Program Update *Periodic Reviews of State Program Implementation*

Implementation of Proposition 99

An Overview

EXECUTIVE SUMMARY

Proposition 99 (November 1988), the Tobacco Tax and Health Protection Act, established a new surtax on cigarettes and tobacco products, thereby generating about $1.5 billion in new revenues for expenditure in 1989-90 and 1990-91. Assembly Bill 75 (Ch 1331/89, Isenberg) allocated the vast majority of these funds. Our review suggests that the major departments responsible for the implementation of AB 75 have generally made reasonable progress in the past two years in implementing the health services and health education programs the act established, although some programs are still experiencing delays in payments or are underutilizing the funds that are available. Our review also indicates that there are currently little data available with which to evaluate the effectiveness of programs.

The Legislature faces several major issues related to Proposition 99. Specifically, AB 75 will sunset June 30, 1991, requiring choices to be made regarding the allocation of Proposition 99 funds beginning in 1991-92 — before evaluations of Proposition 99 funded programs are available. The options for addressing these issues depend on whether legislative funding priorities are the same or have changed since AB 75 was enacted. For example, the Legislature could continue existing programs by extending AB 75's sunset date.

On the other hand, the Legislature could pursue a new course by shifting health services funds to other health services programs. In light of the proposed realignment of public health and indigent care programs, for example, the Legislature may wish to allocate AB 75 funds for specific services it wants to assure are provided (such as preventive or outpatient care). Alternatively, funds could be targeted to a specific population such as children, to establish comprehensive children's health services.

The Legislature could also pursue a new course by shifting health education funds to health services programs or vice versa. For example, it could provide some level of funding for a specific priority — such as children's health services — while continuing to fund (at a higher level than proposed in the Governor's Budget) ongoing health education programs.

In addition, we believe the Legislature in the long term should structure Proposition 99 programs so that program demands can be met recognizing the projected decline in this revenue source.

Legislative Analyst's Office
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INTRODUCTION

In November 1988, the voters approved Proposition 99, the Tobacco Tax and Health Protection Act, which established a surtax of 25 cents per pack on cigarettes and an equivalent amount on all other tobacco products sold in California. Proposition 99 provides a major new funding source — over $500 million annually — for health services, health education, tobacco-related research, and natural resources programs.

In this analysis, we focus primarily on how Proposition 99 has been implemented over the past two years and devote particular attention to the health education programs established in the Department of Health Services (DHS) and the State Department of Education (SDE). Specifically, we (1) provide a brief background on the provisions of Proposition 99 and how it has been implemented; (2) review the 1991-92 Governor's Budget proposal for using Proposition 99 funds; (3) provide a status report on programs established by AB 75, which allocated 90 percent of Proposition 99 funds in 1989-90 and 1990-91; and (4) identify some of the major decisions currently facing the Legislature regarding Proposition 99.

WHAT DID PROPOSITION 99 REQUIRE?

The tobacco surtax went into effect on January 1, 1989. Proposition 99 requires that revenues from the surtax be deposited in the Cigarette and Tobacco Products Surtax Fund (C&T Fund) established by the act, and allocates specified percentages of the fund to six accounts. The act further requires that revenues allocated to the six accounts be spent for specified purposes, and requires all funds to be used to supplement current services, not to fund existing service levels.

Figure 1 identifies (1) the six accounts, (2) the specified purposes for each account, (3) the percent of surtax revenues required for each account under the act, and (4) the percent of surtax revenues allocated to each purpose under the Governor's proposed 1991-92 budget. (In order to change the specified allocations to each account, or the purposes for which funds in each account may be spent, Proposition 99 requires a four-fifths vote of the Legislature.)

HOW HAS PROPOSITION 99 BEEN IMPLEMENTED?

During 1989 and 1990, the Legislature and the voters took several actions to provide for the expenditure of Proposition 99 funds. These actions are described below.

Health Services and Health Education Programs

Assembly Bill 75 (and subsequent clean-up legislation) allocated revenues for 1988-89, 1989-90, and 1990-91 from the Hospital Services, Physician Services, Health Education, and Unallocated Accounts to establish a variety of new health programs and to expand existing health programs. These programs include the California Healthcare for Indigents Program (CHIP), a variety of anti-smoking education programs, expanded eligibility for perinatal care through Medi-Cal, and expanded eligibility for children's medical examinations through the Child Health and Disability Prevention (CHDP) Program.

Figure 1

Proposition 99 Accounts
Comparison of Currently Required Allocations and Governor's 1991-92 Budget Proposal

Account	Purposes	Percent of Proposition 99 Surtax Revenues for Each Purpose: Allocation Required By Proposition 99	Allocation Proposed in 1991-92 Governor's Budget[a]
Health Education	Prevention and reduction of tobacco use, primarily among children, through school and community health education programs.	20%	12%[b]
Hospital Services	To pay hospitals for the treatment of patients who cannot afford to pay themselves, and for whom payment will not be made through private medical coverage or federally funded programs.	35	35
Physician Services	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 medical coverage or federally funded programs.	10	10
Public Resources	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.	5	5
Research	To fund tobacco-related disease research.	5	5
Unallocated	May be used for any of the specific purposes described above. Proposition 117 (the "Mountain Lion Initiative," June 1990) requires that 10 percent of Unallocated Account funds be transferred to the Habitat Conservation Fund.	25	33[c]
Totals		**100%**	**100%**

[a] Percentages shown are approximations as estimated by the Legislative Analyst, based on the *1991-92 Governor's Budget* proposal of January 1991.

[b] Proposition 99 requires that 20 percent of surtax revenues be deposited into the Health Education Account and that funds in this account be used for health education programs. Thus, we assume that 20 percent of Proposition 99 funds are to be used for health education purposes. This means that if the Legislature wishes to adopt the Governor's proposal, it has two options: (1) change the percentage required to be allocated to the Health Education Account or (2) change the purposes for which Health Education Account funds must be used. Both of these options require a four-fifths vote, per the provisions of Proposition 99.

[c] For purposes of illustration, that portion of the proposed perinatal insurance program funded from the Health Education Account in the 1991-92 Governor's Budget is included under purposes for which Unallocated Account funds are appropriate. A combination of Hospital Services Account, Physician Services Account, and Unallocated Account funds may also be an alternative means of allocating funds for the perinatal insurance program.

Research and Public Resources Programs

The 1989 and 1990 Budget Acts allocated funds available in the Research and Public Resources Accounts to various programs, including tobacco-related research at the University of California and habitat conservation projects. Proposition 117 (the "Mountain Lion Initiative"), approved by the voters in June 1990, requires a transfer of 10 percent of Unallocated Account revenues to a new Habitat Conservation Fund (HCF) for funding wildlife habitat-related programs. It also requires that the HCF be funded at a level of $30 million annually. (This $30 million annual appropriation can be funded through a variety of sources, including Proposition 99 funds, the General Fund, or available bond funds.)

Major Risk Medical Insurance Program (MRMIP)

Chapter 1168, Statutes of 1989 (AB 60, Isenberg), established the MRMIP and transferred funds from the Hospital Services, Physician Services, and Unallocated Accounts to develop and implement the program in 1989-90 and 1990-91. Chapter 1168 also continuously appropriates $30 million annually from the Unallocated Account, beginning in 1991-92, to fund the program.

As discussed further below, AB 75 sunsets on June 30, 1991. Thus, decisions need to be made regarding how Proposition 99 funds will be used in 1991-92. At the time of this analysis, the Assembly Oversight Committee for Tobacco Tax Programs and the Senate Task Force on Tobacco Tax Program Oversight are holding a series of hearings on various Proposition 99 issues, including options for funding allocations in 1991-92.

WHAT IS THE GOVERNOR PROPOSING FOR 1991-92?

Figure 2 identifies the highlights of the Governor's proposals for 1991-92 based on the January Governor's Budget. The budget proposes total Proposition 99 related expenditures of $584 million in 1991-92. This is a reduction of $96 million (14 percent) from the current-year expenditure level of $679 million. The proposed reduction results primarily from an artificially high current-year total, which included a significant amount of unspent funds carried over from 1989-90.

As Figure 1 indicates, the Governor's Budget proposal is generally consistent with the allocation requirements of Proposition 99 except with respect to the Health Education and Unallocated Accounts. The Governor's Budget proposes to reduce funding for health education programs (including SDE programs) by about $89 million while providing about $50 million in Health Education Account funds for a proposed perinatal insurance program. (Total funding for the proposed perinatal insurance program would be $90 million — including about $25 million from the Hospital Services Account and $15 million from the Physician Services Account.) This proposal would require approval by four-fifths of the Legislature since it does not fulfill the requirements of Proposition 99 regarding the distribution of funding across the various program categories.

Figure 2

Highlights of the Governor's Proposals for 1991-92[a]

- ☑ Estimated Proposition 99 resources available for expenditure in 1991-92 total $611 million.
- ☑ Budget proposes $584 million in expenditures for 1991-92.
- ☑ Proposed budget is 14 percent below current-year level, primarily because $104 million in carry-over funds are no longer available.
- ☑ Proposed budget reduces funding for health education programs by $89 million and funding for the California Healthcare for Indigents Program by $90 million.
- ☑ The budget proposes to establish a new perinatal insurance program at a total cost of $90 million.

[a] Based on the January Governor's Budget.

Since Proposition 99 requires a certain percentage of revenues to be deposited in each account, and specifies the purposes for which funds in each account *must* be spent, we assume that the revenues in each account must be spent on the specified purposes. This means that if the Legislature wishes to adopt the Governor's proposal, it has two options: (1) change the percentage of revenues required to be deposited in each account or (2) change the purposes for which funds in each account must be used. Both of these options require a four-fifths vote, per the provisions of Proposition 99.

Figure 3 (next page) displays the dollar amount of Proposition 99 resources and their distribution in 1989-90 and 1990-91, as well as expected resources and the Governor's proposed distribution for 1991-92. Below we discuss in detail the resources and expenditures proposed for the budget year. Figures 4 and 5 (page 7) provide highlights regarding revenues and expenditures.

How Much Money Will be Available in the Budget Year?

As shown in Figure 3, the January Governor's Budget estimates that tobacco surtax revenues will total $547 million for the current year. This amount is $26 million, or 4.5 percent, below actual revenues in 1989-90, and is based on a decrease in per-capita cigarette consumption of 5.3 percent in 1990-91. For 1991-92, the budget estimates that surtax revenues will total $531 million, based on a projected further decline of 4.8 percent in per-capita cigarette consumption. This amount is $16 million, or about 3 percent, below estimated current-year revenues. (Because the budget expects population growth to partially offset reduced per-capita sales, the estimated declines in revenues are not as great as projected declines in per-capita cigarette consumption.)

For both 1990-91 and 1991-92, the projected rate of revenue decline reflects a more rapid decline in consumption than the average annual pre-surtax decline rate of 3.6 percent from 1982-83 through 1987-88. The major reasons for the anticipated faster decline in smoking include increased educational efforts to reduce smoking, additional restrictions on smoking in public places and work areas, higher cigarette prices due to the new federal cigarette excise tax increase of 4 cents per pack that became effective January 1, 1991, and the higher state excise tax established by Proposition 99.

Over the longer term, surtax revenues are expected to gradually diminish further. Based on (1) the Department of Finance's estimates for current-year surtax revenue and its projections for population growth and (2) an assumption that the decline in per-capita cigarette sales continues at roughly 3 percent annually, we estimate annual surtax revenues will drop to around $486 million by 1994-95 (a 9.3 percent reduction from their 1991-92 level). Furthermore, to the extent that health education programs succeed in reaching the goal of AB 75 to reduce tobacco consumption by 75 percent by 1999, the decline in revenues could be significantly more than projected.

"The Governor's Budget proposes to reduce funding for health education programs by about $89 million while providing about $50 million in Health Education Account funds for a proposed perinatal insurance program. (Total funding for the proposed perinatal insurance program would be $90 million.) This proposal would require approval by four-fifths of the Legislature."

Figure 3

Proposition 99 Revenues and Expenditures All Funds

(dollars in thousands)

	Actual 1989-90	Estimated 1990-91	Proposed 1991-92	Change from 1990-91 Amount	Change from 1990-91 Percent
Resources					
Revenues from surtax [a]	$572,844	$546,800	$531,100	-$15,700	-2.9%
Interest income	32,763	28,600	18,400	-10,200	-35.7
Carry-over from previous year	329,169	165,725	61,842	-103,883	-62.7
Appropriation per Ch 51/90	4,270	—	—	—	—
Totals	***$939,046***	***$741,125***	***$611,342***	***-$129,783***	***-17.5%***
Expenditures and Transfers					
AB 75 programs					
Department of Health Services					
California Healthcare for Indigents Program (CHIP)	$336,492	$315,854	$226,304	-$89,550	-28.4%
County capital outlay	82,288	—	—	—	—
Uncompensated care assistance	61,931	—	—	—	—
County data systems	10,000	—	—	—	—
Clinics	19,719	18,265	13,324	-4,941	-27.1
Children's hospitals	2,000	1,896	1,422	-474	-25.0
Rural health services	6,972	6,542	4,173	-2,369	-36.2
County Medical Services Program (CMSP) expansion	9,954	9,918	9,918	—	—
Child Health and Disability Prevention (CHDP) Program expansion	8,337	29,748	42,635	12,887	43.3
CHDP dental services in CMSP counties	—	1,000	—	-1,000	-100.0
Health education programs	53,219	99,465	30,000	-69,465	-69.8
Expansion of Medi-Cal perinatal services	11,890	24,155	3,190	-20,965	-86.8
Reinsurance Account	1,000	—	—	—	—
Administration	7,455	9,657	5,792	-3,865	-40.0
Subtotals	***$611,257***	***$516,500***	***$336,758***	***-$179,742***	***-34.8%***
Department of Mental Health [b]	35,000	30,000	40,000	10,000	33.3
Office of Statewide Health Planning and Development (OSHPD) administration	225	452	474	22	4.9
State Department of Education:					
Local assistance	35,093	35,100	15,100	-20,000	-57.0
Administration	605	911	900	-11	-1.2
Totals, AB 75 programs	***$682,180***	***$582,963***	***$393,232***	***-$189,731***	***-32.5%***
Other programs					
Board of Equalization tax collection	1,068 [c]	468	447	-21	-4.5
Major Risk Medical Insurance Program (MRMIP)	18,652	—	30,000	30,000	— [d]
Perinatal insurance program	—	—	90,000	90,000	— [d]
Immunizations	3,833	2,967	—	-2,967	-100.0
Transfers to habitat funds	—	14,858	23,355	8,497	57.2
Resources programs	26,665	46,078	19,791	-26,287	-57.0
University of California (UC) research program	40,923	31,949	26,852	-5,097	-16.0
Pro rata charges	—	—	11	11	— [d]
Totals, all programs	***$773,321***	***$679,283***	***$583,688***	***-$95,595***	***-14.1%***
Reserve carried over to next fiscal year [e]	165,725	61,842	27,654	-$34,188	-55.3%
Amount needed for a 5 percent reserve [f]			*29,184*		
Difference between proposed reserve and a 5 percent reserve			*-1,530*		

[a] Revenue estimate for 1991-92 differs from the January Governor's Budget, which includes a technical error adding $47 million for a one-time accrual adjustment to 1991-92 revenues. Proposition 99 revenues are already accounted for on an accrual basis, making an adjustment in the budget year inappropriate.

[b] Estimated expenditures are actually $25 million for 1989-90 and $40 million for 1990-91; however, the numbers shown here reflect the original appropriations and are consistent with the Governor's Budget.

[c] 1989-90 figure includes 1988-89 expenditures.

[d] Not a meaningful figure.

[e] The 1991-92 reserve is equivalent to 4.7 percent of proposed expenditures.

[f] Calculated by taking 5 percent of proposed 1991-92 expenditures.

Interest Income

Figure 3 shows that the January Govenor's Budget reflects interest income of $33 million in 1989-90, $29 million in 1990-91, and $18 million in the budget year. This interest income represents earnings on the balance of funds in the various accounts established by Proposition 99 prior to when they are expended.

Carry-Over from Prior Years

The January Governor's Budget reflects $62 million in funds that will be unspent in 1990-91 and therefore carried over into the budget year. This amount is $104 million less than the amount carried over from 1989-90 into the current year. As noted above, this reduction in carry-over funding is the major reason that programs cannot be maintained at current-year levels in 1991-92, even in the absence of the Governor's proposal to change program allocations.

Revenue Adjustments

The Governor's Budget includes $47 million in accrual adjustments in its 1991-92 revenue estimate. However, the Department of Finance has since determined that this accrual adjustment is not appropriate, because Proposition 99 revenues are already accounted for on an accrual basis. The data in Figure 3 reflect this correction.

What are Proposed Expenditures in the Budget Year?

Figure 3 details Proposition 99 expenditures for 1989-90 and 1990-91, and the budget's spending plan for Proposition 99 funds for 1991-92 based on the January Governor's Budget.

Health Services and Health Education 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. (In the next section, we describe the implementation of programs supported by these funds.) The 1991 Budget Bill includes funds for state administration of Proposition 99 related programs, but does not include funds for most of the actual programs (which the administration proposes be funded through separate legislation).

The Governor's proposal includes $393 million in funding for AB 75 programs. This is a $190 million (33 percent) reduction from current-year expenditures. The largest proposed

Figure 4

Proposition 99 Revenue Estimates

- Budget estimates $531 million in revenues for 1991-92, a decrease of $16 million (3 percent) from the current year. The decline is due to the net effect of population increases offset by a 4.8 percent decrease in per-capita cigarette consumption.
- Based on historical trends, cigarette tax revenues will decline by a cumulative total of $45 million (9 percent) from 1991-92 through 1994-95.
- If health education programs meet the AB 75 goal of reducing tobacco consumption by 75 percent by 1999, revenues could decrease significantly more than projected.

Figure 5

Proposition 99 Expenditure Estimates

- Proposed AB 75 expenditures for health education and health services programs are $393 million, a $190 million (33 percent) reduction from current-year expenditures.
- The reduction in AB 75 programs primarily reflects declines in available tobacco tax resources and increases in two non-AB 75 programs -- the Major Risk Medical Insurance Program and the proposed perinatal insurance program.
- The largest proposed reductions are in the California Healthcare for Indigents Program ($90 million decrease) and health education programs ($89 million decrease).
- Funding for natural resources and habitat programs is proposed at $43 million in 1991-92, or $18 million below current-year levels due to the decrease in available reserves.

reductions are in the CHIP ($90 million) and health education programs ($89 million). This reduction primarily reflects (1) the decline in resources available for Proposition 99 funded programs in the budget year and (2) increases in two non-AB 75 programs — the MRMIP and the proposed perinatal insurance program. As noted previously, the Governor's proposal would require a four-fifths vote by the Legislature since it does not fulfill the requirements of Proposition 99.

Public Resources Programs

The current-year spending plan for resources programs totals $61 million. This includes (1) expenditures of $46 million from the Public Resources Account for one-time projects and some continuing support costs in various state agencies and (2) transfers of $15 million to habitat programs, primarily the HCF established by Proposition 117. The budget proposes 1991-92 spending totaling $43 million, including (1) expenditures of $20 million from the Public Resources Account for purposes similar to the purposes funded in the current year and (2) transfers to the HCF totaling $23 million to implement Proposition 117.

The proposed allocation of Public Resources Account funds is consistent with the Proposition 99 requirement that 50 percent of the funds be allocated to habitat programs and 50 percent to state and local park and recreation resources. The reduction in funding for resources programs is primarily due to a decrease of $18 million in available funds resulting from spending down carry-over balances in the current year.

Research Programs

The 1990 Budget Act appropriated $32 million from the Research Account to support research at the University of California and for the DHS to analyze data from the cancer registry. The 1991 Budget Bill proposes $27 million to continue these expenditures. The University of California recently released its 1989-90 progress report on the Tobacco-Related Disease Research Program, in which it details a total of $68 million in grant awards for 189 projects to date (including 1988-89 and 1989-90 funds). Most of the awards were for multi-year projects.

Reserves

The budget proposes carrying over into 1992-93 a total reserve of $28 million (4.7 percent). Of this amount, $11 million is in the Health Education Account.

WHAT HAS BEEN ACCOMPLISHED SO FAR WITH AB 75 PROGRAMS?

Figure 6 (beginning on page 10) provides detail on the status of AB 75 programs. Below we highlight several of the larger programs established by AB 75, and focus specifically on the health education programs proposed for reduction in the Governor's Budget. Generally, the major departments involved (the DHS and the SDE) have made reasonable progress in the past two years in implementing both the health education and the health services programs funded through AB 75, although some programs are still experiencing delays in payments or are underutilizing the funds that are available. Our review also indicates that there are currently little data available with which to evaluate programs' effectiveness in achieving their stated objectives.

California Healthcare for Indigents Program (CHIP)

Assembly Bill 75 appropriated about $336 million in 1989-90 and $316 million in 1990-91 to support the CHIP. Assembly Bill 75 requires that CHIP funds be distributed to the 26 counties participating in the Medically Indigent Services Program (MISP) based on specified percentage shares. (The MISP provides state funds to counties for providing health services to medically indigent adults.) The DHS reports that all 26 counties have received full CHIP allocations with the exception of Los Angeles County, pending an appeal of its 1989-90 CHIP application.

The *Hospital Services Account* funds ($200 million in 1989-90 and $189 million in 1990-91) are 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 is 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 million in 1989-90 and $38 million in 1990-91) pay for unreimbursed physician services. Counties must use at least 50 percent of the available funds to pay for unreimbursed emergency services. Assembly Bill 75 caps these reimbursements at 50 percent of a 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 DHS indicates that the Physician Services Account funds are not being fully utilized. The reasons for this include implementation problems and claim reimbursement delays, and may also include cumbersome reporting requirements imposed on physicians in order to receive payments.

The *Unallocated Account* funds ($95 million in 1989-90 and $89 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 medical insurance or by fully or partially federal-funded programs.

In order to receive CHIP funds, counties are required (among other things) to (1) maintain at least the level of county funds dedicated to indigent care and public health services that they had in 1988-89 (referred to as the maintenance-of-effort requirement) and (2) submit plans specifying their proposed expenditure of CHIP funds. Counties are also required to submit cost reports detailing how funds were actually spent. These data are not yet available for 1989-90 or 1990-91.

The 1990 Budget Act reduced MISP funding by $175 million (in addition to another $100 million reduction that was expected to be offset by federal State Legalization Impact Assistance Grant reimbursements). Anecdotal evidence suggests that a large proportion of CHIP funds is being used to backfill this reduction, as well as fund cost increases in counties' indigent care programs. Despite the Legislature's actions giving counties the authority to raise new revenues (jail booking fees and other revenues as authorized by Ch 446/90 (SB 2557, Maddy)), there was uncertainty about the level and timing of these revenues. This uncertainty and the actual level of funds collected meant that these new revenues were not generally available to offset the MISP reductions. In many cases, this may have left counties with no practical alternative but to backfill with Proposition 99 revenues. It is important to note that counties can both backfill and comply with AB 75 maintenance-of-effort requirements. Without Proposition 99 funds, net county costs would most likely have increased to even higher levels.

Figure 6

Major AB 75 Programs[a] Implementation Status for 1989-90 and 1990-91

PROGRAM	DESCRIPTION	STATUS[b]
HEALTH SERVICES		
California Healthcare for Indigents Program (CHIP) – DHS	Provides additional funds to counties, hospitals, and physicians for uncompensated care of medically indigent persons in counties participating in the Medically Indigent Services Program (MISP). Counties may use CHIP funds to pay for child health and disability prevention (CHDP) treatment mandated by AB 75.	CHIP funds are allocated monthly. The participat 26 counties have received full funding with exception of Los Angeles County, pending an app of its 1989-90 CHIP application. (Los Angeles Cou has received funding for 1990-91, however.)
Mental health services -- DMH	Provides additional funding for county mental health programs, including inpatient, outpatient, day treatment, crisis intervention, and case management services.	Mental health services are provided in all 58 count with partial support from Proposition 99 funds. Cou allocations range from $465 to $5.8 million depend on county population, poverty levels, and the count share of all state-allocated mental health resourc
Uncompensated care assistance -- DHS	Provided one-time funding in 1989-90 for uncompensated care given at county and noncounty hospitals, as well as uncompensated care provided by physicians.	All funds have been distributed.
CHDP Program expansion -- DHS	Extends CHDP Program eligibility to additional children, provides additional medical examinations, and adds an anti-smoking education component to CHDP examination.	Approximately 1.5 million children have been adc to the eligible population for medical examinatio Counties received funding to develop programs a outreach materials for minority preteens and tee The DHS reports that as of February 28, 1991, ab 214,000 medical examinations had been provide newly eligible children.
Expanded Access to Primary Care (EAPC) -- DHS	Provides additional funds to primary care clinics for services provided to persons with incomes at or below 200 percent of the federal poverty level, and provided one-time funds for clinic capital outlay projects.	One hundred sixty-five clinics are currently be funded in 53 counties. The DHS indicates t 315,000 EAPC-eligible outpatient visits were provic in 1989-90.
Medi-Cal perinatal services expansion – DHS	Extends coverage for perinatal services to women with incomes between 185 and 200 percent of the federal poverty level and covers their infants up to one year of age.	The DHS estimates that the average number persons per month who are eligible for services w 1,400 in 1989-90 and will be 2,800 in 1990-91. Coverage under the 200 percent program was ma retroactive to October 1, 1989. A multimedia campa on the expanded perinatal care services is schedu to begin in late spring 1991. Thirty-seven counties have received funding eligibility workers who are outstationed at clinics t serve large numbers of pregnant women.
County Medical Services Program (CMSP) expansion -- DHS	Expands the scope of services provided under CMSP and compensates hospitals and physicians for emergency services provided to out-of-county indigent patients.	Thirteen dental clinics are currently being fundec 12 counties. Medical services, including podiat optometry, and audiology, have also been expand under the program. Funding has also been ma available for services provided to undocument persons residing in CMSP counties. In addition, t DHS reports that as of February 15, 1991, payme to 34 hospitals in 17 counties had been made for o of-county care.
Rural health services -- DHS	Provides additional funds to counties, hospitals, and physicians for uncompensated care of medically indigent persons in counties participating in the CMSP. Counties may use rural helath services funds to pay for CHDP treatment mandated by AB75.	Thirty-two counties have received funding under t program.

COMMENTS/PROBLEMS

Anecdotal evidence suggests that a large proportion of CHIP funds are being used to backfill 1990-91 General Fund reductions in MISP and cost increases in counties' indigent care programs. Counties can both comply with AB 75 maintenance-of-effort requirements and at the same time use CHIP funds to backfill. Without these funds, counties' net county costs would most likely have increased to even higher levels.

The Department of Health Services (DHS) indicates that the MISP counties paid out small amounts of funds to providers from the Physician Services Account (PSA) during 1989-90. The DHS anticipates that a significant PSA balance for 1989-90 will have to be reappropriated and that 1990-91 funds may also not be fully spent. This was due primarily to implementation problems and claim reimbursement delays and backlogs. In part, these problems may also be due to cumbersome reporting requirements imposed on providers in order to receive payment; at least one county has required providers to make eligibility determinations before submitting patient claims.

Anecdotal evidence suggests that CHIP funding which counties have put aside for CHDP treatment may not be fully spent. As of mid-spring 1991, only 39 percent of 1989-90 and 25 percent of 1990-91 funds allocated for treatment have been paid out to providers by the counties. In part, this may be due to inadequate follow-up after a CHDP medical examination has been performed. Many counties have established a separate system for follow-up treatment, which may exacerbate this problem. No data are currently available on the number of children treated, however.

No information is available about effectiveness of Proposition 99 funded programs or for what specific services counties are using Proposition 99 funds. It is likely that at least some counties are using at least a portion of Proposition 99 funds to backfill 1990-91 General Fund reductions in mental health local assistance.

No problems were reported in the disbursement of funds to hospitals. Funds for physician services may not have been fully spent.

For 1989-90, the number of additional medical examinations provided (100,000) far exceeded the DHS's initial estimate of 25,000 for this period. Continued growth in the number of examinations is projected for both 1990-91 and 1991-92.

The number of EAPC eligibles was much larger than anticipated by the DHS. In 1989-90, the program reimbursed 55 percent (about 173,000) of eligible EAPC outpatient visits at a fixed rate of $65 per visit.

The DHS estimates that actual expenditures will be about $12 million in 1989-90 and $24 million in 1990-91. These numbers differ from the appropriations in AB 75 primarily because (1) phasing in the program resulted in reduced 1989-90 costs and (2) increased caseloads contributed to higher costs in 1990-91. Projected caseload will continue to increase if the program is continued in 1991-92.

The DHS indicates that during 1989-90, implementation delays, a lack of awareness in counties about the expanded CMSP benefits, and delays related to establishing new clinics led to lower than anticipated payments to providers. The DHS estimates that approximately one-half of the 1989-90 appropriation ($4.9 million) will have to be reappropriated but that almost all of the 1990-91 appropriation will be spent.

Twenty-three of the counties chose to contract back with the DHS to administer their PSA in 1989-90. In 1990-91, counties could also choose to contract back administration of CHDP treatment services and their Hospital Services Account funds. Most counties are contracting back with the DHS for one or more of these programs.

The DHS reports that as of February 15, 1991, only seven of the participating counties had physicians submitting claims, due primarily to implementation delays and problems with the claim reimbursement process. It is important to note that similar problems have been observed in the CHIP (administered by counties).

Continued on next page

Figure 6–contd

Major AB 75 Programs[a] Implementation Status for 1989-90 and 1990-91

PROGRAM	DESCRIPTION	STATUS[b]
HEALTH SERVICES–contd		
Children's hospitals -- DHS	Compensates children's hospitals for uncompensated care provided to indigent children.	The seven eligible facilities have used funds fc variety of purposes, such as providing access bone marrow programs and allergy/pulmon programs, maintaining three primary and acute c clinics to relieve emergency room overcrowding, a providing treatment to CHDP-eligible children wh costs are not covered by Medi-Cal.
HEALTH EDUCATION		
School programs -- SDE	Provides funds for various health education and tobacco information activities designed to reduce tobacco use among school children.	Approximately $29 million has been allocated throu competitive grants to school districts based on stud enrollment ($6 per student). Roughly 70 percen these funds have been used to train teachers a purchase curriculum materials to teach students abstain from smoking. Funding was also ma available to 10 regional health centers to prov technical assistance to school districts and scho Another $6.4 million has been allocated for innova projects to design new approaches to tobacco u prevention.
Local government agency funding -- DHS	Provides funding to local agencies to develop and implement community-based tobacco education and cessation programs.	All 61 city and county health departments designated local government agencies for toba control. Each local agency has established a coali to guide tobacco control planning and implementati and to coordinate with state- and local-level progra
Competitive grants – DHS	Provides grants for tobacco-use prevention and cessation programs aimed at high-risk persons and groups.	The DHS has awarded grants to 212 projects provide services on a statewide, regional, a community basis. Grants are being funded to pro outreach to teens in fast food restaurants, vocati schools, and juvenile halls; develop tobacco educa materials for distribution to physicians and ot health care providers; and for a variety of ot purposes.
Media campaign -- DHS	Provides funds to increase public awareness of the health effects of tobacco use. The campaign uses a wide range of marketing methods, including television, print and outdoor advertisements, and working with communities at the local level.	One hundred sixty-five anti-tobacco advertiseme have been produced and marketed in eight languag As of December 1, 1990, these advertisements been placed on 147 radio stations, 69 televis stations, 775 billboards and buses, and 1 newspapers — with 56 percent of the advertisements targeted to ethnic minorities.
Data analysis and evaluation -- DHS	Responsible for evaluating local, regional, and statewide tobacco-use prevention programs and providing technical assistance to local programs.	A baseline survey conducted in 1989-90 indica there were 750,000 fewer smokers than expec and that there is strong support for tobacco prevention education efforts. Efforts are underwa expand the survey to focus on specific target grou including youth and ethnic minorities.
OTHER PROGRAMS		
County capital outlay -- DHS	Provided one-time funds to counties for capital expenditures and equipment acquisitions associated with the direct delivery of patient care. MISP counties received 90 percent of the funds, and CMSP counties received 10 percent.	Forty-seven counties have received approval funding for their capital outlay proposals. Accord to the DHS, almost 60 percent of the funds were projects related to inpatient services, another percent supported projects related to outpat services, and the remainder was for various ot purposes. About 41 percent was used for movea equipment, while almost 20 percent was used remodeling.
County data systems -- DHS	Provided one-time funds to counties to develop and implement medically indigent care reporting systems.	Fifty-two counties submitted applications for func the development of the data systems and have b approved.

[a] Administering agencies referred to are (1) Department of Health Services (DHS), (2) State Department of Education (SDE), and (3) Department of Mental Health (DMH

[b] Program status provided is as of mid-spring 1991, unless otherwise specified.

COMMENTS/PROBLEMS
No problems were reported in the disbursement of funds to these hospitals.
The SDE was unable to provide a detailed breakdown of school districts' use of the competitive grant funds. Anecdotal evidence suggests mixed success in this program: most schools probably use the funds appropriately, but some schools reportedly use the funds for other purposes. The SDE was unable to provide information on how the innovative projects are progressing.
There were delays in providing payment to local agencies because the majority of the required tobacco control plans were not completed and/or approved until May 1990. These delays resulted, in part, because the DHS is required to comply with detailed administrative procedures required by AB 75 and state contracting requirements. The DHS also reported problems of coordination with the local agencies because of their relative inexperience in tobacco control activities. Similar delays in funding for 1990-91 have occurred. Most of the contracts between the DHS and local agencies extend until December 1992; consequently, a budget-year reduction in these programs would not immediately affect program implementation.
There were initial delays in providing funding because the proposal process takes six to nine months to complete. Thus, contracts were not signed until September/October of 1990. The DHS reports that grantees need technical assistance to implement their programs cost-effectively. Most contracts between the DHS and grant recipients extend until December 1992; consequently, a budget-year reduction in these programs would not immediately affect program implementation.
Media surveys completed in November 1990 indicate that 78 percent of adult smokers and 86 percent of youth were aware of the advertising. The DHS reports that the campaign was unable to tailor advertising for local programs because production had to be completed before local program needs were identified.
Initial development, training, and implementation of the evaluation program took nine months. Since local programs were not fully operational until the summer of 1990, it is too early to measure the impact of these programs. Attempts to develop surveys to track the impact on target groups have been hampered by lack of adequate research staff.
Some counties initially proposed to fund nondirect patient care capital projects (repaving hospital parking lots, for example). This led to delays in implementation and funding until more appropriate proposals were submitted.
Counties have expressed concern that data system development funding may not be sufficient and that the implementation time frame may be inadequate. It is also unclear how counties will pay for ongoing maintenance costs for their data systems.

Mental Health

Assembly Bill 75 appropriated $25 million in 1989-90 and another $25 million in 1990-91 for community mental health services. Subsequent legislation appropriated an additional $15 million for these services between 1989-90 and 1990-91. Of the total $65 million appropriated for the two years, $35 million was allocated to all counties on the basis of a poverty/population formula, and $25 million was allocated to counties whose share of all state-allocated resources for mental health services was below the statewide average. The remaining $5 million was allocated to certain counties as a partial restoration of the $62 million reduction in General Fund local assistance contained in the 1990 Budget Act.

The Department of Mental Health (DMH) does not send separate checks to counties for Proposition 99 and General Fund local assistance. However, the DMH notifies counties as to how much of their allocation is from Proposition 99 revenues, and requires that they report what types of mental health services they are using Proposition 99 funds to provide. The DMH currently has no information regarding the specific types of mental health services counties are providing with Proposition 99 funds, nor is it able to evaluate the effectiveness of those services. This is because county cost reports indicating how various state-allocated funds were used during the two-year period are not yet available.

The only limitation on counties' use of Proposition 99 funds is that they cannot use them to match federal funds. (Counties also are informed that Proposition 99 funds must supplement, rather than supplant, existing funding for programs.) Accordingly, counties can effectively spend Proposition 99 funds for any mental health services they choose. Because of this, it is likely that some counties are using at least a portion of Proposition 99 funds to backfill the $62 million General Fund reduction in the current year. To the extent this has occurred, this practice conflicts with the requirements of Proposition 99.

Child Health and Disability Prevention (CHDP) Program Expansion

Assembly Bill 75 originally allocated about $20 million in 1989-90 and $19 million in 1990-91 to extend CHDP Program eligibility to children between 6 and 18 years old whose family incomes are at or below 200 percent of the federal poverty level. The CHDP Program provides medical examinations to children. The act also adds an anti-tobacco education component to the CHDP medical examination.

In mid-spring 1991, the DHS estimated that actual expenditures for the Proposition 99 funded portion of this program will be about $8 million in 1989-90 and $30 million in 1990-91. These numbers differ from the original appropriations primarily because (1) phasing in the program resulted in reduced 1989-90 costs and (2) costs are driven by caseload increases, which have been significant in the latter part of 1989-90 and 1990-91 to date.

The numbers of children provided medical examinations through the CHDP expansion program far exceed the DHS' preliminary estimates. (The number of General Fund supported examinations also dramatically exceed projections, probably due to increased outreach and education programs.) As of late February 1991, an estimated 214,000 medical examinations had been provided with Proposition 99 funds. Continued growth in the number of examinations (both Proposition 99 funded and General Fund supported) is projected.

The reason the CHDP expansion program has experienced such rapid growth is most likely the fact that the expansion built on an existing program and did not require a new administrative mechanism to be established. Most providers doing the additional medical examinations are probably already familiar with the CHDP Program.

However, while large numbers of additional children are receiving medical examinations, a much smaller number of children appear to be receiving treatment. Anecdotal evidence suggests that inadequate follow-up after the medical examination is done may be partly responsible for this. (Counties pay for follow-up treatment from their CHIP funds, and many have established a separate system for providing and paying for treatment.)

Expansion of Medi-Cal Perinatal Services

Assembly Bill 75 originally allocated about $20 million in 1989-90 and $20 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 also required the DHS to use these funds to conduct outreach activities to increase participation and access to these services.

The DHS implemented expanded eligibility for pregnancy-related services beginning October 1, 1989. The DHS estimates that actual expenditures will be about $12 million in 1989-90 and $24 million in 1990-91. These numbers differ from the original appropriation because (1) phasing in the program resulted in reduced 1989-90 costs and (2) increased caseloads contributed to higher costs in 1990-91. The average number of persons per month eligible for these services was 1,400 in 1989-90 and is estimated to be 2,800 during 1990-91.

The DHS conducted outreach activities with two programs. First, it allocated $3.1 million to permit counties to station eligibility workers at locations other than welfare offices. The DHS used $511,000 in 1989-90 and expects to spend $2.6 million in 1990-91 for 37 county proposals to station eligibility workers in clinics that treat high volumes of pregnant women. At the time of this analysis, the DHS had received preliminary data from these counties, but it had not analyzed the data to evaluate program effectiveness.

Second, the DHS used $3.1 million 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. No information is currently available on the results of these campaigns.

Health Education Programs in Schools

Assembly Bill 75 provided about $36 million in 1989-90 and another $36 million in the current year for school programs to be administered by the State Department of Education (SDE). These programs provide various health education and tobacco information activities designed to reduce tobacco use among school children.

The bulk of these funds — about $29 million each year — has been allocated through competitive grants to school districts. Almost every district in the state (1,007 out of 1,018) has received such grant funding, which is based on district enrollment ($6 per student). According to the SDE, school districts have primarily used these funds to (1) hire staff for coordination within districts, (2) train teachers, and (3) purchase prepared curriculum materials to teach students to resist peer pressure and abstain from smoking. The SDE was unable to provide a precise breakdown on districts' use of these funds. Anecdotal evidence suggests mixed success in this program: most schools are probably using the funds appropriately, but some schools reportedly use the funds for other purposes.

In addition to the grant funds, another $3.3 million was set aside each year in 1989-90 and 1990-91 for local assistance. Of these amounts, $1.7 million annually has been used for 13 pilot projects in 13 counties to study innovative approaches to tobacco-use prevention education. These projects will terminate at the end of 1991-92. Another $1.1 million annually has been used to provide partial funding for 10 regional health centers that provide technical assistance to schools and school districts.

Of the remaining amount of funding, county offices of education have received $2.5 million annually for administration and assistance to school districts, and the SDE has received $900,000 annually for administration.

At the time of our review, no data were available with which to assess the effect these programs may be having on smoking among school children. The SDE is currently funding a three-year study that would assess the cost-effectiveness of various school programs against use of drugs, tobacco, and alcohol. The SDE indicates that the earliest results from this study will be available in July 1991.

Health Education Programs Administered by the DHS

Assembly Bill 75 established the Tobacco Use Prevention Program in the DHS, and provided about $53 million in 1989-90 and $99 million in 1990-91 for the program. The program, as authorized by AB 75, consists of (1) a public information campaign to prevent and reduce tobacco use, (2) a competitive grants program for nonprofit organizations to provide health education and promotion activities, and (3) grants to local agencies for tobacco-use prevention and reduction programs. In addition, AB 75 requires the DHS to evaluate the effectiveness of the programs and establishes an oversight committee to advise the department on the health education programs and evaluations. Below, we describe the status of each of these programs. Overall, the DHS appears to be making reasonable progress in implementing the health education programs.

Grants to Local Government Agencies

Assembly Bill 75 appropriated a total of $71 million for the DHS to issue grants to local government agencies for tobacco-use prevention and reduction programs. The department has issued grants to 61 local government agencies as of March 31, 1991 totaling about $36 million. The DHS indicated that it expected to issue grants for nearly all of the remaining $35 million by the end of April 1991, after it had completed its review and approval of local tobacco-use prevention plans. Local agencies will be authorized to spend the grant funds through December 1992.

Although the majority of the local agencies were authorized to begin billing the DHS for their tobacco-use prevention program costs beginning January 1, 1990 (three months after the enactment of AB 75), the local agencies appear to be somewhat slow in implementing their programs. The local agencies have billed the department for only $7.5 million to date.

Local agencies will be using the funds for programs including (1) smoking prevention and cessation programs, (2) assistance to nonprofit local groups that apply for competitive grant monies, and (3) local tobacco awareness activities such as tobacco-free days at football games, community smoke-out days, and health fairs.

Competitive Grants

The act appropriated a total of $53 million for a competitive grants program administered by the DHS to fund health education and promotion activities designed to reduce tobacco use and tobacco-related diseases among target populations. The department has awarded over 200 grants as of mid-spring 1991 totaling approximately $39 million. The DHS indicates that it will use the remaining funds to extend the existing contracts from December 1991 through December 1992. The majority of the contracts began in September 1990 (11 months after the enactment of AB 75), and grantees have billed the department for $9.4 million as of mid-spring 1991.

Since the enactment of AB 75, the DHS has (1) developed the procedures for applicants to follow in requesting grants, (2) notified potential applicants about the program, (3) evaluated over 450 proposals and selected over 200 proposals to fund, and (4) completed contracts

with 148 grantees. The department also has contracted with persons to provide technical assistance and support to the grantees.

Examples of the grants issued by the DHS include ones for (1) developing and issuing tobacco education materials and instruction to physicians and other health care providers for distribution to their patients, (2) developing and implementing a comprehensive smoking prevention and cessation program for the Asian and Pacific Islander communities in Alameda County, and (3) developing a 30-minute documentary video on smoking targeted towards black women of child-bearing age.

Media Campaign

Assembly Bill 75 appropriated a total of about $29 million in 1989-90 and 1990-91 for a public information campaign designed to prevent people from beginning to smoke and to encourage people who already smoke to quit. Of this amount, the DHS has spent approximately $23 million as of mid-spring 1991 for the campaign. Within six months after the enactment of AB 75, the DHS had (1) completed state contracting procedures for selecting a contractor for the media campaign; (2) identified and developed with the contractor the advertising approaches and advertising placement strategies necessary to reach each target population required by AB 75; and (3) evaluated and approved the design and production of the first set of anti-tobacco radio, television, and print media advertisements.

Since that time, the DHS has developed a wide range of advertisements directed at specific target populations. As of December 1, 1990, the department had placed 165 different advertisements on 147 television stations, 69 radio stations, 775 billboards and buses, and 130 newspapers. The department estimates that 97 percent of the population had been exposed to up to 75 radio or television tobacco education advertisements within the first eight months of the media campaign.

Evaluations, Surveys, and Oversight Committee

The DHS has entered into three contracts totaling $6.5 million to evaluate the tobacco-related health education programs. The first contract (for $2 million from funds appropriated for the competitive grants program and $1 million appropriated in the 1990 Budget Act) provides for a baseline survey of smoking prevalence, and knowledge and attitudes about tobacco use. Between January 30, 1990 and July 1, 1991, the contractor will survey 30,000 households regarding the number of people who smoke and attitudes toward smoking. This will enable the department to evaluate the effectiveness of overall health education program efforts by comparing surveys taken in future years with the baseline survey, and identifying significant changes in tobacco consumption, attitudes, and behaviors.

The second contract (for $2.3 million appropriated in AB 75) is for an evaluation of (1) the accomplishments of the local government agency grants and the competitive grants and (2) tobacco consumption patterns based on cigarette tax data. The contractor has developed standardized data collection systems for the local governments and competitive grantees to report information on accomplishments to the contractor, and has compared tobacco consumption patterns after the imposition of the 25-cent cigarette tax increase with the patterns prior to the tax increase.

The third contract (for $1.2 million from funds appropriated for the media campaign) is an evaluation of the media campaign. The contractor will conduct four surveys between January 1990 and June 1991 on public awareness of the media campaign, and attitudes and behaviors regarding tobacco consumption. Preliminary data show that 75 percent of the people surveyed in the state were aware of the tobacco education advertisements within four months of the media campaign.

In addition to the contracts for evaluation, AB 75 established the Tobacco Education Oversight Committee to (1) advise the DHS and SDE on policy development, as well as on program integration and evaluation for health education programs, and (2) develop a master plan for the future implementation of tobacco education programs. The committee has worked with the DHS and SDE on the implementation, coordination, and evaluation of the health education programs, and recently has published the master plan.

Departments Have Generally Made Reasonable Progress in Implementing AB 75 Programs

Our analysis indicates that in the roughly year and nine months since the enactment of AB 75, the departments responsible for implementing AB 75 programs have generally made reasonable progress in implementing these programs, while at the same time ensuring that reasonable controls are in place prior to the distribution of funds, and complying with the administrative requirements of AB 75.

Certain Administrative Difficulties Have Been Encountered

In implementing AB 75 programs, however, the responsible departments have encountered, and had to address, several administrative difficulties. Among other things, this has slowed the process of issuing grants in DHS health education programs, and resulted in delays in payments to some health services programs. These difficulties have included:

- Complying with the detailed administrative procedures required by AB 75 and established by the departments to ensure that funds are spent appropriately. (In addition, while AB 75 exempted the DHS from some of the state contracting requirements, the department generally has followed state contracting procedures in the health education programs to ensure that the process is fair and delivers services at the lowest costs.)
- Addressing the needs of local governments and grantees that have a wide range of program knowledge and administrative structures.
- Developing several new programs that are administratively complex.

As one example, prior to distributing health education funds to local government agencies, AB 75 requires (1) the DHS to issue guidelines to local agencies for developing plans for preventing and reducing tobacco use, (2) local agencies to develop these plans for 1989-90 and for 1990-91, (3) the DHS to provide technical assistance to local agencies on development of the plans, and (4) the DHS to review and approve the plans. The plans are to include descriptions of the target populations to be served, identification of the number of persons to be served within each target population, a budget proposal, and descriptions as to how local funding decisions will take into account evaluations of program efficiency and effectiveness. Although these procedures are important to ensure that the funds are spent appropriately, they also slow the distribution and expenditure of the funds.

Data With Which to Evaluate Programs' Effectiveness Will Not Be Available in Time for Decisions on 1991-92 Budget

Our analysis indicates that the Legislature will have little information available on the effectiveness of AB 75 programs in time for making decisions on the 1991-92 budget. While the DHS requires AB 75 funded health services programs to submit a variety of data on (1) how programs have been implemented and (2) how funds have been spent, some of these data for 1989-90 have only recently been received by the DHS (or are still outstanding) and are currently under review. No 1990-91 data will be available for a number of months.

In addition, although the DHS has already contracted for studies on the effectiveness of health education programs, these studies will have only preliminary, and incomplete, information prior to July 1, 1991. Two major factors are at work:

- *Programs Have Been in Place for a Very Short Period of Time.* The health education programs generally have been in place for a very short period of time, and little money has actually been spent to date by local agencies and grantees. Furthermore, local agencies and grantees receiving DHS health education funds are authorized to spend these funds through December 31, 1992. Accordingly, the information on the effectiveness of these programs will not be complete until after this date.
- *Program Results Take Time.* For health education programs in particular, the results of programs implemented in the short term are only likely to be seen over the next several years. This is because changing behavior to an addiction such as smoking is a long-term, multi-stage process. For example, the sequential steps necessary for a person to stop smoking may include (1) increasing knowledge about the harmful effects of tobacco consumption; (2) changing beliefs, values, or attitudes toward smoking; and (3) overcoming existing factors that reinforce the smoking behavior. Consequently, to the extent that the DHS' current programs result in a change in knowledge, attitudes, or beliefs toward smoking, the programs may result in a reduction in tobacco consumption in future years.

WHAT DECISIONS DOES THE LEGISLATURE FACE THIS YEAR AND IN FUTURE YEARS?

We discuss specific Proposition 99 related budget issues facing the Legislature in the *Analysis of the 1991-92 Budget Bill* (see pages 537, 580, 584, 643, and 955). Figure 7 highlights the major issues the Legislature faces this spring regarding Proposition 99. We discuss these issues below.

Assembly Bill 75 Will Sunset in June 1991

Assembly Bill 75 sunsets June 30, 1991. Consequently, the Legislature faces decisions regarding how to allocate Proposition 99 funds for 1991-92 from the four accounts affected by AB 75. As discussed above, these decisions will have to be made before data with which to evaluate the programs' effectiveness are available. In light of this fact, the Legislature has several options, depending on whether legislative funding priorities are the same or have changed since AB 75 was enacted.

Figure 7

Proposition 99 – Major Issues

- ☑ Assembly Bill 75 sunsets June 30, 1991, and little information on program effectiveness for either health services or health education programs will be available until after the decisions regarding 1991-92 funding allocations need to be made.
- ☑ The Legislature faces policy choices regarding what level of funding to provide existing programs versus new initiatives, including a trade-off between health education and health services programs.
- ☑ The projected gap between Proposition 99 revenues (which are *declining*) and program costs (which are *increasing*) will widen over time.

Continue Existing Programs

If legislative priorities are the same as they were when AB 75 was enacted, then the Legislature could choose to extend the sunset date of AB 75 and continue funding existing programs in the same proportions as under current law. In contrast to the Governor's proposal, funding for CHIP and other health services programs, as

well as health education programs, would increase under this option. (The dollar amounts allocated to programs would still be reduced from current-year levels, however, since available resources in the budget year are projected to decline. In addition, decisions would need to be made with respect to caseload-driven programs, which are consuming an increasing proportion of the available Proposition 99 funds.)

By extending AB 75 for two or three years, the Legislature would provide the program continuity and the time needed for data on program implementation and effectiveness to become available.

Pursue a New Course

Instead of continuing existing programs as at present, the Legislature may wish to adopt a new course regarding Proposition 99 program funding. Possible reasons for shifting course could include basic changes in legislative priorities, factors relating to county-state program realignment decisions, or reevaluations in response to the declining nature of the Proposition 99 revenue base (see below). The Legislature may wish to consider several types of funding shifts.

Shift Health Services Funds to Other Health Services Programs. If legislative priorities have changed since AB 75 was enacted, the Legislature may wish to consider alternative uses for AB 75 health services funds. For example, in light of the proposed realignment of public health and indigent care programs, the Legislature may wish to allocate AB 75 funds for specific services it wants to assure are provided (such as preventive or outpatient care). Alternatively, funds could be targeted to a specific population such as children, to establish comprehensive children's health services.

Shift Health Education Funds to Health Services Programs or Vice Versa. Again, if legislative priorities have changed since AB 75 was enacted, the Legislature could choose to shift funding for health education and smoking prevention programs to fund additional health services programs or vice versa. For example, it could provide some level of funding for a specific priority — such as children's health services — while continuing to fund (at a higher level than proposed in the Governor's Budget) ongoing health education programs.

In the latter case, the trade-off is between the impact of health education programs designed

"The Legislature may wish to adopt a new course regarding Proposition 99 program funding. Possible reasons for shifting course could include basic changes in legislative priorities, factors relating to county-state program realignment decisions, or reevaluations in response to the declining nature of the Proposition 99 revenue base."

to reduce smoking (thereby decreasing related health care costs) and the impact of providing additional health services to persons who may currently be going without such services. The Legislature faces this decision on health education versus health services without having had a chance to see if the anti-smoking programs are effective. As discussed above, it will be at least another year or two before the results of the program evaluations will be available. Cutting funding after two years, when many of the programs have just become fully operational, will not give these programs the opportunity to demonstrate their effectiveness. To the extent these programs are effective, they could result in major long-term reductions in health care costs for smoking-related diseases. This has to be weighed against both the more immediate savings and health benefits of providing services to persons who may not currently receive care, and the resulting long-term potential reductions in health care costs.

Proposition 99 Revenues are Declining Over Time

The final major issue relates to Proposition 99 revenues and to the support of Proposition 99 funded programs in future years. Over time, relying on Proposition 99 revenues to support ongoing programs will require either infusions of other funds, potentially from the General Fund, or further reductions in one or more of the Proposition 99 funded programs. This is because Proposition 99 revenues are projected to decline each year, perhaps by 3 percent or more annually between now and 1994-95. Figure 8 illustrates the nature of this widening gap between projected Proposition 99 revenues and program costs (assuming current AB 75 programs) from 1990-91 through 1994-95. This issue poses a particular problem for programs providing ongoing health services, especially caseload-driven programs, where demand for services is expected to increase over time.

To the extent health education programs are successful in meeting the goals of AB 75 to reduce smoking by 75 percent by 1999, revenues would be expected to decline even more than projected in Figure 8. This would exacerbate the problem faced by programs relying on Proposition 99 funds—instead of flat or slightly declining revenues in the face of increasing program costs, these revenues could erode much more rapidly. This would not be offset by reduced demand for health services programs funded by Proposition 99 because, as currently authorized, these programs are not directly related to smoking.

"Over time, relying on Proposition 99 revenues to support ongoing programs will require either infusions of other funds, potentially from the General Fund, or further reductions in one or more of the Proposition 99 funded programs. This is because Proposition 99 revenues are projected to decline each year."

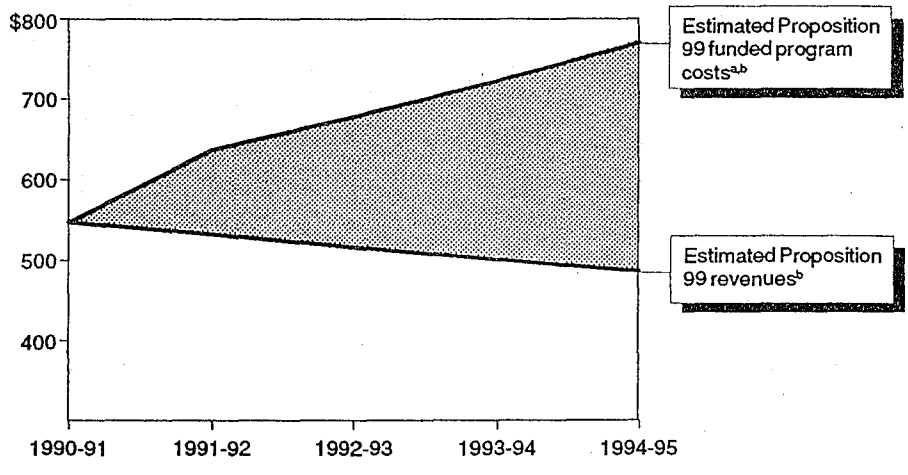
Depending on legislative priorities, the Legislature could address the issue of declining revenues in the short term in several ways. If the Legislature decides to continue existing AB 75 programs, it could choose to fully fund caseload-driven programs and reduce funding proportionally for other programs. Alternatively, if legislative priorities have changed, the Legislature could choose to reduce the number of programs funded with Proposition 99 revenues so as to target funding for the Legislature's highest-priority programs.

In the long term, however, we believe the Legislature should structure Proposition 99 programs so that program demands can be met recognizing the projected declining Proposition 99 revenue stream. In this regard, the Legislature has various options, such as (1) funding primarily one-time activities and programs (such as special projects and capital outlay) not linked to providing ongoing services or (2) designating alternative funding sources as part of the authorization process for ongoing program activities.

Figure 8

The Widening Gap Between Proposition 99 Revenues and Current Program Costs

(in millions)



[a] Assumes existing programs authorized by AB75 continue, with costs adjusted for inflation and population or caseloads. The additional funding required for the MRMIP beginning in 1991-92 accounts for the rapid increase in expenditures between 1990-91 and 1991-92.

[b] Interest income and carry-over from prior years are not included in estimated revenues or program costs. Revenue estimates for 1992-93 through 1994-95 are based on an assumption that per capita cigarette sales continue to decline at roughly 3 percent annually.

CONCLUSION

Overall, our review of programs authorized by AB 75 indicates that reasonable progress has been made in implementing these programs, although some programs are still experiencing delays in payments or are underutilizing the funds available. Our review also indicates that there are currently little data available with which to evaluate programs' effectiveness.

The Legislature faces several major issues regarding how to allocate Proposition 99 funds for 1991-92 and beyond. The options for addressing these issues depend on whether legislative funding priorities are the same or have changed since AB 75 was enacted. For example, the Legislature could continue existing programs by extending AB 75's sunset date. On the other hand, the Legislature could pursue a new course by shifting health services funds to other health services programs. As an example, in light of the proposed realignment of public health and indigent care programs, the Legislature may wish to allocate AB 75 funds for specific services it wants to assure are provided (such as preventive or outpatient care). Alternatively, funds could be targeted to a specific population such as children, to establish comprehensive children's health services.

The Legislature could also pursue a new course by shifting health education funds to health services programs. For example, it could provide some level of funding for a specific priority — such as children's health services — while continuing to fund (at a higher level than proposed in the Governor's Budget) ongoing health education programs.

In addition, we believe the Legislature in the long term should structure Proposition 99 programs so that program demands can be met recognizing the projected decline in this revenue source.