

Chapter 4

**CHILD
HEALTH**

I. CONDITION INDICATORS

A. California Children Without Health Coverage

About 1.62 million children in California were uninsured in 2000, an improvement over 1998, when over 2 million California children were uninsured.¹ The improvement is due to a better economy in 1999 and 2000, with more job-based insurance, combined with fewer children losing Medi-Cal coverage when leaving welfare.² Nevertheless, the rate of uninsured children remained close to that extant in 1996, when California had still not fully recovered from the recession of the early 1990s.³ Moreover, it is likely that by the end of 2002 the number of uninsured will come close to the 2 million uninsured before the vaunted State Child Health Insurance Program (SCHIP) was enacted by the Congress. That likely reversion and failure will be the product of four factors: (1) Continued failure to enroll in Medi-Cal or SCHIP children of CalWORKs adults who have left TANF rolls and remain without child health coverage notwithstanding eligibility. (2) Increasing numbers of working poor who lose jobs where coverage is provided by employers (as unemployment increases). (3) The barrier of premiums required for SCHIP. (4) The confusion and obstacles provided by 17 different programs potentially covering children—each with its own bureaucracy, rules, and eligibility.

All of these barriers are surmountable, and at lower cost than is currently expended. The solution—“true presumptive eligibility”⁴ for all children, with parental assessment *post hoc* on a sliding scale based on income—remains undiscussed among public officials. However, as the percentage of children uncovered and ineligible for public coverage declines to below 5% of the children in the state, the inefficiency of such a policy, and the maintenance of 17 fragmented programs and the denial of coverage to almost 2 million children will compel its discussion and should commend its enactment. Another factor politically favoring the true presumptive solution is the alternative prospect of returning to the federal jurisdiction monies for basic child coverage at a 1 to 2 match over \$1 billion dollars—the largest give-back of federal money by a state in the nation’s history.

The Congress authorized \$850 million per year starting in 1998 for California under the federal SCHIP program, adopted as part of the Balanced Budget Act of 1997. The federal assistance is enough to cover all California children under 300% of the poverty line, and as noted, requires only a one-third match from the state. The SCHIP program continues for a total of ten years, although the original allocation of funds was only for five years. However, California used only a part of the amount available

to it for fiscal years 1998–2001, primarily in its Healthy Families program (see discussion below).

Under the original federal SCHIP law, states would have lost all of their allocated funds they failed to spend during a three-year carryover period. And by 2000 California had failed to spend \$580 million of the \$850 million allocated for the first (1998) year. Indeed, it had failed to spend much of the \$850 million allocated for each of 1999 and 2000 as well. Hence, as of 2000, the state was reaching its three year carryover limit for this first unspent \$530 million from 1998. However, a 1999 federal amendment carried by California's two senators allows the state to keep about 60%, or \$350 million, of this \$580 million in unspent federal funds, losing "only" \$230 million. Those funds and similar funds from other states failing to expend appropriated funds have now been redistributed to the eleven states who have spent their allocation consistent with Congressional intent.⁵

Significantly, California's 1999 dispensation for 2000 was only a reprieve. The state continues to engage in incremental, bureaucratic, and ineffective strategies to cover children, and stands to lose most of its \$850 million SCHIP allotments in 1999 and for each of the three succeeding years and in amounts substantially greater than the total thus far foregone. The combined total to be returned to Washington D.C. for distribution to other states by California will constitute the largest "give-back" of federal funds in the nation's history. Meanwhile, over 15% of the state's children are likely to remain without medical coverage and the percentage could climb toward 20% by 2005. Instead of covering children as intended, the state is now embarked on an effort to expand coverage to parents in order to expend a more respectable portion of federal monies allocated to it. While such expansion may benefit involved children, and has its own justification, these funds are properly prioritized for children. It is possible to use those funds for that publicly intended purpose. If, after that purpose has been accomplished additional monies remain, such a diversion may be entertained. And if additional monies do not remain, alternative funding may well be justified to accomplish parental coverage. But the monies currently available through SCHIF could be expended for children—and should be so applied if adults are to keep faith with promises made.

Of the 1.62 million California children uninsured in 2000, about 768,000, or 48%, were eligible for Medi-Cal. An additional 404,000 uninsured children, or 25%, were eligible for Healthy Families in 2000.⁶ As of April 2002, the state's "Healthy Families" program had signed up 536,294 children.⁷

About 19% of uninsured children—343,000—had income over the Healthy Families limit in 1999.⁸ About 38% of these children—129,500, or 7% of all uninsured children in 1999 with income over the Healthy Families limit—were in families with income between 250%–299% of poverty; another 245,000 uninsured children are undocumented, representing about 13% of all uninsured children in the state.⁹

The 2000 estimate of medical coverage status for children by the American Academy of Pediatrics is:¹⁰

- ◆ Privately financed coverage: 64%
- ◆ Medi-Cal and Healthy Families: 21%
- ◆ Uninsured: 15%

A UCLA analysis of data for 2000 reports a slightly different breakdown for children's coverage: 58.7% privately financed (55.6% job-based, 3.1% privately purchased); 24.2% Medi-Cal, Healthy Families, or other public coverage; and 15.7% uninsured.¹¹

Of the state's uninsured, 30% are under six years of age, and 60% are under twelve years of age.¹² California children are more likely to be uninsured than children in the United States as a whole: 19% in California, 14% in the U.S.¹³ This disparity continues the unfortunate trend of recent years.¹⁴

These uncovered children are generally not from unemployed families or from families on welfare; instead, 89% live in families where at least one parent works, and 58% where at least one parent works full-time.¹⁵ They are substantially the children of the working poor who (1) refuse public assistance or (2) make too much to qualify, but work for employers who do not offer health insurance or offer it but

require employee contributions that are too high to pay. A substantial number of affected children (52%) have parents who work for small businesses of fewer than 25 employees that do not provide coverage.¹⁶

Of the 1.85 million children without insurance in 1999,¹⁷ 31% live below the poverty line, another 43% live between 100%–249% of the poverty line, 7% live between 250%–299%, and another 7% live between 300%–399% of the poverty line.¹⁸ Thus, children in families with income below 250% of poverty make up 74% of all uninsured children, and those with family income below 400% of poverty make up 88%, or 1.63 million, of all uninsured children.

One basic demographic fact emerges from the data: The proportion of the state's children not eligible for public coverage is small. If the Healthy Families limit were raised to 300% of the poverty line (which California is able to do for some groups of children under federal law), only 7% of the state's currently uninsured children would not be eligible for coverage. In terms of all children (including those privately covered), only 3.3% are not eligible even at a coverage limit of 250%. Where the limit is 300%, the total proportion of California children ineligible for publicly assisted or provided coverage is under 1.7%. An additional 2.4% are undocumented children and are ineligible for that reason, bringing the total ineligible proportion to from 4.1% to 5.7%, depending upon the income cut-off (300% or 250% of the poverty line, respectively).¹⁹

1. A Rational Proposal: Cover Children

As discussed in detail below, the state's response to its signal embarrassment has been to move down the same fruitless road: More outreach, incentives to sign children up, use of social service programs, the recruitment of non-profits and the state's considerable social service establishment, forms, entry procedures, all funneled into and through Medi-Cal, Healthy Families and 9 additional, different, fragmented programs—each with different qualifying rules, with many children qualifying for some and not others based on age, income, and disability—sometimes within single families, and each changing over time. At least for Healthy Families, most parents living near the poverty line are required to pay (what for them are substantial) premiums to enroll their children.

As discussed above only 4% to 6% of the state's children are currently not covered privately and are also ineligible by income or citizenship for public coverage. The system of barriers in place is intended to assure that none of this relatively small group of children receives medical services from the public weal. A cursory review of the agencies, paperwork, and resources devoted to the barrier/filtering process makes clear that more is expended on the prevention of unqualified coverage than the coverage itself would cost for the small proportion properly barred.

The benefits here at issue are not typically subject to false claims or abuse. Unlike cash assistance or food stamps, parents and children do not seek out gratuitous shots, treatment, or non-elective operations. The public benefit from comprehensive coverage is well documented in terms of disability prevention and long-term societal gain (see discussion below). Also, children are relatively inexpensive to cover, costing less than one-fifth the per capita cost of adults, and a small fraction of the cost of the elderly—each of whom is provided with relatively expensive and universal Medicare coverage.

The rational approach under the basic demographics presented is the universal provision of basic public health coverage for all children, including screening, vision, dental, immunization, lead contamination prevention, and basic coverage. Where children require specific services costing above a threshold amount, parents of the undocumented or with incomes above the threshold 250% or 300% would then be billed on a sliding scale (based on income and expenses incurred) *post hoc*. Premiums would not be required, but modest co-payments per visit would be required to limit gratuitous overuse. Such an approach (a) provides the benefits of universal child public health coverage to society; and (b) eliminates a currently massive regime of qualification, evidence, enrollment, tracking—all interposed as a prior restraint to services. The approach thus advanced would be two-thirds financed from the existing Healthy Families federal appropriation. As discussed above, the alternative now confronting the state will involve: (a) the continued failure to cover over 1 million eligible children; (b) the return of

over \$2.5 billion to Washington D.C. for redistribution to other states; (c) the continued gratuitous expense of barriers and red tape with the sole justification of preventing publicly provided medical services for under 6% of the state's children who may be ineligible.

The proposed universal coverage would not expend all of the federal funds available, particularly given the significant administrative savings it would entail. Accordingly, as discussed below, the remaining federal funds should be used to provide a refundable tax credit for private employers who provide medical coverage for the dependents of their employees living below 300% of the poverty line, and for such parents buying insurance privately. Such a credit limits "crowd out" deferral to public coverage, and provides some consideration for those who so contribute, which equity commends.

2. Coverage Shortfall Demographics: Immigrants

Hispanic children are over-represented among the medically uncovered, with 28% uninsured, compared to 20% for African American children, 18% for Asian American and Pacific Islanders, and 8% for non-Hispanic white children.²⁰

For Hispanic children—the children with the highest uninsured rates—the rate in 1999 was the same as in 1994 at the depth of California's recession.²¹ Rates worsened for Asian-American and Pacific Islander children over the same time period, increasing from 14% in 1994 to 18% in 1999, and for African-American children, increasing from 13% in 1994 to 20% in 1999.²² Although there was a slight improvement in the overall uninsurance rate for children from 1994 to 1999,²³ it was statistically insignificant and resulted from substantial gains in insurance for white children, who account for 40% of the state's children. Their uninsured rate fell from 14% in 1994 to 8% in 1999, largely as the result of an increase in the rate of job-based insurance for their parents.²⁴ Hispanic children, in contrast, had the lowest rates of job-based coverage, 39%,²⁵ even though their parents are working.

The gains for some children from the job-based insurance of their parents over the period from 1994 through 1999 did not translate into a net gain in the overall children's insurance rate due to the big drop in Medi-Cal coverage for children over that same period: from 25% in 1994 to 19% in 1999, a direct result of the enactment and implementation of welfare reform.²⁶

Significantly, the proportion of non-citizens without coverage increased from a high share of 26% in 1995 to a higher 31% in 1997. These immigrant numbers and the TANF data discussed in Chapter 2 indicate substantial Medi-Cal coverage loss by those who remain below the poverty line.²⁷ One national survey by a University of California at Los Angeles academic center looked at medical insurance coverage for immigrant children specifically. It found that in 1995, 23% of citizen children of non-citizen parents lacked coverage of any kind; that incidence increased to 27% by 1997. The survey of non-citizen children living in the United States found 36% of them without coverage in 1995, increasing to 43% in 1997. Ninety percent of these uninsured children are in families with at least one working adult.²⁸ These figures will generally apply to California given the state's 40% share of immigrant arrivals.

In California, 41% of non-citizen children and 31% of citizen children with non-citizen parents were uninsured in 1999, which is three to four times the uninsured rate for citizen children with U.S.-born parents. Citizen children with naturalized parents fared better than non-citizen children and citizen children in "mixed status" families, but their rate of uninsurance—19%—was still twice that of citizen children with U.S.-born parents.²⁹

Contributing to these high rates of uninsurance for children in immigrant families were the declines in participation in public benefits programs after welfare reform. The percent of non-citizen children covered by Medi-Cal or Healthy Families dropped from 40% in 1994 to 24% in 1999, a major decrease of 16%. In contrast, for citizen children with U.S.-born parents the drop in participation in Medi-Cal or Healthy Families was 4%, going from 19% in 1994 to 15% in 1999.³⁰

However, most of the disparities are driven by differences in access to employment-based health

insurance for the children’s families. Rates of job-based insurance for citizen children with non-citizen parents and non-citizen children range from 26% to 31%, respectively.³¹ Although the rate of job-based insurance is higher for the non-citizen children, the difference is not considered significant.³² In contrast, for citizen children with naturalized parents and citizen children with U.S.-born parents, the rates of job-based insurance range from 60% to 68%, respectively.³³

There are over 800,000 fewer children on the TANF rolls now than in 1995 (see Chapter 2, Table 2-S), a substantial number of whom are also now without Medi-Cal coverage—reflecting families who are declining TANF benefits for their children even though they may qualify, or families who are losing welfare and not retaining Medi-Cal even though they remain eligible for Medi-Cal without welfare. Immigrants are particularly vulnerable to missing out on Medi-Cal benefits for which they qualify. As discussed in Chapter 2, for undocumented immigrants abandonment of coverage comes from fear of deportation³⁴; for legal immigrants, it comes from concern that publicly-financed medical coverage will jeopardize their status or hurt their chances to become citizens.³⁵ As discussed in Chapters 2 and 3, one subpopulation of particular concern are the children of lawful refugees, whose coverage numbers have dropped precipitously from TANF, food stamp, and Medi-Cal coverage without evidence of corresponding improvement in poverty incidence. For example, the “aliens/refugees” Medi-Cal program has declined from over 300,000 enrollees prior to 1998 to 167,000 in March 2001,³⁶ and then partly recovered to 249,800 as of April 2002.³⁷ Since the number of immigrants has increased over this four year period, the coverage shortfall among those eligible is about 100,000 as compared to four years ago.

3. Coverage Shortfall Demographics: TANF Enrollee Loss

Apart from immigrant fears, many children leaving TANF rolls are also not picking up medical coverage, even though eligible for Medi-Cal, due to the failure of caseworkers to arrange it, and internal bureaucratic barriers. And apart from those exiting TANF, a large number of the working poor who are eligible for some TANF do not seek it, have little contact with social workers and lack information about available benefits, which includes Medi-Cal for the working poor (see discussion below); thus, they miss the opportunity to apply for Medi-Cal without cash assistance.³⁸ Families declining TANF but still eligible for Medi-Cal coverage for their children are unlikely to be enrolled in this health insurance program. The California Department of Health Services ascribes lack of enrollment to: (1) a resistance to applying due to the complex application process; (2) lack of awareness of their potential Medi-Cal eligibility; and (3) unwillingness to apply at the welfare office despite awareness of their potential eligibility.³⁹ Another survey confirmed these reasons, and added language barriers, perceived deportation danger if children are enrolled (even where children are citizens born in the U.S.), and the lack of insurance for the whole family as opposed to some members.⁴⁰ As to Healthy Families, as discussed below, premium requirements are obviously a barrier for many parents.

Results from a joint UC Berkeley/UCLA survey comparing 1995 through 1998 data found an overall increase in uncovered children from 17% to 21%,⁴¹ with the most recent survey finding the percentage falling to a low of 15.7% in 2000 due to Healthy Families enrollment and the economic upswing.⁴² As of year 2000 data, 1.1 million children in the state were eligible for public coverage but were not enrolled in any publicly funded program. That number and the percentage of uncovered children is now believed to be substantially higher as the post 9-11 economic slowdown (including some rising unemployment) and other factors to lower the number of children covered through parental employer health coverage. Many of the changes proposed by the Governor for 2002–03 will further inflate the uninsured population, including substantial (20%) cuts in local Medi-Cal county employees, a cessation of all Healthy Families media advertising, reduction in Medi-Cal provider compensation, and delay of waiver for parent coverage. The preoccupation with avoiding revenue demand will result in the loss of over \$2 billion in federal funds available for 50-50 or 66-33 match to provide coverage for children.

The current approach of “you are not covered until you sign up and your application is accepted” approach, combined with premium obligations for many impoverished families will not achieve the intended result of relatively comprehensive coverage for low income children. Under a best case scenario, over 1 million such children will remain uncovered, lacking preventive care and an assigned

provider—and that number is likely to be over 1.3 million unless affirmative steps are taken to raise revenue so that federal funds may leverage coverage for the state’s children—as the Congress intended. The state is capable of using all federal money available and of accomplishing the complete coverage of children—with relatively little additional investment compared to other spending priorities. Such a policy choice would require a state general fund investment of less than one-fourth the new tax expenditures approved over the last five years, as discussed in Chapter 1 and below.

B. California Children with Public Health Coverage (Medi-Cal)

Publicly financed health care coverage increased from the 1980s to the middle 1990s. Early growth was influenced by eligibility expansion (federal law expanded Medicaid eligibility for children in 1989 and 1990⁴³), but was also a result of more children becoming eligible under existing programs, as child poverty increased and job-related insurance declined starting in 1990.⁴⁴ California is one of 34 states to extend Medi-Cal eligibility to pregnant women and infants beyond federal mandates, with coverage to 200% of the poverty line for pregnant women and infants (*i.e.*, from birth through 12 months) and to 133% of the poverty line for children ages 1 through 5 years. The estimated percentage of Medi-Cal deliveries to total California hospital inpatient deliveries was 39.7% in 1997, 40.2% in 1998, and 37.3% in 1999.⁴⁵

Children’s Medi-Cal coverage fell from 25% in 1995 to 20% in 1998,⁴⁶ and then rebounded to 24% in 2000, still below levels in the early 1990s.⁴⁷ The non-elderly population (*i.e.*, ages 0–64) with Medi-Cal and Healthy Families coverage dropped from 14.4% in 1994 to 10.5% in 1999,⁴⁸ again rebounding by 2000 to 13.1%⁴⁹—but still below previous levels and vulnerable to further decline, as noted above.

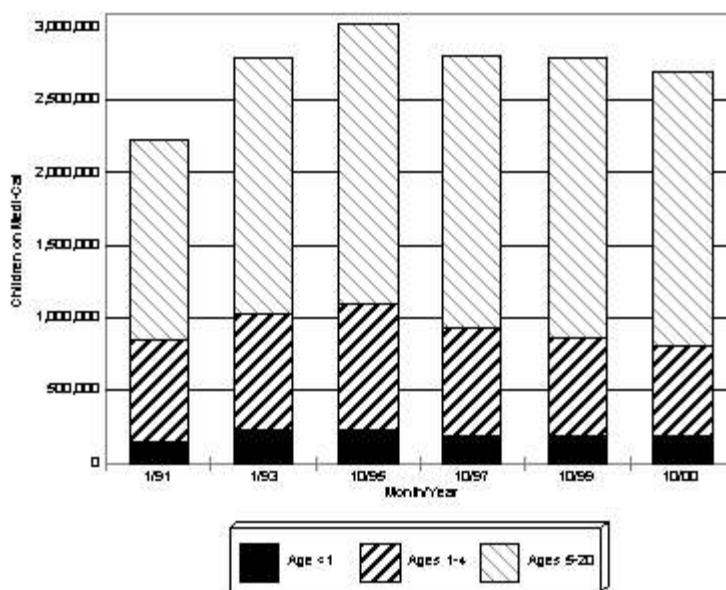


FIGURE 4-A. Trends in Number of Children on Medi-Cal, by Age⁵⁰

As Figure 4-A indicates, according to administrative data from the state Department of Health Services, there were 331,000 fewer enrollees under 21 years of age on Medi-Cal in 2000 than in 1995.⁵¹ Some of this number reflects TANF roll diminution and possible employer coverage—but the number achieving such coverage—or obtaining income above Medi-Cal (or other child public coverage) is substantially less than this figure. While many of the new Healthy Family sign-ups represent new children covered, those losing Medi-Cal coverage reduce the net pick-up of covered children.

C. Child Health Public Coverage Costs

Nationally, children make up about 50% of Medicaid recipients in 2001,⁵² but used only about 14%

of the dollars spent.⁵³ Adults and children in low-income families make up three-fourths of Medicaid beneficiaries, but account for only 25% of Medicaid spending. The elderly and disabled account for 71% of expenditures due to their intensive use of acute and long term care services.⁵⁴ According to a 1995 report, Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total Medicaid expenditures.⁵⁵ As Table 4-A indicates, children cost relatively little to cover; the vast majority of public subsidy is expended on the elderly—much of it during the final weeks or months of life.

	California	U.S. Medicaid
	\$ Per Enrollee	\$ Per Enrollee
Children, aged <21	\$940	\$1,224
Adults, aged 21–64	\$1,576	\$1,891
Elderly, aged 65+	\$6,396	\$11,235

TABLE 4-A. 1998 Average Medi-Cal/Medicaid Payments by Recipient Age⁵⁶

A recent report by the American Academy of Pediatrics estimates that, in 1998, the average annual Medi-Cal expenditure in California for children under age 21 was \$940, while the average cost for adults was \$1,576, and the average cost for the elderly was \$6,396. Nationally, the average annual Medicaid expenditure for children under age 21 in 1998 was \$1,224, while the average cost for adults was \$1,891, and the average cost for the elderly was \$11,235.⁵⁷ The numbers of Table 4-A have gone up somewhat since 1998 for all groups, but children have steadily cost less than 1/6th the per person cost of the elderly in Medicaid expenses.

In terms of broader medical investment, spending for the health care of adults and the elderly in particular is substantially beyond these ratios. Almost all of the Medi-Care budget is devoted to the medical and care needs of the elderly. In addition, much of the Veteran’s Administration budget and portions of other budgets focus on elderly health spending. With the inclusion of the separate Medi-Care federal account of \$23.6 billion in federal monies expended in year 2000 for 3.8 million California senior citizens (another \$6,156 per elderly enrollee),⁵⁸ the disparity in public spending for the elderly versus children exceeds 10 to 1. While the increased medical needs of the elderly may justify a larger sum expended for their needs than for children, the degree of the current disparity is remarkable. All of the elderly are assured at least some substantial coverage, while children—with double the poverty rate of the elderly and at a fraction of the health insurance cost—have 1.1 million without public medical coverage.

D. The Consequences of Lack of Health Coverage

Uninsured children are less likely to have regular health examinations, resulting in less early detection of problems. Timely treatment of children for infectious and chronic diseases such as strep throat, asthma, and ear infections is important to prevent the development of more serious medical conditions; however, uninsured children are at least 70% more likely than insured children to not receive medical care for such problems.⁵⁹

Uninsured children lack a regular medical professional to monitor their development—and are six times more likely than a covered child to lack a regular source of care.⁶⁰ Fewer immunizations, well baby checks, and genetic/chronic disease screening are related consequences. Lower rates of adolescent sexual health care, failed responses to fluid loss and diarrhea, and expensive or debilitating outcomes occur more frequently where coverage is lacking. Uninsured children receive only 70% of the outpatient visits of their insured peers, and 71% of the care received for serious injuries. Notably, uninsured children who are injured are 30% less likely than insured children to receive medical treatment.⁶¹

One survey conducted in 1997 found 34% of the parents of insured children reported difficulties in obtaining medical services for their kids, while 56% of those parents whose children lacked insurance coverage reported problems.⁶² The medical areas with the most limited access for the uninsured include dental care, health care after hours, basic health care, preventive care, and mental health services.

Evidence of coverage benefits include both private and public insurance. From 1986 to 1995, the average Medicaid income eligibility set by states rose from 55% to 169% of the poverty level—substantially increasing care for impoverished pregnant women; as care increased, U.S. infant mortality dropped 21%—from 10.8 per 1,000 live births in 1988 to 8.5 in 1992 to 7.2 in 1998.⁶³ Similarly, California's expanded eligibility after 1984 correlated with an infant mortality drop 9.4 per 1,000 live births in 1984 to 7.0 in 1992 to 5.4 in 2000.⁶⁴

Children who lack health insurance are more likely to lack a usual source of preventive or sick care, to delay seeking care, to use fewer ambulatory health services, and to have fewer visits for common pediatric conditions. Uninsured children also have lower immunization rates, are more likely to be perceived by their parents as being in poor or fair health, and are more likely to be hospitalized for potentially preventable conditions, to be discharged from the hospital early after birth, and to have an increased risk of adverse outcomes after birth.⁶⁵ Such benefits extend beyond those below the poverty line. A study of 2,126 children participating in a New York state program to cover children above the poverty line (on terms similar to the subsequently enacted federal program) was released in February 2000. The study concluded: the statewide health insurance program for low-income children was associated with improved access, utilization and quality of care.⁶⁶ A December 2001 study reviewing 1999 California data found that 77.6% of children with dependent coverage from a parent's employer had visited a doctor, and 85% had visited a dentist, and 71% of Medi-Cal/SCHIP covered children had seen a doctor with 72% examined by a dentist. In contrast, only 44% of medically uncovered children had ever seen a physician and only 45% had ever been examined by a dentist.⁶⁷

E. Causes of Child Deaths and Injuries

Table 4-B lists the leading (non-disease) causes of death of children in California, which have remained consistent through the 1990s. In general, for very young children to age 4, the leading causes of death are accidental suffocations, intentional assaults/homicides (especially those involving abuse and neglect), motor vehicle accidents, and accidental drownings. For children 5 to 15, motor vehicle accidents, intentional assaults/homicides (especially those involving firearms), and accidental drownings head the list. For children 16–20, causes shift markedly to intentional assaults/homicide (especially those involving firearms and knives) as the leading cause, followed by motor vehicle accidents and a particularly tragic 140 suicides by various means.

By gender, unintentional injuries (primarily motor vehicle accidents) are the leading cause of death for all girls after age one. Homicide is among the top five causes in each age group over one. Among boys over one year of age, unintentional injury is the leading cause of death through age 14, and homicide is the number one cause among boys aged 15–19. Improvements in infectious disease control and unintentional injury prevention may be offset by increases in violence, especially homicides, suicides, and injuries by firearms.⁶⁸

Table 4-C presents recent data detailing the causes of non-fatal but hospitalized child injuries in 1999. In general, the leading causes of nonfatal unintentional injuries include falls and auto accidents. Children aged 13–20 were ten times as likely to sustain intentional injuries (either self-inflicted or by a second party) as were younger children. The leading form of self-inflicted injuries for older children was poisoning, which accounted for 79% of the self-inflicted injuries to youth aged 16–20.

Important risk factors associated with violence—such as poverty, domestic violence, and child abuse—have been increasing, as has the availability of handguns, the leading instrument of youth homicide and suicide⁶⁹ (see Chapter 9 discussion of youth violence causation).

Cause	Age in Years					Total
	<1	1-4	5-12	13-15	16-20	
Unintentional						
Cut/Pierce	0	0	0	0	0	0
Drowning/Submersion	10	73	29	12	31	155
Fall	1	3	2	1	11	18
Fire/Burn (Fire/Flame and Hot Surface/Substance)	1	10	12	1	6	30
Firearms	0	2	3	4	10	19
Motor Vehicle—All Categories	15	48	113	56	383	615
Poisoning	4	4	1	7	30	46
Struck by Object	0	3	2	3	0	8
Suffocation	24	16	9	4	4	57
Unintentional, All Other	10	35	37	20	117	219
Totals, Unintentional:	65	194	208	108	592	1,167
Intentional						
Self-Inflicted/Suicide, Cut/Pierce	0	0	0	0	0	0
Self-Inflicted/Suicide, Firearms	0	0	1	12	68	81
Self-Inflicted/Suicide, Poisoning	0	0	1	1	16	18
Self-Inflicted/Suicide, Suffocation/Hanging	0	0	4	19	61	84
Self-Inflicted/Suicide, Other	0	0	1	0	14	15
Assault/Homicide, Abuse and Neglect	10	11	0	0	0	21
Assault/Homicide, Cut/Pierce	1	2	5	5	32	45
Assault/Homicide, Fight-Unarmed	0	0	0	0	1	1
Assault/Homicide, Firearms	1	7	10	39	345	402
Assault/Homicide, Other	16	16	8	4	14	58
Totals, Intentional	28	36	30	80	551	725

Source: California Department of Health Services, Injury Surveillance and Epidemiology Section

TABLE 4-B. Fatal Injuries by Age Group—California, 2000

Cause	Age in Years					Total
	<1	1-4	5-12	13-15	16-20	
Unintentional						
Cut/Pierce	8	166	321	111	385	991
Drowning/Submersion	46	226	111	22	29	434
Fall	485	2,354	3,935	1,442	1,579	9,795
Burn (fire/flame and hot object/substance)	136	559	220	59	175	1,149
Firearms	0	5	34	51	154	244
Motor Vehicle—All	89	757	1,784	861	3,839	7,330
Bicyclist, Other	1	93	683	360	279	1,416
Pedestrian, Other	1	60	54	24	33	172
Poisoning	104	820	201	182	435	1,742
Struck by Object	62	293	607	521	620	2,103
Suffocation	135	188	52	14	15	404
Unintentional, Other	332	1,084	1,332	843	1,569	5,160
Totals, Unintentional:	1,399	6,605	9,334	4,490	9,112	30,940
Intentional						
Self-Inflicted/Suicide	1	4	102	1,178	2,322	3,607
Assault/Homicide	199	107	134	400	2,599	3,439
Totals, Intentional	200	111	236	1,578	4,921	7,046

Source: California Department of Health Services, Injury Surveillance and Epidemiology Section

TABLE 4-C. Nonfatal Hospitalized Injuries by Age Group—California, 2000

II. MAJOR PROGRAMS AND BUDGETS

The state fulfills a general public health role, and also provides or finances clinical health services. The programs doing so have been created over the years to address specific health care needs (e.g., prenatal care and immunizations) or family situations (e.g., low-income uninsured children). Each reflects public policy judgments to provide health services benefits to some segment of the population. The result is the current patchwork “system” of incrementally added programs, each with its own administration, eligibility and funding criteria, benefits, set of providers, payment sources and mechanisms, reporting requirements, and constituency. Each is subject to ongoing contention for political support for available public dollars.

This array of categorical programs presents a complex landscape of public programs to families. A child eligible for services one year may be ineligible the next, based on age, income status, length of residence, school enrollment, health needs, or changing program requirements. A parent may have different children in different programs and may herself be in yet another—if all are covered. Both CHIP and Medicaid after welfare reform provide significant flexibility to states to address the balkanization of programs, to simplify and integrate them, as discussed below. State flexibility is broad enough even to allow for the comprehensive reform we propose in our recommendations, with federal matching funds for all but certain immigrant children, who could nevertheless be covered with available state funds from the tobacco settlement litigation and other sources. While California is creeping in the right direction, the state has yet to maximize the potential to make its child health programs really work for families.

Health programs are funded by federal, state, and county money. Their mix has been changing in recent years, as the state has dealt with structural and cyclical budget pressures by both shifting costs to the counties while also maximizing federal funds, especially through Medicaid. As costs and program decisions are shifted to the counties for adult indigent care both the money and the results of the spending become more difficult to track for the state as a whole.

Figure 4-B shows the extent of reliance on federal funds by the state health programs serving children. By far the most important is the federal contribution to Medi-Cal reimbursements for services, about 50%. The federal contribution is actually somewhat larger, through additional funds such as those to support Disproportionate Share Hospitals (including children’s hospitals), which serve many Medi-Cal and indigent patients, and which are not included in the top bar of the figure.

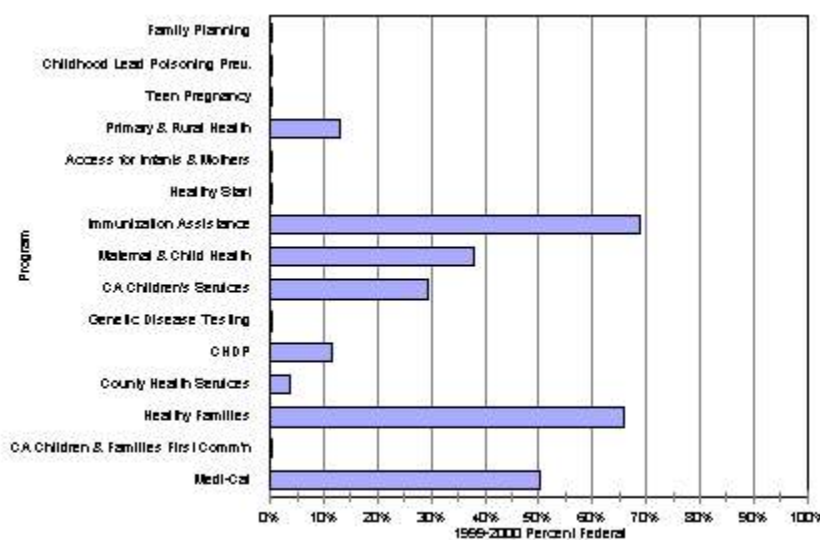


FIGURE 4-B. Federal Share of Spending on Health Programs

Five major sources of federal funding for children's health are routed through the state Department of Health Services (DHS) and are reflected in the state's budget. Federal Medicaid funds Medi-Cal—by far the state's largest health program overall and for children—at a base of about 50%. Funding for Maternal and Child Health Programs (MCH) (SSA, Title V) is allocated to states to promote the development of health care systems for mothers and children, and to provide it for those with inadequate access. The Childhood Immunization Program assists state and local programs in vaccinating children. The Preventive Health and Health Services Block Grant supports state programs in health prevention, education, and screening, including MCH services. And the 1997 federal Balanced Budget Act adds major funds through SCHIP to expand health coverage for children and adolescents of the working poor (implemented primarily through California's new "Healthy Families" program). Except for Medicaid, each of the other federal contributions involves an annual federal appropriation, which is then allocated to the states based on some formula representing need.⁷⁰

Figure 4-B does not include other sources of federal funds for health which are not channeled through the state's budget. These include Migrant and Community Health Centers grants, which are administered directly by the federal Health Resources and Services Administration to the health centers, and Medicare. They contribute significantly to supporting the state's health care infrastructure, but do not come through any state agency and are not part of the state budget. California, like many other states, has been maximizing its federal funds for Medicaid and other services. During the 1990s, reliance on federal funding increased from 43% of the state DHS budget in 1989–90, to 54% in 1999–2000. The anticipated increase in SCHIP funding at the lower 1/3 state match will put the percentage at just above 55% for current year 2001–02.

A. Major Statutory/Litigation Changes in 1996–2001: Welfare Reform, Immigrants, Managed Care, and New Federal and State Money for Child and Parent Coverage Expansion

The final federal welfare reform package (the PRA) rejected a Republican Medicaid block grant proposal (the "Medicaid Restructuring Act of 1996"), which would have ended the entitlement to medical care and cut the federal contribution to California by 25.1% by current year 2002.⁷¹ However, Medicaid is closely tied to the TANF/food stamps safety net and SSI disability systems, which the federal welfare reform legislation dramatically altered, as discussed in Chapter 2. The PRA made citizenship or long-term residency a condition of eligibility for public benefits for most immigrants, posing special concerns in California where during the mid- to late 1990s over 40% of legal immigrants. In 1999, 24% of all children in California were non-citizens or in mixed-status families (*e.g.*, citizen children with non-citizen parents), and another 24% were in families with naturalized parents.⁷²

The federal Balanced Budget Act of 1997 changed substantially the Medi-Cal managed care context in California⁷³ and, as previously mentioned, provided new federal money to expand medical coverage through the State Children's Health Insurance Program (SCHIP)⁷⁴, applicable to many of the children of the working poor now lacking it.⁷⁵ A series of letters and other instructions from HCFA to State Medicaid Directors also provide guidance for states on implementing SCHIP.⁷⁶

California's original SCHIP allotment was about \$850 million a year. As discussed above, states may carry funds over for three years. As of the end of 2000, however, California had not spent or appropriated its full allotment from 1998 or 1999. For 1998, the amount unspent was about \$580 million; California therefore lost 40%, or about \$230 million, of its unspent 1998 funds and was allowed to carry over only \$350 million until the end of fiscal year 2002.⁷⁷ The monies California and 38 other states lost were redistributed to the 11 states that had spent their full allocations to insure more children.⁷⁸

In July 2000, the Health Care Financing Administration (HCFA, the federal administrative agency with jurisdiction over Medicaid and SCHIP), issued guidance to the states on how they may qualify to use a portion of their SCHIP funds to expand coverage to low-income uninsured parents. To receive federal approval to use the children's health insurance funds to cover parents, states must first demonstrate that they are doing a good job enrolling and retaining children in insurance programs and

that they have provided certain protections for child health coverage; states must also show that the ways in which they propose to implement a parental expansion will help to ensure even more children.⁷⁹ California submitted its proposal for a SCHIP parental coverage expansion to HCFA in December 2000 (discussed below.) That application has been approved, but the proposed 2002–03 budget will delay its implementation until late in the fiscal year, or until 2003–04 in order to avoid general fund assessment—notwithstanding the 2 to 1 federal match.

The President's proposed 2003 fiscal budget does make available to states nationally \$3.2 billion in unused SCHIP funds that otherwise to be returned to the federal treasury. That sum will be extended to federal fiscal 2006 to allow states the chance to use more of their allotment. However, even if the waiver to allow parental inclusion is fully implemented—whether in proposed 2002–03 or thereafter—the state's child health policy will result in: (1) over one million (probably 1.5 million) income eligible children remaining uncovered notwithstanding available federal funds at a 2–1 match sufficient to accomplish full coverage, and (2) over \$1 billion in total will be returned to the federal jurisdiction unexpended.

During 1999, California agreed to a settlement of a national lawsuit on behalf of public agencies and the general public against the tobacco industry for recompense for the public costs of tobacco use; the settlement funds were distributed among the state, counties, and some cities (see discussion below).

Also in 1999, the electorate approved the California Children and Families First Act of 1998 (Proposition 10), creating a special fund from a new 50 cent tobacco surtax providing \$651 million in revenue in the 2000–01 fiscal year and an estimated \$641 million in current 2001–02. However, unlike other funding, these monies are not allocated by the Legislature, but by a state and county commissions (see discussion in Chapter 1). The mandate of the Commission funding is the protection of infants and pre-school children. As noted above, the current state priority is directed toward making these children “school ready,” and an uncertain portion of this fund will be expended in the public health/medical services area.

1. PRA: Federal Welfare Reform Legislation. Enrollment Decline, and Medi-Cal Coverage Loss

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRA)⁸⁰ did not end Medicaid entitlement status for impoverished families. Medicaid eligibility rules remain based to a large extent on the eligibility rules for the old AFDC program, which was replaced with TANF by the PRA. At the same time, however, eligibility for cash assistance is no longer a requirement for Medicaid eligibility for families with dependent children; this means that a person need not qualify for welfare to qualify for Medicaid (although families receiving TANF also qualify for Medicaid in all states.)⁸¹ Hence, federal law has “de-linked” Medicaid from welfare. This conceptual break with the past, enacted as Section 1931 of the Social Security Act⁸² has major consequences for both individual rights as well as state flexibility in re-designing Medicaid programs to be more responsive to the working poor.⁸³

As to individual rights, “de-linkage” under Section 1931 means that a person who loses TANF because he or she no longer meets a TANF eligibility requirement (*e.g.*, failure to comply with work requirements; five-year lifetime limit is up; etc.) may nonetheless remain eligible for Medicaid. As to program re-design, “de-linkage” means that states have a new tool for re-casting their Medicaid programs for parents and children as health insurance instead of as part of the welfare system. This is especially so given the flexibility that the PRA has given the states to develop their own “income and resource methodologies” for Medicaid coverage for families, without regard to whether families qualify for TANF cash aid.⁸⁴ States may exercise this flexibility at their own option, through state plan amendments, without the need for federal waivers.

California has used this new flexibility to: adopt rules ensuring that anyone meeting the state's TANF eligibility requirements would also qualify for Section 1931 Medi-Cal, starting with the implementation of welfare reform in California on January 1, 1998⁸⁵; increase the income threshold for family coverage from about 70% of poverty to 100%, effective March 1, 2000⁸⁶; allow families to keep Medi-Cal with income from work up to about 157% of poverty⁸⁷; and allow more two-parent households to qualify for

Medi-Cal family coverage as of March 1, 2000.⁸⁸

As important as these simplification and expansion measures are, 1.4 million low-income parents and children who are eligible for Medi-Cal remained uninsured in 1999: 685,000 parents and 726,000 children.⁸⁹ Enrollment has been inhibited by the old way of thinking in California's social service establishment, which continues for the most part to focus on filtering, qualifying, and excluding rather than on service delivery. In addition, much more needs to be done to restructure eligibility rules and to streamline and coordinate the Medi-Cal and Healthy Families programs: in short, to maximize the new opportunities to provide health care coverage with federal matching funds to low-income families with children when they do not qualify for TANF cash assistance.

Historically, the traditional AFDC system, with its caseworkers who knew that AFDC-eligible families were also eligible for Medi-Cal, facilitated outreach and enrollment in some ways. According to one source, "the data show that children in families who do not receive cash aid are much less likely to be enrolled in the Medicaid program."⁹⁰ Through the mid-1990s, only 38% of children under age 11 who were not a part of TANF but were still eligible for Medicaid were enrolled.⁹¹ A review done in 2000 of welfare leavers studies in 25 states found that many parents and children eligible to continue receiving Medicaid become uninsured after leaving cash assistance.⁹² Those who are now barred from TANF and others not receiving cash assistance—as time limits are applied or welfare caseloads decline in times of economic expansion—will not have caseworker assistance and will require active outreach to include. Increasing enrollment of the working poor will be very difficult to change as long as Medi-Cal is presented as a "welfare" program. The 1.4 million low-income parents and children who are eligible for Medi-Cal but uninsured requires taking information about Medi-Cal eligibility out of the welfare office and to the work and community settings where the parents and children are.

Under longstanding federal and state law, when eligibility for Medi-Cal on one basis ends, coverage may not be terminated until the state has "redetermined" whether eligibility continues on some other basis; this is necessary to prevent breaks in coverage for eligible individuals.⁹³ In the case of a family losing or otherwise leaving TANF, the Medi-Cal redetermination may establish continuing eligibility in a variety of ways. If the family is losing welfare because of time limits, for example, nothing has occurred to affect Section 1931 eligibility.⁹⁴

The state has moved to simplify the Medi-Cal redetermination process,⁹⁵ but in fact such reverification is largely a set of gratuitous obstacles. Few persons on TANF rolls or currently covered by Medi-Cal will lose eligibility for Medi-Cal. Even fewer children will lose eligibility and virtually all who might will be eligible for Healthy Families coverage. As discussed in the applicable programs below, the income levels in the various children's programs give younger children coverage at higher family income levels. Hence, infants are covered in families up to 200% of poverty. Children aged 1–5 are covered up to 133% of the line. Therefore, when CalWORKs ends, unless family income has gone over 157% of poverty (from a source other than job-based earnings or child support) the whole family should continue on Medi-Cal. That continued whole-family eligibility exists under either the Section 1931 program or TMC. Even where Section 1931 or TMC does not apply for coverage, infants and children ages 1 through 5 are likely to be covered under their higher 200% and 133% respective percentages of poverty line allowance.

Finally, when CalWORKs ends, children should retain eligibility for Medi-Cal under yet another rule, the 12-months continuous eligibility regulation that went into effect January 1, 2001, even when their parents have no basis for Medi-Cal eligibility. Currently, children at least have 12 months of continuous eligibility within Medi-Cal and within Healthy Families, respectively.⁹⁶

Although redetermination law does not require a review for Healthy Families eligibility when a child leaves CalWORKs, advocates for a seamless system of child health coverage have urged the state Department of Health Services to instruct the counties to refer the cases of children found ineligible to continue Medi-Cal on any basis after a redetermination to the Healthy Families program which now covers children to 250% of poverty. At present, some counties do so on a voluntary basis. In fact, the

sensible approach is to confine the choice to a single question: do the children go under Medi-Cal or under Healthy Families? Failure to enroll them in one of the two without extraordinary cause should be a cause for departmental budget penalties, administrative sanctions or job discipline. Currently, the state's bureaucracy does not sanction those who deny services to eligible children, but rather those who provide coverage to the ineligible.

During 2000 the Legislature approved AB 93 (Cedillo) which would have eliminated the authority of DHS to require status reports of all enrollees (parents as well as children) more frequently than once a year. Regrettably, the Governor vetoed the measure, stating in his message: "This bill would, in effect, result in continuous eligibility for every Medi-Cal beneficiary for a minimum of one year from the date eligibility is established...and could result in benefits for persons no longer in need of Medi-Cal." Health advocates contend that this continuing emphasis on barring the ineligible imposes administrative costs greater than the minor expense of some extra months of coverage for the small number of persons whose income rises above the qualifying line during the year.

Similarly, the Governor vetoed AB 1722 (Gallegos) which would have eliminated burdensome paperwork to determine the assets of families (aside from income where stringent requirements remained). This simplification (of the Section 1931(b) Medi-Cal program) would have saved \$3 million in direct administrative costs, and retained all federal requirements for asset determination. Although all conceded it would make enrollment more user friendly, the Governor rejected the change with only the conclusory explanation: "This bill is inconsistent with the eligibility rules agreed upon (in 1999)."

Providing health care coverage for parents can benefit children for several reasons. Parents who are ill and are unable to work are more likely to fall back onto TANF—now with time limitations. On the other hand, parents who are covered are more likely to have contact with providers and are more likely to bring their children in for check ups and early treatment when symptoms appear.⁹⁷ In addition, a study done in 2000 shows that parents are much more likely to enroll their children in Medicaid if the parents are eligible, too.⁹⁸

2. Immigrant Responsibility Act

As discussed in Chapter 2, the PRA's changes to the status of legal immigrants have been momentous for California, where, as of 1998, 30% of the nation's lawful immigrants reside.⁹⁹ The PRA cut off all food stamps and SSI benefits categorically from almost all immigrants arriving in the United States after August 22, 1996—for a period of five years after their arrival.¹⁰⁰ Since there is a five-year waiting period for citizenship in the normal course, that prohibition covered the entire waiting period. The major exceptions: refugees, veterans, and those who have worked in the U.S. more than ten years, amount to less than 20% of arriving immigrants. Federal medicaid coverage does not apply to any lawful immigrant arriving after 1996. California provides state-only Medi-Cal coverage for all documented (legal) immigrants regardless of when they arrived in the United States. However, that coverage depends upon separate state appropriations without federal match. As noted in Chapter 3, similar state only food stamp coverage for at least the post-1996 arriving immigrants (including children) also depends on state only funding, is due to sunset on October 1, 2001, and the Governor's May Revise does not extend that sunset date. Accordingly, the retention of basic medical coverage for impoverished children of immigrants depends on continued state budgetary inclusion. That coverage is retained for Medi-Cal purposes for immigrants, including post 1996 arrivals, in the Governor's proposed budget for 2001–02, including the May Revise. And similar coverage for all lawful immigrants, regardless of arrival date, applies to Healthy Families by virtue of AB 2415 (Migden) enacted in 2000.¹⁰¹

Our survey of population data in Chapter 2 indicates the importance of retaining this state-only coverage. Experts estimate that 25,000 legal immigrants (children and adults) arrive in Los Angeles County each year who will qualify by income and need for Medi-Cal but suffer its federal funding denial, a total which will reach nearly 200,000 by 2005.¹⁰²

3. Federal Health Insurance Portability and Accountability Act (HIPAA)

One of the sources of private health insurance coverage decline is the lack of portability of employee coverage. A layoff, transfer, or disability precluding continued employment for a covered worker has historically ended health care coverage. While Medi-Cal or Healthy Families may allow some of these children to be covered, a substantial number achieve employment elsewhere and earn salaries too high for their children to qualify—with employers who do not provide coverage for them, or perhaps not for their children. In addition, some private coverage engaged in “cherry picking,” taking premiums for and from employees for many years, and then when they reach a more expensive age or problems are disclosed, may use employment change to justify abandonment. The children of these parent-employees often lose coverage which is connected to that of their parents. In 1996, the Congress enacted the Health Insurance Portability and Accountability Act (HIPAA), which includes mandated coverage and portability provisions, and which took effect on July 1, 1997.¹⁰³

The new law facilitates some continued coverage which can stimulate coverage of children. First, an uninsured woman who starts a new job with an employer who provides coverage may not be denied coverage because she is pregnant when she enrolls, and may not be denied coverage for a newborn or newly adopted child’s medical problem (if otherwise covered by the plan and if she enrolls the child within 30 days of birth or adoption). And the children she already has at time of enrollment can be covered—and without preexisting exclusions—if they have had either Medi-Cal or other health insurance for the prior twelve months.

Second, a parent changing from one health plan to new group coverage (as when changing jobs) will not be refused coverage for herself or her family, or charged a higher premium, because of pre-existing conditions—again, so long as the person to be covered has had twelve months of previous private or public insurance coverage. If there has been no prior coverage, the pre-existing condition may be excluded up to twelve months, after which it must be covered. The Act does not affect the Medi-Cal population, nor does it benefit the vast majority of uncovered children. However, some children subject to exclusion in the private group insurance market due to pre-existing conditions will now be included, particularly where their parents are newly-hired from the TANF population or shift between employers offering coverage.¹⁰⁴

HIPAA requires all providers and health plans to use a single set of national standards and identifiers if they make administrative and financial transactions electronically. The current budget allocates \$2 million General Fund (plus \$16.7 million federal funds) for the state Department of Health Services to ensure that plans and providers in California comply with the national HIPAA standards, which are intended to promote coordination of health benefits and cost-effective claims processing and protect security and privacy. During current 2001–02, the budget expended \$92 million for HIPAA compliance (mostly in the Department of Health, but with smaller sums allocated to Alcohol and Drug Programs, Mental Health, and Developmental Disabilities. However, in November 2001 this sum was one of the targets of the late fiscal year reduction—declining to \$74 million. The proposed budget for 2002–03 proposed in January to restore funding up to the \$92 million originally agreed necessary to assure compliance with federal standards—necessary for receipt of many millions in federal medical funding. And the Davis Administration did establish an Office of HIPAA Implementation (OHI) within Health and Human Services to assure regulation compliance and oversight, consistent with SB 456 enacted in 2001.¹⁰⁵ However, in the May Revise 2002, proposed spending for HIPAA funding is at \$85 million (\$24.5 million general fund)—a reduction of \$7 million from federally expected implementation spending. It appears that the state will be required to apply for “compliance delay” dispensation, allowed under certain circumstances, but only for one year—and with a timeframe that must begin on April 16, 2003. Governor Davis has announced that he is seeking a further deadline extension.¹⁰⁶

4. Federal Balanced Budget Act of 1997 (BBA 97)

The Balanced Budget Act of 1997¹⁰⁷ (BBA 97) made the largest cuts in Medicaid spending since 1981; it cut from Medicaid beneficiaries \$61.4 billion over ten years. In 2000, \$35 billion was federally restored to medical accounts, however most of this restoration was directed to the elderly through Medicare HMO payments, hospitals, and nursing homes.¹⁰⁸

The BBA 97 also enacted SCHIP and modified the law on Medicaid HMOs (discussed below.) It did not change Medicaid as an entitlement or modify Medicaid eligibility rules. It did, however, restore SSI to certain legal immigrants, such as those who were lawfully present on August 22, 1996 and are "qualified" immigrants with disabilities when they apply, qualified immigrants who were receiving SSI or had applications pending on August 22, 1996, certain Native Americans, and a few other groups (see Chapter 5 discussion below).¹⁰⁹

The BBA 97 also restored federal Medicaid coverage for the groups for whom SSI was restored, but this had no practical effect in California. As described above, California had already opted under the PRA to provide Medicaid with federal matching funds for all legal immigrants who arrived before August 22, 1996, and provides state-only funding for those arriving after 1996. Unfortunately, there is still no federal financial participation for Medi-Cal for immigrants arriving after the 1996 cut-off date during their first five years in qualified immigrant status. Bills to restore federal Medicaid coverage to new legal immigrant children and pregnant women continue to be introduced in Congress.¹¹⁰

Also in the BBA 97 are provisions granting states the option to provide children with "continuous eligibility" for Medicaid and SCHIP for up to twelve months, and to grant "presumptive" eligibility to children after an initial screening.¹¹¹ Thus, the law allows for quicker enrollment at the start and uninterrupted coverage for a year. It included the original SCHIP child health block grant of \$20.3 billion for the five-year period from 1998 through 2003 to reduce the number of uninsured children and authorized its use to cover children in families up to 200% of the poverty line (or higher through the use of "income disregards" or through allowable increases beyond 200% where previous programs covered children above the 100% poverty line level, see discussion of California's Healthy Families program, below).

The BBA 97 also expanded the discretion of states in Medicaid delivery. Accordingly, California no longer requires a federal waiver to shift its Medi-Cal population to managed care. The state need provide a choice of only two "managed care organizations" for recipients.

In order to respond to the growing complaints about managed care delays or denials of service, the law also includes some important consumer protection features, as follows:

- ◆ Managed care organizations must be subject to an annual external review of their quality of care. The resulting reports are to be available to enrollees or potential enrollees. After January 1, 1999, these reviews must use federal protocols to assure consistency and allow for comparison between managed care organizations.
- ◆ States must authorize "intermediate" sanctions (other than contract termination) where a managed care organization "fails substantially to provide medically necessary items and services that are required...under the contract," for overcharging enrollees, discriminating on the basis of health status, giving false information (to officials, enrollees, or providers), or failing to comply with "physician incentive plan" requirements. These sanctions can yield civil penalties up to \$100,000 for some violations, \$25,000 for others, and double the excess amount charged if that is the transgression. The state may appoint temporary management to oversee actual organization management upon a finding that it has continued to engage in egregious behavior or there is a substantial risk to enrollee health.
- ◆ Each managed care organization must set up an internal grievance procedure so enrollees may challenge denials of treatment, coverage, or payment. And "gag rules," which limit a health care professional from advising enrollees of medical status or recommended services, are prohibited.
- ◆ States may impose copayments, deductibles, or other cost-sharing on managed care enrollees, but only consistent with non-managed care recipients. Such payments must

exclude pregnant women and children, all emergency care, family planning, or inpatient hospital care, and must be “nominal” and may not be used to justify service refusal where a beneficiary is unable to pay.

- ◆ To address deceptive marketing and “skimming the cream” practices, promotional materials must be submitted to the state in advance to be reviewed by a medical advisory panel. Materials must be distributed to the entire service area (not just low-cost populations); tie-ins to compel membership are prohibited; and door-to-door, telephonic and other cold-call marketing practices are prohibited.
- ◆ Enrollment and disenrollment in a particular managed care organization is allowed anytime for cause, within the first 90 days of enrollment as of right, and at least every twelve months thereafter. This provision means that after 90 days, a beneficiary—as a practical matter—is locked into the chosen managed care organization for one year, regardless of the level of service or appropriateness for the children involved.

The BBA 97 also eliminated federal minimum reimbursement standards for hospitals, nursing homes, and community health clinics. Most of the huge savings out of Medicaid in 1997 came from limiting federal matching funds for “disproportionate share hospitals” (DSHs), which provide medical care to low-income patients.¹¹² Experts worried about the long-term effects of these and related cuts to providers of Medicaid services given the cross-subsidies now extant through emergency room and clinic services to the uninsured working poor.¹¹³ As mentioned above, about 60% of the 1997 cuts were restored in 2000.

5. Healthy Families and Revised Medi-Cal Coverage

Through AB 1126 (Villaraigosa) (Chapter 623, Statutes of 1997),¹¹⁴ California is now implementing its program to expand medical coverage to children pursuant to the SCHIP program, created by the BBA 97, as described above. The state has created a “Healthy Families” program statutorily, separate from Medi-Cal. As in previous years, the budget for 2001–02 included funds for the required one-third state match to obtain a portion of available federal funds. California’s new program is budgeted separately from Medi-Cal accounts. The account, proposed spending, the state’s selected options, and the impediments they present to optimum coverage of uninsured children are discussed in more detail below.

Related legislation, SB 903 (Lee) (Chapter 624, Statutes of 1997), affected Medi-Cal coverage itself for certain children. First, the assets for Medi-Cal coverage for children was eliminated. The strict limits on the value of car, bank account balance, etc., which are applicable to TANF cash grants or food stamps, no longer apply to Medi-Cal eligibility of children through age 18. As has long been the case with pregnant women, the state legislation gave children coverage based on family income alone. Second, SB 903 increases Medi-Cal coverage of children ages 14 through 18 so all would be covered in families living up to 100% of the federal poverty line.

Accordingly, Medi-Cal qualification is as follows: Pregnant women and children under the age of one are eligible if family income is at or below 200% of the poverty line; children ages 1–5 are eligible if family income is at or below 133% of the poverty line; and children ages 6–18 are eligible if family income is at or below 100% of the line. There is no assets test for any of these groups. If a child loses Medi-Cal because family income rises, an additional 30 days of coverage applies for children to give the family time to enroll in the new and separate Healthy Families program.

In July 2000, HCFA announced that states could apply for permission to use SCHIP funds to cover parents, as studies indicate that extending coverage to the whole family promotes child enrollments and child health.¹¹⁵ California submitted its SCHIP parental coverage application in late December 2000 and amended its proposal in March 2001, as discussed below. The application was approved in January 2002. It would authorize an estimated 275,000 parents to qualify for coverage who are currently lacking

it, and the state DHS estimates that another 25,000 children will be added because of the positive impact of parental inclusion on child enrollment. However, the approval came at an embarrassing point for the Governor—who had been seeking it and complaining about its delay. At the point of its approval, he decided that his general fund shortfall precluded California expansion—even at a 2–1 federal to state match. His May Revise 2002 for proposed 2002–03 defers this expansion until 2003–04.

6. Tobacco Settlement

Discussion continues about where the heralded tobacco settlement funds will be expended. The Governor has a special stake in this fund because of his role as a plaintiff while Lt. Governor of the state. He was one of the named plaintiffs suing the tobacco industry “on behalf of the general public” under the private attorney general provision of California’s Unfair Competition Act.¹¹⁶ The national settlement entered into on November 16, 1998 is scheduled to bring \$25 billion to California over the next 25 years. Half of all funds received are reserved for counties and cities, which filed separate lawsuits. The 2000–01 budget allocated only a small portion of the state’s share to health programs, reserving the rest for the General Fund. Efforts to earmark the state’s portion of the tobacco settlement money died in the waning hours of the 2000–01 legislative session.¹¹⁷

In 2001–02, the state is expected to receive about \$468 million, with local governments receiving a like amount. The Governor’s budget for 2001–02 established the Tobacco Settlement Fund (TSF), into which all funds from the settlement would be deposited for use for health care programs as follows:

- ◆ \$74.4 million to pay for the 34% state match to continue Healthy Families coverage for about 106,000 children with family income between 200% to 250% of poverty.
- ◆ \$76.1 million to pay for the 34% state match to expand the Healthy Families program under the Governor’s proposed S-CHIP waiver (see discussion below) to 174,000 uninsured parents of children in the program (to grow to 250,000 by the end of fiscal 2001–02).
- ◆ \$123 million for the 50% state match to continue Medi-Cal coverage for 249,000 working poor parents not on welfare with income at or below 100% of poverty.
- ◆ \$47 million for Medi-Cal coverage for 52,800 aged, blind, and disabled persons with income between 70% and 133% of poverty.¹¹⁸
- ◆ \$20 million to augment declining Proposition 99 funding (\$114.5 in 2001–02) for the youth anti-smoking campaign.
- ◆ \$20 million for the state match to continue the Breast Cancer Treatment for 1,250 individuals with income up to 200% of poverty.
- ◆ \$20 million to double the Prostate Cancer Treatment program to serve 1,200 individuals.
- ◆ \$64.9 million for health screens and assessments under the Child Health and Disability Prevent program

These allocations represent a substantial shift away from original proposals to place the monies in the general fund, or to allocate them for education. The new direction is more consistent with the traditional intent of indirect class action recovery, which properly seeks to rectify the wrong which led to the settlement fund, or at least to address the same general type of harm at issue in the case. But most of the spending neither expands nor otherwise improves health programs; instead, it pays for programs already in existence and funded, with little net gain to health in 2001–02.

This contrasts with the approach taken in Santa Clara County in 2000, where a significant portion

of the local tobacco settlement funds have been earmarked to cover all uninsured child residents, without regard to immigration status, making Santa Clara the first local government in the country to insure all of its children. As of January 1, 2002, San Francisco County followed suit, with health insurance for children provided to all—regardless of immigration status. It is estimated that up to ½ of the new enrollees will be undocumented immigrant children. At a cost as low as \$4 per month, child coverage will be provided by the same local agency administering the Healthy Families Program. The hope is to enroll all 10,000 currently uninsured children in the county, at an eventual cost of \$6 million per annum in subsidy. Funding comes from the general fund, with some contribution from locally allocated Proposition 10 funds.¹¹⁹ Other counties, such as Orange and San Diego, have also taken local action to allocate a significant part of their tobacco settlement money to county health care.

Beyond the supplantation problem, one other more complicated consideration should guide the spending of a substantial portion of the TSF—provide an equitable remedy to the class of persons whose rights were adjudicated by the settlement. The tobacco settlement in California was accomplished under the unusual allegations of five separate cases (including one brought by the Attorney General) under section 17200 of the Business and Professions Code (the “Unfair Competition Act”). That statute is unusual in its conferral of “private attorney general” authority on any person to sue for equitable relief on behalf of himself or the “general public.” This unusual provision constitutes a private attorney general authority to sue without the barriers (or safeguards) relevant to standard class actions. The last require the class representative to be “adequate”, and require notice and the representation of those who do not “opt out” in the action. Common questions must predominate for the class to be certified, and other class action requirements with some due process implications give the final judgment resulting a finality. This is not the case with a Section 17200 action. Such collateral estoppel cannot be assured where a case may be filed and settled by five different parties representing the general public, without notice, opportunity to opt out, assurance that the interests of those litigated were adequately represented, etc.¹²⁰

Accordingly for the TSF to have final effect it must achieve it through “equitable estoppel.” That is, it must afford a remedy to those who were aggrieved so that they cannot complain—since such complaint would simply give rise to double recovery, which a court in equity may reject. Hence, the TSF monies are properly applied first and foremost to equitable restitution. Some such monies may be expended on health care, but the largest share properly funds de-addiction recompense and de-addiction treatment for all who heard the ads and suffered from the addiction practices of the industry complained of. The civil unfair competition complaints here settled have to do with misleading ads and nicotine addiction practices of the defendants. Some money may well be justified to correct the record—and to fund addiction prevention education—especially that directed at youth given the allegations of youth targeting in the underlying case.

However, as discussed above, existing spending focuses largely on general fund supplantation of money previously spent on medical care. Of greater concern, the proposed budget for 2002–03 removes all pretense. The largest single portion is allocated to “securitization” of a huge bond to be floated for immediate revenue for general fund relief. Almost 30% of the state’s share of the TSF will go to repay these bonds over the next twenty years—year after year—all to repay part of the general fund deficit for the single year of 2002–03. Then the already modest sum of \$35 million for youth anti-tobacco education was removed during the May 2002 Revise. The proposed 2002–03 budget includes no funds for tobacco addictions prevention, none for deaddiction services. The sum is almost entirely devoted to broad health or overall general fund relief. As such, it does not comport with the ethical obligations of counsel and parties here representing the general public in the representation of those injured by the allegations made, and for whom the attorney has a fiduciary duty to represent and obtain recompense. One of the settling parties was now Governor Davis, who brought suit while still Lt. Governor. Counsel in another of the settled cases included the then Attorney General of the state.

7. California Children and Families First Act of 1998 (Proposition 10)¹²¹

The California electorate narrowly approved Proposition 10, the “California Children and Families First Act” during the November 1998 election. Promoted by Hollywood actor and producer Rob Reiner, it imposes a 50-cent surcharge on tobacco products with proceeds intended to “promote, support, and improve early childhood development from the prenatal stage to five years of age.” The funds are administered through a state “California Children and Families First Commission” of seven voting members, three appointed by the Governor and two each by the state Senate and Assembly. The Governor appointed Rob Reiner to chair the state commission. However, the state commission will allocate only 20% of the funds, most of which is pre-directed for mass media communications (6%); education (5%); child care (3%); research and development (3%); administration (1%). Only 2% is unallocated beyond the above list from the 20% to be expended by the state. The remaining 80% of the funds collected are to be channeled directly to counties based on relative numbers of births in each. Local county commissions similar to the state body and appointed by county boards of supervisors will make the spending decisions as to this portion.

The total sum collected under Prop 10 was reduced by \$24 million in both 2000–01 and again in 2001–02 to draw down federal matching funds for the Breast Cancer Treatment program and to compensate Proposition 99 funding reductions caused by this new tax. Proposition 99 (discussed below) is an established account fed by existing tobacco taxes and funding numerous health care programs. It will suffer a reduction due to decreased sales from the higher prices attending the surtax. The fund will also pay the surtax collection administrative costs of the State Board of Equalization. However, these deductions are estimated to be only about \$1 million a year in 2000–01 and 2001–02. The Department of Finance estimates that the measure will produce net revenue to be allocated of \$651 million in 2000–01 and \$641 million in proposed 2001–02. Eighty percent of these funds will be expended by county commissions at the local level. The initiative allocates 20%, the state's share, into categories as listed above.

Child advocates have been concerned about three possible impediments to efficient use of the Prop 10 monies: (1) Will funds be leveraged to capture federal funds—much of it available on a 2 for 1 match basis; (2) Will available funds be invested in preventive impact (e.g., parenting education, public media campaigns to lower unwed births); (3) Will counties supplant the new money—applying it to existing or already planned spending, and freeing those funds for discretionary spending elsewhere? Many of these concerns were confirmed in early county dynamics, as county supervisors were reportedly interested in control of appointees and funding decisions for political advantage rather than early child development. Child advocates have suggested: (1) that counsel be retained to litigate local anticipated spending decisions which act to “supplant” (effectively divert) the new Proposition 10 funds from child related investment to other purposes. And it has been suggested that the limited state discretionary spending should include as a high priority the retention of experienced child advocates to represent children before the state agencies most concerned with public spending affecting young children. (See recommendation #4 below.) Of some promise is the inclusion of “policy advocacy” as a priority by the Commission during early 2001, although spending has not yet been so directed.

During 2001, the Commission developed as a primary priority “school readiness,” a phrase which polls indicate enjoys widespread public support. The Commission has yet to flesh out a full-scale program, but a substantial share of funds collected will be expended in related (and non-health) areas, such as child care and development, education, *et al.* One area of health activity is some spending by local commissions to stimulate medical insurance coverage, which has an important leveraging advantage given the unused federal SCHIP funds available.

8. 2001–02 Budget Act Trailer and Related Measures

Major legislative changes in the 2001–02 budget included trailer language that made the following adjustments to facilitate coverage:

a. Healthy Families Coverage Expanded to 250% of the Federal Poverty Line; Immigrants Covered Regardless of Date.

As noted above, the SCHIP program allows coverage up to 200% of the FPL, or 100% above the state line—whichever is higher. California covers children above the poverty line by varying percentages depending upon age, and had extended that coverage up to 250% of the poverty line. The Budget Agreement of 2001 included parents earning up to the 250% line, adding potentially \$8.9 million in costs. AB 430 requires the state not only to pursue its original waiver request to cover parents up to 200% of the line, but to amend it upward to 250%. The federal waiver was granted in January of 2002 up to the 200% mark. However, the entire program is being deferred due to the general fund shortfall, as discussed below.

In addition, immigrants and qualified aliens are eligible regardless of entry (no restriction on those arriving after 1996).

b. Bridge from Medi-Cal to Healthy Families Expanded

As noted above, the loss of Medi-Cal coverage to many children moving off TANF rolls partly countered the additive effect of Healthy Family sign-ups for those earning too much for Medi-Cal coverage. Several measures seek to provide a “bridge” of continued medical coverage to those leaving TANF. The existing bridge program provides two months of continuous service to all children leaving TANF who are in families with income below 250% of the FPL. In 2001, the Legislature expanded this bridge to parents, providing two months of Healthy Families benefits for any parent no longer eligible for Medi-Cal and with income below 200% of the line.

The Legislature also created a Healthy Families to Medi-Cal program because of the new movement of persons back onto TANF, or into lower income levels qualifying them for Medi-Cal, which many families are not benefitting from. This bridge provides two months of HF benefits to any person eligible for Medi-Cal to give them time to apply for coverage and avoid a lapse.

c. Simplification of Income Proof

The 2001–02 budget included authority for MRMIB (Major Risk Medical Insurance Board, see below) to allow adults and children to self-declare their income by affidavit when they apply for HF— where independent documentation is not available. This is the current policy applicable to Medi-Cal applicants by DHS.

d. Accelerated Eligibility for Medi-Cal

A child Medi-Cal applicant will be considered eligible for Medi-Cal where they appear to be qualified while the final decision on eligibility is made.

e. Partial Continuous Eligibility

A Section 1931 Medi-Cal beneficiary (see below) will be able to disregard income and resource changes until the next annual redetermination. This is separate from the more significant automatic 12 month period of continuous eligibility for Medi-Cal child enrollees effective since 2000 (see AB 2900, Chapter 945, Statutes of 2000).

f. Foster Care

Foster Care families will be able to more easily demonstrate Medi-Cal eligibility of foster children, including ending the requirement that private insurance be unavailable prior to coverage.

g. Direct Marketing

Dental and vision plans will be permitted to engage in application assistance (and receive compensation for sign-ups) as is the case with other health plans.

h. Health-e-App

The Budget Agreement provided \$2.1 million to implement Health-e-App, an electronic—Internet-based application process to enroll in Medi-Cal or Healthy Families.

i. Childhood Lead Poisoning Prevention

The Budget committed \$8.5 million for lead poisoning prevention (see discussion below).

j. Reduced Augmentation for Rural Health Services, Migrant Workers Clinic, and American Indian Health

The Legislature reduced the already modest spending for the above three accounts with particular child related impact (see discussion below).

9. Other Major 2001 Legislative Changes

Over twenty minor legislative changes relevant to child health care were enacted in 2001; however, most of them affect a very small population or locale, or although addressing a major issue, simply authorize “studies.” For example, AB 652 (Horton) asks the UC Regents to report to the Legislature on recruitment of students from underserved areas for medical, dental and optometric education; AB 1589 (Simitian) which requires the Medical Board to conduct a study of the electronic transmission of non-controlled prescriptions. Those measures enacted which are of generalized interest to children include:

a. AB 495 (Diaz)

AB 495 creates the Children's Health Initiative Matching Fund which allows federal matching funds to counties and Medi-Cal managed care local initiative plans for the coverage of certain children up to 300% of the FPL who do not qualify for Medi-Cal or Healthy Families. Note that in its original version it would have covered all children, regardless of immigration status, but was amended to exclude those who do not qualify under federal criteria.

b. AB 59 (Cedillo) Express Lane Medi-Cal Enrollment—Child Lunch Recipients

AB 59 establishes a statewide pilot project to expedite Medi-Cal enrollment for children receiving free lunches under the National School Lunch Program (see Chapter 3). The measure authorizes immediate enrollment of these children where families are below 100% of the poverty line and requires simplified additional information to determine if other children are eligible for Healthy Families (those who may be over 100% of the FPL). The bill also requires county welfare departments to assist food stamp applicants in their Medi-Cal applications and to provide Healthy Families information to those who may qualify for it.

c. SB 493 (Sher) Express Lane Medi-Cal Enrollment—Food Stamp Recipients

SB 493 supplements AB 59 above by facilitating Medi-Cal enrollment through the existing offices of food stamp administrators. The bill requires notice to all recipients no Medi-Cal enrolled to inquire about their interest in enrolling. The food stamp office, for those who return such notices indicating interest, will review the case file, determine eligibility and help with enrollment. Further, those interested in coverage who may be eligible for Healthy Families (*e.g.*, their children or themselves if parental coverage begins) will be passed onto the Health Families program administrator for processing there.

d. Pre-School Chicken Pox Vaccinations

California must receive a chicken pox vaccination in order to enter kindergarten under a state law enacted in 1999 and scheduled to take effect July 1 of 2001.

e. SB 255 (Speier) Kids-n-Cars

SB 255 (Speier) imposes fines of up to \$100 where infants and children under 6 years of age unattended in a motor vehicle, with proceeds to fund public education. During 2000 more than 40 children nationwide died from heat prostration after being left in cars with often unanticipated temperature increases, the number increased in 2001 to over 50.

f. SB 52 (Scott) Handgun Safety

SB 52 (Scott) provides that no person may purchase or receive a handgun without a handgun safety certificate, and no such certificate may be issued to any person under 18 years of age. The certificate requires passing a test on gun safety and applicable laws, and for the first time includes a “handling demonstration” element. The bill will become operative on January 1, 2003.

g. SB 19 (Escutia, Speier)

The “Pupil Nutrition, Health and Achievement Act” was enacted in late 2001 and includes an array of measures to promote the health of school children by improving the nutritional value of publicly subsidized school lunches—with emphasis on reducing obesity. As discussed in Chapter 3, the law requires local school districts to create nutrition and education committees to develop local policies for child health, and include guidelines to stimulate offerings of fresh fruit and vegetables. It also integrates nutrition into the curriculum. It also increases the state’s share of school lunch reimbursements by \$0.23 for free or reduced price meals, and \$0.10 for fully paid meals and authorizes ten pilot projects. However, the law requires separate funding to effectuate and little was appropriated in the current year, nor are funds sufficient for any substantial implementation proposed in 2002–03.

However, while the Governor signed the bill with a flourish, he also cut all of its associated funding (\$5 million) and has not included it in his 2002–03 proposed budget.

h. Youth Anti-Smoking Measures

Two bills—SB 322 (Ortiz) and SB 757 (Ortiz)—were enacted in October 2001 to discourage teen smoking.

SB 322 prohibits “Bidis”—unfiltered, hand-rolled cigarettes wrapped in a tendu leaf and imported into the United States from SE Asia. They are available in candy colors and flavors (licorice, mango) and emit toxic concentrations more harmful than manufactured U.S. cigarettes. They have three times the nicotine and carbon monoxide levels of traditional cigarettes.

SB 757 eliminates the present requirement that a youth involved in a sting operation must state his or her actual age if questioned by a retailer. It also provides a civil penalty on a seller who displays cigarettes to allow self-service selection, sell small package of under 20 cigarettes (referred to as “kiddie packs”), and prohibits the sale of small quantities of loose tobacco popular among youth.

A more significant measure has been introduced in 2002 to raise the allowable age for smoking from 18 to 21 years.

10. Major 2001 Litigation/Rulemaking/Policy Changes

a. Medi-Cal Reimbursement Litigation

The 2001 Budget Agreement also included \$191 million to settle outstanding litigation over reimbursement rates for Medi-Cal outpatient services, of particular relevance to children because of the rate level applicable to pediatric specialists—allegedly at record low levels and the supply of these physicians available to impoverished children is limited. See *Orthopaedic Hospital v. Belshe*, still pending. Reimbursement rates for the limited services included in the litigation are to be increased by 30%, with three successive annual increases of 3.33% on top of this correction beginning July 1, 2002.

b. Tobacco Settlement Fund Allocation to Health Care Fund

The 2001 Budget also redirected Tobacco Settlement Fund monies (see above) to a new special fund for health care, allocating \$401.9 million to the fund and \$73 million for direct general fund reduction. In proposed 2002–03, as discussed below, \$247 million of the TSF monies are allocated to replace almost all general fund spending for the Healthy Families program.

c. New Pilot Disease Screens for Newborns

At the end of 2001, the DHS announced an ambitious pilot program to expand the number of diseases for which newborns are screened. Currently, the state tests for four genetic problems using a single drop of drawn blood. New technology will allow physicians to test for up to 30 diseases from the same sample. The new screening will start in January of 2002. It would increase the Medi-Cal screening budget (38% of new births are Medi-Cal covered) from \$4 million to \$6 million

11. Major 2001 Vetoes and Suspense File Terminations

a. **AB 1279 (Reyes)** would have appropriated \$2 million to improve rural health care.

b. **SB 760 (Murray)** would have appropriated \$1 million to help medical students repay loans if they work in medically underserved areas.

c. **SB 402 (Ortiz)** would extend Healthy Families coverage to 19 and 20 year olds.

d. **SB 833 (Ortiz)** would eliminate the Medi-Cal “assets test” to deny coverage.

e. **AB 32 (Richman and Figueroa)** would have combined Medi-Cal and Healthy Families into a single, integrated system through the creation of “CalHealth.” The agency would be allocated \$1.8 billion and authority to coordinate and eliminate duplication and barriers to coverage with a stated goal of cutting the number of medically uninsured persons in the state in half. The measure would include major public health initiatives designed to reduce the expensive reliance of the states uncovered residents on emergency room treatment. The measure would require approval of a federal waiver.

12. Summary of Major Proposals for 2002–03

The most important new proposals for 2002–03 involve cuts—with health care, particularly for children, suffering major reductions. The January proposal to terminate the Child Health and Disability Program (CHDP) was retracted after it yielded a storm of protest from medical professionals familiar with the proposal's consequences to child health (see discussion of account below). However, other major cuts were maintained in May, and additional reductions were then advanced. The current proposed administration 2002–03 budget includes the following major cuts relevant to children:

a. Medi-Cal Reimbursement to Physicians Cut (\$249 million)

The January budget reduced Medi-Cal reimbursements to physicians by \$155 million. Those reimbursements were scheduled for \$800 million in increases by the 2000 Budget Act—after many years of reductions through failure to match COLA increases. In particular, the supply of specialists for children has been a growing problem, one of concern to the American Academy of Pediatrics. Rates of recompense for medical specialists treating children are often below out of pocket cost for those doctors, and are commonly a fraction of private market rates, or of Medi-Care rates payable for treatment of the elderly. The scheduled increase included a long overdue 39% rise in CCS compensation (California Children’s Services) for chronically ill children (see account below).

The May 2002 Revise then adds another \$94 million in reductions in provider rates on top of the \$155 million, for a total of \$249 million in reduced compensation for physicians treating the poor.¹²² .

An example of the extent of these reductions is provided by the most common charge—a physician office visit. The Medi-Cal compensation had been \$24, ranking the state a low 42nd among the 50 states in amount provided. But the 2002–03 cut moves it back to \$18, ranking California 48th among the 50 states. Moreover, the increase in co-pay from \$1 to \$3 moves the state to last in public subsidy per office visit—at \$15.

b. Increase Medi-Cal Co-pays (\$7.7 million)¹²³

A physician visit would increase from \$1 to \$3, and to \$5 for emergency room visits. While the amount does not seem significant, most Medi-Cal families live below the poverty line, with a large and increasing number of children living in extreme poverty (see data in Chapter 2). These families have income below \$7,500 per annum for a mother and two children, insufficient for rent and utilities plus adequate nutrition. The imposition of a \$5 co-pay will have some impact on such families in delaying the examination of a child who appears to be ill until serious harm may occur. While modest co-pays serve a purpose, and child advocates do not oppose them as applied to Health Family enrollees (who earn above the poverty line) the population here to be assessed is not an appropriate source of general fund revenue, nor are savings from fewer office visits of children that parents would otherwise bring in for examination an appropriate source of savings. Both are here proposed. It is ironic that relatively minor tax increases (see Chapter 1) are eschewed as politically unpalatable and leading to negative press, while a 300% to 500% increase in fees applicable to the poorest Californians for medical care for their children invokes neither political consequence nor media attention.

c. Reinstate Quarterly Reports (\$311 million)

The 2000 Budget Act (AB 287) eliminated the requirement that families receiving Medi-Cal submit quarterly status reports. The failure to complete this continuing paperwork obligation disenrolled thousands of families and children every year. Its elimination led to 218,000 additional persons covered. In reinstating this requirement, the state would save \$142 million¹²⁴ per annum through paperwork denial of coverage to a population in need of medical services, and for whom the alternative is either non-treatment of themselves and their children, or high cost and often delayed emergency room visits in overwhelmed public hospital trauma centers. The May 2002 Revise estimate of savings assumes that 477,450 persons will lose Medi-Cal coverage because of the additional obstacles. The Revise claims that the reimposition of the requirement will not affect child eligibility because children have one year of automatic eligibility.¹²⁵ But the elimination of almost ½ million parents from coverage will have serious implications over a one to three year period on child enrollment, as studies of the relationship between Healthy Families expansion to adults and child enrollment in that program have indicated. .

d. Delay Low Income Parents in Healthy Families Until July 2003 (\$657 million)

A recent 50 state survey found that states that extended eligibility to parents above the poverty line had nearly half the uninsured child rate of those denying parental coverage. Nearly three-fourths of the children without insurance have at least one parent who is uninsured. Most relevant, it found that low

income children with insured parents are nearly twice as likely to have health insurance as those whose parents are not insured.¹²⁶ Accordingly, the extension of coverage to parents as proposed by the Davis Administration in its federal waiver application of 1999 has direct child coverage benefits. It also has indirect benefits because a parent who is healthy and working benefits involved children.

As discussed above, the original California waiver request would have authorized coverage of parents up to 200% of the poverty line, with children eligible up to 250% of the line. The state has authorized possible coverage for parents up to 250% as well, but plans during 2000–01 included the more conservative coverage, and anticipated premiums at \$10 to \$20 per month with coverage projected at 290,000 such parents by 2002–03, after an initial start up year (2001–02) at 174,000. The estimate above is the general fund and federal funds anticipated at the second year for parents up to 200% of the line. After criticizing the federal government for its delay in approving the waiver, the Governor sacrifices the current 2001–02 year start up, and the proposed full operational spending for 2002–03, giving up \$438 million in potential federal funds in order to save \$219 million in state general fund monies.

e. Delay School Lunch/Food Stamp Medi-Cal Expansion to July 2005 (\$51.6 million)

The Governor's 2002–03 Budget Summary noted the importance of ensuring Medi-Cal enrollment for eligible low income children. It declared its commitment to "Express Lane" eligibility—the linking of Medi-Cal coverage with other programs serving the poor. Children who receive subsidized lunches or food stamps are the two populations most promisingly brought into Medi-Cal since almost all participants will qualify for Medi-Cal, and the remainder will be eligible for Healthy Families. Hence AB 59 (see 2001 Legislation discussion above) was enacted in 2001 to automatically enroll children under age six who are receiving school lunches, which should add 21,200 additional children at a cost of \$11.7 million¹²⁷ (Chapter 894, Statutes of 2001). This kind of immediate enrollment is important because a parent will often seek Medi-Cal coverage when a child needs medical help—and time is of the essence. Approval and inclusion only after a two month or two week waiting period discourages enrollment.

Less ambitious but also useful was SB 493 (see 2001 Legislation discussion above), providing that food stamp recipients were to be informed of Medi-Cal and Healthy Families availability upon each annual food stamp "redetermination" of eligibility, they are to be given notices to determine their interest, and their files are to be examined for eligibility (Chapter 897, Statutes of 2001). This linkage is projected enroll 14,900 more parents and children in 2002–03, at a cost of \$18.8 million.

The combined cost of these two programs was then increased to \$51.6 million in the Governor's May 2002 Revise estimate of the general fund cost savings from non-coverage attributable to their delay for an additional three years.¹²⁸

f. Media Advertising Cancellation for Healthy Families Enrollment/Media Cancellation for Youth Anti-Smoking Campaign (\$53.6 million)

The May 2002 Revise removes all \$18.6 million expended currently and proposed for 2002–03 for media advertising to stimulate Health Families enrollment. As noted above, every such enrollment is two-thirds funded from federal monies. While the budget continues enrollment incentive payments and other measures, the barriers to enrollment are considerable (especially the required premiums, discussed above). Re-enrollment of current children is not certain, with anticipated fall-off of from 20% to 30% of those enrolled annually. It is difficult to afford premiums of several hundred dollars when income barely makes rent and utilities and children are not then ill.

The state's goal has been advertised as complete enrollment of all eligible children, with administration congratulatory press releases as sign-ups passed the 300,000, 400,000 and to the current level of 644,000—a substantial increase, but under half of the eligible population—and partly offset by the disenrollment of Medi-Cal children as discussed above. One revealing prognostication of state policy changes are the caseload assumptions of the proposed 2002–03 budget for Healthy Families. The January budget reduces DHS and MRMB spending for the program from \$783 million to \$756

million. The May Revise subtracts \$11.4 million for 2002–03 from the Tobacco Settlement Funds allocated for Healthy Families based on a “projected caseload decline in the program.”¹²⁹ The Budget assumes the first contraction in Healthy Families enrollment since the program’s creation. That reduction appears to be in the range of 5%, or 30,000 fewer covered children. The cancellation of all media and other advertising signals a different emphasis from the state—from “enroll our children”, to “reduce enrollment and save money.”

Apart from Healthy Families, the Tobacco Settlement fund has financed media anti-tobacco education directed at youth. As discussed above, that emphasis keeps faith with the underlying litigation creating the fund. The victims were children who have been led into addiction. Spending to rectify that wrong is an important—arguably central—goal of a restitution fund under court order. While some Proposition 99 anti-tobacco ads may survive into the 2002–03 budget, the \$35 million in allocated TSF funds for that purpose was low, representing less than 10% of the fund scheduled for expenditure. However, the May 2002 Revise removed all of it—diverting the entire award to victims of smoking addiction not to harm prevention or de-addiction services or restitution, but to general medical programs previously funded from the general fund, and to direct general fund relief through the “securitization” mechanism discussed in Chapter 1. (See discussion of Tobacco Settlement Fund below).

g. Section 1931(b) Medi-Cal Program Expansion Rescission (\$184 million)

The originally January proposed 2002–03 budget included \$184 million to provide Medi-Cal coverage for two-parent working families who qualify (consistent with federal law allowing 50% federal contribution). This population currently does not qualify and its inclusion should enhance the health of parents, and stimulate additional child coverage because of the relationship between parent coverage and higher resulting child insurance inclusion, as discussed above.

h. Eliminate Medi-Cal Optional Benefits (\$526 million)

The May 2002 Revise would cut a significant \$526 million under in what the May 2002 Revise refers to as “eliminating certain Medi-Cal optional benefits.” Although not specifying which services will be eliminated, most candidates have substantial child health implications, including birth control, mental health, vision, and dental services.

i. EPSDT Reductions (\$65 million)

The May 2002 Revise reduces the state contribution for EPSDT by \$65 million, constituting most of the current state contribution. The reduction is based on the alleged “pick-up” of these costs by local authorities and managed care providers. The former lack resources for any such transfer of obligation, and the latter have an intrinsic conflict of interest given their capitated structure, in funding a public health child screening enterprise that creates new service demands and costs (see discussion of EPSDT account below).

j. Reduction in County Medi-Cal Administrative Funding (\$176 million)

The Governor proposes in his May Revise 2002 to cut general administrative funding to counties for health and human services by 20%—a remarkable contraction. The burden on other programs (CalWORKs, food stamps, child welfare services—foster care—adoptions) is discussed in Chapters 2, 3 and 8 respectively. The reduction is most severe in the health area, where the proposal would amount to a 20% funding cut, which experts predict will trigger a 30% personnel reduction. The total sum of \$175.9 million in health funding would come from local budgets and require the estimated lay-off of 1,846 local social workers administering the Medi-Cal and related health services. As a population unable to advocate for themselves, children are especially affected by the delays and obstacles created by excessive caseloads among qualifying social workers.

k. Reductions in Infrastructure Support (\$86 million)

Beyond the county administrative cuts above, the proposed budget will cut the two major accounts relied upon for infrastructure support. The Disproportionate Share Hospital (DPS) payments of the federal government are a major source of emergency room and indigent care funding for public hospitals. The proposed 2002–03 budget will increase the “state administrative share” of such federal funding needed by local hospitals by \$86 million in order to reduce general fund requirements by that amount.¹³⁰

I. Direct Federal Assistance Cut to Hospitals Serving the Poor (\$700 million)

The federal government has announced a \$400 million reduction in the \$17 billion federal contribution for California’s Medi-Cal program. The reduction is based on a federal formula that allocates part of these funds based on state per capita income. In addition, the federal jurisdiction purports to make a second cut of \$300 million—based on a federal attempt to terminate over the next eight years (by 2010) what it considers to be a “Medicaid loophole” used by some states to falsely inflate federal contribution. As discussed above, these cuts will have a devastating effect on the already reeling 73 state “safety net” hospitals.

Apart from the \$700 million in federal fiscal year 2003 reductions to California, most federal health spending is either tied to state matches—which California is allowing to limit federal contribution. Spending that is not entitlement based will remain relative static, with small adjusted reductions as change from previous years does not match population and inflation.

The major federal child related health spending for all fifty states arrays as follows:

	FY 2001 (millions)	FY 2002 (millions)	FY 2003 (millions) (proposed)
National Institute of Child Health	982	1,117	1,218
Family Planning	255	266	266
Maternal & Child Health	714	739	739
Healthy Start	90	99	99
Children’s Health Act Programs	na	13	13

California’s share is traditionally 11% to 14% of these national totals. These funds are not stand alone federal programs (such as Head Start), but are funneled to states for delivery. Most of these monies are included in the federal portion of the tables in this Chapter below. One exception is the new Children’s Health Act of 2000 which authorizes \$100 million in grants to combat youth violence, California’s share is approximately \$13 million.

An existing federal tax shelter program affords significant tax expenditures for middle class and wealthy self-employed taxpayers to use tax deductible “Medical Savings Accounts” (MSAs) for medical coverage purposes. The existing program is to be expanded on a trial basis to employee firms of any size. This program may have some benefit, but it does not extend to the children of the working poor who dominate the uncovered population. However, its demonstration program expansion alone (to employee firms of any size) is projected to cost \$5.7 billion nationally over 10 years. California’s annual pro-rata share of these foregone funds is about \$70 million per year.

In addition to these programs, the Bush Administration has proposed in 2001 a tax credit for working families to secure health insurance. The plan would provide a credit of up to \$1,000 for a low-income individual and \$500 per child up to a maximum of \$3,000 for a low-income family and would apply only to those persons without employer coverage and who are ineligible for Medicaid (Medi-Cal). One study using 2001 data and released in 2002 concluded that the insufficient amount of the credit would not allow

substantially enhanced coverage.¹³¹ Few states had plans available at that price, and most offered high deductibles—some as high as \$5,000.¹³²

In addition, the study found that coverage was extremely limited for \$1,000 policies, with office visits, annual health exams, prescription drugs, emergency services and other benefits missing or seriously deficient. No plan at \$1,000 was available at all for a 55-year-old, and a healthy 25-year-old would receive a policy with substandard coverage (below the Federal Employees Health Benefits Program) in every element except for out-of-pocket limits.

However, the tax credit here is refundable—it is fully available even where tax liability does not reach the credit amount. Further, the survey found that a standard policy was available in California at a relatively modest \$ 1,541 for a 25-year-old, and a much higher \$4,296 for a 55-year-old. The Study indicates that the tax credit may be more attractive in California than in other states, particularly if the family credit allows coverage of children—which can cost less/person, or if Healthy Families or other coverage is available for them.

However, three detriments remain. First, the addition of this yet separate program for coverage further fragments coverage and is likely to further require each member of the family to arrange coverage in separate programs. The advantage to children is maximized when parents can sign them up in the same program that applies to them (see the recent 50-state study cited above establishing such a beneficial relationship for children).¹³³ Second, here the tax credit is received after the premiums are purchased. A parent must have cash or savings to make the up-front payment for most tax credits. Third, the tax benefit must be reachable given the income of the parent. Even if children are coverable at \$500 each, coverage is problematical unless the parent can afford the extra sum needed to obtain a standard policy for herself. Where persons are earning under \$25,000 per annum in a high rent state with record utility rates, disposable income is precious. The federal plan asks parents to up-front such money for coverage at a time when nobody is ill. If the federal plan were to be increased to \$1,500 for the parent, with standard policy rates for children in the family credit, the administration proposal could have potential benefit in California for young parents and children. An alternative would be a state tax credit of \$500 per adult and \$250 per child to supplement such a federal credit, similar to the proposal of Chapter 2 for a state Earned Income Tax Credit to supplement the federal EITC.

Two problems would remain—the cost of fragmentation, and the remaining large gap between coverage costs and credit amount for older parents, with plan costs increasing to \$3,000 by age 40 and \$4,000 by age 50. These parents who earn below \$25,000 to \$30,000 will find it difficult to come up with the \$2,000 to \$4,000 needed to obtain standard plan coverage, and open the way for dependent additions. For children with parents over 35 years of age, the critical study's title—"A 10 Foot Rope for a 40 Foot Hole"—appropriately applies.

13. Summary

The chronology of health insurance coverage for children is a study in irrationality. Each new program and effort makes sense by itself, but after implementing ten, then twenty, and then fifty such steps, one looks back to view a meandering trail where the costs, confusion and inefficiency of the system exceed the cost of universal coverage. The system has an initial structure designed to keep out the unqualified—a barrier oriented system where persons are out unless they are accepted as "enrolled." That enrollment process then becomes the dominant preoccupation of the state, with different and often clever programs created *seriatim* to admit new populations. Statutes, rules, pilot programs are all created to enroll. The federal government offers substantial subsidy at 50% or 67% match. Meanwhile, the budget shortfall and the anathema of increased revenues to current public officials leads to the betrayal of years of promises to enroll all children and all needy, and to the sacrifice of hundreds of millions in federal monies.

In 2002–03 the budget will cut far more than previous reports have inferred. Measured against what was previously provided, and promised by 2003, the 2002–03 budget will be \$3.067 billion short in child related health investment in California—a profound retreat for a state with record total personal income.

This abdication does not relate to cash benefits, or even food stamp vouchers, or any benefit amenable to likely abuse. No “welfare as a way of life” approach addresses the diminution of health care coverage for children.

B. Department of Health Services: Medi-Cal

The most important children's health program—in terms of both number served and dollars spent—is Medi-Cal, California's implementation of the federal Medicaid program (Title XIX of the Social Security Act). Nationally, Medicaid covered 18.2 million, or more than one-fifth of U.S. children, in the middle 1990s: 63% of U.S. children in families earning under 100% of the poverty line, and 44% of those below 185% of the line.¹³⁴ In 1999, the number of children covered by Medicaid with family income under 100% of poverty had dropped to 53%.¹³⁵ In 1998, 49% of children were covered by Medicaid.¹³⁶

In 2001–02, Medi-Cal served 5.85 million residents, an increase of 12.3%, as the result of changes in eligibility rules and procedures (see below).¹³⁷ Regrettably, the state's data does not break out the declines in children's Medi-Cal programs or in the Section 1931 family coverage program. Doing so would significantly inform the public policy debate. We have, however, provided our own estimates, as explained above.

1. Medi-Cal Shift to Managed Care

The “managed care” concept has been authorized in California since the 1970s. The rising cost of health care through the 1980s stimulated interest in more efficiently allocating health care resources. “Managed care,” as the term is being applied to Medi-Cal, is similar in structure to health maintenance organization (HMO) set-ups. Groups of medical care providers offer a defined set of services to enrollees. Similar to the basic prepay format of HMOs or a standard insurance policy, enrollees or “members” pay a monthly fee. Charges are not based on “fees charged for services,” but are “capitated”—a negotiated, set monthly amount *per person*. The Medi-Cal type of managed care plan being paid provides or arranges for the provision of all covered medical services.¹³⁸ The theory is that the payment of compensation to providers treating the poor on a fee-for-service basis creates a false incentive to over-test, over-prescribe, over-operate, etc. Payment by procedure increases the number of procedures performed.

By paying a set amount up front, a plan will make money based on how few procedures it need provide. In theory, profits are enhanced by investing in prevention which reduces later, more costly surgeries and treatments. Prevention spending in such a system may save costs over the long run and enhance profit. However, eligible children may not be on Medi-Cal long enough for the managed care provider to realize such savings (particularly if TANF is time-limited). The low level of capitation, based on average fee-for-service expenditures, and the requirement of centralized approval over referred services, also may compel fewer services. A 1993 review by the U.S. Health Care Financing Administration (HCFA) of then-existing Medi-Cal managed care plans recommended adding fiscal incentives for delivering preventive services.¹³⁹ Concern is magnified for private for-profit plans, which spend a smaller share of their revenues on actual services than does Medi-Cal.¹⁴⁰

Put simply, while fee-for-service may provide a false incentive to overtreat, managed care provides a false incentive to deny care. It is possible to create a system where incentives correspond more closely to the medical merits of a decision, but achievement of this goal has thus far eluded public officials. Children are not powerful or articulate advocates of their own treatment, and do not self-generate check-ups, screenings, or immunizations. Although children are the most cost-effective population to screen and treat in the long run, managed care organizations with short-term profit horizons and seeking to maximize retention of the advance payments received per enrollee may not give them priority.

In 1993, California's Department of Health Services announced plans to move 2.3 million of 3.4 million Medi-Cal recipients on what was then the AFDC program in thirteen counties from fee-for-service

into managed care plans over the following five to ten years.¹⁴¹ DHS' plans have resulted in three alternative arrangements:

(1) There are five County Organized Health Systems, in which seven counties participate. Here, a single “quasi-governmental” agency arranges providers and manages a plan which all Medi-Cal eligibles must join. The ten years of experience with such a system in San Mateo and Santa Barbara counties has been extended to Solano (whose COHS also includes Napa County), Santa Cruz (in which Monterey participates), and Orange counties. About 460,000 Medi-Cal beneficiaries are in a COHS.¹⁴²

(2) Two counties use Geographic Managed Care (GMC). Under this system, the state Department of Health Services and the California Medical Assistance Commission negotiate contracts with multiple managed care plans to deliver Medi-Cal services in a county. All TANF beneficiaries must enroll with one of the approved competing plans. Operational in Sacramento since 1994, a variation of this model, with more county and local stakeholder participation in the contracting process, was expanded to San Diego in 1998. About 314,000 Medi-Cal beneficiaries are in GMC.¹⁴³

(3) Twelve counties were initially selected to participate in the “Two-Plan Model,” although one has dropped out. This option involves two competitive plans—one a publicly-run county “local initiative” and the other a commercial provider. All TANF-linked beneficiaries must enroll with one of these two plans. Those who do not choose are assigned to one “by default.” Five organizations dominate the commercial plan option: Blue Cross of California, Foundation Health, Omni Health Care, Molina Medical Centers, and California Care Health Plans. Two or more of these entities partner with each other to form the commercial plan in six of the two-plan counties. About 70% of Medi-Cal managed care enrollees—1.8 million individuals—are in the Two-Plan Model.¹⁴⁴

By September 1996, about 20% of Medi-Cal recipients had been transferred from the previous fee-for-service format; most of them were children and parents on what was then the AFDC program.¹⁴⁵ By the end of 2000, nearly half of all persons on Medi-Cal were enrolled in managed care (slightly less than 2.6 million out of the 5.2 million on Medi-Cal),¹⁴⁶ and over 69% of the managed care recipients were children. Beginning in 2000, children in all three of Medi-Cal's “percent of poverty” programs were required to enroll in managed care unless they qualified for an exemption. Thus, the disproportionate number of children in managed care is expected to grow in coming years. The attraction of children to managed care organizations is attributed to their relatively low cost and undemanding nature. Of those served by fee-for-service Medi-Cal in 2000, only 39.7% were under 21 years of age.¹⁴⁷

a. Infrastructure Loss of Clinics/Services Relied Upon by Uninsured Poor

Health experts have been particularly concerned about the impact of managed care on the state's infrastructure of clinics which provides medical services to most of the poor, including those financed through Medi-Cal, and those services provided the children of the working poor who have no insurance coverage. If these clinics are excluded as providers by the managed care organizations handling Medi-Cal business, they will lose patient volume necessary to remain viable, forcing higher rates on the working poor who remain dependent upon them and who cannot afford expensive medical services.

In March 1998, the Legislative Analyst's Office (LAO) released a report on Medi-Cal managed care's impact on rural health clinics, examining 76 of them in Fresno, Kern, San Joaquin, and Riverside counties.¹⁴⁸ The survey found the clinics to be financially viable and still able to treat uninsured patients. Most of the clinics are participating as providers, contracting with managed care organizations. Critical to this status is state law requiring Medi-Cal managed care organizations in two-plan counties to use existing safety net providers on the same terms as other similar providers under contract, and federal and state law assuring them access to cost-based reimbursement where treating Medi-Cal managed care patients. Further, many enrollees are choosing these clinics as their primary care provider within their managed care plan.

However, dangers were spotted on the horizon. The same LAO report noted that many clinics have cash flow problems because, although they have traditionally been paid by Medi-Cal within two weeks,

the managed care organization delays payment for 60 to 90 days. Of greater concern, the Balanced Budget Act of 1997 phases out the federal requirement of cost-based reimbursement of these clinics, allowing 95% instead of 100% of costs on October 1, 1999, sliding down in 5% increments to 70% of actual cost reimbursement on October 1, 2002, and terminating entirely on October 1, 2003. This danger will turn on the survival of the state statute, which continues to require full-cost reimbursement.¹⁴⁹ Without that assurance, the clinics will be unable to serve the working poor population at a reasonable cost, or may be forced out of business entirely. Finally, the LAO report focused on rural counties where Medi-Cal managed care is now expanding. As the report acknowledges, future competition with other managed care providers could eliminate the critical mass of business needed to serve other populations of children depending upon them.¹⁵⁰

Another study compared nonprofit clinics in non-rural Sacramento County with those in four other counties, which had not switched to Medi-Cal managed care during the period reviewed (Alameda, Riverside, San Bernardino, and San Francisco).¹⁵¹ The study found that the number of patients in Sacramento County's fifteen community clinics almost halved from 1993 to 1995. Annual collections from Medi-Cal dropped precipitously, from \$220,000 per clinic to \$120,000. Medi-Cal collections at counterpart clinics in other counties increased over the same period.¹⁵² Sacramento Clinic spokespersons testified in late 1997 that patient opportunity to choose them as their primary care provider was illusory, and that many of them were concerned about being compelled to close, depriving others who rely on them for needed services.¹⁵³

In addition to clinic infrastructure, hospital emergency rooms continue to be a high cost source of medical treatment for most of those lacking health insurance coverage. The California Medical Association estimated that more than 82% of the state's emergency rooms lost money in 2000, with hospitals providing \$2.96 billion in uncompensated care—much of it to children. That volume represents a 61% increase over 1998. Between 1995 and 2000, 23 California hospitals shut their doors, all based on financial losses. Currently, most trauma centers are located in private hospitals, and are able to close without warning, regardless of the consequences. The trend is in stark contrast to the huge federal investment now taking place to guard America from terrorist attacks, including alleged response to an anthrax or other bio-terror threat. The May Revision includes \$50.8 million in new federal grant funding from CDC to “support anti-bioterrorism activity,” with Los Angeles provided a separate grant. The funds are to “upgrade infectious disease surveillance and investigation, and enhance the readiness of hospital systems to deal with large numbers of casualties.”¹⁵⁴ The money does not restore capacity but is allocated to planning and readiness assessment (38%), surveillance and epidemiology (21%), biologic lab (13%), communications (18%), and education (10%). It is unclear how public safety will be accomplished from such spending given the coextensive closure and retraction of substantial trauma center and clinic capacity, with the Los Angeles collapse of particular concern, as discussed below.

Two accounts have special significance for the maintenance of the clinic infrastructure relied upon by the 1.1 million medically uncovered children: the DSH (Disproportionate Share Hospital) account which compensates hospitals who treat a high number of uncovered/impoorished patients, and the EAPC (Expanded Access to Primary Care) Program, that funds community clinics. The EAPC account receives only \$31 million, and a “trauma support” addition of \$30 million was reduced to \$25 million in the current year, and is not proposed for 2002-03.¹⁵⁵

The proposed 2002–03 budget will add an extraordinary \$86 million to the state's “administrative fee” for DSH administration—a sum to be subtracted from DSH monies normally going to hospitals serving insurance uncovered patients.¹⁵⁶ Needless to say, the state is not spending another \$86 million on the administration of the DSH program, it is using these funds to reduce the general fund. The money comes from hospitals overburdened with demand from Medi-Cal covered persons paying under-cost remuneration, and more seriously by uncovered working poor parents and children. These patients are seen in ER settings, often after simple and inexpensive earlier intervention would have sufficed. A study published in 1992 found that the number of patients treated in emergency rooms increased 27% from 1990 to 1999, while the number of state emergency departments dropped from 407 to 357, a 12% decrease. Interestingly, the study found that the largest increase was in legitimate emergency and urgent care visits.¹⁵⁷

Related to inadequate DSH revenues and EAPC help are three other challenges to existing infrastructure: the loss of an assured critical mass of patients in some areas due to managed care capture tying previous patients to other providers, the loss of \$700 million in federal Medicaid money that largely goes to hospitals providing emergency help (discussed above), and the retraction in promised Medi-Cal compensation rates—funds needed by hospitals and clinics to use to cross subsidize those without any coverage—a cross subsidy which is impossible where the Medi-Cal rates themselves are below cost.

b. The Prospective 2003–05 Collapse of the Los Angeles Health Infrastructure

Almost one-third of California's impoverished children reside in Los Angeles County area, by far the largest concentration in the state. In January 2002, Los Angeles County Department of Health Services Director Fred Leaf proposed a series of cuts that he believes will "lead to virtually dismantling the public health care system"¹⁵⁸ relied upon by 3.2 million poor and uninsured persons. Leaf reported to the Board of Supervisors that his attempt to save funds by sending patients to low cost clinics has failed. Over the last six years, Los Angeles has received bail out money from the state and federal sources—with federal funds amounting to \$2.2 billion over this period. The shut-downs proposed are serious, no funding as an alternative is available and as discussed above, counties are under severe financial pressure due to the assessments and takings of the state for 2002–03, ranging from CalWORKs incentive funds to DSH administrative fees. Counties have no viable revenue resources to draw upon and lack the power to tax, particularly given Proposition 13 limitations.

The multi-phase plan would include in phase one the closing of five public health clinics in North Hills, Burbank, Los Angeles, Paramount, and Compton. In addition, 100 administrative positions would be eliminated. The inpatient rehabilitation facility at High Desert Hospital would be closed. The second phase of the shut down includes four options: (a) privatization of all 120 existing clinics— thus allowing them to demand payment or turn away patients and allowing treatment only in "serious situations." (b) Closure of all public hospital emergency rooms, with only one or two remaining open while relying on urgent care clinic help. (c) Closure of all clinics except for a narrow range of vital services." (d) Closure of all clinics while maintaining all emergency rooms, with public medical services confined to emergency—trauma care and similar vital services.

The plans for Los Angeles are serious, and have not received commensurate media or public official attention. The changes threaten to reduce the largest population of children and parents in the state to a health care comparable to that in third world countries with a fraction of the per capita personal income of California.

On January 30, 2002, the Board approved the closure of the first five clinics, but most of the projected \$688 million deficit for county health services remains unaddressed, and the County will likely be forced to choose among the four "worst case scenarios" presented by Health Director Leaf. The federal bail out funding is being phased out and the Department faces a \$364 million deficit in fiscal 2004 and \$688 million in 2005.

On June 18, 2002, the Board of Supervisors voted to close High Desert Hospital, converting it to a limited clinic. It also voted to close 11 of the 18 county operated clinics, and 6 clinics in the school system serving impoverished youth. The County Department of Health Services, directed now by Thomas Garthwaite, also will reduce its contracts with private clinics by 25%. Combined, these changes are projected to save the County \$158 million during fiscal 2002–03. In October 2002, the County will fact the closing of inpatient facilities at Harbor-UCLA Medical Center (one of the most important providers of care in the region), and similar closure of Olive View. Also up in October will be privatizing Rancho Los Amigos Medical Center and closing almost 100 private outpatient clinics under County contract. Those changes would save an estimated \$259 million. However, as the deficit numbers above indicate, still other cuts would have to be made in 2004, and yet more in 2005. The Los Angeles situation promises—and is witnessing—the substantial dismantling of basic medical care for the uninsured, substantial emergency treatment capacity failure, and facility/provider access difficulties for those covered in publicly subsidized programs.

The desperate straits confronting infrastructure failure in Los Angeles is exacerbated by state legislative avoidance. The failure of the state to address the problem makes the federal withdrawal of help politically possible—the Bush Administration is able to argue that it should not be relied upon to salvage a county's health care system where its own state has not stepped forward to help.¹⁵⁹

c. Medi-Cal Managed Care Access and Service for Children

Some of the problems in implementing Medi-Cal managed care were predictable given the enormity of the transition involved. Managed care organizations had to organize thousands of providers to provide a coherent supply of medical services for a large population, including many new patients. But other problems were inherent in the “incentive not to treat” structure. Problems encountered in Medi-Cal's transition to the Two Plan Model in the mid-1990s and again in 2000 during the conversion of the children's “per cent of poverty” program enrollees into managed include the following:

- ◆ failure to be ready to provide care for potentially assigned patients;
- ◆ because of the above, the “default” enrollment of many beneficiaries in plans geographically far away, or lacking needed services;
- ◆ failure to process enrollments in a timely manner, leaving many in limbo;
- ◆ misleading descriptions of services offered by respective plans;
- ◆ enrollment in the wrong plan;
- ◆ loss of care from physicians familiar with patients; and
- ◆ failure to disenroll a beneficiary who is in the wrong plan.

The disorganization was illustrated in evidence produced by a public health expert in 1997, citing an example from Los Angeles: “A grandmother in San Pedro (Los Angeles County) cared for her six grandchildren. Although she had not received enrollment packets for any of them, she did receive default assignment notification. The children were assigned to a plan, provider and hospital in Pasadena; dental care in El Monte; vision care in Laguna Niguel (Orange County); and pharmacy services in Rancho Cordova (near Sacramento).”¹⁶⁰ Lynn Kersey of the Maternal and Child Health Access Project in Los Angeles has numerous examples of disenrollment difficulties. Capitated payments continue based on enrollment levels, creating a disincentive to timely disenrollment, and a child cannot shift to a needed plan or provider until the former plan disenrolls the family. When simply moving across county lines with different managed care organizations, the previous organization will often delay disenrollment, leaving families without coverage for months after moving. Kersey's testimony before the Assembly Health Committee in late 1997 cited examples of nightmare bureaucracy, requiring in one case 46 calls over 42 days to disenroll a family to receive needed coverage elsewhere.¹⁶¹ Difficulties were again documented by MCH Access and the Western Center on Law and Poverty in 2000 when the children's programs were converted to managed care.

Child-specific concerns include the following:

- ◆ The treatment of child-related and preventive CHDP and EPSDT services (see below); how likely is a managed care plan to screen children and affirmatively look for treatment needs?
- ◆ The treatment of California Children's Services (CCS) recipients (see below). These chronically ill beneficiaries cost much more per capita than the capitated rates allow; will they be avoided by providers who would rather “skim the cream” of low-cost beneficiaries?
- ◆ In two-plan counties, will the commercial entity seek to enroll all low-cost populations, and leave children with disabilities or problems in the county-run program together, with the high-

cost elderly likely to advocate more effectively for attention?

- ◆ Where a child is denied treatment or is assigned to the wrong plan, what is the appeal mechanism? Is it accessible? Expeditious? Fair?

The two- (or more) plan model is intended to ameliorate some of these fears by allowing recipients to choose between managed care organizations presumably competing for their capitated membership. The Balanced Budget Act of 1997 includes information disclosure requirements designed to stimulate informed choice and competition to counter the up-front payment's disincentive to provide services. The option failing to perform will not be chosen by recipients. But partly because of the newness of the choices and allegedly because of inadequate information accessible to Medi-Cal recipients, a large number did not choose during the major transitions to Medi-Cal managed care in 1999 and again in 2000 and were assigned instead to a "default" alternative. This "default rate" in 1999 was lowest in Alameda County at 19%, but Contra Costa, Fresno, San Bernardino, San Joaquin, Santa Clara, and Stanislaus counties had rates above 40%, and Kern's rate was 70%. The lack of consumer education in Los Angeles County led the U.S. Health Care Financing Administration to halt automatic default assignments in that county during 1997 (they have resumed as of 1998).¹⁶²

Managed care critics received some empirical support from a 1997 study based on a sample of focus group interviews of low-income women. Those surveyed complained of lack of coverage, stated that copayment obligations delayed or prevented care, expressed a fear of blockage to specialists, and reported the lack of a preventive health approach. Transportation costs for women in rural areas was a major impediment—with managed care limiting the range of providers available.¹⁶³

A 1998 study ties managed care to an increase in prescription drug related deaths, concluding that medication prescription and dosage errors doubled between 1983 and 1993 in hospitals, and increased more than eight times among outpatients. The report attributes the growth of outpatient incidence and error rates to managed care's general antipathy toward costly hospital stays, noting the high number of patients released early in managed care settings to deal with their own drug delivery during critical post-operative periods.¹⁶⁴

In addition to profit incentives for private managed care organizations and providers, treatment denial may also be driven by lower capitation rates provided by Medi-Cal for persons who enroll. The less money collected, the less available for services even if no profit is extracted. In that regard, the capitation rates paid by Medi-Cal to the respective managed care providers have not matched inflation, and some have suffered extraordinary reduction. For example, LA Care—the Los Angeles local initiative—lowered Medi-Cal capitation rates from \$102 per month to \$75 per enrollee in 1997.¹⁶⁵ However, rates for Two-Plan Model plans were increased by 9% in 2001.¹⁶⁶

The "two-plan model" used by twelve counties involves one private managed care organization and one public entity. The latter is under pressure to provide services at capitation rates below levels charged by public providers (which may have unavoidable and expensive enrollees and obligations). Where public providers are efficient and need not provide any return on equity, a private provider with debt or dividend obligations who underprices may be compelled to deny or cut services in order to remain viable. Even without that pressure, the natural incentive to extract maximum profit may lead private organizations or providers to extract it the only way possible where there is an effective capitated price ceiling—by cutting costs and denying services.

d. Medi-Cal Enrollment Failure/Barriers

Using March 2000 Current Population Survey data, which are based on information collected in 1999, experts estimate a total of 726,000 Medi-Cal eligible children were not enrolled for coverage in 1999.¹⁶⁷ This is a slight improvement over 1998, but still about the same rate of child uninsurance as in 1996 when California had not yet fully recovered from the recession of the early 1990s.¹⁶⁸ Few of these children are in families who can afford the cost of serious illness; most have dubious contact with a primary physician, and unlikely preventive care. Much of the problem since the enactment of federal

welfare reform in 1996 has come from parents declining to enroll in TANF and the dearth of campaigns to educate low-income communities and providers about Medi-Cal eligibility for children and parents not on welfare. Another aspect of the problem has been families leaving TANF rolls and not retaining coverage for their children although qualified, either because they do not believe they are qualified, do not think they will need coverage, or are not informed of their eligibility and otherwise helped by caseworkers upon TANF exit. As discussed above, this problem is of special concern given the evidence that large numbers of those leaving TANF rolls are not achieving incomes above the poverty line (see data in Chapter 2) Even where such income is obtained, virtually all the children in these families are eligible for either Medi-Cal or Healthy Families. And as also discussed above, the high number of immigrants withdrawing their children from coverage is caused by fear of deportation (where undocumented) or fear that participation in public programs will jeopardize their chances for citizenship.

In addition to these barriers, three others act to block higher Medi-Cal coverage rates for children: simplification, deductibles, and outreach.

(1) Simplification

Access is inhibited to some extent by the complexity of a separate, “add-on” Healthy Families program for children, with separate qualifications and costs, particularly when qualification changes based on the age of children, and independently on family income—both of which alter over time. Rather than integrating children’s health coverage into a single, seamless system, the state has required a “joint” application for both systems to meet justified criticism of undue and separate paperwork, and allows applications to be submitted by mail instead of via in-person line wait. The combined application form initially drawn was 28 pages long and not easy to complete even for those who understand English well and have no disability. The combined application was simplified to a five-page form during 1999, which is still intimidating to many. Moreover, as discussed below, Medi-Cal is actually over twelve different programs, most of which have their own separate criteria. Children will qualify under one program, then lapse and perhaps qualify under another—depending upon the age of the child, income of the mother, CalWORKs status, and other factors which constantly change. The “incentive payment” of \$50 for each application that an “assistor” succeeds in having processed, regardless of the number of individuals in a household applying with one form, may not be sufficient to facilitate desired enrollment of children in such a setting,¹⁶⁹ especially when problems develop that may take a lot of time to address, as is the case with applications rejected as incomplete: incomplete applications, including those with insufficient documentation, make up 41% of rejected applications, the most common reason for rejection by far.¹⁷⁰ Too few of the available resources have gone to non-profit community-based organizations as grants to sustain their efforts at outreach, education, application assistance and follow-up for problem-solving to ensure enrollment.

Last year, significant progress was made toward alleviating some of these problems. Effective January 1, 2001, children in Medi-Cal will be covered continuously for 12 months.¹⁷¹ This important reform should not only greatly improve Medi-Cal retention for children, but it also aligns Medi-Cal with Healthy Families for children, which has provided 12-months continuous eligibility since its inception in 1998. The proposed budget for 2001–02 allocates \$134.8 million from the General Fund to improve continuity of coverage and care for the state’s lowest income children. As a result of this reform, it is expected that 369,000 more children will have Medi-Cal each month.¹⁷² The Governor’s support for the measure came only after widespread embarrassing media reports that California was about to lose hundreds of millions of unspent federal SCHIP dollars that had been provided to the states at very generous matching rates for children’s health insurance and after HCFA announced in July 2000 that states would not be permitted to use SCHIP funds for parental coverage (discussed below) unless they had demonstrated significant progress in child health enrollments.

Also starting January 1, 2001, California has eliminated quarterly status reporting for all Medi-Cal programs.¹⁷³ This means that Medi-Cal program participants will no longer have to essentially re-apply every three months to keep their coverage; failure to submit the quarterly reports has long been a major reason why so many individuals lost their insurance coverage during any given year. Implementation, however, may be complicated by the state’s failure to date to issue uniform guidelines to the counties

about what kinds of changes Medi-Cal program participants will have to report under the longstanding ten-day “change reporting” rule, which has been retained (although it no longer applies to children, who will enjoy twelve months of continuous eligibility, regardless of changes in family income.) Overzealous implementation of “change reporting” at the county level by requiring, for example, a report for every extra nickel earned would completely undermine the intent of this reform. The proposed budget for 2001–02 provides \$71 million in General Fund for Medi-Cal coverage for the approximately 218,000 adults who are expected to keep their Medi-Cal now that they have been relieved of the unnecessary paperwork requirements of the quarterly reports.¹⁷⁴

The third major Medi-Cal program development, which will take effect by July 1, 2001, improves the process for allowing eligible individuals to keep Medi-Cal when eligibility on one basis ends. This applies to all Medi-Cal programs. In just one of many possible examples, a family leaving TANF will stay on Section 1931(b) Medi-Cal unless the county has specific facts to show that its Medi-Cal case should be transferred to another program, such as Transitional Medi-Cal, or that there is no basis under Section 1931 or any other Medi-Cal program, including the one for disabled persons, to continue eligibility. The new measure clarifies how California will implement longstanding federal redetermination law in the aftermath of welfare reform, and will likely have the greatest impact on the large number of cases where the reason a family is dropped from TANF is its failure to send in the monthly TANF reporting form. Many parents who get jobs “communicate” their wish to leave welfare in this way. Since eligibility for cash assistance is no longer a requirement for any Medi-Cal program (see above), losing TANF for failure to meet a TANF reporting requirement means nothing for Medi-Cal eligibility.¹⁷⁵

The new procedures clarify that even when counties have information indicating that an individual no longer meets a condition of eligibility for the Medi-Cal program in which he or she is currently enrolled, coverage must continue until the county has facts to show that eligibility does not exist on any other basis. For example, when a five-year old child turns six during her twelve-month period of continuous eligibility, she must be continued on the 100% program for older children at her annual review; only if the county has facts showing that the child’s family exceeds 100% of poverty and that she does not qualify for any other Medi-Cal program, including those for individuals with disabilities, may Medi-Cal be ended. Moreover, the county may not require the individual to come forward with information showing the alternative basis for eligibility until after the county has conducted its own review of all information readily available to it, such as the information in a family’s closed TANF file or in a child’s open Food Stamps case. Only when it is not possible for the county to obtain sufficient information from such sources may the county require the individual to respond to a request for specific information concerning Medi-Cal eligibility. Finally, individuals must be informed of the opportunity to claim disability as the basis for Medi-Cal eligibility, and new procedures for beginning the Medi-Cal disability review process when necessary at redetermination will be adopted.¹⁷⁶ The proposed budget for 2001–02 estimates that 15,790 adults will benefit from these new measures, at a General Fund cost of \$9 million.¹⁷⁷ The relatively small number of persons estimated to be affected accurately reflects that fewer individuals will need to invoke the improved redetermination process since children will enjoy twelve months of continuous eligibility and adults will no longer face termination every three months for failure to submit quarterly status reports.

Starting March 1, 2000, parents became eligible for Medi-Cal with family income up to 100% of poverty (up from the former 70% limit), and a rule that had barred many two-parent families was dropped (see discussion above). To implement the 100% program for two-parent families, the proposed budget for 2001–02 provides \$123 million in Tobacco Settlement Funds, to draw down a like amount in federal match, for a total of \$245.8 million.¹⁷⁸ By the end of 2000, 99,400 adults were enrolled in Medi-Cal under this program, and an additional 149,400 enrolled in 2001–02.¹⁷⁹

The current budget for 2001–02 estimated that the Medi-Cal caseload will grow 12.3%, from 5.2 million to 5.85 million. In contrast, state population is expected to increase only 1.73% during 2001–02. The budget proposal attributes the significant projected Medi-Cal caseload growth to the simplification measures described above.¹⁸⁰ The enrollment growth occurring due to these incremental measures (as well as the express lane and continuous coverage measures implemented in 2001-02 and described) above, empirically correlate with additional enrollment.

(2) Deductibles and Asset Tests

A further and critical disincentive to Medi-Cal enrollment are high deductibles for families who are close to the qualifying poverty line (applicable to California's "Medically Needy" Medi-Cal category). The system sets a "maintenance income need level" (MINL) above which a monthly "share of cost" is imposed; Medi-Cal coverage begins for services received in a month only after the share of cost has been incurred. The MINL has not been raised with inflation for over ten years. As a result, a family of four with \$16,450 per year in income will have to pay the first \$271 (for adults or children 6 through 19 years of age in what is still referred to as the AFDC-MN program) in medical expenses incurred each month as a "deductible." Medi-Cal only picks up the excess. For many families, this feature makes Medi-Cal not a source of insurance coverage, but a kind of medical disaster plan—with enrollment put off until a disaster requires coverage. The MINL deductible amounts can and do discourage enrollment. Moreover, for those who are enrolled, it limits the effective use of the program for children. While the copayment per visit properly limits visits with every minor symptom, imposition of high deductibles undermines the early detection and treatment of children which is cost-effective to society.

The Western Center on Law and Poverty contends that in an average month as of 1999, 22,780 disabled persons, 71,721 poor families, and 63,032 medically indigent children, cannot meet their share of required monthly Medi-Cal cost ("monthly deductible"), hence, they "cannot access health care unless they or their families suffer a medical catastrophe or otherwise become destitute."¹⁸¹ Effective January 1, 2001, aged, blind and disabled persons will no longer have any deductible at all in the Medically Needy program if their income is at or below 133% of poverty, as opposed to about 70% under the previous law.¹⁸² The proposed budget for 2001–02 allocates \$141.1 million, of which \$47 million is from the Tobacco Settlement Fund, for this new program, to benefit 52,800 aged, blind and disabled persons a year.¹⁸³ If permitted to go into effect by the Bush administration, a new federal regulation would make federal matching funds available for this program,¹⁸⁴ so that California could finance half the cost with federal funds in the future. The new federal option is not limited to the aged, blind and disabled, but could be used for family coverage as well in Medi-Cal's AFDC-Medically Needy program.

Perhaps more timely for 2002–03 is the failure of the Davis Administration to support the elimination of asset tests for Medi-Cal benefits. The paperwork and proof necessary to establish virtually no assets is another unnecessary barrier to coverage. Few families with total income of under \$15,000 per year have considerable liquid assets available. SB 833 (Ortiz) would have eliminated the Medi-Cal "assets test" to deny coverage, but was killed due to administration opposition.

(3) Outreach

The Governor's 2001–02 budget spent \$69.2 million on Healthy Families outreach alone through DHS; the 2002–03 budget reduces that amount to \$28.9 million. As listed above, the retractions in both Healthy Families and Medi-Cal outreach are significant—with all HF media advertising eliminated, express lane enrollment delayed, and funding cut.

As outlined above, these and additional millions devoted to outreach, paperwork, filtering, qualification, premium collection, *et al.*, could be used to instead simply cover all California children for preventive and basic primary care, with assessment of families with income over 300% of poverty to pay for the cost of expensive services on a sliding scale *post hoc*. Available federal funds plus substantial savings from this approach would then finance a tax credit to employers who provide child dependency coverage for their employees whose families are below 300% of the poverty line, and for those parents who buy coverage for their children on the private market. As argued above, we currently expend many millions of dollars to filter out the under 6% of California's children who are now uncovered and unqualified for public coverage. The automatic qualification of all children (with *post hoc* collection where justified) would confer great social benefit, allow for the optimum use of available federal funds, eliminate non-coverage as a problem, and save millions of dollars wasted in the current child by child enrollment travail. The balance of covered versus uncovered and qualified versus unqualified has now reached the point where the cost of barring the 5.7% who may not be eligible exceeds the cost of their

coverage. At that point, a shift from presumptive exclusion to presumptive inclusion is sound public policy. Indeed, the alternative—currently being pursued—is irrational.

2. Overall Medi-Cal Account

Starting in the 1980s, Congress has expanded Medicaid eligibility to include additional segments of low-income children and pregnant women. Pregnant women and infants to 185% of the federal poverty line (FPL) have been covered since July 1989; children between the ages of one and six in families with incomes to 133% of the FPL have been covered since April 1990; and since July 1, 1991, all states must cover children under age 19 born before September 30, 1983, if the family income is at or below 100% of the FPL.¹⁸⁵ Since October 1989, California also has covered pregnant women and infants between 185% and 200% of the FPL—using state Proposition 99 tobacco tax money under Medi-Cal (although this group does not receive federal financial participation (FFP) under Medicaid).¹⁸⁶ The big increase in children on Medi-Cal in the early 1990s was due to increasing poverty, as well as expanded eligibility for low-income children. Accordingly, as Figure 4-A indicates, the 2.2 million persons under 21 years of age enrolled in Medi-Cal in 1990 grew to 3.07 million by 1995. However, the economic recovery, and more critically, flight from coverage by lawful immigrants, and the failure to enroll those declining to enroll in TANF or leaving TANF rolls—most of whom remain eligible for Medi-Cal, has led to a decline in Medi-Cal enrollment since 1996, to approximately 2.8 million as of October 1999 (see Figure 4-A).

Medi-Cal benefits for children are extensive under the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, which mandates preventive and diagnostic screening services and treatment for any condition discovered by a covered screen. Federal law (the Omnibus Budget Reconciliation Act of 1989, or “OBRA ‘89”) requires EPSDT coverage of any of the allowed optional services permitted under federal law, regardless of whether it is regularly covered by the state’s Medicaid program for adults. California provides EPSDT screening services under the state’s Child Health and Disability Prevention (CHDP) Program, which also covers preventive services for an expanded pool of low-income children using state money (see below for discussion of CHDP).

As Medi-Cal enrollment (adult and child) increased during the early to mid-1990s, costs of the overall program also increased. The biggest spending jump occurred in 1991–92 due to a change in accounting methods that has been estimated to have added perhaps \$1 billion each to the general fund and federal fund accounts that year. Increasing costs during the early 1990s also reflected increases in the number of poor children, the expansion of the program’s eligibility standards, and DHS’ efforts to maximize the number of persons qualifying for Medi-Cal—who would otherwise be served by other state programs using state-only dollars.

The federal share of Medi-Cal has risen much faster than the state share as California, like many states, has tried to maximize the federal funds pulled down for the program, including greatly increased federal payments for Disproportionate Share Hospital payments (inpatient adjustment), to help support sites providing more services to Medicaid and indigent patients.¹⁸⁷ After 1995, both the numbers of persons covered by Medi-Cal and budgeted monies have somewhat leveled. The scheduled federal match ratio for Medi-Cal spending in 2001–02 is 51.40%.

a. California Per Person and Per Child Medi-Cal Costs

Rapidly rising Medicaid costs in the early to mid-1990s became the targets for both state and federal cost control attention. However, California’s large Medi-Cal bill is due to its large population of poor people rather than to extravagant payments. In the early 1990s, California’s per capita costs were below the national Medicaid averages, and children receiving Medi-Cal cost substantially less than the national Medicaid average.¹⁸⁸ In 1998, the average national annual cost of a child on Medicaid was \$1,555; the average California Medi-Cal child cost \$1,021. The average national cost of an adult (age 21–64) on Medicaid was \$5,006; the average California adult (age 21–64) on Medi-Cal cost \$2,928. See Table 4-A. In 1998, California served the highest percentage of state residents—18.9% compared to the national average of 15.3%—but had the lowest average annual cost per eligible—\$2,693 compared to the

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national average of \$3,895.¹⁸⁹

	Budget Year					Estimated 2001-02	Proposed 2002-03	Percent Change	
	1989-90	1997-98	1998-99	1999-2000	2000-01			'89-'01	Proposed
General Fund	\$3,489,321	\$6,825,673	\$7,536,090	\$8,135,268	\$9,233,306	\$9,796,003	\$10,163,332	180.7%	3.7%
Prop. 99 (Tobacco Tax)	\$12,007	\$72	\$114	\$74	\$0	\$0	\$0	-	0.0%
Cnty Adm in Claiming Fund	\$0	\$5,890	\$0	\$0	\$0	\$0	\$0	-	0.0%
Emerg. Svc. & Sply Pay Fund	\$0	\$442,718	\$533,699	\$616,329	\$671,387	\$669,617	\$688,902	-	2.9%
Inpatient Adj't Fund	\$0	\$1,205,576	\$1,190,191	\$1,233,746	\$1,030,775	\$1,028,288	\$993,056	-	-3.4%
Other	\$339,239	\$9,319	\$3,287	\$4,222	\$3,424	\$188,303	\$156,219	-44.5%	-17.0%
SLIAG	\$36,482	\$0	\$0	\$0	\$0	\$0	\$0	-	0.0%
Fed. Trust Fund	\$3,627,655	\$10,023,496	\$11,151,639	\$12,207,396	\$13,584,156	\$15,344,897	\$15,207,173	323.0%	-0.9%
Total	\$7,504,704	\$18,512,744	\$20,415,020	\$22,197,035	\$24,523,048	\$27,027,108	\$27,208,682	260.0%	0.7%
Adj'd Total	\$13,461,938	\$21,656,208	\$23,095,512	\$24,216,965	\$25,675,631	\$27,027,108	\$25,864,573	100.8%	-4.3%

Dollar amounts are in \$1,000s. Sources: Governor's Budgets.

Adjusted to CPI-Med (2001-02=1.00). Adjustments by Children's Advocacy Institute.

TABLE 4-D. Medi-Cal

From 1993–94 through 1995–96, although about 55% of Medi-Cal fee-for-service (FFS) recipients were under age 21, they used only about 26% of the program's benefit dollars.¹⁹⁰ The Urban Institute's analysis of 1993 HCFA data reported that California children comprised 47% of beneficiaries but used only 15% of total expenditures.¹⁹¹ Nationwide, children under age 21 comprised 49% of all beneficiaries but used 16% of Medicaid's expenditures.¹⁹² These ratios are typical of the relatively low cost of children to cover, commonly cost one-third to one-fifth per person of an adult. They cost less than one-tenth the per person annual cost of the elderly subject to Medi-Cal and Medicare system benefits.

As noted above, the fee-for-service cost per recipient is shifting in importance to the managed care capitated rate now capturing about 52% of the caseload.¹⁹³ However, the fee-for-service allocations by type of patient and procedure outlines costs normally hidden in the provision of capitated services where costs are grouped. The itemization of those costs in the fee-for-service setting to 2000 affirms that children receive a small per capita share of public spending as compared to adults, or as compared to children in other jurisdictions.

The numbers suggest that increased spending for children from Medi-Cal comes from caseload changes, not alteration of costs per child. As described above, Medi-Cal data show that the average cost per eligible for every eligibility category that includes children (even those including infants) is substantially less than the overall state average. The main Medi-Cal eligibles other than children (and their parents) are the aged and disabled—two very high-cost medical care users. In 2000, for example, the average monthly Medi-Cal cost for adults on TANF was \$125, compared to \$5,310 a month for a disabled person in long-term care.¹⁹⁴

	Budget Year					% Change '89-'97
	1989-90	... 1993-94	1994-95	1995-96	1997	
Expenditures	\$6,020,190	\$10,024,294	\$10,280,386	\$9,781,913	\$10,057,984	67.1%
Users	18,525,165	26,780,738	28,151,266	27,335,412	25,582,568	38.1%
Eligibles	37,774,230	57,753,888	58,951,902	58,018,200	43,847,465	16.1%
Cost/User, monthly avg.	\$324.97	\$374.31	\$365.15	\$365.11	\$393.16	21.0%
Cost/Elig., monthly avg.	\$159.37	\$173.57	\$174.39	\$174.35	\$229.39	44.0%
Adjusted \$/User	\$504.03	\$431.95	\$401.67	\$386.58	\$393.16	-22.0%
Adjusted \$/Eligible	\$247.18	\$200.30	\$191.83	\$184.60	\$229.39	-7.2%

Dollar amounts are in \$1,000s except per case per month as noted. Adjusted to CPI-Med (1997=1.00). Source: DHS. Adjustments by Children's Advocacy Institute.

TABLE 4-E. Medi-Cal Fee-for-Service Expenditures per Eligible

There has been some overall and per person decline in Medi-Cal “fee for service” accounts since 1989 (see Table 4-E). However, there is a per person increase for 1997; according to some experts, this reflects the start of managed care implementation, and indicates the “skimming of the cream” danger of its critics, *i.e.*, managed care plans attempt to market to and recruit low cost populations where service demands will be minimal, while leaving high cost populations (chronically ill, elderly) to fee-for-service. Their thesis has been a likely increase in per capita fee for service costs, and 1998–2000 data seems to confirm their critique.

b. Reimbursement Rates

Current federal Medicaid law requires that state plans set provider reimbursement rates to guarantee provider participation so that Medicaid recipients have choices comparable to those available to an area’s general population. Medicaid reimbursement rates are set well below usual provider rates.

In 1992, a federal district court held that DHS acted “arbitrarily and capriciously” in setting six Medi-Cal reimbursement rates for outpatient services at inadequate levels (*Orthopaedic Hospital v. Kizer*). The federal Balanced Budget Act of 1997 allowed for the phase out of cost-based reimbursements, and a phase out was scheduled to begin in October 1999 to allow states to “decrease payments from 100% of costs to 70% of costs” by 2003. Thus far, California has not reduced rates, aware that their extant inadequacy made such cuts unrealistic. The 1998–99 budget increased physician reimbursement rates, the first increase in twelve years. These raises amount to 20% for pediatric preventive and primary care. However, these increases compensated for about one-half of the inflation decline from 1986, and still left California well behind rates paid by the private sector, and even well under Medicare rates. In April 1999, DHS and the Medical Assistance Commission agreed to incorporate the fee for service increases into Medi-Cal managed care rates. In the 1999–2000 budget, small and scattered increases were approved: 5% for CCS services (discussed below), and small increases for surgery, anesthesiology, radiology, and optometrist services.

Even after these increases, Medi-Cal reimbursement rates, both for fee-for-service patients, and as reflected in capitated rates for managed care, were still among the lowest in the nation. According to a March 2000 report, Medi-Cal fee-for-service office visit payments, for example, are typically 40% of typical market (or Medicare) charges.¹⁹⁵ Moreover, the average annual expenditures per Medi-Cal covered child in 1997 was \$907, while the national average reflecting rates more in compliance with the federal statutory “adequacy” mandate, was \$1,517.¹⁹⁶

Medi-Cal rates have been so low that provider supply has declined. Only 31% of physicians would accept Medi-Cal patients as of 1994. Fee-for-service rates rank 47th in the nation, and capitation rates for the majority now in managed care were at the very bottom of the nation as of 1999.¹⁹⁷ Reimbursement rates are a fraction of common veterinarian charges for similar procedures on animals.¹⁹⁸ It is against this background that the rate increases adopted in 2000–01 must be assessed:

physician rates were increased 15.6%, reimbursements for primary care to children were increased 9.1%, and rates for some emergency room services went up 40%.¹⁹⁹ Hospital outpatient reimbursement rates were increased by 30%. These changes amount to over \$500 million per year in additional costs, but the degree of state undercompensation is such that expenditures per covered person remains near the bottom of the nation.

Moreover, Medi-Cal providers are able to survive only by processing large numbers of patients. Historically inadequate rates combined with daunting paperwork billing requirements have reduced the supply and quality of medical services for California’s poor.

3. Early Periodic Screening, Diagnosis and Treatment Program (EPSDT)

The independent EPSDT account allows monitoring of public spending on the major account in the child health area. As Table 4-F indicates, per capita spending on basic preventive services for children (medical screenings through EPSDT) has declined over the same period. The American Academy of Pediatrics has found that preventive services are particularly cost-effective for children.²⁰⁰ However, Table 4-F shows that spending on EPSDT screenings, when adjusted for inflation and caseload, has also declined since 1989–90. Data after 1998 is not comparable because of the increasing domination of caseload by managed care providers, as discussed above.

	Budget Year					Percent Change	
	1989-90	1994-95	1995-96	1996-97	1997-98	'89-'96	'96-'97
No. EPSDT Screens	1,025,371	1,667,235	1,750,708	1,729,712	1,726,252	68.7%	-0.2%
Screen Fee	\$53.36	\$61.21	\$61.88	\$62.50	\$62.50	17.1%	0.0%
Total screenings cost	\$54,714	\$102,051	\$108,334	\$108,107	\$107,891	97.6%	-0.2%
Adjusted Total	\$139,745	\$115,945	\$114,034	\$108,107	\$104,961	-22.6%	-2.9%

Dollar amounts are in \$1,000s except per screen as noted. Sources: Governor’s Budgets, DHS. Adjusted to number of screens and CPI-Med (1996-97=1.00) Adjustments by Children’s Advocacy Institute.

TABLE 4-F. EPSDT Screenings Costs

State budgets after 1999 do not separate out EPSDT to allow comparison with prior levels. The appropriations theoretically follows the number of screens, which are theoretically conducted based on public health merits. The 2002–03 budget, as revised in May 2002 would subtract from the EPSDT budget of the current year \$65 million to “reflect the reduction of the State’s share of the cost of growth.”²⁰¹ The shift indicates delegation of EPSDT financing from state funding to managed care take-over. That change is problematical for the public health/detection/diagnosis purposes of EPSDT. The child beneficiaries are not articulate advocates for their own preventive screening. And reliance on managed care providers is misplaced given their incentive to avoid sources of additional treatment and cost. Precise spending within managed care settings is difficult to identify. Health advocates believe that the number of screens—static since 1995—may now be in decline to 2001–02.

4. Child Health and Disability Prevention Program (CHDP)

Enacted in 1973,²⁰² California’s Child Health and Disability Prevention (CHDP) program is a major preventive health program for low-income children and youth. It is modeled after federal EPSDT (above) and covers immunizations and health screens for children through age 20 and with family income at or below 200% of poverty. For some eligible children, CHDP also includes follow-up treatment. Thus, CHDP helps to provide at least some access to basic health care for uninsured children and youth who are eligible for Medi-Cal or Healthy Families but not enrolled, or who lack eligibility for the two major children’s health insurance programs altogether. CHDP is also a reimbursement source for safety net providers who give basic preventive or primary care to children and youth during periods of uninsurance. Its potential as a “gateway” to enrollment in Medi-Cal and Healthy Families, however, has not yet been fully realized.²⁰³

CHDP coverage is available to children through age 20 on Medi-Cal as part of the federal Medicaid EPSDT program; to other children through age 18 from families at or below 200% of federal poverty level²⁰⁴ and to children enrolled in Head Start or state preschool programs (see Chapter 6). Children may be enrolled into the CHDP program on-site, at a certified provider’s office, with a very simple application form and process.

All children covered by CHDP can receive screens or health assessments, which are provided on the same schedule that is required in Medi-Cal under the federal EPSDT program.²⁰⁵ After a CHDP screen, a Medi-Cal eligible child must be referred for all necessary follow-up diagnosis and treatment, even if the Medi-Cal scope of coverage for an adult wouldn’t include the needed care. If not eligible for Medi-Cal, whether the child is referred for diagnosis and follow-up treatment depends on whether hospitals or other providers in the county in which he or she resides receive funds from the Prop 99 indigent care accounts; if they do, the county should have a provider network for referral from the CHDP screening program, as providing CHDP follow up treatment is a condition for counties and providers to receive Prop 99 indigent health care funds.²⁰⁶ Children’s advocates report, however, that in practice very few services are available in most counties for CHDP follow-up treatment for children not covered by Medi-Cal.

For Medi-Cal eligible children, CHDP services are funded by federal and state general fund dollars as part of Medicaid EPSDT. For other children, the state’s CHDP budget has historically covered screening with general fund money for the earlier groups covered by the program (primarily children under 29 months of age and children aged 4–6 who are eligible for a preschool checkup), plus screening for older children with Prop 99 funds. The proposed budget for 2001–02, which anticipates 3.6% caseload growth for CHDP, includes \$49.3 million in General Fund and replaces Prop 99 funds with \$64.9 million from the Tobacco Settlement Fund.²⁰⁷

Local health departments administer the county CHDP program. They recruit and certify providers; perform direct activities, including outreach, health education, follow-up, and support services such as assistance with transportation and medical appointment scheduling; handle assessment/claims forms (PM-160s) and submit them to the state for reimbursement; and monitor the school entry program, which requires all children entering the first grade to present a certificate of health examination or have a waiver on file with the school. They do not monitor CHDP activities in managed care plans for the Medi-Cal eligible children.

CHDP spending increased markedly in 1990, when CHDP eligibility was expanded from ages 0–6 to ages 0–18 (from 900,000 children aged 0–6 to 2.3 million aged 0–18). The 1989 Proposition 99 dollar level reflects funding beginning in mid-budget year, an influx that made expansion to older children possible. The large change in federal funding in 1992 and 1993 comes from Title V money used to provide the second Hemophilus influenza B vaccine, given near the time of school entry.

	Budget Year						Estimated	Proposed	Percent Change	
	1989-90	1996-97	1997-98	1998-99	1999-00	2000-01			2001-02	2002-03*
General Fund	\$24,212	\$37,600	\$23,860	\$24,201	\$21,879	\$102,431	\$48,312	\$49,946	99.5%	3.4%
Tobacco Tax	\$8,337	\$26,592	\$47,878	\$49,291	\$56,025	\$0	\$0	\$0	–	0.0%
Federal	\$0	\$6,342	\$6,342	\$7,744	\$6,692	\$6,748	\$6,804	\$6,800	–	0.0%
Other	\$0	\$0	\$3,600	\$2,640	\$0	\$9,072	\$74,006	\$74,000	–	0.0%
Total	\$32,549	\$70,534	\$81,680	\$83,876	\$84,596	\$118,251	\$129,122	\$130,746	296.7%	1.3%
Adjusted Total	\$71,272	\$90,100	\$100,193	\$98,390	\$94,491	\$125,570	\$129,122	\$122,709	81.2%	-5.0%

Dollar amounts are in \$1,000s. Sources: Governor’s Budgets. *Estimate of Children’s Advocacy Institute. Adjusted to 0–19 population and CPI-Med (2001–02=1.00). Adjustments by Children’s Advocacy Institute.

TABLE 4-G. Child Health and Disability Prevention (CHDP)

During 1996–97, CHDP lost \$25.9 million in Proposition 99 funds, disallowed as a result of the December 1996 decision in *American Lung Association v. Wilson*.²⁰⁸ The funds were backfilled from the

general fund for that year. During 1997–98, the resolution of the suit and subsequent legislation allowed these accounts to be resupplied from Proposition 99 to CHDP (see Table 4-G).²⁰⁹

In recent years, CHDP funding in general has become heavily dependent on the Proposition 99 Tobacco tax revenue source. The passage of Proposition 10 worries some CHDP providers because the 50-cent per pack addition is likely to reduce sales. Although all health professionals celebrate the reduction in smoking incidence—whether from public education or higher prices—it is unclear if the Proposition 10 provision relating to payments to the Proposition 99 Fund for the surtax caused revenue decline will in fact provide comparable compensation. As Table 4-G and the history of the account above indicates, most of the shortfall from Proposition 99 revenue reductions required backfill from the state's general fund. Starting in the current year, Tobacco Settlement Fund monies (“Other” in the CHDP Table above) will replace reliance on Proposition 99 funds, and is budgeted at a significant \$74 million for current 2001–02 and a similar level for proposed 2002–03.

The number of state-funded CHDP screens has increased faster than the population adjustor used for Table 4-G. They increased by 28% from 1989 to 1996, reducing inflation adjusted compensation per screen, which declined for both general fund and Proposition 99 screens (the latter including more older children). The 1997–98 budget responsibly included a “catch-up” addition for that year, an \$11 million increase.²¹⁰ The problem has traditionally been stagnant CHDP reimbursement rates. Originally set above Medi-Cal's in order to attract more providers and thus improve access, they have not moved up with inflation, and are now lower than is a Medi-Cal reimbursement for the same procedure (see discussion above regarding the inadequacy of the latter).

Many providers take both Medi-Cal and CHDP patients; as reimbursement for both programs is reduced, fewer providers serve eligible children. Where payment for the EPSDT and CHDP screening and preventive interventions declines per screen and procedure, screenings will decline. The budget for 2001–02 more than keeps pace with inflation, but not with screens properly ordered. As of 2002, the program performs health assessments of 1.1 million California children annually, only slightly more than in 1997–98. Treatment after EPSDT or CHDP screening depends upon other funding streams. CHDP does not itself provide medical treatment or dental or vision care.

In January 2001, the Office of Legislative Analyst (LAO) released its review of California's CHDP performance. The Report's title reflects its thesis: “Obstructed Entry: CHDP Fails as Gateway to Affordable Health Care.”²¹¹ The gist of the LAO critique is that the program never functioned fully as an effective “gateway” and has become essentially one of many fragmented, uncoordinated state programs designed to medically cover children. It was originally designed to fill a “gap” in coverage (as with many of the programs discussed above and below). It has not been integrated into the larger Medi-Cal, Healthy Families macro-programs but remains as yet another “niche” system, applicable to some children some of the time, and offering only limited medical services consistent with its initial charter. The LAO concluded that CHDP has never and does not now function as an effective gateway into the more comprehensive coverage offered by Medi-Cal or Healthy Families, and that the Department of Health Services has “not developed a system of coordination.”²¹² The LAO recommends altering CHDP in marginal ways to facilitate its gateway role into enhanced Healthy Families sign ups, including referrals, better data collection, and aligning CHDP eligibility with Healthy Families. See the alternative strategy of a comprehensive system of coverage for children which would effectively absorb CHDP's functions and make “gateway” functions irrelevant.

In his 2002–03 proposed budget, the Governor sought to reduce \$69.5 million (\$6.2 million general fund and \$63.3 million in tobacco settlement funds now feeding CHDP) for spending elsewhere. The proposal was to shift the program to Medi-Cal / Healthy Families under the theory that the screening of CHDP is likely to make it a natural gateway to connect with these two basic insurance providing programs for a similar population. However, the gist of the proposal is the elimination of CHDP, since its absorption into Medi-Cal / Healthy Families occurs without its separate and assured funding. Instead, to make up for what is a reduction in basic child preventive health spending, the Governor proposed to take \$17.5 million from the Tobacco Settlement Fund to add to the EAPC program (infrastructure support for clinics—which presumably provide health assessments for children up to 200% of the poverty

line. However, the additional EPAC funding is not targeting the same population losing coverage through CHDP reduction. CHDP applies only to children and is effective statewide. EPAC funding affects patients of all ages, does not have the CHDP preventive child health focus, and may not go to geographic areas losing CHDP financing. Based on these problems, and the small amount of savings accomplished through the absorption of CHDP into Medi-Cal, the Governor withdrew his proposed reorganization in his May 2002 Revise. That Revise includes a more constructive way to bring CHDP into a coordinated role—an augmentation of \$2.7 million to develop an Internet pre-enrollment application for Medi-Cal and Healthy Families available to CHDP recipients—moving toward a constructive gateway role for CHDP. The Governor would allow pre-enrolled children to be immediately eligible for up to two months, for a CHDP health assessment, followed by comprehensive medical care as appropriate through either Medi-Cal or Healthy Families as appropriate.²¹³

5. California Children’s Services Program (CCS)

CCS provides treatment and case management services for children under 21 years of age with specified chronic conditions, whose families earn below \$40,000 per year or spend over 20% of their income on health care.²¹⁴ It also provides diagnostic evaluation and physical and occupational therapy in public schools, regardless of financial status, and medical care case management to eligible children, including those receiving care under Medi-Cal. Services from physicians, hospitals, and special centers are reimbursed at Medi-Cal rates. There is a small, sliding program fee to 200% of poverty. CCS also runs the Genetically Handicapped Persons Program, providing comprehensive case management and medical care services to adult Californians with specified genetic conditions. Eligibility criteria and benefits have not changed since 1988.

CCS is a jointly-administered and funded state/county program. Realignment in 1991 changed the state/county funding mix from 75%/25% to 50%/50%, with the requirement that counties maintain funding at least at the 1990–91 level. That “maintenance of effort” standard, however, is not pegged for adjustment with inflation or population/need changes. For small counties, tying funding to a single year’s payments rather than a several-year average and/or a regional level leaves them open to great influence from a few expensive cases.

	Budget Year							Estimated 2001-02	Proposed 2002-03	Percent Change	
	1992-93	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01			'89-'01	Proposed
General Fund	\$54,896	\$42,771	\$40,821	\$43,232	\$48,786	\$49,478	\$66,689	\$72,696	\$81,696	32.4%	12.4%
Federal Funds	\$4,704	\$4,704	\$4,704	\$4,811	\$9,581	\$6,410	\$8,898	\$11,528	\$18,928	145.1%	64.2%
Other	\$0	\$0	\$360	\$314	\$200	\$0	\$180	\$743	\$758	–	2.0%
Total	\$59,600	\$47,475	\$45,885	\$48,357	\$58,567	\$55,888	\$75,767	\$84,967	\$101,382	42.1%	19.7%
Adjusted Total	\$97,229	\$63,477	\$58,614	\$59,317	\$68,702	\$62,425	\$80,264	\$84,967	\$95,150	-12.6%	12.0%

Dollar amounts are in \$1,000s. Sources: Governor’s Budgets.
Adjusted to age 0–19 population and CPI-Med (2001–02=1.00). Adjustments by Children’s Advocacy Institute.

TABLE 4-H. California Children’s Services (CCS)

The county program submits claims to the state, which matches county funds dollar for dollar. Adjusted spending for CCS declined steadily between 1989 and 1997 (see Table 4-H), undermining the program as caseload kept growing and the CCS reimbursement rates remained the lowest in the nation, even below the seriously sub-market level for Medi-Cal. There was some effort at catching up in 1998, when the CCS budget was increased by about \$10 million in state general fund monies, as shown in Table 4-H. CCS rates were finally increased in the Budget Act of 2000 for the 2000–01 fiscal year, which the Table reflects. That increase was a long overdue 33% for physician provided services (an additional \$18 million). Although seemingly enormous, it still fails to match the reductions from inflation over the prior 15 years. The current 2001–02 budget allocates \$72 million in state general fund for CCS, an increase based on caseload.²¹⁵ The 2002–03 proposed budget shows another increase based on further caseload increase projections—particularly likely given the cuts taking place in other accounts affecting chronically ill children. The proposed year increase assumes that reimbursement rates will not change, and the Governor’s May 2002 Revise rescinded recent Medi-Cal compensation increases for 2002–03. CCS is a Medi-Cal related program for purposes of compensation, so unless it is specifically

exempted from the rate cut backs, the spending figures of Table 4-H for the proposed year will fall, and per case spending will fall more significantly. These cut restorations, given the extent of previous under payment, will be momentous over time for this population, affecting services for the chronically ill children relying on this account.

Many CCS services are provided by California's seven children's hospitals, where the intensive and specialized treatment needs of children with severe and chronic problems can often best be served. With uncertainty about how to maintain services while integrating children with special CCS conditions into capitated Medi-Cal managed care plans, legislation enacted in 1994²¹⁶ continues fee-for-service reimbursements for services for CCS conditions, even while CCS children's general care is covered under Medi-Cal's standard capitation rate. This "carve-out" may be followed in future years by the integration of CCS into managed care Medi-Cal plans, with the possible "cream-skimming" and denial of service problems discussed above. The separation of the program continues to date. However, as noted above, the protection of fee-for-service compensation remains a problem where the allocated fees are below market.

During 2000, the Senate Office of Research issued a report critical of CCS performance and making a series of sensible recommendations, including:²¹⁷

- ◆ Remove the program from county realignment and transfer it to state responsibility (see discussion of the difficulties of county financing in Chapter 1);
- ◆ Restore CCS eligibility to 300% of the poverty line as was the case until 1982;
- ◆ Expand provider networks to eliminate treatment delays which are common (and increase state positions to eliminate the credentialing backlog);
- ◆ Direct staff and providers to train families so they may provide services where possible;
- ◆ Increase case-management staff to ensure that needed services are received.

6. Maternal and Child Health Program (MCH)

The Maternal and Child Health (MCH) program is directed at reducing low birthweight, premature delivery, mortality, and preventable diseases and handicaps among children. The state MCH program supports the infrastructure of a county-based MCH service delivery system, and assists county health departments, community clinics, and other local and regional organizations to deliver services throughout the state. It provides MCH physician residency training, maintains an MCH Epidemiology Unit for surveillance of health indicators, and runs projects with local health departments, such as the Comprehensive Perinatal Services Program, Adolescent Family Life Program, High-Risk Infant Follow-Up, Perinatal Regionalization Program, the African-American Infant Death Program, Perinatal Substance Abuse Pilot Project, the Sudden Infant Death Syndrome Program, and the Childhood Injury Prevention Program.²¹⁸ The account funds public health programs, up to 30 per county, to ensure the health of at-risk pregnancies and infants. These programs make sure impoverished pregnant women see a physician, understand the doctor's orders (language assistance), and are educated in maintaining their health and the health of their baby.

The majority of MCH funds comes from the federal Title V block grant. The state must maintain at least its pre-1989 funding level, submit an annual spending plan which requires federal approval, and perform a needs assessment every five years. OBRA '89 language requires states to spend at least 30% of this funding to assure child and adolescent access to preventive and primary care, and another 30% to develop systems for providing services to children with special needs (part for perinatal access), and places a 10% cap on administration. However, the state's plans largely continue existing programs, with most of MCH's money going for perinatal services.

	Budget Year						2000-01	Estimated 2001-02	Proposed 2002-03*	Percent Change	
	1989-90	1995-96	1996-97	1997-98	1998-99	1999-00				'89-'01	Proposed
General Fund	\$7,127	\$16,791	\$28,144	\$30,876	\$35,326	\$37,654	\$45,051	\$45,130	\$45,130	533.2%	0.0%
Federal Funds	\$30,198	\$38,066	\$27,509	\$22,420	\$23,110	\$32,356	\$32,856	\$33,001	\$33,001	9.3%	0.0%
Other	\$0	\$0	\$0	\$5,053	\$3,419	\$2,308	\$2,022	\$2,023	\$2,000	na	0.0%
Total	\$37,325	\$54,857	\$55,553	\$58,349	\$61,885	\$72,318	\$79,929	\$80,154	\$80,131	114.7%	0.0%
Adjusted Total	\$60,471	\$65,454	\$63,753	\$65,449	\$67,492	\$76,956	\$82,166	\$80,154	\$77,563	32.5%	-3.2%

Dollar amounts are in \$1,000s. Sources: Governor's Budgets. *Estimated by Children's Advocacy Institute. Adjusted to 0-19 population and deflator (2001-02=1.00). Adjustments by Children's Advocacy Institute.

TABLE 4-I. Maternal and Child Health

Prior to 1991-92, the federally-funded Women, Infants and Children (WIC) Supplemental Food Program was included in the budget for the Maternal and Child Health program. The *California Children's Budget* treats WIC separately in Chapter 3.

California's share of Title V funds has been disproportionately small compared to the state's population. Overall spending has increased since 1989, but is scheduled for an adjusted 3% decline in proposed 2002-03. The Governor announced a cut in these programs in July of 2001 of \$2.6 million in general fund monies, which would have inflicted a reduction of \$7 million given the federal funds loss from match failure. A cut of that magnitude would have significant public health impacts²¹⁹ and most of the money was restored so that account spending is now static—with reductions over the last two years from population and inflation change. As Table 4-I indicates, current year 2001-02 represents an adjusted reduction of about 3%, with another 3% reduction proposed for 2002-03.

C. Healthy Families Program [Managed Risk Medical Insurance Board]

The state's 1998 "Healthy Families" program was enacted in 1997 pursuant to the Balanced Budget Act of 1997 creation of the Children's Health Insurance Program (CHIP).²²⁰ The state statutes here implement the intent of Congress to provide medical care for more children. The program provides subsidized coverage for children aged 1-18 in families up to 200% of the poverty line, although the effective limit may go higher through the use of income deductions. Coverage is funded at \$2 for every \$1 in state monies matched. Further, the statute's terms allow states which had been covering some children at above 100% to add 50% to that previous coverage even if covering persons above 200% of the line. For example, California provided coverage up to 200% of the poverty line for prenatal care, and could cover them to 250%, or even higher, under the law. Accordingly, as of 1999, the federal jurisdiction has approved an overall increase to 250%.

The California Healthy Families statute implementing the federal law allows inclusion of children with prior private coverage (usually from a parent's employer) if they have not been covered for the three-month period prior to applying. It includes a \$50 reward to certified agencies and organizations for each enrollment application in Healthy Families or Medi-Cal. Initially, the state estimated that 580,000 uninsured children would qualify for the program. However, federal funds offered could have been used starting in 1998 to facilitate coverage for up to 1.4 million of the state's 1.8 million children who were uncovered at that time.²²¹

Because California used only a small part of the amount available to it for fiscal years 1998 and 1999, it lost about 40%, or \$230 million, of its \$580 million unspent federal funds from fiscal year 1998, with the amount to be forfeited for 1999 not known at this time.²²² Unless the state enrolls more of its uninsured children and parents, it risks losing hundreds of millions of dollars from its SCHIP allotment again.

As of July 2000, HCFA allows states to apply to use a part of their SCHIP allotments to cover uninsured parents. However, to qualify for such permission, states must first demonstrate that they are doing enough to try to provide coverage to children. The SCHIP law permits parental coverage, with prior federal approval, because opportunities for the whole family to enroll promotes child health enrollment and children's health care.²²³

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As discussed above, the federal government has approved California’s waiver request. It allows state extension of coverage to about 290,000 parents of children eligible for Healthy Families. It was originally intended to begin in current 2001–02 at 174,000 enrolled and increase to full 290,000 enrollment by 2003–04. But the federal delay in approval moved the program back to proposed 2002–03. Now the Governor’s May Revise, in order to avoid the one-third portion that is the state match and relieve the general fund, proposes to begin the program in fiscal 2003–04. At the planned phase in rate, full implementation would not occur until 2005–06 and will include parents to 200% of the poverty line, although children are now covered to 250% of the line.

In the original proposal, premiums for parents would have been from \$20 to \$25 per month per parent, significantly higher than those for children. After extensive public comments, premiums have been dropped to \$10 to \$20 per month per parent.²²⁴ The benefits package would be similar to the one provided to state employees. The estimated cost for the parental coverage expansion is about \$219 million state general fund per year, matched 2 for 1 with SCHIP funds, at full implementation.²²⁵ While an expansion for parents is an important improvement in many respects, the administration’s proposal regrettably continues the “patchwork quilt” approach to health care programs and further undermines efforts to coordinate the two main children’s and families health care programs. Specific concerns about the proposal are summarized below.

	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02 (Estimated)	2002-03 (Proposed)	Proposed Change %
General Fund	\$0	\$1,465	\$16,363	\$77,522	\$141,301	\$148,652	\$1,777	-98.8%
Federal Fund	\$0	\$0	\$37,820	\$134,733	\$248,522	\$340,036	\$398,597	17.2%
Reimbursements	\$0	\$0	\$7,482	\$2,482	\$3,483	\$12,271	\$9,467	-22.9%
Tobacco Settlement Fund	\$0	\$0	\$0	\$0	\$0	\$55,272	\$247,121	347.1%
Total	\$0	\$1,465	\$61,665	\$214,737	\$393,306	\$556,231	\$656,962	18.1%

Dollar amounts are in \$1,000s. Source: Governor’s Budgets.

TABLE 4-J. Healthy Families: MRMIB

Table 4-J presents the MRMIB Healthy Families budget. Some Healthy Families spending also occurs in the DHS and other minor accounts. Total Healthy Families related spending currently is \$820 million, including \$128 million for DHS administered outreach in the current year. Projected 2002–03 spending is \$1.04 billion, with a reduced \$99 million in DHS outreach. The overall increase is based on the child expansion from 559,000 currently to 624,000 in 2002–03.

The program potentially provides comprehensive health, dental, and vision benefits equivalent to those provided to state employees.

1. Administration; Integration with Medi-Cal

Having been threatened with a veto, the Legislature enacted Healthy Families as a stand-alone add-on program, administered by a separate Managed Risk Medical Insurance Board (MRMIB), with assistance from a Healthy Families Advisory Board. The budget for administration included \$21 million for an outreach campaign contract, and for local activities to identify and assist those not yet enrolled—in either Medi-Cal or the new Healthy Families program. In addition, the statute directs MRMIB to recommend how children in families above 200% of the poverty line can participate at their own cost. And the regulator is also directed to explore use of federal funds for county mental health and alcohol/drug treatment for additional children at the county level; provide for simplified application; provide for appeal of eligibility disputes; and allow CHDP payment for 30 days while children in that program apply to Healthy Families. It also maintains CCS as a separate program, as with Medi-Cal managed care.

The consensus among child health experts in the state was that the new federal money would be best used to expand the existing Medi-Cal program to include additional children up to the maximum allowable line (200%, 133% and 100% of the poverty line for pregnant women and infants, children 1 to 5, and children 6 to 18, respectively). However, former Governor Wilson rejected that advice and insisted on creating a separate, stand-alone program. Thirty-two states expanded their Medicaid programs with SCHIP funds, while eighteen created separate systems as California did with “Healthy Families.” Both Wilson and Davis contend that families feel “stigmatized” by Medi-Cal because they associate it with “welfare.” But the research shows otherwise. One of the many recent studies on the alleged welfare stigma reaching similar conclusions summarized the key finding as follows: people don’t dislike the Medicaid program itself or feel stigmatized, i.e., negatively about themselves, for using Medicaid; instead, they feel badly about how they are *treated by others* for participating in the program.²²⁶ The repackaging of Medi-Cal and coordination with Healthy Families could resolve this problem without imposing an additional regulatory bureaucracy and burdensome entry barriers.

Experts in the child health field²²⁷ argue that the continuing pattern of separate, add-on programs creates red tape, bureaucratic excess, and fragmentation. Critics note that a family could be at 130% of the poverty line and have one child eligible for Medi-Cal, another for the Governor’s AIM program, and a third eligible for Healthy Families (depending on age)—all with separate application systems and administration. Further, in the case of many families with children of different ages, children will become ineligible for Medi-Cal and eligible for Healthy Families based on the complexities of family income increase and the age changes of individual children. The parental coverage expansion proposal further complicates the problem, as all parents with income over 100% of poverty would go into Healthy Families, even when their children are in Medi-Cal’s 133% program for children ages 1–5.²²⁸ Parents are already confused about which program their children belong in, and they lament not being allowed family unity.²²⁹

Health care experts view the alleged stigma problem as resolvable. Note that Medi-Cal for children is not coextensive with TANF welfare or food stamps, and does not require waiting in welfare lines; a mail-in application can be used—for children and, as of July 1, 2000, parents applying for Medi-Cal, too. Under the state’s SCHIP parental coverage expansion proposal, the Medi-Cal mail-in application for family coverage may finally be implemented. The benefit here is not cash or voucher assistance from the state, but medical coverage for children who need treatment—which the citizenry widely acknowledges can be ruinously expensive. Medi-Cal recipients are required to make some copayments, and the Healthy Families program is a public subsidy for medical coverage as well. The difference is not qualitative, but one of degree.

Experts have made other arguments in support of a Medi-Cal expansion: (1) expanding Medi-Cal allows more predictable and secure federal matching payments—likely to extend beyond the January 2003 termination of this initial federal child health block grant; (2) combining the new program with Medi-Cal gives the state a stronger bargaining position when negotiating with plans and providers; (3) a combined system promotes seamless efficiency and clarity for recipients, and a non-duplicative administrative structure; and (4) the federal policy now gives states increasingly wide discretion in fashioning Medicaid (Medi-Cal) coverage for low-income parents.²³⁰

Regrettably, the parental expansion proposal would increase the stigma that comes from Medi-Cal’s burdensome assets test, as only parents with income below 100% of poverty would be subject to an assets test while those with up to twice the income would not in the Healthy Families program. Families with income below poverty would have to go through a three-step application process under the expansion proposal. First, all applications must go to MRMIB for screening. Second, families income below poverty will have their applications sent to the county for application of the complicated assets test and verification requirements. Third, if the family has a car or other asset over the Medi-Cal limit, the application will be returned to MRMIB for review again for Healthy Families eligibility. The irony is that almost none of the families with income below poverty amass assets over the Medi-Cal limits. The real danger from the proposal then, is that eligible children as well as parents will wind up not covered by either Medi-Cal or Healthy Families, as families will be overwhelmed by all the hoops and demeaning grilling about personal possessions.²³¹ A similar kind of stigma would have been created by the

administration's initial proposal that only the lowest income parents, those with income below poverty, be denied twelve-months continuous eligibility.²³² In response to extensive public comment, this limitation has been dropped, and the lowest income parents will enjoy twelve-months continuous eligibility along with their children and counterparts in the Healthy Families program.²³³

AB 32 (Richman and Figueroa) was introduced in 2001 to combine Medi-Cal and Healthy Families into a single, integrated system through the creation of "CalHealth." The bill would allocate \$1.8 billion and take as its goal the coverage of at least one-half of the currently uninsured population. The bill did not pass, but is a creative approach consistent with the recommendations of many health professionals when SCHIP was initially enacted. That unitary approach was rejected by the previous Wilson Administration on the theory that Healthy Families—which involved premiums as well as co-pays—would be stigmatized through association with the "welfare" patina of Medi-Cal—a fear with some support in polls of uncovered working poor, but one surmountable with accurate publicity and education.

2. Safety Net Provider Subtraction Effect

The Healthy Families statute authorizes MRMIB to stimulate inclusion of "traditional" (existing) safety net providers (giving priority to providers in the neighborhoods where qualified children live), and confer premium discounts to reward "community provider plans" which include existing clinics and professionals serving low-income populations. The policy emanates from the same concern discussed above applicable to Medi-Cal managed care. Will the new program subtract patients from safety net providers so they fall below the critical mass necessary to remain in business? If they close or lose business because patients must be charged a higher rate, what will the impact be on those still dependent on this safety net? Eligible but uninsured families as well as ineligible families with income above 250% of the poverty line will still depend on the clinic/low-income provider safety net. The combination of Medi-Cal managed care and a separate program on the scale funded means that health clinics and those serving low-income families must be a provider in both systems to avoid patient loss and supply diminution.

3. Premiums/Co-Payments

In one of its most controversial features, the Healthy Families legislation imposes substantial premiums, as well as expected co-payments, on families to qualify for Healthy Families coverage. As the statute reads, families at 100%–150% of the poverty line contribute \$48 per year per child up to \$168 per year, plus co-payments of \$5 for most outpatient services (excluding those which are preventive). Families at 151%–200% of the poverty line contribute \$72 per year per child up to \$324, plus the co-payments of \$5 per visit for services other than prevention. Discounts of \$36 dollars a year are available for selecting a "community provider plan," designated on the basis of safety net provider inclusion. A maximum of \$250 per year per family or 5% of total income is statutorily provided. However, a mother with two children on a family income of \$14,630 to \$21,945 per year (*i.e.*, 100% to 150% of poverty as of April 1, 2001) must pay \$168 of it to enroll her children, plus the \$5 per visit charge.²³⁴ If a family is late with a premium payment for 61 days, the family's children are mandatorily disenrolled from coverage (even if payments are cured) for a minimum of six months.²³⁵

For parents, under the modified expansion proposal, if income is between 100% and 150% of poverty, premiums will be \$120 per year (\$10 a month) per parent, with a discount of \$36 a year (\$3 a month) per person for enrollment in community provider plans. Parents with income between 150% and 200% of poverty would pay \$240 per year (\$20 a month) per parent, with a discount of \$36 a year (\$3 a month) per person for community provider plans. Families with income at or below 150% of poverty will pay child premiums for a maximum of two children, with additional children in the family covered without cost; therefore, total family cost would be \$34 a month for the standard plan and \$22 a month for the community provider plans for a family of four or more. For families with income over 150%, the maximum child premiums will be for three children, and total family cost would be \$58 a month for the standard plan and \$46 a month for the community provider plan for a family of five or more.²³⁶

The original waiver proposal would have imposed co-payments for parents at the same high

amounts paid by state employees with significantly higher incomes. As revised, the proposed copayments would be \$5 per service for health, mental health and vision, with a \$250 annual cap. However, dental copayments would remain at the state employee level,²³⁷ imposing a serious barrier to access for dental care.

A 1997 survey of Medi-Cal parents found that even the much lower co-payments they are assessed (without premium obligations) constitute a real impediment to medical care for their children,²³⁸ particularly when they are expected absent any current symptoms of ill health. As Chapter 2 indicates, the Healthy Families' premiums of \$150 to \$325 are imposed on families living below self-sufficiency levels and where virtually all available cash is required for rent, utilities, clothing and food. Ideally, children are enrolled and subject to preventive care and examinations before they have cause for emergency room visits to trigger enrollment. It is not easy to pay sums of this scale to cover a child who is then healthy, and where the trade-off may be the failure to pay rent or food deprivation. MRMIB data show that 16% of Healthy Families participants disenroll by the end of the year for reasons other than the child losing eligibility upon reaching age 19 or the family obtaining other coverage.²³⁹ Many are concerned that the current premiums contribute to these disenrollment rates. The state's proposal for even higher premiums for parents will put the Healthy Families program further out of reach for many.

4. Income Definition for Coverage

During April 1998, former Governor Wilson announced that the Healthy Families plan he submitted to the U.S. Health Care Financing Administration had been signed by an automatic pen without his review, and that he was retracting it to amend income definitions. The plan as submitted allowed coverage for families earning up to 200% of the poverty line, with "income" defined in the same manner as for Medi-Cal and other programs—with allowed deductions ("income disregards") for child care, certain work expenses, and other costs.²⁴⁰ Potential coverage to over 50,000 children would have been foreclosed by the accounting change. Governor Davis announced in April 1999 that he would reimpose the prior income definition used for TANF, food stamps, and other means tested programs which allow the disregards and which will qualify these children for coverage. The parental coverage expansion proposal would also allow the parents to take the disregards.

5. Current and Projected Spending: Federal Money Returned Projection

Initially, the total amount to be provided to California for child health coverage expansion was \$859 million per year through calendar year 2003.²⁴¹ According to the California Health and Human Services Agency, the amounts actually appropriated so far are \$855, \$851, and \$766 million for 1998, 1999, and 2000, respectively.²⁴² In previous *Children's Budgets*, we noted that, given the average monthly net cost of Healthy Families per child as originally projected (\$69.75 per month) and the number of children the state then estimated would qualify (580,000 children), the state would be spending only \$485 million in SCHIP a year, plus the required state match of \$170 million.

Since that time, the annual SCHIP allotment for California for 2000 as actually appropriated was only \$766 million, and MRMIB expects Congress to appropriate \$736 million for 2001, \$542 million a year for each year from 2002 through 2004, and \$697 million a year in 2005 and 2006; these amounts are instead of the almost \$860 million a year initially anticipated under SCHIP, but remain beyond the sums which will be expended for children under existing budget plans. To summarize, the total federal allocation for the five years of 1998 to 2003 is \$3.75 billion, and California has captured only about \$1.5 billion to date, leaving \$2.35 billion to either be lost, or rolled over. Of this sum, Congress has allowed the state to keep 60% of its unspent allotment in 1998 and 1999, resulting in a loss of about \$450 million in unspent federal funds those two years. It is unclear how much of the post-2000 unspent allocation will be allowed to roll-over. This would include almost \$200 million in unspent funds in 2001–02.²⁴³

Given the shortfall to date in capturing available federal money, the state has expanded the eligibility limit for the Healthy Families program for children to 250% of poverty. And as of January 8, 2001, 362,373 children were enrolled in Healthy Families, with a gradual increase to 574,000 in June of 2002, and a projection of 624,000 by June of 2003.²⁴⁴ Spending has increased from \$131 million in

1998–99 to a budgeted \$820 million in 2001–02, to a proposed \$1.04 billion total for 2002–03.

Under-enrollment of children in Healthy Families implies substantial send-back of federal monies. The state is using three tactics to capture maximum federal monies: (1) allocating state funds for ancillary but related purposes to the SCHIP account, including some CHDP, mental health, CCS, and outreach spending (approximately \$140 to \$150 million per year in such spending); (2) rolling over previous unspent monies into future years; and (3) planning the inclusion of parents at least to 200% of the poverty line as beneficiaries. [At full implementation in 2003–04, the estimate for annual SCHIP funds needed for this parental coverage is \$371 million (plus \$219 million in state funds,²⁴⁵ for a total of \$590 million a year, to cover 290,000 adults.)]²⁴⁶

Thus, the annual cost for Healthy Families at full implementation and including parental coverage at 200% of poverty and children at 250% of poverty is approximately \$1.3 billion a year (allowing some reduction in outreach spending). This \$900 million federal assessment will use the entire allotment now assigned to California—and allow a \$200 million to \$350 million annual absorption of rolled over (unspent) federal funds per year when fully operating. Additional federal extension of time to so expend these funds becomes critical to their capture. The Congress has a proposal for such extension to 2006 that is understandably supported by the California delegation. If it is not approved, we estimate the return of federal funds allocated for California would exceed \$500 million.

Discussion focusing simply on full capture of now available federal funds misses the catch-22 reality that failure to use the \$855 million California share of the initial five year plan from 1998 to proposed 2002–03 led to momentous federal reductions in amounts to be allocated to the state. State share of federal funds was cut to \$542 million by proposed 2002–03 and for two years thereafter, to be increased only to \$697 million in 2005 and 2006. The failure to spend funds promised made it possible for the Congress to politically cut its contribution to much lower levels. Assuming no upward adjustment for inflation, the \$855 million original promised from proposed 2002–03 to fiscal 2006 would total \$4.275 billion over those five years. The maximum now promised is \$3.02 billion, \$1.275 billion less. That sum, plus reasonable inflation adjustment over the five years, in addition to those sums already foregone, and those sums that still remain in surplus and cannot be rolled over—will amount to a total of well over \$2 billion in lost federal monies for child health coverage assurance. This sum represents perhaps the largest sacrifice of promised and presumably available federal funds by any state for any purpose to date. Meanwhile, over 1 million California children eligible for health insurance will remain uncovered.

To capture the reduced share of federal monies, California has not ramped up its coverage efforts through a “true presumptive” system of coverage for children, but has instead included a large population of parents. Such coverage assists children, as discussed above. However, it will now likely subsume all available federal money and remove pressure to expand coverage to all children in an efficient and assured manner. A better approach is to fulfill the original intent of the SCHIP statute and cover the children—and in a manner that does not depend upon parental sign-ups or premium payments (see proposal below). Then extend such funds to parents—in a manner that does not produce “crowd-out” inequities more evident with parental coverage than child inclusion (e.g., employers dumping health coverage for employees living below 200% of the poverty line and relying instead on public subsidy financing, see discussion below).

6. Efficient Coverage of Children and “Crowd-Out” Prevention

a. Traditional Approaches and Recent Reforms

The state's approach toward child health coverage has reflected either the traditional view of a “welfare benefit” to be limited to those clearly eligible, or as analogous to a private insurance system requiring purchase. The former model assumes that all applicants are seeking a benefit for private gain and unless carefully screened and limited will obtain value at public cost. Advocates argue that both models do not reflect the reality of medical coverage for children: It is inexpensive, without serious motivation for fraud (does not involve cash benefits—but the delivery of services which are inherently screened for necessity by professionals). It has public/social benefits outweighing its costs. And, two-

thirds of it is financed by the Congress pursuant to a bipartisan national policy to cover the vast majority of America's children. Finally, child advocates argue that beyond statutory intent, the current "don't let anyone in unless" mentality is inequitable in a world purporting to put its children first, but which provides complete coverage for its elderly at more than five times the per person cost.

Since 1998, over 20 major studies, surveys and reports, many funded by leading foundations, have documented the failure to achieve coverage for children in California and nationally.²⁴⁷ Their recommendations seek to incrementally remove barriers within the current structure. Hence, they involve measures such as relaxation of qualification criteria, presumptive eligibility for those children receiving benefits from other means-tested programs (to piggyback on the paperwork of another program which implies qualification), or the creation of new categories of coverage. Some California children's advocates continue to recommend phasing in a series of incremental reforms, over a finite time period, arguing that, given the political realities, this approach is more likely to succeed than introducing legislation mandating comprehensive reform now.²⁴⁸

Measures undertaken from 1999 to date are intended to facilitate retention of eligible Medi-Cal child enrollees, and to expand Healthy Families enrollment further.²⁴⁹ See discussion of Express Lane, continuous eligibility, outreach, et al above. Other incremental suggestions could further the rate of enrollment.²⁵⁰ However, the relatively small percentage of children who are uncovered and ineligible for coverage warrants a system of inclusion, rather than one where the cost of exclusion exceeds its savings through coverage denial.

b. Fragmentation and Transaction Cost

The current system has absorbed the incremental reforms listed above and would presumably benefit from those additional suggestions above. Each is an improvement standing alone. However, when the entire system is viewed together, it presents an edifice which is fragmented, inefficient, and is likely to leave uncovered over one million eligible California children. At the same time, it is likely to lose \$2 billion in federal monies by 2006, as discussed above. These funds could instead be used to provide coverage, as proposed below. The fragmented and costly system of barriers which has produced the following patchwork quilt of separate programs, many independently regulated, and which cumulatively carry significant transaction costs:

- ◆ Section 1931(b) Coverage (Medi-Cal for low-income families, with or without participating in CalWORKs (divided into "cash-based Section 1931(b)" and "Section 1931(b)-Only");
- ◆ "Edwards" Coverage (30 days coverage allowed persons transitioning off TANF aid under *Edwards v. Myers* mandating it);
- ◆ Transitional Medi-Cal (TMC) (up to 24 months of coverage after TANF aid or Section 1931 Medi-Cal ends—first twelve months federal and state funded, second twelve months state funded only);
- ◆ Four Month Continuing Medi-Cal (FMCM) (cash assistance or Section 1931 Medi-Cal ends due to child support payments received);
- ◆ Medi-Cal: Medically Needy (pregnant women, deprived children, blind, disabled with income over the Section 1931 limits);
- ◆ Medi-Cal: Medically Indigent (distinguished from entirely separate *county* "medically indigent adult" programs, and including children in two-parent families with too much family income for the children's "per cent of poverty" programs and who lack "deprivation" for the Medically Needy program (*i.e.*, family income is over 100% of poverty and at least one parent works more than 100 hours a month);
- ◆ Income Disregard 200% Program (continuous coverage for pregnant women and infants up

to one year of age under 200% of the FPL);

- ◆ 133% Program (coverage for children ages 1 through 5 whose family income is at or below 133% of the FPL);
- ◆ 100% Program (coverage for children ages 6 through 18 whose family income is at or below 100% of FPL).
- ◆ Minor Consent Services (preventive services for children living with parents and claimed as a dependent regardless of income to provide substance abuse treatment, mental health services, family planning, STD, and or services after sexual assault);
- ◆ Restricted Benefits Program (coverage for undocumented persons for emergency (OBRA) and pregnancy-related care);
- ◆ AIM (private health coverage subsidy for maternity and delivery care for women with family income between 200% and 300% of the FPL and their infants (to age two), see below);
- ◆ CHDP (preventive services to children through age 20 and to Head Start children);
- ◆ Healthy Families (coverage of children with too much family income to qualify for free Medi-Cal; up to 250% of the FPL).

This list excludes many smaller programs, including those which address the medical needs of many specific disabled child populations (California Children's Services, DDS, *et al*, see Chapter 5).

Qualification for the programs listed above turns on the age of a child, income, condition of the child, reason for and timing of TANF loss. A parent who successfully moves off of TANF due to employment may remain eligible for the 1931(b) program, which will then provide access to transitional Medi-Cal coverage. This would then likely be followed by Healthy Families coverage if wages increase to above about 157% of the poverty line. Meanwhile, she may have a young child who moves in and out of up to ten different programs.

The fragmented structure of child health care is mirrored in its public regulation and administration. While MRMIB administers Healthy Families, the Department of Health Services runs Medi-Cal, with a separate unit overseeing hospitals and clinics. The Department of Corporations, which is in an entirely separate cabinet agency (and one which is wholly unrelated to health care regulation), until 2000 regulated much of the HMO industry and is now being replaced with yet another separate regulatory body, the state Department of Managed Care. Meanwhile, other HMO insurers are subject to the jurisdiction of the independently elected Insurance Commissioner. Medical professionals are all regulated by one of a dozen different boards or commissions within the Department of Consumer Affairs in yet another cabinet-level agency.

c. The Optimum Approach: From Barriers to “Inclusion with Assessment”

The simple step supported by child advocates to reverse this policy and prevent the return of federal funds is as follows: **all California children are covered, subject to post-services contribution by parents with income over 300% of the poverty line.** Any child seeing any health care professional is covered presumptively. The demographics suggest the futility of the current approach of individual sign-ons, screenings, qualification. As discussed above, in 1999 nearly 74% of currently uncovered children are now eligible for Medi-Cal or Healthy Families.²⁵¹ An additional 7% of uninsured children have family incomes between 250% and 299% of poverty.²⁵² Raising child health coverage to 300% of poverty would therefore include 81% of the California children for whom federal matching funds are available. The cost of the current sign-up, form filling, screening system far exceeds the cost of providing coverage to the 7% of uninsured children who are uncovered and whose parents earn more than 250% but less than 300% of the poverty line and who would qualify for federal matching funds.

If we consider the proportions not in relation to the publicly insured, but from the perspective of all of the state's children, setting the limit at 300% will leave only 4.1% of the state's children who are uncovered (publicly or privately) and who would not qualify for public coverage. This is the group the fragmented system of qualification is designed to exclude. Some of these children have parents earning over 300% of the poverty line, most of them are undocumented immigrants. As of January 2002 Santa Clara County and San Francisco County have raised the modest funds necessary to include these children—substantially from scarce county general fund dollars (see discussion above). For San Francisco, the administrative costs and inefficiencies from the more than 17 separate child health related programs extant is greater than the \$6 million the County projects it will cost to provide health coverage for all children now excluded—including the undocumented. San Francisco and Santa Clara could be repaid their extra costs, and other counties could similarly provide universal coverage—were the state to declare such eligibility the law and were it to provide the savings from the elimination of most of the social work filtering, verification, paperwork, approvals, delays et al. now in place among the state's fragmented child health programs.

All public health programs, screening via EPSDT or CHDP, Medi-Cal, Healthy Families, and the ten other programs listed above would be merged into one simple, efficient program. The public health, immunization, assignment of primary care physicians, examinations, *et al* would be provided to all, no questions asked. Where services above \$1,000 (or some other limit) are provided in a given year, parents could be billed on a sliding scale where they earn above 300% of the poverty line or are otherwise unqualified for public assistance. For example, an extraordinary \$50,000 medical services bill may result in a bill to a parent for 10% to 50% of the total, on a sliding scale depending upon parental income and assets, to assure both contribution and affordability. Premium requirements would be removed—while the \$5 co-pay per visit would remain.

Such a system reverses the present arrangement of “keep out unless qualification demonstrated,” to “cover children and assess contributions where warranted.” Such a change is commended by the numbers involved, and could bypass the labyrinthine separate program barriers, as discussed above. It is likely that efficiencies of such an approach would save more than the cost of covering the small portion of uncovered children with parental income above 300% of the poverty line who would seek access to the public system, or the children of undocumented immigrants who might receive preventive care or medical treatment. *Query*, should the state spend more on a system of barriers to exclude a small percentage of children from coverage than the coverage itself would cost?

d. The Problem of “Crowd Out”

The fear of possible “crowd out” chills comprehensive coverage for children. As discussed above, 56% of the state's children are covered through employer health plans.²⁵³ The fear: if all children are assured public coverage, employers will refuse to provide dependent or child coverage privately. Further, those employers who fail to provide such coverage will enjoy a “free ride” at public expense, and enjoy a competitive (cost reduction) advantage over those who provide such coverage.

California has taken some measures to discourage such crowd out. First, it prohibits public coverage of children who have had employer-provided coverage for the prior three to six months. Second, the state prohibits the referral to public coverage by insurance agents of dependents who are privately covered. Third, it is an unfair labor practice under state law to refer children to Healthy Families when child coverage exists privately, or to change the cost of private coverage to induce employees to shift to public coverage. However, the first two measures essentially punish the child, denying coverage contrary to the purpose of SCHIP and sound public policy. A tax credit approach can blunt crowd out.

Studies have criticized the use of tax credits to induce new coverage by employers. Most such employers now not providing coverage tend to be small and tend to operate at the margin. Such credits do not accrue until after one year, and are not refundable and hence will be of no use except as an offset against problematic profits. However, the employers currently providing employee and child coverage are generally more amenable to tax credit influence. They tend to be larger, more established businesses. Hence, if the state were to offer a refundable tax credit of one-half the cost expended by an employer on dependency health coverage at fair market rates for employees who earn below 300%

of the line, the inducement to cut those dependents from private coverage would be suppressed.

Such an approach substitutes the carrot for the current disincentive of refusal to cover privately covered children for substantial periods of time. It would be expensive, but the funding is available given the low cost for child coverage and funding sources already extant. No corporate or personal tax increase would be required. We estimate the cost at between \$900 million to \$1.2 billion²⁵⁴ per year, less than the additional tax expenditures made available to business for less socially beneficent purposes over any of the last three years (see discussion in Chapters 1 and 2). The exact credit percentage could be adjusted to as low as 25%, or half that amount, based on revenues remaining after coverage is afforded for all children. But substantial new resources will be made available from the extraordinary efficiency gain of a single system and from full use of federal funds. The required sum could come from two available sources with appropriate legal preparation. First, the state estimates its federal new SCHIP funds for the next five years (2002–03 through 2006–07) to be \$3.020 billion. The implementation of a universal system would allow full use of those funds, plus the over \$2 billion in SCHIP carryover funds from pre-2002–03.

A targeted tax credit of the proposed size (however denominated legally for SCHIP qualification purposes) could be financed with full use of SCHIP resources, the considerable administrative savings a single system and automatic eligibility would entail, and some percentage of the tobacco settlement proceeds which the Governor has now committed to health related spending. The expansion of Healthy Families to parents benefits their children and should be undertaken, but only after all children are covered and effective “crowd out” measures put in place—particularly since crowd-out is more of a danger where parent (employee) coverage is publicly available than the add-on of child coverage. Both parent expansion and crowd-out diminution that it might stimulate are a meritorious but secondary priority to universal child coverage. Child coverage was the state intention and explicit promise of the SCHIP statute. It is one of the few major public financial commitments have made to our children over the last decade. While we have made such a universal commitment to the elderly, at great financial cost, we have not done so for our children, who have a higher poverty rate, are less able to fend for themselves than are adults, whose health is less expensive to assure, and has many years of accruable benefits from its assurance.

D. Office of Family Planning/Teen Pregnancy

OFP's charge is to make comprehensive medical assistance, knowledge, and services related to planning families available to all state citizens of childbearing age. Eligibility for services to women and men is based on income (below 200% of the federal poverty line), non-availability of third-party coverage, and family size. OFP contracts with local public and nonprofit agencies to provide services, and also funds information and education programs serving youth, including family life education for youth, teacher training, and parenting education. Expanded teen counseling services are provided to TANF, GAIN, foster care, and other teenagers who are at high risk of unintended pregnancy. OFP also promotes sexually transmitted disease prevention services.²⁵⁵

Teenagers are an important target population for family planning services. As discussed in Chapter 2, a recent study found almost one in ten teen women becoming pregnant each of the study years. It found 51% of the women 15–19 years of age had sexual experience, and that 40% were “sexually active” (had sexual intercourse within the prior 90 days). The pregnancy rate within this sexually active group amounts to “more than 1 in five” becoming pregnant in 1995, with 2/3 of them now choosing to give birth. The study also noted that 78% of teen births are unintended, and acknowledged some increases in contraceptive use, with rate of use at first intercourse increasing from 65% to 76% between 1988 and 1995; and 18% are not “current contraceptive users.” The data supports the conclusion that the minority not using contraception, or those using it improperly or inconsistently, account for an extraordinary fertility rate notwithstanding lack of pregnancy intent. More recent data indicates declining birth control use and rates of sexual intercourse now engaged in by about 50% of youths before high school graduation, and with 20% experiencing sex at age 15 or before. (See Chapter 2 “Unwed Teen Birth” discussion and citations).

Unwed births to teens raise special problems for involved children, from low birthweights to intractable poverty. Only one-half of those who are pregnant as teens finish high school by age 30.²⁵⁶ Within the teen births, two groups are at special risk: those under 18 years of age, and those who are unwed.

The most recent data shows 11.1% of the state's births to teens,²⁵⁷ with 56,268 births to women under 20 years of age in year 2000.²⁵⁸ One-quarter of these are second or third babies (about 20% will have subsequent births while still a teen). About 75% of these are to unmarried teens.²⁵⁹ California's teen birth rate has declined somewhat since 1992, and has fallen from 74.7 births per 1,000 to 62.6 births in 1996, to 48.1 in 2000. African American rates in California have fallen from 99 per 1,000 births to 60 during this period, while Hispanic rates have dropped from 122 per 1,000 births to 90.²⁶⁰ However, as noted above, the birth rate decrease is partly the result of more frequent birth control use among the approximately 25% of teen parents who are married. The actual decrease in teen unwed births is not as significant. It is based on somewhat less sexual activity, higher rates of condom use, and somewhat higher rates of abortion.²⁶¹ However, the most recent (1995–98) data indicate less condom use among sexually experienced teens, a flattening of sexual activity rather than further decline, and some increases among Hispanic teen populations which are demographically increasing in California, with almost 2/3 of teen unwed births now coming from Hispanic women.²⁶² The Hispanic rate of 90 per 1,000 is not much higher than rates extant in some third world countries.

As Chapter 2 discusses, teen pregnancies remain a serious problem, however, child poverty is driven substantially beyond its purview—by births to unwed mothers in general.²⁶³ The decline here has not matched teen pregnancy reductions, and has been substantially flat at 32% of all births in California, with about 60% of African American and a rising 40% of Hispanic babies so born.²⁶⁴ Importantly, the unmarried mother trend applies to all income and age groups.²⁶⁵ Given the correlation of unwed and unintended births to child poverty and to child neglect, public policies that stimulate intended children and reduce unintended children are a top priority for child advocates.

In 1989, the Legislature blocked an attempt by then-Governor Deukmejian to eliminate OFP, but local assistance was cut by two-thirds that July—from \$34.2 million to \$11.5 million. The money was restored seven months later, but many clinics reported significant disruptions.²⁶⁶ Funding was increased through 1992–93 under former Governor Wilson, who supported the control of teen pregnancies and births, but it has stayed nominally level since, and has been declining in real terms.

The enacted 1996–97 budget redirected \$23 million from OFP to a state-only Medi-Cal Expanded Family Planning Program, and added \$20 million of general fund money to it. Total funding for family planning included this \$43 million, plus \$35 million remaining in an OFP account. This \$78 million total is 19% more than prior-year spending of \$63 million.

Beyond the accounts in Table 4-K, former Governor Wilson proposed and obtained \$46 million in new funding for teen pregnancy programs: \$10 million to expand media campaign for teens (including \$5 million redirected from the ENABL program, which has since been abandoned as unsuccessful), \$1 million for an abstinence-based curriculum, and \$40 million in community prevention funds.

	Budget Year							Estimated 2001–02	Proposed 2002-03*	Percent Change	
	1989-90	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01			'89-'01	Proposed
Office of Family Planning:											
Total	\$39,945	\$63,543	\$32,895	\$9,981	\$10,660	\$10,611	\$11,694	\$11,720	\$11,720	70.6%	0.0%
Adj. Total	\$85,461	\$86,268	\$43,021	\$12,505	\$12,756	\$12,040	\$12,485	\$11,720	\$10,944	-86.3%	-6.6%
Teen Pregnancy Prevention											
Total	\$0	\$2,549	\$34,467	\$30,616	\$31,138	\$31,729	\$32,522	\$32,521	\$32,521	na	0.0%
Adj. Total	\$0	\$3,461	\$45,077	\$38,357	\$37,259	\$36,001	\$34,721	\$32,521	\$30,367	na	-6.6%

Dollar amounts are in \$1,000s. Sources: Governor’s Budgets. *Estimated by Children’s Advocacy Institute Adjusted to California population and CPI-Med (2001–02=1.00). Adjustments by Children’s Advocacy Institute

TABLE 4-K. Family Planning and Teen Pregnancy Prevention

Also in 1996, former Governor Wilson started a new program called the Family PACT Program, which provides comprehensive family planning services for uninsured adults up to 200% of the poverty line within the larger Medi-Cal account. The program provides contraceptive, pregnancy counseling, testing, some infertility services and screening, and treatment of sexually transmitted diseases. Family PACT is administered by the Office of Family Planning and Medi-Cal within the Department of Health Services, and involves paying fee for service rates to private physicians and groups. Eligible persons are enrolled on-site at the provider’s office with a very simple form and process, making the Family PACT program much easier to enroll in than either Medi-Cal or Healthy Families. This ease of access produced results. As of 2000, there were a record 1.5 million persons participating, with 61% identifying themselves as Hispanic.²⁶⁷ Provider participation in family planning programs has also increased significantly under Family PACT, going from 450 provider sites in 1995–96 to 2,650 by June 1999.²⁶⁸ Related to the Family PACT program is SB 41 (Speier), enacted in 1999, which measure requires employer-based health plans, with some exceptions, to include contraceptive services for women.²⁶⁹

Fiscal year 1997–98 was the first full year of operation for Family PACT, with the program spending its budgeted allocation of \$113 million (\$85.8 million General Fund). It is estimated that for every dollar spent, \$4.48 were saved by avoiding costs associated with pregnancy.²⁷⁰

The Governor’s proposed budget also retains the third new program outside the Office of Family Planning line account above and which is included with Public Health funding: Community Challenge Grants to local agencies for programs to reduce the number of teenage and unwed births. This program currently operates at a \$20 million level, using federal funds awarded in 2000–01 as a bonus under the PRA.

The stand-alone accounts in Table 4-K above do not reflect this ancillary spending and legislative change. Counting all public spending, family planning funding has increased since 1996. Some of the spending has extended beyond the “teen pregnancy” normal target to include the major source of unwed births: births to older, impoverished and unwed women. However, spending in the two budgets presented by the Davis administration has tended to restate the same raw numbers as in the current year, accomplishing a 8% to 12% real spending reduction over the three years including the proposed 2002–03 budget. The two programs covered by Table 4-K remain important separate and apart from these ancillary special efforts. They represent the ongoing account for the designated purpose. Although the problem of teen pregnancies remains serious, the proposed budget cuts current spending an adjusted 6.6% for the Office of Family Planning and a similar cut for Teen Pregnancy Prevention.

The Governor vetoed AB1363 (Davis) in October of 1999, a bill to add funding for school based clinics. Currently, the state has only 66 school medical clinics and the measure would have allowed use of Healthy Families funds (two-thirds federal;) to expand services to children up to 250% of the poverty line. California has ultimately lost substantial unspent S-CHIP funds (see discussion above). The Governor responded to objections from those opposed to contraceptive or other services without parental consent. Supporters contended that there has never been a complaint of failure to obtain such consent. Moreover, child advocates argue that there is a tendency for youth not to seek parental consent before intercourse. A majority of high school juniors and seniors have engaged in sexual

intercourse (see data in Chapter 2 above). Child advocates point to adult sexual immaturity, and the hypocrisy of fearing “sexual permission” stimulating more teen sex given the extent of sexual obsession in teen and adult popular culture. As the discussion of the infrastructure threat to Los Angeles noted, all of the existing school clinics in that County are now in jeopardy and likely to be closed.

As noted, the transfer of programs makes irrelevant the 1989 to current year trend comparison. But the accounts have covered consistent programs since 1997 and show 20% to 33% adjusted declines from then to proposed 2002-03. Similarly, the challenge grant and other programs ancillary to Table 4-K are now in jeopardy and some are proposed for cuts in proposed 2002–03 (see Chapter 9 discussion of OCJP accounts).

E. County Health Services Branch

Welfare and Institutions Code § 17000 designates counties as the providers of last resort for those otherwise lacking access to care. In 1983, the state shifted Medically Indigent Adult care (a state-funded program with no federal contribution) from Medi-Cal to the counties, with a 30% cut in state funds allocated. As a result, since the early 1980s, many counties’ indigent health programs have been underfunded in the face of expanding need. Indigent care was transferred to the counties under the Medically Indigent Services Program (MISP) or, for the smaller counties contracting back with the state to provide these services, the County Medical Services Program (CMSP), for medically indigent adults in 34 counties. An unknown number of those served under MISP in the various counties are children.

In 1989, Proposition 99 created a new revenue source for county indigent care for hospital, physician, and related health services. It requires that any public or private providers receiving Proposition 99 funds ensure that follow-up treatment is provided to children for conditions discovered during CHDP screens, when those children could not be covered under Medi-Cal. However, such follow-up care could be provided in a variety of ways, including through county hospitals.

The 1991 state-to-county “realignment” shifted funding for county indigent health programs from the state to the counties’ budgets, and state funding of the County Health Services budget fell from \$1.363 billion to \$407 million. Costs were transferred to the counties for AB 8 county (public and indigent) health programs, including CMSP and MISP. County funds then came from the Public Health (PH) subaccount of the sales tax fund and the Vehicle License Fund (VLF). The realignment was supposed to be revenue-neutral, but the actual revenues received were only \$830 million rather than the \$891 million originally expected.²⁷¹ Thus, the counties took an unbudgeted cut of 11% in revenues for these programs in 1991–92. Realignment funds for health and indigent care programs did not reach the expected 1991–92 level until 1994–95, during which time inflation and population increases assured effective funding decreases.²⁷²

	Budget Year						Estimated	Proposed	Percent Change	
	1994-95	1996-97	1997-98	1998-99	1999-2000	2000-01	2001-02	2002-03	'94-'01	Proposed
County Health Services Total	\$455,583	\$199,217	\$204,195	\$190,479	\$89,081	\$126,143	\$116,488	\$114,818	-74.4%	-1.4%
Adjusted Total	\$569,085	\$225,842	\$233,936	\$211,906	\$96,294	\$130,686	\$116,488	\$110,575	-79.5%	-5.1%

Dollar amounts are in \$1,000s. Adjusted to California population and deflator (2001–02=1.00)
Sources: Governor’s Budgets. Adjustments by Children’s Advocacy Institute.

TABLE 4-L. County Health Services

Since realignment, the main source of County Health Services Branch (CHSB) funding remaining in the state budget is tobacco tax revenue, which fell until 1993–94, leveled somewhat between 1995–98, and fell precipitously in 1999–00.²⁷³ Federal State Legalization Impact Assistance Fund (SLIAG) federal funds have been phased out. Adjusted current-year funding for CHSB represents a substantial decline to less than half 1994–95 levels, with realignment PH subaccount revenues uncertain. The picture would be even bleaker had more Prop 99 funds not recently been re-directed to CHSB: \$25

million in 2000–01 and 2001–02,²⁷⁴ included in Table 4-L. These re-directed Prop 99 funds, however, have been earmarked for costly emergency room physicians and specialists, raising a major concern that uninsured children and adults will have less access to preventive and primary care or insurance under CHSB.

The decline in this and related accounts is of special concern to advocates for the poor. The facilities funded by these accounts may be subject to pressure from patient losses in selected counties as managed care removes Medi-Cal paying patients.²⁷⁵ These facilities have provided the emergency and related care to the large population of uninsured children—one increasing in size until leveling off in 1999 notwithstanding Healthy Families implementation, as discussed above.

It is difficult to accurately describe the entire range of expenditures and services for children under these county programs. The CHDP follow-up treatment mandate for providers receiving Prop 99 funds have not been adequately reported.

As the Infrastructure and Los Angeles crisis discussion above suggests, the various accounts able to provide underlying support are in jeopardy—even without continuing reductions in this account. The combination of \$700 million less in federal Medicaid support, the reduction in Disproportionate Share Hospital funds, and low funding for “Expanded Access to Primary Care” (EPAC) all combine with other county financial shortfalls and a lack of local revenue generating capacity. The end consequence of the trends and spending decisions discussed above is recounted in the closures and retraction of basic safety net clinics and emergency room facilities in Los Angeles now underway.

F. Primary and Rural Health Care Services

DHS’ Primary and Rural Health Care Branch helps to support and fund indigent care in community-based outpatient clinics which provide primary and preventive care. It funds 56 migrant farmworker, Indian, and rural health clinics, primarily from state general funds; many of these also are among the 160 clinics receiving Proposition 99 tobacco tax money under the Expanded Access to Primary Care program, which reimburses on a fee-for-service basis, and which has enjoyed increases over the last three years. Most of the clinics funded under this state budget item also receive funds under a variety of other federal programs, including Medi-Cal. In addition to helping to fund services, this unit provides technical support to clinics, including small amounts for administration.

The Primary and Rural Health Care Services branch was joined with the programs under Family Health Services in 1991–92, at which time some of its county-contracted services were transferred into County Health Services. Therefore, each of its main 1989 funding sources has declined substantially. SLIAG money was made available to clinics after the counties’ share fell from \$13.46 million in 1990 to \$.43 million in 1991,²⁷⁶ but that money has disappeared.

As Table 4-M reflects, the budget increased moderately to 2000-01 and has suffered an adjusted reduction to the current year, and as proposed for 2002-03. Children make up about 30% of those served by this account.²⁷⁷

	Budget Year							Estimated 2001-02	Proposed 2002-03*	Percent Change	
	1989-90	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01			'89-'01	Proposed
General Fund	\$13,748	\$11,210	\$11,200	\$16,397	\$25,380	\$36,152	\$43,145	\$39,728	\$39,728	188.9%	0.0%
Prop 99	\$20,305	\$11,599	\$15,527	\$18,209	\$14,517	\$7,936	\$18,448	\$18,449	\$18,449	-9.1%	0.0%
Other	\$0	\$0	\$0	\$3	\$17	\$17	\$17	\$17	\$17	na	0.0%
Federal funds	\$15,282	\$1,469	\$1,660	\$1,616	\$5,257	\$1,566	\$987	\$981	\$981	-93.6%	0.0%
Total	\$49,335	\$24,278	\$28,837	\$36,255	\$45,171	\$45,671	\$62,597	\$59,175	\$59,175	19.9%	0.0%
Adjusted Total	\$105,551	\$32,961	\$37,714	\$45,422	\$54,050	\$51,820	\$66,830	\$59,175	\$55,256	-43.9%	-6.6%

Dollar amounts are in \$1,000s. Sources: Governor’s Budgets. * Estimates of the Children’s Advocacy Institute Adjusted to California population and CPI-Med (2001–02=1.00). Adjustments by Children’s Advocacy Institute.

TABLE 4-M. Primary & Rural Health Care

As discussed above regarding county health services, these providers may be particularly vulnerable to Medi-Cal managed care and prospective Healthy Families capture of existing patients. They may also be affected by increasing and prospective restrictions on disproportionate share compensation for treating low-income patients. Finally, they may be affected by further projected reductions in Proposition 99 funding (see discussion above).

G. Specialized Prevention Accounts

1. Immunization Branch

The Immunization Branch works with other DHS programs, local health departments, and providers to protect California’s population against vaccine-preventable diseases. It provides vaccines to local clinics, which it estimates immunize one-quarter of the state’s children; provides technical assistance on immunization practices, disease surveillance, and outbreak control; develops immunization education and promotional materials; assesses immunization levels in target populations; and monitors implementation of the laws requiring immunization at entry to school or child care facilities. The target population for the branch’s activities includes all children, with most of the vaccines going to community and public clinics for young and low-income children. This account does not include all immunization spending for children. For example, a substantial portion of CHDP funding is for immunization costs for children who qualify for and use that program. However, the Immunization Branch account funds provision and coordination of vaccine to clinics and physicians and oversees the screening/immunization of others.

There has been renewed attention to the state’s child immunization needs since the 1989–90 measles outbreak. California had about 12,000 cases (40% of the cases nationally), including 37 deaths.²⁷⁸ Unlike many earlier epidemics which spread largely through contact at schools, cases here were concentrated in the preschool population.²⁷⁹ The state’s rate of adequate immunization for two-year-olds remained just under 50% until 1994, when the state estimates it rose to 57%.²⁸⁰ The national “Year 2000” objective calls for 90% of children to have adequate basic immunizations by age two. Barriers to better immunization rates have included a meteoric rise in vaccine costs over the last decade, lack of access to primary care, and lack of information to parents.

	Budget Year							Estimated	Proposed	Percent Change	
	1989-90	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03*	'89-'01	Proposed
General Fund	\$11,371	\$8,643	\$16,611	\$16,770	\$16,615	\$24,656	\$17,803	\$16,703	\$16,703	46.9%	0.0%
Federal funds	\$17,107	\$32,563	\$37,523	\$33,040	\$21,727	\$13,356	\$29,563	\$29,563	\$29,563	72.8%	0.0%
Total	\$28,478	\$41,206	\$54,134	\$49,810	\$38,342	\$38,012	\$47,366	\$46,266	\$46,266	62.5%	0.0%
Adjusted Total	\$56,611	\$49,823	\$64,509	\$58,244	\$43,550	\$41,620	\$49,781	\$46,266	\$43,642	-18.3%	-5.7%

Dollar amounts are in \$1,000s. Sources: Governor’s Budgets. *Estimates of the Children’s Advocacy Institute. Adjusted to age 0–4 population and CPI-Med (2001–02=1.00). Adjustments by Children’s Advocacy Institute.

**TABLE 4-N. Immunization Assistance Program
(Local Assistance)**

In 1992, the Legislature passed AB 3351 and AB 3354,²⁸¹ bulk-purchase immunization bills which require the state to bulk-purchase vaccines for Medi-Cal and pass the savings on to improve immunization coverage, especially by improving access to primary care. Bulk purchase contracts were slow to be negotiated by the state, and then the Clinton administration included the bulk purchase of vaccines as a required part of federal procurement—and their provision to the states at no cost. As a result, California saved perhaps \$30 million in Medi-Cal and public health vaccine costs starting in 1994. That year, the Governor proposed to use two-thirds of those savings to improve immunization rates.²⁸² These savings, delayed until 1995 instead, became the federal Vaccine For Children (VFC) program. The state, which has supplied vaccines for an estimated one-quarter of the state’s infants who receive them in public and nonprofit clinics, has expanded its distribution to another 35% of the state’s children as of 1998, including children in Medi-Cal and CHDP and uninsured children enrolled by providers in the VFC program.

The VFC program means the state receives vaccines free from the federal government and saves the cost of buying vaccine through Medi-Cal and other public programs. The federal government also saves money because it bulk-purchases at reduced prices rather than reimbursing at half the much higher market rate for vaccines through Medicaid. The Republican Congressional reconciliation bill in 1996 that would have reduced and block-granted Medicaid (in lieu of entitlement status) also would have eliminated VFC and prohibited government bulk purchases at the behest of pharmaceutical interests. The bill was vetoed by President Clinton.

However, in 1997–98, the U.S. Health Care Financing Administration issued rules to deny free vaccines to the state's Healthy Families child beneficiaries. The federal policy extends free coverage to states which expanded Medicaid to cover more children under the Balanced Budget Act of 1997, but distinguished the states which created separate programs. California's children covered by its Healthy Families add-on option are excluded as beneficiaries of a "private plan" rather than a public program entitlement.

California expended \$18–25 million to receive the vaccines for the Healthy Families program that would be available at no state cost had the state expanded its Medi-Cal program instead. Some observers feared that the state would expect pediatricians to absorb much of the cost—by paying only Medi-Cal rates which do not cover the out-of-pocket cost of the vaccine and lowering the financial incentive to provide it. On May 18, 1998, the California Medical Association (CMA) filed suit to require federal inclusion of Healthy Families children.²⁸³ However, on April 30, 1999, U.S. District Court Judge Lawrence K. Karlton rejected CMA's suit, reluctantly saying that he was bound by law to uphold Health and Human Services Secretary Donna Shalala's interpretation of the relevant law. In his ruling, Judge Karlton stated that "the deprivation of \$18 million in medical care for underprivileged children must be a matter of urgent concern to California's Legislature and new governor."²⁸⁴

State and federal spending on this account has been in slight decline since 1996–97 and is proposed for a 5.7% adjusted reduction. The reduction occurs when recent legislation now mandates chicken pox vaccinations by all children entering kindergarten (see legislation discussion above).

2. Genetic Disease Testing and Laboratory Services

DHS' Genetic Disease Testing and Laboratory Services Branch focuses on reducing and controlling disorders having a hereditary or genetic basis through early detection, public and professional education, preventive interventions, and counseling. These programs have universal access and operate statewide. The newborn screening activity is designed to screen all newborns for four preventable causes of physical handicap or mental retardation: and tests a single drop of blood for four diseases: sickle cell anemia, phenylketonuria, galactosemia, and hypothyroidism. This program is now entirely funded by the collection of users' fees (now at \$60 per child). General fund contributions are no longer made directly. For 1997–98, \$3 million was added from the fund for equipment modernization, and \$1 million for expected caseload (birth) increases. The account is 8.7% above child population growth and inflation from 1989, but a 5.1% adjusted cut was proposed for 2002–03.

Part of the "user fees" paid into this account come from the infants covered by Medi-Cal; these children make up 38% of the state's current births. In January 2002, the DHS proposed an important advance for the health of children. The single drop of blood now tested for four diseases could be tested for up to 30 diseases given new technology (e.g., including fatty acid metabolism disorder, maple syrup urine disease, and citrullinemia). The expansion in test scope was authorized by AB 2427, approved in September 2000. It could easily be applied to the 400,000 birth samples now examined annually. Catching some of the new detectable diseases early can make a difference between a manageable handicap and a life cut short, or dependent on others. Approximately one in 5,000 children will have a genetic disorder now detectable under the new procedure. Some of these genetic diseases bear a strong correlation to Sudden Infant Death Syndrome. The marginal cost of covering the Medi-Cal children—the only public cost involved, would require a Medi-Cal budget increase from the current \$4 million to \$6 million. Its expenditure is in doubt given the current general fund crisis.

	Budget Year							Estimated	Proposed	Percent Change	
	1989-90	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01			2001-02	2002-03*
Genetic Disease Testing Fund	\$28,077	\$54,319	\$41,194	\$60,460	\$52,979	\$57,795	\$61,342	\$68,683	\$69,065	144.6%	0.6%
Other	\$3,715	\$0	\$171	\$63	(\$21)	\$7	\$0	\$0	\$0	-100%	0.0%
Total	\$31,792	\$54,319	\$41,365	\$60,523	\$59,958	\$57,802	\$61,342	\$68,683	\$69,065	116.0%	0.6%
Adjusted Total	\$63,199	\$65,678	\$49,293	\$70,771	\$68,102	\$63,289	\$64,469	\$68,683	\$65,148	8.7%	-5.1%

Dollar amounts are in \$1,000s. Sources: Governor's Budgets. *Estimated by Children's Advocacy Institute. Adjusted to 0-4 population and CPI-Med (2001-02=1.00). Adjustments by Children's Advocacy Institute.

TABLE 4-O. Genetic Disease Testing

3. Birth Defects Monitoring Program

The Birth Defects Monitoring Program (BDMP) collects and analyzes confidential data from a birth defects registry. The goal is to identify causes and risks for such defects so that prevention strategies can be developed. Each year, over 17,000 (one in 33) California children are born with serious structural birth defects, the causes of 80% of which are unknown. BDMP tracks over 200 defects and tries to identify risks for them, including environmental exposures such as those occurring from toxic spills.

	Budget Year						Estimated	Proposed*	Percent Change	
	1990-91	1996-97	1997-98	1998-99	1999-00	2000-01			2001-02	2002-03
Total	\$7,039	\$3,925	\$3,925	\$3,925	\$3,925	\$3,925	\$3,925	\$2,347	-44.2%	-40.2%
Adj. Total	\$11,520	\$4,720	\$4,591	\$4,440	\$4,282	\$4,109	\$3,925	\$2,231	-65.9%	-43.2%

Dollar amounts are in \$1,000s. Source: BDMP. * Estimate of Children's Advocacy Institute. Adjusted to CPI-Med (2001-02=1.00). Adjustments by Children's Advocacy Institute.

TABLE 4-P. Birth Defects Monitoring Program (BDMP)

The population base for the registry expanded from the original five Bay Area counties in 1983 to all 58 counties in 1990. In 1991, however, funding was cut by 47%, requiring the elimination of 45 counties—with half the state's births—from the registry. Funding has been gradually reduced in this important account from 1995 to the current year by maintaining raw number amounts and allowing population and inflation to accomplish reductions. For 2002-03, however, a 43% adjusted cut is proposed.

Separate from the BDMP account, the proposed budget will include \$400,000 from state taxpayer check-off contributions to expand birth defect research.

Cost studies by BDMP suggest the long-term cost-efficacy of both monitoring and research, currently funded at token levels by the state. The 1988 cost to three public programs (Medi-Cal, CCS, and the Department of Developmental Services) for twelve types of birth defects was over \$230 million. For one defect, spina bifida, about 400 cases occur each year; 90% of these children live to adulthood at an average lifetime cost of \$250,000 per case (1993 data).²⁸⁵ A 1995 study suggested that folic acid fortification of grain could prevent many cases of spina bifida (and ancephaly), with a potential net benefit of hundreds of millions of dollars.²⁸⁶

4. Childhood Lead Poisoning Prevention Branch

a. Lead Incidence: Surveys

As of 1995, close to three million California families, with over one-quarter of a million children, lived in homes with lead paint. A large amount of lead from vehicle exhaust and paint also contaminates the soil; over 1.5 billion pounds of lead are believed to have been used in petroleum products and paint in the state between 1929 and 1986.²⁸⁷ The CLPP Fund, established in the 1992-93 budget by AB 2038

(Connelly) (Chapter 799, Statutes of 1991) to implement a Childhood Lead Poisoning Prevention Program, assesses fees from the largest environmental lead contributors to support follow-up widespread childhood lead screening tests (as required under the 1991 settlement of *Matthews v. Coye*), and development of abatement policies and practices.

Blood lead screenings under Medi-Cal and CHDP have increased dramatically—from 9,000 in 1991 to 332,000 in 1994.²⁸⁸ In that time, almost 2,200 children with moderate or severe lead poisoning (blood lead levels of more than 25 ug/dl) were identified, 13% needing urgent treatment (>45 ug/dl). More than 750 moderate (or worse) cases were found in 1993, compared to fewer than 40 in the years before screening began in 1991.

In 1998, California's Department of Health Services released its own study of lead contamination in elementary schools and child care centers. The Department took samples of paint, soil, and drinking water from a cross-section of such facilities from 1994 to 1998. The survey concluded that 37% of public elementary schools have deteriorating lead-containing paint significant enough to pose a hazard. More alarming, 18% have lead levels in drinking water above the federal action level of 15 parts per billion (ppb) and 6% have soil lead levels above the federal action level of 400 ppb.²⁸⁹ The Department stated that, because of the findings, "[w]e should be alerted, but not alarmed," pointing out that those diagnosed with lead poisoning "consumed water with lead levels 6–80 times higher than the highest levels found in the survey."²⁹⁰

Child health advocates counter that brain damage from lead occurs at levels far below those resulting in a "lead poisoning" diagnosis, that children are subject to school dosages for many hours per day over most of the year, and that the total intake of lead is the danger. They also point to one other important fact ignored in the Department's release: In relation to body weight, children ingest on average two and one-half times the amount of water consumed by an adult.²⁹¹ Health experts add that lead is not like a typical poison; it is cumulative in nature, with new intake adding to previous ingestion, which means that "continuing exposure to low levels of lead can result in significant exposure over time."²⁹²

A school could meet federal standards for water, paint, and soil, but the additive effect of all three, in addition to possible intake at home, can have a permanently damaging effect on the brain. The Department's *apologia* for its tepid response points to a "safety margin" present in each U.S. Environmental Protection Agency (EPA) lead standard. But the EPA standard assumes realistically that there will be other sources of lead intake. Taking each source as an isolated exposure and measuring it alone against a standard leading to gross symptoms fails to reflect the nature of the hazard. Experts also caution against such failures to acknowledge the cumulative nature of the lead injury. According to health and lead-safe advocates, such an omission is particularly inappropriate where the Department's survey shows high levels in many schools from one or both of the other two sources of lead as well (paint, water, soil), and where the contamination is of a continuing nature. Child advocates point to the blood screening results discussed above, which indicate that many children are at the lead intake budget margin as they enter school, and warn that further contamination can create curvilinear damage.²⁹³

In January 1999, the General Accounting Office released a substantial report on lead levels, effects, and public agency performance. The Report included California within its sample area. Its findings confirmed the California DHS survey: more than 8% of surveyed children ages one to five who were served by federal health care programs (Medicaid, WIC) had "harmful" lead levels. These levels are substantially higher than "elevated" and correlate with known brain development effects. The incidence of these elevated levels was five times greater among the impoverished population served by the major federal health programs than for the general population. Critically, for WIC children, the prevalence of highly elevated "harmful" lead levels was almost 12%.²⁹⁴

For two-thirds of the children tested, the GAO test was the only screening they had experienced. Three quarters of children tested from 1–5 years of age were found to have elevated lead levels.²⁹⁵

b. Effects of Elevated Lead Levels: The Evidence

One source summarizes the health evidence: “Recent studies of children with low but elevated blood-lead levels strongly link lead with decreased intelligence and impaired neurobehavioral development.”²⁹⁶ A 1995 study published in *Epidemiology* suggests that the 80 ug/dL level (which produces visible symptoms cited by the California Department of Health Services) is not the extent of the danger. Even low levels of lead in blood (10 ug/dL) can drop the IQ of young children measurably—and to below normal ranges.²⁹⁷ The result “could be a tripling of the number of youngsters who need specialized educational services.”²⁹⁸

The first of the two leading studies examined and followed 494 infants in Port Pirie, Australia—where some children are subject to low-level contamination from a lead smelter. Examining levels at the relatively low 20 ug/dL rate, the study found clear deficits in ability to read, write, and solve math problems because lead harms brain mechanisms which recognize and copy shapes, visualize objects, and form nonverbal concepts.²⁹⁹ The second study tested expelled childhood teeth from first- and second-graders, and found levels above 20 ppm associated with an extraordinary sevenfold risk of not graduating from high school, and sixfold risk of having a reading disability, as well as vocabulary and attention span problems and lower academic achievement.³⁰⁰ Other recent studies associate elevated lead levels—even moderate elevation—with antisocial, aggressive, and delinquent behavior in children and youth³⁰¹ (see discussion in Chapter 9 below).

c. Lead and the Childhood Lead Poisoning Prevention (CLPP) Branch

The Childhood Lead Poisoning Prevention (CLPP) Branch conducts epidemiological studies, develops lab testing and case management protocols, trains health officials and providers and the public in case identification and management, and writes regulations related to assessment, CLPP Fund fees, and abatement.

	Budget Year						Estimated 2001-02	Proposed 2002-03*	Percent Change	
	1994-95	1996-97	1997-98	1998-99	1999-00	2000-01			'94-'01	Proposed
General Fund	\$11,518	\$1,881	\$3,126	\$3,285	\$3,514	\$4,226	\$5,376	\$5,300	-53.3%	0.0%
CLPP Fund	\$0	\$13,940	\$9,011	\$13,977	\$11,993	\$13,801	\$14,138	\$21,300	-	50.6%
Other	\$2,170	\$2,453	\$1,679	\$1,624	\$2,078	\$2,825	\$2,863	\$2,800	31.9%	0.0%
Total	\$13,688	\$18,274	\$13,816	\$18,886	\$17,585	\$20,852	\$22,377	\$29,400	63.5%	31.4%
Adjusted Total	\$16,851	\$21,776	\$16,155	\$21,451	\$19,254	\$21,915	\$22,377	\$27,732	32.8%	23.9%

Dollar amounts are in \$1,000s. Sources: Governor’s Budgets. *Estimates of the Children’s Advocacy Institute. Adjusted to age 0–4 population and CPI-Med (2001–02=1.00). Adjustments by Children’s Advocacy Institute.

TABLE 4-Q. Childhood Lead Poisoning Prevention (CLPP) Program

The CLPP Fund is limited by its enabling statute to collecting no more than \$16 million per year. In 1995–96, it produced \$14.4 million, but the budget called for a collection halt in the 1997–98 fiscal year “to protect the fund’s solvency.”³⁰² The majority of the fund has been used for county education, environmental investigation, and follow-up (abatement) activities. The paint industry had challenged the assessment as a tax (therefore requiring a two-thirds vote of the Legislature to enact),³⁰³ and in May 1995 the trial court granted summary judgment for the plaintiffs, placing the fund in jeopardy. That ruling was affirmed by the Third District Court of Appeal, but the California Supreme Court reversed and upheld the fee in June 1997.³⁰⁴

The initial court setback cost the fund two years of substantial growth. The state backfilled only part of the special fund level, declining to anticipate a favorable final outcome, or to make a large general fund investment in this child health preventive area. With the state Supreme Court decision, the account has stabilized and is proposed for its first major increase in a decade, to \$29.4 million—a 24% gain.

In 1999, the California State Auditor reviewed the DHS performance in protecting children from lead contamination. The Auditor’s findings are indicated by its title: *Department of Health Services: Has Made Little Progress in Protecting California’s Children from Lead Poisoning*.³⁰⁵ The findings include the following:

- ◆ After more than a decade, the Department is not closer to determining the extent of childhood lead poisoning statewide—having only identified about 10% of the estimated 40,000 children needing services.
- ◆ Children are not receiving blood-lead tests from Medi-Cal and CHDP programs as required.
- ◆ Reporting of laboratory test results is insufficient for the Department to identify children requiring medical care.

Child advocates argue that the amounts assigned to prevent and treat child lead poisoning in recent years do not address the extent of the danger or the evidence adduced—particularly given the levels in elementary schools, the cumulative nature of contamination with other sources, and the permanent brain development consequences for young children implicated. In related developments in 2000, the Legislature provided \$2.2 million to the California Department of Housing and Community Development (HCD) to be used in new pilot projects for coordinating residential housing code enforcement activities between county health and housing departments.³⁰⁶ The Legislature also provided another \$2.5 million for a Code Enforcement Incentive Program, which also has a coordination emphasis. An appropriation of \$1.83 million (\$1,514,000 General Fund) was made for child lead screenings and evaluations.³⁰⁷

It is hoped that lead screenings can reach 200,000 children, of whom it is anticipated 4,000 will have elevated blood lead levels.³⁰⁸ In addition to screenings, lead poisoning case management (under EPSDT) and environmental investigation costs can be handled under Medi-Cal, with its 50% FFP.³⁰⁹ However, as of 2001, case management has not been adequately implemented through Medi-Cal for lead poisoning cases, and is the subject of pending litigation.³¹⁰ That case involves a challenge by Public Advocates Inc, and Bay Area Legal Aid of Oakland contending that DHS has failed to comply with the specific mandate of the 1991 statute. One contention is that the DHS regulations adopted in October of 2000 required physicians to test all children in Medi-Cal, Healthy Families, and CHDP (as discussed above). However, petitioners contended that no provision was made for enforcement. The lack of any consequences for non-compliance allegedly rendered them nugatory. They would effectively function as they have for the prior nine years as an advisory which may be ignored. On November 30, 2000, San Francisco superior court judge Ronald Quidachay issued an order supporting petitioners' factual contentions and requiring the Department of Health Services to adopt rules consistent with the law and including an enforcement mechanism with the monitoring/screening mandate now in effect. Perhaps anticipating the order, the DHS adopted rules on an emergency basis on October 10, 2000. The new rules require doctors to tell the parents of young children about lead poisoning, and to either test or evaluate all children in terms of contamination. Doctors would be required to test all children in Medi-Cal, CHDP, Health Families, and WIC (who are believed to be a vulnerable population) with the consent of parents. Doctors are also instructed to inquire about peeling paint, and to screen children at age one and at age two, and any child under 6 who has not been screened. On June 4, 2001 the rules were readopted and on November 19, 2001 they were approved by the Office of Administrative Law.³¹¹

This development on the monitoring front end was then followed by another critique of DHS performance to address high blood levels with treatment at the back end (when high blood levels are discovered). In May 2001, the California State Auditor followed up her earlier critique of the program (see above) with a follow-up study, acknowledging some progress, but concluding that the Department remains "unsuccessful at meeting [the statute's] goals." The Auditor, in uncommon bluntness, concluded: "As a result of the department's difficulty in meeting its goals, thousand of lead-poisoned children may have been allowed to suffer needlessly. The department itself estimates that approximately 128,000 children between the ages of 1 and 5 have elevated blood-lead levels, with 38,000 having levels that would warrant case management....Yet, as of January 2001, the department reported that it was providing case management to a mere 3,700 children..."³¹² Eight recommendations were made by the State Auditor, including the adoption of "screening rules" making "providers accountable"—a reference to the Public Advocates suit and court order noted above. The other recommendations included requiring local programs to document provided case management and closer monitoring of local mitigation/treatment; regulations requiring labs to report all blood lead test results; new legislation to grant local jurisdictions lead abatement authority; development of a comprehensive statewide outreach

plan, and requests for adequate resources and staff to carry out its important public health staff.

In order to expedite mitigation, five San Francisco Bay Area counties filed suit against the lead industry in Santa Clara County, claiming fraud, negligence, unfair competition, and public nuisance. On September 17, 2001, superior court judge Gregory Ward rejected the nuisance cause of action, but the remaining contentions are scheduled for trial in late 2002. The plaintiff counties seek mitigation/restitution/damages to pay for the clean up, monitoring, treatment or treatment of previous paint surfaces dangerous to children. In a suit with some parallel to tobacco litigation, the plaintiffs contend that the industry knew of the lead hazard prior to its 1970s ban from paint, and misled the public at to its dangers—thus preventing its earlier prohibition and imposing substantial public mitigation costs on the counties.

5. Other Environmental Dangers

In addition to the harm caused children from lead ingestion, other environmental dangers disproportionately harm them. One 1997 report identifies the four most dangerous sources after lead as air pollution, pesticides, environmental tobacco smoke, and drinking water contamination.³¹³ As to each of these sources, children are not merely “little adults,” but suffer more harm from levels of exposure which adults can tolerate. As child health advocates have long complained, federal and state regulatory officials have set standards based on danger to adults, and generally have not factored in disproportionate child impacts.³¹⁴

a. General Air Pollution

Children are more susceptible to asthma and respiratory problems from the ozone, particulates, nitrogen oxides, and sulfur dioxides from California’s continuing high air pollution incidence. Childhood asthma rates have almost doubled over the past twenty years. Asthma is now the most chronic illness among children; it is the leading cause of school absenteeism. The major recent public policy decision in this area has been to exclude tens of thousands of children with respiratory problems from SSI coverage (see Chapter 5 discussion below).

b. Pesticides

Pesticides are a dangerous source of environmental contamination for children. Many pesticides exposed to pregnant women are closely connected with birth defects, and others lower infant and child immunity, and have disproportionate carcinogenic impact on children. By 1993, the United States was using an estimated 2.3 billion pounds of pesticide active ingredients in agriculture, wood preservatives, disinfectants, and water treatment. In a 1997 report, child health experts concluded that increased chemical exposure relates to an increase in childhood cancer rates of 10.8% between 1973 and 1994.³¹⁵

In 1988, Congress asked the National Academy of Sciences to examine pesticide food residues relevant to child health.³¹⁶ The ensuing report, issued in 1993, documented the substantially disproportionate danger to infants and children from numerous contaminants, and the fact that the standards extant failed to recognize that disparity—setting standards at adult tolerance levels to the probable health detriment of children.³¹⁷ Most recently, Congress responded by enacting the Food Quality Protection Act of 1996 to require—for the first time—that EPA measure infant and child tolerances of pesticide and other foodborne contaminants. Information about those disparate tolerance levels will be published, and *future* EPA decisions as to chemical residue levels must determine that they are not harmful to infants and children.³¹⁸

However, it is unclear how the new statute will affect child pesticide ingestion levels over the next decade. California has yet to take initial steps to acknowledge disparate child vulnerability. In addition to food as a source, home and school/park use provide the most exposure to children. The state continues to allow use of specific pesticides on school grounds—where children are exposed for hours and days continuously—which have been banned from use in agriculture as excessively hazardous. Legislation to ban the use of pesticides from school grounds which have been adjudged too dangerous

for agriculture has been rejected by the Legislature after strong industry opposition. Child advocates scored a partial success in the enactment of AB 2260 (Shelley) in year 2000.³¹⁹ Although compromised from its initial version, this legislation orders schools to use “least toxic pest management practices” and requires them to keep records of all pesticide use at the school site for a period of four years, provide some notice of expected pesticide use and post warning signs on site prior to application. The practical effect of the enacted measures will assist those students who know they have strong allergic reaction to certain pesticides to avoid some contact, but will not ameliorate the underlying problem of low level but lengthy exposure.

Apart from schools and gradual contamination is the problem of younger children directly ingesting pesticides. According to a 1996 report, nationally over 100,000 children directly ingest pesticides by accident each year.³²⁰ In this area, the state proposed the closure of all poison control “hotlines” for physician and parent use as an economy measure in 1993—the account was restored after monies from “Kids’ Plates,” a customized vehicle license plates program, were directed for its future funding,³²¹ but they remain minimally funded and limited in coverage.

c. Tobacco Smoke

Environmental tobacco smoke includes 40 carcinogenic chemicals. According to a 1997 report, nationally secondhand smoke is responsible for an estimated 150,000–300,000 lower respiratory tract infections in infants (children under 18 months of age) each year. It also worsens asthma among the over 200,000 seriously afflicted children annually, and is associated with increased sudden infant death syndrome (SIDS) incidence.³²² Forty-three percent of children from 2 months to 11 years of age live in homes with at least one smoker.³²³

One 1999 source contends that even second hand smoke has substantial long term effects on as many as 1.1 million California children. Effects cited from existing studies³²⁴ include:

- ◆ Low birthweight—1,200 to 2,200 cases
- ◆ Sudden Infant Death Syndrome—120 deaths
- ◆ Middle ear infections—78,600 to 188,700 office visits
- ◆ New cases of asthma—960 to 1,320 cases
- ◆ More severe asthma—48,000 to 120,000 children
- ◆ Bronchitis or pneumonia in infants—900 to 1,800 hospitalizations, 16 to 25 deaths

Because of California's Proposition 99, the state has expended substantial public relations and education spending for tobacco use reduction and safety purposes, including secondhand smoke ingestion from adult usage. The budget proposed for 2001–02 includes a total of \$114.5 million for efforts to reduce tobacco use, of which \$45.2 million is from Proposition 99 funds for the state's anti-tobacco media campaign and \$20 million is from the Tobacco Settlement Fund reduce smoking specifically among teens.³²⁵ Local communities have adopted ordinances governing smoking in public places. Smoking was prohibited on intrastate air flights before federal rules similarly applied. However, the impact of measures thus far undertaken on secondhand smoke ingestion by children is unclear. Their exposure is dominated by fetal receipt, smoking in their homes, and in automobiles—where children are often present and in a confined setting.

Direct smoking by youth represents a particular state public health failure. The average currently addicted smoker begins to smoke regularly by the age of 16. The state is now beginning to make at least some impact on youth smoking rates, which have leveled and are declining in small degree for most groups. However, smoking remains at high incidence among African-American youth, and of greatest concern, among young women. Among the groups with the highest rates of use are women under 23 years of age, the population subject to the highest rate of pregnancies. Smoking while pregnant delivers many of the dangerous contaminants in concentrated fashion through the placenta to the fetus.

The tobacco settlement is limiting some pro-tobacco advertising, and state sponsored advertising is increasingly effective. California has become a national leader in local smoking restrictions (tobacco free areas) and in state spending against the industry. The effort has spread nationally to some extent, and a study released in October of 2001 found that teen smoking nationally has dropped by one-third from 1997 to 1999. The number of youth who began smoking was down from over 3,000 each day to 2,145.³²⁶

However, use rates are high enough to subject a substantial percentage of children to danger while *in utero*, youth addiction continues at rates devastating to millions of youth in later years. Recent legislation allows more effective sting operations (see discussion of legislation above). In 2002, the Legislature is considering for the first time raising the age for lawful tobacco smoking to 21 years of age (AB 1453 (Koretz)).

d. Drinking Water Contamination

As noted above, children are at particular risk from drinking water contamination because they ingest two and one-half times the daily water intake of adults in relation to their body weight.³²⁷ Hence, any contaminant will accordingly concentrate itself. In addition, the same rate of exposure on developing organs can have disproportionate impact. Nevertheless, drinking water standards set limits on microorganisms, trihalomethanes, arsenic, radon, and pesticides, based on their effect on adults. Federal legislation enacted in 1996 now requires “consideration of children,” but the impact of this new law on standards and water quality is problematical or unknown.³²⁸

In 1996, EPA issued a report (using 1994–95 data) indicating that 45 million Americans were drinking from water systems that fell short of federal standards—standards based on their effect on a 155-pound male adult.³²⁹ California has not comprehensively tested its water, applied child-appropriate standards, required effective disclosure of available test results from existing water providers, or even fluoridated most of its water supply (as discussed below).

In general, California has not actively protected her children from environmental hazards. Lead screening/mitigation funding has been partly restored, but at a small fraction of the level required to address the serious dangers identified and currently causing damage. In the other four areas where children need special protection from environmental hazards, there is no account to present in the *California Children’s Budget*. Some education accounts relate indirectly (e.g., tobacco dangers), but the major hazards have not generated an agency or office assigned a child protection mission with identifiable resources and authority. Child advocates argue that both are needed as to each major environmental source of harm to children—for attention, priority, and outcome responsibility.

6. Dental Disease Prevention Program

In September 1997, the Dental Health Foundation released the first-ever statewide assessment of the oral health of California’s children. The study was conducted during the 1993–94 school year and used teams of dental examiners to survey a sample of 6,643 children in 156 schools in 10 geographic regions. The findings documented what was termed a “neglected epidemic” of oral disease, with the state’s incidence of problems double that of the national average, and substantially deteriorated from 1987.³³⁰ The examinations found high levels of untreated tooth decay and even gum disease among preschool and school-aged California children. The report described the consequences as “significant pain, interference with eating, poor self-image, overuse of emergency rooms, and loss of school time.”

The report coincided with the announcement by The California Wellness Foundation of an initiative to develop ten school-based preventive dental programs within the state, and the formation of a task force to develop long-term solutions.

In May 2000, the Dental Health Foundation re-released its findings in a new format,³³¹ highlighting 1994 data that:

- ◆ 31% of preschoolers, and over two-thirds of elementary school children have tooth decay problems;
- ◆ More than one-half of all California school age children have untreated tooth decay; and
- ◆ Among tenth graders, 79% have tooth decay, 61% have gum disease, and 21% need intensive dental care for decay, pain, or infection.

The Report concludes that the oral health of California's children is at or near the bottom of the nation, and that decay incidence among 6- to 8-year-olds is twice the national average. The Report notes that California still has low fluoridation rates. Only 10% of the children surveyed in critical 6- to 8-year-old range (permanent teeth and high cavity rate).

The severity of the crisis in access to dental health care nationwide and the importance of dental care for overall health and well-being were confirmed in a report released by the U.S. Surgeon General in 2000.³³²

Dental experts contend that waiting for cavities and treating them with fillings, followed by caps and expensive crowns, is unnecessarily expensive with existing technology. And the alternative of untreated caries with attendant damage is more indefensible. Dental sealants are available to protect the teeth of children against decay and are remarkably effective. However, only 10% of the 6- to 8-year-olds surveyed had received this inexpensive and cost-effective preventive treatment. In contrast, Ohio has already applied sealants to over one-quarter of its children.

Similarly, although 62% of the nation's children have access to fluoridated water, only about 30% of California's children receive such treated water as of 2000 (up from about 16%, according to The Dental Health Foundation), with coverage more prevalent in wealthier neighborhoods, such as Long Beach and Beverly Hills. Legislation in 1995 which would have provided substantial new fluoridation supplies was not funded in the state budget. Advocates for dental health argue the public health investment in fluorides and sealants is as effective as are many of the vaccines in the state's immunization strategy and the US Public Health Service has identified water fluoridation as one of the ten great public health achievements of the twentieth century.

The state's major account addressing the Study's findings is the Dental Disease Prevention Program (SB 111), a school-based effort to reduce the incidence of dental disease in children. Program components include classroom oral health presentations, teacher in-services, and fluoride and plaque control programs. The target population is preschool through sixth grade. The program reaches 24 counties through 26 contracts with county health departments and school districts.

The program relies on in-kind contributions by providers to supplement the state general fund appropriation, which, until last year, had remained constant except for a 4% cut in 1991. The state's contribution to the program, however, when adjusted for inflation and the increase in K–8 school enrollments, represented a 49% decline between 1989–90 and 1998–99. The estimated number of children actually served has been declining; even when adjusted for this figure (rather than the student population), funding has fallen by 25% in recent years. "Level" funding in 2000 would have constituted a real cut of another 4%, given enrollment increases and inflation. For 2000–01, the reimbursement rates were increased from \$4.50 to \$10 per child, at a general fund cost of \$1.65 million—this constitutes the first increase in over ten years. Additionally, schools were given the authority to provide sealants. However, \$3.4 million to add 200,000 more children to the program was vetoed by Governor Davis.

In 1994–95, as a cost-saving measure the administration abolished the position of Chief of the Dental Health Section,³³³ and the program is now administered by a physician with other duties. A 2002 survey of Santa Clara County children under the age of 9 found that 31% suffered from untreated tooth decay. The study estimated that dentists in the county can accommodate 20,000 of the 140,000 children through existing social programs³³⁴—a problem exacerbated by an acute shortage of pediatric dentists.

	Budget Year						Estimated 2001-02	Proposed 2002-03*	Percent Change		
	1989-90	1995-96	1996-97	1997-98	1998-99	1999-00			2000-01	'89-'01	Proposed
Total	\$1,680	\$1,614	\$1,613	\$1,613	\$0	\$1,596	\$1,614	\$1,614	\$1,614	-3.9%	0.0%
Adjusted Total	\$3,501	\$1,999	\$1,924	\$1,863	\$0	\$1,724	\$1,685	\$1,614	\$1,530	-53.9%	-5.2%

Dollar amounts are in \$1,000s. Sources: Governor's Budgets.
Adjusted to age 0-9 population and CPI-Med (2001-02=1.00). Adjustments by Children's Advocacy Institute.

TABLE 4-R. Dental Disease Prevention Program

The low level of dental funding and coverage for the state's over five million school children is of special concern, because: (1) community water supplies are fluoridated, (2) Medi-Cal fails to provide many of the children enrolled in the program with dental services, and (3) a substantial number of California children are still uninsured even after the adoption of Healthy Families (see above), with dental insurance rates substantially lower than general health coverage. The problems highlighted by the Oral Health Needs Assessment go well beyond the current scope of the Table 4-R; however, it is an account which addresses the problem area, and one which could be the vehicle for prevention enhancement. Instead, it has been reduced 54% from 1989 to the current year, and is scheduled for another 5% adjusted cut.

7. Epidemiology and Prevention for Injury Control

The Epidemiology and Prevention for Injury Control (EPIC) Branch of DHS includes a variety of small programs and activities. Among other things, EPIC conducts epidemiological investigations and control programs for prevention of unintentional and intentional injuries. Injury control program functions include state and local injury control programs, educational and informational activities, and development of an advisory task force and state injury control plan.

	Budget Year							Estimated 2001-02	Proposed 2002-03*	Percent Change	
	1989-90	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01			'89-'01	Proposed
General Fund	\$295	\$741	\$708	\$716	\$711	\$0	\$151	\$150	\$150	-48.9%	0.0%
Other Funds	\$0	\$374	\$1,377	\$1,433	\$1,899	\$487	\$491	\$491	\$491	-	0.0%
Federal funds	\$271	\$1,317	\$1,126	\$1,015	\$1,036	\$0	\$0	\$0	\$0	-	0.0%
Total	\$566	\$2,432	\$3,211	\$3,164	\$3,646	\$487	\$642	\$641	\$641	13.4%	0.0%
Adjusted Total	\$1,211	\$3,302	\$4,199	\$3,964	\$4,363	\$553	\$685	\$641	\$599	-47.1%	-6.6%

Dollar amounts are in \$1,000s. Sources: DHS EPIC Program, Governor's Budgets. *Estimates of Children's Advocacy Institute.
Adjusted to California population and CPI-Med (2001-02=1.00). Adjustments by Children's Advocacy Institute.

Table 4-S. Epidemiology and Prevention for Injury Control (EPIC)

EPIC programs especially relevant to children include domestic and community violence prevention. There is also a small Childhood Injury Prevention Program (CHIPP) in the MCH branch.

Recent important California legislation enhancing child safety has included bicycle helmet requirements, swimming pool safety, playground safety standards, and amusement ride safety standards—five bills enacted from 1991 to 1999 sponsored by the Children's Advocacy Institute, and others. During 2000, a new child passenger restraint law was enacted to address a leading cause of serious young child injury—automobile accidents. SB 567 (Speier) expands the requirement to use child passenger safety restraints in vehicles for all children up to six years of age or 60 pounds.³³⁵ Prior law required use of such restraints for children up to four years or 40 pounds. The law corresponds to research establishing (a) the importance of restraints for children past infancy but under 6 years of age

and (b) the somewhat different type of restraint necessary for those young children, with enforcement phased in over a two- to three-year period. The law is an important precedent and will lead to what national child advocates believe is important, an inexpensive fold down back portion on back seats to allow children of this age to ride at the proper height and achieve maximum safe restraint protection in a crash (built in booster seats).

During 2001, the Legislature enacted AB 255 (Speier), the “Kids-N-Cars” bills described above, and addressing the tragic consequence of leaving young children in locked cars unattended with temperature increases injuring many and killing over 40 per year.

Notwithstanding these measures, unintentional and intentional injuries remain the leading cause of death among California boys and girls age 1–20 (see above). In 1996, the medical cost of fatal and nonfatal injuries was \$7.1 billion, more than half of which were billed to public payors.³³⁶ Injury prevention program funding for children *vis-a-vis* adults is disproportionately low in relation to injuries and deaths. The amount expended, as Table 4-S reflects, is insubstantial and decreasing.

**8. Access for Infants and Mothers Program
[Managed Risk Medical Insurance Board]**

This program subsidizes private health insurance coverage for maternity, delivery, and infant and toddler care services for uninsured low-income women and children. Pregnant women between 200% and 300% of the federal poverty level are eligible (those with incomes below 200% are eligible for Medi-Cal). Infants born under the AIM program are covered to age two, for a fee. The program is housed in the Managed Risk Medical Insurance Program, which uses state appropriations and women’s payments to purchase insurance from eleven participating plans.

The program’s funds come from the Perinatal Insurance Fund, which the Wilson Administration began to augment with Proposition 99 funds. Eligible women are required to make contributions capped at no more than 2% of family income. Enrollment in AIM is limited to the number of women who can be served with the funds appropriated. Coverage began in January 1992, and new enrollments of pregnant women were suspended in January 1994 due to lack of funds. Enrollments began again in September 1994, and were lower than expected in 1995–96 and 1996–97. The income limit for the program was raised from 250% to 300% of poverty to increase the pool of eligible participants. The budget for 2001–02 increases Prop 99 funding for AIM by \$11 million for anticipated caseload growth; some of these funds are from the remaining Prop 99 litigation reserve.³³⁷ The proposed 2002–03 spending is slightly down but the May 2002 Revise increases the Table 4-T spending by \$2.7 million due to recently projected caseload growth.

	Budget Year						Estimated 2001-02	Proposed 2002-03*	Percent Change	
	1989-90	1996-97	1997-98	1998-99	1999-00	2000-01			'89-'01	Proposed
General Fund	\$0	\$0	\$0	\$1,413	\$1,235	\$1,292	\$1,429	\$1,429	na	0.0%
Perinatal Insurance Fund	\$42,776	\$40,255	\$39,914	\$37,499	\$51,710	\$57,234	\$61,971	\$61,971	44.9%	0.0%
Other	\$0	\$0	\$0	\$2,748	\$2,414	\$2,502	\$2,768	\$2,768	na	0.0%
Total	\$42,776	\$40,255	\$39,914	\$41,660	\$55,359	\$61,028	\$66,168	\$66,168	54.7%	0.0%
Adjusted Total	\$67,712	\$47,297	\$45,727	\$46,346	\$59,842	\$63,226	\$66,168	\$63,723	-2.3%	-3.7%

Dollar amounts are in \$1,000s. Sources: Governor’s Budgets. *Estimated by Children’s Advocacy Institute. Adjusted to California population and deflator (2001–02=1.00). Adjustments by Children’s Advocacy Institute.

TABLE 4-T. Access for Infants & Mothers

AIM is yet another example of a stand-alone categorical program that appeared to contradict the state’s aims of providing integrated health services, controlling health care costs, and maximizing federal financial participation in paying for health care. Rather than extending an existing program so that its participants might have seamless coverage, it creates yet another program whose members must change plans within a short time. By purchasing insurance on the private market, it bypasses less expensive public care and subsidizes more costly private insurance. AIM’s report to the Legislature in

1994 cited an average cost of \$5,674 for delivery-related services under AIM, compared to \$4,153 for Medi-Cal.³³⁸

AIM should be terminated and subsumed by either Healthy Families, or the comprehensive coverage recommendation below.

9. Healthy Start [Department of Education]

Healthy Start is a program which provides grants to schools and local governments to establish school-linked integrated services. The goal is to provide efficient, cost-effective services to families with an emphasis on prevention and convenience. Services are often located at or near a school site. Staff in Healthy Start programs are trained to help families with multiple problems, whether with education, health care, or social problems.

Program funding in 1994–95 was \$19 million. For 1995–96, the Legislature enacted a \$20 million expansion to \$39 million, and further increases brought it to a high of \$49 million in 1997–98 fiscal year. Governor Davis terminated the program in the current 2001-02 year and it remains terminated for 2002–03 (note its elimination from Categorical Funding in Chapter 7).

	Budget Year							Estimated 2001-02	Proposed 2002-03	Percent Change	
	1991-92	1995-96	1996-97	1997-98	1998-99	1999-2000	2000-01			'91-01	Proposed
Total	\$20,000	\$39,000	\$34,664	\$49,000	\$49,000	\$49,000	\$49,000	\$1,000	\$0	-95.0%	-100.0%
Adjusted Total	\$36,519	\$54,271	\$45,618	\$61,476	\$58,261	\$55,170	\$52,314	\$1,000	\$0	-43.3%	-100.0%

Dollar amounts are in \$1,000s. Sources: Governor's Budgets.
Adjusted to K-12 Enrollment and CPI-Med (2001-02=1.00). Adjustments by Children's Advocacy Institute

TABLE 4-U. Healthy Start

10. Infant Hearing Screens

From 800 to 3,000 infants born in California will have permanent hearing disability, and many will not be diagnosed until speech delays are apparent at age 2, thus losing over one year of treatment at the age where compensating skills are teachable with greater efficacy.

For 1998–99, the Legislature enacted a Newborn Hearing Screening Program, requiring all 100 CCS-approved hospitals to offer hearing screening for all babies they deliver (about 70% of the births in the state). Funding comes from CCS and Medi-Cal accounts (for CCS and Medi-Cal eligible children), and \$6.1 million (\$3.5 million from the general fund) was added during the 1998 May Revision to cover additional infants. The state has also established three regional Early Hearing Detection and Intervention Centers to assist hospitals, including follow-up tracking of infants, and maintain a data system, and funds an outreach program to inform parents, physicians, and the public about screening, signs of hearing loss, and the need for early intervention/treatment for maximum effect.³³⁹

The stated goal is to cover all newborns with such screening—where parents consent. The initial goal was 116,000 newborns screened in 1998–99, and 392,000 upon full implementation in 1999–2000.³⁴⁰ The state has about 560,000 births each year. However, implementation has been delayed from this ambitious timeline. In 1999–2000, the Governor allocated \$6.9 million (\$4 million from the general fund) for this account, enough to accommodate 116,000 newborns. The law now requires hospitals to provide services to 392,000 by the end of current year 2001–02.³⁴¹

11. Vision Screening

Although covered by no current account, vision screening and care are presumably a part of the EPSDT services discussed above. California does not provide consistent, assured early screening of her children for basic preventive purposes. In addition to lead and other dangers listed above, the state

fails to conduct adequate vision examinations. As with hearing omission, such a failure can result in false disability diagnoses. As with hearing and other early detection, vision exams can often yield treatable results, particularly if detection is early.

Illustrating this failure is the new technique available to detect eye imbalance, called preventable amblyopia, and currently the leading cause of later monocular blindness among adults. A simple digital camera flash test taking only a few minutes can now detect anomalies between the two eyes. Virtually costless treatment can then mitigate eye degeneration, particularly if detected before the age of two. The method similarly detects strabismus, and a normal examination in conjunction with the camera flash exam would detect other problems early-on. California does not provide widespread or assured vision examination.³⁴²

III. SUMMARY AND RECOMMENDATIONS

A. Summary/Consequences

Impoverished children have suffered substantial safety net cuts over the past decade—moving from 89% of the federal poverty line to 70%. Over the past six years, over 1.2 million persons have left TANF (and food stamp) rolls, about 2/3 of them children. Some of it is the welcome result of the economic recovery and parental employment. But the data discussed in Chapter 2 indicate disturbing anomalies. Many of those leaving TANF and food stamp aid are not achieving full time work or family income above the poverty line—and although still eligible, they are also losing Medi-Cal coverage for their children. They are not picking up coverage for which they are still eligible, nor are many of those who are employed receiving it as a benefit. In addition, large numbers of immigrants—including legal immigrants—are eschewing all public assistance for their children—Medi-Cal included—fearing status or citizen qualification problems.

Since July 1998, the net drop in children covered cancels some of the increase from Healthy Families, the main state vehicle for using the state's SCHIP allotments. Meanwhile, the source of coverage decline may grow worse; the implementation of welfare reform will begin to hit children during proposed 2002–03, with particular force after 2003. Counties are required to implement community employment for all parents receiving aid and registered for two years starting from 1998–99. Given the economics making public employment and child care extremely expensive, and the loss of current unspent surpluses without new resources, counties will be under severe pressure. One consequence may be cut downs or cut offs from TANF, certain to occur after 2003 due to the 60-month deadline. Substitute coverage from state funds may provide partial assistance, but the source of funding is unclear after current TANF surpluses from enrollment decline dissipate.

Child advocates cite the marked contrast in subsidies for the elderly—provided universally, and at more than five times the per person cost for children. They contend that federal funds are available on a 2-for-1 basis to cover the 1.85 million of California's children eligible for medical coverage.³⁴³

As discussed above, the problem emanates from a longstanding state mindset about help for the poor. The services are viewed as a prize sought by large numbers of undeserving persons. The roll of state administration is to filter, qualify, police, and let in only those clearly and demonstrably qualified, with the burden on the applicant. Apart from concerns about freeloading and public fund abuse themselves, many fear that easy public money for some would lead to widespread replication over time. However, in the context of preventive health policy and medical care for children, such concerns have historically been considered inapplicable. Another approach to medical coverage of children was manifested by our grandparents when a polio vaccine first appeared. There were no multi-page forms to fill out, no questions about immigration status, how much money our parents made, how many children were in the family, with interviews and monthly qualification to move to the second and third booster shots. The vaccine was generated as quickly as possible, it was distributed *en masse* to schools, and if you were a child and breathing, it was administered—in fifty states, first the Salk vaccine,

then the Sabin oral version. After all, polio attacked children and we had a preventive measure available. There was no discussion, hesitation, or barrier.

Advocates for the poor argue that medical coverage is not cash assistance generating false claims for unrelated enrichment. Medical coverage involves vaccinations, examinations, preventive care, and treatment for ill children—services rarely sought without *bona fide* belief in their need. Although important steps have been taken in recent years, California's SCHIP program, Healthy Families, will not reach over one million income qualified children under the most optimistic scenario of DHS. Instead of changing course to fulfill Congressional intent, the state has decided to spend the available money on parents. Such expenditures to protect parents also help their children in many ways. However, the promise was and has been coverage of every child under 200% (or 250%) of the poverty line. If parental coverage consumes available federal monies, pressure should not abate to fulfill the primary mandate of child coverage. Such is realistic, with resources remaining to address "crowd out" problems, and hopefully for expanded parental coverage as well—but as a second priority and not as a substitute for the statute's original intent.

The flaws in the current system, range from unnecessary premium charges imposed on those living close to the poverty line, to bureaucratic barriers to enrollment, as outlined above. Many of these flaws continue in the proposed expansion of the Healthy Families program to cover adults; in some ways, they are even made worse, with higher premiums for adults and more burdensome application rules for the lowest income parents whose coverage is to be funded under Medi-Cal. The state continues to administer more than seventeen separate programs from a fragmented regulatory structure of six uncoordinated agencies. The basic approach of California is not optimum. It is the familiar pattern of individual sign-ups, with \$150 to \$350 in premiums—which will jump much higher under the state's proposal to add parents to Healthy Families—from families barely able to make rent.

Children who are enrolled face a secondary barrier to medical services: managed care incentives to deny services and to avoid screening and preventive treatment which do not immediately produce savings. The majority of Medi-Cal recipients are now in a managed care format. Children have been moved at particularly high rates; they are targeted for inclusion by plans because of their low per capita cost, and their relatively passive nature *vis-a-vis* more articulate and demanding adults. California has one of the lowest per child costs-of-service in the nation, reflecting her penurious reimbursement rates for Medi-Cal providers, even after rate increases in 2000, and those increases are now being withdrawn.

Critics of managed care argue that its results have included confusion, barriers to coverage, misenrollment, dislocations from known or preferred providers, and denials of care. The long-run consequences may be further disinvestment in prevention and inefficiencies as provider supply is artificially limited, and as private plans seek to avoid costly enrollees and service expense.

Overall, the medical safety net has evolved into a patchwork quilt of specific programs, generally uncoordinated. The Healthy Families add-on, together with other "crazy-quilt" programs, means that a family with children of different ages may have members of the family in four to six separate systems—each one of which will change with age change and family income change.

Finally, the proposed 2002–03 reduces accounts and reneges on prior commitments in an amount in excess of \$3 billion—an unprecedented shortfall of commitment for child health. Cuts include major reductions or retractions in twelve subject areas, as discussed above. The reductions take many forms, from cancellation in lieu of other alleged programs capable of pick-up that are themselves under funding pressure to diversion of federal funds for general fund relief. Infrastructure consequences are now being felt in Los Angeles County with *in extremis* measures being approved and under discussion.

These failures of the state are exacerbated by a general failure to put a priority on preventive health for children, except in the area of immunization. Hence, injury prevention, lead monitoring, vision screening, and dental sealant and fluoride assurance are generally lacking, and the state's performance in most health related areas is among the lowest in the nation, notwithstanding its wealth.

B. California Children's Budget Recommendations

Recommendation #1. Medically cover all children. Provide screening and prevention statewide without regard to income. Where children receive substantial services and parents have income above 300% of the poverty line (or are unqualified as non-citizens), assess the parents a percentage of the cost on an income-based scale. Provide a tax credit for employers equal to 20% to 30% of their contribution to insurance premiums for children of employees earning under 300% of the poverty line. Estimated Cost: \$1.8 billion (\$650 million state general fund monies)

Basic medical care for children is a private adult obligation where affordable, and a public adult obligation as a back-up resort. The current practice—reserving that commitment for 1.8 million children to “emergency care”—endangers children, misallocates resources, and costs more. All children in families up to 300% of the poverty line should be assured minimum medical coverage. Such coverage should be managed through a single, seamless Medi-Cal system—subject to its minimum guarantees, income disregards, and as an entitlement for every child.

Such a system should require no premiums, impose modest \$3 copayments per visit—AIM, EPSDT, CHDP, Medi-Cal, immunization, and the federally-funded Medicaid expansion should all be folded into a single system of assured care. CCS, injury control, and some prevention programs unrelated to medical care itself could be separately funded on a fee for service basis, with reimbursement increased periodically to match market levels.

The status of various beneficiaries can be “packaged” or “labeled” to minimize the cited “welfare stigma” impediment, and substantial sums should be allocated for advertising, outreach, and public education to emphasize the public benefit from assured child coverage and illness prevention, and the appropriate inclusion of children given the severe medical costs where unexpected serious illness or injury occurs. However, those sums need be less than is currently expended in separate outreach efforts for 17 different state programs.

The *California Children's Budget 2002–03* proposes the creation of a fund to provide comprehensive coverage for children. Revenue is readily available from four sources: (a) existing Medi-Cal funding, (b) full use of Healthy Families funds; (c) part of tobacco settlement funds, and (d) assessments of parents with incomes above 300% of the poverty line for a percentage of major treatment costs.

The first principle is: All California children not privately covered are covered publicly.³⁴⁴

Such a policy is compelled by current numbers. With the expansion of Healthy Families to 300% of the line, only 4.1% of the children in the state are (publicly or privately) uncovered *and* ineligible for an existing public program. This includes both those children without private insurance in families over 300% of the line, and undocumented children. The number is only 5.7% if the Healthy Families cut-off is left at 250%. We have created 17 different programs to cover those lacking private insurance, each with different criteria, and all changing over time, as children age and income changes. All of it is designed to make certain none of the 5.7% gets in. At this point in population balance, it is prudent to reverse the presumption, and allow all in, while assessing the parents of the small percentage who do not qualify post hoc. The public policy in subsidizing preventive care for all regardless of income commends its inclusion as a generalized benefit without charge. Major treatment required for a child with a parent able to afford contribution should yield an assessment based on a sliding scale.

The cost of full coverage can be borne easily within the existing Medi-Cal available funds together with Healthy Families money California will otherwise be returning unspent. Funds remaining should be divided between child care tax credits for employer dependency coverage of children under 300% of the poverty line, and additional parental coverage. It is the parental coverage that is most likely to trigger crowd-out concern and inequity between employers who pay for coverage and those who assign their

workers to a system of public subsidy. Hence, as those subsidies are increased, some credit should be directed to employers who make the decision to cover dependents. The cost of such a credit and possible parental expansion will be substantial, from \$700 million to \$1.2 billion, depending on the line for parental coverage (200% of the poverty line or 250%) and the amount of tax credit offered. Half of that cost can be provided from monies available from full use of Healthy Families, and the other half can be financed from the state's share of the tobacco settlement, 50% of \$1 billion per year for the next 25 years, with remaining tobacco settlement monies expended on smoking diminution—focusing on youth, and the provision of de-addiction services to all who want it.

The proposed solution has the following advantages: (1) almost all of the monies do not count against the Gann spending limit because of the tax credit format; (2) it allows full use of the hundreds of millions in federal funds requiring only a one-third match, a portion of which might otherwise be lost; (3) the tobacco settlement health related purposes are properly met. Most important, savings in filtering, paperwork, and confusion will be momentous. Those savings would be substantial and could finance the Medi-Cal and CCS reimbursement rate increases needed.

Such a system for children reverses the present “keep out unless you can prove you qualify,” to “we cover every child, we'll bill you later if you are able to pay.” The public harm from erroneous coverage where a parent may be able to pay is not the same as a cash benefit which can induce fraudulent schemes. Rather, expense is usually triggered because of the illness of a child. There is no incentive to obtain publicly provided benefit apart from direct services for a child needing medical treatment.

Recommendation #2. The “Medi-Cal Managed Care” experiment should be frozen at its current 52% share of enrollees until refined to assure adequate medical care for children—especially cost effective preventive services. Estimated cost: none

As discussed above, the shift to managed care for Medi-Cal-covered children involves serious dangers. The new system includes a distorting incentive to deny services. The extensive history of bad faith insurance law—involving non-payment of legitimate claims by the insurance industry—is a market model with similar features.

Many of the problems facing children caught in managed care are addressable through six systemic adjustments:

- isolate the gatekeeper deciding who receives what services from any financial reward or sanction based upon decisions made (he or she may not have an equity interest in the enterprise or be subject to sanction by those who do);
- adopt regulatory oversight sensitive to the limitations of marketplace checks in medical service delivery, and include within it independent consumer representation and an accelerated process for review of treatment denials;
- provide a real incentive to invest in prevention by reserving a portion of the capitated payments for the accrual of interest and “bonus” payment at five-year intervals based upon improvement in health indices (unrelated to procedures performed);
- pay for the important child screening, prevention, and treatment functions on a fee-for-service basis as an add-on to the capitated payments, or alternatively withhold the capitated payment for children until specified screening and services have been performed as to each;
- take advantage of the Balanced Budget Act of 1997's allowance for presumptive eligibility for Medi-Cal coverage, following the Massachusetts precedent,³⁴⁵ and allow expeditious disenrollment; and

- change California's currently fragmented structure of HMO/managed care regulation (under which four departments in four different cabinet-level agencies have some role in overseeing managed care organizations,³⁴⁶ and dozens of health care practitioner regulatory boards in yet another cabinet-level agency oversee the practitioners who actually provide the care) by: creating a single child health agency.

Recommendation #3. Substantially increase funding for environmental safety and injury prevention, with particular attention to lead dangers, vision/hearing screening, and dental disease prevention. Estimated cost: \$60 million

As discussed in the text above, screens and lead samples from schools warrant the immediate testing of all child care centers and elementary schools, and the immediate mitigation of lead levels where above EPA action levels. Additional investment should be made in monitoring drinking water, and requiring wider disclosure of existing test results of water providers. All of California's supplies should be fluoridated immediately. The expanded Medi-Cal system proposed above should include immunization and dental sealants as a required benefit for all covered children; where coverage is by managed care companies, capitated compensation should be provided for each child enrolled in managed care only after both of the above, and EPSDT/CHPD examination/screening, are provided.

Current injury prevention (EPIC) funding levels should be tripled, with further increases beyond 1999–2000 as warranted, and with emphasis on bicycle helmet compliance, swimming pool safety, parenting education, fire, auto, firearm safety and removal from children, and suicide prevention—that is, consistent with the major causes of child death in the state.

Vision screening is inexpensive and cost effective with new camera flash and other techniques and should be conducted at or before the two year old immunization mark.

California is at or near the bottom of the nation in the dental care of her children, with among the highest rates of dental cavities, infection, and gum disease. Fluoridation and sealants are readily available and are cost-effective in preventing cavities.

Recommendation #4. The Proposition 10 State Commission should fund independent legal representation of children before the state agencies affecting the health and development of young children. Estimated cost: None (\$4 million from Proposition 10 funds)

Although not a large fiscal item, the presence of professional, full time advocates for children before the state's regulatory agencies will influence the spending of over \$20 billion dollars related to their health and safety. The proposed legal advocacy would not constitute or compete with existing legal aid providers. Its mandate would not be to take individual cases—unless illustrative of a larger problem requiring a precedent. It would be charged with the representation of children as a group—to function as child advocates.

Coverage should include the Department of Health Services, MRMIB, the new HMO regulatory Department, Department of Social Services, Department of Developmental Services, Board of Control (crime victim fund), subsidiary agencies, and other departments deciding child health and safety related policies. Representation before those agencies should trigger intervenor compensation under standards similar to those in place at the Department of Insurance and Public Utilities Commission to augment the appropriation recommended over time.

Sacramento includes 1,050 full-time, professional registered lobbyists who cover the Legislature and the state's major agencies.³⁴⁷ Two of these lobbyists represent children without any obligation to service providers, trade associations, or commercial interests. The balance of advocacy determining the rules which govern who receives aid when is overwhelmingly dominated by interests with a vested

and short term profit stake in those decisions. The institutional addition of ten to twelve professional counsel representing the interests many agencies are intended to serve as their highest priority would make a substantial difference in how policies are implemented—and allow arguments from the child's perspective to become an institutional part of public decisionmaking affecting them.

Chapter 4

ENDNOTES

1. E. Richard Brown, Shana Alex, Lida Becerra, *Number of Uninsured Californians Declines to 6.2 Million—2 Million are Eligible for Medi-Cal or Healthy Families*, UCLA Center for Health Policy Research Fact Sheet (Los Angeles, CA; March 2002) (hereinafter "*Number of Uninsured Californians*") at 1.
2. E. Richard Brown, Ninez Ponce, Thomas Rice, *The State of Health Insurance in California: Recent Trends, Future Prospects*, UCLA Center for Health Policy Research (March 2001) at vii and 3 (hereinafter "*The State of Health Insurance*").
3. *Id.* at 17, Ex. 10 and 18, Ex. 12; see also *Policy Brief: Health Insurance Coverage of Californians Improved in 1999—But 6.8 Million Remained Uninsured*, UCLA Center for Health Policy Research (February 2001) at 1 (hereinafter "*UCLA Policy Brief*") at 1.
4. The term "true presumptive eligibility" is used because the phrase "presumptive eligibility" is a term often employed by advocates to describe various short cuts to enrollment, such as considering those on food stamps automatically qualified for Medi-Cal. The Governor more accurately refers to these shortcut measures as "streamlining enrollment." Similarly, "continuing eligibility" gives recipients a period of continuing eligibility after leaving a program on the assumption that they will qualify for another program. Usually, such continuation is time limited— usually for twelve months. "True presumptive eligibility" for children grants them eligibility immediately, with a *post hoc* assessment of costs on a sliding scale (based on parental income and costs to be assessed) if subsequent paperwork determines the child unqualified. The difference is significant because such a true presumptive system may preclude the need for 17 separate qualification systems serving as barriers to enrollment. It will accomplish cost savings in the removal of social worker caseloads under the pressure of deciding enrollment so a child can be treated. It transfers from expensive and misallocating ER treatment the majority of impoverished children now there treated. And it facilitates efficient public health measures.
5. Section 801 of P.L. 106-554, The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. See also memo from Managed Risk Medical Insurance Board, January 17, 2001, Hearing Agenda Item #3c; "Tardy States Get a Break on Funds for Children's Health Insurance," S. F. CHRONICLE, January 6, 2001.
6. *Number of Uninsured Californians*, *supra* note 1, at 1.
7. Managed Risk Medical Insurance Board, *Healthy Families Program Enrollment Data* (Sacramento, CA; April 2002) at www.mrmib.ca.gov/MRMIB/HFP/HFPRptSum.html.
8. *UCLA Policy Brief*, *supra* note 3, at 2.
9. Email Correspondence from Ninez Ponce, Ph.D., UCLA Center for Health Policy Research, to Lucy Quacinella (April 2, 2001) (hereinafter "*Email Correspondence from Ninez Ponce*").
10. American Academy of Pediatrics, *Children's Health Insurance in the United States, 2000 Projections* (Elk Grove Village, IL; 2000) at 1–2.
11. *Number of Uninsured Californians*, *supra* note 1, at 2.
12. Helen Schauffler, Sara McMenamin, Juliette Cubanski, Richard Brown, and Thomas Rice, *The State of Health Insurance in California 1998*, Center for Health and Public Policy Studies, U.C. Berkeley with Center for Health Policy Research, UCLA (January 1999) at 16 (hereinafter "*The State of Health Insurance in California 1998*"); see also Nadereh Pourat, E. Richard Brown, Roberta Wyn, UCLA Center for Health Policy Research, *1.6 Million California Children Are Uninsured* (Los Angeles, CA; March 1997) at 1 (hereinafter "*California Children Are Uninsured*").
13. *The State of Health Insurance*, *supra* note 2, at 17, Ex. 10 and at 18, Ex. 11.
14. The 1997 national percentage of uninsured children was 14.7%; see *The State of Health Insurance in California 1998*, *supra* note 11, at 1. See also U.S. Bureau of the Census, *Income Improves, Poverty Levels, Health Insurance Coverage Slip, Census Bureau Reports* (The Official Statistics, CB 97-162) (Washington, D.C.; September 29, 1997) at 1; Kaiser Commission on the Future of Medicaid, *Health Needs and Medicaid Financing: State Facts* (April 1995) at 16 (hereinafter "*Kaiser State Facts*"); E. Richard Brown, R. Burciaga Valdez, Hal Morgenstern, William Cumberland, Chao Wang, Joyce Mann, California Policy Seminar, University of California, *Health Insurance Coverage of*

Californians in 1989 (1991) at 4; Martha A. Teitelbaum, Children’s Defense Fund, *The Health Insurance Crisis for America’s Children* (Washington, D.C.; March 1994), at 25, ranks California 41st among states for proportion of children who are uninsured.

15. *The State of Health Insurance*, *supra* note 2, at 20 and Ex. 14 at 21.
16. *California Children Are Uninsured*, *supra* note 12, at 2.
17. *The State of Health Insurance*, *supra* note 2, at 17.
18. *Id.* at 22 and Ex. 15 ; see also *Email Correspondence from Ninez Ponce*, *supra* note 9.
19. The 2001 calculation of total child population is 10.368 million (see Table App-B in the Appendix below). These percentages represent the proportion of uninsured children living in families over 300% of the poverty line (179,500), and the number of estimated undocumented children (245,000), see text *supra*. The total percentage not eligible based on income above 250% of the poverty line plus those ineligible by reason of citizenship failure total 5.7% of the state’s children.
20. *The State of Health Insurance*, *supra* note 2, at 24 and Ex. 17.
21. *Id.* at 25.
22. *Id.*
23. *Id.* at 18, Ex. 12.
24. *Id.* at 24.
25. *Id.*
26. *Id.* at 18.
27. Medi-Cal coverage of children in non-working families fell from 76% in 1995 to 68% in 1997. See *The State of Health Insurance in California 1998*, *supra* note 12, at 17.
28. *The State of Health Insurance*, *supra* note 2, at viii.
29. *The State of Health Insurance*, *supra* note 2, at 26.
30. *Id.* at 27, Ex. 20.
31. *Id.* at 26.
32. *Id.*
33. *Id.*
34. If otherwise eligible for Medi-Cal, undocumented immigrants qualify for emergency and pregnancy-related care.
35. The theoretical basis for the “public charge” objection turns on a likelihood that the applicant will become a burden on the public treasury. INS rules emphasize prior receipt of cash benefits (TANF/SSI), and existing rules allow deportation only where the immigrant became a public charge within five years of entry and the cause preexisted entry, or a legal debt compelling repayment exists, it has been demanded and not paid. Technically, these conditions rarely apply.

As noted briefly in Chapter 2, “public charge” fear was stimulated by 1997–99 INS practices in screening lawful immigrants who re-enter the United States (e.g., at San Diego and Los Angeles airports) and informing them that their immigration status is in jeopardy unless they repay previously received public benefits, including Medi-Cal services for themselves and their families. INS has admitted that repayment demands have been contrary to law and has suffered

a superior court judgment in San Diego County Superior Court requiring repayment of immigrants who have returned properly received public benefits.

As discussed above, on May 25, 1999, the Clinton Administration released a clarification of the "public charge" barrier to citizenship, making clear that it categorically does not include medicaid (Medi-Cal) or the Children's Health Insurance Program (Healthy Families in California).

36. Department of Health Services' Medical Care Statistics Section, *Persons Certified for Medi-Cal, March 2001* (Sacramento, CA; April 2001) at 1. The "alien/refugee" Medi-Cal category includes persons with refugee special assistance codes and aliens eligible under IRCA/OBRA 1986 legislation. See www.dhs.ca.gov/MCSS for more information.
37. Department of Health Services, Medical Care Statistics Section, *Persons Certified Eligible for Medi-Cal* (Sacramento, CA; April 2002) at 1.
38. Laura Summer, Sharon Parrott, Cindy Mann, Center on Budget and Policy Priorities, *Millions of Uninsured and Underinsured Children are Eligible for Medicaid* (Washington, D.C.; 1996) at 5-7 (hereinafter "*Millions of Uninsured Children*"). The traditional welfare caseworker is likely to inform TANF recipients of their qualification for Medi-Cal; those not receiving TANF have no caseworker to assist them in understanding eligibility and in filling out forms.
39. See California Department of Health Services, *Medi-Cal Enhancements for Children: Fast Facts* (Sacramento, CA; January 1998) at 1.
40. Kirsten Clausen and Gina Caro, *Survey Explains Why Eligible Children of Ethnic Minorities Are Not Enrolled in Public Health Insurance Programs*, Tomas Rivera Policy Institute (April 18, 2002) at 1-3, see summary at www.calendow.org/news/NewsReleases/2002/special/press041802/041802TRivera.htm.
41. Helen Halpin Schauffler, E. Richard Brown, *The State of Health Insurance in California, 1999* (January 2000) (hereinafter "*The State of Health Insurance in California, 1999*") at 24–25.
42. E. Richard Brown, Shana Alex, Lida Becerra, *Number of Uninsured Californians Declines to 6.2 Million—2 Million Are Eligible for Medi-Cal or Healthy Families*, Health Policy Fact Sheet, UCLA Center for Health Policy Research (Los Angeles, CA; March 2002) at 1 (hereinafter "*Health Fact Sheet 2002*") (see www.healthpolicy.ucla.edu).
43. For a description of federal Medicaid legislation, see U.S. General Accounting Office, *Medicaid Expands; Fiscal Problems Mount* (HRD-91-78) (Washington, D.C.; 1991) at 3–6.
44. See Chapter 2 at 2-1 to 2-5; see also Children Now, *Working Families and Their Uninsured Children* (Oakland, CA; 1997) at i-ix (hereinafter "*Working Families*").
45. Department of Health Services Medical Care Statistics Section, *Medi-Cal Funded Deliveries, 1999* (Sacramento, CA; May 2001) at 1; Department of Health Services Medical Care Statistics Section, *Medi-Cal Funded Deliveries, 1998* (Sacramento, CA; May 2000) at 1.
46. *The State of Health Insurance in California, 1999*, *supra* note 41, at xii.
47. *Health Fact Sheet 2002*, *supra* note 42, at 1.
48. *The State of Health Insurance*, *supra* note 2, at 3-4, Ex. 3.
49. *Health Fact Sheet 2002*, *supra* note 42, at 1.
50. For 2000 data, see California Department of Health Services, *Advance Report—County Data, California's Medical Assistance Program Calendar Year 2000* (Sacramento, CA; Aug. 2001) at Table 1. For 1999 data, see California Department of Health Services, *California's Medical Assistance Program, Annual Statistical Report, Calendar Year 1999* (Sacramento, CA; Feb. 2001) at Table 17 (Medi-Cal Program Persons Certified Eligible by County, Sex and Age (including COHS, HCPs, and FFS)). For prior data, see prior annual statistical reports at www.dhs.ca.gov.
51. For sources of data, see *supra* note 45.

52. Health Care Financing Administration, *2001 HCFA Statistics* (Washington, D.C.) at Table 11.
53. *Id.* At Table 34.
54. *Id.*
55. Maternal and Child Health Coalition, *Medicaid Protects Maternal and Child Health* (March 1995) at 2 (hereinafter "*Medicaid Protects Maternal and Child Health*").
56. The Henry J. Kaiser Family Foundation, *State Health Facts Online*. See also Health and Human Services' Health Care Financing Administration, HCFA-2082 Report for Federal Fiscal Year 1998 (www.hcfa.hhs.gov). Health Care Financing Administration, *A Profile of Medicaid, Chartbook 2000* (Washington, D.C.; Sept. 2000) at Figure 2.12.
57. Health Care Financing Administration, *A Profile of Medicaid, Chartbook 2000* (Washington, D.C.; Sept. 2000) at Figure 2.12.
58. Note that Healthy Families and arguably WIC provide medically related services disproportionately to or for children outside of the penumbra of Medi-Cal (California's medicaid program). In addition, some spending from the Proposition 10 Commissions may be health related and will focus on young children. However, Healthy Families is now being expanded to cover 250,000 or more parents of working poor families above the Medi-Cal limits, as discussed below. And the prime priority of the state Proposition 10 Commission is "school readiness. The numbers involved in both of these programs combined does not reach 10% of California Medicare spending of \$23.6 billion, as presented below, and is spread out across two and one-half times the population (3.8 million elderly Medicare enrollees versus 10.1 million children). Substantial additional funds finance other health related benefits exclusively for adults and the elderly, including the substantial Veteran's Administration health program. This discussion is not intended to imply excess spending for the elderly, whose health needs involve greater expense and whose health is a proper high priority. However, it suggests that a comparable priority is not accorded to the health and medical care provision for our children.
59. Kaiser Commission on Medicaid and the Uninsured, *Children's Health—Why Health Insurance Matters* (Washington, D.C.; May 2002) at 1. See also Roberta Wyn, Rebecka Levan, E. Richard Brown, UCLA Center for Health Policy Research, *The Consequences of Being Uninsured in California* (Policy Brief) (Los Angeles, CA: February 1998) at 2.
60. Kaiser Commission on Medicaid and the Uninsured, *Children's Health—Why Health Insurance Matters* (Washington, D.C.; May 2002) at 1.
61. *Id.* at 1.
62. The Field Institute for California Center for Health Improvement, *Parents Report Many Problems in Accessing Health Care Services for Their Children* (Sacramento, CA; January 15, 1998) (hereinafter "*Field Institute Survey*"). The survey covered October–November 1997.
63. See Center for Health Statistics, *Data Summary: California's Infant Death Rate 1997* (December, 1998) at 1 (hereinafter "*Infant Death Rate 1997*"). See also March of Dimes, *Facts on Medicaid for Pregnant Women and Infants* (Washington, D.C.; 1995) at 1-2. See also March of Dimes, *Infant Mortality Rates by State, United States 1998* (2001).
64. California Department of Health Services, Center for Health Statistics, *Infant Death Rate* (Sacramento, CA; 2001). See also *Infant Death Rate 1997*, *supra* note 63, at 1; see also *Medicaid Protects Maternal and Child Health*, *supra* note 52, at 1-2, citing census data, HCFA data, National Center for Health Statistics Hospital Discharge Survey information, and related data.
65. Kaiser Commission on Medicaid and the Uninsured, *Children's Health—Why Health Insurance Matters* (Washington, D.C.; May 2002) at 1. See also Peter G. Szilagyi, M.D., M.P.H., *et al*, *Evaluation of a State Health Insurance Program for Low-Income Children: Implications for State Child Health Insurance Program*, *PEDIATRICS*, Vol. 105, No. 2 (February 2000), at 363-364. Quote omits citations to prior studies supporting each listed finding from among 46 referenced, see 370-371.
66. *Id.* at 363.

67. Jennifer M. Haley and Matthew Fragale, *Health Insurance, Access, and Use: California, State Profiles* (Tabulations from the 1999 National Survey of America's Families–SP-02, Assessing the New Federalism, Urban Institute (December 2001) at Table 16.
68. G. K. Singh, S. M. Yu, *U.S. Childhood Mortality, 1950 through 1993: Trends and Socioeconomic Differentials*, 86:4 AM. J. PUB. HEALTH 505-13 (Apr. 1996); C. W. Sells, R. W. Blum, *Morbidity and Mortality among U.S. Adolescents: An Overview of Data and Trends*, 86:4 AM. J. PUB. HEALTH 513-19 (Apr. 1996); G. K. Singh, S. M. Yu, *Trends and Differentials in Adolescent and Young Adult Mortality in the United States, 1950 through 1993*, 86:4 AM. J. PUB. HEALTH 560-65 (Apr. 1996).
69. The California Wellness Foundation, *The Campaign to Prevent Handgun Violence Against Kids* (reporting a Feb. 22, 1995 teleconference) at 17. Note that over 1,000 handguns are sold in California per day.
70. U.S. General Accounting Office, *Federally Funded Health Services: Information on Seven Programs Serving Low-Income Women and Children* (GAO/HRD-92-73FS) (Washington, D.C.; May 1992) at 15. As to SCHIP, authorized in 1997, the ratio is \$2 in federal funds for each \$1 in state match, up to the maximum sum allocated to the state.
71. Center on Budget and Policy Priorities, *Cuts Resulting from the Medicaid Restructuring Act of 1996* (Washington, D.C.; June 18, 1996) at 1 (distributed by Families USA).
72. *The State of Health Insurance*, *supra* note 2, at 27.
73. Section 4701 *et seq.* of the 1997 Balanced Budget Act.
74. Section 4901 of the BBA1997, amending the Security Act by adding new Title XXI. Sections 4911 and 4912 amended Title XIX of the Social Security Act to expand state options for coverage of children under the Medicaid program.
75. In early 2001, federal regulations were issued to implement the SCHIP program. 66 *Federal Register* 2490 (January 11, 2001)(effective April 11, 2001), Parts 431, 433, 435, 436 and 457 of Title 42 of the *Code of Federal Regulations*. Implementation has been delayed, pending review by the Bush administration.
76. See www.hcfa.gov.
77. Section 801 of P.L. 106-554, The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000; see also memo from Managed Risk Medical Insurance Board, January 17, 2001, Hearing Agenda Item #3c; "Tardy States Get a Break on Funds for Children's Health Insurance," S. F. CHRONICLE, January 6, 2001.
78. *Id.*
79. State Medicaid Directors' Letter, HCFA, July 30, 2001, available at www.hcfa.gov/medicaid.
80. Pub. L. No. 104-193.
81. California law requires that the rules for the state's welfare reform family coverage program include persons eligible for CalWORKs. Welf. & Inst. C. Section 14005.30(a)(2); see "Medi-Cal for Low-Income Families", Ch. VIII, *CalWORKs Manual*, Western Center on Law and Poverty (updated Spring 2000) (hereinafter "*Medi-Cal for Low-Income Families*").
82. 42 USC Section 1396u-1(b).
83. See generally, *Supporting Families In Transition: A Guide to Expanding Health Coverage in the Post Welfare Reform World*, HCFA Guide (March 22, 1999) (see www.hcfa.gov/medicaid) (hereinafter "*Supporting Families In Transition*").
84. 42 USC Section 1396u-1(b); *Supporting Families In Transition*, *supra* note 80; Jocelyn Guyer and Cindy Mann, *Taking the Next Steps: States Can Now Take Advantage of Federal Medicaid Matching Funds to Expand Health Care Coverage to Low-Income Working Parents*, Center on Budget and Policy Priorities (August 1998).
85. WELF. & INST. CODE § 14005.30 (a)(2).

86. WELF. & INST. CODE § 14005. 30(c).
87. *Id.*; DHS All County Letter No.(ACL) 98-43, Attachment 1, pp. 1-2 and ACL 99-27 (defining “applicants” and “recipients;” *Medi-Cal for Low-Income Families*, *supra* note 81, at 11 and 14–15 (describing more generous “income disregards” for “recipients.”
88. Welf. & Inst. C. Section 14008.85(a)(2), relaxing the “100 hour” rule, derived from the old AFDC program, which defined “unemployment” for the principal wage earner in a two-parent family as working less than 100 hours in the month, regardless of whether the family’s income fell below Medi-Cal’s income limit. Without “unemployment” or some other basis for meeting the technical definition of “deprived” child in the home, two-parent families could not qualify for Medi-Cal. Under the new rule, a family with income from employment at or below the current income limit for Section 1931 applicants, i.e., 100% of poverty, will be deemed “deprived,” regardless of the number of hours either parent works. See, *Medi-Cal for Low-Income Families*, *supra* note 81, at 19.
89. Steven P. Wallace, UCLA Center for Health Policy Research, *Welfare Reform Could Add 25,000 Uninsured L.A. County Residents Per Year* (Policy Brief) (hereinafter “*Policy Brief*”) (Los Angeles, CA; August 1997) at 2. Wallace found that in Los Angeles County 18% of legal immigrants arriving from 1986 to 1995 are receiving Medi-Cal. Significantly, the percentage of children is 37%.
90. *Millions of Uninsured*, *supra* note 38.
91. *Id.* at 13.
92. Guyer, J., Center on Budget and Policy Priorities, *Health Care After Welfare: An Update of Findings from State-Level Leaver Studies* (Washington, D.C.; 2000).
93. *Edwards v. Myers*, 167 Cal.App.3d 1070 (1985); SB 87 (Chapter 1088, Statutes of 2000). This continuation applies to all Medi-Cal programs, with or without a family being on cash assistance, including the children’s “per cent of poverty” programs as well as the Section 1931 family coverage, the Medically Needy, and the Medically Indigent programs. Disability must be considered among the alternative bases for continuing Medi-Cal eligibility; under SB 87, California will finally start implementing this requirement by July 1, 2001.
94. Similarly, when increased income is the reason for losing welfare, Section 1931 eligibility for Medi-Cal may continue to exist, as the income limit for recipients under this program is about 157% of poverty, which is above the CalWORKs limit for recipients. Even when income exceeds the Section 1931 limits for Medi-Cal recipients, eligibility may continue under the Transitional Medi-Cal (TMC) program, which provides coverage for up to two years for families who have been receiving or who are eligible to receive TANF for at least three of the last six months and whose TANF ends due to an increase in job-based earnings. For the first six months, TMC has no income limit. There is also TMC coverage for four months when income increases above the Section 1931 limits to any amount due to an increase in child support and the family has been on or eligible for Section 1931 Medi-Cal, with or without TANF cash assistance, for at least three of the last six months.
95. See, e.g., SB 87 (Escutia), enacted in 2000, which simplifies Medi-Cal redetermination somewhat for families of former CalWORKs recipients. (Chapter 1088, Statutes of 2000).
96. AB 2900 (Gallegos), c. 945, Stats. 2000.
97. *Youth Law News*, National Center for Youth Law, Oakland, 1999 (review of the literature).
98. Ku, L. and Broaddus, M., *The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms* Washington, D.C.: Center on Budget and Policy Priorities (Sept. 2000).
99. *Immigrants’ Health Care: Coverage and Access*, The Kaiser Commission on Medicaid and the Uninsured (August 2000) at 2 and 5, Figure 5.
100. Pub. L. No. 104-208, part of the Joint Continuing Budget Resolution enacted on September 30, 1996, amending and modifying the Personal Responsibility and Work Opportunity Reconciliation Act enacted on August 22, 1996.
101. Chapter 944, Statutes of 2000.

102. *Policy Brief, supra* note 89, at 2.
103. Pub. L. No. 104-191, referred to as the Kennedy/Kassebaum measure, after its Senate sponsors.
104. For a detailed discussion of the statute, see Anne Markus, George Washington University Center for Health Policy Research, *Children's Continuity of Coverage under the Kassebaum/Kennedy Bill*, 3:4 HEALTH POLICY & CHILD HEALTH 1–5 (Fall 1996).
105. Chapter 635, Statutes of 2001.
106. See Office of the Governor, *Governor's Budget Summary 2002–03* (Sacramento, CA; Jan. 2002) at 178-179; for May Revise changes, Office of the Governor, *May Revise 2002* (Sacramento, CA; May 2002) at 31-32.
107. Pub. L. No. 105-33, generally adding new Social Security Act §§ 1932 *et seq.*, codified at 42 U.S.C. § 1396 *et seq.*
108. P.L. 106-554I, Omnibus Spending bill.
109. Sections 5301-5306 of BBA 97. "Not qualified" immigrants (those who were permanently residing in the U.S. under color of law) who were receiving SSI on August 26, 1996 were able to retain their benefits as a result of the Non-Citizen Benefit Clarification and Other Technical Amendments Act of 1998 (Oct. 28, 1998).
110. See, e.g., S. 1227 and H.R. 4707 in the 106th Congress (2000).
111. A state may grant to children's hospitals, Head Start programs, child care agencies, WIC agencies, etc. authority to presumptively qualify children for quick coverage.
112. Concerned about alleged state abuses in diverting federal DSH matching funds to other purposes, Congress in 1991 placed state-by-state limits on such payments; these limits are lowered substantially further by the Balanced Budget Act (BBA) of 1997—enough to achieve \$10.4 billion in savings over the next five years and \$40.4 billion over the next ten years. The BBA regrettably failed to take the alternative option of requiring DSH payments to go to children's hospitals and other providers of care to low-income populations to address the diversion issue. Instead, it reduced the amount overall—and kept in place state flexibility to divert such funds to university hospitals or to facilities which do not serve low-income populations.
113. See Andy Schneider, Center on Budget and Policy Priorities, *Overview of Medicaid Provisions in the Balanced Budget Act of 1997*, P.L. 105-33 (Washington, D.C.; September 8, 1997) at 8–10.
114. CAL. INS. CODE § 12694 *et seq.*
115. HCFA State Medicaid Directors Letter, July 30, 2000 (see www.hcfa.gov/medicaid).
116. Section 17200 *et seq.* of the Business and Professions Code.
117. SB 687 (Escutia).
118. Welf. & Inst. C. Section 14007.40. A new federal regulation, scheduled to take effect March 12, 2001, would permit the state to claim federal matching funds at the usual Medi-Cal rate (50%) for this program. Final Rule, 42 CFR Part 435.66 *Federal Register* 2316 (January 11, 2001). This new rule also gives the states flexibility to draw down federal matching funds to make Medicaid more accessible to other groups who are already covered, such as 19 and 20 year olds. *Id.* at p. 2320; see also, SMDL Letter #01-007, January 10, 2001, Attachment 5-A, www.hcfa.gov/medicaid/smdhmpg.htm. As of this writing, however, it is not known whether the new Bush administration will challenge the new rule.
119. Sabin Russell, *New SF Health Insurance for Kids, County-Run Program One of Two in State*, S.F. CHRONICLE, December 26, 2001.
120. See Robert Fellmeth, *Representation of the General Public Under California's Unfair Competition Act*, 5:1 COMPETITION (the journal of the Antitrust and Trade Regulation Section of the State Bar of California) (Summer 1995); see esp.

- Unfair Competition Litigation*, Recommendation and Report, CALIFORNIA LAW REVISION COMMISSION (Sacramento, CA; Nov. 1996).
121. See Health and Safety Code 130100 *et seq.*; see also Revenue and Taxation Code § 30131 *et seq.*
122. *May Revise 2002*, *supra* note 106, at 34.
123. This estimate includes only the increased fee for children. It is calculated by assuming the 2.56 million children currently enrolled in Medi-Cal see a physician once in a year, and visit an emergency room for treatment once in four years. The per visit increase of \$2 plus the per ER visit increase of \$4 totals \$7.69 million at the assumed rate of medical services contact.
124. *Governor's Budget Summary 2002–03*, *supra* note 106, at 174.
125. *May Revise 2002*, *supra* note 106, at 34.
126. See Jeanne Lambrew, *Health Insurance: A Family Affair (hereafter "Family Affair 2001")*, The Commonwealth Fund (May 2001) (see www.cmwf.org/programs/insurance/lambrew_familyaffair_464.pdf).
127. *Governor's Budget Summary 2002–03*, *supra* note 106, at 174.
128. *May Revise 2002*, *supra* note 106, at 34.
129. *Id.* at 39.
130. *Id.* at 35.
131. Kathleen Stoll and Erica Molliver, *A 10-Foot Rope for a 40-Foot Hole—Tax Credits for the Uninsured*, 2002 Update, Families USA (May 2002) (see <http://www.familiesusa.org>).
132. As such, they serve more to provide some protection against a major accident or disease, but are of little use in regular health coverage since few of the working poor anticipate more than \$5,000 in annual medical costs, nor can they afford such cost levels.
133. *Family Affair 2001*, *supra* note 126 (see www.cmwf.org/programs/insurance/lambrew_familyaffair_464.pdf).
134. U.S. Department of Health and Human Services, Health Care Financing Administration, *Medicaid: An Overview* (HCFA Pub. No. 10965) (Washington, D.C.; 1995) at 17–18 (hereinafter "*Medicaid Overview*").
135. *Building on Medicaid and CHIP to Expand coverage of the Low-Income Population*, Figure 5, Presentation by Barbara Lyons, Ph.D, Deputy Director, Kaiser Commission on Medicaid and the Uninsured, Families USA Annual Meeting, Washington, D.C., January 27, 2001.
136. *Id.*, Figure 6.
137. Office of the Governor, *Governor's Budget Summary 2001–02* (Sacramento, CA: January 2001) at 146 and 147 (hereinafter "*Governor's Budget Summary 2001–02*").
138. For a synopsis of Medi-Cal managed care plans, see Legislative Analyst's Office, *Analysis of the 1995–96 Budget Bill* (Sacramento, CA; 1995) at C-63 (hereinafter "*LAO 1995–96*").
139. U.S. Department of Health and Human Services, Health Care Financing Administration, *Review of California's Administration of Its Managed Care Program* (Washington, D.C.; 1993). See also Dana Hughes, Paul Newacheck, Jeffrey Stoddard, Neal Halfon, *Medicaid Managed Care: Can It Work for Children?* 95:4 PEDIATRICS 593 (Apr. 1995).
140. See California Medical Association, *Back to the Future: Medi-Cal Managed Care Reform in the '90s and CMA's Legislative Proposals* (Mar. 1995) at 32–33; California Medical Association, *Knox-Keene Plan Expenditure Summary, FY 1993/94*, at 5–11; Arthur Louis, *HMO Report Card: Big Contrast in Cash Spent on Care*, S.F. CHRON., Dec. 16,

- 1994, at D-1.
141. California Department of Health Services, *Letter to Physicians* (Sacramento, CA; May 14, 1993) (including Executive Summary from the DHS plan for the expansion of managed care in the Medi-Cal program).
142. *Governor's Budget Summary 2001–02*, supra note 137, at 150.
143. *Id.*
144. *Id.* at 149.
145. Children's Advocacy Institute, *California Children's Budget 1998–99* (San Diego, CA; June 1998), Table 4-D at 4-20.
146. *Governor's Budget Summary 2001–02*, supra note 137, at 147 and 150.
147. California Department of Health Services, *Medi-Cal Beneficiaries by Age Category*, Pivot Table (Sacramento, CA; 2000) (www.dhs.ca.gov/admin/ffdmdb/mcsss/RequestedData/files.htm).
148. Legislative Analyst's Office, *Medi-Cal Managed Care Has Not Had an Adverse Effect on Rural Health Care Clinics* (Sacramento, CA; March 16, 1998) (hereinafter "*Medi-Cal Managed Care Has Not Had an Adverse Effect*").
149. CAL. WELF. & INST. CODE § 14087.325.
150. *Medi-Cal Managed Care Has Not Had an Adverse Effect*, supra note 148, at 1.
151. Each of these counties is now part of the Two-Plan Model.
152. University of California at San Francisco, Institute for Health Policy Studies, *Medi-Cal Managed Care Clinic Impact in Sacramento County* (San Francisco, CA; 1997).
153. See Dorsey Griffith, *Medi-Cal Plan Hurting Clinics*, SAC. BEE, Nov. 4, 1997 at A-1.
154. *May Revise 2002*, supra note 106, at 37–38.
155. *Governor's Budget Summary 2002–03*, supra note 106, at 179.
156. *May Revise 2002*, supra note 106, at 35.
157. Dr. Susan Lambe, *Emergency Room Visits 1990-99*, ANNALS OF EMERGENCY MEDICINE, April 2002.
158. See Leaf quote in Anderson, *Los Angeles Health Director Proposes Steep Service Cuts to County Health System*, (January 29, 2002).
159. See Statement of Supervisor Molina expressing similar sentiments in Anderson, *Los Angeles Supervisors Approve Closure of Five Clinics; Larger Health Cuts Loom*, L. A. DAILY NEWS, January 30, 2002.
160. Maryann O'Sullivan, et al., Medi-Cal Community Assistance Project, *Rush to Managed Care: The California Two-Plan Model for Medi-Cal* (San Francisco, CA; March 1997) at 12.
161. Lynn Kersey, Maternal and Child Health Access Project, *The Impact of Medicaid Provisions of the Federal Balanced Budget Act on Medi-Cal Managed Care: Oversight and Monitoring Issues* (Los Angeles, CA; November 8, 1997) at 4 (testimony before the Assembly Health Committee) (hereinafter "*The Impact of Medicaid Provisions of the Federal Balanced Budget on Medi-Cal Managed Care*").
162. Health Access, *State Reconsiders Approach to Two-Plan Model in Los Angeles* (San Francisco, CA; Summer 1997) at 5.

163. Roberta Wyn, Joanne Leslie, Deborah Glik, Beatriz Solis, UCLA Center for Health Policy Research, *Low-Income Women and Managed Care in California* (Los Angeles, CA; August 1997) at i–iii.
164. David Phillips, Nicholas Christenfeld, Laura Glynn, *Prescription Drug Errors and Managed Care*, THE LANCET (February 1998).
165. See Assembly Health Committee, *Medi-Cal Managed Care: Two-Plan Model* (Sacramento, CA; November 5, 1997) at 7 (background paper for public hearing).
166. Statement of Stan Rosenstein, state Department of Health Services, at Medi-Cal Roundtable (March 28, 2001).
167. *The State of Health Insurance*, supra note 2, at 33.
168. *Id.* at 17, Ex. 10 and at 18, Ex. 12; see also *UCLA Policy Brief*, supra note 3, at 1.
169. See Title 10, California Code of Regulations, section 2699.6629(d). The initial level of \$25 was increased to \$50 on November 1, 1998.
170. "Healthy Families Program children Ineligibility Statistics By County (as of 3/12/01)" at HFP Enrollment Data (see www.mrmib.gov).
171. AB 2900 (Gallegos), c. 945, Stats. 2000.
172. *Governor's Budget Summary 2001–02*, supra note 137, at 151.
173. The 2000 Budget Act, c. 93, Stats. 2000.
174. *Governor's Budget Summary 2001–02*, supra note 137, at 151.
175. SB 87 (Escutia), c. 1088, Stats. 2000.
176. *Id.*
177. *Governor's Budget Summary 2001–02*, supra note 137, at 151–52.
178. *Id.* at 150.
179. *Id.*
180. *Governor's Budget Summary 2001–02*, supra note 137, at 146–147, 150–52.
181. See, e.g., data and discussion in Letter from Yolanda Vera and Holly Mitchel, Western Center on Law & Poverty, to Assemblyman Martin Gallegos, April 5, 1999.
182. Welf. & Inst. C. Section 14007.40.
183. *Governor's Budget Summary 2001–02*, supra note 137, at 27 and 151.
184. Final Rule, 42 CFR Part 435, 66 *Federal Register* 2316 (January 11, 2001).
185. For a synopsis of Medicaid expansions since the mid-1980s, see U.S. General Accounting Office, *Medicaid: Spending Pressures Spur States Toward Program Restructuring* (GAO/T-HEHS-96-75) (Washington, D.C.; 1996).
186. AB 75 (Isenberg) (Chapter 1331, Statutes of 1989), adding CAL. WELF. & INST. CODE § 14148.5.

187. For a discussion of DHS funding, see Legislative Analyst's Office, *Background Information on the Health Care "Safety Net"* (Sacramento, CA; 1995) 6–8; see also California Budget Project, *What Would a Medicaid Block Grant Mean for California and California Counties? Budget Brief* (Sacramento, CA; 1995) at 3, and *Medi-Cal Quick Facts* (November 1995).
188. U.S. House of Representatives, Committee on Ways and Means, *1992 Green Book Overview of Entitlement Programs* (Washington, D.C.; May 15, 1992) at 1653–59; *Kaiser State Facts*, *supra* note 14, at 17; *Medicaid Overview*, *supra* note 134, at 39, Appendix.
189. *Governor's Budget Summary 2001–02*, *supra* note 137, at 147–48 and Figure HHS-12.
190. Calculated from the following Medi-Cal data: Costs: 1993 fee-for-service costs for ages 0–20, plus EPSDT screen costs; Recipients: January 1994 non-prepaid health plan (PHP) certified. Youth under age 21 constitute a much higher proportion of PHP certified, 69.7%, and the cost percentage is overestimated, because EPSDT screen costs include some services for children in County Organized Health Systems (PHPs) for which EPSDT has been billed separately rather than included in capitation rate.
191. See Senate Fiscal and Policy Staff, California State Senate, *Briefing Document on the Status of the Federal Budget and Its Impact on California Children and Families* (Sacramento, CA; Mar. 18, 1996) at Attachment II.
192. *Medicaid Overview*, *supra* note 134, at V.
193. As of January 2000, slightly less than 2.6 million of Medi-Cal's 5.2 million enrollees are in managed care. *Governor's Budget Summary 2001–02*, *supra* note 137, at 147 and 150.
194. *Governor's Budget Summary 2001–02*, *supra* note 137, at 148.
195. Michele Prestowitz, Lucy Streett, M.P.H., Medi-Cal Policy Institute, *A History of Medi-Cal Physician Payment Rates* (March 2000) at 17.
196. American Academy of Pediatrics, *Medicaid State Reports—FY 1997* (Elk Grove Village, IL; 1999) at 1.
197. S. Hunt, L. Peters, and J. Saari, Medi-Cal Policy Institute, *Capitation Rates in the Medi-Cal Managed Care Program* (Oakland, CA; May 1999).
198. "By point of comparison, Medi-Cal pays \$43 for a physician to set a broken arm, while a veterinarian would receive \$500 to \$800 for treating a similar injury to a dog." Karen Nikos, CMA News, *CMA Urges 25% Increase in Medi-Cal Reimbursement Rates to Physicians Who Care for Poor* (April 4, 2000) at 1.
199. See Department of Health Services website, Medi-Cal Home Page (as of 3/30/01), Provider Rates (see www.dhs.ca.gov).
200. See Children and Youth Policy Project, Institute for the Study of Social Change, *Immunizing California's Children* (Berkeley, CA; 1991) (hereinafter "*Immunizing California's Children*").
201. *May Revise 2002*, *supra* note 106, at 35.
202. AB 2068 (Brown), Chapter 1069, Statutes of 1973.
203. *Obstructed Entry: CHDP Fails as Gateway To Affordable Health Care*, Legislative Analyst's Office (January 30, 2001) (hereinafter "*Obstructed Entry*").
204. *Id.*; Health and Safety Code Section 124090; Title 17, Calif. Code of Regulations, Section 6830.
205. See description in California Department of Health Services, *Primary Care and Family Health: Annual Report 1993–94* (Sacramento, CA; February 1995) at 48 (hereinafter "*PCFH Annual Report*").

206. *Obstructed Entry*, *supra* note 203, at 2.
207. *Governor's Budget Summary 2001–02*, *supra* note 137, at 28.
208. 51 Cal. App. 4th 743 (Dec. 13, 1996).
209. Office of the Governor, *Governor's Budget Summary 1997–98* (Sacramento, CA; 1997) at 112–13 (hereinafter "*Governor's Budget Summary 1997–98*").
210. *Id.* at 113.
211. *Obstructed Entry*, *supra* note 203.
212. *Id.*, at 1-6. Note that in all fairness that DHS is impeded in facilitating such coordination by the narrow statutory definitions and authority extant for CHDP.
213. *May Revise 2002*, *supra* note 106, at 36–37.
214. For a description of CCS and recent data on it, see *PCFH Annual Report*, *supra* note 205, at 44.
215. *Governor's Budget Summary 2001–02*, *supra* note 137, at 145.
216. SB 1371 (Bergeson) (Chapter 917, Statutes of 1994).
217. See discussion of SOL Report in Senate Committee on Budget and Fiscal Review, *Overview of the 2001–02 Budget Bill, Health and Human Services Overview*, Subcommittee #3 (2001) at 3-18.
218. For a description of the MCH program, see *PCFH Annual Report*, *supra* note 205, at 27.
219. For a discussion of the impacts on small counties, see Brye Butler, *State Budget Cuts Imperil Health Programs for Low-Income Children*, SACRAMENTO BEE, September 4, 2001.
220. AB 1126 (Villaraigosa) (Chapter 623, Statutes of 1997).
221. According to the most recent study, 75% of California's 1.85 million uninsured children live in families earning less than 200% of the poverty line (1.38 million). Eighty eight percent live below 300% of the line (1.63 million). See *The State of Health Insurance in California 1998*, *supra* note 12, at 17. Healthy families allows coverage up to 200% for all children and above 200% for some. *E.g.*, the federal statute allows states to go 50% above existing state coverage. California already provides coverage for women and infants to 200% of the poverty line, and Healthy Families funding can move to 250% of the line for this group, and above 200% for other populations now covered at above 150% of the line. If one half of the 240,500 children living between 200% and 300% of the line qualify, the total will reach 1.5 million.
222. Section 801 of P.L. 106-554, The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000; see also, memo from Managed Risk Medical Insurance Board, January 17, 2001, Hearing Agenda Item #3c; "Tardy States Get a Break on Funds for Children's Health Insurance," S. F. CHRONICLE, January 6, 2001.
223. State Medicaid Directors Letter, HCFA, July 30, 2000.
224. Managed Risk Medical Insurance Board, *California's Healthy Families 1115 Demonstration Project: Summary of Modifications and Clarifications* (Sacramento, CA; March 1, 2001).
225. *Id.*
226. Stuber, Maloy, Rosenbaum and Jones, *Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid?*, Issue Brief, The George Washington University Medical Center, July 2000, at 2; see also, *Medi-Cal and Healthy Families: Focus Groups with California Parents to Evaluate the Medi-Cal and Healthy Families Programs*, Kaiser Family Foundation, January 2001.

227. See, e.g., Cindy Mann, Center on Budget and Policy Priorities, *Why Not Medicaid? Using Child Health Funds to Expand Coverage through the Medicaid Program* (Washington, D.C.; November 20, 1997) (hereinafter "*Why Not Medicaid?*").
228. California Health and Human Services Agency, *California's Healthy Families SCHIP 1115 Demonstration Project* (Sacramento, CA; December 2000) at 3-4.
229. *Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment: Findings from Eight Focus Groups in California with Parents of Potentially Eligible Children*, Kaiser Family Foundation, October 1998.
230. *Why Not Medicaid?*, *supra* note 227.
231. See, e.g., Letter to Governor Davis, Summary of Concerns, and Comments on Proposed CHIP 1115 Waiver, Western Center on Law and Poverty, Maternal and Child Health Access and others (January 11, 2001).
232. *Id.*
233. "California's Healthy Families 1115 Demonstration Project: Summary of Modifications and Clarifications," MRMB, March 1, 2001. Note that AB 2900 (Gallegos) was enacted in year 2000 which provides for 12 months of continuous eligibility for children in Medi-Cal, consistent with the existing 12 month automatic eligibility for children in undersubscribed Healthy Families (Chapter 945, Statutes of 2000).
234. California offers a "Family Value Package" which are a combination of health, dental and vision plans extant at the lowest competitive price in the relevant region. This pattern of competitive bidding stimulates low-ball capitated or fee-for-service pricing, in turn creating pressure for service barriers or denials to maintain profit margins.
235. Former Governor Wilson had proposed a twelve-month disenrollment after a 31-day delay in payment. Under consumer law principles and precedents applicable to late payments, such a penalty—if applied by a private party—would be unlawful and void. See, e.g., *Garrett v. Coast and Southern Federal Savings & Loan Ass'n*, 9 Cal. 3d 731 (1973).
236. California's Healthy Families SCHIP 1115 Demonstration Project," California Health and Human Services Agency (December 19, 2000) at 4–5; "California's Healthy Families 1115 Demonstration Project: Summary of Modifications and Clarifications," MRMB, March 1, 2001; and "Quick Summary Comparison of Administration's Initial Waiver and Modified Waiver," Senate Budget Committee, March 3, 2001.
237. *Id.*
238. *Field Institute Survey*, *supra* note 62.
239. Managed Risk Medical Insurance Board, *Retention in Healthy Families* (as of 3/12/01) (see www.mrmib.gov).
240. The rationale for allowing these deductions/disregards is that they involve expenses necessary to produce earnings, and only the net earnings are spendable for food, housing, utilities, transportation, and medical expenses (*i.e.*, discretionarily available). "Income" definitions commonly allow subtraction of expenses incurred in order to achieve gross revenue. For example, businesses are taxed on net income, and are allowed deductions for normal and necessary expenses incurred to obtain those revenues. Only the net income remaining after expenses, and subject to discretionary use, is taxed. The former Governor's disallowance of such deductions for families seeking medical coverage contrasts with his support of tax deductions and credits offsetting income for business interests (see discussion of tax policies in Chapter 2).
241. The original \$855 million was augmented on December 19, 1997, by an additional \$4.056 million in the U.S. Health Care Financing Administration's final child health grant figures.
242. California Health and Human Services Agency, *California's Healthy Families SCHIP 1115 Demonstration Project* (Sacramento, CA; December 2000).
243. The state now estimates the SCHIP allotments available for California from 2000 through October 31, 2006 to be about \$4.52 billion. (See *California's Healthy Families SCHIP 1115 Demonstration Project*, projected federal cost chart, California Health and Human Services Agency (December 19, 2000). Congress let California keep \$350 million, or

60%, of its unspent SCHIP allotment for 1998, effectuating a \$233 million loss of federal funds. A similar amount was unspent in 1999, with additional sums unspent in 2000 and 2001. In December 2000, the state estimated it would have to return \$1.34 billion in unspent SCHIP allotments by 2003 unless granted dispensation. (*Id.*) In 1998-99 total Healthy Family expenditures were \$131 million—growing steadily to \$655 million in current 2001–02 in the MRMIB account, or \$820 million if all spending is counted. See *Governor's Budget Summary 2002–03*, *supra* note 106, Figure HHS-15 at 181.

244. *May Revise 2002*, *supra* note 106, at 42.
245. A fourth tactic used for proposed 2002-03 is to avoid general fund commitment to accomplish the one-third match. Any source of state funds will meet the match obligation. Accordingly, as noted above regarding Table 4-J (covering the MRMIB portion of Healthy Families), the proposed 2002–03 budget would eliminate almost all general fund contribution, replacing it with \$247 million from the Tobacco Settlement Fund. *Governor's Budget Summary 2002–03*, *supra* note 106, Figure HHS-15 at 181.
246. Managed Risk Medical Insurance Board, *California's Healthy Families 1115 Demonstration Project: Summary* (Sacramento, CA; January 2001).
247. See *Losing Health Insurance: The Unintended Consequences of Welfare Reform*, Families U.S.A., May 1999; See also *One Step Forward, One Step Back: Children's Health Coverage after CHIP and Welfare Reform*, Families U.S.A., October 1999; See also Marilyn Ellwood, *The Medicaid Eligibility Maze: Coverage Expands, but Enrollment Problems Persist*, Mathematica Policy Research Inc. (funded by the H.J. Kaiser Foundation and the Urban Institute), Cambridge, Massachusetts, September 1999; See also Judith Feder and Sheila Burke, *Options for Expanding Health Insurance Coverage*, Henry J. Kaiser Foundation, October 1999; See also Diana M. Bianco, *The Tie That Binds: Linking Children's Health Insurance with School Nutrition Programs in California*, Consumer's Union (funded by the H.J. Kaiser Foundation), December 1999; See also Abigail English, J.D., Madlyn Morreale, M.P.H., Amy Stinnett, M.P.A., *Adolescents in Public Health Insurance Programs: Medicaid and CHIP*, Center for Adolescent Health & the Law, December 1999.
248. See, e.g., *Healthy Families: Family Health Insurance Through One Door, Recommendations for Creating A Unified Health Insurance Program for California's Children and Their Parents*, The 100% Campaign, a collaborative of Children Now, Children's Defense fund and The Children's Partnership (February 2001 Pre-Publication Draft).
249. Some of the measures undertaken are discussed above, and include in major part:
- (a) Providing children on Medi-Cal with 12-months continuous eligibility;
 - (b) Changing Medi-Cal income reporting from quarterly to annually so that eligible parents and children won't lose coverage simply for failing to keep up with unnecessary paperwork;
 - (c) Improving the Medi-Cal "redetermination" process when a child or adult leaves CalWORKs or loses a basis of Medi-Cal eligibility, to prevent breaks in coverage for eligible persons;
 - (d) Allowing more two-parent working families to qualify for Medi-Cal family coverage by eliminating the "100 hour" rule;
 - (e) Allowing parents to qualify for Medi-Cal with income up to 100% of poverty (up from 70%);
 - (f) Using federal Section 1931(b) to allow parents and children to remain on Medi-Cal with income up to about 157% of the poverty line, regardless of whether an individual receives cash assistance.
 - (g) Allowing parents as well as children to use a mail-in application form to apply for Medi-Cal, rather than having to go to the welfare office to apply in person;
 - (h) Expanding Healthy Families eligibility for children from 200% to 250% of the FPL;
 - (i) Expanding Healthy Families eligibility to legal immigrants arriving after 1996 (accomplished in 2000 via AB 2415 (Migden), (see Chapter 944, Statutes of 2000);
 - (j) Allowing youth who "age out" of foster care at 18 to keep Medi-Cal coverage with no share of cost through age 20.
250. Suggestions made have included:
- (a) Allow Medi-Cal and Healthy Families applicants to self-declare income, as federal laws allow, and avoid a major barrier to the enrollment process;
 - (b) Drop the Medi-Cal assets test for parents, and extend 12-months continuous eligibility to parents, as has been done for children and in Healthy Families for children and adults alike;
 - (c) Unify the two major children's programs by aligning income-counting and household composition rules;
 - (d) Children who leave TANF are deemed covered for three years thereafter with TANF exit documents automatically conferring that status;
 - (e) Other presumptive eligibility categories, e.g., automatic enrollment of any child in a family receiving any means tested benefit.
 - (f) Cover pregnant women and infants to 300% of the line through use of the AIM program (described below). Cover transitional Medi-Cal recipients to 235%.
 - (g) Drop all advance premiums beyond the \$5 co-payment;

- (h) Remove the partial pay provisions of Medi-Cal which limit benefits where parents have even minor income (see discussion above);
 - (i) Increase incentive payments to \$100 per new member—with \$25 going to the child's parent;
 - (j) Increase outreach;
 - (k) Replace earned income disregards with a standard income deduction;
 - (l) Adopt one form to allow children with non-custodial parents to sign onto the employer benefits offered those employees (a pending federal Department of Health and Human Services regulation).
251. *The State of Health Insurance, supra* note 2, at 22, Ex.15. Over 60% of California's children are privately covered. *Id.* at 18, Ex. 11.
252. *Email Correspondence from Ninez Ponce, supra* note 9.
253. *The State of Health Insurance, supra* note 2, at 18, Ex. 11.
254. This total assumes conservatively that (1) 4.4 million of the 5.6 million children currently covered privately are in families earning under 300% of the FPL, (2) 50% of employers require a 50% employee contribution for dependency health care coverage and the remainder pay all of it; (3) 20% of employers will not have profit to take advantage of the credit in a given year; (4) coverage costs \$1,000 per year per child.
255. For a description of the OFP program, see *PCFH Annual Report, supra* note 205.
256. Senate Office of Research, *Teen Pregnancy and Parenting in California: Background* (Sacramento, CA; March 1996) at 6. Factors correlating with teen pregnancy include sexual abuse, history of foster care, daughter of a teenage mother, single-parent household, and parents with low educational attainment. Trends correlating with increased teen pregnancy rates include lower age of menstruation onset (now dropping to 11), and increased sexual activity—with more than half of all girls and two-thirds of all boys having sex prior to age 18.
257. Note the anticipated problem of the approaching population bulge in California's adolescent population, projected to increase 34% by 2005 (compared to a 13% national increase). Even further decline in birth rates will produce substantially more numbers of newborns with unwed teen parents than is currently the case.
258. Carla Rivera, *State Teen Birth Rate Drops Nearly One-Third in Decade*, L. A. TIMES, April 4, 2002.
259. See Kristin Anderson Moore, Ph.D. et al., *CTS Facts at a Glance*, Child Trends (Washington D.C.; December 1999) at Table 1 (hereinafter "*CTS Facts at a Glance*").
260. Stephanie J. Ventura, M.S., T.J. Mathews, M.S., Sally C. Curtin, M.A., *Declines in Teenage Birth Rates, 1991–97: National and State Patterns* (Centers for Disease Control and Prevention, National Vital Statistics System; December 17, 1998) Vol. 47, No. 12, at Table 6.
261. Recent data from 1996 places California's teen pregnancy rate at the second highest in the nation (125 against a national average of 97), and with a 36% abortion rate compared to the national figure of 30%. See *CTS Facts at a Glance, supra* note 259, at Table 1.
262. *Id.*
263. One recent study reached similar conclusions, finding teen pregnancy to be a relatively minor contributor to AFDC caseload, but that overall (older) single parenthood was the single most correlative factor for AFDC, and correlates even more highly with the "highly dependent" or longer-term population within the AFDC recipient group. See Thomas MacCurdy, Margaret O'Brien-Strain, Public Policy Institute of California, *Who Will Be Affected by Welfare Reform in California?* (San Francisco, CA; February 1997) at 96–100.
264. The most recent percentages are reduced from the 1994 estimate of 35% because of a flaw in the methodology of presuming that different last names of mothers and fathers or of babies and mothers on birth certificates inferred unmarried status. The more recent findings are based on a more sophisticated protocol. A birth is inferred as nonmarital if one of the following factors (in priority order occurs) (1) paternity acknowledgment received; (2) no father's name listed; or (3) father and mother surnames are different. Beginning in 1997, California began to adjust for the hyphenated or atypical naming practices possibly inflating the (3) numbers above—particularly in the Asian and Hispanic communities. Beginning January 1, 1997, the marital status is counted based on a new question then added to the birth certificate document concerning mother's maternal status. The enactment of AB 2680 in 1998 adds Section 102426 to the Health and Safety Code, requiring birth registration to "electronically capture the mother's marital status

- in an electronic file.” The information is to be transcribed onto the birth certificate hard copy. The information gathered is confidential except for statistical analysis purposes without name identification.
265. The increase in single-parent births is society-wide. It is occurring among middle class and wealthy populations at the same or higher rates than among the poor; it occurs regardless of welfare level changes over time, and independent of welfare level disparities between states. See research cited and summarized in Center on Budget Policy and Priorities, *Welfare, Out-of-Wedlock Childbearing, and Poverty: What is the Connection?* (Washington, D.C.; 1995) at viii–x, 3–17 (citing National Center for Health Statistics, *Monthly Vital Statistics Report, Advance Report of Final Natality Statistics, 1983 and 1992*). Unwed birth increases are international in scope, with some European rates surpassing American levels.
266. Claire Brindis, Patricia Reyes, Madeline Stanionis, Institute for Health Policy Studies, *The Impact of the California Office of Family Planning Budget Cuts: A Clinic-Based Study* (San Francisco, CA; 1991).
267. For information on the program, see www.dhs.ca.gov/prp/ofp/FamPACT/proghi.htm. See also *Family PACT Program Evaluation Report*, UCSF (January 2000) at v (hereinafter “*Family PACT Program Evaluation Report*”).
268. *Id.*
269. Termed the Women’s Contraception Equity Act, the measure added Section 10123.196 to the Insurance Code, requiring all individual and group disability policies after January 1, 2000 to provide certain FDA approved contraceptive services, subject to exemptions based on religious objection.
270. *Family PACT Program Evaluation Report*, *supra* note 267, at vii.
271. Data provided by the Division of Accounting, State Controller’s Office (Apr. 1993) (available at the Children’s Advocacy Institute).
272. Office of the Legislative Analyst, *LAO 1995–96* (Sacramento, CA; 1995) at Fig. 1.
273. See Office of the Governor, *Governor’s Budget Summary 2001–02*, *supra* note 137, at 142–143. Proposition 99 total funding fell steadily from \$473 million in 1993–94 to \$462, \$450 and \$372 million in 1995–96, 1997–98 and 1999–00, respectively. Prop 99 revenues (for 2000–01) were about \$360 million, and the estimate for 2001–02 is \$355 million.
274. *Governor’s Budget Summary 2001–02*, *supra* note 137, at 28 and 142.
275. See mixed findings in initial studies of managed care impact on the clinic infrastructure relied upon by uninsured populations, discussed above.
276. State Legalization Impact Assistance Grant (SLIAG); see 8 U.S.C. section 1255(a) *et seq.*
277. *PCFH Annual Report*, *supra* note 205, at 52.
278. See *Immunizing California’s Children*, *supra* note 200, at 5.
279. See *Worse Measles Year*, S.D. UNION-TRIB. (June 7, 1991) at A18.
280. California Department of Health Services, *DHS 1995–96 Budget Highlights* (Sacramento, CA; 1995) at 6; see also California Department of Health Services, Immunization Branch, *Annual Kindergarten Retrospective Survey for 1989–1994* (Sacramento, CA; April 20, 1995). The two-year-old immunization rates reported were 43.9% in 1989; 43.3% in 1990; 48.7% in 1991; 48.2% in 1992; 48.4% in 1993; and 57.2% in 1994.
281. AB 3351 (Gotch) (Chapter 1110, Statutes of 1992); AB 3354 (Gotch) (Chapter 1111, Statutes of 1992).
282. California Department of Health Services, *Highlights from the Governor’s 1994–95 Budget Proposal* (Sacramento, CA; 1994) at 2, 6–7 (hereinafter “*DHS 1994–95 Budget Highlights*”).
283. See Julie Marquis, *Group Sues U.S. Over Curbs on Free Shots*, L.A. TIMES, May 13, 1998, at A-1.

284. Denny Walsh, *Judge: State Health Plan Deprives Kids*, SACRAMENTO BEE, May 1, 1999, at A-1.
285. Interview with BDMP staff (March 1993).
286. Patrick Romano, Norman Waitzman, Richard Scheffler, Randy Pi, *Folic Acid Fortification of Grain: An Economic Analysis*, 85:5 AM. J. OF PUB. HEALTH 667 (May 1995).
287. California Department of Health Services, Childhood Lead Poisoning Prevention Branch, *Summary of Childhood Lead Poisoning in California* (Sacramento, CA; 1995) at 3.
288. *Id.* The program funded approximately 9,000 publicly funded screenings in 1991, 200,000 in 1992, 258,000 in 1993, and 332,000 in 1994.
289. California Department of Health Services, *Lead Hazards in California's Public Elementary Schools and Child Care Facilities* (Sacramento, CA; 1998).
290. California Department of Health Services, Office of Public Affairs, *State Health Director Issues Strategies for Lead-Safe Schools* (Press Release No. 24098) (Sacramento, CA; April 17, 1998) at 2.
291. Lawrie Mott, Natural Resources Defense Council, *Our Children at Risk: The Five Worst Environmental Threats to Their Health* (New York, NY; November 1997) at vii (hereinafter "*Our Children at Risk*").
292. *Id.* at 11.
293. See the legislative file on AB 481 (Kuehl), the Comprehensive Childhood Lead Poisoning Prevention Act, which was considered (but not enacted) in the 1997–98 legislative session.
294. General Accounting Office, *Lead Poisoning: Federal Health Care Programs Are Not Effectively Reaching At-Risk Children*, GAO/HEHS-99-18, January 1999, at 3–5.
295. *Id.*
296. See *Our Children at Risk*, *supra* note 291, at 12, citing P. Mushak, *et al.*, *Prenatal and Postnatal Effects of Low-Level Lead Exposure: Integrated Summary of a Report to the U.S. Congress on Childhood Lead Poisoning*, 50 ENV. RES. (1989) at 11–36. See also P. Baghurst, *et al.*, *Exposure to Environmental Lead and Visual-Motor Integration at Age 7 Years: The Port Pirie Cohort Study*, 6:2 EPIDEMIOLOGY 104–09 (March 1995) (hereinafter "*Exposure to Environmental Lead*").
297. *Exposure to Environmental Lead*, *supra* note 296, at 104–09.
298. See *Our Children at Risk*, *supra* note 291, at 12.
299. *Exposure to Environmental Lead*, *supra* note 296, at 106–09.
300. See H. L. Needleman, *Deficits in Psychologic and Classroom Performance of Children with Elevated Dentine Lead Levels*, 300 NEW ENG. J. MED. 689-95 (1979); H. L. Needleman and D. Bellinger, *The Health Effects of Low-Level Exposure to Lead*, 12 ANN. REV. PUB. HEALTH, 111-40 (1991).
301. H. L. Needleman, *et al.*, *Bone Lead Levels and Delinquent Behavior*, 275:5 JAMA 363-69 (February 7, 1996).
302. *Governor's Budget Summary 1997–98*, *supra* note 209, at 112.
303. The paint industry argued that because lead contamination from paint ceased in the 1970s (as lead was removed from house paint), many new companies and owners—most of whom did not contribute to lead contamination—would bear the brunt of the assessment. Since a fee must be related to a benefit received or cost incurred, the industry argued there was insufficient nexus between the persons causing the problem and the persons assessed. Child advocates argued that where the marketing of a substance dedicated to a particular use causes injury, it is appropriate to

internalize the costs of past injury to the same product type. The notion here is that marketers of potentially hazardous substances will bear some risk if an assessment is allowed against the substance because it will affect the value of the enterprise and assets devoted to that purpose, even if sold to a successor corporation later. Such a successor will then be on notice of that liability in judging the value of purchased machinery. And the market will not allow as much of a free ride (e.g., escape through sale) to one causing damage. Advocates also argued that the paint producers are not paying because the fee is industrywide—which means it is passed onto consumers who buy paint. Hence, consumers of paint products are paying for some of the damage caused by prior use of the product type. The paint industry pays a small fraction of the fee, and—in the litigation challenging the lead fee—served as a stalking horse for the oil industry, which pays the majority of it. That industry is controlled by the same corporations which added lead to gasoline to create substantial environmental hazard in heavily urban areas—well after publicly-disclosed research documented its impact on children.

304. *Sinclair Paint Co. v. State Board of Equalization*, 15 Cal. 4th 866 (1997).
305. California State Auditor, *Department of Health Services: Has Made Little Progress in Protecting California's Children from Lead Poisoning* (Sacramento, CA; April 1999) at 1.
306. AB 1382 (Lowenthal).
307. AB 1730 (Cardenas).
308. *Id.*
309. Leslie Zellers, Children's Advocacy Institute, *Using Medicaid for Case Management in Lead Poisoning Cases* (Apr. 22, 1993).
310. *Healthy Children Organizing Project, et al. vs. DHS, et al.*, San Francisco County Superior Court, No. 313012, filed June 19, 2000.
311. See 17 CCR Section 37000 et seq., see also CHILDREN'S REGULATORY LAW REPORTER, Vol. 3, No. 2 (2002) at 15.
312. California State Auditor, *Department of Health Services: Additional Improvements Are Needed to Ensure Children Are Adequately Protected from Lead Poisoning* (Sacramento, CA; May 2001) at 1.
313. See *Our Children at Risk*, *supra* note 291.
314. See, e.g., The George Washington University Medical Center, *Environmental Policy: Increasing Focus on Children's Health*, 4:1 HEALTH POLICY: CHILD HEALTH (Winter 1997) at 1–4.
315. *Our Children at Risk*, *supra* note 291, at v.
316. The two major relevant federal statutes are the Federal Insecticide, Fungicide, and Rodenticide Act, which regulates pesticide application, and the Federal Food, Drug, and Cosmetic Act, which sets maximum tolerances for residue levels for specific pesticides on specific foods, generally based on overall adult hazard research and information.
317. See National Academy of Sciences, *Pesticides in the Diets of Infants and Children* (1993).
318. Pub. L. No. 104-170, the Food Quality Protection Act of 1996.
319. Chapter 718, Statutes of 2000.
320. U.S. Environmental Protection Agency, *Environmental Health Threats to Children* (EPA 175-F-96-001) (Washington, D.C.; September 1996).
321. AB 3087 (Speier), sponsored by the Children's Advocacy Institute, was enacted in 1992. The bill overhauled the state's regulation of child care facilities, and created a funding mechanism for the new program (and other specified children's health and safety programs) by creating the "Kids' Plates" personalized vehicle license plates program, with proceeds diverted to a new "Children's Health and Safety Fund." The bill specified that the "Kids' Plates" program would not go into effect unless 5,000 plates were sold by December 31, 1993. The private organization sold the 5,000th plate on December 31, assuring a future source of revenue for poison control hot lines and other child health program funding.

The dependence of basic child health and safety measures on such ephemera suggests its lack of priority within state offices.

322. *Our Children at Risk*, *supra* note 291, at vi, 80-91.
323. *Id.*, citing J. Pirkle, *et al.*, *Exposure of the U.S. Population to Environmental Tobacco Smoke: The Third National Health and Nutrition Examination Survey, 1988 to 1991*, 275 JAMA 1233–40 (April 24, 1996).
324. See 23 references cited and summarized by Virginia P. Quinn, Ph.D., California Center for Health Improvement, *Millions of California Children Still Exposed to Tobacco Smoke; Harms to Health, Higher Costs Result* (December 1999) (see www.policymatters.org).
325. *Governor's Budget Summary 2001–02*, *supra* note 137, at 143 and 145.
326. See U.S. Substance Abuse and Mental Health Services Administration, *2000 National Household Survey on Drug Abuse* (Washington, D.C.; October 2001) (see www.samhsa.gov/statistics/statistics.html).
327. *Our Children at Risk*, *supra* note 291, at vii.
328. *Id.* at 91–100 (citing 1996 amendments to the Safe Drinking Water Act). Under the Bush administration, the EPA has blocked a Clinton administration decision to significantly reduce the allowable amounts of arsenic in drinking water, to the standard allowed by the World Health Organization and the European Union. See *EPA Blocks Tighter Rules For Arsenic in Water*, S.F. CHRONICLE (March 21, 2001) at 1.
329. See B. Cohen, *et al.*, Natural Resources Defense Council, Environmental Information Center, *Just Add Water: Violations of Federal Health Standards in Tap Water 1994–95* (New York; NY; May 1996).
330. The Dental Health Foundation, *Selected Findings and Recommendations from the California Oral Needs Assessment of Children, 1993–94* (Sacramento, CA; September 18, 1997).
331. Dental Health Foundation, *The Oral Health of California's Children—A Neglected Epidemic* (May 25, 2000) reporting from the 1993–94 California Oral Health Needs Assessment of Children (see www.dentalhealthfoundation.org/children.html).
332. *Oral Health in America*, U.S. Surgeon General, May 25, 2000.
333. See letter from Jared L. Fine, D.D.S., M.P.H., Chair, The Dental Health Foundation (Oct. 1993) (elimination of the Chief, Dental Health Section, California Department of Health Services).
334. See Report summary in Ben Winograd, *Agency Aims to Boost Dental Care for Kids*, SAN JOSE MERCURYNEWS, May 6, 2002.
335. Chapter 675, Statutes of 2000.
336. California Department of Health Services, Emergency Preparedness and Injury Control Branch, *Injuries in California, 1991* (EPIC Proportions Report #4) (Sacramento, CA; 1994) at 51. See *DHS 1994–95 Budget Highlights*, *supra* note 282, at 2.
337. *Governor's Budget Summary 2001–02*, *supra* note 137, at 142–43.
338. Managed Risk Medical Insurance Board, *AIM Access for Infants and Mothers: Report to the Legislature* (Sacramento, CA; January 1994) at 27. This report provides the last available systematic data on AIM. Based on AIM's data about its cases, it appeared that about 55% of the 13,590 pregnant women enrolled might have qualified for Medi-Cal (below 185% of poverty) had California implemented an assets waiver (a Medicaid option, available since 1986, allowing a waiver of the existing assets limit). Assuming costs at the Medi-Cal 185–200% level cited by AIM, this would have saved the state \$11.4 million in reduced costs of care, and half the remaining costs (or \$15.5 million) due to federal financial participation, at a cost of perhaps \$2–\$2.5 million in payments made by the women. In 1996–97, California finally implemented the Medi-Cal assets waiver, after years in which such legislation had been defeated or vetoed annually. As a result, AIM is now serving women above 200% of the FPL, with women from 185% to 200% covered by state-only Medi-Cal (no FFP), established by AB 816 (Isenberg) (Chapter 195, Statutes of 1994) (which was

- invalidated in *American Lung Association, et al. v. Wilson*, 51 Cal. App. 4th 743 (Dec. 13, 1996).
339. See California Department of Health Services, *Highlights: Governor Wilson's 1998–99 Budget Proposal* (Sacramento, CA; January 1998) at 8.
340. Office of the Governor, *Governor's Budget Summary 1998–99* (Sacramento, CA; 1998) at 20.
341. Office of the Governor, *Governor's Budget Summary 1999–2000* (Sacramento, CA: 1999) at 127.
342. For more information, see www.consumernet.org/lazyeye/.
343. Three-fourths of California's uninsured children live below 200% of the poverty line, and some additional children above that line may be covered under federal law.
344. The Balanced Budget Act of 1997 authorized presumptive eligibility and requires only that application be made for income determination by the last day of the month following the initial presumption (*i.e.*, treatment). The Act does not preclude the provider, school district, or others from doing the application work, so long as the recipient certifies or otherwise demonstrates qualifying income.
345. See Donna Ross, Center on Budget and Policy Priorities, *Presumptive Eligibility for Children: A Promising New Strategy for Enrolling Uninsured Children in Medicaid* (Washington, D.C.; August 5, 1997); see also *The Impact of Medicaid Provisions of the Federal Balanced Budget Act on Medi-Cal Managed Care*, *supra* note 161.
346. The Department of Managed Care regulates Knox-Keene health care service plans. The Department of Insurance regulates preferred provider organizations. The Department of Health Services oversees managed care plans which provide services to Medi-Cal recipients. The Department of Industrial Relations oversees managed care plans which provide services under the state's workers' compensation program. The Managed Risk Medical Insurance Board regulates the Healthy Families program. And more than a dozen occupational licensing boards within the Department of Consumer Affairs regulate individual health care practitioners who provide services at managed care organizations.
347. The Political Reform Act of 1974 requires lobbyists to register; "lobbying" is defined to include advocacy before either the Legislature or executive branch agencies. Reporting and rules are similar, whether advocating before the Legislature or agencies. See Papageorge and Fellmeth, *California White Collar Crime* (LEXIS Publishing; Carlsbad, CA; 1997) at Chapter 11.

