between state programs and local service levels.
- ***Proportion of GPR Dedicated to State-Required Programs.*** A third indicator is the percentage of total GPR spent on state-required programs. The advantage of this measure is that it enables one to compare the relative load that various counties carry in the financing of state-required programs.

For purposes of this analysis, all of these measures are computed on a per capita basis, unless otherwise indicated.

Our review of county fiscal capacity is based on county revenue and expenditures from 1984-85 to 1987-88 (the latter is the most recent year for which complete data are available). We obtained data on county financial transactions from the State Controller's Office, the Department of Mental Health, the Department of Health Services, and the Department of Social Services. Our analysis excludes San Francisco because, as a city/county, it is not directly comparable to other counties. For example, San Francisco's charter city powers allow it greater ability to raise local revenues.

FINDINGS REGARDING COUNTY FISCAL CAPACITY

Statewide, the capacity of county governments to meet local needs with local revenues did not keep pace with the growth in population and the cost of living over the period 1984-85 through 1987-88. On a statewide basis, county LPR increased 12 percent during this period. After adjusting for population growth and inflation, however, LPR *declined* 6.5 percent over the period.

Counties also bore an increasing share of costs for state-required programs. In 1984-85, counties used approximately 50 percent of their general purpose revenues to support state-required programs. By 1987-88, this share had increased to 55 percent. This trend is attributable to the fact that, statewide, the cost increases in state-required programs outpaced local revenue growth. Between 1984-85 and 1987-88, the costs of state-required programs increased 40 percent, while general purpose revenue increased by only 26 percent.

Variations in County Fiscal Capacity

The statewide trends mask considerable variation in fiscal capacity among counties. The counties vary in terms of their total LPR, as well as in the growth or decline of this funding base over time.

As Figure 1 shows, in 1987-88, the average county had LPR of $108 per capita. However, county LPR ranged from Solano County, with only $57, to Sierra County, with $599. Alpine County is an outlier in this comparison, with LPR of $1,837. Alpine County exhibits much higher per capita LPR because it receives a relatively large *share* of the local property tax (68 percent), has an extremely small population, and spends relatively lower amounts for state-required programs.

The counties also show considerable variation as to changes in their LPR over time. For example, Solano County experienced a 33 percent *decline* in LPR between 1984-85 and 1987-88, while Alameda County experienced a 50 percent *increase* during the same period. In all, 23 counties experienced a decline in LPR during this period, while 14 of these counties experienced a *double-digit* decline in this revenue. In contrast, 34 counties experienced an increase in LPR, with 20 of these counties experiencing a double-digit increase in this revenue.

Figure 2 identifies the counties which experienced a double-digit decline in LPR between 1984-85 and 1987-88. These counties are of interest because they appear to have shifted a relatively large share of general purpose revenue from local purposes to support state-required programs. It is interesting to note that many of these counties are clustered in the northern central valley.

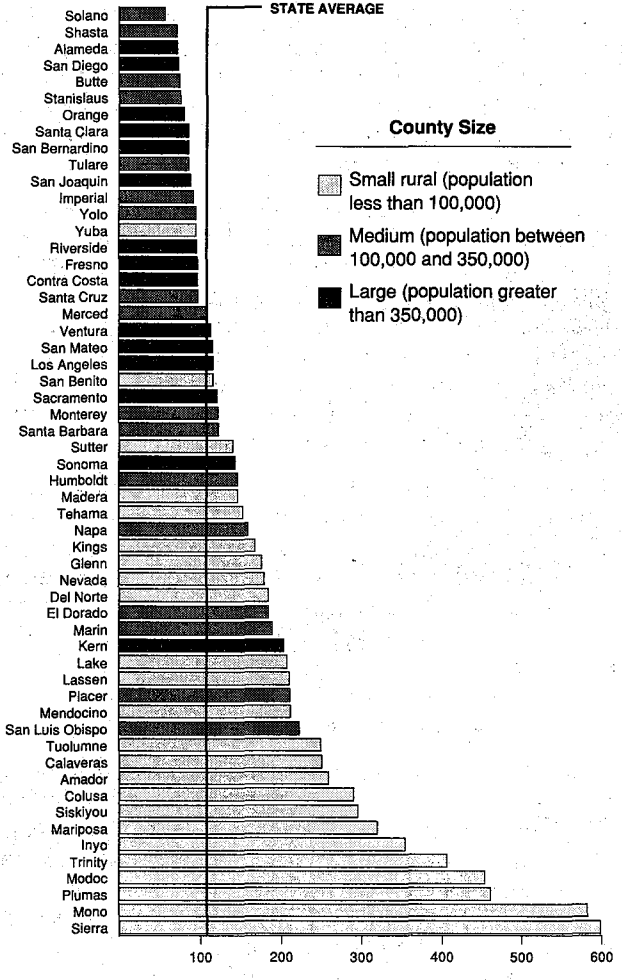
County Fiscal Capacity and Fiscal Distress

It is difficult to determine whether a county is experiencing fiscal distress based purely on these measures of fiscal capacity. Clearly, a county with low fiscal capacity is *more likely* to experience fiscal distress; however, the level of distress depends on the unique circumstances of each county. For example, a county which has a high level of LPR may be better equipped to sustain a decline in LPR without serious detriment to its residents. On the other hand, if the residents demand a high level of local services, the county may face practical difficulty in limiting services, and residents may feel deprived if traditionally local resources are shifted to support state-required programs. Conversely, a county with high *growth* in LPR may still have difficulty "making ends meet" if the *absolute level* of such resources was low to begin with.

Figure 1

Per Capita Local Purpose Revenue

1987-88 (dollars)



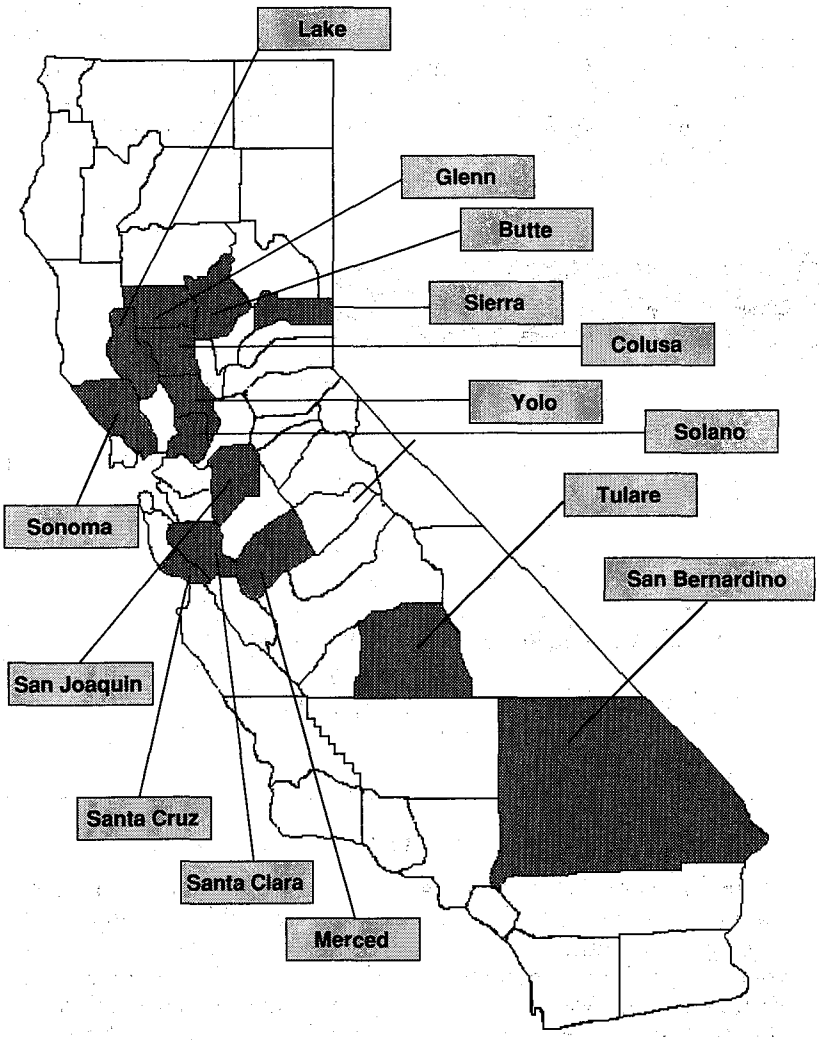
Note: Alpine County is excluded because LPR is off this chart at $1,837 per capita. San Francisco County is excluded due to lack of comparability.

Source: Legislative Analyst Office estimate.

Figure 2

Counties Experiencing Double-Digit Decline in Local Purpose Revenues

1984-85 to 1987-88



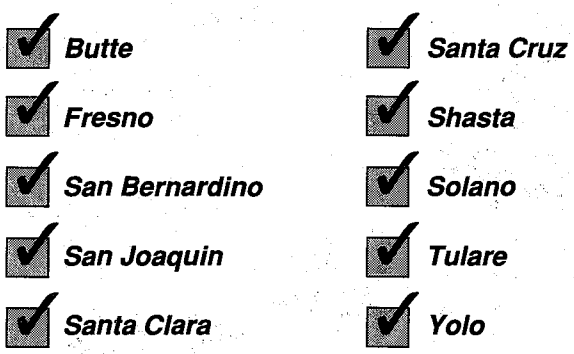
Source: Legislative Analyst's estimate.

Counties are particularly likely to face fiscal distress when they experience both a low level of LPR, and a decline in that level. For example, Butte County experienced a double-digit decline in LPR between 1984-85 and 1987-88. At the same time, Butte County had the fifth-lowest per capita LPR in the state in 1987-88. Butte County also spends less than the state average (measured on a per-capita basis) for a variety of local programs, including general administration, public health, social services, and recreation/cultural programs. Thus, the county has less flexibility to implement local service reductions in response to the increasing expenditures required in state-required programs. As Figure 3 shows, 10 counties are characterized by both a below-average amount of LPR, and a decline in LPR between 1984-85 and 1987-88.

Figure 3

Counties Characterized by Both Below-Average and Declining LPR

1987-88



Source: Legislative Analyst estimates

Low Fiscal Capacity—Not Just a Rural County Problem

In the past, rural counties have appeared to be particularly plagued by the gap between resource availability and service requirements, and state programs have been established to address the unique problems of such counties. For example, the Homicide Trials Program primarily benefits small rural counties. The *1990-91 Governor's Budget* also reflects the perception that low fiscal capacity is a particularly rural problem, and calls for a "Rural County Review" to examine the situation. Our analysis indicates, however, that the problem of low fiscal capacity is not merely a rural county problem.

Figure 4 provides information about changes in LPR for small rural, medium-sized, and large counties. Small rural counties are defined as those with populations under 100,000, medium-sized counties as having populations between 100,000 and 350,000, and large counties as those with populations in excess of 350,000. In each category of county size the figures indicate that there are counties with improving as well as declining fiscal capacity. For example, among small rural counties (upper panel), change in LPR varies from a 31 percent decline (Lake County) to a 38 percent increase (Inyo County). Among medium-sized counties (middle panel), it varies from a 33 percent decline (Solano County) to a 36 percent increase (Monterey County). Among large counties (lower panel), San Joaquin experienced a 16 percent decline in LPR, while Alameda County experienced a 50 percent increase.

Further, some of the larger counties which show declines in LPR also have a relatively low *base* amount of LPR (please refer to Figure 1). These counties include Santa Clara, San Bernardino, and Fresno. Thus, these data indicate that the problems of low and declining fiscal capacity are not confined to the rural counties.

The Role of State Fiscal Relief in Preventing Fiscal Decline

In 1987-88, the state established one-time block grants for county fiscal relief under Chapter 1286, Statutes of 1987 (AB 650, Costa). This program provided $110 million to California's counties. Of the total, $89 million was allocated to counties based on their relative shares of certain county health services grants, discretionary COLAs, and population. An additional $21 million was allocated based on a "revenue stabilization" formula established by Chapter 1286. Specifically, these grants were intended to stabilize the percentage of county GPR expended for the county share of costs in AFDC (exclusive of Foster Care), the IHSS program, the Community Mental Health program, and the Food Stamps program. In addition to the grants provided under Chapter 1286, several rural counties received state grants in 1987-88 for the reimbursement of certain homicide trial costs ($2 million) and for marijuana eradication ($2.8 million).

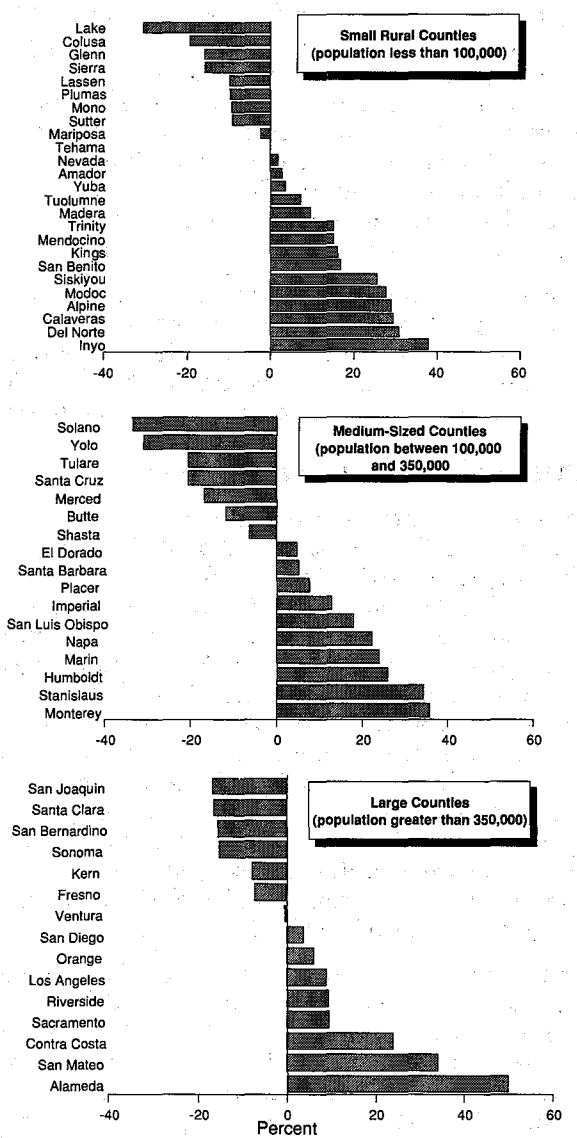
Our analysis indicates that the fiscal relief provided in 1987-88 reduced the magnitude of the fiscal decline experienced by counties between 1984-85 and 1987-88. In the absence of this relief, counties would have experienced a *10 percent* decline in inflation-adjusted LPR, rather than the 6.5 percent decline they did experience. Thus, state fiscal relief appeared to have a *marginal* positive effect on overall county fiscal capacity in 1987-88.

The state fiscal relief provided in 1987-88 played a more important role in improving the fiscal capacity of the *smaller*

Figure 4

County Percentage Changes in Local Purpose Revenue

1984-85 to 1987-88



Source: Legislative Analyst estimates.

counties. These counties were the primary recipients of the $21 million in revenue stabilization grants, as well as the grants for homicide trials reimbursement and marijuana eradication. In 1987-88, small rural counties received $16 per capita in this state fiscal relief, compared to $5 per capita received by medium-sized counties, and $3 per capita received by large counties. In the absence of this relief, small rural counties would have experienced a *5 percent decline* in LPR, rather than the *3 percent increase* that actually occurred.

It is important to note that, following 1987-88, counties did not receive large block grants for fiscal relief. In 1988-89 and subsequent years, however, counties did begin to receive new state assistance under the Trial Court Funding Program. Although information is not yet available to measure the impact of this program on individual counties, it is unlikely to provide the same level of relief to counties with low fiscal capacity. This is because the Trial Court Funding program provides its assistance in proportion to the number of judges in each county, and this bears little relationship to relative fiscal capacity.

FACTORS CONTRIBUTING TO LOW FISCAL CAPACITY

The specific factors contributing to low fiscal capacity vary considerably from county to county. For example, Butte County has experienced a decline in LPR primarily because of slow growth in local revenue sources. In contrast, San Bernardino County's declining LPR appears to stem primarily from dramatic growth in expenditures for state-required programs. Between 1984-85 and 1987-88, San Bernardino's expenditures for state-required programs grew at almost double the statewide pace—77 percent compared to 40 percent. Generally speaking, however, low fiscal capacity stems from some combination of limited revenue growth and increasing expenditures for state-required programs. As discussed below, counties have only limited control over these factors.

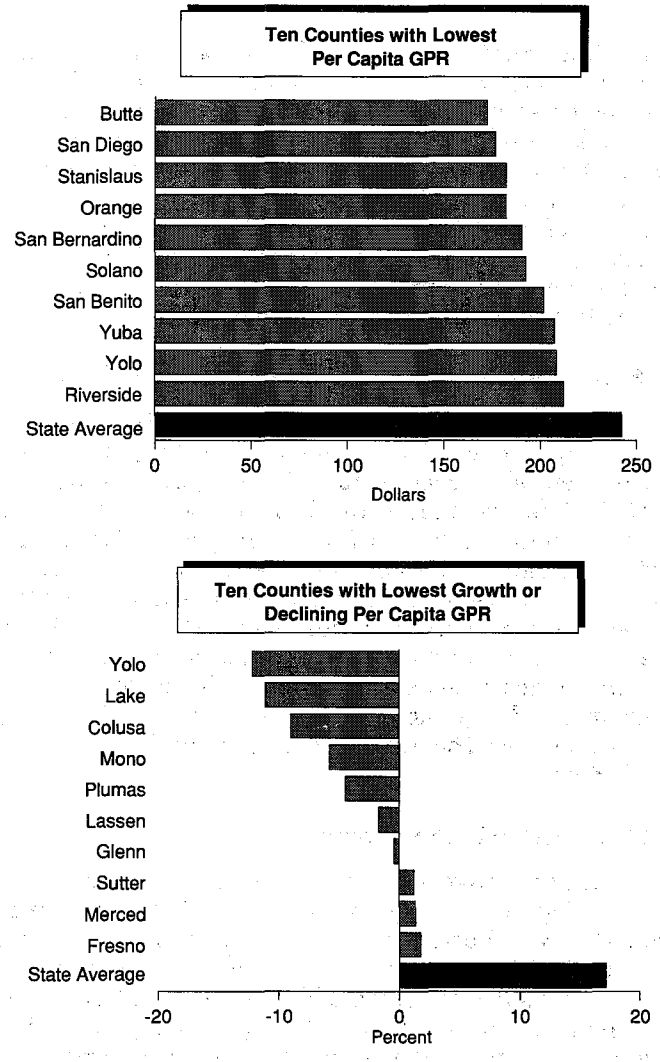
Limited or Low-Growth in Revenue

Our analysis suggests that a number of counties were characterized by low GPR, or by low growth in GPR, during the study period. Figure 5 shows the 10 counties with the lowest total GPR per capita in 1987-88 (upper panel), and the 10 with the lowest growth (or actual declines) in GPR between 1984-85 and 1987-88 (lower panel). The counties with low-growth or declining GPR include primarily smaller counties. There are, however, several large counties with low absolute levels of GPR (San Diego, Orange, San Bernardino, and Riverside Counties). Only one county—Yolo—was in the bottom 10 both in terms of absolute level and

Figure 5

Counties With Low or Low-Growth GPR

1984-85 to 1987-88



Source: Legislative Analyst Office estimate.

changes to GPR during the study period. As discussed below, a variety of factors are responsible for a county experiencing a low level of GPR, or low growth in that base.

Economic Characteristics. The county's characteristics, such as its economic base and the pace and pattern of development within its boundaries, are critical factors in determining GPR. For example, counties with primarily agricultural economies tend to have lower property values and retail sales and, therefore, more limited revenue. Even if a county has a growing economy, it will receive only limited fiscal benefit from this growth if commercial or industrial growth occurs within *city* boundaries.

Actions of Other Entities Within the County. The actions of overlying governmental entities can have an important effect on county resources. For example, Yolo County's decline in GPR during the study period is largely attributable to the incorporation of the City of West Sacramento in January 1987. While a county may experience some reduction in service responsibilities as a result of incorporation, these reductions are not always commensurate with its loss of revenues. In addition, city redevelopment policies can have an effect on county revenue. This is because current law allows redevelopment agencies to retain most of the increased property tax revenues (tax increment) occurring within a redevelopment project area.

State Policies. State policies also can affect county resource availability. One of the most important of these is the allocation of county property tax revenues established by state law. Under the AB 8 property tax allocation formula (enacted following the voters' approval of Proposition 13), the share of the property tax allocated to each local agency is based on its share of the total amount of property taxes collected in the county during the three fiscal years prior to 1978-79. Many counties imposed low property tax rates during this period and, therefore, currently receive a relatively low share of countywide property tax revenues. While counties receive on average 33 percent of total property tax revenues, county shares range from 18 percent in Orange County to 68 percent in Alpine County.

As discussed above, counties have extremely limited access to independent revenue sources. One potential revenue source for smaller counties is the sales tax. Chapter 1257, Statutes of 1988 and Chapter 277, Statutes of 1989 (both AB 999, Farr), allow counties with populations under 350,000 to increase sales taxes by one-half cent, subject to voter approval. Counties have had difficulty, however, obtaining voter approval for general sales tax increases. In all, 16 county measures have sought sales tax increases under these provisions. Only two of these measures have succeeded (in San Benito and Monterey Counties).

High or Rapidly Increasing Costs for State-Required Programs

Our analysis indicates that a number of counties expend a disproportionate amount per capita for state-required programs. Figure 6 shows the 10 counties with the highest per capita expenditures for state-required programs (upper panel), and the 10 with the highest *growth* in per-capita expenditures for state-required programs (lower panel). While many of the counties with high or increasing costs for state-required programs are small rural counties, several larger counties are also included (Alameda, Sacramento and San Bernardino Counties). Three counties show both extremely high *and* rapidly increasing costs for state-required programs (Trinity, Sierra and Mariposa Counties). Of these, only two are characterized by declining *LPR* (Mariposa and Sierra Counties). Trinity County did not experience a decline in LPR primarily because its increase in GPR outpaced cost increases during this period.

A variety of factors contribute to a county experiencing high or rapidly increasing expenditures for state-required programs.

Population Characteristics. Counties face high costs for state-required programs in large part because of local population characteristics. For example, in 1987-88, AFDC caseloads ranged from six cases per thousand residents in Marin County, to 50 cases per 1,000 in Del Norte and Yuba Counties. Counties also have differing populations in need of specialized services, such as elderly individuals or recent immigrants.

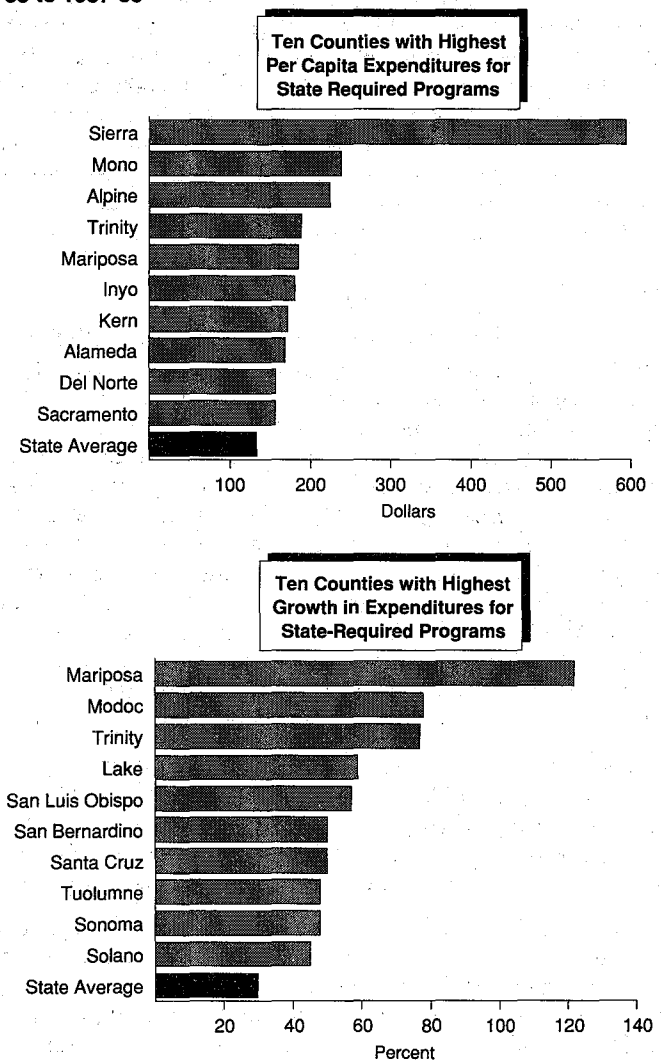
Local Program Choices. Counties can exert some influence over program costs through decisions regarding program administration, access to services and service levels. The ability of counties to determine eligibility and service levels varies, however, from program to program and from county to county. For example, counties have extremely limited control over expenditures in AFDC because the eligibility criteria and grant levels are established by the state and federal government. Counties generally have more control over general assistance expenditures because the state does not impose specific standards in this program. County decisions regarding law enforcement also have a substantial impact on their costs for administration of the courts and correctional facilities.

Court Actions. In many counties, the courts have established guidelines for state-required programs which restrict the county's ability to control program costs. For example, a number of counties face court-imposed minimum eligibility standards and grant levels for general assistance. The courts also have imposed

Figure 6

Counties with High or Increasing Costs for State-Required Programs

1984-85 to 1987-88



Source: Legislative Analyst Office estimate.

population caps on correctional facilities in 19 counties, requiring those counties to incur increased costs for staffing and operations of new or expanded correctional facilities.

Actions of Other Governments. The actions of other governmental entities also affect county expenditures for required programs. For example, the state is constitutionally required to reimburse counties for the costs of new programs or higher levels of service imposed after 1975. This requirement specifically does not apply, however, in the case of county program costs resulting from changes in crimes and infractions. Thus, county court and correctional costs are sensitive to state criminal justice policies. In addition, the law enforcement actions of cities, whose police departments operate independently of counties, can increase county costs by placing demands on the courts and jail facilities.

Variations in State Funding Affect Fiscal Capacity

As we discussed above, targeted state fiscal relief played a role in mitigating fiscal decline in 1987-88. Ironically, differences in state grants also may *contribute* to county fiscal disparities. Figure 7 illustrates the per capita state assistance provided to counties in 1987-88. This measure includes general purpose state subventions as well as state grants for programs such as mental health, county health services, and social service administration. It *excludes* payments for programs providing direct grant payments to individuals (such as the Supplemental Security Income/ State Supplementary Program and AFDC). It also excludes state payments for social service program costs that are primarily caseload driven. We exclude these caseload-driven payments because they are directly related to the service population and, therefore, would distort county-by-county comparisons.

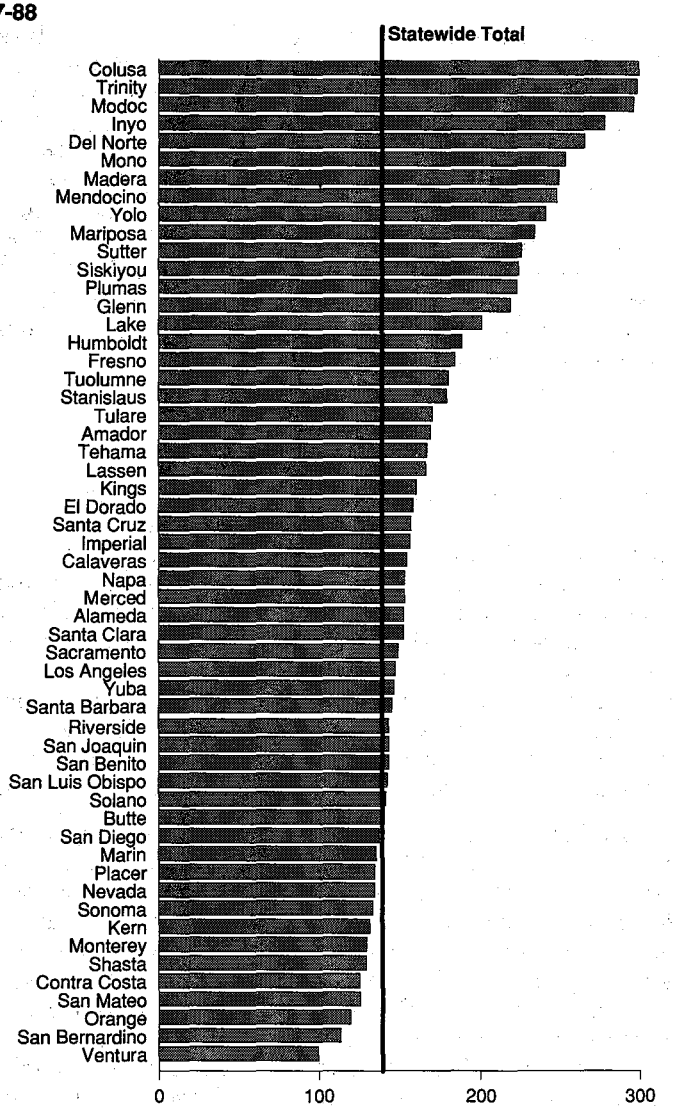
As Figure 7 demonstrates, state assistance payments vary considerably, from $100 per capita in Ventura County, to $300 per capita in Colusa County. To the extent that these variations do not accurately reflect variations in county service requirements or fiscal need, they may contribute to county fiscal strain.

Our analysis indicates that this may in fact be the case, for two reasons. First, funding for many programs is allocated in proportion to each county's relative level of expenditure during a "base year." For example, the subvention for county public health services is based partially on the level of "net county costs" for health programs during the 1977-78 fiscal year. Counties which chose to provide higher levels of service that year, at county expense, are now rewarded by higher allocations of state funds than counties that were providing lower levels of services at that time. As these allocations are fixed, they do not respond to changes

Figure 7

Per Capita State Assistance

1987-88



Note: Alpine and Sierra Counties excluded because they are off the chart at $1,094 and $831, respectively. San Francisco County excluded due to lack of comparability.

Source: Legislative Analyst Office estimates.

in service demands over time. Second, some programs, such as the state's alcohol and drug programs, provide a minimum amount of assistance regardless of population. This results in a higher per capita allocation of program funds for the less-populous rural counties.

These differences in state funding levels can have the effect of requiring counties to bear differing burdens for state programs. For example, state payments for community mental health under the Short/Doyle Act vary considerably from county to county. Until recently, these grant levels had not been adjusted to better reflect current county populations in need of these services. Counties which receive relatively low grant levels may find it necessary to increase expenditures to respond to their increasing service needs. As a result, they may bear a higher share of program costs than counties receiving higher levels of state assistance. This differential in county costs for state-required programs is responsible for some of the difference in LPR between counties shown in our data.

CONCLUSIONS

In sum, while county fiscal capacity varies considerably throughout the state, our analysis indicates that a number of counties are characterized by low fiscal capacity. Low fiscal capacity is not confined to small rural counties, as a number of the larger counties also are characterized by low or declining LPR. While the specific contributing factors vary from county to county, low-capacity counties generally experience some combination of limited revenue, low growth in revenue, and/or high or increasing costs for state-required programs. In addition, the state may contribute to fiscal disparities to the extent that the state aid it provides does not reflect current county fiscal conditions.

Low fiscal capacity can have many negative ramifications. As we describe in *The 1989-90 Budget: Perspectives and Issues* (please see p. 348), low fiscal capacity may require counties to restrict local services, or result in counties having difficulty meeting statewide objectives in programs of state interest. It also results in pressure to increase local revenue, and this may have an undue influence on local land use decisions. Moreover, counties' revenue constraints may hamper their ability to respond to future infrastructure needs and to facilitate local economic development. Fiscally distressed counties also may have difficulty providing adequate funding levels for state programs with matching requirements, which can result in them not meeting state objectives. For example, some counties may not have the fiscal resources to aggressively pursue child support collections, which may result in higher net state costs for AFDC. At the extreme, a

county may consider bankruptcy action in federal court. Given the lack of precedence and the complex issues involved, the state would face considerable uncertainty as to the outcome of such an action.

How Can the Legislature Improve County Fiscal Conditions?

The fiscal difficulties faced by counties are long-term and structural in nature. They result from the programmatic relationship between the state and counties, as well as the revenue constraints imposed by Proposition 13. Given the complexity of factors involved, and the diversity of California's counties, it will not be an easy task to find *long-term* solutions to county fiscal distress. In the short term, however, the Legislature should take into account the fiscal difficulties faced by counties when considering the Governor's budget proposals, many of which may have a negative impact on counties (see Figure 8 for the major proposals).

In addition, the Legislature will need to examine its options for providing short-term fiscal relief, as well as investigate longer-term solutions to the county fiscal dilemma. Figure 9 summarizes some of the alternatives for providing fiscal relief to counties. Three of these options are shorter-term in nature, and could be implemented in the budget year. These include the provision of targeted relief, reduction in county match requirements for state-required programs (or increased funding levels), and the reallocation of program funding (or allocation of future funding) based on measures of current program service requirements.

Our analysis indicates that increased funding and expanded program coverage for the existing County Revenue Stabilization program is an effective means of providing targeted fiscal relief to counties. This is because the statutorily determined grants provided by this program are designed to reflect the impact of state-program requirements on the revenue available for local purposes. The Governor's Budget proposes to provide $15 million for this program. Our analysis indicates, however, that to fully "stabilize" revenues in the manner contemplated by the statutory formulas would require considerably more than this amount (please see our discussion of this program in the *Analysis of the 1990-91 Budget Bill*, Item 9210).

While these options may close the gap between revenue and responsibilities in the short term, they are unlikely to solve the long-term structural budget problem experienced by counties. In the longer term, the Legislature should examine more permanent solutions to the county fiscal dilemma. As Figure 9 indicates, potential longer-term options include modification of the current

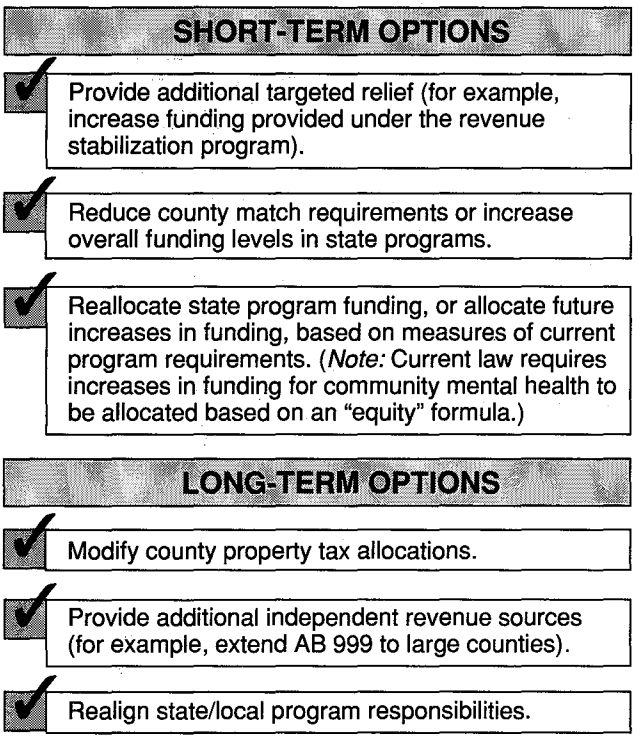
Figure 8

Impact of Governor's Budget Proposals on County Fiscal Capacity

Positive Impact	Amount	Analysis Reference
+ Augmentation for open-space subventions to counties under the Williamson Act	$5 million	Item 9100
+ Increased funding for the Community Mental Health Program	$10 million	Item 4440
+ Increased funding for the California Healthcare for the Indigent Program (CHIP)	$35 million	Item 4260
+ Shift the responsibility for mental health and residential services for children, as required by Ch 1747/84 (AB 3632, Brown) and Ch 1274/85 (AB 882, Brown), from the Department of Mental Health and Department of Social Services to the Department of Education	Unknown positive impact	Item 6110
Negative Impact		
− Reduction in payments to counties under the AB 8 County Health Services Program	$150 million	Item 4260
− One-year suspension of the statutory cost-of-living adjustments for AB 8 health services grants	$23.5 million	—
− Reduction in payments to counties under the Medically Indigent Services Program	$25 million	Item 4260
− Program growth "adjustment" under the Child Welfare Services program	$24 million	Item 5180
− Deferral of payment for the prior-year costs for certain mandates until the Budget Acts of 1991, 1992, and 1993	$40 million	Item 8885

Figure 9

Legislative Options for Improving County Fiscal Conditions



county property tax allocations, provision of additional independent revenue sources, or the realignment of relative state and local program responsibilities. These options should be considered, however, in the context of the overall county-state relationship and the programmatic goals of the state social service system. As such, these options merit additional study prior to state action.

Proposition 103--One Year Later

What Has Been Done to Implement Proposition 103 During the Last Year and What Issues Are Still Outstanding?

Summary

On November 8, 1988, California voters approved Proposition 103, which called for 20 percent rate rollbacks and ongoing regulation of the insurance industry. Our review of the past year's activities by the department suggests that considerable time will pass before the regulatory process has been fully developed and implemented. The department has proceeded slowly; thus, there are many elements of the regulatory approach that have not yet been developed and numerous issues remain to be resolved. In effect, while much activity has occurred over the past year, we are in essentially the same place as when the initiative passed.

One of the stated purposes of Proposition 103 is to encourage a competitive insurance marketplace. Our analysis suggests that many competitive elements already are present. Thus, it is not clear that California's high insurance premiums are due to a noncompetitive industry. This suggests that the insurance industry may not require a very intrusive regulatory approach in order to adequately safeguard the public against noncompetitive behavior and performance, including excessive premium rates. Our analysis also indicates that, in setting the level of allowable premium rate increases, it is very important that this process be based on sound assessments of a company's current and projected financial position and of investment market conditions.

In addition, we recommend that the Legislature review the statutes establishing the California Automobile Assigned Risk Plan in order to clarify the plan's purpose so that actions by the Insurance Commissioner are consistent with legislative intent. Finally, we recommend that the Legislature continue its review of factors that affect the underlying cost of insurance claims, since we believe there are significant opportunities for gaining control over insurance costs.

Almost 14 months ago, California voters approved Proposition 103, which required insurance premium rate rollbacks, ongoing regulation of rates for all property/casualty insurance companies, and changes in the way individual premiums are set for automobile insurance. Last year we examined Proposition 103 (please see "Insurance Reform," *The 1989-90 Budget: Perspectives and Issues,* page 289) in order to assess the effects of the initiative on the automobile insurance market. We concluded then that:

- The full effects of Proposition 103 on buyers of insurance (prices and availability) and sellers of insurance (profitability and regulatory environment) would be known *only after* the measure is fully implemented.
- The insurance industry exhibits many characteristics of a competitive industry and we were unaware of evidence of persistently high or "excessive" profits on an industry-wide basis.
- Costs of insurance claims are a key factor in explaining increasing premiums.

During the last year, a number of events related to the implementation of the initiative have occurred, most involving the Department of Insurance and its Commissioner. However, for many reasons the full implications of Proposition 103 *still are not yet known.* (For a discussion of the budget implications of delays by the department, please see our *Analysis of the 1990-91 Budget Bill,* pages 238-40.) Given the far-reaching implications for insurance buyers and sellers of these implementation activities, in this analysis we update where things currently stand and identify the key issues that are being dealt with. Our analysis again focuses on automobile insurance since that remains the segment receiving the greatest amount of attention.

First, we discuss the status of the 20 percent rollbacks specified in the proposition. Second, we examine the implications of the Commissioner's regulations governing "rating methodology"—the way insurance companies price insurance to groups of drivers. Third, we review the issues under consideration during the "generic" rulemaking hearings currently underway. (The purpose of these hearings is to determine the appropriate overall level of revenues that insurance companies should be permitted to realize.) Finally, we examine two issues not directly addressed by Proposition 103 but that have an important impact on the overall level of automobile insurance rates—the assigned risk plan and factors affecting the cost of claims.

BACKGROUND

Figure 1 provides a summary of the major provisions of Proposition 103, taking into account the Supreme Court's May 1989 decision regarding the initiative. While the court upheld most of the provisions of Proposition 103, it modified the measure in several important ways. The most significant change was the determination that companies are entitled to a fair and reasonable profit. Additionally, the court ruled that during the period from November 8, 1988 through November 7, 1989, companies could change premiums upon filing a notice with the Department of Insurance (this is known as a "file and use" system). Finally, the court ruled unconstitutional the creation of a nonprofit consumer advocacy corporation.

Figure 2 provides a chronology of the significant events associated with the implementation of the initiative since its passage. Several areas of activity are especially noteworthy: (1) the Supreme Court decision (referenced above), (2) the 20 percent rollbacks, (3) the Commissioner's rating methodology regulations, (4) consolidated hearings that deal with generic issues, and (5) the assigned risk plan premium rate increase decision.

Supreme Court Decision. The court's finding that companies are entitled to a fair and reasonable return is particularly important because it overturned the "substantially threatened with insolvency" standard found in the initiative. The court found that the solvency standard was "confiscatory" in accordance with a long chain of U.S.Supreme Court rulings regarding the right of companies subject to regulation to earn "normal" profits. (The term "normal" profits essentially means that companies should be allowed to both cover their costs and also have a profit margin left over equivalent to what could be earned elsewhere in the economy.) While this ruling applied specifically to the rollbacks, it also has applicability to future "prior approval" rate filings. Thus, determination of appropriate profit levels is one of the key decisions driving the implementation proceedings discussed below.

20 Percent Rollbacks. Proposition 103 requires insurance companies to reduce their premiums by 20 percent. Once the court upheld this provision, the Commissioner issued regulations specifying the data required from companies in order to request exemptions from the rollbacks. The resulting exemption requests, which virtually all insurance companies filed by the June 5, 1989 deadline, were then reviewed by the department. Based on that review, the Commissioner ordered hearings for seven of the largest insurers to determine whether they should be required to roll back rates. These hearings were originally expected to be the primary forum for developing the basic regulations that would

Figure 1

Provisions of Proposition 103 as Upheld by the California Supreme Court[a]

Category	Key Provisions
Rate Changes:	
Initial rollback	❒ 20% below rates in effect on November 8, 1987 for all policies written or renewed after November 8, 1988, subject to a "fair and reasonable" return on investment standard
Additional changes	❒ "File and use" rates until November 8, 1989 ❒ Additional 20% reduction in auto insurance rates for all "good drivers" beginning November 8, 1989
Rate Regulation:	
Filing and justification	❒ Effective November 8, 1989, "prior review" and approval of all rate changes ❒ Justification for all rate changes
Basis for rates	❒ Rates must reflect investment earnings ❒ No consideration given to "competitive conditions"
Factors for Establishing Rate Classes	❒ Primary consideration given to driving record, miles driven, and years of driving experience, in that order ❒ Secondary consideration given to other factors as determined by the Commissioner
Antitrust	❒ Removes current exemption from antitrust and unfair business practice laws
Consumer Assistance	❒ Requires Department of Insurance to provide comparative rate information for consumers upon request
Other Features	❒ Permits sale of insurance by state-chartered banks ❒ Permits discounts and rebates by insurance agents ❒ Requires election of Insurance Commissioner ❒ Increases gross premiums tax and regulatory assessments to offset administrative costs and state revenue losses due to insurance rate reductions (the court declined to rule on the constitutionality of the gross premium tax provisions)

[a] These provisions generally apply to all lines of insurance covered by Proposition 103 (including auto, fire and liability).

Figure 2

Major Milestones in the Implementation of Proposition 103

1988	
November 8	***Initiative Passed*** Proposition 103 approved by voters.
December 7	***Rollbacks Put on Hold*** Except for the rollbacks, the state Supreme Court allows Proposition 103 to take effect pending formal review.
1989	
May 4	***Supreme Court Upholds Proposition 103*** The court, however, rules that rollbacks can be exempted if companies are denied a reasonable return and that companies can use a "file and use" process for rate increases until November 8, 1989.
June 5	***Rollback Exemption Filings Deadline*** Deadline for filing rollback exemption petitions. Virtually all companies file for partial or total exemptions.
June 19-23	***Implementation Hearings*** The Commissioner holds public hearings on general implementation issues.
August 1	***Rollback Exemption Decision*** The Commissioner announces the 11.2 percent profit rate standard, accepts many exemption requests, and rejects exemption requests of 7 large insurers.
August 14-18	***Rating Methodology Hearings*** The Commissioner holds a series of public hearings to help determine the methods by which insurers could set individual premium rates.
October 2	***Interim Rate Increase Freeze*** The Commissioner imposes a six-month rate freeze in response to almost 500 "file-and-use" requests and to provide time to develop prior approval and rating methodology regulations.
November	***Generic Issues Consolidated Hearing (GICH), Rating Methodology Phase*** The Commissioner initiates a series of hearings to determine generic regulations for rating methodology.
December 5	***Rating Methodology Rules*** The Commissioner releases emergency regulations governing rating methodology. Key provisions required reduced emphasis on territory in setting individual rates and imposed a cap on future rate increases.
December 18	***Assigned Risk Pool Decision*** The Commissioner denies the assigned risk pool rate increase request because it does not consider the new rating methodology rules and insurance affordability.
December-Present	***GICH, General Regulation Phase*** The Commissioner initiates a series of hearings to determine generic regulations for rollbacks and prior approval regulation process.

govern the industry under Proposition 103. However, the hearings have never been held.

Rating Methodology Decision. During the time that the department was reviewing the rollback exemption requests, it was also attempting to write the regulations that would govern the way insurers developed individual rates for automobile insurance (referred to as the "rating methodology"). Proposition 103 mandates specific individual characteristics that must be given precedence in the development of rates. The weighting of the mandatory factors is quite different from that used by the insurance industry prior to enactment of the initiative. The regulations were announced by the Commissioner in December of 1989 following hearings in August and November of 1989.

Generic Rulemaking Proceedings. There are two main elements to the department's new regulatory program: (1) the rollbacks and (2) the "prior approval" regulatory program mandated to begin in November of 1989. Under prior approval, insurance companies must obtain approval of proposed rates *before* they can use them. As we indicated above, the Commissioner attempted to use the seven-company rollback hearings as a way to develop the regulations that would be needed to administer the prior approval regulatory program. Once it became clear that this approach to the development of regulations would not work, the Commissioner called for a set of hearings that began in December 1989. These hearings—called the generic issues consolidated hearings (GICH)—are expected to provide the data and concepts needed to develop the basic regulatory structure to be used by the department. The hearings are expected to last into the spring of 1990.

Assigned Risk Pool Ratefiling. California, like most states, has provisions for the use of a pooling arrangement to allocate "bad" risk and otherwise uninsurable drivers among automobile insurers. The California arrangement is known as the California Automobile Assigned Risk Plan (CAARP) and is managed by the insurance industry. The CAARP's rates have long been determined using a form of prior approval regulation. In recent years, the CAARP rate increase requests have been large and the Commissioner (as well as her predecessor) has systematically authorized smaller increases than have been requested. Holding down CAARP rates relative to rate increases in the regular market has resulted in both increasing enrollments, and increasing deficits in the plan. While Proposition 103 does not directly address the CAARP, there are issues (related to the role and purpose of CAARP) raised by a December 1989 CAARP rate increase decision that affect the regulation of insurance companies pursuant to Proposition 103.

WHAT IS HAPPENING WITH THE 20 PERCENT RATE ROLLBACKS?

Under the provisions of Proposition 103 as enacted by the voters, insurance companies were required to reduce rates to a level 20 percent below the rates in effect on November 8, 1987 unless the company was *substantially threatened with insolvency.* As noted earlier, the Supreme Court ruled that the threat of insolvency was too strict a standard and replaced it with the *fair and reasonable return* standard common to other regulated industries. As noted earlier, this standard means that a company is entitled to a "normal" profit rate.

Exemption Filings

Once the court upheld the central provisions of Proposition 103, implementation of the initiative began. Within a week after the court ruling, the Commissioner released regulations specifying: (1) how insurance companies were to file for exemptions from the rollbacks and (2) the information and data needed in order to support an exemption filing. About 450 insurance companies—virtually the entire industry—filed a total of more than 4,000 individual line-of-business (such as automobile, homeowners, commercial liability) exemption requests. These requests were examined by the department and the Commissioner's initial rulings were announced August 1.

At the same time, the Commissioner announced the profitability standard the department would use for evaluating the exemption filings. The department adopted a profit rate of 11.2 percent as the basis for determining whether company profits were excessive. Using that standard, the Commissioner agreed with a significant number of the exemption requests, withheld on many others, and found that seven of the largest insurers (including State Farm, Allstate, USAA and California State Automobile Association) would be subject to rollbacks of varying amounts. Rollbacks were ordered for a number of insurance lines—including automobile insurance. The largest percentage-of-premium rollbacks, however, generally were ordered for earthquake, homeowners, and inland marine insurance. Only relatively small rollbacks (less than 6 percent) were ordered for private passenger automobile insurance (with one exception, USAA, which was ordered to reduce rates by about 16 percent). Each of the seven companies that was ordered to roll back rates petitioned for a hearing.

Rollback Hearings

The purpose of the hearing process was to determine whether the department's analysis of and conclusions regarding the exemption filing was justified. The usual practice in regulatory agencies is to have an *already established* set of basic regulations to govern the industry. Rather than issue these regulations *prior to* beginning the rollback hearings, however, the Commissioner chose to use the individual company hearings *themselves* as the forum for developing basic regulations. Among the basic issues that the hearings needed to resolve were: (1) the methods for calculating both actual and allowable profits, (2) the method for allocating owners' equity (insurance regulators and companies call this "surplus") between lines of business, and (3) the general regulatory approach (discussed below).

The Commissioner's approach to developing regulations quickly became bogged down by challenges from the companies. These challenges delayed the start of the hearings (in fact, these hearings have not yet been rescheduled) and led the Commissioner to propose a set of consolidated hearings to produce a set of generic regulations to govern both the rollbacks and future prior approval regulation. The generic issues consolidated hearings which resulted from this decision are discussed later.

Summary Regarding Rollbacks

Virtually all insurers filed for exemptions from the rollbacks for automobile insurance (and many other lines, as well). The Commissioner ordered rollbacks for a number of the largest insurers, which then requested hearings. These hearings were to be the forum for developing basic regulations governing the industry. Problems with this approach, however, put the rollbacks "on hold" indefinitely.

WHAT ARE THE IMPLICATIONS OF THE RATING METHODOLOGY REGULATIONS?

In December of 1989 the Commissioner released regulations on the subject of "rating methodology." This section discusses the possible effects of those regulations.

Why Is Rating Methodology Important?

Rating methodology refers to the techniques used by insurance companies to determine premium rates for individual policyholders. Because development of truly unique rates for each individual would be too costly and because probabilities of claims occurring must be used, insurance companies typically assign

each policyholder to a group of individuals that exhibit similar degrees of risk for incurring claims costs. This process is important to the financial viability of a company. Therefore, companies use statistical techniques, usually under the direction of an experienced actuary, to evaluate various individual characteristics that would allow the company to determine a driver's approximate degree of risk.

Among the characteristics reviewed are: driving records, number of years of driving, use of vehicle, miles driven, geographic location of drivers, and automobile characteristics (such as make and model of vehicle, engine size, safety features, and company experience with the vehicle). The companies assign weights to each significant factor, which are then used in calculating actual premiums. In the past, the most significant weight (up to 50 percent) was given to "territory" (that is, where a person lives based on groups of zip codes). However, there has been disagreement about the proper relative weighing between territory and other factors.

What Are the Regulations Proposed by the Commissioner?

The rating methodology regulations describe both the mandatory and the optional factors insurers can use, and the relative weighting of these factors. The regulations also provided a cap on rate increases.

Mandated Factors Given Precedence. Proposition 103 identified three factors that must be considered *before* any optional factors could be used when developing premiums. These *mandated* factors are (1) driving record (including both traffic violations and at-fault accidents), (2) number of miles driven annually, and (3) number of years of driving experience. The Commissioner ruled that the second factor (miles driven) could have no more weight than the first factor (driving record), and that the third factor (years of driving experience) could have no more weight than the second factor.

Optional Factors Specified. The Commissioner banned the use of territory, gender, age, sex and certain other factors when making individual rates. In their place, the Commissioner identified 22 optional factors that could be used by companies to help set premiums *after* the mandated factors are considered. All of these optional factors affect the cost of paying a claim (such as cost of repairs, theft rates, litigation rates, average medical costs in an area, and vehicle characteristics—including safety features). Additionally, some factors are also territory-related (such as population density and vehicle density). Before any optional factor is used, however, companies must show that it bears a

substantial relationship to the risk of loss. Significantly, the Commissioner also ruled that the *combined* weight of *all* of the optional factors could have no more weight than the third most important mandated factor listed above. This effectively limits the total weight of *all* optional factors to less than 25 percent.

Cap on Rate Increases. As we discuss below, it is likely that any given individual's premium rates under the Proposition 103 rating methodology will be different from what they are now. Arguing that Proposition 103 called for lower—not higher—rates, the Commissioner ruled that no rate could be increased in any year by more than the California Consumer Price Index (CCPI).

How Will These Regulations Affect the Price of Auto Insurance?

The rating methodology is the basis for all individual premium rates. Substantially changing the existing rating methodology is likely to have significant effects on the rates some individuals pay. We have identified two such effects: (1) potentially substantial cross-subsidies between different groups of insurers (due to the reduced weighting of the optional factors), and (2) overall limitation of premium increases to less-than-actual increases in the cost of providing coverage.

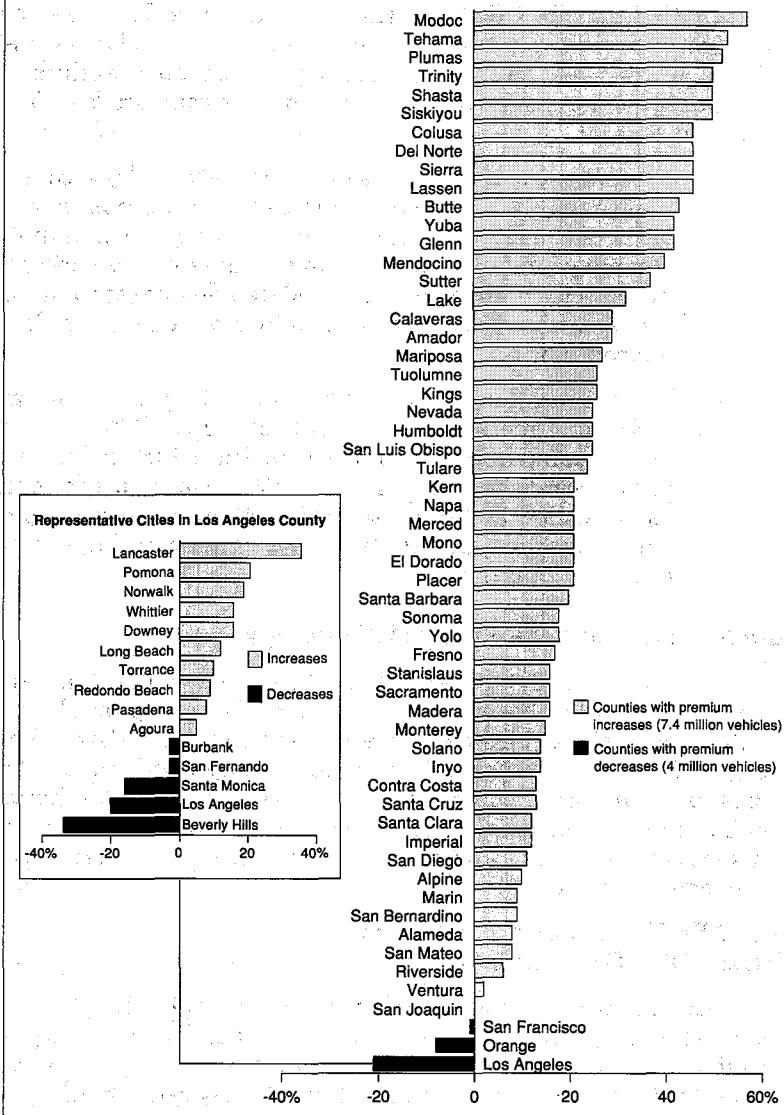
Cross-Subsidies. Cross-subsidies occur when one group of consumers is charged a premium that exceeds the cost of providing coverage to that group, while another group of consumers is charged a premium that is below the cost of providing that group's coverage. The group that pays insurance premiums that are in excess of the cost of providing coverage, in effect, helps to pay for (that is, subsidize) the below-cost coverage provided to the other group.

There is wide agreement among actuaries that territory (as a surrogate for certain of the optional factors discussed above) should have a greater weight than is allowed by Proposition 103. The greater the difference between the true weight of the optional factors and the allowed weight, the greater the extent of the cross-subsidy between consumers.

Figure 3 shows the department's rough estimate of county-by-county average premium changes that would result by reducing the importance of territory as a rating factor under the proposed regulations. We must caution the reader that it is impossible to predict the precise impact of the proposed changes for any given policyholder. Nonetheless, the figure provides an indication of the *general magnitude* of the premium changes. It indicates that drivers in all but three counties would experience premium increases and that the increases would be *quite large* in some

Figure 3

Automobile Insurance Average Premium Changes Due to Reduced Effect of Territory [a]



[a] This estimate applies to liability coverages and assumes that the weight of territory as a rating factor is reduced to 24.7 percent.

Source: California Department of Insurance 1987 Premium Data.

counties (primarily rural counties). The figure also provides a breakout of premium changes for selected locations within Los Angeles County. It shows that even within the county that would, on average, benefit the most from the change in methodology, there are still many drivers who would experience premium increases.

CCPI Cap. The CCPI cap was imposed by the Commissioner primarily to limit premium increases in counties adversely affected by the new rating methodology. A cap on premium increases could, however, threaten an insurance company's profitability in several ways:

- In response to the changes in rating methodology, companies probably would need to increase premiums in some parts of the state by many times the CCPI (which in the current year is expected to be in the range of 4 to 5 percent) in order to compensate for mandated decreases in premiums elsewhere if they were to maintain their current level of profitability.
- Many of the underlying costs of providing insurance are increasing more rapidly than the CCPI. If the cap prevented companies from recovering these increasing costs in future rate proceedings (using the prior approval process specified in Proposition 103), then company profits would decline, potentially resulting in some firms withdrawing from the market.

Summary Regarding the Rating Methodology

Proposition 103 required changes in the way individual rates are set. Except for the rate cap, the Commissioner's regulations follow the basic requirements mandated by the initiative. These regulations do, however, result in potentially significant subsidies to certain buyers of insurance at the expense of other buyers of insurance. Additionally, the rate cap could make it difficult for insurers to earn a "fair and reasonable" profit without challenging the legality of the cap.

WHAT ARE THE KEY REGULATORY ISSUES STILL TO BE RESOLVED?

As we indicated above, the Commissioner originally attempted to develop regulations for the industry using individual company rollback hearings. It quickly became apparent that this process would not work, so the Commissioner next proposed a separate set of hearings (announced in October of 1989) to determine generic rules for regulating the industry. The first phase of the GICH ended with the promulgation of the rating methodology regulations discussed above. The second phase, currently underway, is

expected to end in March of 1990 and to result in regulations governing both the rollbacks and future prior approval rate filings. This section presents an overview of the more fundamental issues that must be resolved before regulation can begin.

What Regulatory Approach Should Be Taken?

The first step in developing a regulatory process is establishing the kind of oversight of insurance companies to be exercised by the department. This issue must be resolved before the other issues under consideration during the GICH can be addressed. Since regulation generally is used to approximate the results one would expect to find in a competitive market, the choice of regulatory approach should be guided by (1) the degree to which the industry is already subject to competitive forces, (2) the extent to which "excessive" profits exist, and (3) the degree to which the initiative allows competitive forces to be considered in regulatory proceedings.

Degree of Competition. Last year (please see *The 1989-90 Budget: Perspectives and Issues,* pages 293-294) we examined the insurance industry and found that competitive elements are present. Specifically, we found that there are many companies selling insurance and there is significant freedom of "entry and exit" in the industry. Additionally, a survey of industry studies (produced by academics, consultants, and government agencies) indicates that most experts agree that the insurance industry generally exhibits competitive characteristics.

Profitability. In last year's review we also examined a number of automobile insurance profitability studies. We found that these studies do not support the view that the industry has been earning excessive profits. This industry has a history of volatile profitability, and in any given year some companies could be earning larger profits than would be normal for the long-run. However, over time, the industry as a whole appears to exhibit competitive performance. During the past year, we examined additional studies and have been unable to find evidence of persistent excess profits. The department's review of rollback exemption filings (discussed above) provides additional support to the view that automobile insurance profits have not been excessive.

Consideration of Competition. While the evidence suggests that competitive elements are present, the Commissioner may be prevented from considering these elements in the regulatory program. One of the *stated* purposes of Proposition 103 is "...to encourage a competitive insurance marketplace...." Elsewhere in the initiative, however, the Commissioner is instructed to give

"...no consideration to the degree of competition..." when approving insurance rates. If, in fact, the industry is competitive and the Commissioner must ignore that fact, an inappropriate type of regulatory oversight could result.

What Ratemaking Approach Is Appropriate? Some participants in the GICH argue that insurance companies require very close scrutiny during rate review because the industry has been exempt from antitrust oversight for many years (the initiative removed these exemptions). The regulatory approach proposed by this group would include: (1) a formal public utility rate-of-return ratemaking proceeding (perhaps some variation of the way in which the California Public Utilities Commission—CPUC—regulates electric or gas utilities), (2) a close and detailed review of all company records, and (3) so-called "social" regulation (use of the regulatory process to achieve specified public policy goals such as income redistribution, caps on certain expenses or "good service incentives").

Other participants in the GICH argue that insurance companies exist within a basically competitive environment, thus requiring relatively less intrusive oversight by the department (such as the way the CPUC regulates the trucking industry). The regulatory approach proposed by this group would give the department much more discretion about the intensity of individual company reviews. In essence, this approach would include more emphasis on general policies to guide reviews and the use of bands of rate flexibility within which companies could set their premiums without in-depth review.

There are many regulatory approaches that would fit within these two relative extremes. It is not clear at this time, however, what regulatory approach the Commissioner will choose.

As we noted last year, regulation of the insurance industry, like any industry, should proceed from a neutral perspective and focus on the underlying economic realities of the industry. *In our view, the available evidence on the competitive forces in the industry suggests that a less intrusive regulatory approach is warranted.*

How Will Profits Be Measured?

The court ruled that insurance companies are entitled to a fair and reasonable return. This requirement establishes the importance of profit calculation in the regulatory process since the regulator must know both the standard to be used to determine *allowed* profits and the method for calculating *actual* company profits. There are many technical factors that must be resolved in

order that these calculations are performed in a manner that is consistent with good economic analysis. The principal issues are:

- ***How to Measure Profits?*** In prior-approval ratemaking, profits must be determined so the regulator can determine whether proposed premiums are too high or too low to allow firms to earn an adequate rate of return. Several major issues need to be resolved before actual regulation can proceed in an appropriate manner. These include determination of: (1) the appropriate accounting standards to use in measuring profits, (2) rules for allocating "owner's equity" and overhead costs between lines of insurance when computing their profitability, and (3) the appropriate time frame for calculating profit rates (for example, should the focus be on past or projected future profits).
- ***How to Establish the Level of Allowable Profits?*** In order to determine whether an individual company is earning a fair and reasonable return, the regulator also must define a standard (so-called *allowable* profits) against which to compare a company's actual profits. Some of the issues yet to be resolved include: (1) whether different standards should be used for rollback and for future rate proceedings, (2) whether allowable profits should be an industry average versus company or line-of-business averages, and (3) what an adequate profit return is in order for an insurance company to remain economically viable over time.

What Is a Fair and Reasonable Profit Rate? A fair and reasonable profit rate is that which is sufficient to attract needed financial capital to an industry and keep it there. Stated another way, it would be the profit rate that would make investors earn as much by investing in an insurance company as they would in other industries having a similar degree of risk. This suggests that proper regulation of the insurance industry requires ongoing adjustments of the allowable profit rate because economic forces change from year to year and would affect investment decisions. Additionally, since premiums in regulatory proceedings are set for the *coming* year, it is important that allowable profits take into account future (that is, prospective) profits, rather than simply on how companies have performed in the past.

As noted earlier, the Commissioner adopted an *allowed* profit rate of 11.2 percent for use during the department's reviews of the rollback exemption filings. This profit rate was arrived at by taking a 15-year average of industry-wide return on equity—including all investment income.

The department's decision to use return on equity as a measure of allowable profits is appropriate. It is not clear to us, however, whether the department's approach in arriving at the 11.2 percent figure gives:

- Adequate consideration to the longer-run profitability requirements of the industry;
- The proper recognition to future economic conditions; and
- Proper consideration to differences in the riskiness of individual lines-of-business.

The department's methodology in arriving at this standard currently is under review as part of the GICH.

How Will Reserves, Surplus, and Expenses Be Measured?

Once the regulatory approach and a method for measuring profits are determined, another set of issues must be resolved. These issues generally relate to the treatment of certain critical accounting variables such as loss reserves, surplus, and expenses.

Loss Reserves and Surplus. Loss reserves (funds set aside to pay claims) and surplus (under regulatory accounting rules surplus is roughly equivalent to owners' equity) represent large pots of money which, some parties allege, could be subject to manipulation by the companies to the detriment of policyholders. Specifically, these parties contend that insurance companies frequently place more funds into loss reserves and surplus than is required on actuarial grounds. If true, the premiums paid by consumers would be higher than they otherwise would be while reserves and surplus are being built up. On the other hand, regulators (and good business practice) require companies to set aside an appropriate level of funds to assure that monies are available to pay off all claims. Specifically, unduly holding down the size of reserves and surplus could increase the danger that a company might be unable to pay off claims in a timely fashion or might not be able to survive a large catastrophe.

Allocation of Surplus. Accounting issues have been raised regarding the *allocation* of surplus among the lines-of-business for the purposes of determining the profitability of individual lines. Companies typically do not organize their accounting records in a way that directly allows for a line-of-business division of the surplus; consequently, some method must be devised for doing the allocation. Since surplus is treated as backing for premiums written (much the same way as banks hold loan reserves), a natural method for allocating surplus among lines would be to use the degree of risk faced by each line-of-business. This kind of allocation, however, is apparently very difficult to accomplish.

Hence, some other method for allocating the surplus must be devised.

The department proposes to use so called "premium-to-surplus norms" to allocate surplus among lines-of-business. A premium-to-surplus norm represents the number of dollars of premiums a company can write for each dollar of surplus held. Some parties have proposed the use of premium-to-surplus ratios that were developed by regulators as "rules-of-thumb" to trigger closer examination of companies during solvency reviews. Hence, these norms represent the limit beyond which a company is thought to become sufficiently risky to merit closer evaluation. While this approach has some surface appeal because the norms are easy to use, the department has provided little analytical support for the use of these norms. There are at least two problems with their use:

- Norms, in effect, establish a standard for the "correct" level of surplus and make no allowance for operating differences between companies.
- Companies that choose to hold "extra" surplus (to reduce their exposure to large unanticipated losses) would be disadvantaged by having to accept a lower profit rate. This is because regulators would not permit premium increases large enough to maintain this excess.

Should Companies Be Held to Efficiency Standards? Some participants in the GICH argue that expenses also should be evaluated using industry norms. Thus, all companies would, in effect, be reviewed based on the behavior of the "average" or, alternatively, the lowest-cost (the most efficient) company. Use of norms or "efficiency standards" are proposed as a way to force less efficient (higher cost) companies to improve their performance. Other participants argue that each company must be reviewed based on its individual choices regarding the level of expenses it incurs. This view is based on the notion that companies in the industry are diverse in many ways, and thus face different costs. Hence, norms could reduce incentives to innovate by forcing all companies to become more alike.

Should Certain Expenses Be Excluded or Capped? Some participants argue that certain expense items should be capped or excluded when setting rates and computing profits. These items include political contributions, executive salaries, image advertising, and bad faith judgments. Other participants argue that the department does not need to cap or exclude any expense categories because the market would exert discipline over management to contain these, and all other, costs. In January of this year, the Commissioner announced her intent to use such caps and exclusions.

Summary Regarding the Key Regulatory Issues

There are many generic issues yet to be resolved before Proposition 103 can be implemented fully. The previous discussion touched on only the more important and, perhaps, contentious issues. The GICH process is only the beginning. Once the Commissioner issues her generic regulations sometime in spring 1990, she must then apply them to individual company rollback and prior approval rate filings. It is not yet clear how difficult it will be to make the generic rules workable in the context of everyday company regulation. Most observers expect challenges both to the generic regulations and to their application to individual companies. Resolving those challenges likely will take some time.

OTHER KEY ISSUES RELATED TO PROPOSITION 103

While we have focused above on the implementation of Proposition 103 during the last year, there are two closely related insurance issues that are deserving of the Legislature's attention. These include:

- The role of the California Automobile Assigned Risk Plan (CAARP).
- How to gain control over the rising cost that companies incur in order to provide insurance.

What Is the Purpose of CAARP?

We recommend that the Legislature review the statutes establishing the California Automobile Assigned Risk Plan to clarify the Legislature's intent whether (1) the CAARP was established as a self-supporting pool, (2) its purpose is to insure only bad drivers, and (3) it is to subsidize insurance to low-income drivers.

CAARP Deficits Are Large and Growing. As described earlier, the CAARP was established to provide insurance for "bad" drivers (that is, drivers with extremely poor driving records). In recent years the number of policyholders insured through CAARP has been growing rapidly because of the plan's relatively low rates. As recently as 1986 the CAARP provided insurance coverage for about 423,000 drivers (approximately 3 percent of all insured drivers in California). The department estimates that at the end of 1989 about 1.2 million drivers were in CAARP (more than *10* percent of all insured drivers), and it further estimates that the enrollment could reach about 1.5 million by the end of 1990. In recent years, the relatively low rates have caused the plan to change so that many, perhaps most, of the drivers currently insured through the CAARP would be considered "good"

drivers under Proposition 103 (that is, no more than one moving violation during the previous three years). As mentioned above, these drivers appear to be choosing the CAARP, in part, because: (1) it offers *lower* premiums for basic coverage than does the regular market and (2) insurers providing regular coverage are reluctant to serve some of these customers. Currently, this practice is limited primarily to Los Angeles County but could become a concern in other urban areas in the future.

The CAARP administrators estimate, and department staff concur, that in 1989 the expected cost of claims and expenses associated with settling those claims from the CAARP policies *exceeded* premium revenues by at least $600 million. The department staff estimate that the deficit could reach $1 billion in 1990 given present trends. The funds needed to cover these deficits come from the premiums paid by drivers purchasing insurance in the regular market. In effect, the regular market is subsidizing insurance coverage for both the good and bad drivers in CAARP. Those subsidized drivers, however, are not necessarily low-income individuals.

1989 CAARP Rate Proceeding. In February 1989 the CAARP administrators filed a request for an approximately 112 percent increase in the average assigned risk pool premium. Actuarial estimates done by the industry and confirmed by department actuaries indicate that this increase in average rates is required in order for the plan to cover its costs. The request was then set for hearings which focused on a number of issues including:

- Whether concerns about the ability of drivers to afford insurance should affect the CAARP premiums, and
- Whether passing the CAARP deficits through to non-CAARP policyholders would establish "unfairly discriminatory" premium rates for the regular market (because of the cross-subsidies).

On December 4, 1989, the presiding Administrative Law Judge (ALJ) found that the CAARP rate increase request was justified because disallowing the request would result in a subsidy of CAARP policyholders by non-CAARP policyholders (the regular market). This subsidy would violate provisions of Proposition 103 which mandate that voluntary market premiums cannot be unfairly discriminatory. Thus, the ALJ concluded that the current CAARP rate structure is inadequate and the premium increase is justified.

The Commissioner, in her decision filed December 18, 1989, disagreed with the ALJ (whose findings are advisory only) and denied the CAARP rate request on the grounds that it did not

adequately take into consideration affordability concerns raised during the hearings. Additionally, she found that the CAARP administrators did not adequately justify their premium increase request since they failed to consider changes in rating methodology mandated by Proposition 103. The deficits identified in the premium increase request could be partially offset by these changes. The Commissioner ordered the CAARP administrators to submit a rating plan within 60 days that includes two rate tiers: (1) a lower, subsidized tier for low-income drivers and (2) a second, nonsubsidized tier for other CAARP policyholders. The decision, however, did not address whether lower-income bad drivers should be subsidized.

Summary Regarding CAARP. Proposition 103 does not directly address the CAARP. The relationship between the initiative and the CAARP ratefiling became more explicit, however, when parties to the proceeding raised issues regarding the purpose of the CAARP and its use as a means to redistribute the cost of insurance among policyholders. Nevertheless, significant questions remain regarding (1) whether the CAARP was established as a self-supporting pool, (2) whether its purpose was to insure only bad drivers, and (3) whether it is to subsidize insurance to low-income drivers. Because CAARP was created by statute, these are basic policy issues which the Legislature can address.

Therefore, we recommend that the Legislature review the statutes establishing the CAARP and enact whatever changes are appropriate to clarify the Legislature's intent regarding the above issues. This would provide the necessary guidance to the Commissioner in regulating the CAARP.

How Can the Cost Side of Insurance Be Addressed?

Proposition 103 primarily focuses on: (1) improving competition (such as requiring the department to provide comparative premium quotes, subjecting companies to antitrust statutes, and removing some restrictions on who can sell insurance policies), and (2) regulating premiums charged by insurance companies. The costs of providing coverage and paying claims is not directly addressed by the initiative. Yet, as we concluded last year, these costs play an important role in the high and rapidly increasing cost of insurance in California.

There are many factors that make up the cost of insurance. These include repair costs, medical costs, theft, fraud, type of car insured, legal fees, wage loss, pain and suffering, selling expenses and operating expenses. Individual companies can directly affect some of these cost components. Other cost components are not so easily controlled by either insurance companies or drivers.

Because there are many factors that affect insurance costs, a variety of different approaches must be pursued to control costs. The following are most often identified as ways to gain some control over insurance costs.

Double Payments. Currently, individuals involved in an auto-related personal injury lawsuit may receive awards which include medical costs even though they have already received payment from their medical or disability insurer. This is because under the "collateral source rule," juries must ignore such payments when determining awards. The problem is that the medical or disability insurer has no direct way of knowing about the lawsuit award (the second payment). One way of addressing the problem of double payments is to require notification of medical and other insurance companies of these awards. They could then recover their costs by placing a lien on the award. This kind of insurance coordination currently exists for workers' compensation insurance. Eliminating double payments could reduce the incentive for individuals to bring suit hoping to profit from an award by pocketing that part of the payment representing economic damages already paid by other insurers. Department staff feel it is a significant cause of litigation in some areas of the state. It is difficult to estimate the extra costs due to double payments. However, one actuarial consulting firm estimated in a recent study that double recoveries could have increased the cost of automobile insurance in California by between $176 million and $374 million in 1989.

Fraud. Insurance fraud (including faked accidents, faked injuries, false repair cost estimates and other false statements) is often mentioned as a significant factor affecting the cost of insurance. Many kinds of fraud are difficult and costly to investigate and prosecute; therefore, it is often cheaper to pay suspect claims than to pursue them. Chapter 1609, Statutes of 1988 (SB 2344, Lockyer) established a surcharge on insurance *policies* that would be used by local prosecutors and the department to investigate and prosecute fraud cases. Chapter 1119, Statutes of 1989 (SB 1103, Robbins) increased the surcharge and applied it to insured *vehicles,* in order to double the amount of money available for fraud investigations and prosecutions. This increased attention by investigators and prosecutors should help to reduce the incidence of these crimes, thereby helping to reduce premium costs.

Theft Prevention and Stolen Vehicle Tracking Equipment. Some insurance companies give premium discounts for the use of theft prevention equipment (in fact, some companies make the use of this equipment a condition of coverage for certain high-theft-rate vehicles). Technology currently exists that may make it

feasible for police to track stolen vehicles, though installing and operating the equipment is costly. Greater use of these devices and greater incentives for the use of theft prevention devices could help reduce the cost of comprehensive insurance coverage if this equipment proves to be cost effective.

No Fault Insurance. No fault insurance removes the need to determine fault before insurance claims are paid to injured parties. The U.S. Department of Transportation reviewed no fault plans and concluded that *well-designed* plans *could* help to limit the rate of growth in costs. They concluded, however, that even with good plans it is unlikely that insurance costs would decrease in absolute terms since reduced litigation costs would be offset by larger average payments to injured parties. Clearly, these plans would trade more frequent and higher average payouts to injured parties for the loss of the right of a party to bring personal injury suits (except for very serious injury or for death). No fault plans sometimes are criticized for reducing economic incentives to be a good driver. While this could occur, insurance companies could take account of accidents by increasing premiums for the parties cited in accidents. Thus, some incentive to avoid accidents would continue to be reflected in insurance premiums.

As far as we know, there is no strong empirical record for or against the ability of no fault to control auto insurance costs. Given the cost constraining potential of a well-designed and implemented plan, however, no fault deserves more in-depth study to determine if an economically beneficial plan can be devised.

Improved Information. One of the basic requirements of competitive markets is that consumers must have enough comparative product information to make informed decisions. Better decisionmaking and more effective shopping could put pressure on insurance companies to be more efficient and innovative, thus holding premium costs below what they otherwise would be. Proposition 103 mandates that the department make available to the public an extensive comparative premium data base. (This data base is expected to be available later in 1990.) This data base should help consumers become more effective shoppers.

Another area in which the information available to consumers might be improved is in reporting of complaints. Many consumers base insurance purchase decisions on service provided by insurers. Currently, it is difficult for consumers to obtain information about the behavior and service quality of insurance companies at the time they make purchase decisions. Improved monitoring and frequent, periodic reporting of complaints received by the department (cross-referenced by company, by type of complaint and by

manner resolved) could provide important information to: (1) consumers, when shopping for insurance; (2) consumer groups, when evaluating companies; and (3) the Attorney General and local prosecutors, for use during consumer protection investigations. Regular reporting also could encourage companies, brokers and agents to improve their performance.

SUMMARY AND CONCLUSIONS

Our analysis of the past year's effort by the department to implement Proposition 103 suggests that considerable time will pass before the regulatory process has been fully developed and implemented. The department has proceeded slowly in developing the basic regulations needed to govern the industry. Thus, there are many procedures needed to regulate the industry that have not yet been developed. In effect, while much activity can be identified over the past year, the public is in essentially the same place as when the initiative passed. The GICH process, however, offers some expectation that basic regulations ultimately will be formulated.

As we discussed above, one of the stated purposes of Proposition 103 is to encourage a competitive insurance marketplace. Our analysis of the industry suggests that competitive elements are present in this industry and that it is not clear that California's high insurance rates are due to a noncompetitive insurance industry. Consequently, we feel that the insurance industry may not require a very intrusive regulatory approach in order to adequately guard against noncompetitive performance. Whatever approach is used should take account of a company's current and projected financial position.

With regard to issues related to Proposition 103, we recommend that the Legislature review the statutes establishing CAARP to clarify the Legislature's intent regarding the plan's purpose. In addition, we recommend that the Legislature continue to review the factors that affect the costs of insurance.