Medi-Cal and the Politics of Healthcare Policy in California

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Executive Summary

Medi-Cal, California's Medicaid program, is the largest in the United States, providing vital healthcare services to over 15 million low-income residents. This report provides a comprehensive historical overview of the Medi-Cal system, tracing its development and highlighting how a historical approach can inform current policy challenges.

1. Historical Context

- **Early Developments:** Healthcare assistance in California dates back to the 19th century with the 1855 Statute for Indigent Care and the Pauper Act of 1901, establishing early statutory rights for the state's poor.
- **Progressive Era:** In the early 20th century, California was at the forefront of social insurance proposals, with efforts like the 1915 Social Insurance Commission advocating for health insurance for workers.
- **Postwar Reforms:** In the 1930s and 1940s, California was the epicenter of efforts to implement a universal system of healthcare coverage, including Governor Earl Warren's unsuccessful attempt to introduce a state-level single-payer system.
- **Rise of Employer-Provided Plans:** The mid-20th century witnessed the growth of employer-provided health insurance, such as Kaiser Permanente in California, which supplanted efforts for government health insurance coverage.
- **Medicare and Medicaid:** The establishment of Medicare and Medicaid in 1965, followed by the creation of Medi-Cal in 1966, marked a significant expansion of healthcare coverage in California.

2. Growth and Challenges

- **Reagan Era Reforms:** The 1970s and 1980s saw a shift towards managed care with the introduction of HMOs, driven by political and economic pressures to reduce costs and privatize services.
- **Proposition 13 and Budget Cuts:** The passage of Proposition 13 in 1978 led to reduced local government revenue, resulting in cuts to healthcare services, including the elimination of the Medically Indigent Adult category in 1982.

- **1990s Crisis and Reform:** The 1990s were marked by a healthcare coverage crisis, with rising uninsured rates and attempts at state-level reforms, culminating in the defeat of Proposition 186 for a single-payer system.

3. Recent Developments

- **Affordable Care Act:** The 2010 Affordable Care Act significantly expanded Medi-Cal, increasing enrollment by 60% and enhancing access to care for low-income Californians.
- **COVID-19 Pandemic:** The pandemic exposed deep-seated disparities in healthcare access and outcomes, disproportionately affecting communities of color and low-income populations.

4. Current Challenges

- **Medicaid Unwinding:** The transition back to regular Medicaid operations post-COVID has resulted in significant coverage losses, disproportionately affecting vulnerable populations.
- **Homelessness Crisis:** The rising homeless population, coupled with healthcare access barriers, exacerbates health issues and strains Medi-Cal services.
- **Managed Care Issues:** The dominance of managed care organizations, often providing substandard care, highlights the need for increased oversight and quality control.

5. Policy Recommendations

- **Addressing Historical Inequities:** Recognize the historical roots of current challenges and incorporate this perspective into policymaking to create more equitable and effective solutions.
- **Reforming Managed Care:** A historical perspective on managed care provides insight into the need for quality standards and enhance state oversight.
- **Mitigating Medicaid Unwinding:** Past periods of mass Medicaid disenrollment demonstrate the imperative of enhanced outreach and streamlined administrative processes to reduce procedural disenrollment and ensure continued coverage.

Introduction

Medi-Cal, California's Medicaid public health insurance program for low-income residents originally formed in 1966, is the single largest Medicaid program in the United States. With a budget of roughly $139 billion, Medi-Cal funds a comprehensive range of services, including doctor visits, inpatient care, pregnancy-related services, mental health treatment, substance abuse services, and preventive care, as well as dental, vision, and long-term care services. It offers free or low-cost health insurance coverage to more than 15 million people – an astonishing one in three Californians – who might not otherwise be unable to afford adequate medical care. Almost 6 million of these are under the age of 20, amounting to almost 40 percent of the state's children; more than half of all births in the state are covered under the program. Medi-Cal is also an important source of care for older adults: more than 1.7 million Californians are dual Medicaid/Medicare enrollees, and Medi-Cal funds half of all nursing home stays.[1]

Medi-Cal, California's Medicaid public health insurance program for low-income residents originally formed in 1966, is the single largest Medicaid program in the United States.

In many respects, Medi-Cal is a triumph of social care within a notoriously fractured, privatized, and stratified national healthcare system. Slightly more than half of Medi-Cal enrollees are Hispanic/Latinx, and more than two-thirds are Californians of color. More than a third speak a language other than English as their primary language. Medi-Cal is the first, and currently the only, state Medicaid program to have expanded coverage to all eligible adults regardless of citizenship or immigration documentation. Some two million Medi-Cal recipients have one or more major disabilities. In recent years, innovative and experimental programs have applied Medi-Cal funding to services beyond the traditional scope of medical care, offering nutritional services, housing subsidies, and transportation services for the unhoused and other vulnerable populations.

Nevertheless, Medi-Cal is currently facing a set of complex and multifaceted challenges, some endemic to the broader Medicaid system and some more specific to California's unique state system. Like state Medicaid programs throughout the country, Medi-Cal is beset by an ongoing crisis caused by "Medicaid unwinding," the process of transitioning back to regular Medicaid operations and eligibility reviews following COVID-era emergency measures to ensure continuity of coverage. Since unwinding began in March of 2023, over 10 million Medicaid enrollees have lost their coverage nationwide, the largest single disruption in health insurance coverage that has ever occurred in the United States. As the nation's largest Medicaid program, Medi-Cal has been heavily affected by Medicaid unwinding. As of May 2024, 1.9 million

1 California Department of Health Care Services, "Characteristics of the Medi-Cal Population as Captured by the Medi-Cal Eligibility Data System (MEDS)," July 2023.

Medi-Cal recipients had lost coverage. Particularly concerning is that the vast majority of these enrollees, and a disproportionate number of enrollees of color, have not lost benefits because they no longer meet income requirements, but for so-called "procedural" reasons such as missing or incorrect paperwork.

In addition to the acute crisis of unwinding, Medi-Cal also faces numerous interconnected challenges of a more enduring and structural nature. Among the most pressing is the severe and worsening crisis of homelessness in California, a problem that is both a symptom of healthcare shortcomings and also an enormous strain on healthcare services. The unhoused population, almost all of whom qualify for Medi-Cal, has been rising rapidly in recent years as a result of increased substance abuse, inadequate mental services, and above all, by rising income inequality and a dire shortage of affordable housing. In addition to homelessness, the Medi-Cal system also faces deeply problematic quality-of-care issues stemming from the practice of outsourcing of care to a convoluted, labyrinthine, and unstandardized system of managed care organizations, many of them for-profit, that operate with little systematic oversight from the state. Medi-Cal reimbursement rates to providers have long been among the lowest in the country, limiting provider participation in the program and creating barriers to access for patients, especially outside of major metropolitan centers. Like the healthcare system on the national level, Medi-Cal also faces challenges providing long-term care to an aging population, as well as deep-seated inequities of healthcare access and outcome correlated with race, class, and immigration status.

While there is no lack of policy analysis and debate over the present and future of the Medi-Cal system, our current discourse is sorely lacking in one vital respect: historical perspective. Few existing studies of the Medi-Cal system offer more than cursory sketch of the history of medical assistance in California. The unfortunate result is that problems with our healthcare system too often appear as inevitable, intractable, and even natural, when in fact they are rooted in historically specific and contingent policy decisions. This report, undertaken by the Luskin Center for History and Policy at UCLA, seeks to provide that historical perspective. It traces the historical evolution of healthcare assistance to the indigent in California, ranging from the early "pauper acts" of the nineteenth century, to the foundation of Medi-Cal as part of the Medicaid system in 1966, to the COVID-19 crisis and beyond. It concludes by offering concrete, actionable policy recommendations based on our findings that we believe to be of use to policymakers, analysts, and legislators. To our knowledge, this is the first study to attempt a comprehensive historical overview of the Medi-Cal system with an eye towards how history might positively inform current policy debates.

Problems with our healthcare system too often appear as inevitable, intractable, and even natural, when in fact they are rooted in historically specific and contingent policy decisions.

The report shows how Medi-Cal has emerged from a contested terrain fought over by California's labor unions, insurance companies, physicians, policymakers, grassroots activists, trade associations, and corporate employers. We pay particular attention to the ways that California has been, at various points, both a catalyst and microcosm for broader, national healthcare policy debates. We maintain a focus on the racial and gendered dimensions of Medi-Cal's development, as well as tensions and oscillations between public and private governance that have defined the history of medical assistance in the state. We find that although California has been a leader in progressively expanding health insurance coverage, healthcare access and equity remain problematic. It is our hope that this historical perspective can serve as a key to better understanding Medi-Cal's many accomplishments, and also to addressing its many difficult current and future challenges.

Historical Narrative

Healthcare Assistance in California before 1900

The earliest history of medical assistance in California dates to the years immediately following the end of the Mexican-American War and the cession of Alta California to the United States. During the Gold Rush of the late 1840s, newly formed communities of transient gold prospectors were sites of repeated outbreaks of typhus, malaria, and cholera. In 1855, the California state legislature approved the first statute in the state, and one of the earliest in the country, which made provisions for the medical care of indigent persons. Chapter LVII of the 1855 California Statutes authorized the State Treasurer to issue bonds to collect revenue for "the protection and support of the Indigent Sick." This fund was turn allotted to the state's counties based on their population and dispersed at the discretion of each county's board of supervisors.[2]

Most poor and working-class Californians paid for medical care out of pocket, relied on private charity, or—most often—went without care.

Money allotted for the indigent sick under the 1855 statute was meagre. In 1862, for example, the state dispersed only $1,197 to counties for hospital care for the indigent sick out of a total state expenditure of $1.15 million, and varied widely from country to county.[3] Most poor and working-class Californians paid for medical care out of pocket, relied on private charity, or—most often—went without care.[4]

The "Pauper Act" of 1901 expanded on the 1855 statute, adding that counties "shall relieve and support all pauper, incompetent, poor, indigent persons and those incapacitated by age, disease, or accident."[5] The two statues had established a clear, albeit inchoate and limited, statutory right to some form of healthcare assistance for the state's indigent population. It also put the discretion to distribute and administer that assistance firmly in the hands of county governments, a precedent that would come to be highly significant in the future of health politics in the state.

2 California Statutes, 1855 pp. 67-69

3 Annual Report of the Controller of State for the Year 1862 (Sacramento, 1862), p. 41.

4 James Leiby, "State Welfare Administration in California, 1879-1929," ***Pacific Historical Review*** 41, no. 2 (1972).

5 California Statues, 1901, p. 636.

The Social Insurance Commission and Proposition 20

During the Progressive Era in the early decades of the twentieth century, reformers in California and around the country began to call for compulsory social insurance of the kind that was then taking root in Germany, France, and other Western European countries. Through organizations such as the American Association for Labor Legislation (formed in 1915), these reformers lobbied for state- and national-level legislation for social insurance programs to protect the livelihood of workers in the nascent industrial working against hazards such as unemployment, disability, old age, and sickness.[6]

In a 1917 study, the Commission found that the majority of wage earners were unable to afford medical care and hospital services.

A prominent and vocal supporter of these social insurance proposals was Hiram Warren Johnson, the 23rd Governor of California who served from 1911 to 1917. A staunch progressive (he was Theodore Roosevelt's running mate on the Progressive Party ticket 1912), Johnson oversaw the implementation of a series of state-level progressive reforms, including workers' compensation and an eight-hour workday for women.[7] In the wake of these reform victories, Johnson ordered the creation of a state Social Insurance Commission in 1915 to study the feasibility of future social insurance measures. This Commission was the first of its kind in the nation and the model for several other similar state commissions that formed in the following years.[8] The Commission took a particular interest in the question of health insurance, which they saw as crucial form of income maintenance for the working class. In a 1917 study, the Commission found that the majority of wage earners were unable to afford medical care and hospital services. "The present laissez faire method of ignoring the great problem of illness among wage earning families until actual destitution... is socially wasteful in the extreme," the Commission argued, and it unanimously concluded that spreading the risk of illness through group insurance was the most practical and desirable solution.[9]

California Governor Hiram Warren Johnson (1911 to 1917), an early advocate for progressive social reform and social insurance in the state of California. Source and permissions: Harris & Ewing, photographer, Library of Congress, public domain

Based on the Commission's recommendations, the California legislature introduced Proposition 20, which would have amended the state constitution to allow for a state-run health insurance system for Californians below a certain income threshold. Many of the state's women's organizations, trade unionists, social workers, and prominent members of the clergy strongly supported the measure. Business leaders, insurance companies, and many state doctors' organizations strongly opposed it, arguing that health insurance systems were foreign imports that would interfere with the prerogatives of free enterprise and stifle individual initiative. Capitalizing on fierce anti-German sentiment

6 Daniel T. Rodgers, ***Atlantic Crossings: Social Politics in a Progressive Age*** (Cambridge: Belknap Press of Harvard University Press, 1998), chapter 6.

7 Frederick Haller, ***California Progressive Campaign Book for 1914: Three Years of Progressive Administration in California under Governor Hiram W. Johnson***. (San Francisco: Allied Printing, 1914); Richard Coke Lower, ***A Bloc of One: The Political Career of Hiram W. Johnson*** (Stanford: Stanford University Press, 1993).

8 U.S. Bureau of Labor Statistics, "Compulsory Health Insurance Proposed By Social Insurance Commission Of California," Monthly Review, 4, no. 4 (April 1917).

9 California Social Insurance Commission, ***California's Need of Social Health Insurance*** (Sacramento: California State Printing Office, 1917).

in the United States during World War I, opponents of Proposition 20 repeatedly emphasized the German origins of social insurance and argued that the bill was an "attempt to foist Prussianism on California."[10]

Proposition 20 was one of the first health insurance bills in the country, and the debate surrounding it drew the political lines around the issue of health insurance, in California and beyond, for decades to come.

In the face of this opposition, Proposition 20 was defeated by a large two-to-one margin. Nevertheless, the influence of the California Social Insurance Commission and Proposition 20 outlasted the referendum itself. As the first government body in the United States devoted to studying the implementation of health insurance, the California Social Insurance Commission inspired other state commissions in the late 1910s, including New York, Illinois, and Ohio. Proposition 20 was one of the first health insurance bills in the country, and the debate surrounding it drew the political lines around the issue of health insurance, in California and beyond, for decades to come.

Husband-and-wife team Clem Whitaker Sr. and Leone Baxter, whose political advertising consulting company Campaigns, Inc. launched a successful campaign to defeat universal healthcare proposals in California, and later on the federal level. Source and permissions: California State Archives

The Warren Plan, Organized Medicine, and the Truman Plan for Universal Healthcare

With the defeat of Proposition 20, the Pauper Act of 1901 remained California's only healthcare safety net during the Great Depression of the 1930s, when millions of Californians were thrown out of work and into destitution. The crisis upended traditional ideas about social provision and entitlement: a large population of the "deserving" poor, not only a stigmatized minority, now struggled to provide for their basic needs, including healthcare. Reflecting this cultural and political shift, in 1932 California courts ruled that the Pauper Act applied to not only the most marginalized and incapacitated Californians, but also to healthy, working-age male breadwinners who had been thrown into unemployment by the Depression.[11] In 1933, the state legislature amended the Pauper Act to expressly include "all able-bodied indigent persons" in addition to those "incapacitated by age, disease, or accident."[12] In 1937, the language of the revised Pauper Act (minus the important phrase "able-bodied") was codified as section 17000 of the California Welfare and Institutions Code. Still in effect today, section 17000 reaffirmed a general right to medical assistance that is to be administered by the counties.

The crisis upended traditional ideas about social provision and entitlement: a large population of the "deserving" poor, not only a stigmatized minority, now struggled to provide for their basic needs, including healthcare

10 "More Burdens, New Offices," Los Angeles Times, January 19, 1918.

11 Cited in Mooney v. Pickett, S.F. No. 22788. April 28th, 1971.

12 California Statues, 1933, p. 2005.

On the federal level, Congress in the 1930s passed a series of sweeping social welfare reforms as part of the Franklin Roosevelt administration's New Deal reform and recovery agenda. The Social Security Act of 1935 (and its subsequent revisions) instituted old age, disability, and unemployment insurance, as well as financial assistance for needy families. Along with labor protections and financial regulations, the Act created the foundations of the modern U.S. welfare state (albeit one skewed heavily in favor of white male family breadwinners). Notably absent from the Social Security Act was health insurance, which had already been incorporated into the social insurance systems of numerous countries in Western Europe. Labor unions, progressive federal administrators, and African-American organizations lobbied for a health insurance provision in the Act, but the Roosevelt administration declined to seriously pursue it, fearing that strong backlash from the American Medical Association and congressional conservatives would endanger the passage of the entire Act. Progressives and powerful new industrial unions, however, continued to press for an amended Social Security Act that would include healthcare. Most prominently, the Wagner-Murray-Dingell Bill, introduced several times in Congress in the early to mid 1940s, would have created a unified single-payer system of health insurance funded through a social security payroll tax.[13]

Notably absent from the Social Security Act was health insurance, which had already been incorporated into the social insurance systems of numerous countries in Western Europe.

In California, labor and liberals pushed for a single-payer system on the state level that might serve as a model for a national system. In 1939, Governor Culbert Olson, a Democrat and strong supporter of the New Deal, presented to the state legislature a plan for a compulsory system for Californians earning under $3,000 a year (a solidly middle-class income), which would be financed by a one percent payroll tax from workers and their employers. Those earning over $3,000 could participate in the system voluntarily. This plan died in committee in the state legislature in 1943, but Olson's successor, moderate Republican (and future Chief Justice of the Supreme Court) Earl Warren, backed a similar bill for a single-payer system, introduced in the state legislature in 1944 as AB 800.

Like the Wagner-Murray-Dingell bill on the federal level, Warren's state-level plan was popular among Californian voters: early polls indicated that a majority of Californians favored the bill. But in a state-level microcosm of the American Medical Association's campaign against the Wagner-Murray-Dingell Bill, the California Medical Association (CMA) immediately launched an aggressive lobbying and public relations campaign against Warren's health insurance plan. The CMA hired California-based political consulting firm Whitaker and Baxter (also known as Campaigns, Inc.). Run by husband-and-wife team Clem Whitaker Sr. and Leone Baxter, the firm was a pioneer in applying modern techniques of political advertising. The CMA poured financial resources into Whitaker and Baxter advertisements that depicted Warren's plan as a socialistic ploy that would lead to deteriorated care and excessive state regimentation. Backers of the plan were no match for the funds the CMA was spending to defeat it, and no match for the skillful political advertising campaign that Whitaker and Baxter had set in motion. Although the Warren administration succeeded in pushing through a state disability insurance program, there would be no state-wide single payer health insurance program for California.[14]

13 Beatrix Hoffman, ***Health Care for Some: Rights and Rationing in the United States Since 1930*** (University of Chicago Press, 2012), chapter 3.

14 Daniel J. B. Mitchell, "Impeding Earl Warren: California's Health Insurance Plan That Wasn't and What Might Have Been," ***Journal of Health Politics, Policy and Law 27***, no. 6 (December 1, 2002): 947–76.

But the Warren plan, and the CMA's aggressive campaign to defeat it, had a momentous impact on health insurance politics on the national level. Upon assuming the presidency in 1945, Harry Truman opted to take up the cause of universal healthcare that his predecessor had largely avoided. In November 1945, Truman announced his administration's support for a bill, similar to the series of wartime Wagner-Murray-Dingell bills, which would establish a federal system through a social security payroll tax. The American Medical Association took many of the lessons of the California Medical Association's campaign against the Warren plan and applied them to their fight against the Truman-backed bill on the federal level. After Truman won the 1948 presidential election and made his health insurance plan a central goal of his second term, the AMA hired Whitaker and Baxter on retainer and launched a massive radio and newspaper political advertising campaign against the Truman health plan with the tagline, "The voluntary way is the American way." The campaign proved highly effective in turning public opinion away from the Truman bill. By 1950, enthusiasm for the bill had fallen off beyond repair, and there would not be another major campaign for a universal healthcare system for decades to come.

Kaiser Permanente and the Rise of Commercial Health Insurance

Within this political stalemate over government-administered healthcare, novel and alternative models of care and forms healthcare financing emerged in California, again with important implications for the healthcare landscape on the national scale. Prepaid employer-provided health insurance plans, an alternative to the traditional fee-for-service model of healthcare financing, first emerged in California prior to World War II. In 1929, two California doctors named Donald Ross and H. Clifford Loos started one of the first prepaid medical plans in the country. The "Ross-Loos Medical Group," as it came to be called, offered clinical and lab tests, x-rays, consultations, home visits, medicines and drugs, hospitalization for $2 a month. Over the course of the 1930s, the Ross-Loos group contracted with UCLA faculty, Los Angeles city and county employees, Department of Water and Power, and the Southern California Telephone Company, as well as schoolteachers in seven California counties.

Prepaid employer-provided health insurance plans, an alternative to the traditional fee-for-service model of healthcare financing, first emerged in California prior to World War II.

In 1938, the Henry J. Kaiser shipbuilding company began offering workers a unique system that combined prepayment, group practice, and medical facilities. Shipbuilding workers in Richmond, California (among other facilities) were offered a supplemental health program to workers for 50 cents per week. In 1945, the company opened the plan, now called Kaiser Permanente, to the public; Kaiser Permanente quickly became one of the largest prepaid medical programs in the United States and would come

to serve as the primary model of the prepaid HMO system in subsequent decades.[15]

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Beginning in World War II, private employer-provided plans became more widespread. With unions barred from striking over wages during the war, they began to demand in-kind benefits such as health insurance from their employers. In 1943, the Internal Revenue Service began to incentivize these plans by making them tax exempt for employers. The AMA, although initially wary of any form of prepaid healthcare, began to embrace voluntary plans as an alternative to a government-provided system such as those proposed in the Wagner-Murray-Dingell bills. Private employer-provided plans, typically negotiated through collective bargaining agreements, thus began to cover a large percentage of the American workforce, although workers covered under these plans tended to be overwhelmingly white and male.[16]

Los Angeles County Hospital, circa 1950s. Source and Permissions: UCLA Library Special Collections

Public Assistance Medical Care (PAMC) and Medical Assistance for the Aged (MAA)

By the 1950s, these employer-provided plans had become entrenched as the dominant form of health insurance in the United States. With a national single-payer system of health insurance soundly defeated by the end of the 1940s, reformers in the 1950s shifted to limit their efforts to building federal systems for the poor and elderly – particularly vulnerable groups that were less likely to be covered by insurance in the workplace, and generally considered too risky to be insured by private commercial insurance. Reforms limited to these populations, many reformers believed, might open a legislative pathway for more universal forms of coverage.

The state spent $86.5 million on PAMC in its first three years of operation, and by October 1960, a total of 562,731 people were receiving assistance under the program.

These efforts led to several significant changes to national healthcare legislation over the next decade. Under the 1950 and 1956 amendments to the Social Security Act, the federal government began to match states' expenditure on medical care to the needy aged, the blind, the disabled, and aid-eligible dependent children.[17] In response, California created the Public Assistance Medical Care (PAMC) program in 1957 under the authority of the California State Social Welfare Board. The program

15 C. C. Cutting and M. F. Collen, "A Historical Review of the Kaiser Permanente Medical Care Program," ***Journal of the Society for Health Systems*** 3, no. 4 (1992): 25–30.

16 Jennifer Klein, "The Politics of Economic Security: Employee Benefits and the Privatization of New Deal Liberalism," ***Journal of Policy History*** 16, no. 1 (2004): 34-65.

17 Charles I. Schottland, "Social Security Act Amendments of 1956: A Summary and Legislative History," ***Social Security Bulletin***, September 1956.

funded care for needy children, the aged, the blind, and from 1959, the disabled. The state spent $86.5 million on PAMC in its first three years of operation, and by October 1960, a total of 562,731 people were receiving assistance under the program.[18]

The Kerr-Mills Act, passed in 1960, established a federal matching program for states to distribute for medical, hospitalization, and nursing home care for the indigent elderly population.[19] To administer the program on the state level, the California legislature passed a bill in 1961 that created the Medical Assistance for the Aged (MAA) program. The federal government paid 50 percent of the cost of all hospital, nursing home, and medical care and the state and counties divided the other 50 percent. By the middle of the 1960s, the program was reaching 60,000 Californians.[20]

Throughout the late 1950s and early 1960s, the PAMC and MAA programs expanded care to tens of thousands of Californians who had been shut out of the solidifying model of private employer-provided health insurance. Nevertheless, the programs were limited. They did not cover preventative care or rehabilitation, and they did not include dental or vision coverage. The plans also operated under strict and often degrading means tests: under MAA, for example, Californians over the age of 65 could qualify only if they held personal cash reserves under $1,200. It would take further legislation on the federal level to expand such care beyond the most desperately impoverished residents of the state.

The Birth of Medi-Cal and Battles Over the Budget

That federal legislation came with the establishment of Medicare and Medicaid in 1965, part of a broader liberal reformist agenda of the Johnson administration's Great Society. While Medicare created a federally administered medical insurance program for those over 65, Medicaid was a means-tested program partially funded by the federal government and partially funded by the states. On October 27, 1965, the California State assembly passed, by a 69-5 vote, legislation that implemented Medicare and Medicaid on the state level. Governor Pat Brown, a liberal democrat who supported the Johnson administration's Great Society programs, hailed it as "the single most important item of social legislation passed by the California legislature in the last decade."[21]

In its first year of operation, a monthly average of 1,181,053 Californians were eligible for Medi-Cal, equaling roughly six percent of the state population.

California's state-administered Medicaid program Medi-Cal (originally called Cal-Med) went into effect in 1966. In its first year of operation, a monthly average of 1,181,053 Californians were eligible for Medi-Cal, equaling roughly six percent of the state population.[22] The new program provided drugs, physical therapy, radium therapy, orthotics, psychiatric services, and dental care. It was, along with New York State, among the most generous Medicaid programs in the country.[23]

18 Margaret Greenfield, ***California's Public Assistance Medical Care Program; an Examination of Its Performance, 1957-1960*** (Sacramento: California Department of Social Welfare, 1961).

19 Matthew Gritter, "The Kerr–Mills Act and the Puzzles of Health-Care Reform," ***Social Science Quarterly*** 100, no. 6 (2019): 2209–22.

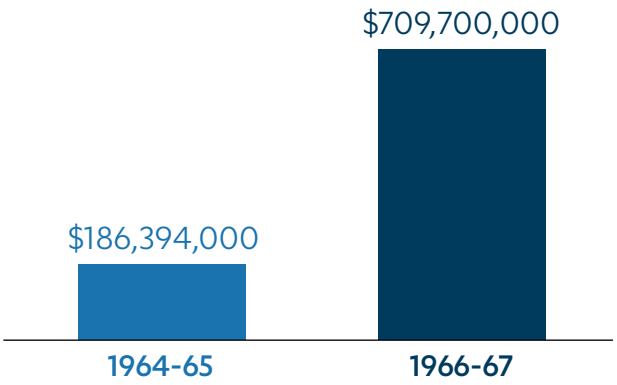
20 Bruce M. Brown and Mary A. Brubaker, ***Public Welfare Medical Care in California from 1957 to 1966*** (Sacramento: State of California Office of Health Care Services, 1966).

21 Ray Zeman, "Medicare Bill Passed by Senate," ***Los Angeles Times***, November 4, 1965.

22 California Department of Health Care Services' Research and Analytic Studies Division, "Medi-Cal Statistical Brief: Medi-Cal's Historic Period of Growth," August 2015.

23 Jonathan Engel, ***Poor People's Medicine: Medicaid and American Charity Care Since 1965*** (Duke University Press, 2006), 62.

With the advent of Medi-Cal, however, came a substantial increase in California state healthcare expenditure. In the fiscal year 1964-1965, the total federal, state, and county expenditures for PAMC and MAA programs was $186,394,000. In the 1966-1967 fiscal year the figure was $709,700,000. By 1967, the state Health and Welfare Agency was projecting a significant deficit in the state healthcare programs.[24]



The total federal, state, and county expenditures for PAMC and MAA programs increased exponentially

To the newly inaugurated Reagan administration, the ballooning expenses seemed to prove their conviction that an overly generous welfare state would necessarily lead to spiraling costs at taxpayer expense. As a means-tested program bearing the taint of "welfare," Medi-Cal stood out as a target for the new conservative administration, which was also dedicated to reforming other means-tested social programs on the state level such as Aid to Families with Dependent Children. "Our program is sicker than the people it is intended to aid," Reagan said in 1967. "Unless Medi-Cal is revived and revamped, it not only can, but most assuredly will, bankrupt our state, and in a very few years." Reagan was determined that the solution to the fiscal crisis was not to increase revenue through expanded taxation, but by dramatic cuts in services and changes to the ways that the state's medical programs were administered.[25] In 1967, Spencer Williams, the new appointee to the Health and Welfare Agency, announced cuts to Medi-Cal intended to save $30 million in the next fiscal years, which included deferring elective procedures and limiting hospitalization services.[26]

In response, Democrats accused Reagan of prioritizing his political career over the health needs of the people of California. Assemblyman Bob Moretti, a Democrat from North Hollywood, said in 1967 that he was "convinced that the governor has raised the unfounded deficit as an excuse to cut back on medical services to the needy so that at the end of the year he can parade a large budget surplus before the people and his presidential ambitions can be realized."[27] Patients fought back as well through a network of grassroots advocacy organizations: in 1967, a legal aid organization called California Rural Legal Assistance filed a lawsuit on Medi-Cal patients' behalf, charging that the cuts were in violation of federal law. The lawsuit resulted in a temporary enjoinder of most of the more drastic cuts in services proposed by Williams, which was affirmed by the California Supreme Court later that year.[28]

Patients protesting cuts to the Medi-Cal program in Los Angeles, September 1967. Source and permissions: Los Angeles Times Photographic Collection, UCLA Library Special Collections.

24 David F. Chavkin and Anne Treseder, "California's Prepaid Health Plan Program: Can the Patient Be Saved," ***The Hastings Law Journal*** 28, no. 3 (1977).

25 "Medi-Cal Changes Vital, Reagan Says," ***Los Angeles Times***, September 21, 1967.

26 David F. Chavkin and Anne Treseder, "California's Prepaid Health Plan Program: Can the Patient Be Saved," ***The Hastings Law Journal*** 28, no. 3 (1977).

27 "Demos Win Round in Medi-Cal Row," ***Los Angeles Times***, November 20th, 1967.

28 Morris v. Williams, 67 Cal.2d 733; "What Reagan's Medi-Cal Cuts Are All About," ***California Journal*** July, 1970.

Medi-Cal's Reagan Revolution: The Rise of Managed Care

With most of their most severe cuts to Medi-Cal blocked by the courts, Reagan and his advisors became increasingly attracted to the idea of replacing Medi-Cal's traditional fee-for-service financing with prepaid group plans. This still relatively novel system of prepayment had recently been tentatively endorsed in a 1970 report by a task force organized by the federal Department of Health, Education, and Welfare.[29] Like many of their Republican colleagues in the Nixon administration and in Congress, Regan and his advisors hoped that Health Maintenance Organizations (HMOs) would simultaneously reduce costs, increase efficiency, and also channel government funds into the private sector.[30]

Like many of their Republican colleagues in the Nixon administration and in Congress, Regan and his advisors hoped that Health Maintenance Organizations (HMOs) would simultaneously reduce costs, increase efficiency, and also channel government funds into the private sector.

In 1971, Republican lawmakers successfully passed legislation that increased the powers of the Director of Health Care Services to contract with "health corporations" that offered medical services to which Medi-Cal beneficiaries were entitled.[31] The first nonpilot prepaid Medi-Cal contract, with an HMO called Innovative Health Systems, went into effect in April, 1972. By the end of the year, over 130,000 Medi-Cal patients were enrolled in one of numerous new prepaid plans, the majority of them for-profit. As was noted by HMO's detractors and proponents alike, the potential profits in the new system were enormous: some organizations promised investors returns of 3,000 percent. "Another gold rush is underway at the capital," said a Los Angeles Times exposé at the end of 1972, "only this time the nuggets are a new form of franchise – state Medi-Cal contracts to provide health care for the poor."[32]

Officials in the Department of Health Care Services warned of major potential problems in the new systems. They predicted that because they were prepaid a flat rate, for-profit entities with government Medi-Cal contracts would be incentivized to discourage patient utilization of medical services and understaff facilities in an attempt to reduce costs and increase profits. It quickly became clear that many of these fears were well-founded: patient organizations almost immediately complained to the state of misrepresentation by enrollers, unavailable clinicians, and shoddy care.[33] By the mid-1970s, it was becoming clear that many of these Medicare and Medicaid HMOs were also rife with physician's kickbacks, unnecessary procedures, fraud and other forms of fraud and abuse.[34] In 1975 and again in 1976, the mismanagement of Medi-Cal HMOs was the subject of investigations by the Federal Senate Permanent Subcommittee on Investigations, which concluded in a scathing report that the "corporate

29 ***Recommendations of the Task Force on Medicaid and Related Programs***, June 1970, Department of Health, Education, and Welfare, 1970.

30 Richard Nixon, "Special Message to the Congress Proposing a National Health Strategy," February 18th, 1971; ***Assembly Daily Journal***, 1971 Regular Session, March 3, 1971.

31 "Tough Trading Breaks Executive-Legislative Deadlock on Welfare and Medi-Cal," ***California Journal***, July-August 1971.

32 "New Gold Rush – Prepaid Medi-Cal Franchises Sought," ***Los Angeles Times***, December 10, 1972

33 David F. Chavkin and Anne Treseder, "California's Prepaid Health Plan Program: Can the Patient Be Saved," ***The Hastings Law Journal*** 28, no. 3 (1977).

34 "Widespread Medicare Test Frauds Cited," ***Los Angeles Times*** February 16th, 1976.

structure and contracting practice" of California's HMOs "opened the way for the diversion of Medicaid funds away from the program's purposes." [35]

By the mid-1970s, it was becoming clear that many of these Medicare and Medicaid HMOs were also rife with physician's kickbacks, unnecessary procedures, fraud and other forms of fraud and abuse.

In 1976, Ccongress passed legislation that introduced some limited regulations of the for-profit HMO business model. The legislation specified that states could only use federal matching funds if they met federal regulatory requirements, and only if HMOs maintained an enrollment that was no more than 50 percent Medicaid patients (on the assumption that this ratio would disincentivize unscrupulous HMOs from entering the Medicaid market).[36] However, upon his election in 1980, Ronald Reagan took to the White House his enthusiasm for the for-profit prepaid group plan model that he had helped pioneer during his governorship of California. In 1981, as part of his broader agenda to scale back the welfare state and government entitlements, the Reagan administration pushed a bill through Congress removed many of the 1976 bill's federal regulations.[37] The legislation helped to firmly entrench the HMO and managed care model in Medicaid financing and delivery.

Proposition 13, Patient Dumping, and the End of the Medically Indigent Adult Category

At the same time, an influential grassroots movement to lower property taxes was gaining significant traction in California. In 1978, California voters overwhelmingly approved Proposition 13, a landmark piece of antitax legislation that froze real estate assessments and limited future tax increases to two percent a year. Proposition 13 led to a sharp decline in local government revenue, putting pressure on state and local hospital systems.

The 1986 Emergency Medical Treatment and Active Labor Act (EMTALA) established a national right to a basic level emergency care. Source and permissions: Wiki Commons.

In 1982, in response to the healthcare budget crisis in the wake of Proposition 13, California eliminated the optional Medically Indigent Adult eligibility category for Medi-Cal that had been introduced in compromise legislation in 1971. Beginning in 1983, 270,000 low-income adults became uninsured in California, many of whom suffered

35 Findings of Permanent Subcommittee on Investigations on Health Maintenance Organizations: Hearing Before the Subcommittee on Health of the Committee on Finance, United States Senate, Ninety-fifth Congress, second session, May 18, 1978; "Medicare Bill Advances," ***Los Angeles Times*** September 15th, 1976.

36 H.R.9019 - Health Maintenance Organization Amendments, 94th Congress (1975-1976).

37 Omnibus Budget Reconciliation Act of 1981. Public Law 97-35, 97th Congress, 95 Stat. 357 (1981).

from serious and chronic medical conditions. The elimination of the Medically Indigent Adult category saved the state and estimated $30 to $60 million over the coming years ($11 to $24 million in Los Angeles County alone).[38] But the result was precipitous decline in healthcare access, satisfaction, and outcomes for this patient population, over half of which was African-American or Latinx. A 1986 study by the UCLA Center for the Health Sciences found that one year after they had lost access to coverage, former Medi-Cal patients' overall general health had deteriorated 8 points on a 100-point scale.[39]

A 1986 study by the UCLA Center for the Health Sciences found that one year after they had lost access to coverage, former Medi-Cal patients' overall general health had deteriorated 8 points on a 100-point scale.

As a result, low-income patients who had lost Medi-Cal coverage increasingly turned to hospital emergency rooms for routine as well as emergency care. The shift exacerbated a practice, already underway since the 1960s and 1970s, in which private (often for-profit) hospitals refused care to indigent or uninsured emergency room patients and redirected them to beleaguered public hospitals: a process known as "patient dumping." Throughout the state, growing crises of AIDS, gun violence, homelessness, and drug abuse threatened to overwhelm emergency providers. After a series of particularly egregious patient dumping scandals in Alameda County, the district's congressional representative, Peter Stark, introduced the Emergency Medical Treatment and Active Labor Act (EMTALA), which established a national right to a basic level emergency care for the increasing number of patients who were uninsured.[40]

38 California Legislature, Special Committee on Medi-Cal Oversight, ***Oversight Hearing on Medically Indigent Adults and State Funding for County Health Services: Transcript*** (Sacramento, CA: Joint Publications Office, 1985).

39 Nicole Lurie et al., "Termination of Medi-Cal Benefits," ***New England Journal of Medicine*** 314, no. 19 (May 8, 1986): 1266–68.

40 Beatrix Hoffman, "Emergency Rooms: The Reluctant Safety Net," in ***History and Health Policy in the United States: Putting the Past Back In***, ed. Rosemary A. Stevens, Charles E. Rosenberg, and Lawton R. Burns (Rutgers University Press, 2006).

The 1990s

By the dawn of the 1990s, California healthcare politics became enfolded in a broader national crisis of health insurance coverage, as well as a renewed discourse surrounding the question of a comprehensive national overhaul of the healthcare system. Throughout the 1980s, healthcare costs had grown far more rapidly than inflation; healthcare spending accounted for one seventh of the gross national product by the early 1990s. Fearing that healthcare costs were increasingly eating into profits, employers began to either drop health plans or raise premiums and deductibles to a point where they were prohibitively expensive. In the three-year period between 1989 and 1992, 5 million Americans lost their health insurance, and by 1992, an astounding 40 million Americans, or 16 percent of the population, were uninsured.

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Democrats, progressives, and even the AMA and some corporate interests, began to push for some form of government intervention into the healthcare system. Bill Clinton made healthcare reform a top priority upon his assumption of the presidency in 1992. Yet in a time of growing consensus around the power of market forces to solve social issue, Clinton and his advisors felt that any form of universal single-payer system on a national scale remained a dead political letter. Shortly after Clinton's election, John Garamendi, the California insurance commissioner and Clinton's campaign manager, introduced to Clinton a plan of "managed competition" of the insurance market: the federal government would stimulate and oversee competition between newly formed private "health insurance purchasing cooperatives." The "managed competition" concept formed the basis of the Clinton administration's Task Force on National Health Care Reform, headed by First Lady Hillary Clinton, which would define the terms of the national healthcare debate throughout Clinton's first term.

California was particularly hard hit by the health insurance coverage crisis of the early 1990s. Due to healthcare costs that were significantly higher than the national average, employers in California were especially likely to cut health benefits or eliminate plans altogether. In 1988, almost two-thirds of Californians were covered by a private employer-based plan. Just six years later, the percentage had fallen to around 55 percent. Disproportionally represented among the uninsured were immigrants and Californians of color, as growing numbers of undocumented migrants, especially concentrated in the Los Angeles area, were completely shut of out the health insurance system. In 1992, roughly one in five Californians were uninsured – significantly higher than the national average of 16 percent.[41]

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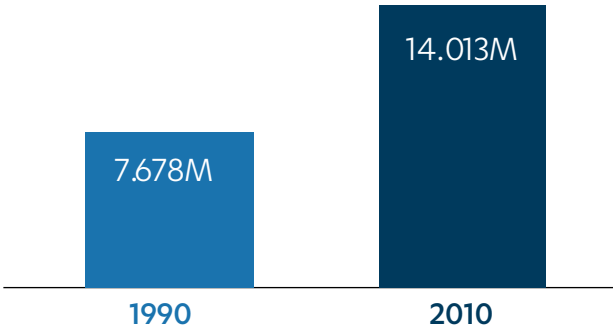
Meanwhile, increasing numbers of Medi-Cal patients were being moved to HMOs and other forms of managed care. In 1993, for example, Medi-Cal patients in Los Angeles County were forced to choose between com-

41 California Health Care Foundation, "Insurance Coverage Source and Unemployment Trends, California, 1987 to 2016".

mercial HMO HealthNet and the quasi-public insurance entity LA Care; patients who did not actively make the choice were generally assigned to HealthNet.[42] The 1997 Balanced Budget Act increased the ongoing deregulation of managed care organizations in Medicaid by removing the longstanding 25/75 rule, shunting Medi-Cal patients further into the private sector.

By 1993, the Clinton health plan was on the defensive, encountering strong pushback from organized retail, restaurant, hospitality firms, and after the 1994 midterm elections, Congressional Republicans. With federal legislation blocked, insurers, unions, corporations, grassroots movements in California turned with renewed attention to reform on the state level. The result of these efforts



Number of Californians identifying as Latinx of any race

was Proposition 186 in 1994, which would have created a comprehensive single-payer system for all Californians financed out of new payroll, income, and tobacco taxes. While Proposition 186 was defeated on the state level, it won the majority of several demographics, including young voters, low-income households, and Black and Latinx voters.[43]

Demographic Changes

Over the course of the 1990s and 2000s, California underwent profound demographic transformations. In 1990, 7.687 million Californians identified as Latinx of any race, about a quarter of the population. By 2010, the number had almost doubled to 14.013 million, almost 38 percent of the population. An increasing percentage of Medi-Cal patients during this period were Latinx, but undocumented migrants, estimated at almost three million in California in 1990, were shut out of the system entirely by federal law: the original text of the 1965 Social Security amendments that created Medi-Cal specified that beneficiaries must be citizens or lawfully-admitted legal residents.


Mexican migrant workers undergoing a medical examination before entering California, Mexicali, 1954. Source and permissions: UCLA Library Special Collections

The undocumented population also faced obstacles to care on the state level. In 1994, on the same ballot that Californians voted down Proposition 186 for single-payer healthcare, they passed Proposition 187 on immigration reform. Known by supporters as the "Save Our State" referendum, Proposition 187 severely restricted undocumented residents' access to state social and public services, including public education and healthcare. Moreover, education and healthcare workers were re-

42 Michael R. Cousineau and Robert E. Tranquada, "Crisis & Commitment: 150 Years of Service by Los Angeles County Public Hospitals," ***American Journal of Public Health*** 97, no. 4 (April 2007).

43 Krista Farey and Vishwanath R. Lingappa, "California's Proposition 186: Lessons from a Single-Payer Health Care Reform Ballot Initiative Campaign," ***Journal of Public Health Policy*** 17, no. 2 (1996).

quired by law to report to California immigration authorities anyone that they suspected to be undocumented. Several organizations challenged the proposition on the grounds that it violated federal law, including the Mexican American Legal Defense and Education Fund and the American Civil Liberties Union. These efforts led to a federal injunction against Proposition 187, and eventually, courts struck it down as a violation of the Equal Protection Clause of 14th Amendment.[44] But the referendum demonstrated how deeply politicized undocumented access to health services had become, and set a precedent for similar legislation in other states that barred access to the undocumented.

In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). Mostly remembered as a "welfare reform" bill that ended the Aid to Families with Dependent Children program, PRWORA also had a substantial impact on healthcare. PRWORA denied federally-funded public medical coverage (with the exception of emergency services) for five years to all immigrants who arrived in the United States after August 1996. Subsequent studies showed that nationwide, the uninsured rate skyrocketed among immigrant populations; the insured rate plummeted by 23 percent among poorly educated single foreign-born women, and by an astonishing 68 percent among their children.[45] While California used state funds to continue to offer services to documented immigrants (undocumented immigrants remained ineligible), studies found that the legislation had a "chilling effect" that reduced applications and coverage even for people who continued to qualify for Medi-Cal.[46]

The Affordable Care Act and Medicaid Expansion

Few pieces of federal legislation have transformed Medi-Cal, and indeed the entire US healthcare system, more profoundly than the 2010 Affordable Care Act (the ACA, or "Obamacare" as it became popularly known). The signature domestic accomplishment of the Barack Obama presidential administration, the ACA established subsidized health insurance marketplaces, prohibited insurance denials based on preexisting conditions, and implemented mandates requiring most Americans to be covered by insurance or face a tax penalty. The ACA also significantly expanded the Medicaid program by broadening eligibility to include all non-elderly adults with incomes up to 138% of the federal poverty level. In 2010, California became the first state to create a health benefit exchange under the ACA, a program that would eventually become known as Covered California. The most transformative effect of the ACA, however, was a vast expansion of Medi-Cal and an enormous injection of federal funding into the program. Between December 2012 and December 2014, the ACA increased the Medi-Cal population by 4.5 million, from 7.6 million to more than 12 million, an increase of almost 60 percent.[47] In 2012, fifty California counties enrolled over 550,000 Californians in Low Income Health Programs, which was the majority of expanded Medicaid patients in the nation. Between Covered California and the expansion of Medi-Cal, the ACA cut the uninsured rate in the state by half. In early 2010, about 7.2 million Californians were covered by Medi-Cal. By 2015, the Medi-Cal rolls had swelled to 12.7 million people, or one in three Californians. Overall,

44 R. Michael Alvarez and Tara L. Butterfield, "The Resurgence of Nativism in California? The Case of Proposition 187 and Illegal Immigration," ***Social Science Quarterly*** 81, no. 1 (2000): 167–79.

45 Neeraj Kaushal and Robert Kaestner, "Welfare Reform and Health Insurance of Immigrants," ***Health Services Research*** 40, no. 3 (June 2005).

46 Wendy Zimmerman and Michael E. Fix, "Declining Immigrant Applications for Medi-Cal and Welfare Benefits in Los Angeles County," The Urban Institute, July 1st, 1998.

47 California Department of Health Care Services, "Historic Growth of California's Medi-Cal Program: 1977-2017," California Department of Health Care Services, 2018.

Medi-Cal enrollment grew 78 percent from January 2010 to August 2019.[48]

Few pieces of federal legislation have transformed Medi-Cal, and indeed the entire US healthcare system, more profoundly than the 2010 Affordable Care Act

The expansion of Medicaid under the ACA vastly increased access to care to low-income Californians, and particularly to African Americans, indigenous and Latinx Californians, and other Californians who have historically been systematically failed by the American healthcare system. At the same time, however, the expansion exposed inequities within the program. By 2018, half of patients covered by Medi-Cal were Latinx. Nevertheless, significant disparities in access persisted between white Medi-Cal recipients and Latinx patients and other Medi-Cal patients of color. Many critics charged that Medi-Cal reimbursement rates to providers was a leading structural cause of racial and ethnic inequities in access. State officials had made drastic cuts to the Medi-Cal reimbursement rate in 2008 in the midst of budgetary crisis following the Great Recession, and it remained among the lowest Medicaid reimbursement rates in the nation.

Moreover, undocumented migrants in California, the majority of whom were of Mexican and other Latinx decent, remained mostly shut of out of non-emergency Medi-Cal and Covered California services. By 2015, the undocumented population accounted for nearly half of the three million Californians who still lacked health insurance coverage.[49]

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By the middle of the 2010s, there was strong legislative push to bring undocumented children under Medi-Cal coverage. In 2015, the legislature passed a bill that expanded Medi-Cal coverage to eligible undocumented children under the age of eighteen.[50] In 2019, newly-elected Governor Gavin Newsom, who had run on a platform that centered single-payer healthcare, signed legislation into law that raised the Medi-Cal age limit to 26 for undocumented migrants.[51] The legislature subsequently included the undocumented elderly, and in 2023, California became the first state in the country to extend Medicaid coverage all who are eligible in the undocumented population.

48 Lisa Gillespie Young, "Medi-Cal's Very Big Decade," ***KFF Health News***, December 13th, 2021.

49 "Plan May Swell Medi-Cal Rolls," ***Los Angeles Times***, November 10th, 2015.

50 "Big Test to Boost Migrant Care Looms," ***Los Angeles Times***, April 27th, 2015.

51 "Medi-Cal Plan Would Expand Coverage of Undocumented," ***Los Angeles Times***, January 8th, 2019.

Current Issues: The COVID-19 Pandemic to the Present

Governor Gavin Newsom came into office in 2019 with an ambitious $47 billion agenda for healthcare that included investment in generic drug manufacturing facilities in California and broadening Medi-Cal's mental health and addiction provisions. The plans were quickly disrupted by the global outbreak of the onset of the COVID-19 pandemic in the spring of 2020, which placed significant strain on the state's hospitals, public health infrastructure, providers, and healthcare budgets, all while decimating economic activity and gutting tax revenue during pandemic-related lockdowns and social distancing.[52]

In June of 2020, data compiled by the California Department of Public Health showed that 45.6 percent of COVID-related deaths were among a Latinx population that comprised 38.9 percent of the population; African-Americans, meanwhile, made up 6 percent of the population and 8.5 percent of COVID deaths.

By the summer of 2020, it was clear that in California and around the country, the COVID-19 crisis had laid bare long-standing structural disparities in healthcare outcomes along line of race, ethnicity, documentation status, and class. In June of 2020, data compiled by the California Department of Public Health showed that 45.6 percent of COVID-related deaths were among a Latinx population that comprised 38.9 percent of the population; African-Americans, meanwhile,

52 Angela Hart and Rachel Bluth, "Newsom's Ambitious Health Care Agenda Crumbles in a Radically Changed World," ***KFF Health News***, August 3, 2020; Kaitlyn E. Jackson et al., "Characterizing the Landscape of Safety Net Programs and Policies in California during the COVID-19 Pandemic," ***International Journal of Environmental Research and Public Health*** 19, no. 5 (January 2022).

The COVID-19 pandemic has exposed and exacerbated longstanding inequities in the Medi-Cal system. Source and permissions: Creative Commons.

made up 6 percent of the population and 8.5 percent of COVID deaths.[53] Despite the broad expansion of healthcare coverage through Medi-Cal, Medicare, and Covered California, large numbers of Californians endured the COVID-19 pandemic with no health insurance coverage. Some three million Californians reported being completely uninsured in the spring of 2022. This uninsured population is likewise heavily skewed towards lower income and nonwhite Californians. 68 percent were Lantinx, 38 percent were noncitizens, and 80 percent were low income (under 400 percent of the federal poverty level).[54]

The pandemic's disruptions to the Medi-Cal system created a series of challenges that continue to reverberate to the present day. Among the most pressing is the issue of Medicaid "unwinding" following COVID-era expansions to the program. After the declaration of COVID-19 as a public health emergency, the federal Families First Coronavirus Response Act tied federal funding of Medicaid programs to a requirement that states maintain continuous coverage of Medicaid recipients throughout the period of the emergency. The provision allowed for millions of Medi-Cal recipients, and Medicaid recipients around the country, to maintain their coverage without undergoing previously required annual checks to determine their continued eligibility.

On the first of April 2023, Medicaid resumed annual checks for eligibility, beginning a period of "unwinding" of the continuous coverage requirement. Medicaid patients who now earned too much to qualify were removed from the Medicaid rolls. By November 2023, over 10 million Medicaid enrollees had lost their coverage nationwide, the largest single disruption in health insurance coverage in the history of the country. The federal Department of Health and Human Services has estimated that that number might rise as high as 15 million. While many of these enrollees were eligible for employer-provided plans or subsidies on the ACA health insurance market exchanges, many were without another source of coverage or experienced a significant lag in coverage. Many of those who were disenrolled had incomes that disqualified them from the Medicaid program, but the majority, 71 percent, met the income requirements for renewal but were disenrolled for so-called "procedural" reasons: they had failed to return forms or filled them out incorrectly, for example. Enrollees with disabilities and with limited English proficiency, as well as the unhoused and people of color, are at a greater risk of disenrollment on procedural grounds.

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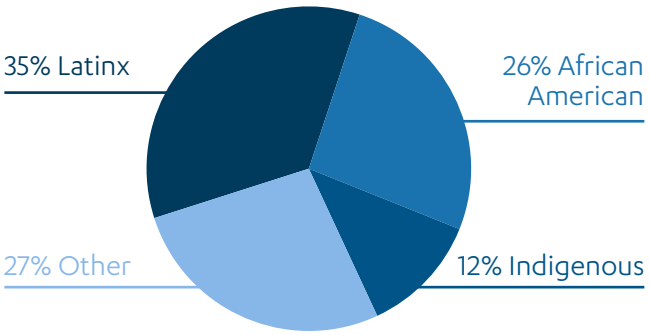
California began its unwinding program in July 2023, and by June of 2024, more Californians had lost their Medicaid coverage due to unwinding than any state in country but Texas. More than 1.8 million Californians had lost coverage, more than a quarter of all Medi-Cal recipients. Almost a quarter of these were children. 88 percent of these recipients had their coverage for procedural rea-

53 Bernard J. Wolfson, "Medi-Cal Agency's New Head Wants to Tackle Disparities and Racism," ***KFF Health News***, January 14th, 2021.

54 Unites States Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2022.

sons, far higher than the national average.[55] The majority of Medi-Cal patients in Los Angeles County, for example, were disenrolled because the county had not received the requisite renewal paperwork, and many of these individuals face language barriers and precarious or unfixed housing situations. To mitigate loss of Medi-Cal coverage for eligible residents, the Department of Health Care Services has created programs to reach Medi-Cal enrollees in "culturally and linguistically appropriate ways," but the majority of those dropped from the Medi-Cal rolls procedural grounds remain unenrolled.[56]



Demographics of Unhoused Population

Between 2014 and 2020, as the rise in the cost of housing in the state has outpaced income gains, the unhoused population has grown by 42 percent.

In addition to Medi-Cal unwinding, one of the most pressing challenges to California's healthcare system is the precipitous rise in the state's unhoused population over the last decade. Between 2014 and 2020, as the rise in the cost of housing in the state has outpaced income gains, the unhoused population has grown by 42 percent. By mid-

A COVID-19 testing center in Ventura County, California, November 2020. Source and permissions: Creative Commons.

2023, 30 percent of the nation's homeless population and half of the nation's unsheltered population, over 170,000 people, lived in California. People of color are vastly overrepresented in the unhoused population; a large statewide sample in a recent study was 35 percent Latinx, 26 percent African-American, and 12 percent indigenous.[57]

Homelessness is not only a social and political crisis, but an inherently medical one as well. A loss of housing is often a direct result of ill health, as workers who become ill and injured become unable to maintain employment and employer-provided healthcare. In turn, homelessness exacerbates preexisting medical conditions and creates new ones through communicable disease, malnutrition, and exposure. Two-thirds of California's unhoused population struggle with a psychiatric condition and 60 percent have at least one chronic illness. While the majority of the state's unhoused population is eligible for Medi-Cal, there are significant barriers to healthcare access. Almost a quarter of participants in a recent study reported that they had been able to get healthcare over the last six months, and almost half reported they had regular source of healthcare outside of emergency rooms.[58]

55 "Medicaid Enrollment and Unwinding Tracker," Kaiser Family Foundation, June 4th, 2024.

56 California Department of Health Care Services, "Medi-Cal COVID-19 Public Health Emergency Unwinding Operational Plan," February 2023.

57 "Toward a New Understanding: California Statewide Study of People Experiencing Homelessness," University of California, San Francisco, June 2023.

58 "Toward a New Understanding: California Statewide Study of People Experiencing Homelessness."

A loss of housing is often a direct result of ill health, as workers who become ill and injured become unable to maintain employment and employer-provided healthcare.

Another congoing concern is the quality and administrative concerns within Medi-Cal's managed care organizations. Managed care organizations now administer the care of the vast majority of Medi-Cal patients. In 2010, half of Medi-Cal patients received care on a fee-for-service basis. By the end of the 2019, those covered under a managed care organization had swelled to 82 percent.[59] As many as 90 percent of Medi-Cal children are covered by a managed care organization. Plans are in place to put increasing numbers of Medi-Cal long-term care under managed care organizations by 2027.[60]

For-profit managed care companies have profited handsomely from the state's Medicaid expansion; from 2014 to 2021, the state's largest managed care organizations collectively generated $2.9 billion in net profits from Medi-Cal reimbursements. Yet these managed care organizations continue to offer Medi-Cal care that is problematic and often substandard. In March of 2022, state regulators fined L.A. Care, the largest Medi-Cal managed care organization, a record $55 billion for over 100,000 violations, ranging from treatment delays to failing to ensure an adequate standard of care. A 2020 study by the California Department of Health Care Services found that among Medi-Cal managed care organizations, significant racial and ethnic persisted in areas such as mental health, contraceptive care, and developmental screening for young children. A study by the Auditor of the State of California ranked the state 40th in the nation for preventative care for children, blaming a lack of state oversight of managed care organizations. Many of these Medi-Cal managed care plans often outsource services to independent physician associations through elaborate systems of subcontracting, which in turn often hire management and consulting firms to handle authorizations and claims. This complex, multilayered system often shields providers from adequate state oversight and hampers patients' timely access to care.[61]

59 Lisa Gillespie Young, "Medi-Cal's Very Big Decade," ***KFF Health News***, December 13th, 2021.

60 California Health Care Foundation, "Managed Long-Term Services and Supports: Status and Trends in California," March 2023.

61 Bernard J. Wolfson, "California's Reboot of Troubled Medi-Cal Puts Pressure on Health Plans," ***KFF Health News***, March 23rd, 2023; Bernard J. Wolfson, "Record Fines Might Mean California Is Finally Serious About Improving Medi-Cal," ***KFF Health News***, April 13th, 2023; California Department of Health Care Services, "2019 Health Disparities Report, Managed Care Quality and Monitoring Division," December 2020; Auditor of the State of California, "Millions of Children in Medi-Cal are Not Receiving Preventative Health Services," March 2019; Bernard J. Wolfson, "Layers of Subcontracted Services Confuse and Frustrate Medi-Cal Patients," ***KFF Health News***, May 26th, 2023.

Policy Recommendations

Medicaid Unwinding

Among the most urgent problems now facing Medi-Cal, and the California healthcare system as a whole, is the ongoing "unwinding" of Medicaid following the end of its pandemic-era expansion. In the wake of renewed eligibility checks beginning in mid-2023, almost three-quarters of a million Californians had lost Medi-Cal benefits as of November. The California Department of Health Care Services estimates that by the time the unwinding process comes to a close, between two and three million Californians may lose coverage.[62] It is particularly concerning that the vast majority of Medi-Cal beneficiaries currently being unrolled are not losing coverage because they have incomes over the threshold of eligibility, but for "procedural" reasons related to issues such as missing or incomplete eligibility paperwork. The percentage of those disenrolled for procedural reasons is significantly higher in California than the national average, and evidence suggest that patients in this population are disproportionally Latinx and African-American and more likely to be disabled or unhoused.

In the wake of renewed eligibility checks beginning in mid-2023, almost three-quarters of a million Californians had lost Medi-Cal benefits as of November 20__ .

Historical evidence shows that a sudden, mass disenrollment of Medi-Cal beneficiaries can have detrimental effects on patients' access to care and overall health and wellbeing. In 1982, California, facing a healthcare budget crisis due to falling property tax revenue, eliminated the Medically Indigent Adult eligibility category for Medi-Cal. Healthcare access, satisfaction, and outcomes significantly declined, and death rates rose, for the 270,000 low-income adults who lost coverage, the majority of whom were African-American or Latinx. It is reasonable to suspect that the unwinding process will result in similar adverse effects for vulnerable populations. The Department of Healthcare Services has put a number of flexibilities and initiatives in place to mitigate procedural disenrollment. But the scale of the problem necessitates greater administrative action and investment of resources, including enhancing outreach for the state's diverse population, automating eligibility verification, and, if necessary, legislative action to expand the eligibility grace period.

62 California Department of Health Care Services, "Medi-Cal COVID-19 Public Health Emergency Unwinding Operational Plan," February 2023.

Managed Care Reform

The percentage of Medi-Cal patients receiving their care through managed care organizations, rather than the tradition fee-for-service model, has been rising rapidly in recent years; more than 90 percent of the Medi-Cal population is now covered under one of these plans. Managed care has broad bipartisan support in the state legislature, and the Newsom administration has recently voiced interest in further entrenching the managed care system. However, these managed care organizations, especially ones operating on a for-profit basis, continue to generate quality-of-care concerns and lack of accountability and transparency. In recent years there have been legislative and policy efforts to enforce standards of care among managed care organizations: there have been increasing calls from legislators, patients' groups, and healthcare advocates to tie state Medi-Cal reimbursements to managed care organizations to quality of care, for example. A new system of statewide bidding competition for managed care organizations, designed to raise standards of care, is set to go into effect in 2024, but the ability of the state to adequately enforce new contracts remains uncertain. The new bidding is system is expected to cause significant disruption of care for patients who must change plans, and potentially, their primary care physicians. A controversial backdoor concession to Kaiser Permanente, moreover, will allow the managed care giant to operate Medi-Cal plans in 32 counties without having to bid for contracts.[63]

By highlighting the historical background of managed care, we see that the managed care system did not arise out of pragmatic necessity, but political expediency, and we are better able to denaturalize a system that often seems inevitable and intractable.

Typically absent from these policy discussions and debates is a historical perspective on the growth of the managed care model in California, and its subsequent spread to other states in the Medicaid system. From early HMO experiments in the late 1960s to the entrenchment of the HMO and managed care model in the 1980s and 1990s, the model has been marked by a range of problems including reduced access, understaffing, and questionable care quality. Perhaps most importantly, a historical perspective shows that the managed care model arose out of a specific political-ideological project, undertaken by the Reagan governorship in the late 1960s, to impose austerity on means-tested "welfare" programs like Medi-Cal while also channeling public funds into private for-profit healthcare entities. By highlighting the historical background of managed care, we see that the managed care system did not arise out of pragmatic necessity, but political expediency, and we are better able to denaturalize a system that often seems inevitable and intractable.

63 Samantha Young and Bernard J. Wolfson, "California's Resolve Questioned After It Grants Medi-Cal Contract Concessions," California Healthline, May 3rd, 2023; Bernard J. Wolfson, "Health Plan Shake-Up Could Disrupt Coverage for Low-Income Californians," KFF Health News, August 10th, 2023; Bernard J. Wolfson, "Newsom's Big Kaiser Permanente Deal Divides California's Medicaid Insiders," KFF Health News, January 27th, 2022.

County-Level Administration and State Oversight

Due to the historical role of California's counties in financing and delivering medical care to low-income residents, Medi-Cal's managed care system is distinctive in that it operates under different models in different counties. County governments generally have great leeway to determine the composition of the mix of public versus private services, and to determine how much emphasis they place on medically indigent versus other healthcare priorities. Many counties have a "two-plan" model that consists of a public entity and a commercial plan, while others operate under County Organized Health Systems overseen by a County Board of Supervisors. The result is a standard of care that varies widely from county to county. Medi-Cal patients who move from one county to another face particular difficulty, as they are often bumped from their plan and into traditional fee-for-service Medi-Cal and then billed directly. Increased standardization, greater state oversight, and more administrative centralization would bring about a greater balance of local control and statewide consistency to Medi-Cal than has historically been the case.

Medi-Cal and Homelessness

The current and growing of crisis homelessness will remain among California's most pressing healthcare concerns over the coming years. Any effective legislative and policy solutions to the homelessness crisis must be based on a firm grounding in the historical and structural factors that have led to its rise in California: widening income inequality, failure of mental healthcare services, systemic racism, the ravages of the opioid epidemic, and, perhaps above all, the increasing lack of affordable housing in major metropolitan centers. Currently, a five-year, multibillion pilot dollar project, called California Advancing and Innovating Medi-Cal (or CalAIM) is underway to channel Medi-Cal funds homeless and precarious populations to address areas outside the program's traditional scope, such as housing assistance, medically tailored meal delivery, and toxic mold removal. The first of its kind in the nation, this program is a novel policy attempt to holistically address the multifaceted social determinants homelessness.[64] Nevertheless, the $6 billion allotted to the program will reach only small fraction of the states unhoused population. Increased funding and infrastructure are needed to expand the program into a large-scale, statewide initiative that can serve as a model for Medicaid programs beyond California.

The current and growing of crisis homelessness will remain among California's most pressing healthcare concerns over the coming years.

64 Bernard J. Wolfson, "Newsom's Big Medicaid Shake-Up Faces Giant Headaches," ***KFF Health News***, February 17, 2022.

California Healthcare in National Context

One of the most striking and consistent patterns that emerges from this study is the degree of influence that the state of California has historically had on healthcare policy nationwide. As the largest state with a diverse population and expansive economy, California has served as a laboratory, model, or cautionary precedent for other states and on the national level, from single payer healthcare debates to the rise of HMOs to the expansion of Medicaid to undocumented patients. As the Medicaid system faces significant challenges in the coming years from the unwinding crisis, the drug epidemic, and budgetary pressures, any future discussion of state-level policy must take into account the relationship between Medi-Cal and the broader Medicaid system.

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