

Chapter 4

**CHILD
HEALTH**

I. CONDITION INDICATORS

A. Child Deaths and Injuries: Non-Illness

Table 4-A-1 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 cause of death is accidental drowning. Tragically, homicides/assaults (usually associated with child abuse) place second as the cause of non-illness death. Accidental motor vehicle collisions and suffocation make up the next significant sources of death for infants and toddlers. For children 5 to 15, motor vehicle accidents dominate—with 190 children dying on the roads in 2001. Firearm assaults and drownings follow in order. Death rates inflate substantially for youth 16 to 20 years of age, with an extraordinary 590 dying in traffic accidents in a single year. Deaths from intentional assault by firearm also spike up alarmingly, to 392. Finally, a substantial group of youth also die from suicide—with 148 ending their own lives in 2001 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.¹

Table 4-A-2 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) than are younger children. The leading form of self-inflicted injuries for youth aged 16–20 was poisoning, accounting for 79% of their self-inflicted injuries.

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 suicide² (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	9	76	28	10	39	162
Fall	1	3	4	1	14	23
Fire/Burn (Fire/Flame and Hot Surface/Substance)	2	12	9	1	10	34
Firearms	0	0	4	0	14	18
Motor Vehicle—All Categories	7	45	108	82	508	750
Poisoning	4	2	3	3	38	50
Struck by Object	1	1	5	0	4	11
Suffocation	22	12	10	4	5	53
Unintentional, All Other	7	30	17	10	41	105
Totals, Unintentional:	53	181	188	111	673	1,206
Intentional						
Self-Inflicted/Suicide, Cut/Pierce	0	0	0	0	1	1
Self-Inflicted/Suicide, Firearms	0	0	2	8	54	64
Self-Inflicted/Suicide, Poisoning	0	0	0	3	9	12
Self-Inflicted/Suicide, Suffocation/Hanging	0	0	5	13	65	83
Self-Inflicted/Suicide, Other	0	0	1	2	19	22
Assault/Homicide, Abuse and Neglect	16	14	0	0	0	30
Assault/Homicide, Cut/Pierce	1	0	4	6	29	40
Assault/Homicide, Fight-Unarmed	0	1	0	0	2	3
Assault/Homicide, Firearms	1	7	10	38	354	410
Assault/Homicide, Other	14	8	3	3	12	40
Totals, Intentional	32	30	25	73	545	705

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

TABLE 4-A-1. Fatal Injuries by Age Group—California, 2001

Cause	Age in Years					Total
	<1	1–4	5–12	13–15	16–20	
Unintentional						
Burn (fire/flame and hot object/substance)	151	536	249	66	169	1,171
Cut/Pierce	11	165	292	97	347	912
Drowning/Submersion	40	248	101	15	23	427
Fall	532	2,268	4,064	1,512	1,577	9,953
Firearms	2	5	39	40	159	245
Motor Vehicle—All	71	639	1,717	890	4,122	7,439
Bicyclist, Other	1	96	525	354	244	1,220
Pedestrian, Other	1	50	43	11	34	139
Poisoning	102	724	160	203	502	1,691
Struck by Object	52	280	670	508	674	2,184
Suffocation	132	191	59	20	18	420
Unintentional, All Other	344	1,053	1,439	843	1,572	5,251
Totals, Unintentional:	1,439	6,255	9,358	4,559	9,441	31,052
Intentional						
Self-Inflicted/Suicide	0	1	103	1,137	2,687	3,928
Assault/Homicide	220	119	140	378	2,463	3,320
Totals, Intentional	220	120	243	1,515	5,150	7,248
Other/Undetermined Intent						
Total, Other/Undetermined Intent	68	159	416	308	874	1,825
TOTAL	1,727	6,504	10,017	6,382	15,465	40,095

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

TABLE 4-A-2. Nonfatal Hospitalized Injuries by Age Group—California, 2001

B. Child Illness and Health

Beyond injury from accident or intentional infliction, a larger population of children is subject to illness—ranging from ear infections and viral illness, to chronic problems or disability, to terminal cancer. And they are subject to underlying nutrition, exercise, and environmental hazards affecting their health. The variety of illnesses, disabilities, and hazards are not amenable to the injury table presentation above. However, the 2001 California Health Interview Survey findings released in July 2003 present substantial and recent evidence of overall health status. This survey included random interviews and surveys of providers of 4,733 children under the age of five, with some attention to other children in the household.³ It is the most extensive examination of health status undertaken to date in any state. The study looked at parental evaluation of overall health, and then examined specific indicators, including asthma and other physical handicaps, dental care, and obesity/nutritional health.

The major findings included the following:

- Parents of 75% of children 0–5 years of age describe their health as “very good or excellent.” Nationally, the average response is substantially higher, at 85%.
- Latino children have substantially lower ratings of overall health, with only 60% described by their parents as “very good or excellent.”
- Children in rural areas or inner cities have relatively lower health status and poorer access to medical care.
- Childhood asthma is the most common young child adverse health condition, with 10.5% of children aged 1–5 so diagnosed, and with African-American child levels at 20.4%. Just over half are taking medication to control the condition. A high 33.7% of children 1–2 years of age had symptoms so severe they were taken to a hospital emergency room during 2001.
- About 3.7% of California children from 0–5 years of age have a condition that limits normal child activity; the number increases to 5% at age 5. (See more extensive data on learning disability related conditions in Chapter 7).
- Over 50% of California children from 2–5 years of age have never seen a dentist; 24% have no dental insurance coverage—public or private.
- Over 6% of young children are sleeping with a bottle—greatly increasing risk of dental problems, ear infections, and other illnesses and indicating a lack of parental education about child health (see detailed status and spending in dental account discussion below).
- California children from 2–5 years of age receive adequate fruit in their diets, but only 18% receive the daily recommended serving of vegetables (despite the fact that California is the leading producer of vegetables in the world).
- Soda begins to substitute for milk at three years of age, with substantial and increasing intake thereafter, particularly for children living below the poverty line (with 46% drinking sugar sodas by three years of age). Sugar sodas lacking any nutritional value provide 20% to 24% of the entire calorie intake of children 2–19 years of age.
- Children exercise too little, spending excessive hours in sedentary and passive activities, resulting in increased obesity, ill health, and vulnerability to negative health outcomes.⁴

The survey also examines nutritional adequacy (hunger) finding “CHIS 2001 shows that many California households with young children have been unable to provide balanced meals for financial reasons. Among young children....below the poverty line, about 51.2% of parents report that their food

did not last and they could not afford to get more, either 'sometimes' or 'often' within the last 12 months"⁵ (see more complete recitation of nutritional status in Chapter 3 above). The survey also notes continuing serious environmental hazards, including tobacco (see detailed discussion below of tobacco, lead, and other environmental health threats, as well as health-related family planning, genetic testing, immunization, dental health, injury prevention, and vision/hearing screening).

Additional findings from the 2001 California Health Interview Survey, released in December 2003, focus on long-term and intermittent lack of health insurance coverage.⁶ Some of the findings include:

- Among children with family income below the federal poverty level, 24.8% experienced lack of coverage for all or part of the year, including 14.4% of all poor children who were uninsured all year: only 4.5% of children with family incomes above 300% of the federal poverty level experienced a lack of coverage.
- Nearly one in four Latino children were uninsured at least some of the year, including 13.8% who were uninsured all year—the highest rate among all ethnic groups.
- Children whose parents were both born in the U.S. are least likely to be uninsured for all or part of the year (7.7%); while 23.4% of children whose parents are noncitizens without a green card and 42.6% of noncitizen children were uninsured all or part of the year, including 34.1% of noncitizen children who were uninsured all year.
- Just under 50% of the nearly 3.5 million Californians who were uninsured all year and more than 25% of the 2.8 million who were uninsured part of the year said the main reason they lacked coverage was that they could not afford health insurance premiums.
- Nine in 10 children with Medi-Cal coverage at the time of the interview had Medi-Cal coverage all year, showing high rates of continuous care (only 7.3% previously had been uninsured in the past year).
- However, one in seven (16.1%) covered by Healthy Families at the time of the interview had been uninsured in the past year, underscoring the program's role in insuring a population of children who had few other options and previously no health coverage at all.
- Close to 650,000 Latino children and adults eligible for Medi-Cal or Healthy Families were uninsured all year, compared to 116,000 white children and even smaller numbers of children in other racial/ethnic groups, suggesting the urgency of intensive targeting of outreach and enrollment efforts to Latino communities.

Finally, a special report titled "Asthma in California: Findings from the 2001 California Health Interview Survey"⁷ found that 9.6% of California children were diagnosed with asthma and reported symptoms of asthma in a 12-month period. The report found that more than 330,000 state residents visit emergency rooms at least once per year for treatment of asthma, and nearly 136,000 of those visits are made by children. Not surprisingly, African Americans, Latinos, and those in the lowest income groups had the highest rates of ER visits. These emergency visits are mostly preventable. The report concluded that children were at particular risk of being unable to manage their asthma symptoms and that more than half of adolescents ages 12–17 who experienced shortness of breath or other asthma symptoms every day or every week missed on or more school days each month. According to the report, most people with asthma are unable to control their symptoms in part because of lack of access to health care, lack of insurance, inappropriate use of medications, and exposure to toxins like tobacco smoke.

C. Medical Coverage of California Children

Whether children require medical care due to illness or accident, having secure coverage benefits

them. They are likely to be more closely monitored, to see a practitioner familiar with their needs, and to benefit from public health guidance of a professional physician. Such coverage, whether provided privately (usually through the employers of parents) or publicly, has important and measured benefits. It means that medical services are available, generally resulting in timely and effective treatment and competent records. It allows children to be examined and vaccinated, as well as monitored for lead levels, eye sight acuity, hearing, dental problems, *et al.* Such coverage facilitates both preventive and primary care. The alternative to such prophylactic and early care is emergency room treatment with its expense, danger, and delayed timing.

About 1.3 million California children were medically uninsured (uncovered) at some time during 2001, an improvement over 1998, when almost 2 million California children were uninsured.⁸ The improvement is due to a better economy in 1999, 2000, and part of 2001, with more job-based insurance, combined with fewer children losing Medi-Cal coverage when leaving welfare.⁹ Nevertheless, the rate of uninsured children remained close to the 1996 level, when California had still not fully recovered from the recession of the early 1990s.¹⁰ Moreover, it is likely that by 2006 the number of uninsured will begin to approach the two million level that existed before the State Child Health Insurance Program (SCHIP) was enacted by Congress. That likely reversion and failure is the predicted product of five factors discussed below: (1) continued deficiency (despite some improvement) in enrolling the children of families leaving TANF rolls into Medi-Cal or SCHIP although still eligible; (2) families losing employer coverage where laid-off (including recently hired CalWORKs parents); (3) employer health premium costs increasing nationally (36.8% from 1999–2002 and another 14.7% in 2003). This extraordinary cost increase has led more smaller employers to eschew coverage;¹¹ (4) barriers to SCHIP enrollment, including a difficult application process and required premiums; and (5) the confusion and obstacles created by 15 different programs potentially covering children—each with its own bureaucracy, rules, and eligibility.

1. Coverage Incidence and Demographics

In 2001, approximately one-third of the uninsured children in California were eligible for Medi-Cal; another one-third were eligible for Healthy Families¹² (California's name for the State Child Health Insurance Program (SCHIP) covering children uncovered by Medi-Cal up to from 200% to 250% of the poverty line). Enacted as part of the federal Balanced Budget Act of 1997, SCHIP allocated about \$850 million per year to the state with only a one-third state funding match required. Importantly, only one-third of currently uninsured children are ineligible for both programs (usually because their family incomes exceed eligibility levels or because they are not citizens and have no green card).¹³

Despite the high number of children who are eligible for Healthy Families, parents of nearly one in four uninsured children eligible for Healthy Families did not know of the program's existence as recently as 2001.¹⁴ As of December 2003, the Healthy Families program had signed up 683,787 children.¹⁵ Even though California has recently expanded public coverage, 80% of uninsured children age 0–5 years (158,000) are eligible but not enrolled; this includes children who did enroll but lost eligibility due to premiums or small income fluctuations, which is a "retention" problem.¹⁶

The 2001 estimate of medical coverage status for California's children by the American Academy of Pediatrics is:¹⁷

- Privately financed coverage: 56.5%
- Medi-Cal and Healthy Families: 25%
- Uninsured: 18.5%

A different analysis of 2001 data indicated that 57.4% of children's coverage was privately financed; 27% was provided by Medi-Cal, Healthy Families, or other public coverage; and 15.6% of children were uninsured.¹⁸ Of the state's uninsured, 30% are under six years of age, and 60% are under twelve years of age.¹⁹ California children are more likely to be uninsured than children in the United States as a whole: 15.6% in California, 12.2% in the U.S.²⁰ California has consistently remained among the bottom ten states nationally in her percentage of medically insured children.

California Children's Budget 2004–05

These uninsured children are generally not from unemployed families or from families on welfare; 76.7% live in families where at least one parent works, and 68.1% where at least one parent works full-time.²¹ They are substantially the children of the working poor who (1) refuse public assistance or (2) make too much to qualify for public assistance, 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.²²

Over 30% of uninsured children live below the poverty line; another 43% live between 100%–249% of the poverty line; 7% live between 250%–299%, and another 7% live at 300%–399% of the poverty line.²³ Thus, children in families with income below 250% of poverty make up 73% of all uninsured children, and those with family income below 400% of poverty make up 87% 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. In terms of all California children (including those privately covered), at a Healthy Families coverage limit of 250%, only 3.3% of children are ineligible for public coverage. If the limit were raised to 300% of the poverty line (which California is able to do for some groups of children under federal law), the total percentage of California children financially ineligible for publicly-assisted coverage drops to 1.7%. An additional 2.4% of children are ineligible due to their undocumented status. Adding that percentage to the financially ineligible group brings the total ineligible proportion to 4.1% (under a 300% limit) or 5.7% (under at 250% limit).²⁴

Coverage is somewhat higher for younger children (e.g., Medi-Cal limits are higher); a 2003 study of children 0–5 years of age, includes the following demographics:

	Uninsured	Medi-Cal	Healthy Families	Employment-Based	Other
Less than 100% FPL	13.1%	73.5%	0.0%	11.4%	2.1%*
100 – 199% FPL	10.9%	32.9%	12.0%	40.1%	3.2%
200 – 299% FPL	4.8%	10.0%	7.5%	74.4%	3.4%
300% FPL and above	1.1%	4.3%	0.4%	88.7%	5.5%
Race/Ethnicity					
Non-Latino White	3.5%	11.6%	1.9%	77.1%	6.0%
Latino	11.9%	45.5%	5.7%	33.9%	2.9%
African-American	2.5%*	45.2%	3.4%*	47.3%	1.6%*
Asian/Pacific Islander	2.6%*	18.1%	7.8%	69.3%	2.3%*
Area of Residence					
Urban	8.0%	36.2%	5.4%	46.8%	3.6%
Second City	6.4%	25.2%	2.9%	61.8%	3.7%
Suburban	3.7%	17.7%	2.5%	71.6%	4.6%
Small Town	8.8%	18.1%	4.5%	61.9%	6.8%
Rural	10.4%	40.8%	5.6%	40.7%	2.6%*
Citizenship Status					
Child and both parents U.S. born citizens	2.9%	17.1%	2.3%	73.1%	4.5%
Child citizen, parent naturalized citizen	4.9%	26.2%	5.6%	60.2%	3.2%
Child citizen, parent noncitizen with green card	12.9%	36.3%	7.1%	39.8%	3.8%
Child citizen, parent noncitizen without green card	13.3%	61.9%	5.1%	16.2%	3.5%*
Child is non-citizen	31.9%	32.9%	3.0%*	23.6%	2.2%*

Source: UCLA Center for Health Policy Research and First 5 California, *The Health of Young Children in California* (July 2003) at Exhibit 14.

Table 4-B. Insurance Coverage and Type by Family Income, Race/Ethnicity, Geography, and Citizenship, Children Age 0–5 Years, California 2001

The 2001 California Health Interview Survey (CHIS) discussed above finds a lower percentage of 7% of young children entirely uncovered medically, but nearly 20% of young children suffered coverage

lapse just within the prior 12 months.²⁵ The data suggests that episodic coverage may be based on employment changes, and on enrollment only immediately after serious illness requiring emergency room visits. The UCLA Center for Health Policy Research comments at length on the disadvantages caused by this sporadic coverage pattern.²⁶

The CHIS findings outline the demographics of current coverage lapse, with about 80% eligible for public programs, but eschewing them because of ignorance and lack of outreach, deportation fears (although children may be eligible), paperwork, or premium burden. Table 4-B presents the coverage breakdown, indicating that Latino children suffer high rates. Although the sample size precludes a reliable percentage calculation for young African-American children, other data confirms their similarly disproportionate lack of coverage. Children in low-income families, children located in rural areas and inner cities, and noncitizen children have lower health enrollment.

2. Coverage Shortfall Demographics: Immigrants

The data covering all children has a similar basic pattern, with Latino children over-represented among the uninsured, at 18.7% uninsured in 2001, compared to 15.0% Asian American and Pacific Islander children and 4.8% non-Hispanic white children.²⁷

For Latino children—the children with the highest uninsured rates historically—the rate in 1999 was the same as in 1994 at the depth of California’s recession.²⁸ 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 1999.²⁹ Although there was a slight improvement in the overall uninsurance rate for children from 1994 to 1999,³⁰ 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.³¹ In contrast, Latino children had the lowest rates of job-based coverage in 2001, 36.4%,³² 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.³³

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.³⁴ 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.³⁵ These figures will generally apply to California given the state’s 40% share of immigrant arrivals.

In California, 39.9% of non-citizen children and 31.4% of citizen children with non-citizen parents were uninsured in 2001, compared to the 4.5% 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—13.8%—was still three times that of citizen children with U.S.-born parents.³⁶

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. 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 1999.³⁷

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.³⁸ Although the rate of job-based insurance is higher for the non-citizen children, the difference is not considered significant.³⁹ 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.⁴⁰

The number of children on TANF rolls now is 800,000 fewer than in 1995 (see Chapter 2, Table 2-P). Many of those leaving safety net assistance are also now without Medi-Cal coverage—reflecting families who are refusing TANF benefits for their children even though they may qualify, or families who are losing welfare and not retaining Medi-Cal despite continuing eligibility. 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 deportation;⁴¹ for legal immigrants, it comes from concern that publicly-financed medical coverage will jeopardize their status or hurt their chances to become citizens.⁴² 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 2001,⁴³ but has partly recovered to 252,400 as of December 2002.⁴⁴ Since the number of immigrants has increased over this four year period, the coverage shortfall among this immigrant group should be 80,000–100,000, as compared to four years ago.

3. Coverage Shortfall Demographics: TANF Enrollee Loss

Beyond immigrant populations, children are leaving TANF rolls and not picking up medical coverage, even though eligible for Medi-Cal. One problem is the loss of caseworkers who might arrange coverage. This failure parallels the similar coverage decline in Food Stamp coverage for former TANF recipients, and for the qualified working poor generally, as discussed in Chapter 3. The Department of Health Services ascribes lack of continuing 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.⁴⁵ 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.⁴⁶ A recent study of current retention rates found that 36% of children enrolled in Medi-Cal lose their coverage after one year, and 40% of Healthy Families children fail to renew—almost all continue to qualify (see discussion of the “Retention” problem below).⁴⁷

Results from a joint UC Berkeley/UCLA survey comparing 1995 through 1998 data found an overall increase in uncovered children from 17% to 21%;⁴⁸ the most recent survey indicates the percentage fell to a low of 15.6% in 2001 due to Healthy Families enrollment and the economic upswing.⁴⁹ 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. The percentage of uncovered children is now believed to be somewhat higher as the post 9-11 economic slowdown (including some rising unemployment) and other factors lower the number of children covered through parental employer health coverage. Recent and prospective loss of private coverage is driven by health premium increases as noted above, with 13% average premium hikes in California imposed during 2002, and 15.8% increases imposed during 2003—a rate that is higher than the national average and nearly seven times the rate of inflation.⁵⁰ A 2002 survey found that the worker's share of premiums rose 30% to \$1,806 for family coverage; \$5 copayments for visits have become ubiquitous; and copays for drugs have doubled from \$10 to \$20 for many plans.⁵¹

Many of the changes made in the 2003–04 budget and proposed by Governor Schwarzenegger in his 2004–05 budget will further inflate the uninsured population, including substantial local infrastructure cuts, reductions in Healthy Families media advertising, reductions in Medi-Cal provider rate compensation (currently blocked in court (see below), and cancellation of parental Healthy Families coverage. As discussed below, the current preoccupation with avoiding new taxes will result in the loss of \$5 billion through 2006 in federal funds available for a 50/50 or a 2-to-1 match to provide coverage

for children.

The current “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. Of the 1 million children who currently remain uninsured, over 80% are eligible, and they can be covered substantially from available federal funds. As discussed below, current policies will increase the number of uninsured children to 1.5–2 million by 2006.

D. California Child Medi-Cal Coverage Lines and Costs

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 1990⁵²), but was also a result of more children becoming eligible under existing programs, as child poverty increased and job-related insurance declined starting in 1990.⁵³ 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 1–5 years. The estimated percentage of Medi-Cal deliveries to total California hospital inpatient deliveries has fallen from 47.75% in 1994 to 42.36% in 2000.⁵⁴

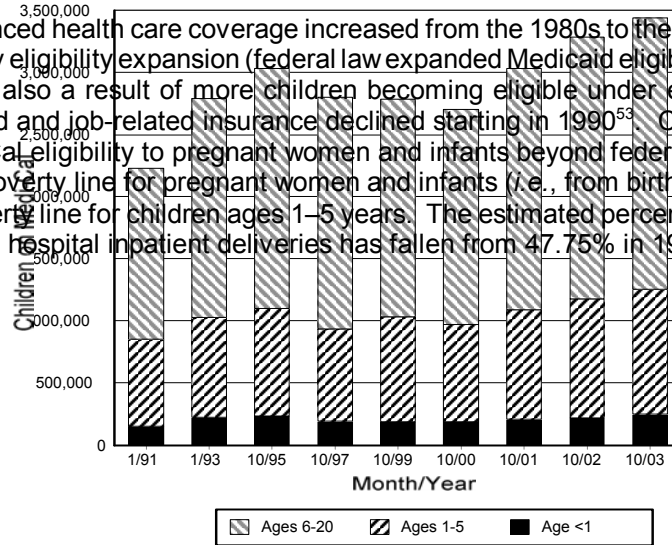


FIGURE 4-A. Trends in Number of Children on Medi-Cal, by Age⁵⁵

Nationally, children make up about 50% of Medicaid recipients,⁵⁶ but use only about 14% of the dollars spent.⁵⁷ 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.⁵⁸ 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.⁵⁹ As Table 4-C 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-C. 1998 Average Medi-Cal/Medicaid Payments by Recipient Age⁶⁰

A report by the American Academy of Pediatrics estimated 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 \$11,235.⁶¹ The numbers as presented in Table 4-C have gone up somewhat since 1998 for all groups, but children have steadily cost less than one-fifth 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 federal Medicare budget is devoted to the medical care and 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 Medicare 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),⁶² the disparity in public spending for the elderly versus children exceeds 10–1. 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. Under Medicare, all people over 65 years of age are assured some substantial coverage, while over 1 million California children—with double the poverty rate of the elderly and at a fraction of the health insurance cost—lack medical coverage.

E. Lack of Health Coverage Consequences

Uninsured children are less likely to have regular health examinations, resulting in less early detection of problems. Timely treatment for infectious and chronic diseases such as strep throat, asthma, and ear infections can 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.⁶³

Uninsured children lack a regular medical professional to monitor their development, and are six times more likely than an insured child to lack a regular source of care.⁶⁴ 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.⁶⁵

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.⁶⁶ 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 federal 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 6.7 in 2002.⁶⁷ Similarly, California's expanded eligibility after 1984 correlated with an infant mortality drop from 9.4 per 1,000 live births in 1984, to 7.0 in 1992, to a record low 5.3 in 2001.⁶⁸

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.⁶⁹ 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 was released in February 2000. The study concluded that the statewide health insurance program for low-income children was associated with improved access, utilization, and quality of care.⁷⁰ A December 2001 study reviewing 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, while 71% of Medi-Cal/SCHIP-covered children had seen a doctor, with 72% examined by a dentist. In contrast, 44% of medically uninsured children had ever seen a physician and 45% had ever been examined by a dentist.⁷¹

A study released in 2003 found that enrollment in Healthy Families correlated markedly with positive indicators, including less school days missed, improved overall health and a measurable improvement in school attentiveness.⁷²

In addition to the overall negative health consequences for uninsured children, having a partial population of the state's children uninsured results in problematic cost repercussions. As identified in the discussion of AB 232 (Chan) (see below), parents of uninsured children who properly seek emergency, hospital, or other necessary medical treatment when their children are seriously ill, risk financial ruin because the rates charged in such situations are unjustifiably inflated in order to cross-subsidize below-cost Medi-Cal rates and emergency care of indigents, from whom collection is largely unsuccessful. Excessive charging by hospitals and other providers for services provided to the uninsured is an issue that affects a large population within the state. There are over 6.3 million uninsured Californians—80% of whom are in working families; one trip to the emergency room for a child could leave these families destitute.

It is common for hospitals to charge uninsured recipients of care prices that are four times higher than the cost of actually delivering the services,⁷³ and far more than that charged under Medi-Cal, Medicare, or even private insurance. Unable to pay, and unaware of their financial options, parents may find themselves being pursued by collection agencies within a short period of time, and possibly filing for bankruptcy because they have no other recourse. This can result in even fewer uninsured parents taking their children to get necessary medical care; parents fearing the financial repercussions leave their children open to even more devastating health outcomes.

The state has opposed limiting charges to self-pay patients because of the attendant loss of federal matching funds that would result from charging, and thus collecting, less money from the uninsured. Thus, the state places the burden of unfortunate cost outcomes on those who are least able to pay. Providing coverage for the uninsured would be another method to increase federal matching funds coming into the state, since many of the uninsured are eligible under existing publicly funded programs.

One national study found that uninsured Americans could incur nearly \$41 billion in uncompensated health care treatment in 2004, with federal, state, and local governments paying as much as 85% of the care.⁷⁴ Another finding of the study is that if the U.S. provided coverage to all the uninsured, nearly 44 million individuals, the cost of additional medical care provided to the newly insured would be \$48 billion—an increase of .4 percent in health care spending's share of the gross domestic product. A similar state report found that providing health coverage to California's 6.3 million uninsured is estimated to cost about \$7.4 billion and could stabilize health care spending.⁷⁵ This estimated cost does not take into consideration the savings that may occur due to reduced morbidity and mortality because of improved health status, better access to care, or increased use of preventive services. The report also found that direct health care expenditures in California for the uninsured total \$7.4 billion annually.

These reports show the cost of covering the uninsured is comparable to the costs to the health care system when a large population of uninsured seek uncompensated medical care. This argument is even stronger for children in California, where an increase in federal funds brought in by extending coverage to all children could likely pay for the costs incurred by those children who are otherwise ineligible. Many advocates argue the cost burden of providing uncompensated health care to the uninsured could be alleviated by providing universal coverage with its attendant focus on preventive health.

II. FEDERAL AND STATE STRUCTURE/STATUTES

The state fulfills a general public health role, and also provides or finances clinical health services. Within or beyond the generic Medi-Cal and Healthy Families public programs are specialized public subsidies or coverage to address specific health care needs (e.g., prenatal care and immunizations) or family situations (e.g., low-income uninsured infants). These specialized programs tend to fall under the direction of DHS or MRMIB and cover additional populations (e.g., based on young age) at a higher percentage than the 100% of poverty line cut-off for generic Medi-Cal coverage. The percentages of publicly-covered children cited above include all of these programs in their total application. Each specialized program reflects a public policy judgment to provide health benefits to some segment of the population beyond the base group covered. 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 for 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 SCHIP 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. Child advocates argue that California has yet to bring medical coverage to children the state has agreed should receive it.

Public 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. That difficulty was exacerbated by the 2003–04 budget, which offered an array of direct and indirect reductions.

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 lower bar in Figure 4-B.

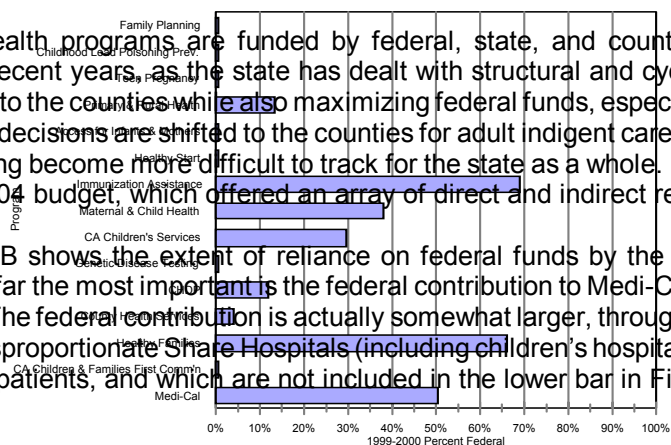


FIGURE 4-B. Federal Share of Spending on Health Programs

The following 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:

(1) The federal Medicaid program funds California's Medi-Cal program—by far the state's largest health program overall and for children—at a base of about 50%.

(2) Funding for Title V Maternal and Child Health (MCH) Programs 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. This Title V funding goes to states through a formula-based block grant process, which includes a matching funds requirement (states match \$3 in funds or resources for every \$4 in federal funds they receive). Among other things, these funds are aimed at developing service systems to meet critical challenges in maternal and child health, including significantly reducing infant mortality and incidence of handicapping conditions; promoting the health of children by providing preventive and primary care services; increasing the number of children who receive health assessments, diagnostic and treatment services; and providing family-centered, community-based, coordinated care for children with special health care needs.

(3) The Childhood Immunization Program assists state and local programs in vaccinating children.

(4) The Preventive Health and Health Services Block Grant supports state programs in health prevention, education, and screening, including MCH services.

(5) The 1997 federal Balanced Budget Act added 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 upon some formula representing need.⁷⁶ A 2003 General Accounting Office (GAO) report found that California suffers under the formula used to calculate federal Medicaid payments, creating a funding gap that dramatically reduces the amount of medical help the state is able to offer the poor. Although the Social Security Administration, which administers the Medicaid program, agreed with the GAO assessment, no action has yet been taken to even out this disparity for California.⁷⁷

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 Center grants, which are administered directly by the federal Health Resources and Services Administration to the health centers, and Medicare. These programs 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 increase in SCHIP funding at the lower one-third state match put the percentage at just above 55% for 2002–03. The enhanced Medicaid share promised as part of the federal tax reductions of 2003 will increase the federal contribution somewhat above this percentage for 2003–05, after which assistance will terminate, as discussed below.

A. Major Federal Health Related Statutory/Rule Changes 1996–2002

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 2002.⁷⁸ 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 for California (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 parents⁷⁹).

The federal Balanced Budget Act of 1997 changed substantially the Medi-Cal managed care context in California⁸⁰ and, as previously mentioned, provided new federal money to expand medical coverage through the State Children's Health Insurance Program (SCHIP)⁸¹ applicable to many of the children of the working poor otherwise lacking coverage.⁸² A series of letters and other instructions from the Health Care Financing Administration (HCFA) (the federal administrative agency with jurisdiction over Medicaid and SCHIP) to State Medicaid Directors also provide guidance for states on implementing SCHIP.⁸³

California's original SCHIP allotment was about \$850 million per 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 2002.⁸⁴ The monies California and 38 other states lost were redistributed to the eleven states that had spent their full allocations to insure more children.⁸⁵

In July 2000, HCFA 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 insure even more children⁸⁶. California submitted its proposal for a SCHIP parental coverage expansion to HCFA in December 2000 (discussed below). The application has been approved, but the 2003–04 budget was altered to delay its implementation until 2006 in order to avoid general fund assessment, notwithstanding the 2–1 federal match.

The federal 2003 fiscal year budget does make available to states nationally \$3.2 billion in unused SCHIP funds that otherwise are 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 were to be fully implemented, California's child health policy will result in between 1.5–2 million income eligible children remaining uncovered—notwithstanding available federal funds at a 2–1 match sufficient to accomplish full coverage, and over \$1 billion likely returned to the federal jurisdiction unexpended.

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

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRA)⁸⁷ 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).⁸⁸ Hence, federal law has “de-linked” Medicaid from welfare. This conceptual break with the past, enacted as Section 1931 of the Social Security Act,⁸⁹ 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.⁹⁰

As to individual rights, “de-linkage” under Section 1931 means that a person who loses TANF because he/she no longer meets a TANF eligibility requirement (e.g., failure to comply with work requirements, exhaustion of 60-month time limit to aid, etc.) may nonetheless remain eligible for federal Medicaid (Medi-Cal in California). Such “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.⁹¹ 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 (1) 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, 1998⁹²; (2) increase the income threshold for family coverage from about 70% of poverty to 100%, effective March 1, 2000⁹³; (3) allow families to keep Medi-Cal with income from work up to about 157% of poverty⁹⁴; and (4) allow more two-parent households to qualify for Medi-Cal family coverage as of March 1, 2000.⁹⁵

Historically, the pre-1996 Aid to Families with Dependent Children (AFDC) system included caseworkers who knew that AFDC-eligible families were also eligible for Medi-Cal. 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.”⁹⁶ 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.⁹⁷ A 2000 review in 25 states found that many parents and children eligible to continue receiving Medicaid nonetheless became uninsured after leaving welfare.⁹⁸ 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. Increasing enrollment of the working poor will be very difficult to change as long as Medi-Cal is presented as a “welfare” program. Where a “sign-up” (prior restraint qualification) system is in place, coverage for the 1.5 million low-income parents and children eligible for Medi-Cal requires outreach by the state to the work and community settings where parents can be reached.

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.⁹⁹ 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.¹⁰⁰

California has moved to simplify the Medi-Cal redetermination process,¹⁰¹ 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 on the merits for Medi-Cal. Virtually all will be technically eligible for either Medi-Cal or 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. Continued whole-family eligibility exists under either the Section 1931 program or transitional Medi-Cal (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 the 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 have 12 months of continuous eligibility within Medi-Cal and/or Healthy Families.¹⁰²

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 cases of children found ineligible to continue Medi-Cal after a redetermination to the Healthy Families program, which now covers children to 250% of the poverty line. At present, some counties do so on a voluntary basis. Child advocates

argue that the redetermination should involve a single question: Do the children receive coverage under Medi-Cal or Healthy Families? Advocates contend that 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 does sanction those who provide coverage to children who are 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. And parents who are covered are more likely to have contact with providers and hence to bring their children in for check-ups and early treatment when symptoms appear.¹⁰³ In addition, a study done in 2000 shows that parents are much more likely to enroll their children in Medicaid if the parents are also eligible.¹⁰⁴ As discussed below, the Governor's proposal to expand Healthy Families to include parents and capture federal 2–1 matching funds otherwise lost has been approved federally, but has been put on hold by the continuing budget crisis.

2. Federal 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.¹⁰⁵ The PRA cut off all Food Stamps and SSI benefits categorically from almost all immigrants arriving in the U.S. after August 22, 1996—for a period of five years after their arrival.¹⁰⁶ 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 U.S. However, that coverage depends upon separate state appropriations without federal match. Such state-only funding for Medi-Cal qualified children includes post 1996 arrivals. And similar coverage for all lawful immigrants, regardless of arrival date, applies to Healthy Families by virtue of AB 2415 (Migden) enacted in 2000.¹⁰⁷

Our survey of population data in Chapter 2 indicates the importance of retaining this immigrant coverage. Experts estimate that 25,000 legal immigrants (children and adults) arrive in Los Angeles County each year and qualify by income and need for Medi-Cal, but suffer its federal funding denial, a total which will reach nearly 200,000 by 2005.¹⁰⁸

3. Consolidated Omnibus Reconciliation Act (COBRA) and 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, many 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. Some private insurers engage in “cherry picking”—taking premiums from employees for many years, but when the employees reach a more expensive age or problems are disclosed, using employment change to justify abandonment. The children of these parent-employees often lose coverage as well.

The problem of employee termination and loss of medical benefits is covered by 1985 legislation under Title X of the Consolidated Omnibus Reconciliation Act (COBRA).¹⁰⁹ It allows an employee who is medically insured and is laid-off or terminated for reasons other than gross misconduct to continue to be covered under the previous employer’s plan. However, there are important conditions. The option is only available for firms with more than twenty employees, and the entire cost (employee and employer contribution) must be paid by the ex-employee, plus 2% for “administrative expenses.” In 2003, COBRA coverage for an adult and two children exceeded \$500 per month. Only 7% of unemployed workers nationally were eligible for COBRA and used it. Almost all children without coverage are in families below 200% of the poverty line. Where their parents have family coverage and then change jobs to a new employer who does not offer medical coverage, COBRA requires payment levels difficult for such parents to manage. As Chapter 6 discusses, only a limited number of working parents have access to child care subsidy (those in the first two years of leaving TANF rolls). The working poor parent without child care help may incur a \$4,000 to \$6,000 per child annual expense. For those earning under \$30,000 per year in gross income, payroll taxes, child care, rent, clothing and food will not leave the \$6,000 necessary for COBRA full-payment coverage (see discussion in Chapter 2).

In 1996, the Congress adjusted employee continuation coverage through the Health Insurance Portability and Accountability Act (HIPAA), effective July 1, 1997.¹¹⁰ The law marginally facilitated continued coverage for some children—largely by prohibiting discriminatory refusal of coverage at a second job where other employees are covered based on a pregnancy or other pre-existing condition. Thus, 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). Further, 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.

Further, 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.¹¹¹

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. HIPAA impacts 14 departments statewide, and the California Office of HIPAA Implementation is statutorily required to provide statewide oversight for HIPAA implementation. The 2003 Budget Act included \$75.4 million (\$21.2 million general fund) to continue HIPAA compliance efforts; however, the 2003–04 mid-year spending reduction proposals reduced that funding to \$61.2 million (\$15.8 million general fund), primarily as a result of unexpended prior year or unneeded current year funding for contracts. The Governor’s budget for 2004–05 proposes \$65 million (\$18.5 million general fund) to continue HIPAA compliance efforts.¹¹²

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

The Balanced Budget Act of 1997¹¹³ (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.¹¹⁴

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.¹¹⁵

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 in 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.¹¹⁶

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.¹¹⁷ Thus, the law allows for quicker enrollment at the start and uninterrupted coverage for a year. It also 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. States 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 enrollees' 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, 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.¹¹⁸ 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.¹¹⁹ As mentioned above, about 60% of the 1997 cuts were restored in 2000.

5. Federal Tax Policies

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 uninsured population. However, its demonstration program expansion alone (to employee firms of any size) is projected to cost \$5.7 billion nationally over ten years. California’s annual pro-rata share of these foregone funds is about \$70 million per year.

Additionally, the Bush Administration has proposed a tax credit for working families to secure health insurance. Under the proposal, working families with adjusted gross incomes up to \$25,000 (\$15,000 for individuals) would get a subsidy for up to 90% of the cost of a health insurance policy, with a maximum of \$1,000 per adult and \$500 per child, or \$3,000 per family; subsidies would decline as incomes rise.¹²⁰ The tax credit here would be refundable—fully available even where tax liability does not reach the credit amount. As of April 2004, the Bush plan is still being considered by the Congress in the Fair Care for the Uninsured Act of 2003, S. 1570 and H.R. 583.

However, at least one study has concluded that the insufficient amount of the credit would not allow substantially enhanced coverage.¹²¹ Few states had plans available at that price, and most offered high deductibles—some as high as \$5,000.¹²² 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.

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 per person, or if Healthy Families or other coverage is available. However, three disadvantages remain. First, the addition of this tax credit further fragments the available alternatives for 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.¹²³ Second, the tax credit is received after the

premiums are paid; thus, a parent must use cash or savings to make the up-front payment, and then seek the tax credit. Third, the tax benefit must be reachable given the income of the parent. Even if children can be covered 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 pay money up-front for coverage at a time when nobody is ill. If increased to \$1,500 for the parent, with standard policy rates for children in the family credit, the Administration’s 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 Chapter 2 proposal for a state Earned Income Tax Credit to supplement the federal EITC.

However, two problems would remain: (1) the cost of fragmentation; and (2) 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.

Another problem with the Bush proposal was detailed in a 2004 study by Dr. Jonathan Gruber, an economics professor at the Massachusetts Institute of Technology. The study concludes that the proposed tax credits are not the best or cheapest way to reduce the number of uninsured Americans.¹²⁴ Dr. Gruber determined that the federal government would spend \$3.32 for every dollar of new health coverage obtained through the tax credits—primarily because many of those credits would be used by people who already have insurance. Dr. Gruber opines that this shift in policy would induce many businesses to stop offering employee-sponsored health plans, causing 2.13 million more people to become uninsured.¹²⁵ As an alternative, Dr. Gruber noted that expanding public health coverage programs such as Medicaid would cost the government only \$1.17 for every dollar of health coverage purchased. Under such a proposal, an expansion would cover all adults earning up to 80% of the federally designated poverty level, or \$7,448 a year. Dr. Gruber opined that expanding existing programs like Medicaid would not push businesses to drop employee coverage or cause an increase in the number of uninsured.¹²⁶

6. Direct Federal Assistance to Hospitals Serving the Poor

In addition to general Medicaid, SCHIP, and the accounts listed below, the federal government separates out a portion of Medicaid for grants to hospitals that provide disproportionate service to Medicaid and non-paying (charity) cases. This form of aid preserves the infrastructure serving the many children and non-elderly adults who lack health coverage under the current system (see infrastructure discussion below).

7. Federal Specialized Child Health Programs

Apart from the major federal matching funds for Medi-Cal and Healthy Families noted above, several other specialized federal accounts have child health implications. This spending is generally not entitlement-based and commonly takes the form of grants to the states. These accounts array as follows nationally:

	FY 2001*	FY 2002*	FY 2003*	FY 2004*	FY 2005*
National Institute of Child Health (CDC, including immunization, birth defects, injury prevention, preventative health)	\$982	\$1,117	\$1,218	\$1,245	\$1,281
Family Planning	\$255	\$266	\$273	\$278	\$278
Maternal & Child Health Block Grant	\$714	\$739	\$731	\$730	\$730
Healthy Start	\$90	\$99	\$98	\$98	\$98

Emergency Medical Services For Children	\$19	\$19	\$19	\$19	\$20
Poison Control Centers	\$21	\$21	\$21	\$24	\$24
Community-Based Abstinence Grants	na	na	\$55	\$70	na
Newborn Screening	na	na	\$9	\$10	na
Children's Health Act Programs	na	\$13	\$13	\$13	\$13

*Numbers in millions.

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.

8. 2003 Federal Tax Reduction: Health Assistance to California

As discussed in Chapter 1, the total federal tax reductions from the 2001 and 2003 revenue cuts for Californians will average over \$37 billion per year over the next ten years. This estimate assumes that tax breaks enacted will not be terminated over the next decade—a prudent assumption given the politics of a public vote to raise taxes. This substantial sum will almost double in average annual cost over the next ten-year period thereafter (2013–23). Responding to harsh deficits in many state budgets, the Congress included in the 2003 tax package direct fiscal relief to states. However, the amount nationally was a single sum of \$20 billion to be disbursed over 18 months, with California's share at \$2.4 billion. The relief amounts to two-thirds of one percent of the ten-year total.

Since the state match required for federal Medicaid was a major source of expense inflation among the several states, the measure is entitled the Federal Fiscal Relief (FFR) to the States for Medicaid Programs. Just over half of the relief takes the form of increasing the federal share of Medicaid (\$1.3 billion for California) from April 1, 2004 to June 30, 2004. The remainder can be used more broadly, with \$690 million in grant funds going to the state, and \$470 million to local government.

Importantly, the FFR legislation includes limitations, such as states may not reduce Medicaid eligibility levels below those effective on September 2, 2003, and states cannot increase the local government-required contribution to the state's match that was effective on April 1, 2003. Both conditions may be relevant to California, where cuts could be accomplished by changing eligibility and by increasing county obligations. These monies are not part of the DSH funds to hospitals noted above (see discussion below).

9. Federal Medicaid Restructuring Proposals

On January 1, 2003, federal Health and Human Services Secretary Tommy Thompson outlined the Bush Administration plans to end entitlement-based spending for child health. Framed as a policy change to enhance "state flexibility," the proposal would convert current matches to capped block grants similar to those now in effect for safety net protection of children. The proposal would increase spending for the next several years on the condition the states agree to accept a capped annual federal allotment—essentially converting the program from entitlement to block grant status. The additional money totals \$3.25 billion for fiscal 2004, with a total of \$12.7 billion in additional funds over seven years. However, the Secretary notes that the total over ten years "will be revenue neutral," anticipating a substantial federal shortfall *vis-a-vis* entitlement funding for all those enrolled in out-years 8–10. States would have the option of refusing the additional funds, hence retaining a right to matching federal funds based on the entitled needs of affected children (the number covered).¹²⁷

After the Administration's proposal, the 2003 tax package then enacted and discussed above provides an enhanced federal match for Medicaid, providing some of the extra funds that would tempt states to accept the block grant structure. But California's particular need for money and the administration's continued interest in the block grant approach may make a refusal of still more funds for entitlement termination difficult to resist, particularly where funding shortfall for child coverage will occur in a future year. Many current officials (especially in California with six- and eight-year term limits)

will be out of office at the eight-year mark when federal capped funds will be substantially less than the sum received on a matching basis.

Child advocates are also concerned about the perverse effect of an economic downturn—as is now occurring. That fluctuation increases the impoverished population and demand for medical services at the very time it produces budget shortfalls for states. The federal government, with its greater flexibility to borrow from itself during difficult times, is then needed to preserve a health safety net for children. Under a matching regime, the federal jurisdiction adds money automatically when this factor increases demand—lending coverage important stability. Adding to this problem, the critical Disproportionate Share Hospital (DSH) payments that are paid to hospitals caring for a large share of Medicaid and uninsured patients would stop—jeopardizing the infrastructure relied upon by one million California children without coverage (to increase substantially as discussed below) and further exacerbating the planned Medi-Cal compensation cuts.

Finally, advocates are concerned about the misincentive effect of block grants applied to medical services. The current opportunity to capture federal funds motivates the state to seek maximum coverage since every dollar so expended is matched 50/50 or even 2–1. However, a block grant type structure produces the opposite incentive for the state—to disenroll children and cut spending on their health. Advocates argue that the state is placed in a position similar to the HMOs and insurers who receive an advance payment of a sum certain—and then keep all they do not pay out in claims. Hence, claims payment (or child health coverage) becomes an expense taking dollar for dollar from other possible uses for funds in-hand. This fear is exacerbated by the fact that two-thirds of Medicaid spending is for “optional” services or for optional beneficiaries not on the federal “required” list. These options include the current 90% federal share for family planning (see Chapter 2 for discussion of importance). They also include the possible elimination of EPSDT for “optional children” (e.g., immigrants for the first five years in the U.S. and children in families above poverty line levels).

The plan would require states to maintain the same level of state spending as in 2002 (the maintenance of effort requirement), but it is unclear if this MOE will be adjusted adequately by population and inflation. Medicaid costs in raw numbers have grown an average of 9% per annum nationally given the consistent pattern of medical costs exceeding overall inflation. By 2008, population growth and inflation will allow a 60% cut in actual coverage/services, a shortfall growing each year thereafter.

B. State Legislation/Rulemaking/Funding 1997–2001

1. Healthy Families and Revised Medi-Cal Coverage

Through AB 1126 (Villaraigosa) (Chapter 623, Statutes of 1997),¹²⁸ California implemented the “Healthy Families” program in order to provide expanded medical coverage to children pursuant to the SCHIP program, as authorized by BBA 97. The Healthy Families program is budgeted separately from the Medi-Cal account. The Healthy Families 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 asset test 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 increased Medi-Cal coverage for children ages 14–18 so all children would be covered in families living up to 100% of the federal poverty line.

Accordingly, Medi-Cal eligibility 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 poverty line. There is no asset 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 certain parents, as studies indicate that extending coverage to the whole family promotes child enrollment and health.¹²⁹ 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 former Governor Davis—who had been seeking it and complaining about its delay. At the point of its approval, the former Governor decided that the general fund shortfall precluded California expansion— even at a 2–1 federal to state match. This proposed expansion has been deferred until 2006.

2. California Children and Families First Act of 1998 (Proposition 10)¹³⁰

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 \$0.50 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 Commission will allocate only 20% of the funds—and most of this amount is pre-directed for mass media communications (6%); education (5%); child care (3%); research and development (3%); and 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 Proposition 10 is reduced each year in order to pay the surtax collection administrative costs of the State Board of Equalization, and to compensate Proposition 99 funding reductions caused by the new tobacco tax. Proposition 99 (discussed below) is an established account fed by existing tobacco taxes and funding numerous health care programs; it has suffered a reduction due to decreased sales from the higher prices attending the surtax. Prop 10 transferred a total of \$21.7 million to the Prop 99 account in 2003–04, and is expected to transfer the same amount in 2004–05. Governor Schwarzenegger estimates that Prop 10 will generate \$586 million in 2003–04 and \$584 million in 2004–05. Eighty percent of these funds will be expended by county commissions at the local level on early childhood development programs, including but not limited to, health care, child care, education, domestic violence prevention, maternal nutrition, and child abuse prevention.

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.* However, attention is increasingly given to health expenditures, especially Health Families expansion given concern over the federal funds requiring only a one-third state match, but irretrievably lost without enrollment.

In fact, in May 2004, the state and county children’s commissions announced new efforts to insure children 0–5 years of age in families up to 300% of the federal poverty line, and regardless of immigration status.¹³¹ Under the proposal, First 5 California (the state Commission) will put up \$1 for every \$4 that counties agree to spend out of their own cigarette tax revenues. “Healthy Kids”, the regional insurance program covering five Sacramento counties, is scheduled to begin running in May

2004.

Child advocates have been concerned about three possible impediments to efficient use of the Prop 10 monies: (1) whether available funds will be invested in programs or services having a preventive impact (e.g., parenting education, public media campaigns to lower unwed births); (2) whether counties will supplant the new money—applying it to existing or already planned spending, and freeing those funds for discretionary spending elsewhere; and (3) whether the state Commission, which has announced “advocacy” as a major priority, will provide funding for advocates to appear before regulatory agencies on issues affecting early child health.

3. Tobacco Settlement of 1999

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. Efforts to earmark the state's portion of the tobacco settlement money died in the waning hours of the 2000–01 legislative session.¹³² In 2001–02, the state was estimated to receive about \$468 million, with local governments receiving a like amount. The 2001–02 budget established the Tobacco Settlement Fund (TSF), into which all funds from the settlement would be deposited for use for health care programs. However, most of the funds were not directed at new spending, but at supplanting general fund money traditionally or previously expended for medical programs.¹³³

However, as discussed in Chapter 1, these funds due over the next twenty years have now been almost entirely expropriated to pay for bonds (and incurring interest expense) for one to two years of general fund relief. The expropriation of this Fund for a purpose unrelated to the grievance stated in the civil pleadings may be a breach of fiduciary duty by counsel. Its diversion from any benefit for those victimized by the alleged Business & Professions Code section 17200 violations (the Unfair Competition Law, or UCL) removes the settlement's collateral estoppel effect. Such finality is possible under the terms of the UCL and where no class is certified, no notice or opportunity to object provided, only where the victims have received a remedy such that a further suit will result in duplicate recovery. Lacking any such recovery for the stated victims (e.g., de-addiction services, corrective advertising, related medical treatment), suits may lie against the industry. To date, the most egregious diversion of the Tobacco Settlement Funds occurred with the cancellation of the token \$35 million for youth anti-tobacco education during the May 2002 Revise.

4. Exemplary County Child Medical Coverage Beyond State Levels (Use of Proposition 10/Tobacco Funds)

In 2000, Santa Clara County used a portion of its allocated tobacco settlement funds to cover all uninsured child residents, without regard to immigration status. The policy made Santa Clara the first local government in the country to effectively cover almost all of its children.

As of January 1, 2002, San Francisco County followed suit, with health insurance provided for all children regardless of immigration status; it was estimated that up to one-half 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 county general fund, with some contribution from locally allocated Proposition 10 funds.¹³⁴

The replication of this Healthy Families expansion by at least seven other major counties is discussed below. Counties that have implemented these universal child health care programs typically use their local funding to directly draw down a federal match (either at a 50/50 or 2–1 match), using MRMIB as the conduit to effectively bypass state politics.

C . Recent and Pending Litigation/Legislation**1. 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 2002 up to the 200% mark. However, the entire program is being deferred due to the general fund shortfall.

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 Families 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 coverage 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 Healthy Families benefits to any person eligible for Medi-Cal to give them time to apply for coverage and avoid a lapse.

c. Other Budget Trailer Enrollment Facilitation

Other budget trailer measures in 2001 were intended to facilitate Medi-Cal or Healthy Families enrollment for those who qualify, including allowing Healthy Families applicants to self-declare income where documentation is not available (consistent with the Medi-Cal rule); enrollment for children pending application decision; “partial continuous eligibility,” allowing a Section 1931 Medi-Cal beneficiary to disregard income and resource changes until the next annual redetermination;¹³⁵ foster care children are covered without proof of the unavailability of private insurance; dental and vision plans may assist with Healthy Families enrollment (and receive compensation for sign-ups); and 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.

2. Major 2001–03 Litigation/Rulemaking/Policy Changes**a. Medi-Cal Reimbursement Litigation**

The 2001 Budget Agreement included \$191 million to settle outstanding litigation over reimbursement rates for Medi-Cal outpatient services, of particular relevance to children because of the record low rate levels applicable to pediatric specialists, resulting in a low supply of pediatric physicians available to treat children covered by Medi-Cal, and decreased access to health care for this population. Reimbursement rates for the limited services included in the litigation are to be increased by 30%, with three successive annual increases of 3.33% in addition to this correction beginning July 1, 2002.

Partly because of this litigation, the California Children Services (CCS) rates for children with chronic illness or disability were raised, see the CCS account discussion below. However, Medi-Cal provider rates for children in general have not been substantially increased and have fallen to below out-of-pocket cost for many physicians. The rates are a fraction of compensation paid by Medicare for the same services performed for the elderly. The additional cuts physicians serving poor children face and their illegality under federal law (prohibiting comparative discrimination against a patient grouping) are discussed below.

b. New Pilot Disease Screens for Newborns

At the end of 2001, DHS announced an ambitious pilot program to expand the number of diseases for which newborns are screened. Previously, the state tested for four genetic problems using a few drops of drawn blood. New technology allows physicians to test for up to 30 diseases from the same sample. The new screening started in January 2002; however, funding for the expanded program ran out in June 2003. As a result, the state will return to testing only for the four basic disorders unless additional funding becomes available.

c. State Drug Pricing Savings

On May 19, 2003, a divided U.S. Supreme Court upheld a creative system in Maine to substantially reduce prescription drug costs—ruling that it was not preempted by Medicaid statutes, nor was it otherwise unlawful or unconstitutional as contended.¹³⁶ Maine's plan implemented discount prescriptions for all of its residents, with drug manufacturer's compelled to finance rebates. Failure to agree would subject all drugs by that manufacturer to "prior authorization" for drug sales, including those drugs prescribed for Medicaid covered patients. However, this appeal was brought before the HHS Secretary had a chance to approve or disapprove of the state system. Four Justices indicated that such a disapproval by the Secretary might invalidate the system as contravening federal Medicaid statutes. The three-judge plurality opinion identified effects from the plan consistent with the Medicaid statute, although they also noted that if a result included blocked access to drugs by Medicaid patients, their decision might change. The overall impact of the decision implies some strengthening of state options to implement cost cutting or pro-competition strategies where consistent with Medicaid purposes. The specific Maine policies have resulted in substantially lower prescription drug prices for its residents.

d. Provider Liens

In 2003, the California Supreme Court invalidated provisions of the Welfare and Institutions Code that took tort proceeds obtained by a Medi-Cal patient and paid it to providers not merely at the amount of Medi-Cal allowable rates, but at an amount "as charged" by the provider.¹³⁷ After this ruling, a provider may receive recompense from a damage award to the cost-sharing charge allowed under a state Medicaid plan. The holding has particular significance for children who may be awarded damages to cover present and future medical costs from an injury. If a provider is allowed to recover the amount as charged, which could be double or triple Medi-Cal rates, that could take a sizeable chunk of an award meant to pay for the child's ongoing or future medical treatment. Since a provider would not, under normal circumstances, be able to recover an amount greater than the standard Medi-Cal rates for treatment of a Medi-Cal beneficiary, the ruling allows for equity.

e. Medi-Cal Recipient Right to Refunds

In *Conlan v. Bonta*,¹³⁸ the First Appellate District of California held that refunds to Medi-Cal patients who bear out-of-pocket costs while awaiting state compensation must be promptly reimbursed. The Medi-Cal system had created a catch-22, leaving large numbers of poor parents in debt for advances made for the care of their children (which the state law obligates parents to provide). The lead plaintiff, Kevin Conlan, paid for the October 1997 birth-related costs of his son and applied for benefits at that time. Indicative of the many problems with the "out unless in" structure of medical coverage for children, his application was not approved until April 1998. The state refused to reimburse Conlan for the \$2,196 he managed to pay for the child birth. Another plaintiff (whose case was consolidated with the Conlan suit) had been trying to collect \$82 owed by the state for eight years. Federal law requires states to

make prompt reimbursements during the “retroactivity period,” which begins three months before application. Importantly, this decision requiring compliance with federal law removes the unfortunate incentive of providers (and the state) to delay application approval or payment, relying on reimbursement refusals.

3. 2001 Legislation

Several minor legislative changes relevant to child health care were enacted in 2001. However most either 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; and AB 1589 (Simitian) requires the California Medical Board to conduct a study of the electronic transmission of non-controlled prescriptions. The measures enacted which are of generalized interest to children include:

AB 495 (Diaz) 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. 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.

AB 59 (Cedillo) 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.

SB 493 (Sher) supplements AB 59 by facilitating Medi-Cal enrollment through the existing offices of Food Stamp administrators. The bill requires county welfare departments to develop a data list of individuals on Food Stamps who are eligible for but not enrolled in Medi-Cal or Healthy Families, and send a notice about enrolling to the individuals at the time of annual recertification. For those who return the notice, the Food Stamp office 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 on to the Healthy Families program administrator for processing.

SB 255 (Speier) imposes fines of up to \$100 where infants and children under 6 years of age are left 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.

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.

SB 19 (Escutia, Speier) includes an array of measures to promote better nutrition in subsidized school lunches with emphasis on reducing obesity. As discussed in Chapter 3, the measure 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 integrates nutrition into the curriculum. And it 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 has been appropriated since the measure’s enactment.

SB 322 and SB 757 (Ortiz) were enacted in October 2001 to discourage teen smoking. SB 322 prohibits the marketing of “Bidis”—unfiltered, hand-rolled cigarettes wrapped in a tendu leaf and imported into the U.S. from southeast Asia, available in candy colors and flavors (licorice, mango) and allegedly emitting 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/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, sells small packages of under 20 cigarettes (referred to as “kiddie packs”), and prohibits the sale of small quantities of loose tobacco popular among youth.

4. 2002 Legislation

Health and safety related legislation in 2002 was affected by the growing budget crisis, which effectively precluded any reform, extension, or alteration that involved the expenditure of public funds at state or local levels. When a measure appropriates state funding over \$150,000, it is referred to the “suspense file” of the Senate and/or Assembly Appropriations Committees—from which very few bills emerge for public vote. However, a number of child health-related measures did achieve passage in 2002, including:

SB 460 (Ortiz) facilitates the screening and reporting of child blood lead levels, mitigation, and prevention of new hazards (see detailed discussion in lead-related account below).

AB 1830 (Frommer) prohibits cigarette sales by mail or through any delivery service to children under age 18, and requires sellers to verify the age of buyers. No such order may be for less than two cartons.

AB 1867 (Vargas) prohibits smoking within 25 feet of a playground and sets a fine of \$250.

SB 1670 (Scott) requires that firearm safety devices on all firearms sold or transferred by a firearms dealer meet minimum standards. The measure defines the term firearm safety device as a device other than a gun safe that locks and is designed to prevent children and unauthorized users from firing a firearm.

SB 59 (Escutia) allows counties to provide the one-third match for Healthy Families expansion (see discussion below of substantial child coverage accomplished by certain counties using this statute in 2003).

5. 2003 Legislation

As in 2002, child health and safety related legislation in 2003 was hindered by the budget crisis, which effectively precluded any reform, extension, or alteration that involved the expenditure of public funds at state or local levels. However, a number of child health-related measures did achieve passage in 2003, including:

SB 2 (Burton) enacts the Health Insurance Act of 2003 to provide health coverage to specified individuals (and in some cases their dependents) who do not receive job-based health coverage and who work for large and medium employers, as defined. It is estimated that the bill will cover an additional one million currently uninsured individuals. In addition to increasing access for these individuals, the bill will result in efficiencies in the health care system and ease the strain on the public health system.

SB 24 (Figueroa) creates the Prenatal Gateway and the Newborn Hospital Gateway to simplify enrollment of prenatal women and certain newborn infants into the Medi-Cal program. This bill expedites access to preventive care for pregnant women and infants, saving lives and preventing disabilities.

AB 24 (Negrete McLeod) encourages a private entity, in consultation with the Epidemiology and Prevention for Injury Control Branch within DHS, to produce an informative brochure or booklet explaining the child drowning hazards of, possible safety measures for, and appropriate drowning hazard

prevention measures for home swimming pools and spas, and to donate the document to DHS. The bill requires DHS to review and approve the document and post it on the DHS website in an easily downloadable or publishable format. This document will help educate consumers on pool and spa safety and accident prevention.

AB 195 (Chan) authorizes school districts to provide pupils with preventative health care instruction, including dietary information relevant to diabetes and obesity—two increasing child-related health hazards. Those physicians and professionals participating in the initiative may not have a conflicting product or health plan marketing role. The rationale behind AB 195 is important, however the budget crisis relegates it to primarily an aspirational statement to districts for a voluntary program.

AB 1286 (Frommer) revises and expands existing “continuity of care” laws under which a health plan is required, under certain circumstances, to allow an enrollee to continue to see a health care provider who is no longer contracting with the plan. Care of a newborn between birth and 36 months is one of the circumstances that triggers the bill’s continued care provisions. This bill ensures that a child’s health is not compromised by contract disputes between providers and insurers.

AB 1697 (Pavley) requires that all children under the age of six or who weigh less than 60 pounds be secured in a child passenger restraint system located in the rear seat, except under specified circumstances. The requirement becomes effective January 1, 2005. The new requirements, which are based on recommendations by the National Highway Traffic Safety Administration, will further protect children traveling in vehicles.

6. Recent Vetoes and Suspense File Terminations

A substantial number of meritorious bills have been vetoed or terminated in the “suspense file” of the appropriations committees of the Senate and Assembly. Where a measure involves \$150,000 or more in state appropriations, it is assigned to the “suspense file” of one of these two committees after it passes through the relevant policy committee. It then does not emerge for public vote unless put forward by the committee chair or by majority vote to release it. Often, this involves consultation between the committee chair and the Governor—particularly where both are in the same party. Most child-related measures so terminated have enjoyed strong bipartisan support in their public votes before reaching this fate. The suspense file technique allows measures enjoying strong public support to be killed without a visible rejection.

During the past few years, the following are noteworthy child health-related measures that were either vetoed or terminated through the suspense file process:

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

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

SB 402 (Ortiz) would have extended Healthy Families coverage to 19- and 20-year-olds.

SB 833 (Ortiz) would have eliminated the Medi-Cal “asset test” to deny coverage.

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.

7. 2004 Major Pending State Legislation

SB 921 (Kuehl) would provide universal health coverage for low-income Californians in a single payer system retaining physician choice. The “Health Care for All Californians Act” is intended to be revenue neutral, relying on fund shifts and the efficiency implicit in the elimination of the existing separate programs. The plan would increase reimbursement rates, implement bulk purchasing of pharmaceuticals, and provide all Californians with a primary care physician. The standard plan includes medical, dental, mental health, prescription medication, and durable medical equipment coverage. Premiums would be replaced with a low-percentage, means-based payroll tax that would total no more than current health care premiums. One critical element of the plan is to shift current medical insurance taxation from assessing “profit” to taxing premiums. In contrast, a “premium” tax acts more as a sales tax, assessing premiums paid from whomever and to whomever. The latter option allows all those providing and paying for health care to share in collecting revenues needed to broaden care to those unable to pay. And contribution is not avoided based on corporate form (e.g. non-profit systems), nor is it reduced through tax expenditures or loopholes applicable to taxable corporate profits. Property insurers already pay taxes on premiums and this change would yield substantially more revenue for health care. Republican Keith Richman, a physician with special interest in health care, has proposed a “carrot” approach that would take advantage of federal dollars. Richman would offer employer contributions and federal dollars for three-fourths of the cost of universal coverage. The remaining 25% would come from the state—and could perhaps be generated by the shift from health insurer profits tax to a premiums tax.¹³⁹

AB 221 (Koretz) would increase the legal smoking age from 18 years of age to 21. Alabama, Alaska, and Utah prohibit sales and smoking by those under 19 years of age. The legislation is sponsored by the California Medical Association. Proponents argue that teens commonly begin smoking sporadically in their teens, but the easy access to cigarettes between 18–21 years of age stimulates substantial addiction. While adult smoking rates have fallen to 17.4%, the lowest of the fifty states except for Utah, the number of 18-year-olds who smoke has increased from 18.9% in 1989 to 23.6% currently.

AB 232 (Chan) would require hospitals to bill uninsured patients that may be liable for their own medical care, limiting charges collectible from low or moderate income patients. The billing limit would be the highest of Medi-Cal, Medicare, or workers' compensation rates. The limit applies to families of two below 500% of the poverty line, or families of three or more below 400% of the line. And it puts some limits on current hospital collection practices. This measure has profound implications for the working poor and the just over one million children who remain without public or private coverage. The parents of these children risk economic ruin where their children become ill. Rates charged in such cases are radically inflated in order to cross-subsidize below-cost Medi-Cal rates (see below) and emergency care of indigents where collection is unsuccessful. The result is the effective bankruptcy of parents as the price of medical treatment for their children in order to accomplish the irrational cross-subsidies now interposed.

D. Child Enrollment Enhancement Programs

1. Twelve-Month Continuing Eligibility for Children

Pursuant to AB 2900 (Gallegos) (2000), children 19 years of age and younger receive twelve months of continuous Medi-Cal eligibility once determined eligible. However, California has required re-application for infant coverage at the two-month mark—and is apparently the only state to impose such a barrier. In January 2003, DHS issued an All County Letter clarifying that this two-month cut-off, although a part of the state's computer program, was in error and that any infant born to a mother who is Medi-Cal qualified have continued eligibility for at least one year, regardless of the mother's status during that period. The Maternal and Child Health Foundation in Los Angeles monitored the state's activities.

Due to lack of compliance with this stated policy, a lawsuit was filed on behalf of an infant whose Medi-Cal benefits were terminated after two months.¹⁴⁰ On September 12, 2003, the San Francisco County Superior Court ordered the State to stop terminating the Medi-Cal benefits of “deemed eligible” infants who begin receiving Medi-Cal through the CHDP Gateway, regardless of whether their families

send in a regular Medi-Cal application. “Deemed eligible” infants are those whose mothers had Medi-Cal for the delivery and who lived with the mother during the birth month. The State represented to the court that the Gateway process will be re-programmed by April 1, 2004, to automatically grant Medi-Cal to these infants until they turn one year of age. On November 24, 2003, plaintiffs successfully moved for a second order to protect infants who had already gone through the Gateway or would go through it before April 1, 2004, to ensure these infants do not lose coverage or are reinstated if they have lost their Medi-Cal coverage. The State appealed this ruling and requested the deadline to implement the computer changes be extended to July 1, 2004. Adequate funding was appropriated to DHS in the 2003–04 budget to make the computer corrections. A news report in February 2004 stated that DHS had spent over \$61,000 in legal fees to defend the matter.¹⁴¹

Although twelve months of continuous eligibility for children is a step in the right direction, the state’s recent movement from annual to biannual renewal (and additional paperwork) for parents has a dampening effect on child enrollment. Since parents must perform the paperwork (and with Healthy Families pay premiums), impediments to parents may serve as practical barriers to child coverage.

2. Restoration of Section 1931(b) Coverage

As discussed below, California has restored Section 1931(b) coverage back to its year 2000 level to include parents with income up to 100% of the federal poverty line.

3. 2003 School Lunch and Food Stamp “Express Lane” for Medical Coverage

The former Davis Administration noted the importance of ensuring Medi-Cal enrollment for eligible low-income children, and 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 59¹⁴² (discussed above) was enacted in 2001 to automatically enroll children under age six who are receiving school lunches, which was projected to add 21,200 additional children at a cost of \$11.7 million.¹⁴³ 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.

Also important was SB 493 (Sher)¹⁴⁴ (discussed 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. Food Stamp recipients are to be given such notice to determine their interest, and their files are to be examined for eligibility.

In June 2003, former Governor Davis announced his support for the school lunch Express Lane program to enhance medical coverage of children. Families of children enrolled in the free lunch program who are income qualified for either Medi-Cal or Healthy Families would be able to use those applications to facilitate medical coverage. About 70% of the state’s eligible uninsured children are in a subsidized school lunch program. The program began on July 1, 2003, but in only five of the state’s school districts: Redwood City, San Diego Unified, Fresno Unified, Los Angeles Unified, and San Jose’s Alum Rock Union Elementary. Within those five districts, 73 schools, with a total of 35,000 students, are participating in the program during 2003–04.¹⁴⁵

4. CHDP Gateway Program

In addition to the streamlining of child coverage from the school lunch population above, efforts are underway to use related specialized coverage programs as a conduit for general Medi-Cal or Healthy Families inclusion. First among these strategies is the CHDP Gateway program, which aims to reduce access barriers to health coverage for uninsured children. The Gateway program, implemented on July 1, 2003, allows CHDP providers to “pre-enroll” children under 19 in temporary (providing eligibility during the month the application is submitted and the following month, or up to sixty days), full-scope, no-cost Medi-Cal at the time of the CHDP assessment visit.¹⁴⁶ Eligibility for the Gateway program is based on

family size and an income at or below 200% of the federal poverty level (FPL).¹⁴⁷ The Governor's 2004–05 proposed budget estimates that efforts to expedite the enrollment of CHDP children into more comprehensive health care coverage will result in nearly 146,000 eligibles being added to the Medi-Cal program in 2004–05.

Unfortunately, the implementation of the CHDP Gateway inadvertently caused some newborns to be denied the twelve-month continuous Medi-Cal coverage to which they were entitled. Children born to mothers covered by Medi-Cal are automatically entitled to twelve months of continuous coverage. However, some medical providers mistakenly signed those children up for the shorter Gateway coverage, and were thus dropped from Medi-Cal coverage after two months.¹⁴⁸ The providers' mistakes are exacerbated by the fact that the Gateway computer system and the Medi-Cal computer system are not linked together. Health advocates subsequently filed suit against DHS on behalf of those who had been denied coverage to which they were entitled. As discussed above, in September 2003, the San Francisco County Superior Court ordered DHS to fix the problem by April 1, 2004, and to reinstate Medi-Cal coverage to the affected infants¹⁴⁹. Although DHS was given \$357,000 in the 2003–04 budget to make the necessary corrections, it has filed an appeal of the trial court's decision; it is also seeking until July 1, 2004 to fix the problem.¹⁵⁰

5. Accelerated Enrollment—Single Point of Entry

In 2002, DHS sought and received federal approval of its plan to implement an accelerated enrollment program for children, utilizing a single point of entry. The purpose of the program is to accelerate temporary, fee-for-service, full-scope, no-cost Medi-Cal coverage for children under the age of 19, instead of billing indigent parents and expecting them to seek reimbursement after coverage is approved (often months later). Because so many children are enrolled at point of emergency treatment, and given the problematical record of the state in paying reimbursements, this reform is important for children.

6. Healthy Kids Initiative (County Health Coverage Expansion)

In July 2000, Alameda County initiated an expansion of health care to uninsured adults and children between 250% and 300% of federal poverty line.¹⁵¹ In January 2001, Santa Clara initiated its "Healthy Kids" program covering uninsured children under age 19 whose family income is below 300% of the federal poverty line.¹⁵² In January 2003, San Mateo, San Francisco, and Solano counties announced an expansion of this "Healthy Kids" initiative. These counties follow a similar policy of offering close to universal basic medical coverage, including dental and vision services. That is, the counties will offer coverage to children of undocumented immigrants and those in families above 250% of the poverty line and not eligible for either Medi-Cal or Healthy Families. Most of the counties are covering children living in families up to 300% of the poverty line, although San Mateo covers children up to 400% of the line. The funding for this coverage extension does not draw upon scarce county general fund revenues, but is provided by local Proposition 10 funds totaling about \$31 million, together with some additional assistance from the Packard Foundation.

On July 12, 2003, Los Angeles County announced that its Proposition 10 Commission has allocated up to \$100 million to provide health insurance to infants and preschoolers (children under six years of age). As with the existing county efforts, the idea is to cover those children left out of Medi-Cal and Healthy Families. Hence, undocumented children and those in families above 250% of the poverty line would be eligible. Premiums of \$4 to \$6 per month per child would be required. Those in families above 300% of the poverty line would not be included. The county estimated that 15,000 children in the county will qualify. If those numbers prove accurate, and it achieves 100% enrollment, only about 20% of the publicly announced sums will be required.

As in Los Angeles, most of the counties implementing these initiatives draw the line of inclusion at 300% of the poverty line. The programs may require families to pay from \$4 to \$18 in monthly premiums depending on annual income. Such premiums may be necessary lest those on Healthy Families paying similar premiums leave the program for this new overarching coverage option, and because it would be

inequitable to charge wealthier families a lower premium. The Santa Clara County effort alone, now in its fourth year, has had more than 76,000 eligible children apply for health insurance.¹⁵³

In October 2002, the Riverside Press-Enterprise reported on its County's similar efforts to expand Healthy Families coverage using an allocation of \$2 million in local Proposition 10 funds. Riverside has announced the theoretical inclusion of 6,000 of the County's 13,000 uninsured children (adding undocumented immigrant children for qualification). By the end of 2002, about 600 had been enrolled.¹⁵⁴ The Press-Enterprise also looked at San Bernardino's expansion. Instead of taking the immigrant group of uninsured, San Bernardino included those children from 0–5 in families from 250% to 300% of the poverty line, numbering an estimated 2,200. San Diego and Orange Counties are considering similar expansions.

These efforts are applauded by child advocates, but highlight the merits of the “presumptive eligibility” proposal of this chapter. The Healthy Kids Initiatives add another population of children for coverage. But it maintains the basic exclusionary structure and does not accomplish “universal coverage” as advertised. Large numbers of children in each of these counties remain unenrolled in Medi-Cal and Healthy Families, and only a minority of children within the wider net they include are likely to be covered. However, the relatively small numbers of children who are available to target up to 300% or even 400% of the poverty line, demonstrate the appropriate shift to an inclusive system. Such automatic enrollment of any child, subject to later assessment where a family is above 300% of the poverty line and high costs are incurred for treatment, is logically compelled as the number of children not eligible is reduced in number. The exclusionary system imposes substantial direct costs (outreach, incentive payments to enroll, application, review, filtering, appeal, collection of premiums, cancellation for non or late payment, monitoring, enforcement of entry violations) and indirect costs (delay in treatment, relegation to expensive emergency room options, public health diminution).

Where counties or the state decide to cover immigrants and children up to 300% of the poverty line, the percentage of those uncovered and unqualified (whose exclusion is the object of program qualification) moves from below 5% of children in a jurisdiction to below 1%. This is because almost all families earning above 300% of the poverty line have employer-based coverage of dependents or will have such coverage after SB 2 is implemented (see below). The number within the 1% uncovered and unqualified who will incur substantial expense is a small subset, certainly under one-tenth of one percent of the state's children. Hence, the non-coverage of one million qualified children—a number likely to grow to 2 million over the next three years—is based on the fear that services may be received undeservedly by such a fractional group. Child advocates contend that at some point the burden properly shifts to inclusion with *post hoc* assessment of the few parents who do have income above the qualification line, with additional measures to assure continued employer provided coverage (see detailed proposal below)

E. 2003 Child Health Budgetary Changes

In addition to statutory and litigation changes discussed above, the current 2003–04 budget incorporates several major budgetary changes enacted during 2003. These recent decisions help for the context for proposed 2004–05 health spending. These changes include:

- **Child Health and Disability Prevention (CHDP) Gateway.** The 2003–04 budget includes \$80.2 million to implement the CHDP “gateway,” to streamline children's enrollment into Medi-Cal and Healthy Families. As discussed above, the CHDP gateway, effective July 1, 2003, provides up to two months of full-scope Medi-Cal coverage for low-income children who are not currently enrolled in Medi-Cal or Healthy Families.

- **Express Lane Eligibility.** The 2003–04 budget provides a total of \$11.2 million (\$5.6 general fund) to implement Express Lane eligibility, which will extend Medi-Cal eligibility to children receiving school lunches and families receiving Food Stamps.

- Rural Health Demonstration Projects. The budget renews funding and repeals the sunset for Healthy Families Rural Health Demonstration Projects that fund collaborative health care networks to alleviate unique problems of health care access in rural areas.

- Transitional Medi-Cal. The 2003–04 final budget eliminates the second year of Transitional Medi-Cal coverage to former welfare recipients starting October 1, 2003, for general fund savings of \$2 million in 2003–04.

- Healthy Families Parental Expansion. The 2003–04 budget did not include funding to expand Healthy Families to cover the uninsured parents of eligible children; many advocates predict that such an expansion would promote children's access to and use of health care services. Implementation of the expansion is postponed to July 2006.

- Medi-Cal/Healthy Families Bridge. Currently, children who become ineligible for Medi-Cal can receive two months of "bridge" coverage while they apply for Healthy Families. The 2003–04 budget reduces that bridge to one month until implementation of the Healthy Families parental expansion, which has been postponed until July 2006.

- Semi-Annual Reporting Under Medi-Cal. The budget maintains the semi-annual reporting requirements previously in place for Medi-Cal.

- Medi-Cal Provider Reimbursement Rates Reductions. The 2003–04 final budget reduces the reimbursement rates for a majority of Medi-Cal providers by 5% for three years starting January 1, 2004, for general fund savings of \$115.1 million in 2003–04. Affected Medi-Cal providers include fee-for-service providers, managed care plans, Family PACT programs (stimulating family planning), physician services, pharmacy services, dental services, ESDST, and other child-related medical compensation. Exemptions were provided for nursing facilities, sub-acute care programs, and adult day health centers. Similarly, reimbursement rates for health, vision, and dental plans participating in the Healthy Families Program were frozen until June 30, 2005, a move that may cause similar access problems for children, see discussion below. A judge has imposed a preliminary injunction preventing the state from imposing the 5% rate reductions, however, a final ruling in that case has not been made.

III. MAJOR CHILD HEALTH PROGRAMS AND BUDGETS

A. 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 mid 1990s: 63% of U.S. children in families earning under 100% of the poverty line, and 44% of those below 185% of the line.¹⁵⁵ In 1999, the number of children covered by Medicaid with family income under 100% of poverty had dropped to 53%.¹⁵⁶ In 1998, 49% of children nationally were covered by Medicaid.¹⁵⁷

In 2001–02, Medi-Cal, which is administered by the Department of Health Services (DHS), served 5.85 million state residents, an increase of 12.3%, as the result of changes in eligibility rules and procedures (see above.)¹⁵⁸ 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 from Fee-for-Service 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 provides or arranges for the provision of all covered medical services.¹⁵⁹ 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. (*i.e.*, 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.¹⁶⁰ Concern is magnified for private for-profit plans, which spend a smaller share of their revenues on actual services than does Medi-Cal.¹⁶¹

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.

a. Medi-Cal Managed Care Health Plans

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.¹⁶² 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 610,000 Medi-Cal beneficiaries are in a COHS.¹⁶³

(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 335,000 Medi-Cal beneficiaries are in GMC.¹⁶⁴

(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 73% of Medi-Cal managed care enrollees (2.5 million individuals) are in the Two-Plan Model.¹⁶⁵

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.¹⁶⁶ 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),¹⁶⁷ 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.¹⁶⁸ By 2002–03, the managed care portion of Medi-Cal had reached 3.4 million enrollees.¹⁶⁹

Despite the state's current fiscal crisis, and in the health care sector in particular, the financial performance of the 22 health plans participating in Medi-Cal improved as a group during the period of 1998–2002. A Medi-Cal Policy Institute study found on average, these health plans have remained profitable, and several plans have used Medi-Cal revenues to provide non-Medi-Cal covered services or to provide services to non-Medi-Cal enrolled members. This profitability may be explained by several factors, including (1) the "incentive not to treat" because of capitated rates; (2) the incentive to "skim the cream" of low-cost beneficiaries, leaving more expensive to treat children under fee-for-service structures; and (3) the ability of large plans to contract and bargain for higher provider reimbursement rates for their physician services (compared to the weak bargaining power of individual fee-for-service providers (see below)), which results in greater Medi-Cal payments by the state to those plans. In order to determine the factors contributing to this profitability, one study's authors suggest that DHS require more detailed supplemental financial data for specific operations and that DHS conduct independent reviews of the plans to ensure efficiency and effectiveness.¹⁷⁰

b. Medi-Cal Managed Care Access and Services 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 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 the ability to provide necessary 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)."¹⁷¹ 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.¹⁷² Difficulties were again documented by MCH Access and the Western Center on Law and Poverty in 2000 when additional children's programs were converted to managed care.

Child-specific concerns remain as follows:

- 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, or 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 1997 Act presumes those plans which fail to perform will not be chosen by recipients. However, partly because of the newness of the choices and allegedly because of inadequate information for 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 resumed in 1998).¹⁷³

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.¹⁷⁴

A 1998 study ties managed care to an increase in prescription drug related deaths, concluding that medication prescriptions 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.¹⁷⁵

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 County local initiative) lowered Medi-Cal capitation rates from \$102 per month to \$75 per enrollee in 1997.¹⁷⁶ However, rates for Two-Plan Model plans were increased by 9% in 2001.¹⁷⁷

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.

2. 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 1999.¹⁷⁸ Enrollment over the past three years has picked up some of these children, but over 500,000 remain unenrolled. As discussed above, the Healthy Families eligible children and others qualified for public coverage who remain unenrolled total about one million, and are likely to increase back to the historical levels of 1.5 million to 2 million. Much of this retraction will come from Healthy Families losses, but some reversion to lower enrollment is likely to impact Medi-Cal eligible children as well. The reduction in Express Lane funding, semi-annual redeterminations, and cuts in the number of local social workers will combine with other factors to accelerate disenrollment. Three additional barriers impede higher Medi-Cal coverage rates for children: administrative complexity, deductibles, and lack of outreach.

a. Administrative Complexity, Including Renewal Paperwork

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 change 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 in-person by waiting in line. 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 several different programs, most of which have their own separate eligibility criteria. Children will qualify under one program, then lapse and perhaps qualify under another—depending upon the age of the child, income of the parent(s), 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.¹⁷⁹ Problems may develop that take time to address, as is the case with applications rejected as incomplete, including those with insufficient documentation, which make up 41% of rejected applications, the most common reason for rejection.¹⁸⁰ 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.

Over the last two years, some of these problems were alleviated. As noted above, effective January 1, 2001, children in Medi-Cal are covered continuously for twelve months.¹⁸¹ This policy change aligns Medi-Cal with Healthy Families for children, which has provided twelve-months continuous eligibility since its inception in 1998. Some experts attribute such continuity of care as a source of coverage for 369,000 more children otherwise disenrolled from Medi-Cal.¹⁸² The 2001–02 budget allocated \$134.8

million from the general fund to improve this continuity of coverage and care for the state's lowest income children.

Starting January 1, 2001, California eliminated quarterly status reporting for all Medi-Cal programs.¹⁸³ That meant that Medi-Cal program participants no longer had to essentially re-apply every three months to keep their coverage. Failure to submit the quarterly reports had long been a major reason why so many individuals lost their insurance coverage during any given year. Implementation, however, may have been complicated by the state's failure to issue uniform guidelines to the counties about what kinds of changes Medi-Cal program participants would 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 reform. Moreover, the interim cuts enacted by SB 26x in April 2003 have now regressed from annual reporting to semi-annual reporting. This paperwork barrier has little to do with prevention of unqualified assistance, since large numbers of Medi-Cal recipients are not rising above the poverty line on a monthly basis. Ironically, the new more onerous burden of proof is being imposed as unemployment is rising and income is falling among the Medi-Cal population.

Even though state guidelines have been implemented, beneficiaries continue to lose coverage through county errors in technology or otherwise. For example, the Los Angeles Times reported in April 2004 that 122,000 of the 2.5 million Medi-Cal beneficiaries in the county had to reapply for enrollment in the program or risk losing coverage purportedly due to technological errors—the state and county computer systems cannot share information regarding beneficiary lists. In order for these 122,000 individuals to remain enrolled, they will have to update their personal information with DHS and continue to update the information every three months (even though only semi-annual reporting is required under state law). Health care advocates continue to be concerned about errors that cost county workers, beneficiaries, and state workers undue time and energy.

The third major Medi-Cal program development took effect on July 1, 2001 and improves the process for allowing eligible individuals to keep Medi-Cal when eligibility on one basis ends. This applies to all Medi-Cal programs. Traditionally, Medi-Cal was offered through the AFDC welfare system. But with welfare reform and the removal of large numbers from TANF rolls, the Congress was aware of the need for many of these families to retain medical coverage—an intention vindicated by the large number not receiving coverage through employment and continuing to earn close to or below poverty line income. Hence, the Congress "de-linked" Medi-Cal from the welfare system and requires the coverage of persons who would qualify for AFDC in 1996 when the federal welfare reform PRA was enacted. Such persons are eligible under Section 1931 whether they are receiving welfare, have left welfare, or have never received welfare. In addition, once a person enrolls in Medi-Cal under that section, he/she has a right to continued coverage for at least one year under what is termed Transitional Medi-Cal coverage. 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 does not affect Medi-Cal eligibility.¹⁸⁴

Congressional Section 1931(b) eligibility levels must be no lower than AFDC levels in place on July 16, 1996. Since no allowance is made for inflation, California could lower eligibility to 61% of the poverty line. However, a state may confer more generous coverage, and California has done so—granting coverage to adults up to 100% of the poverty line. This parental coverage is less liberal than coverage for children, which extends above the poverty line for some ages, and with Healthy Families reaches 250% of the line. However, parental coverage is important to child enrollment as discussed above. Parents are relied upon to enroll their children, and are more likely to do so if they are also enrolled.

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/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.¹⁸⁵

b. 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 aged 6–19 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 would be more cost-effective.

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, could not meet their share of required monthly Medi-Cal cost ("monthly deductible"), and thus could not access health care "unless they or their families suffer a medical catastrophe or otherwise become destitute."¹⁸⁶ Effective January 1, 2001, the population of aged, blind and disabled no longer have a deductible in the Medically Needy program if their income is at or below 133% of poverty.¹⁸⁷ The budget for 2001–02 allocated \$141.1 million, including \$47 million from the Tobacco Settlement Fund, for this program, to benefit 52,800 aged, blind and disabled persons that year.¹⁸⁸ The necessary allocation for 2004–05 will be substantially higher, as LAO predicts a 6.8% increase in the Medically Needy aged, blind, and disabled caseload. Note that this special dispensation is given only to the elderly and disabled—more than half of whom are also beneficiaries of Medicare, the federal health insurance program for persons 65 and older and for younger persons with disabilities who cannot work.¹⁸⁹

Perhaps even more problematic was 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 yet another unnecessary barrier to coverage. Few families with total income of under \$15,000 per year have considerable liquid assets available. SB 833 (Ortiz), introduced in 2001, would have eliminated the Medi-Cal asset test, but those provisions were deleted in its final form due to opposition from the former Governor.

3. Overall Medi-Cal Account

Starting in the 1980s, the Congress expanded Medicaid eligibility to include additional segments of low-income children and pregnant women. Pregnant women and infants to 185% of the federal poverty level (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.¹⁹⁰ 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).¹⁹¹ The big increase in children on Medi-Cal in the early 1990s was due to increasing poverty and 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. Although the figure dropped temporarily in the late 1990s, it increased to approximately 3.4 million as of October 2003 (see Figure 4-A above).

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 discussion of CHDP below).

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 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.¹⁹² After 1995, both the numbers of persons covered by Medi-Cal and budgeted monies have somewhat leveled. The federal match ratio for Medi-Cal spending in 2002–03 was just over 50%, and has increased somewhat in 2003–04 due to the Congressional grant of additional Medicaid monies to states discussed above. The state currently covers 6.6 million persons under the Medi-Cal program and the Governor’s budget proposal projects the addition of 219,800 for a total of 6.8 million in enrollment for 2004–05.

Medi-Cal state-only costs were one source of unexpected expense during 2003. The 2002–03 estimate of state Medi-Cal costs was \$9.8 billion, but actual state costs reached \$10.7 billion. Part of the overage is attributable to the state’s success in cutting the extreme enrollment losses flowing from welfare reform and loss of social worker contact, as discussed below. But some of the overage is the result of the state’s budgeting in 2002 for a reduction in fees to hospitals and physicians that was not implemented during that year. The Legislature also assumed \$124 million in savings from “anti-fraud” measures that failed to materialize.

Table 4-D presents the Governor’s January proposal for Medi-Cal spending; the 2004 May Revise increased the general fund contribution for 2004–05 to \$11.9 billion. The Table indicates an increase in general fund spending of 18.4% in 2004–05 over current year spending; that increase primarily reflects the costs of using one-time savings in 2003–04 from the accrual-to-cash accounting change, and the discontinuation of the enhanced federal financial participation provided in the federal Jobs and Growth Tax Relief Reconciliation Act of 2003.¹⁹³ Total spending from all accounts, adjusted to reflect changes in inflation and population, would increase 2.7% in 2004–05 over current year levels. Caseload would increase in 2004–05 by about 220,000, for a total of about 6.8 million average monthly eligibles.

California Children's Budget 2004–05

	Budget Year							Estimated	Proposed	% Change	
	1989-90	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03			2003-04	2004-05
General Fund	\$3,489,321	\$6,825,673	\$7,536,090	\$8,135,268	\$9,233,306	\$9,827,623	\$10,646,240	\$9,859,531	\$11,673,239	182.6%	18.4%
Prop. 99	\$12,007	\$72	\$114	\$74	\$0	\$0	\$0	\$0	\$0	-100.0%	na
County	\$0	\$5,890	\$0	\$0	\$0	\$0	\$0	\$0	\$0	na	na
Other	\$375,721	\$1,657,613	\$1,727,177	\$1,854,297	\$1,705,586	\$1,875,770	\$1,493,377	\$2,107,597	\$1,816,588	460.9%	-13.8%
Federal	\$3,627,655	\$10,023,496	\$11,151,639	\$12,207,396	\$13,584,156	\$15,544,772	\$17,629,795	\$17,565,434	\$18,055,007	384.2%	2.8%
Total	\$7,504,704	\$18,512,744	\$20,415,020	\$22,197,035	\$24,523,048	\$27,248,165	\$29,769,412	\$29,532,562	\$31,544,834	293.5%	6.8%
Adjusted Total	\$14,629,670	\$23,535,251	\$25,098,226	\$26,316,805	\$27,902,324	\$29,613,306	\$30,811,341	\$29,532,562	\$30,330,358	101.9%	2.7%

Dollar amounts are in \$1,000s. Sources: Governor's Budgets. Adjusted to CPI-Med (2003–04=1.00). Adjustments by Children's Advocacy Institute.

TABLE 4-D. Medi-Cal

a. Proposed 2004–05 Medi-Cal Budget Issues

In Governor Schwarzenegger's January 2004–05 budget, he proposed a number of changes to the Medi-Cal program that would hamper access to health care for impoverished children. These included plans to retain a mid-year reduction of 5% in Medi-Cal compensation, and to impose yet another 10% reduction, bringing the cut to 15% unadjusted. The reductions would save the general fund \$960 million in the proposed year, and also cost the state an equivalent sum representing the federal match. Also, as with other programs like Healthy Families, discussed below, the Governor proposed to cap enrollment in several state-only Medi-Cal programs, such as the Breast and Cervical Cancer Treatment Services Program for undocumented individuals, non-emergency services for legal immigrants, and non-emergency services for undocumented individuals. Under this proposal, DHS would establish statewide waiting lists on a "first come, first served" basis. Total general fund savings that would be realized by capping enrollment in these Medi-Cal programs would be \$17.2 million. In the Governor's May Revise, these proposals were rescinded—restoring almost \$2 billion in general fund Medi-Cal spending and accounting for the increase in Table 4-D. Note that the January proposal would have represented an unprecedented reduction in current year spending. The May Revise retraction of the cuts sets proposed total spending at an adjusted 2.7% above current year levels.

The Governor assumes one-time general fund savings of \$143 million reflecting a one-week delay in payment to Medi-Cal providers from the last week of 2004–05 into the next fiscal year. More ominously, the Governor's proposed budget includes some information about his proposal to seek a federal "section 1115" Research and Demonstration Waiver to restructure components of the Medi-Cal program. Although exact details are not yet available, provisions under serious discussion include access impediments, such as aligning Medi-Cal's eligibility standards and processes with CalWORKs and the SSI/SSP program. They also include a "multi-tiered benefit/premium structure." Such a scheme carves out "core" coverage for all, but then assesses additional premiums or co-pays for "non-core" services such as dental or vision coverage. Other cost cutting plans include impediments on mental health benefits provided under the EPSDT Program for children; and expanding Medi-Cal managed care to additional counties.

The Governor is no longer considering submitting statutory changes to the Legislature in time for the constitutional deadline for the 2004–05 budget process. Instead, the Governor announced in his May Revise that the waiver proposal language will be submitted to the Legislature on August 2, 2004: he announced if the Legislature is unable or unwilling to approve the Medi-Cal program and financing reforms, he will "work with the federal government to secure plan amendments or waivers" and return to the Legislature in January 2005 for its concurrence.

The Governor anticipates a general fund savings of \$400 million in 2005–06 from his Medi-Cal "reform" efforts, and is seeking an increase of almost \$6 million (\$2.2 million general fund) in 2004–05

for new state positions and system changes related to this proposed reform. Many advocates fear that the federal budget neutrality requirement (necessary to obtain a federal section 1115 waiver) would effectively place a limit on the federal Medicaid funds available to the state for the entire Medi-Cal program over the next five years.¹⁹⁴ Unlike current Medicaid funding, which is entitlement based and guaranteed at a 50/50 match, a cap would provide a fixed amount of federal funding irrespective of the state’s actual needs. This type of inflexible funding could be problematic if the state faces “unexpected circumstances” such as an economic downturn, an epidemic, or a natural disaster. Such funding would virtually preclude any expansions of coverage or increases to provider reimbursement rates as many advocates have sought over the years. Perhaps the most drastic measure of the waiver is that the budget neutrality calculation will be based on historical costs of Medi-Cal, thereby incorporating the state’s lower-than-average per capita spending—due in large part to California’s unreasonably low provider reimbursement rates, especially for children’s specialty services, as discussed below.

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

Rapidly rising Medicaid costs in the early to mid-1990s became the target 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.¹⁹⁵ 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 (ages 21–64) on Medicaid was \$5,006; the average California adult (age 21–64) on Medi-Cal cost \$2,928 (see Table 4-C). 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 national average of \$3,895.¹⁹⁶

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.¹⁹⁷ The Urban Institute’s analysis of 1993 HCFA data reported that California children comprised 47% of beneficiaries, but used only 15% of total expenditures.¹⁹⁸ Nationwide, children under age 21 comprised 49% of all beneficiaries, but used 16% of Medicaid’s expenditures.¹⁹⁹ These ratios are typical of the relatively low cost of covering children, commonly costing one-third to one-fifth of the per person cost of an adult. Children cost less than one-fifth 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.²⁰⁰ 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 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.²⁰¹

As Table 4-E indicates, the number of eligibles and users reached a zenith in 1995, as welfare reform began. The movement over the last eight years into managed care has reduced eligibles for fee-for-service as more counties offer Medi-Cal services through specified entities charging capitated (per person) rates. The last two rows adjust the costs by user and enrollee respectively based on the medical cost inflator for a constant dollar comparison. Interestingly, costs per enrollee in the fee-for-service format declined from at least 1989 to 1995-96, at which point fee-for-service costs started to (and continue to) climb markedly. These trends suggest the “skimming the cream” predilection of managed

care systems—their capture of the least costly patients for capture of funds on a per person basis without substantial cost pay-out, while leaving costlier patients to fee-for-service compensation. An alternative explanation would be that costs have risen dramatically overall (reflected in the per patient increase of Table 4-E from 1995–2001) and may be more fully reflected in a fee-for-service system where consumers do not have the purchase bargaining power of a managed care entity.

	Budget Year						% Change, 89-01
	1989-90	1993-94	1994-95	1995-96	1997-98	2000-01	
Expenditures	\$6,020,190	\$10,024,294	\$10,280,386	\$9,781,913	\$10,057,984	\$12,800,755	112.6%
Cost/User/Per Month	\$325	\$374	\$365	\$365	\$393	\$591	81.8%
Cost/Eligible/Per Month	\$159	\$174	\$174	\$174	\$229	\$395	148.4%
Adjusted \$/User	\$612	\$427	\$493	\$475	\$484	\$638	4.2%
Adjusted \$/Eligible	\$300	\$246	\$236	\$227	\$282	\$427	42.3%

Dollar amounts are in \$1,000s except per case per month as noted. Adjusted to CPI-Med (2002-03=1.00).
Source: DHS. Adjustments by Children’s Advocacy Institute.

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

c. Medi-Cal Provider Reimbursement Rates

Federal Medicaid law mandates that each state must “assure that payments [to providers]... are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” 42 U.S.C. section 1396a(a)(30)(A). This section is often referred to as the “equal access” standard. In essence, it means that patients covered by Medicaid are entitled to the same quality of care and access to care as are individuals covered by other insurance, including private health care insurance and Medicare. California is responsible for complying with this federal mandate by adequately setting provider rates for Medi-Cal services.

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. The 1998–99 budget increased physician reimbursement rates for the first time in twelve years. These raises amounted 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 the 1999 increase, Medi-Cal reimbursement rates, both for fee-for-service patients and as reflected in capitated rates for managed care, were 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.²⁰² 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 \$1,517.²⁰³

Medi-Cal rates have been so low that provider supply has declined. In 1994, only 31% of physicians would accept Medi-Cal patients. In 1999, fee-for-service rates ranked 47th in the nation, and capitation rates for the majority now in managed care were at the very bottom of the nation.²⁰⁴ Reimbursement rates are a fraction of common veterinarian charges for similar procedures on animals.²⁰⁵ 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%.²⁰⁶ 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.

Many recent studies have found Medi-Cal provider rates to be low in California—particularly for services to children. These rates have not been adjusted consistent with medical cost or consumer price inflation for more than a decade, and many practitioners complain that Medi-Cal patients in general and Medi-Cal-covered children in particular, impose out-of-pocket costs. Accordingly, an increasing number of practitioners refuse to handle Medi-Cal patients. The American Academy of Pediatrics published its Medicaid Reimbursement Survey in 2001, finding California's reimbursement rates for physicians and other specialists who treat children to be significantly less than compensation paid for the same medical procedures for the elderly under Medicare. In many cases, California compensation is substantially less than national average fee-for-service rates.²⁰⁷ Of special concern are rates paid to pediatric specialists—those physicians needed to treat a significant illness or injury after diagnosis. These critical medical providers for children include allergy/immunology, critical care, emergency care, perinatal pediatrics, and urology and dialysis. It also includes hospital care, office visits, psychiatry, and even child preventive services (EPSDT). Most rates applicable to these practitioners are now less than 50% of the amount paid for the identical treatment for an elderly Medicare patient. For example, under Medicare a doctor treating an elderly patient would receive \$203.15 for an initial inpatient consultation of high complexity. Under Medi-Cal, the same doctor treating a child would receive \$82.25 for the same service. This disparity is common between pediatric specialty Medi-Cal rates and their Medicare counterparts.

In 2001, the Legislative Analyst's Office (LAO) released “A More Rational Approach to Setting Medi-Cal Physician Rates,” finding that rates paid to physicians for services provided under Medi-Cal are low compared to the rates paid by the federal Medicare Program and other healthcare purchasers. The LAO also found that the Medi-Cal program has not met state and federal requirements for setting rates ensuring reasonable access to health care. The LAO concluded that the California Department of Health Services has “no established routine method” for the periodic evaluation and adjustment of physician rates. The LAO made the unsurprising finding that higher physician fees improve both access to care and its quality. The LAO proposed that Medi-Cal rates be increased to 80% of Medicare rates, a proposition advocated by many in the health care field.

Another recent study chose 50 randomly selected offices of orthopedic surgeons and compared responses for an identical problem, a serious broken arm for a ten year old boy—except one patient was covered by private insurance, and the other by Medi-Cal.²⁰⁸ All 50 offices offered an appointment to see the child with private insurance within 7 days. Only one was available within the week for the Medi-Cal covered child. Of the offices that would not see a child with Medi-Cal, 87% were unable to recommend an orthopedic surgeon that accepted Medi-Cal. The study concluded that children covered by Medi-Cal had significantly less access to timely orthopedic care than individuals covered by private insurance. The study further suggests that the federal guidelines for Medicaid regarding equal access are not being followed in California.

One national study of pediatric rates ranks California among the lowest in its Medi-Cal provider rates. The study finds that only 33.1% of pediatricians participate in Medicaid in California—and their rates are not as depressed as the pediatric specialists now in extreme short supply. The only state with a lower percentage of doctors treating Medicaid patients is Tennessee.²⁰⁹ The study also finds a direct correlation between low provider reimbursement rates and lack of equal access to medical care and treatment.

The Medi-Cal Policy Institute released its Medi-Cal compensation study in 2003,²¹⁰ and made the following findings regarding access to care:

- In 2001, 56% of primary care physicians, 55% of medical specialists, and 52% of surgical specialists in urban counties said they had Medi-Cal patients in their practice;
- Fewer physicians were willing to accept new Medi-Cal patients into their practices. Only 55%

of primary care physicians, 48% of medical specialists, and 43% of surgical specialists who were accepting new patients said that they were open to new Medi-Cal patients;

- Despite efforts in the late 1990's to increase physician participation in the Medi-Cal program, including expansion of managed care and an increase in physician fees, there was no measurable increase in physicians' participation in the program between 1996 and 2001;
- Overall, the ratio of primary care physicians available to Medi-Cal patients in 2001 (46 per 100,000) was well below the standards set by the federal Health Resources Services Administration, which recommends 60 to 80 primary care physicians per 100,000 people.

Of the various medical services covered by Medi-Cal, few suffer from lower compensation levels than do medical procedures for children—especially for the pediatric specialists listed above. Litigation currently underway in four states is now challenging their respective Medi-Cal pediatric compensation levels as discriminatorily inadequate and in violation of federal law. California's rates are lower than any of these states where challenges have been mounted and are proceeding to trial. And given California's relatively high commercial rents and other costs, its extraordinary compensation shortfall may have a disproportionate effect in cutting provider supply for children than in other states.

Former Governor Davis recognized the inadequate and discriminatory rates for Medi-Cal in his statement opposing Medi-Cal cuts in September 2002, stating:

Before I took office, California had nearly the lowest reimbursement rates for physicians in the Medi-Cal system of any state in the country. These low reimbursement rates reduced access to medical care by reducing the number of physicians willing to serve Medi-Cal patients. In the last three years, we've made substantial efforts to improve reimbursement rates, expand eligibility, and increase the number of people with health coverage...In this difficult budget year, the Administration and legislative leaders discussed rolling back some of the rate increases approved in recent years. However, any savings that might accrue by signing AB 442, the omnibus health budget trailer bill, and rolling back rates to pre-August 2000 levels would be offset by costs associated with increases in emergency room visits, administrative costs of implementing the rate reductions, and the loss of physicians who would surely leave the Medi-Cal program.²¹¹

Notwithstanding the evidence discussed above, rather than increase rates to be more equivalent with Medicare or other lawfully mandated levels (requiring the approximate doubling of rates for pediatric specialists), the 2003–04 budget cut Medi-Cal provider rates by 5%, a small but disastrous improvement from the 15% reduction proposed by former Governor Davis. In response to these cuts, the California Medical Association, the American Academy of Pediatrics, and several other provider and beneficiary organizations joined forces to sue the state to prevent the reduction. On December 23, 2003, a federal district court enjoined the state from implementing the 5% provider rate reduction that would have gone into effect on January 1, 2004. In its ruling, the court stated "because the state failed to consider the effect of a rate reduction on beneficiaries' equal access to quality medical services, in view of provider costs, the pending rate reduction is arbitrary and cannot stand."²¹² The preliminary injunction, however, did not apply to rates paid to managed care plans, several of which have threatened bankruptcy within the next few years if continued rate cuts are implemented. Notwithstanding the early (but not final) success of this lawsuit, the Governor's proposed 2004–05 budget included 10% provider rate reductions across the board. Although Schwarzenegger later rescinded this proposal in his May Revise, providers continue to be vigilant in protecting their fees, for good reason.

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. Now failure by DHS to timely process applications of potential Medi-Cal doctors can be added to the long list of bureaucratic barriers to participation in the program. A report in March 2004 revealed that 40% more physicians would be available to treat Medi-Cal beneficiaries if the state eliminated its backlog of 10,500 applications from physicians seeking to participate in the program.²¹³ For some doctors, they may be forced to submit up to five separate

applications, and the process can extend over one year. Partly due to drastic anti-fraud measures put in place by DHS since 2003 (even though the agency cannot measure how much fraud is actually stops or prevents), physician applications are taking longer to process. The Department claims that lack of adequate staff and an increase in applications is also to blame. Ironically, if beneficiaries cannot see a doctor due to lack of access, the state saves money on its Medi-Cal account.

B. Child Health and Disability Prevention (CHDP) Program

Enacted in 1973,²¹⁴ California's Child Health and Disability Prevention (CHDP) program is a major preventive health program for low-income children and youth. CHDP, which is administered by DHS, provides periodic preventive health services to Medi-Cal recipients based on the federally-mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, which is required in every state for all Medicaid (Medi-Cal) beneficiaries up to age 21. Under EPSDT, children receive periodic screenings including physicals and visual, hearing, and dental screenings; if a child is found to have a medical condition, Medi-Cal pays for services and treatments to correct or ameliorate the condition, and is responsible for providing assistance with scheduling appointments for screening and treatment services and for providing assistance with transportation to screening and treatment appointments. CHDP incorporates two parts of the EPSDT program: the periodic screenings and assistance with scheduling and transportation.²¹⁵ 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 has finally been realized with the July 1, 2003 implementation of the "CHDP Gateway" program (discussed above), which serves as an automated pre-enrollment process for providers to enroll uninsured children into Medi-Cal or Healthy Families.

CHDP coverage is available to children through age 20 on Medi-Cal as part of the federal EPSDT program; to other children through age 18 from families at or below 200% of federal poverty level;²¹⁶ and to children enrolled in Head Start or state preschool programs (see Chapter 6). 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 EPSDT program.²¹⁷ 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 would not 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.²¹⁸ 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 Governor's 2004–05 budget proposes \$4.2 million (\$3.9 million general fund) in total expenditures for CHDP, for 71,000 CHDP health screens. This is a 76% decrease in all funds and a 48% decrease in general fund expenditures from the current year, which covered 300,000 CHDP screens. A small part of this decrease in proposed program expenditures is due to the proposed, and now rescinded, reductions in reimbursement rates for CHDP providers. However, most of the proposed decrease in the CHDP budget is due to the assumed full implementation of the CHDP gateway in the budget year.²¹⁹

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/claim 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. Local health departments do not monitor CHDP activities in managed care plans for Medi-Cal eligible children.

	Budget Year								Estimated 2003-04	Proposed 2004-04	Percent Change	
	1989-90	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03*			'89-'03	Proposed
General Fund	\$24,212	\$37,600	\$23,860	\$24,201	\$21,879	\$102,431	\$48,312	\$32,200	\$7,500	\$3,900	-69.0%	-48.0%
Tobacco Tax	\$8,337	\$26,592	\$47,878	\$49,291	\$56,025	\$0	\$0	\$0	\$0	\$0	-100.0%	0.0%
Federal	\$0	\$6,342	\$6,342	\$7,744	\$6,692	\$6,748	\$6,804	\$6,800	\$0	\$0	na	0.0%
Other	\$0	\$0	\$3,600	\$2,640	\$0	\$9,072	\$74,006	\$60,000	\$10,000	\$300	na	-97.0%
Total	\$32,549	\$70,534	\$81,680	\$83,876	\$84,596	\$118,251	\$129,122	\$99,000	\$17,500	\$4,200	-46.2%	-76.0%
Adjusted Total	\$78,616	\$99,371	\$110,486	\$108,479	\$104,209	\$138,179	\$144,680	\$104,002	\$17,500	\$3,977	-77.7%	-77.3%

Dollar amounts are in \$1,000s. Sources: Governor's Budgets, Legislative Analyst's Office. Estimate of Children's Advocacy Institute. Adjusted to 0-19 population and CPI-Med (2003-04=1.00). Adjustments by Children's Advocacy Institute.

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

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.

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*.²²⁰ 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-F).²²¹

In recent years, CHDP funding in general has become heavily dependent on the Proposition 99 Tobacco tax revenue source. The passage of Proposition 10 adding 50-cents per pack and effective anti-smoking ads are reducing tobacco sales and the revenues for this account. As Table 4-F 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 2001-02, Tobacco Settlement Fund monies ("Other" in the CHDP Table above) were scheduled to replace the declining Proposition 99 funds while relieving the general fund. However, as Chapter 1 discusses, the Tobacco Settlement Fund has now been largely expropriated for the remainder of its twenty years in order to pay interest on floated bonds to cover two years of general fund shortfall.

The number of state-funded CHDP screens has increased faster than the population adjustor used for Table 4-F. Screens 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.²²² 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 Medi-Cal reimbursement for the same procedure (see discussion below 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. 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."²²³ 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). The LAO found 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 functioned 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."²²⁴ LAO recommended 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.

Former Governor Davis had proposed the elimination of CHDP altogether in January 2002, contending that it could be “absorbed” into Medi-Cal. Although he later retracted that proposal, he cut the program substantially over the current year. While the LAO recommended the integration of CHDP into a more streamlined system of medical coverage, straight funding reductions for health screens and increased provider compensation was not part of that recommendation. The complete or partial “absorption” of CHDP into Medi-Cal is disingenuous where the latter is suffering its own reductions.

C. Healthy Families Program

The state’s 1998 “Healthy Families” program (administered by the Managed Risk Medical Insurance Board) was enacted pursuant to the Balanced Budget Act of 1997, which created the federal State Children’s Health Insurance Program (SCHIP).²²⁵ 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. The program potentially provides comprehensive health, dental, and vision benefits equivalent to those provided to state employees. Coverage is federally funded at \$2 for every \$1 in state monies spent. 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.²²⁶

	Budget Year								% Change
	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	Proposed
General Fund	\$1,465	\$16,63	\$77,522	\$141,301	\$143,359	\$25,891	\$295,909	\$307,075	3.8%
Federal Fund	\$0	\$37,820	\$134,733	\$248,522	\$338,762	\$436,124	\$504,159	\$527,059	4.5%
Reimbursements	\$0	\$7,482	\$2,482	\$3,483	\$11,281	\$6,958	\$7,307	\$5,971	- 18.3%
Tobacco Settlement Fund	\$0	\$0	\$0	\$0	\$59,946	\$229,450	\$1,047	\$4,202	301.3%
Total	\$1,465	\$61,665	\$214,737	\$393,306	\$553,348	\$698,423	\$808,422	\$844,307	4.4%

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

TABLE 4-G. Healthy Families: MRMIB

Table 4-G presents the MRMIB Healthy Families budget. Some Healthy Families spending also occurs in the DHS and other minor accounts. The overall changes in spending on this account is driven by enrollment size. Governor Schwarzenegger proposed to cap enrollment in the Healthy Families program at 732,300 children as of January 1, 2004 as part of his mid-year reductions. Assuming that the enrollment cap had been implemented, Healthy Families would have 737,304 children enrolled as of June 30, 2005, for an increase of only 4,960 children over the revised 2003–04 enrollment level.²²⁷ The Governor also proposed a two-tiered benefit structure for children with a family income between 201% and 250% of the federal poverty level beginning in 2005–06.

Under the Governor's proposed Healthy Families enrollment cap, 22,200 children would have been denied enrollment in 2003–04, and almost 114,000 children denied in 2004–05.²²⁸ Thus, over just two years, the Governor's plan would deny over 136,000 children access to health, dental, and vision care. Further, no medical necessity criteria would be used for establishing the waiting lists—it would be done strictly done on a “first come first served” basis.²²⁹ As is noted by the Senate Budget Committee, children put on the waiting list will need to seek health care, dental and vision services from other sources, including county indigent programs, emergency room care, other available state programs, and charity care (as available), or become sicker and more medically involved.²³⁰

In the Governor's May Revise, both the enrollment cap and the two-tiered benefit structure were rescinded, however, the Administration continues to propose an increase in premiums for all children with family incomes between 201% and 250% of the FPL. Thus, effective July 1, 2005, Healthy Families premiums would increase from \$9 to \$15 per child and from \$27 to \$45 for three or more children.

Former Governor Davis tried to capture more federal funds by expanding the number of uncovered persons who qualify, as with the movement of eligibility for children from 200% to 250% of the poverty line. 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. SCHIP permits parental coverage, with prior federal approval, as opportunities for the whole family to enroll promotes child health enrollment and children's health care.²³¹

As discussed above, the federal government approved California's waiver request, which would allow state extension of coverage to about 290,000 parents of children eligible for Healthy Families. This expansion was originally intended to begin in 2001–02 at 174,000 enrolled and increase to full 290,000 enrollment by 2003–04. However, the federal delay in approval and related circumstances have caused California to push back the anticipated implementation to 2006. When it occurs, full implementation will include parents to 200% of the poverty line (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 had been dropped to \$10–\$20 per month per parent.²³² 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 2–1 with SCHIP funds, at full implementation.²³³

It is unlikely the target of \$219 million in state funds will be available until at least 2006 given the roll-over of many billions of dollars to future years (see discussion in Chapter 1). Child advocates acknowledge the unprecedented budget shortfall that requires difficult decisions. However, as discussed in Chapter 1, this denial occurs at the same time federal tax reductions have been approved in 2001 and 2003 yielding an average reduction of \$37 million per year for California individual taxpayers over the next decade. Less than one percent of this annual tax reduction could fund the state portion necessary to provide more comprehensive health care for children and their parents and capture the available federal match.

The amount unspent that can be rolled-over is limited in number of years of carryover allowed. Hence, delay in parental coverage will cause the loss of over \$1 billion in federal funds, including \$100 million foregone for 2003–04, increasing to \$370 million thereafter.²³⁴ In addition, substantial sums have been and will be foregone because of the substantial number of children who remain uncovered. All available federal funds may be collected and used for child coverage alone with the enactment of the true “presumptive eligibility” proposal above, combined with tax credits for employers who cover dependents (see below).

D. California Children's Services (CCS) Program

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.²³⁵ 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 provided by physicians, hospitals, and special centers are reimbursed at Medi-Cal rates. There is a small, sliding program fee up to 200% of poverty.

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.

Governor Schwarzenegger’s proposed budget includes \$142 million (\$67 million from the general fund) in funding for CCS for 2004–05; this reflects a 3% decrease in all funds and a 8% decrease in spending compared to the current year. The Governor had proposed to cap enrollment in the CCS program—a strategy for service denial that mechanically denies medical help to children otherwise eligible until those currently receiving services reduce their numbers—regardless of relative need. The cap was proposed to freeze services to these chronically ill children at the January 2004 caseload level.²³⁶ The administration noted that the state would save \$1.9 million by creating a waiting list of denied children that would grow to 1,256 in 2004–05. The waiting list would then be tapped on a “first-come, first-served” basis as existing children leave the program.²³⁷ That bar would apply even to children seeking terminal cancer amelioration, or dialysis help. The Governor withdrew this proposal in his May Revise – but its serious advancement over a six month period of advocacy raises disturbing questions about his judgment and that of his health and finance appointees. The Governor also retracted in May the recent 5% reduction in Medi-Cal provider rates that had been successfully challenged in court by the California Medical Association, and also his 10% add-on reduction. California has one of the lowest Medicaid reimbursement schedules for child related services in the nation, set substantially below identical Medicare services for the elderly.

	Budget Year								Estimated 2003-04	Proposed 2004-05	Percent Change	
	1992-93	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03			'89-'03	Proposed
General Fund	\$54,896	\$40,821	\$43,232	\$48,786	\$49,478	\$66,689	\$72,696	\$71,474	\$74,400	\$67,000	35.5%	-9.9%
Federal Funds	\$4,704	\$4,704	\$4,811	\$9,581	\$6,410	\$8,898	\$11,528	\$4,704	\$4,704	\$5,000	0.0%	6.3%
Other	\$0	\$360	\$314	\$200	\$0	\$180	\$743	\$500	\$5,700	\$6,000	na	5.3%
County Funds	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$66,184	\$61,530	\$64,000	na	4.0%
Total	\$59,600	\$45,885	\$48,357	\$58,567	\$55,888	\$75,767	\$84,967	\$142,862	\$146,334	\$142,000	145.5%	-3.0%
Adjusted Total	\$143,952	\$64,645	\$65,411	\$75,746	\$68,845	\$88,535	\$95,205	\$150,080	\$146,334	\$134,471	1.7%	-8.1%

Dollar amounts are in \$1,000s. Sources: Governor’s Budgets.
Adjusted to age 0–19 population and CPI-Med (2003–04=1.00). Adjustments by Children’s Advocacy Institute.

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

The CCS county programs submit claims to the state, which matches counties dollar for dollar. Adjusted spending for CCS increased markedly in 2002–03 due to a long overdue increase in compensation for CCS services, which had fallen to the lowest levels in the nation and below out-of-pocket cost. However, the proposed year total is an adjusted 8% below the current 2003–04 figure.

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 1994²³⁸ 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. However, the separation of the program continues to date, and 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:²³⁹

- Remove the program from county realignment and transfer responsibility to the state (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; and
- Increase case-management staff to ensure that needed services are received.

E. Genetically Handicapped Persons Program

The Genetically Handicapped Persons Program (GHPP) provides health coverage for Californians 21 years of age and older who have certain specific genetic diseases, including cystic fibrosis, hemophilia, and certain neurological and metabolic diseases. The GHPP also serves children under the age of 21 with GHPP-eligible medical conditions who are not financially eligible for CCS. Although there are no maximum income eligibility requirements, families with incomes exceeding 200% of the federal poverty level pay program fees based upon their family size and income.

The Governor's budget proposal provides \$49.5 million for GHPP (\$49.3 million general fund) in 2004–05, which reflects a 13% decrease compared to the current year.²⁴⁰ As with the CCS program, the Schwarzenegger Administration proposed caps on enrollment for GHPP-only clients and reductions to provider rates by 10% percent in GHPP. The proposal also would cap enrollment at the January 2004 caseload level.²⁴¹ Again, the May Revise rescinded the proposal to cap enrollment and reduced provider rates in this program.

The Governor's budget retains in his May Revise the implementation of a GHPP co-payment structure. Under this proposal, the co-payment would be deducted from the amount that the state pays the provider for each service. The provider in turn would collect the co-payment from the patient. Clients would be required to pay \$10 per service—providing approximately \$576,000 in savings to the general fund. Such a fee increase appears to be in a different category than revenue enhancement via tax assessment. Child advocates argue that the general body politic gains enormously from preventing lifetime disabilities associated with serious genetic problems—and that any co-pay impediment to its expansive use is contrary to the long term public interest.

F. Maternal and Child Health (MCH) Program

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 Adolescent Family Life Program, Adolescent Sibling Pregnancy Prevention Program, Battered Women Shelter Program, Black Infant Health Program, Breastfeeding Program, California Diabetes and Pregnancy Program, Childhood Injury Prevention Program, Comprehensive Perinatal Services Program, Fetal and Infant Mortality Review Program, Oral Health Program, Regional Perinatal Programs of California, School Health Connections, Sudden Infant Death Syndrome Program, and Youth Pilot Program.²⁴² The account funds public health programs, up to 30 per county, to ensure the health of infants and mothers during at-risk pregnancies. These programs ensure impoverished pregnant women see a physician, understand the doctor's orders, and are educated in maintaining their health and the health of their baby.

The majority of MCH funding 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 (including perinatal access), and places a 10% cap on administration. However, the state's plan largely continues existing programs, with most of MCH's money going for perinatal services.

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. The federal MCH Block Grant for fiscal 2004 is \$730 million, of which \$600 million is divided by the fifty states. The same amount—\$730 million—is proposed for fiscal 2005.

G. Specialized Child-Related Health Programs

1. Office of Family Planning (OFP)

OFP's charge is to make comprehensive medical assistance, knowledge, and services related to family planning 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, foster care, and other teenagers who are at high risk of unintended pregnancy. OFP also promotes sexually transmitted disease prevention services.²⁴³

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 women aged 15–19 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 one in five becoming pregnant (in 1995), with two-thirds of them 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 increasing rates of sexual intercourse (now engaged in by about 50% of youths before high school graduation), with 20% experiencing sex at age 15 or younger (see Chapter 2 "Unwed Teen Birth" discussion).

Unwed births to teens raise special problems for the children involved, from low birthweights to intractable poverty. Only one-half of those who are pregnant as teens finish high school by age 30.²⁴⁴ Within the teen births, two groups are at special risk: those under age 18, and those who are unwed.

As Chapter 2 discusses, teen pregnancies are high by historical standards but have leveled and declined somewhat over the last five years. These pregnancies remain a serious problem. However, child poverty is driven substantially beyond its purview—by births to unwed mothers in general.²⁴⁵ 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.²⁴⁶ Importantly, the unmarried mother trend applies to all income and age groups.²⁴⁷ 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.²⁴⁸ 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.

In 1996, former Governor Wilson started a new program within OFP called Family PACT (Planning, Access, Care and Treatment), 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 1.5 million persons participating, with 61% identifying themselves as Hispanic.²⁴⁹ 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 1999.²⁵⁰ Related to the Family PACT program is SB 41 (Speier), enacted in 1999, which requires employer-based health plans, with some exceptions, to include contraceptive services for women.²⁵¹

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). In 2000, it was estimated that every dollar spent in the Family PACT program saves the state \$4.48 in other costs.²⁵² Under Governor Schwarzenegger's proposed budget for 2004–05, Family PACT provider reimbursement rates would have been cut by 10%, but that proposal was rescinded in his May Revise.

Also within OFP, the Community Challenge Grant program promotes community-based partnerships for the development of effective local prevention programs targeting teen and unwed pregnancies and fatherlessness resulting from these pregnancies. The major goals of the program are to reduce the number of teenage and unwed pregnancies; reduce the number of children growing up in homes without fathers as a result of these pregnancies; and promote responsible parenting and the involvement of the father in the economic, social, and emotional support of his children. The CCG program targets specific population groups; however, local programs are not limited to only the target populations specified by the program. The target populations specified by the program are as follows: (1) pre-sexually active adolescents; (2) sexually active adolescents; (3) pregnant and parenting teens; (4) parents and families; and (5) adults at risk for unwed motherhood or absentee fatherhood. Under Governor Schwarzenegger's proposed budget for 2004–05, all TANF funding for the Community Challenge Grant program (\$20 million) would have been eliminated, but his May Revise rescinded the proposal, leaving the TANF funding intact.

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 during the previous Davis Administration restated the same raw numbers over and over, accomplishing a 8%–12% real spending reduction over three years.

2. 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 vaccines to clinics and physicians, and oversees the screening and 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. Unlike many earlier epidemics which spread largely through contact at schools, cases here were concentrated in the preschool population.²⁵³ 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%.²⁵⁴ 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.

In 1992, the Legislature passed AB 3351 and AB 3354,²⁵⁵ 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.²⁵⁶ 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 vaccines 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 have been 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.²⁵⁷ 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."²⁵⁸

3. Genetic Disease Branch

DHS' Genetic Disease Branch focuses on reducing and controlling disorders having a hereditary or

genetic basis though early detection, public and professional education, preventive interventions, and counseling. It operates the largest screening program in the world, and provides services such as screening newborns and pregnant women for genetic and congenital disorders in a cost-effective and clinically effective manner (the screening programs provide testing, follow-up and early diagnosis of disorders to prevent adverse outcomes or minimize the clinical effects); ensuring quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance with them; fostering informed participation in its programs in an ethical manner through a combination of patient, professional, and public education, and accurate and up-to-date information and counseling; providing ongoing critical review, testing, and evaluation of existing programs to ensure that program objectives and goals are being met; developing programs to adopt new methods and implement new services that further enhance the effectiveness and efficiency of current and future prevention programs; and promoting use of high-quality consumer education materials on genetic disorders, screening for birth defects and genetic services.

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. It tests a few drops 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.

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. However, this additional testing has not yet been added to the newborn screening program. 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 1 in 5,000 children will have a genetic disorder detectable under this additional procedure. Some of these genetic diseases bear a strong correlation to Sudden Infant Death Syndrome. The marginal cost of covering Medi-Cal children—the only public cost involved—would require a Medi-Cal budget increase from the current \$4 million to \$6 million.

As noted above, the current fee for this testing is \$60 per child. Until December 2001, the fee had been \$42 per child. However, DHS engaged in two back-to-back emergency rulemaking actions to raise the fee to its current level—effectuating a 42.8% fee increase over a six-month period. According to DHS, the increase was necessary to keep the program consistent with medical standards, medical knowledge, and the mandates of the Hereditary Disorders Act. Specifically, the fee increases were sought in order to fund the costs of the Genetic Disease Branch Screening Information System (GDB SIS) Project, the purpose of which is to replace an obsolete automation system used to screen newborns for genetic diseases.

However, even with the fee increase, the special fund did not have a sufficient revenue balance to pay the project's up-front costs. Accordingly, the Legislature approved a \$5.3 million general fund loan as part of the 2003–04 budget to help fund the project. Governor Schwarzenegger's proposed budget for 2004–05 proposes yet another \$5 million general fund loan to pay for additional development costs. However, according to the Legislative Analyst's Office, DHS has not provided the Legislature with reports detailing the costs, schedules, and status of the GDB SIS, as were required as a condition of its approval last year. Since these reports would have provided needed information about the finances and status of the project, LAO is recommending that the Legislature deny the administration's proposal for an additional \$5 million general fund loan for this project unless the reports are submitted and DHS is able to demonstrate its ability to manage the project.²⁵⁹

4. 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 (1 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.

BDMP is a joint project of DHS and the March of Dimes. Core funding comes from the state budget, but research studies are also sponsored by the Maternal Child Health Block Grant, the Centers for Disease Control and Prevention, the Environmental Protection Agency, and the University of California's Tobacco-Related Disease Research Program.

Cost studies by BDMP suggest the long-term cost-efficacy of both monitoring and research. 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).²⁶⁰ 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.²⁶¹

5. Programs Addressing Environmental Hazards

a. Childhood Lead Poisoning

(1) 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 1986.²⁶² 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 1994.²⁶³ 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, the 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.²⁶⁴ 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.”²⁶⁵

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.²⁶⁶ 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.”²⁶⁷

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 lead poisoning. 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.²⁶⁸

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%.²⁶⁹ 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.²⁷⁰

(2) 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."²⁷¹ 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.²⁷² The result "could be a tripling of the number of youngsters who need specialized educational services."²⁷³

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.²⁷⁴ The second study tested expelled childhood teeth from first- and second-graders, and found levels above 20 ppm associated with an extraordinary seven-fold risk of not graduating from high school, and six-fold risk of having a reading disability, as well as vocabulary and attention span problems and lower academic achievement.²⁷⁵ Other studies associate elevated lead levels (even moderate elevation) with antisocial, aggressive, and delinquent behavior in children and youth²⁷⁶ (see discussion in Chapter 9).

In April 2003, the *New England Journal of Medicine* published two studies indicating that serious injury from lead occurred at lower levels than previously assumed. The first found that blood levels below 10 ug/dl were associated with a large 7.4 point decline in IQ. Surprisingly, the lower levels were actually more damaging than somewhat higher concentrations for the three- and five-year-olds tested.²⁷⁷ The second study found that levels as low as 3 ug/dl correlated with delayed growth and puberty onset in African-American and Mexican-American girls.²⁷⁸ These significant effects occur at levels far below the triggers for treatment/mitigation now accepted by DHS.

(3) Childhood Lead Poisoning Prevention Branch

DHS' Childhood Lead Poisoning Prevention (CLPP) Branch conducts epidemiological studies;

develops lab testing and case management protocols; trains health officials, providers, and the public in case identification and management; and writes regulations related to assessment, CLPP Fund fees, and abatement.

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.”²⁷⁹ 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),²⁸⁰ and in May 1995 the trial court granted summary judgment for the plaintiffs (paint industry), 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 1997.²⁸¹ 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.

One study released in 2000 concluded that California’s CLPP Program is “woefully underfunded,” estimating that DHS collects only three-fourths of the \$16 million it is authorized to collect from lead polluters annually, and that the program receives less than 20% of its funding from the state.²⁸² As a result, since 1992 the state has failed to identify or provide care for an estimated 200,000 lead-poisoned children ages 1– 5; about 212,000 California children in that age range had harmful blood lead levels between 1992 and 1998, but the state identified only 14,900.²⁸³ Statewide, no more than 1 in 5 children is tested for lead poisoning.²⁸⁴

The California State Auditor has also reviewed 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*.²⁸⁵ 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. It is hoped that lead screenings can reach an additional 200,000 children, of whom it is anticipated 4,000 will have elevated blood lead levels.²⁸⁶ In addition to screenings, lead poisoning case management (under EPSDT) and environmental investigation costs can be handled under Medi-Cal, with its 50% federal funding match.²⁸⁷

However, as of 2001, case management had not been adequately implemented through Medi-Cal for lead poisoning cases; accordingly, a lawsuit was filed by Public Advocates, National Center for Youth Law, and Bay Area Legal Aid, contending that DHS had failed to comply with the specific mandate of Childhood Lead Poisoning Prevention Act. Specifically, plaintiffs alleged that DHS failed to promulgate regulations establishing a standard of care for evaluating California’s children for the risk of lead poisoning; failed to ensure that children identified as having lead poisoning receive appropriate case management after April 1, 1993; and failed to collect and analyze information needed to monitor their case management efforts and prepare a public report. In November 2000, the court issued a peremptory writ of mandate providing complete relief to the plaintiffs.²⁸⁸ DHS subsequently adopted rules consistent with the law and including an enforcement mechanism with the monitoring/screening mandate now in effect. The 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 are 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 November 19, 2001, the regulations were approved by the Office of Administrative Law.²⁸⁹

This development was followed by another critique of DHS performance to address high blood levels with treatment once high blood levels are detected. In May 2001, the California State Auditor followed up her earlier critique of the program (see above) with a study acknowledging some progress, but concluding that the Department remains “unsuccessful at meeting [the statute’s] goals.” The Auditor, in uncommon bluntness, concluded that “As a result of the Department’s difficulty in meeting its goals, thousands 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...”²⁹⁰ 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. 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 benefit.

In order to expedite mitigation, Santa Clara County filed suit against lead paint manufacturers, claiming fraud, negligence, unfair competition, and public nuisance; several other counties later joined on as plaintiffs. However, on September 17, 2001, Superior Court Judge Gregory Ward rejected the nuisance cause of action, and on July 8, 2003, Superior Court Judge Jack Komar dismissed the suit on statute of limitations grounds.²⁹¹ The plaintiff counties sought mitigation/restitution/damages to pay for the clean-up, monitoring, and treatment for 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, and misled the public regarding lead’s dangers, thus, preventing its earlier prohibition and imposing substantial public mitigation costs on the counties. However, Judge Komar ruled that the action, filed in 2000, should have been filed within three years of the time the paint was applied.

The federal Lead Hazard Reduction Act of 1992 requires sellers and landlords to disclose to buyers and tenants the presence of known lead-based paint and hazards, with civil and criminal remedies provided for violations. Several prosecutions have resulted in convictions in the District of Columbia and New Hampshire, but enforcement has essentially been symbolic. Massachusetts is credited with substantially lowering blood levels in children through a law that imposes on a homeowner where a child under the age of six resides, an affirmative obligation to abate the hazard (e.g., containment where paint is deteriorating or subject to friction as in window casings). But one by-product has been alleged discrimination against families with young children in the rental market. Indiana has a model with substantial child advocacy support that presumes lead-based paint is present on any older home (built when lead was commonly in house paints). It also requires lead training for health and housing authorities. In Rhode Island—one of the most lead-endangered states—the Attorney General has filed a lawsuit similar to the *Sinclair* case (which upheld the California statute, see above). The public nuisance suit against the Lead Industries Association seeks to force lead producers to abate the nuisance arising from their products (e.g., contribute monies for abatement/mitigation). Over 40 cities, counties, and organizations have joined the Attorney General in his suit, with trial expected in September 2003.²⁹²

In California, SB 460 (Ortiz) took effect in January 2003,²⁹³ making lead hazards a housing violation requiring abatement under the regime of local building and health departments, and gives DHS some coextensive jurisdiction. Abatement means repair, rehabilitation, vacation, or demolition. The new statute also prohibits new construction that creates such hazards. Perhaps most important, it requires laboratories to report the results of all lead blood screens to DHS. Lead hazards include “disturbing lead-based paint without containment” and “deteriorated lead-based paint” as defined in the new law, and

applies wherever a hazard is associated with a blood lead level equal to or greater than 10 micrograms per deciliter. The impressive terms of the new law will depend upon funding for screening and for local housing standards enforcement along new lines. Such expansion is unlikely without substantial new funding.

On May 8, 2003, Attorney General Bill Lockyer announced settlements with two Los Angeles area apartment owners that requires them to remove lead-based paint from their buildings and to fund programs to assess and prevent lead poisoning in children. The settlement covers 1,843 apartments owned by Westside Rehab Corporation and 1,380 managed by SK Management Company. The underlying statute invoked was not the recent state statute discussed above, but the federal Residential Lead-Based Paint Hazard Reduction Act of 1992 (see above), requiring landlords to inform renters of lead hazards. The underlying case was filed by the U.S. Department of Housing and Urban Development (HUD) and the Environmental Protection Agency (EPA). The federal agencies filed in federal court, and the state AG brought a reinforcing action in Los Angeles Superior Court, alleging unfair competition in violation of section 17200 of the Business and Professions Code. Both federal and state actions were settled, with the California case requiring the funding of a Child Health Improvement Project (CHIP), which includes \$60,000 for Los Angeles hospitals to fund lead testing.

b. 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.²⁹⁴ 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.²⁹⁵

(1) 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 prevalent 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).

(2) Pesticides

Pesticides are a dangerous source of environmental contamination for children. Many pesticides to which pregnant women are exposed are closely connect with birth defects, and other pesticides lower infant and child immunity and have a disproportionate carcinogenic impact on children. By 1993, the U.S. 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 related to a 10.8% increase in childhood cancer rates between 1973 and 1994.²⁹⁶

In 1988, Congress asked the National Academy of Sciences to examine pesticide food residues relevant to child health.²⁹⁷ 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.²⁹⁸ More recently, Congress responded by enacting the Food Quality Protection Act of 1996 to require for the first time that the EPA measure infant and child tolerances of pesticides 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.²⁹⁹

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 that 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 the Healthy Schools Act of 2000.³⁰⁰ 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 reactions to certain pesticides to avoid some contact, but will not ameliorate the underlying problem of low level, but lengthy exposure.

Building on the Healthy Schools Act of 2000, Assembly Member Judy Chu introduced AB 1006 on February 20, 2003, to implement the Healthy Schools Act of 2003. Among other things, this measure would make certain findings relating to the potential risk of pesticide use, the susceptibility of children to toxic chemicals, higher than average cancer rates for female teachers, and a need to further encourage less toxic strategies to control pests at school sites. Furthermore, this bill would ban public schools from using the “most highly toxic” pesticides, as defined, on school property. AB 1006 has been made a two-year bill; as of this writing, it is pending in the Senate Agriculture and Water Resources Committee.

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.³⁰¹ In this area, the state proposed the closure of all poison control “hotlines” for physician and parent use as part of the budget plan in 1993. The account was restored after monies from “Kids’ Plates,” a customized vehicle license plates program, were directed for its future funding,³⁰² but they remain minimally funded and limited in coverage.

(3) Tobacco Smoke

Environmental tobacco smoke includes 40 carcinogenic chemicals. According to a 1997 report, second-hand smoke is responsible for an estimated 150,000–300,000 lower respiratory tract infections in infants (children under 18 months of age) nationally 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.³⁰³ Forty-three percent of children from 2 months to 11 years of age live in homes with at least one smoker.³⁰⁴

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 studies³⁰⁵ 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 sums on public relations and education for tobacco use reduction and safety purposes, including second-hand smoke ingestion from adult usage. The budget for 2001–02 included a total of \$114.5 million for efforts to reduce tobacco use, of which \$45.2 million was from Proposition 99 funds for the state’s anti-tobacco media campaign and \$20 million was from the Tobacco Settlement Fund to reduce smoking specifically among teens.³⁰⁶ Local communities have adopted ordinances governing smoking in public places. Smoking was prohibited

on intrastate flights before federal rules similarly applied. However, the impact of measures undertaken on second-hand 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.

Youth smoking rates represent another public health failure. Studies show that the average smoker began 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 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 2,145.³⁰⁷

Notwithstanding these improvements, use rates are high enough to subject a substantial percentage of children to danger while *in utero*, and youth addiction continues at rates devastating to millions of youth in later years. Recent legislation allows more effective sting operations to catch and prosecute tobacco sales to underage youth (see discussion of legislation above). In 2001–02, the Legislature considered for the first time, but ultimately rejected, a proposal to raise the age for lawful tobacco smoking to 21 years of age (AB 1453 (Koretz)). Although Assemblymember Koretz reintroduced his proposal as AB 221 in 2003, it failed passage in the Assembly Governmental Organization Committee by a vote of 12–6 (eight members of the 26-member Committee were listed as “absent, abstaining, or not voting”).

In 2004, Assemblymember Marco Firebaugh introduced AB 2997, which would make it an infraction for a person to smoke a pipe, cigar, or cigarette in a vehicle in which there is a driver or passenger who is 18 years of age or less. According to the author, a recent DHS survey revealed that 29% of youth in the state had been exposed to second-hand smoke in a vehicle within the previous seven days of the survey. As written, the bill would suffice as probable cause for a motorist to be stopped and cited for committing this offense.³⁰⁸ Conviction will be punishable as an infraction, with a base fine of up \$25; with additional penalties, this would bring the fine to \$96.³⁰⁹

(4) 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.³¹⁰ 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.³¹¹

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.³¹² California has not comprehensively tested its water, has not applied child-appropriate standards, has not 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 its 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

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 1987.³¹³ Examiners 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,³¹⁴ highlighting 1994 data showing that:

- 31% of preschoolers and over 66% 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 also notes that California still has low fluoridation rates.

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 2000.³¹⁵ More recently, the California Health Interview Study found that over 50% of California children from 2–5 years of age have never seen a dentist and 24% have no dental insurance coverage (public or private).³¹⁶

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 cavities 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 U.S. Public Health Service has identified water fluoridation as one of the ten great public health achievements of the twentieth century.

The California Children's Dental Disease Prevention Program (CDDPP) is a school-based effort to reduce the incidence of dental disease in children. The CDDPP currently serves more than 300,000

California preschool and elementary school children annually. Need is based on the proportion of Free and Reduced School Lunch Program participation for each county. Currently, the CDDPP operates 33 school-based programs in 32 counties throughout the state. The state contracts with local health departments, the county superintendent of schools, and nonprofit agencies. Two dental program consultants oversee the CDDPP at the state level. Local coordinators are responsible for implementation and evaluation of the program at the local level. Health educators and teachers deliver oral health messages and oversee the brushing and fluoride components in the classroom.

The CDDPP has five required program components: (1) weekly fluoride mouthrinse or daily fluoride supplement; (2) plaque control; (3) classroom oral health education; (4) dental sealants screening and/or application; and (5) an active oral health advisory committee. Local teams work on increasing access to dental care, educating the public to prevent early childhood caries, oral injuries, and dental disease. In 2002, a parent oral health/nutrition education component was implemented.

The low level of dental funding and coverage for the state's over five million school children is of special concern because (1) some major community water supplies are not 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.

Underlining some of these problems, the Health Consumer Alliance published its study of dental services offered through Medi-Cal on January 16, 2003. The study found that Medi-Cal funded dental services suffer from the following impediments: (1) providers are misinformed about coverage and do not offer some procedures; (2) dental HMOs lack Spanish interpreters impeding communication about Hispanic patient needs; (3) the Department of Health Services denies coverage requests erroneously and erects gratuitous barriers (including requests for documentation that has already been provided), and the Department's interpretation of coverage excludes treatments required under federal law. Finally, as discussed above, "the California Department of Health Services does not abide by federal law in guaranteeing access to oral health services, particularly preventive dental care for children."³¹⁷ The study cites problems impeding EPSDT compliance, including barriers to receiving dental services. Barriers include gratuitous red tape, for instance, the use of Treatment Authorization Request (TAR) paperwork to obtain what federal law requires to be "routine" dental care for children.

Indeed, the state's Denti-Cal Manual itself violates federal law; instead of granting more liberal treatment for children under the EPSDT mandate, it restricts them as a group. The study cites as an example that "periodontal service benefits...*shall be limited to beneficiaries 18 years of age and older.*"³¹⁸ Another example is the purported refusal to cover "spacers" in braces. While cosmetic choices are legitimately not covered, such spacers are often required therapeutically and payment denial can effectively preclude braces and proper teeth alignment.³¹⁹ Indeed, the study found that access to orthodontics is pervasively and unlawfully denied to children—with DHS using a modified "Handicapping Labio-Lingual Deviation (HLD) Index" to allow coverage and requiring a "score" of 26 or higher. The straightening of a child's permanent teeth for reasonable chewing efficacy should not turn on marked inability to talk or visible mouth distortion, and the EPSDT standard requires treatment short of such extreme deformity.³²⁰

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. EPIC programs especially relevant to children include injury prevention programs and violence prevention programs, including a child maltreatment surveillance program and a family and domestic violence prevention program.

Important state legislation enhancing child safety has included bicycle helmet requirements,

swimming pool safety, playground safety standards, and amusement ride safety standards—successful measures sponsored by the Children’s Advocacy Institute. Other measures have been enacted, such as a new child passenger restraint law enacted in 2000 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.³²¹ Prior law required use of such restraints for children up to four years or 40 pounds. The law corresponds to research establishing the importance of restraints for children past infancy, but under 6 years of age, and the somewhat different type of restraint necessary for those young children, with enforcement phased in over a two- to three-year period.³²² The law is an important precedent and may to an inexpensive fold down 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). AB 1697 (Pavley) (Chapter 524, Statutes of 2003) now prohibits most children under age 6 from riding in the front seat of automobiles, where their size and weight may make air bags a hazard. Studies indicate that the rear seat location for young children reduces fatal injury incidence by 36%. AB 1697 excludes cars without back seats, where a restraint system cannot be installed, where more children are being carried than can fit in the back, or for special medical reasons.

During 2001, the Legislature enacted AB 255 (Speier) (Chapter 855, Statutes of 2001), the Unattended Child in Motor Vehicle Safety Act. This bill addresses the tragic consequence of leaving young children in locked cars unattended, where high temperatures injure many and kill over 40 children per year. The bill creates a new infraction for a parent, legal guardian, or other person responsible for a child age six or younger who leaves that child inside a motor vehicle without being subject to the supervision of a person who is twelve years of age or older (1) where there are conditions that present a significant risk to the child's health or safety, or (2) when the vehicle's engine is running or the vehicle's keys are in the ignition, or both. A violation is an infraction punishable by a fine of \$100, except that the court may reduce or waive the fine if the defendant establishes to the satisfaction of the court that he/she is economically disadvantaged and the court instead, refers the defendant to a community education program that includes education on the dangers of leaving young children unattended in motor vehicles, and provides certification of completion of that program.

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 it billed to public payors.³²³ Injury prevention program funding for children *vis-a-vis* adults is disproportionately low. The amount expended is insubstantial and decreasing.

8. Access for Infants and Mothers

Access for Infants and Mothers (AIM) 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 administered by the Managed Risk Medical Insurance Board, which uses state appropriations and women’s payments to purchase insurance from eleven participating health plans.

The program’s funds come from the Perinatal Insurance Fund, which the former 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 budget for 2001–02 increased Proposition 99 funding for AIM by \$11 million for anticipated caseload growth; some of those funds were from the remaining Proposition 99 litigation reserve.³²⁴

AIM is yet another example of a stand-alone categorical program that appeared to contradict the state’s goal 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.³²⁵

	Budget Year								Estimated	Proposed	Percent Change	
	1989-90	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	'89-'03	Proposed
General Fund	\$0	\$0	\$0	\$1,413	\$1,235	\$1,292	\$0	\$366	\$7,377	\$6,517	na	-11.7%
Perinatal Insurance Fund	\$42,776	\$40,255	\$39,914	\$37,499	\$51,710	\$57,234	\$64,003	\$81,358	\$97,631	\$99,532	128.2%	1.9%
Other	\$0	\$0	\$0	\$2,748	\$2,414	\$2,502	\$2,939	\$11,886	\$13,701	\$12,103	na	-11.7%
Total	\$42,776	\$40,255	\$39,914	\$41,660	\$55,359	\$61,028	\$66,942	\$93,610	\$118,709	\$118,152	177.5%	-0.5%
Adjusted Total	\$72,331	\$50,513	\$48,837	\$49,487	\$63,909	\$67,655	\$71,523	\$96,725	\$118,709	\$114,343	64.1%	-3.7%

Dollar amounts are in \$1,000s. Sources: Governor's Budgets. *Estimated by Children's Advocacy Institute. Adjusted to California population and deflator (2003-04=1.00). Adjustments by Children's Advocacy Institute.

TABLE 4-I. Access for Infants & Mothers

As Table 4-I indicates, a total of \$118.1 million is proposed for AIM in 2004–05. A total of 8,783 women and 160,880 infants are expected to enroll in AIM in 2004–05. The AIM program, benefitting politically from its quasi-private nature (involvement of private insurers), is one of the few programs not subject to any significant policy or budget adjustments. However, it exhibits a long list of problems, including regulations that:

- require written documentation of pregnancy (other programs allow self-reporting given the ability of most women to detect their own pregnancy);
- exclude women beyond the 30th week of pregnancy if their income rises to above the Medi-Cal limit (leaving them in limbo when facing expensive costs— including labor and delivery and during the 60-day post-partum period);
- exclude women who cannot demonstrate residency over the preceding six months;
- require women to pay 2% of their income after deductions, a cost ranging from \$478 to \$1,640, depending on the size of the family; and
- require AIM payments for twelve months even where coverage begins in the sixth month and only five months of coverage is provided.³²⁶

Because of its private connection, AIM will often not inform women that they qualify for less expensive Medi-Cal where their income drops to below 200% of the poverty line, and may report delinquent premium payments to credit reporting agencies, causing serious damage to family finances.³²⁷

Some advocates argue that AIM should be terminated and subsumed by either Healthy Families or the comprehensive coverage recommendation discussed below.

9. Healthy Start

The Department of Education's Healthy Start program 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, including education, health care, and social problems.

Each local Healthy Start initiative provides comprehensive school-integrated services and activities to meet the desired results identified for Healthy Start children, youth, and families. These services and activities may include academic/education (tutoring, mentoring, dropout prevention, adult education, and staff training); youth development services (tutoring, employment, community services, recreation, and sports); family support (child protection, parenting education, English as a second language, citizenship classes, child care, case management, child abuse prevention, and family advocacy); basic needs (supplemental food, nutrition education services, clothing, shelter/housing, transportation, and legal assistance); medical/health care (vision, hearing, dental, CHDP, acute care, preventive health care, and

health insurance); mental health care and counseling (therapy, support groups, and substance abuse prevention); and employment (career counseling, job placement, economic security, job preparation and development). Healthy Start does not necessarily pay for these services; rather, Healthy Start coordinates integrated service delivery which links children and families to needed supports and services.

	Budget Year								Estimated	Proposed	Percent Change	
	1991-92	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03			2003-04	2004-05
Total	\$20,000	\$34,664	\$49,000	\$49,000	\$49,000	\$49,000	\$1,000	\$2,000	\$2,000	\$0	- 90.0%	- 100.0%
Adjusted Total	\$52,166	\$51,328	\$69,084	\$65,482	\$61,871	\$58,373	\$1,118	\$2,093	\$2,000	\$0	- 96.2%	- 100.0%

Dollar amounts are in \$1,000s. Sources: Governor's Budgets.
Adjusted to K-12 Enrollment and CPI-Med (2003-04=1.00). Adjustments by Children's Advocacy Institute

TABLE 4-J. Healthy Start

As Table 4-J indicates, funding for this program has been minimal since 2001-02. Governor Schwarzenegger is proposing its elimination as of 2004-05.

10. Newborn Hearing Screens

The Newborn Hearing Screening Program establishes a comprehensive coordinated system of early identification and provision of appropriate services for infants with hearing loss by offering the parents of approximately 400,000 infants the opportunity to have their newborn babies screened for hearing loss at the time of the hospitalization for birth; tracking and monitoring of up to 25,000 infants to assure that appropriate follow-up testing and diagnostic evaluations are completed; providing access to medical treatment and other appropriate educational and support services; and providing coordinated care through collaboration with those agencies delivering early intervention services to infants and their families.

The incidence of permanent significant hearing loss is approximately 2-4 infants for every 1000; it is the most common congenital condition for which there is a screening program. The Newborn Hearing Screening Program identifies as many as 1,200 infants with hearing loss each year.

All CCS-approved hospitals offer hearing screenings to all newborns born in their hospitals and perform hearing screenings on all infants receiving care in a CCS-approved neonatal intensive care unit (NICU) prior to the infant's discharge. DHS assures the quality of the screening tests by certifying that the hospital's hearing screening program meets CCS standards. This certification allows the hospitals to be reimbursed by the state for Medi-Cal eligible infants.

The major focus of the program is to assure that every infant, who does not pass a hearing test, is linked quickly and efficiently with the appropriate diagnostic and treatment services and with the other intervention services needed for the best possible outcome. Recent research shows infants with hearing loss, who have appropriate diagnosis, treatment and early intervention services initiated before six months of age, are likely to develop normal language and communication skills.

11. Vision Screening

Vision screening, despite its significance to learning, is sometimes given through CHDP or EPSDT, both now weakened by reductions in progress. 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 assure consistent and adequate vision examinations. As with hearing and other early detection tests, 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.³²⁸

IV. Major Child Medical Coverage Failures

A. Healthy Families Creation Instead of Medi-Cal Expansion

When federal SCHIP funding became available in the late 1990s, 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 age 1–5, and children age 6–18, 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 former Governor Wilson and former Governor Davis contended 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.³²⁹

Experts have made other arguments in support of a Medi-Cal expansion: (1) expanding Medi-Cal allows more predictable and secure federal matching payments; (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.³³⁰

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 have allocated \$1.8 billion and taken as its goal the coverage of at least one-half of the then-uninsured population. The bill did not pass, but was a creative approach consistent with the recommendations of many health professionals when SCHIP was initially enacted.

B. Larger Fragmentation/Inefficiency

The inefficiency in current medical services for children is not confined to the separation between Medi-Cal and Healthy Families. The child health system suffers from a larger fragmentation, both within Medi-Cal and between it and other related programs. Child health qualification may occur through the following separate vehicles, each with its own standards:

- 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) (until recently, this provided up to 24 months of coverage after TANF aid or Section 1931 Medi-Cal ends—as a result of the 2003–04 budget act, only twelve months are available);
- 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), including children in two-parent families with too much family income for the children’s percent 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 per 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 other 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);
- California Children’s Services (CCS) providing medical services for the chronically ill;
- Early, Periodic Screening, Diagnosis and Treatment (EPSDT) as an adjunct to Medi-Cal;

- Specialized programs and treatment for various special needs populations (see Chapter 5).

Qualification for the programs listed above turns on the age of a child, income, condition of the child, and 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 health care programs.

Experts in the child health field³³¹ argue that the continuing pattern of separate, add-on programs creates red tape, bureaucratic excess, and fragmentation. The parental Healthy Families coverage expansion proposal adds additional complication, as many 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 1–5.³³² Parents are already confused about which program their children belong in, and lament the denial of unified family coverage in one system.³³³

The fragmented structure of child health care is mirrored in its public regulation and administration. While MRMIB administers Healthy Families, DHS runs Medi-Cal, with a separate unit overseeing hospitals and clinics. The new state Department of Managed Care regulates the HMOs. 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.

Each of the programs listed above was intended to serve children in need, and each may have achieved an incremental gain. However, when the entire system is viewed together, it presents a fragmented edifice of confusion and gratuitous cost. The system has left over one million children uncovered even though two-thirds of them qualify for coverage. The number of uninsured are likely to rise, while the state continues to lose billions in federal matching funds. As proposed below, these funds could be used to provide universal coverage for eligible children as intended by Congress.

C. Safety Net Infrastructure Endangerment

The current irrational system of health coverage requires a basic safety net system centered in hospital emergency rooms and local clinics to treat children (and others) who lack assured coverage. Such treatment may mean the difference between a minor antibiotic expense and the loss of a child. State and local public officials are aware of state law's command to the counties to provide basic health care for the indigent. In order to pay for these largely uncompensated costs, hospitals, clinics and physicians engage in a cross-subsidy from sources who do pay. Survival of the infrastructure to perform this cross-subsidy depends upon four factors: (1) direct compensation (largely from federal Medicaid monies) based on the number of Medi-Cal and/or charity patients treated at a loss; (2) sufficient numbers of paying patients to assure economy-of-scale efficiency of operation and finance cross-subsidy help for those unable to pay; (3) adequate levels of Medi-Cal compensation to cover at least out-of-pocket (direct) costs of treatment; and (4) adequate private insurance compensation participation to finance fixed costs (plant and equipment). All four of these elements are either in collapse or threatened, and are discussed below.

1. The Loss of Cross-Subsidy Sources

Any institution or provider that accepts a disproportionate share of charity or Medi-Cal patients only meeting direct costs of treatment suffers a loss that may be both inequitable and debilitate proper care. Accordingly, the federal government has a system of payment to such institutions drawn primarily from Medicaid monies and it is appropriately called "Disproportionate Share Hospital" (DSH) payments. A large portion of these DSH payments comes from federal Medicaid dollars.

The federal Balanced Budget Act of 1997 (discussed above) reduced Medicaid DSH payments to the states by 20%.³³⁴ California's share was cut by more than 20%, with current payments \$264 million less

than pre-1997 adjusted levels. In year 2000, about 60% of the 1997 cuts were restored. Then on October 1, 2002, the state lost \$184 million in DSH funds, with experts in the field expressing worry about the long-term effect of such reductions given reliance on their cross-subsidy impact.³³⁵

The 2002–03 budget added an extraordinary \$55 million to the state’s already generous \$31 million “administrative fee” for DSH oversight. This sum is subtracted from the DSH monies given to hospitals for their indigent expense.³³⁶ 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. Meanwhile, a study published in 2002 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.³³⁷

On February 10, 2003, Secretary for Health and Human Services Tommy Thompson announced a federal extension of the contractor program waiver for Medi-Cal through calendar 2004. The decision could direct substantial additional Medicaid funds to California hospitals under what is termed the Selective Provider Contractor Program (SPCP), which directs the funds as per the DSH payments discussed above. However, the amounts are less than current budgetary shortfalls. Most important, their prospects of continuation at current levels after 2004 are problematical given the looming federal budget deficit.

Three other smaller sources of cross-subsidy exist. First, 1988's Proposition 99 assessed a tax of \$0.25 per pack on cigarette products to fund specified programs, including the California Healthcare for Indigents Program, reflecting the statutory obligation imposed by the state on counties to provide minimal medical care for the indigent. Since 1989, however, smoking has declined, and Proposition 99 funds have declined 44%—from \$573 million received in 1989–90 to an estimated \$321 million in 2004–05. Governor Schwarzenegger proposes to reduce CHIP funding by \$5.9 million in 2004–05, thus reducing allocations to all 24 participating counties. Under this proposal, fewer outpatient services will be provided, and treatment services to children under CHDP will be diminished.

Second, a DHS program called Expanded Access to Primary Care seeks to improve the quality of health care and expand access to primary and preventive health care to medically underserved areas and populations. Beneficiaries are those persons at or below 200% of the federal poverty level who do not have any third-party health or dental coverage. Current law provides for reimbursement to certain primary care clinics for the delivery of expanded outpatient medical services. These include preventive health care, smoking prevention and cessation, health education, health assessments, and treatment and referral services for children that qualify for CHDP services. For the current 2003–04 fiscal year, DHS has awarded \$30 million to over 150 clinics and health care providers.

Third, whatever their theoretical obligation, counties cannot be relied upon as payors of last resort given recent development. Their property tax revenue base has been constricted by Proposition 13 assessment limitations for 25 years—limitations separate and apart from its one percent ceiling on the taxation of real property. The counties lost substantial monies in the last fiscal crisis of 1991, when substantial state obligations were devolved locally in return for the assignment of Vehicle License Fee and a small sales tax allocation. As the discussion of current county budget cuts below suggests, California counties are no longer viable sources of safety net reliance.

The problem is exacerbated by the growth in cross-subsidy needed as Medi-Cal compensation declines. California ranks 49th in compensation rates, and 50th in amount per beneficiary. Hospitals that contract to provide in-patient services have received virtually no increase in base rates for over ten years. Outpatient rates have been substantially frozen for 14 years and providers contend that they now provide 43% of the actual cost of the services provided.³³⁸ The medical cost inflator has risen 88% since 1990 while basic Medi-Cal hospital compensation has increased less than 10% over that period.³³⁹ The public hospitals report that their costs increased at a somewhat higher rate, 53.6% between 1995 and 2001.³⁴⁰

2. The Subtraction of Patients from Facilities—Economy of Scale Loss

Quite apart from the amount of cross-subsidy assistance to below-cost medical providers, is the amount of business they are able to sustain from those who are able to pay. The fear is that signing up most children into Healthy Families or Medi-Cal, and then confining both of those programs to one or two managed care systems will leave those not in those systems without business. That is, a clinic treating 350 “charity” patients a week and with no compensation may receive some direct subsidy as described above, but still counts on its population of 1,000 privately or publicly covered patients to provide additional cross-subsidy and pay the fixed costs of the plant and equipment. What happens when a clinic is not included in a provider group of the only managed care plans operating and most children are diverted to different providers? Those without coverage—about one million children likely to grow to close to two million over the next three years—depend upon the existing cross-subsidy. If the 1,000 patients providing that small surplus becomes 700, and the clinic loses economy-of-scale efficiency, how will treatment be financed for the 350 “charity patients,” who may increase to 500 or more as projected by many?

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. But this has not been the uniform pattern at all. Indeed, as discussed below, outright closure of clinics relied upon by the remaining uncovered population has become common. In other words, although the number of uncovered children has been almost halved, that change has spawned a managed care structure increasingly concentrated—only a few enterprises now choose who is in as a provider for those who are covered and those who are out. If a clinic or hospital or physician group is “out” and its patients have been taken for exclusive treatment by a favored collection of providers, the fate of those who are not chosen may be problematical. Indeed, large numbers of clinics and other facilities are now subject to direct closure due to local budget crises at the county level and discussed below. Where is the infrastructure to serve those who remain without coverage and who are not chosen by the managed care decisionmakers? Child advocates argue that if the infrastructure is destroyed without assured universal coverage and without a substitute, we shall have created the worst of all possible worlds. We shall have started with a promise of coverage, not kept it, but harmed the vestiges of care available to the few uncovered, and then relegated a large number of the newly-covered back into the old system. The data, budgets, and current policies indicate that is where California is headed.

3. Accounts Particularly Relevant to Infrastructure Maintenance

a. County Health Services Branch

Welfare and Institutions Code section 17000 designates counties as the providers of last resort for those otherwise lacking access to care. DHS' Office of County Health Services (OCHS) supports the provision of indigent care, environmental health, and other public health services by local health departments. Funding for providing both inpatient and outpatient medical services to low-income persons not eligible for Medi-Cal, or medically indigent adults, in the 34 small, rural counties is provided through the County Medical Services Program, in addition to the Rural Health Services Program, and the Hospital Services and Physician Services contract back programs. Financial support for indigent medical services for children and adults in the 24 large counties is provided through the California Healthcare for Indigents Program (discussed above). Reimbursements for medical treatment of conditions identified in health screens performed through local Child Health and Disability Prevention programs are made through the OCHS' Children's Treatment Program. In addition, the Medically Indigent Care Reporting System is maintained by the OCHS to improve the availability of and accessibility to data and information on California's medically indigent populations.

In 1983, the state shifted Medically Indigent Adult (MIA) 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.

The 1991 state-to-county “realignment” further 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.³⁴¹ 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.³⁴²

In 1991, the statutory depreciation schedule used to determine the VLF was changed to reflect the fact that vehicles retained value longer. The increased revenues from this change were transferred to the new Local Revenue Fund for local health and mental health programs as part of the realignment of state and local program responsibilities. However, the 1991 realignment legislation included “poison pill” language, specifying that if any county successfully sues the state over operations of social welfare programs, the higher depreciation schedule would be repealed, and the lower depreciation schedule would go into effect, thus, funding for realignment programs would be lost.³⁴³

In September 2003, the Fourth District Court of Appeals did in fact rule against the state in a Medically Indigent Adult (MIA) case brought by the County of San Diego. Specifically, the court found that the County expended funds for MIA activities in excess of the amounts provided by the state, and thus the program constitutes a reimbursable mandate; accordingly, the court ordered the state to reimburse San Diego County \$3.5 million.³⁴⁴ This holding against the state thus triggered the “poison pill” provision, and the state started withholding these funds on March 1, 2004. Since then, the state has withheld \$92 million in vehicle license fees from counties.³⁴⁵ However, AB 1457 (Assembly Budget Committee), which is pending on the Senate floor at this writing, would eliminate the poison pill provisions of the 1991 realignment, thus retaining the current programmatic structure of the realigned programs, as well as their sources of funding, including the current vehicle depreciation schedule.³⁴⁶

Since realignment, the main source of County Health Services funding remaining in the state budget has been Proposition 99 tobacco tax revenue, which fell until 1993–94, leveled somewhat between 1995–98, and has now fallen precipitously since 1998. The picture would be even bleaker had more Proposition 99 funds not recently been re-directed to County Health Services: \$25 million in 2000–01 and 2001–02,³⁴⁷ included in Table 4-K. These re-directed Proposition 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 County Health Services.

	Budget Year							Estimated	Proposed	Percent Change	
	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03			2003-04	2004-05
County Health Services Total	\$199,217	\$204,195	\$190,479	\$89,081	\$126,143	\$114,963	\$88,944	\$56,512	\$51,810	-71.6%	-8.3%
Adjusted Total	\$249,984	\$249,846	\$226,265	\$102,839	\$139,841	\$122,830	\$91,903	\$56,512	\$50,140	-77.4%	-11.3%

Dollar amounts are in \$1,000s. Adjusted to California population and deflator (2003–04=1.00)
Sources: Governor’s Budgets. Adjustments by Children’s Advocacy Institute.

TABLE 4-K. County Health Services

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.³⁴⁸ 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.

The various accounts able to provide underlying support are in jeopardy even without continuing reductions in this account. The reduction in Disproportionate Share Hospital funds and low funding for Expanded Access to Primary Care combine with other county financial shortfalls and a lack of local revenue-generating capacity. The prospects for the future are problematical given the extra federal DSH and Medicaid monies due to terminate after 2004 and with a growing federal deficit impeding their renewal.

b. Primary and Rural Health Care Systems

DHS' Primary and Rural Health Care Systems Branch seeks to improve the health status of special, targeted population groups living in medically underserved urban and rural areas of California. The principal objective of the PRHCS Branch is to improve and make more accessible comprehensive primary and preventive health care services and other public health services for at-risk persons, including the medically uninsured or indigent, and those who would otherwise have either limited or no access to services due to cultural or language barriers. 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.

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. These providers 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).

In March 2004, Secretary of Health and Human Services Tommy Thompson granted a waiver to allow California to use some funds intended for Healthy Families administration to supplement rural health services, including the treatment of children in rural areas. The initiative is designed to improve access to health care for 73,000 medically underserved and uninsured children in rural areas. According to the release, HHS approved a similar project in 1999, but the state ended it last year due to budget concerns.³⁴⁹ Although the state's implementation of this initiative will be beneficial to children, it remains to be seen whether the funding and implementation of the waiver will take place on a date certain, similar to the problems the state is facing with the implementation of the Healthy Families parental extension.

At the same time, the Governor has proposed in his 2004–05 budget to change the rate methodology for community-based clinics (specifically Federally Qualified Health Centers and Rural Health Centers), resulting in lower reimbursement rates for general fund savings of \$72.6 million—offering yet another set back to these struggling clinics and providers.

4. Evidence of Infrastructure Loss for Uninsured Poor

Health experts have been particularly concerned about the impact of managed care on the state's infrastructure of clinics, which provide 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.³⁵⁰ The survey found the clinics to be financially viable and 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. 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 organizations delay payment for 60–90 days. 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.³⁵¹ 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.³⁵²

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).³⁵³ 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.³⁵⁴ 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.³⁵⁵

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. Governor Schwarzenegger has proposed increased spending of \$6 million in federal funds in 2004–05 on the continued development and implementation of regional plans to improve the capacity of hospitals for responding to situations requiring mass immunization, treatment, isolation and quarantine in the event of infectious disease outbreaks or bioterrorism.

5. County Closures and Retraction of Health Facilities

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 believed would "lead to virtually dismantling the public health care system"³⁵⁶ 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 can tax on a limited basis and only with difficulty, particularly given Proposition 13 limitations.

The multi-phase closure plan includes 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, 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; or (d) closure of all clinics while maintaining all emergency rooms, with public medical services confined to emergency care (trauma care and similar vital services).

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 Los Angeles County 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.

On August 22, 2002, Los Angeles County announced substantial cutbacks in basic immunizations for children. The Board of Supervisors approved cuts of up to 84,000 or 97,000 annual child immunization visits. Public health immunization clinics will cut hours of operation, appointments, and numbers of children immunized.³⁵⁷ The reductions were implemented in the month before the school year is to begin. Complicating matters further, many students lack private health insurance, are uncovered publicly, and must have immunization proof in order to register for school at the age of five.

The County has temporarily suspended additional closures, but has a proposal before it to close inpatient facilities at Harbor-UCLA Medical Center (one of the most important providers of care in the region), and may similarly close Olive View. Also remaining on the table are the privatizing of Rancho Los Amigos Medical Center and the closing of almost 100 private outpatient clinics under County contract. Those changes would save an estimated \$259 million.

In November 2002, the electorate approved a Los Angeles County bond measure to raise property taxes for some additional funds for county trauma care centers and emergency rooms. The measure authorizes 3 cents per square foot of structural improvements excluding parking. It amounts to \$43 per year for an average home. The new revenue is expected to generate \$168 million per year.

On February 10, 2003, then-Governor Davis announced that the state would provide \$100 million beyond the \$150 million available to the County from federal extension of its waiver through 2004. This \$250 million is important for this troubled system, but federal bail-out assistance (started in 1995 and renewed in year 2000) will expire in 2005 with further extensions unlikely.

On February 12, 2003, the Los Angeles Board of Supervisors voted to ask the Legislature to authorize the county to impose a five-cent tax on poured alcoholic beverages to raise revenue for the health care system. Sponsored by Supervisor Gloria Molina, the measure would raise as much as \$250 million per year. Molina argues that such a tax is warranted by the high incidence of alcohol-related injuries and illness at trauma centers.

As of 2004, Los Angeles County is estimating that its health services budget will have a positive balance in 2003–04 through 2005–06, but will incur shortfalls beginning in 2006–07 that will grow to \$655 million by the end of 2007–08.³⁵⁸

On May 28, 2003, the Senate Office of Research released a report finding that allegedly inadequate compensation rates for ER physicians were causing refusals to answer calls and creating long delays in treatment. The report cites inadequate Medi-Cal rates as a major precipitating cause.³⁵⁹ The report notes that patients are shuffled from hospital to hospital until a specialist relevant to the emergency can be found. The most serious shortfall in Medi-Cal rates and supply affect specialists treating children (see discussion of compensation cut-backs below).

The problems in Los Angeles are extreme due to its high population of uncovered persons dependent upon the safety net system of clinics and emergency rooms. But similar shortages are occurring across California as many counties face budget shortfalls and lower state assistance. For example, Ventura County announced plans to cut staff and hours at 23 outpatient clinics serving impoverished populations, predicting that 62,000 persons would be denied treatment under proposed plans.³⁶⁰ On June 11, 2003, Orange County announced its closure of eight community health clinics and other services due to its budget shortfall. The closures include the county-administered health clinics providing free child immunizations, prenatal care, and preventive care for low-income children. The cutbacks also include a county program that sends nurses to the homes of newborns with health problems to assure their adequate treatment.³⁶¹

On May 6, 2003, the California Association of Public Hospitals and Health Systems issued an alarming report predicting an imminent budget deficit of \$3 billion over the next five years. Unlike governmental entities, these hospitals are not in position to borrow or to tax, but must deny medical services well beyond the cuts discussed above and on an unprecedented scale. The report found that these public hospitals absorb 55% of the cost of treating uncovered persons, including the one million currently uninsured children.³⁶²

D. Healthy Families Premiums/Co-Payments Barrier

California's Healthy Families legislation includes substantial premiums to be paid by relatively low income parents for child coverage, in addition to expected co-payments where services are provided. The Healthy Families premium is between \$4 and \$9 for each child, and up to a maximum amount of \$27 per month for all children in the family. Healthy Family members also pay a co-payment (usually \$5) for most services. Co-payments are usually required for visits to the doctor, for prescription drugs, for emergency services, and for other services. Some services are free. Free services include immunizations and other preventive care. In each year (July 1 to June 30), the most a family has to pay in co-payments is \$250. If a family fails to make its premium payments for two consecutive months, the child(ren) will be disenrolled. If a child is disenrolled for non-payment, the coverage will end at the end of the second consecutive month for which a premium payment was not made.³⁶³

For parents, under the modified expansion proposal (unimplemented due to lack of funding), 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.³⁶⁴

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 co-payments would be \$5 per service for health, mental health and vision, with a \$250 annual cap. However, dental co-payments would remain at the state employee level,³⁶⁵ 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,³⁶⁶ particularly when they are expected absent any current symptoms of ill health. As Chapter 2 indicates, the Healthy Families' premiums 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. MRMI data shows 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.³⁶⁷ Many are concerned that the current premiums contribute to these disenrollment rates. The Governor's proposal for even higher premiums for children in families with incomes between 201% and 250% of the federal poverty level will put the Healthy Families program further out of reach for many.

E. Outreach to Enroll Children in Medi-Cal and Healthy Families

Medi-Cal enrollment is essentially a task of retention facilitated by automatic transitional coverage, paperwork reduction, and qualification liberality as to the right to own a vehicle and other limitations discussed above. Healthy Families coverage for those above the poverty line requires aggressive outreach, particularly given the premiums required. As discussed above, substantial new enrollments have been achieved, albeit with some countervailing loss of Medi-Cal enrollments unretained.

Former Governor Davis' 2001–02 budget allocated \$69.2 million to Healthy Families outreach through DHS, but then reduced the amount to \$49.6 million. The 2002–03 budget appropriated \$28.9 million and ended up expending \$10.3 million. The result eliminated the system of enrollee sign-up assistants (independent contractors paid \$50 per enrollee) and eliminated the toll free number. The contractors had been the source of more than 60% of new children covered. As listed above, the retractions in both Healthy Families and Medi-Cal outreach are significant—with all Healthy Families media advertising eliminated and funding for outreach substantially cut.

On November 20, 2002, the University of California at San Diego and the San Diego Children's Hospital released a major study of 6,000 families enrolled in Healthy Families. Compared to a control group, those enrolled measurably and substantially gained in physical and psycho-social health, experienced fewer sick days and missed less school, dramatically improved in ability to pay attention in class and to keep up, and unsurprisingly encountered "fewer difficulties" in accessing medical care.³⁶⁸ The day the report was released, then-Governor Davis issued a press release claiming credit for the program's success, accurately recounting his support for simplified applications in 11 languages, and extending eligibility to recent legal immigrants and up to 250% of the poverty line. In his press release, Davis repeated the UC San Diego study major conclusions and stated: "These findings demonstrate that Healthy Families has a tremendous impact on the quality of life among children with the greatest health care needs...." ³⁶⁹ Five months later, Davis' May 2003 Revisé proposed the cessation of almost all outreach spending and made other decisions likely to deplete Healthy Families enrollment substantially (see discussion of "Retention" below).

F. Retention of Children in Coverage

In August 2002, the Rand think-tank released a study on health insurance coverage for former welfare recipients, finding: (1) 25% of those leaving welfare are now without health insurance, and 20% of their children are uncovered, although virtually all are eligible (the number of uninsured children among the 800,000 leaving TANF rolls translates to 160,000 subtracted from coverage); (2) of the 80% who have retained coverage, most have re-enrolled in Medi-Cal, only 20% are covered through employer health plans; and (3) keeping families connected to Medi-Cal has important implications for access to care and for county budgets (former welfare recipients who are uninsured are 50% more likely to receive care in a hospital emergency room, outpatient department, or clinic).³⁷⁰

The Office of Management and Budget predicts a general 21% decline in SCHIP state enrollments from 2003 to 2006.³⁷¹ The California predicted reduction is reasonably greater given outreach withdrawal and difficult premium burdens in a high cost-of-living state.

The 100% Campaign report entitled "Children Falling Through the Cracks," released on January 20, 2003 underlined the RAND disenrollment finding and the OMB retention national estimate. The 100% Campaign, a foundation-supported effort to enroll eligible children led by Children Now, the Children's

Defense Fund, and the Children's Partnership, concluded that 40% of children enrolled in Healthy Families lose their coverage after one year, and 36% of Medi-Cal children lose coverage over a similar period. This retention loss covers a broader population than the welfare leavers examined by RAND. The report concludes that retention requires a continuing effort to re-enroll year after year. The authors observe that "a significant number...lose coverage unnecessarily."³⁷² The report identifies three leading causes of retention failure, consistent with other evidence discussed above: (1) switching from Medi-Cal to Healthy Families; (2) complex paperwork for annual renewals; and (3) difficulty in paying premiums (for Healthy Families).

The April 2003 mid-year budget change from annual to biannual Medi-Cal renewal will further lower retention rates. A sixty-day delay in premium payments—here imposed on persons well below the "self-sufficiency" levels discussed in Chapter 2—results in disenrollment of involved children for a minimum of 6 months.³⁷³ Consistent with the RAND analysis, the Children Now/Partnership Report associates coverage with service delivery—children are signed up at the emergency room after the illness has reached an advanced stage. The percentage lapse estimates of the Report translate to 1 million Medi-Cal and 171,000 Healthy Families children possibly joining the one million income-qualified children now lacking coverage. The question presented: How many of these not-retained 2.2 million qualified children who will need to be enrolled or re-enrolled will be covered during fiscal 2003–04 and thereafter? Such coverage will have to be accomplished via a token express lane effort, virtually no outreach or incentive payments, and continued premium demands, as discussed above.

We estimate that the number of uncovered children will rise to over 1.5 million by the end of fiscal 2003–04 and that by the end of the subsequent 2004–05 fiscal year it will surpass 2 million—levels extant two years before the Congress enacted SCHIP.

G. Federal Money Foregone Projection: \$5 Billion

The two major streams of federal monies for child coverage are SCHIP (Healthy Families) at a 2–1 federal match, and Medicaid (Medi-Cal) at a 50/50 match.

1. SCHIP Monies Lost: \$3 Billion

Initially, the total amount to be provided to California for child health coverage expansion under SCHIP was \$859 million per year through calendar year 2003.³⁷⁴ According to the California Health and Human Services Agency, the amounts actually appropriated were \$855, \$851, and \$766 million for 1998, 1999, and 2000, respectively.³⁷⁵ 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 spending a year, with the required state match at \$162 million of this total and the federal draw-down at \$323 million. Actual numbers of children eligible under the more liberal 250% of the poverty line could raise the total to \$675 million and the federal portion draw-down to \$450 million. Remaining monies above this amount could be used for parental coverage, or for tax credits to reduce "crowd out" (employers abandoning coverage), discussed below.

Since that time, the annual SCHIP allotment for California after 2000 has been reduced as some of the larger states (especially California) have failed to spend the funds offered. Accordingly, the appropriation was reduced to \$736 million for 2001, and set at \$542 million a year for each year from 2002 through 2004, and \$697 million a year in 2005 and 2006; these amounts are in place of the nearly \$860 million a year initially anticipated under SCHIP—already a casualty of the failure to arrange universal child coverage as Congressionally intended, together with some incentive to employers to maintain their dependent coverage. 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. The number of children covered through Healthy Families increased from 50,000 to 362,373 children as of January 8, 2001, followed by a gradual increase to 574,000 in June 2002, and to 624,000 by June 2003.³⁷⁶

To summarize, the total federal allocation for the period of 1998–2006 is \$6.4 billion. 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 \$706 million in unspent federal funds for those two years), \$250 million for 2000, and \$740 million for 2001. The 2002 and 2003 givebacks are likely to be larger given the rollover amount of \$1.9 billion. Even if the Congress extends the three-year carryover period to five or six years, the state’s use of funds will remain below amounts appropriated year to year.³⁷⁷ The accumulated amount lost to date is \$1.7 billion. Importantly, outreach spending has been reduced to token amounts, further large child enrollment growth is unlikely, with retraction prudently predicted, and parental coverage has remained unfunded. Under current policies, the total returned from 1998–2006 will exceed \$3 billion—about one-half of the funds proffered.

2. Medicaid Monies Lost: \$2 Billion

In addition to the loss of 2–1 matched federal SCHIP funds for Healthy Families, the state also loses its 50/50 match for Medicaid, with children the largest single recipient group. The 300,000–700,000 children disenrolled between 1998–2006 will add another \$2 billion in lost federal funds.³⁷⁸

3. Federal Funds To Be Lost for Child Medical Coverage 1998-2006: \$5 Billion

The state’s persistence in maintaining an exclusionary system of barriers to child coverage will cost the state \$5 billion in Medicaid and SCHIP federal funds foregone. These estimates are conservative, and if our estimated projection of retention failure and disenrollment growth are correct, the total could exceed \$7 billion. The lower estimate of unclaimed federal funds—although the state’s recipients have been and remain fully qualified—represents an amount unprecedented in American history. The state’s policy of non-coverage contrasts markedly with the Medicare system serving senior citizens. Medicare operates under a philosophy of inclusion, and is funded by federal funds at a level five times the per capita cost of child coverage. That funding now comes from payroll taxes disproportionately paid by the working poor and lower middle class—the very group with over one million qualified children in the state lacking coverage, and with hundreds of thousands more to join them over the next three years.

H. The Alternative to Failure: Child Coverage and “Crowd Out” Prevention

1. Traditional Approaches and Recent Reforms

The state’s approach toward low income public child health coverage has reflected the traditional view of a “welfare benefit,” strictly limited to those clearly eligible. The implicit assumption is that health care for children is not a right, nor even a public investment yielding a return, but a benefit sought by those who are not fully qualified or in-need. Lawmakers and state officials presume applicants seek a private gain and, unless carefully screened and limited, will obtain value at public cost. Advocates argue that child coverage 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). Advocates cite its public/social benefits as 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, and all of her children under 200% of the poverty line. Finally, child advocates argue that beyond statutory intent, the current “don’t let anyone in unless” mentality is inequitable in a country 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.³⁷⁹ Their recommendations seek to incrementally remove barriers within the current structure. Hence, they involve measures such as relaxation of qualification criteria, presumptive eligibility or “express lane” for those children receiving benefits from other means-tested programs (to piggyback on the paperwork of another program which implies qualification), automatic continuation (transitional benefits) for some period of time after leaving welfare or other programs conferring coverage, or the creation of new categories of coverage.

As discussed above, measures undertaken from 1999 to date are intended to facilitate retention of eligible Medi-Cal child enrollees, and to expand Healthy Families enrollment further.³⁸⁰ These efforts are now in abeyance or disarray, and other suggested enrollment enhancements have not been implemented.³⁸¹ But even if prior efforts are restored and some of the new suggestions followed, the basic incremental approach of pre-qualification has gratuitous barriers, which is not appropriate where the outcome is blocking public health and medical treatment for children. On the other hand, the relatively small percentage of children who are uncovered and ineligible for coverage warrants a system of inclusion, rather than one of exclusion that relies on overcoming barriers child by child.

As the percentage of children uncovered and ineligible for public coverage declines to below 6% of the children in the state, the inefficiency of a “separate program” enrollment approach becomes more apparent. The alternative of “true presumptive eligibility”³⁸² for all children remains curiously undiscussed among public officials or in the media. Such an approach treats all children as covered for public health and treatment purposes, and then assesses parents where children incur substantial expense *post hoc* on a sliding scale based on income. Such presumptive coverage becomes more compelling as those uncovered and ineligible for public coverage decline in number. As those who may receive such services diminish to 30%, then to 20%, 10% and now to below 6%, the rationale for an extensive system of barriers and qualification fails. Such a shift transforms the current “out unless previously certified as in” to “in—with costs later assessed where incurred.” Those costs will only have to be collected in the small number of cases where substantial treatment is provided and ability to pay combine—a small fraction of the population now required to navigate pre-coverage barriers. The factors making such presumptive coverage advantageous include: (1) the inexpensive per capita cost of insuring children (about one-fifth the expense of older adults); (2) the lack of abusive motivations (e.g., cash gain as with TANF or SSI); (3) efficiency enhancement from the removal of costly pre-qualification; (4) the preventive benefits from broad child public health coverage; and (5) the availability of \$697 million in annual federal Healthy Family funds (plus accrued carryover money unexpended from previous years) requiring only a one-third state match and another \$350 million in annual federal Medicaid monies lost at a 50/50 match.³⁸³

As discussed above, the state's response to its embarrassment over its return of federal funds has been to consider coverage of parents to capture more money. The persistent path here is to increase coverage through more outreach, money incentives to enroll children, use of social service programs, the recruitment of non-profits and the state's social service establishment, forms, entry procedures, all funneled into and through Medi-Cal, Healthy Families or one of the 15 sub-part or separate programs, each with different qualifying rules. Children qualify for one program and leave another based on age, income, and disability—sometimes within single families, and each changing over time. At least for the Healthy Families program largely relied upon for coverage expansion, most parents living near the poverty line are required to pay (what for them are substantial) premiums to enroll their children. This approach is in marked contrast to Medicare for senior citizens who are the major beneficiaries of a “presumptive eligibility” policy, and whose costs are now borne by substantial payroll taxes cross subsidizing from young to old.

2. From Barriers to “Inclusion with Assessment”

Some child advocates support a replacement of the “you're out unless in” approach with the following: **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, and qualification. As discussed above, Medi-Cal already covers those living below the poverty line, and Healthy Families covers those up to 200% of the poverty line—and up to 250% of the line for some groups of children. Most children in middle class to wealthy families are covered privately through a parent's employment plan. Very few children living in families above 300% of the poverty line are uncovered privately. Public coverage to the 300% mark would leave only 4%–6% of the state's children uncovered (publicly or privately). The state's complex system of 15 separate programs—each with separate qualification and each involving application, documentation, review, entry decision, appeal, reporting, and renewal—rests on the stated need to exclude the uncovered/unqualified. Where the state has decided to cover impoverished immigrants (as effectively happens through emergency room inefficiencies), the percentage of California children to be assessed based on parental income is less than 2% of the population, and would then only apply to those in that group using substantial medical services

making a parental assessment appropriate.

All public health programs, screening via EPSDT or CHDP, Medi-Cal, Healthy Families, and the other programs listed above would be merged into one efficient program. The public health, immunization, assignment of primary care physicians, examinations, *et al* would be provided to all. 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%–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.

The demographics above commend a burden shift toward universal provision of basic public health coverage for all children, including immunization, screening for vision and hearing, lead contamination prevention, dental and basic coverage. Such an approach provides the benefits of universal coverage for society; and eliminates the “prior restraint” regime of qualification, evidence, enrollment, tracking, and enforcement. It would be financed by existing federal Medicaid (Medi-Cal) and SCHIP (Healthy Families) appropriations and its own efficiencies.

The proposed universal coverage would not expend all of the federal funds available, particularly given the significant administrative savings it would entail. Accordingly, other funds may be used to address “crowd out.”

3. 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.³⁸⁴ The fear is that 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. Further, recent premium increases, including a 13% rise in 2002, may stimulate private coverage abandonment or deferral to a public system.

Two alternatives may address crowd out. The first is the assessment of a small fee from employers who fail to provide medical coverage for worker dependents. Such an assessment is equitable, in that it addresses the “free ride” many employers are able to fashion. Those who provide or help with coverage suffer a competitive disadvantage vis-a-vis those who pay employees below the 200% of the poverty line and rely on taxpayer subsidy to provide those benefits. The concept is not unlike the system for auto insurance requiring contribution for default coverage availability. And the rationale is similar—the societal advantage in securing universal coverage. Current legislation to impose a fee on employers who avoid employee coverage is now facing an initiative challenge from business interests.

A second technique to combat such “free ride” “crowd out” is to use the carrot of a tax credit to benefit those who do provide such dependency coverage for employees earning below 250% of the poverty line. Ideally, a combination of the two may be utilized, where a small fee is collected from those who fail to provide coverage to finance the tax credit enjoyed by those who provide such coverage.

Some 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-third the cost expended by an employer on dependency health coverage at fair market rates for employees who earn below 250% of the line, the inducement to cut those dependents from private coverage would be suppressed.

Such an approach substitutes the carrot for the current slender stick. 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 billion³⁸⁵ per year, representing about 4% of current tax expenditures (special credits/deductions) made annually. The exact credit percentage could be adjusted to a level sufficient to provide an incentive to retain private dependent coverage.

A targeted tax credit (however denominated legally for SCHIP qualification purposes) could be financed with full use of federally available child health care funds, the considerable administrative savings a single system and automatic eligibility would entail, and some percentage of the tobacco settlement proceeds if not sacrificed for general fund relief. 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 are put in place. That is, if parents earning less than 200% of the poverty line can receive Healthy Families coverage at no cost to an employer, many will seek that subsidy for their employees—and the termination of their own contribution. And inclusion of parents is more of a private “crowd-out” enticement than is public coverage of children given the lower private cost of the latter.

Child coverage was the explicit promise of the SCHIP statute, one of the few major public financial commitments made to children over the last two decades—particularly given the marginal increases in federal education investment discussed in Chapter 7. While making and recently enhancing markedly our medical coverage commitment to the elderly, we have not done so for our children. All of the elderly are presumptively covered even though they have less than half the poverty rate of children, are more able to fend for themselves, and require more than five times the per person capital amount to cover.

V. SUMMARY AND RECOMMENDATIONS

A. Commentary

Impoverished children have suffered substantial safety net cuts over the past decade—moving from 89% of the federal poverty line to 74% over the past nine years, and now proposed for a record low 70% for 2004–05. Over that same period, over 800,000 children have left TANF (and Food Stamp) rolls. Some of that reduction 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 losing Medi-Cal coverage for their children. They are not all 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 (although not all) 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 has begun to hit children during 2003–04, with particular force expected after 2004 as sixty-month lifetime limits are reached for hundreds of thousands of children. 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.

Child advocates cite the marked contrast in subsidies for the elderly, which are provided universally and at more than five times the per person cost for children. They contend that federal funds are available at a 2–1 basis to cover more than one million of California’s children eligible for medical coverage.³⁸⁶

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, this mentality does not logically apply to medical care for children. 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, premium demands, 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 decided to spend the available money on parents, and then withdrew that expansion. 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. Universal child coverage is not only realistic, its absence given the small numbers unqualified and the gratuitous maize created for its provision deprives one million children of coverage, a number likely to grow to 2 million by 2006, as discussed above. And the final tragedy and mark of official incompetence, is the return of \$5 billion to the federal treasury projected through 2006—the largest give-back of funds by a state in the nation’s history—most of it offered at a 2–1 match basis.

Funds are available to easily cover all children with very small additional state general funds required. The state has enacted \$9 billion in tax and fee cuts since 1996 and has now \$30 billion in tax expenditures (deductions and credits)—all subtracting from the general fund monies relied upon for child health care. Such care, unlike Medicare for the elderly, does not benefit from a large payroll tax contribution assessed upon all who work. The commitment of modest general fund amounts, just 10% of the federal tax savings from 2001 and 2003 reductions accruing to California adults provide the needed match to capture federal monies, end fragmentation and ancillary cost and provide universal child coverage.

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 fifteen separate programs from a fragmented regulatory structure of six uncoordinated agencies. The approach of California is not optimum. It is the familiar pattern of individual sign-ups, with \$150–\$350 in premiums—which will jump much higher if the one proposal to add parents to Healthy Families is enacted, or if the Governor’s idea of much higher premiums is approved—from families barely able to pay the 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 that 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 may now be partially 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 and family income.

Finally, recent budgets have reduced accounts and reneged 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 and eight other major counties with *in extremis* measures approved—and further retraction 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 extraordinary wealth.

B. California Children's Budget Major 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 assess the parents a percentage of the cost on an income-based sliding scale. Estimated Cost: \$1.8 billion: \$300 million general fund, \$300 million efficiency savings, 1.2 billion in federal 2–1 matching funds.

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 over one million children to “emergency care”—endangers children, misallocates resources, and costs more. Indeed, the current system puts the parents of uncovered children in an untenable position. For medical billing of the uncovered is at two to four times the rates charged to HMOs or the state negotiating prices with bargaining power. Hence, such working parents must often choose to seek treatment for a child knowing that even a short hospital stay will mean ruinous billing by a hospital of any remaining assets, whether for child higher education or their own retirement. All children, especially those in families under 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 and impose modest 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 *California Children's Budget* proposes the creation of a fund to provide comprehensive coverage

for children. Revenue is readily available from four sources: (1) existing Medi-Cal funding; (2) full use of Healthy Families funds; (3) use of special funds and general fund savings from significant efficiencies and bureaucracy reduction; and (4) assessments of parents with incomes above 300% of the poverty line for a percentage of major treatment costs where incurred by their children *post hoc*.

The first principle is: All California children not privately covered are covered publicly.³⁸⁷

Current numbers commend a shift from a presumption of uncovered to one of coverage. Currently, only about 4% of the state's children are (publicly or privately) uncovered *and* ineligible for an existing public program. This small population is limited to children without private insurance in families over 250% of the line, and undocumented children. And yet the state has created 15 different programs to cover those lacking private insurance, each with different criteria, and all changing over time, as children age and income changes. This complicated system is designed to make certain none of the 4% is given coverage they are not entitled to. Indeed, many large counties, notwithstanding the budget crisis, and using local Proposition 10 commission help, are adding all children up to 300% of the poverty line and/or undocumented immigrants. In a county where both are covered, the percentage of unqualified and uncovered approximates 1%. Only a small percentage of this one percent is likely to incur substantial individual medical expense. At this point in population balance, it is prudent to reverse the presumption, and allow all children 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 for under \$300 million in additional general fund spending—a small sum given the momentous public benefit secured. Another \$300 million can be generated from special fund contribution (Propositions 10 and 99, remaining funds from the tobacco MSA, and assessments of parents earning over 250% of the poverty line on a sliding scale after services are rendered). Another source for the additional non-general fund \$300 million is general fund savings obtained because some ten fragmented programs providing medical coverage may terminate, including their bureaucracies and red tape. Instead of spending substantial sums to filter, qualify and block, such resources may be expended on child coverage. When the number uncovered and ineligible falls to the current relatively small percentage, the “qualify, screen, enroll, premium payment, overcome obstacles approach becomes increasingly irrational. California's system entered such an irrational domain once the federal SCHIP program brought all but 4% of her children into coverage eligibility—particularly at the available 2–1 match.

The \$600 million thus generated will produce \$1.2 billion in federal funds, allowing coverage of the state's children.

Such a system for children reverses the present “you're out unless you can prove that you qualify” to “we cover every child, and 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. To combat “crowd out” by employers halting dependency coverage to “free ride” public coverage, assess a fee of all employers with more than ten full time employees who fail to provide dependency coverage for employees earning under 300% of the poverty line. Use those monies to finance a tax credit of 30% of the cost for such dependency coverage for employers who do provide it. Estimated Cost: self-funding.

As access to public coverage becomes easier, many private employers now providing most dependency (child) coverage in the state will have an increasing incentive to abandon that coverage in lieu of publicly provided coverage—particularly if their competitors gain a cost advantage in doing so. In order to prevent such a “free ride” danger that could seriously inflate public cost, a two step equitable

system is proposed. First, assess those employers with more than ten full time employees a fraction of the cost of dependency coverage (e.g., 30%) for the dependents of employees earning under 300% of the poverty line that they do not cover privately (e.g., where they fail to contribute at least 50% of the cost). Dependency coverage is relatively inexpensive and such a cost should be substantially less than the employer assessment for adult coverage imposed by 2003 legislation and now being contested by a 2004 initiative. Second, take the proceeds from those assessed fees, and use them to finance a refundable tax credit for all employers who do provide such coverage at a level approximating 30% of its cost. Such a system would be revenue neutral, modest in amount given the relatively low cost of dependency coverage, and would equitably address the problem of those who provide coverage being forced to cross subsidize those who do not to their competitive advantage and at public cost..

Recommendation #3. 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/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,³⁸⁸ 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,³⁸⁹ 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 #4. 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 #5. 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 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 DHS and MRMIB, as well as the Department of Managed Health Care, 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 1,300 full-time, professional registered lobbyists who cover the Legislature and the state's major agencies.³⁹⁰ 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. 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).
2. 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.
3. Moira Inkelas, PhD., Neil Halfon, MD, MPH, Kim Uyeda, MD, MPH, Greg Stevens, PhD, Janel Wright, *The Health of Young Children in California, Findings from the 2001 California Health Interview Survey*, UCLA Center for Health Policy Research and First 5 California (July 2003) at vii, (hereafter “UCLA Child Health 2001”).
4. *Id.*, at vii- xi, 48.
5. *Id.*, at 65.
6. E. Richard Brown, Ninez Ponce, Thomas Rice, Shana Alex Lavarreda, *The State of Health Insurance in California: Long-Term and Intermittent Lack of Health Insurance Coverage*, UCLA Center for Health Policy Research (Los Angeles, CA; November 2003) at 1-4.
7. Ying-Ying Meng, Susan H. Babey, Elizabeth Malcolm, E. Richard Brown, Neetu Chawla, *Asthma in California: Findings from the 2001 California Health Interview Survey*, UCLA Center for Health Policy Research (Los Angeles, CA; November 2003) at 1-4.
8. E. Richard Brown, Ninez Ponce, Thomas Rice, Shana Alex Lavarreda, *The State of Health Insurance in California Findings from the 2001 California Health Interview Survey*, UCLA Center for Health Policy Research (Los Angeles, CA; June 2002) (hereinafter “State of Health Insurance in California 2001”) at 9 (Exhibit 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.
9. 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”).
10. *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.
11. Average annual increases in the premiums paid by employers for employee health coverage array as follows: 1999 +4.8%, 2000 + 8.3%, 2001 +11%, 2002 + 12.7%, see *Worrisome Changes Loom in the Private Health Insurance Market*, HEALTH ACTION, November 2002, Families USA, at 1, summarizing data from the Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2002 Annual Survey*.
12. *State of Health Insurance in California 2001*, *supra* note 8, at 4; *Number of Uninsured Californians*, *supra* note 6, at 1.
13. *State of Health Insurance in California 2001*, *supra* note 8, at Exhibit 22.
14. *State of Health Insurance in California*, *supra* note 9, at 4.
15. Managed Risk Medical Insurance Board, *Healthy Families Program Enrollment Data* (Sacramento, CA; February 2004) at www.mrmib.ca.gov.
16. UCLA Center for Healthier Children, Families and Communities, Public Health Institute, UCLA Center for Health Policy Research, *The Health of Young Children in California* (Los Angeles, July 2003) at 24.

17. American Academy of Pediatrics, *Children's Health Insurance Status and Public Program Participation; State Reports, 1999 and 2001 Estimates* (Elk Grove Village, IL; 2002).
18. *Health Insurance Coverage in America: 2001 Data Update*, The Kaiser Commission on Medicaid and the Uninsured (January 2003) at Table 14 (hereinafter "*Health Insurance Coverage in America*").
19. Helen Schauffler, Sara McMenamain, 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*").
20. *Health Insurance Coverage in America*, *supra* note 18.
21. *Id.* at Table 9.
22. *California Children Are Uninsured*, *supra* note 19, at 2.
23. *The State of Health Insurance*, *supra* note 9, at 22 and Ex. 15.
24. 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.
25. See *UCLA Child Health 2001*, *supra* note 3 at ix - x.
26. *Id.*, at 25–32.
27. *The State of Health Insurance 2001*, *supra* note 8, at 45 and Ex. 21.
28. *The State of Health Insurance*, *supra* note 7, at 25.
29. *Id.*
30. *Id.* at 18, Ex. 12.
31. *Id.* at 24.
32. *The State of Health Insurance 2001*, *supra* note 8, at 45 and Ex. 21.
33. *The State of Health Insurance*, *supra* note 9, at 18.
34. 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 19, at 17.
35. *The State of Health Insurance*, *supra* note 9, at viii.
36. *The State of Health Insurance 2001*, *supra* note 8, at 24, Ex. 12.
37. *The State of Health Insurance*, *supra* note 9, at 27, Ex. 20.
38. *Id.* at 26.
39. *Id.*

40. *Id.*
41. If otherwise eligible for Medi-Cal, undocumented immigrants qualify for emergency and pregnancy-related care.
42. 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).
43. 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.
44. Department of Health Services, Medical Care Statistics Section, *Persons Certified Eligible for Medi-Cal* (Sacramento, CA; December 2002) at 1.
45. See California Department of Health Services, *Medi-Cal Enhancements for Children: Fast Facts* (Sacramento, CA; January 1998) at 1.
46. 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.
47. Kristen Testa, Larissa Mohamadi, Dawn Horner, Wendy Lazarus, Jayleen Richards, Len Finocchio, *Children Falling Through the Cracks*, 100% Campaign, funded by the California Endowment, January 2003, at 1, 9-14.
48. Helen Halpin Schaffler, 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.
49. 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). *Health Insurance Coverage in America*, *supra* note 18, at 34, Table 14.
50. Health Research and Educational Trust, *California Employer Health Benefits Survey—2003*, Kaiser Family Foundation, March 2004, see www.kff.org/statepolicy/chp031604pkg.cfm.
51. Health Research and Educational Trust, *California Employer Health Benefits Survey—2002*, Kaiser Family Foundation, February 2003, see www.kff.org/content/2003/6070/
52. 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.
53. 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*”).
54. Department of Health Services Medical Care Statistics Section, *Medi-Cal Funded Deliveries, 1994–2000* (Sacramento, CA; August 2002) at Table 1; Department of Health Services Medical Care Statistics Section, *Medi-Cal Funded*

Deliveries, 1998 (Sacramento, CA; May 2000) at 1.

55. See California Department of Health Services, Medical Care Statistics Section, *Medical Beneficiaries by Age Category*, (Sacramento, CA).
56. Health Care Financing Administration, *2001 HCFA Statistics* (Washington, D.C.) at Table 11.
57. *Id.* At Table 34.
58. *Id.*
59. Maternal and Child Health Coalition, *Medicaid Protects Maternal and Child Health* (March 1995) at 2 (hereinafter "*Medicaid Protects Maternal and Child Health*").
60. 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.
61. Health Care Financing Administration, *A Profile of Medicaid, Chartbook 2000* (Washington, D.C.; Sept. 2000) at Figure 2.12.
62. 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.
63. 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.
64. Kaiser Commission on Medicaid and the Uninsured, *Children's Health—Why Health Insurance Matters* (Washington, D.C.; May 2002) at 1.
65. *Id.* at 1.
66. 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.
67. 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; March of Dimes, *Infant Mortality Rates by State, United States 1998* (2001); Infoplease, *Infant Mortality and Life Expectancy for Selected Countries, 2002* available at www.infoplease.com/ipa/A0004393.html.
68. Office of the Governor, *California's Infant Mortality Rate Drops to Record Low 7/17/2003* (Sacramento, CA; July 17, 2003); California Department of Health Services, Center for Health Statistics, *Selected Health Indicators Concerning Live Births, California 1992–2001* (Sacramento, CA; January 2003); California Department of Health Services, Center for Health Statistics, *Infant Death Rate* (Sacramento, CA; 2001). See also *Infant Death Rate 1997*, *supra* note 67, at 1; see also *Medicaid Protects Maternal and Child Health*, *supra* note 59, at 1–2, citing census data, HCFA data, National Center for Health Statistics Hospital Discharge Survey information, and related data.
69. 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. Szilagy, 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.
70. *Id.* at 363.
71. 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.
72. Health Status Assessment Project, University of California at San Diego and Children's Hospital of San Diego, November, 2002, at 1-3.
73. See, e.g., Health Access, *Your Money or Your Health: Discriminatory Pricing and Aggressive Debt Collection Practices by Sutter Health* (Oakland, CA; April 2004) at 5.
74. Kaiser Commission on Medicaid and the Uninsured, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?* (Washington, D.C.; May 2004) at 2-6.
75. Gerald F. Kominski, Dylan H. Roby, *Estimating the Cost of Caring for California's Uninsured*, UCLA Center for Health Policy Research Policy Brief (Los Angeles, CA; May 2004).
76. 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.
77. U.S. General Accounting Office, *Medicaid Formula: Differences in Funding Ability Among States Often are Widened* (GAO/03-620) (Washington, D.C.; July 2003) at 4,9, 12–13.
78. 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).
79. *The State of Health Insurance*, *supra* note 9, at 27.
80. Section 4701 *et seq.* of the 1997 Balanced Budget Act.
81. Section 4901 of the BBA 1997, 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.
82. 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.
83. See www.hcfa.gov.
84. 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.
85. *Id.*
86. State Medicaid Directors' Letter, HCFA, July 30, 2001, available at www.hcfa.gov/medicaid.
87. Pub. L. No. 104-193.
88. 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*").

89. 42 USC Section 1396u-1(b).
90. 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*").
91. 42 USC Section 1396u-1(b); 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).
92. WELF. & INST. CODE § 14005.30 (a)(2).
93. WELF. & INST. CODE § 14005.30(c).
94. *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 88, at 11 and 14–15 (describing more generous "income disregards" for "recipients."
95. 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 88, at 19.
96. 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).
97. *Id.* at 13.
98. 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).
99. *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 "percent 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 implemented this requirement on July 1, 2001.
100. 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.
101. See, e.g., SB 87 (Escutia) (Chapter 1088, Statutes of 2000), which simplifies Medi-Cal redetermination somewhat for families of former CalWORKs recipients.
102. AB 2900 (Gallegos) (Chapter 945, Statutes of 2000).
103. *Youth Law News*, National Center for Youth Law, Oakland, 1999 (review of the literature).
104. 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).

105. *Immigrants' Health Care: Coverage and Access*, The Kaiser Commission on Medicaid and the Uninsured (August 2000) at 2 and 5, Figure 5.
106. 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.
107. Chapter 944, Statutes of 2000.
108. Stephen P. Wallace, UCLA Center for Health Policy Research, *Welfare Reform Could Add 25,000 Uninsured L.A. County Residents Per Year*, Policy Brief (Los Angeles, CA; August 1997) at 2.
109. Pub. L. No. 99-272.
110. Pub. L. No. 104-191, referred to as the Kennedy/Kassebaum measure, after its Senate sponsors.
111. 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).
112. See Office of the Governor, *Governor's Budget Summary 2004-05* (Sacramento, CA; Jan. 2004) at 105.
113. Pub. L. No. 105-33, generally adding new Social Security Act § 1932 *et seq.*, codified at 42 U.S.C. § 1396 *et seq.*
114. Pub. L. No. 106-554I (omnibus spending bill).
115. 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).
116. See, e.g., S. 1227 and H.R. 4707 in the 106th Congress (2000).
117. 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.
118. 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.
119. 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.
120. Merrill Matthews, Jr., *Health Insurance Tax Credit Would Help on Two Levels*, INVESTOR'S BUSINESS DAILY, Sept. 23, 2002.
121. 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>).
122. 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.
123. See Jeanne Lambrew, *Health Insurance: A Family Affair*, The Commonwealth Fund (May 2001) (see www.cmwf.org/programs/insurance/lambrew_familyaffair_464.pdf) (hereinafter "*Family Affair 2001*").

124. Chris Grier, *Study: Bush Uninsured Proposal Would Make Matters Worse*, BESTWIRE, April 12, 2004.
125. *Id.*
126. *Id.*
127. For discussion, see National Health Law Program, *The Administration's Proposal for Medicaid: Block Grants Revisited* (February 2003) (see <http://nhelp.org/publications.shtml>).
128. CAL. INS. CODE § 12694 *et seq.*
129. HCFA State Medicaid Directors Letter, July 30, 2000 (see www.hcfa.gov/medicaid).
130. See Health and Safety Code § 130100 *et seq.*; see also Revenue and Taxation Code § 30131 *et seq.*
131. "Cigarette Tax Revenues Could Plug Insurance Hole for Kids," THE SACRAMENTO BEE, May 12, 2004.
132. SB 687 (Escutia).
133.
 - \$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.
 - \$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
134. Sabin Russell, *New SF Health Insurance for Kids, County-Run Program One of Two in State*, S.F. CHRONICLE, December 26, 2001.
135. (Chapter 894, Statutes of 2001). 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).
136. See *Pharmaceutical Research & Manufacturers of America v. Walsh* (2003) 538 U.S. 644, 123 S.Ct. 1855, 155 L.Ed.2d 889.
137. See *Olszewski v. Scripps Health* (2003) 30 Cal.4th 798.
138. (2002) 102 Cal.App.4th 745.
139. See Dan Weintraub, *Capitol GOP Idea to Give More Workers Health Care*, LOS ANGELES TIMES, December 15, 2002.
140. *Baby Doe v. California State Department of Public Health* 03-503305 (San Francisco Superior Court, order September 12, 2003).
141. Kim Quach, *Computer Problem Removes Infants From Medi-Cal*, ORANGE COUNTY REGISTER, February 9, 2004.
142. Chapter 894, Statutes of 2001.
143. Office of the Governor, *Governor's Budget Summary 2002–03* (Sacramento, CA; Jan. 2002) at 174.

144. Chapter 897, Statutes of 2001.
145. The Children's Partnership, *California's Express Enrollment Program: Expediting Medi-Cal Enrollment for Children in the Free School Lunch Program* (Santa Monica, CA; 2003) at 1.
146. Community Health Councils, Inc., *Child Health and Disability Prevention Gateway Program* (Los Angeles, CA; July 2003) at 1.
147. *Id.*
148. Joy Buchanan, *Infants Denied Medi-Cal Coverage; Some Are Dropped from the Rolls After Being Signed Up in Error for Another Program*, LOS ANGELES TIMES, Feb. 23, 2004, at B1.
149. *Id.*
150. *Id.*
151. Lisa Chimento, Joanne Jee, Pooja Shukla, *How Policy Changes Impact Enrollment: A Look at Three County Efforts*, California Healthcare Foundation (Oakland, CA; May 2004) at 6.
152. *Id.*
153. *Id.* at 12.
154. See California Healthline summaries of Riverside Press Enterprise study of Riverside County expansion efforts, and similar efforts by San Bernardino's Proposition 10 Commission, at *Press-Enterprise Looks at Options for Children Who Do Not Qualify for Public Health Plans*, CALIFORNIA HEALTHLINE, 10-08-02, at www.californiahealthline.org
155. 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*").
156. *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.
157. *Id.*, Figure 6.
158. 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*").
159. 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*").
160. 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).
161. 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.
162. 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).
163. Office of the Governor, *Governor's Budget Summary 2003–04* (Sacramento, CA; January 2003) at 111.

164. *Id.*
165. *Id.*
166. Children's Advocacy Institute, *California Children's Budget 1998–99* (San Diego, CA; June 1998), Table 4-D at 4-20.
167. *Governor's Budget Summary 2001–02*, *supra* note 158, at 147 and 150.
168. California Department of Health Services, *Medi-Cal Beneficiaries by Age Category*, Pivot Table (Sacramento, CA; 2000) (www.dhs.ca.gov/admin/ffdbm/mcss/RequestedData/files.htm).
169. *Governor's Budget Summary 2003–04*, *supra* note 163, at 111.
170. Medi-Cal Policy Institute, *The Impact of California's Fiscal Crisis on Medi-Cal Health Plans* (Sacramento, CA; September 2003).
171. 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.
172. 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*").
173. Health Access, *State Reconsiders Approach to Two-Plan Model in Los Angeles* (San Francisco, CA; Summer 1997) at 5.
174. 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.
175. David Phillips, Nicholas Christenfeld, Laura Glynn, *Prescription Drug Errors and Managed Care*, THE LANCET (February 1998).
176. See Assembly Health Committee, *Medi-Cal Managed Care: Two-Plan Model* (Sacramento, CA; November 5, 1997) at 7 (background paper for public hearing).
177. Statement of Stan Rosenstein, state Department of Health Services, at Medi-Cal Roundtable (March 28, 2001).
178. *The State of Health Insurance*, *supra* note 9, at 33.
179. See Title 10, California Code of Regulations, section 2699.6629(d). The initial level of \$25 was increased to \$50 on November 1, 1998.
180. "Healthy Families Program children Ineligibility Statistics By County (as of 3/12/01)" at HFP Enrollment Data (see www.mrmib.gov).
181. AB 2900 (Gallegos), c. 945, Stats. 2000.
182. *Governor's Budget Summary 2001–02*, *supra* note 158, at 151.
183. The 2000 Budget Act, c. 93, Stats. 2000.
184. SB 87 (Escutia), c. 1088, Stats. 2000.
185. *Id.*

186. 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.
187. Welf. & Inst. C. Section 14007.40.
188. *Governor's Budget Summary 2001–02*, supra note 158, at 27 and 151.
189. Legislative Analyst's Office, *Analysis of the 2004–05 Budget Bill* (Sacramento, CA; Feb. 2004) at C-74.
190. 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).
191. AB 75 (Isenberg) (Chapter 1331, Statutes of 1989), adding CAL. WELF. & INST. CODE § 14148.5.
192. 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).
193. Senate Committee on Budget and Fiscal Review, *Overview of the 2004–05 Budget Bill* (Sacramento, CA; February 2004) at 3-10.
194. Edwin Park (Center on Budget and Policy Priorities), Kristen Testa (Children's Partnership and 100% Campaign), *Memorandum: State of California Would Be Accepting Risky Budget Neutrality Cap if the State Proceeds with Medi-Cal Restructuring through a Comprehensive Section 1115 Waiver*, April 27, 2004.
195. 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 Commission on the Future of Medicaid, *Health Needs and Medicaid Financing: State Facts* (April 1995) at 17. See also *Medicaid Overview*, supra note 155, at 39, Appendix.
196. *Governor's Budget Summary 2001–02*, supra note 158, at 147–48 and Figure HHS-12.
197. 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.
198. 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.
199. *Medicaid Overview*, supra note 155, at V.
200. 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 158, at 147 and 150.
201. *Governor's Budget Summary 2001–02*, supra note 158, at 148.
202. Michele Prestowitz, Lucy Streett, M.P.H., Medi-Cal Policy Institute, *A History of Medi-Cal Physician Payment Rates* (March 2000) at 17.
203. American Academy of Pediatrics, *Medicaid State Reports—FY 1997* (Elk Grove Village, IL; 1999) at 1.
204. S. Hunt, L. Peters, and J. Saari, Medi-Cal Policy Institute, *Capitation Rates in the Medi-Cal Managed Care Program* (Oakland, CA; May 1999).
205. "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.
206. See Department of Health Services website, Medi-Cal Home Page (as of 3/30/01), Provider Rates (see www.dhs.ca.gov).
207. *Medicaid Reimbursement Survey (California)*, American Academy of Pediatrics Division of Health Policy Research, 2001 (available at <http://www.aap.org/research/medreimpdf01/ca.pdf>).
208. David Skaggs, M.D., *Access to Orthopedic Care for Children with Medicaid Versus Private Insurance in California*, PEDIATRICS, June 2001.
209. Steve Berman, M.D., *Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients*, PEDIATRICS, August 2002.
210. Andrew B. Bindman, M.D., Jean Yoon, M.H.S., Kevin Grumbach, M.D., Lucy Streett, M.P.H., *Physician Participation in Medi-Cal, 2001*, Medi-Cal Policy Institute (May 2003) at 1-2.
211. Governor Gray Davis' message to the Members of the California State Assembly upon signing Assembly Bill 3006 (September 30, 2002).
212. *James Clayworth, et al. v. Diana M. Bonta, et al./California Medical Association, et al. v. Diana M. Bonta*, downloaded from <http://207.41.18.73/caed/DOCUMENTS/Opinions/Levi/03-2110.pdf>.
213. *Application Frustration: Despite a need for more Medi-Cal providers, there is a long backlog of doctors waiting to be approved by the state*, THE ORANGE COUNTY REGISTER, March 10, 2004.
214. AB 2068 (Brown), Chapter 1069, Statutes of 1973.
215. National Health Law Program, *Fact Sheet: Child Health and Disability Prevention (CHDP) Program* (2000, updated 2001).
216. *Id.*; Health and Safety Code Section 124090; Title 17, Calif. Code of Regulations, Section 6830.
217. 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*").
218. Legislative Analyst's Office, *Obstructed Entry: CHDP Fails as Gateway to Affordable Health Care* (Sacramento, CA; January 2001) at 2 (hereinafter "*Obstructed Entry*").
219. Legislative Analyst's Office, *Analysis of the 2004–05 Budget Bill* (Sacramento, CA; Feb. 2004) at C-131.
220. 51 Cal. App. 4th 743 (Dec. 13, 1996).
221. Office of the Governor, *Governor's Budget Summary 1997–98* (Sacramento, CA; 1997) at 112–13 (hereinafter "*Governor's Budget Summary 1997–98*").
222. *Id.* at 113.
223. *Obstructed Entry*, *supra* note 218.
224. *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.
225. AB 1126 (Villaraigosa) (Chapter 623, Statutes of 1997).
226. According to a 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 UCLA Center for Health Policy Research, *The State of Health Insurance in California 1998* (Los Angeles, CA) 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.

227. See California Budget Project, *Governor Proposes to Cap Enrollment*, December 2003, available at <http://www.cbp.org/2003/031209enrollmentcaps.pdf>
228. *Id.*, see also Senate Budget Committee, *Overview of the 2004 – 05 Budget Bill* (Sacramento, CA; 2004) at 3-24.
229. *Id.*
230. *Id.*
231. State Medicaid Directors Letter, HCFA, July 30, 2000.
232. Managed Risk Medical Insurance Board, *California's Healthy Families 1115 Demonstration Project: Summary of Modifications and Clarifications* (Sacramento, CA; March 1, 2001).
233. *Id.*
234. At full implementation, the estimate for annual SCHIP funds needed for this parental coverage is \$371 million (plus \$219 million in state funds), for a total of \$590 million a year, to cover 290,000 adults. See Managed Risk Medical Insurance Board, *California's Healthy Families 1115 Demonstration Project: Summary* (Sacramento, CA; January 2001).
235. For a description of CCS and recent data on it, see *PCFH Annual Report*, *supra* note 217, at 44.
236. Legislative Analyst's Office, *Analysis of the 2004–05 Budget Bill* (Sacramento, CA; Feb. 2004) at C-131.
237. *Id.*
238. SB 1371 (Bergeson) (Chapter 917, Statutes of 1994).
239. 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.
240. Legislative Analyst's Office, *Analysis of the 2004–05 Budget Bill* (Sacramento, CA; Feb. 2004) at C-131.
241. *Id.*
242. See <http://www.mch.dhs.ca.gov/programs/factsheets.htm> for more information about these programs.
243. For a description of the OFP program, see *PCFH Annual Report*, *supra* note 217.
244. 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.
245. 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 MaCurdy, 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.

246. 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 three factors 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.
247. 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.
248. 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).
249. 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*").
250. *Id.*
251. 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.
252. *Family PACT Program Evaluation Report*, *supra* note 249, at vii.
253. See *Worse Measles Year*, S.D. UNION-TRIB. (June 7, 1991) at A18.
254. 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.
255. AB 3351 (Gotch) (Chapter 1110, Statutes of 1992); AB 3354 (Gotch) (Chapter 1111, Statutes of 1992).
256. 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*").
257. See Julie Marquis, *Group Sues U.S. Over Curbs on Free Shots*, L.A. TIMES, May 13, 1998, at A-1.
258. Denny Walsh, *Judge: State Health Plan Deprives Kids*, SACRAMENTO BEE, May 1, 1999, at A-1.
259. Legislative Analyst's Office, *Analysis of the 2004–05 Budget* (Sacramento, CA; Feb. 2004) at C-142.
260. Interview with BDMP staff (March 1993).
261. 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).
262. California Department of Health Services, Childhood Lead Poisoning Prevention Branch, *Summary of Childhood Lead Poisoning in California* (Sacramento, CA; 1995) at 3.

263. *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.
264. California Department of Health Services, *Lead Hazards in California's Public Elementary Schools and Child Care Facilities* (Sacramento, CA; 1998).
265. 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.
266. 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*").
267. *Id.* at 11.
268. 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.
269. 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.
270. *Id.*
271. See *Our Children at Risk*, *supra* note 266, 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*").
272. *Exposure to Environmental Lead*, *supra* note 271, at 104–09.
273. See *Our Children at Risk*, *supra* note 266, at 12.
274. *Exposure to Environmental Lead*, *supra* note 271, at 106–09.
275. 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).
276. H. L. Needleman, *et al.*, *Bone Lead Levels and Delinquent Behavior*, 275:5 JAMA 363-69 (February 7, 1996).
277. Richard L. Canfield, Ph.D., Charles R. Henderson, Jr., M.A., Deborah A. Cory-Slechta, Ph.D., Christopher Cox, Ph.D., Todd A. Jusko, B.S., and Bruce P. Lanphear, M.D., M.P.H., *Intellectual Impairment in Children with Blood Lead Concentrations below 10 µg per Deciliter*, NEW ENGLAND JOURNAL OF MEDICINE, Volume 348:1517-1526 (April 17, 2003), Number 16.
278. Sherry G. Selevan, Ph.D., Deborah C. Rice, Ph.D., Karen A. Hogan, M.S., Susan Y. Euling, Ph.D., Andrea Pfahles-Hutchens, M.S., and James Bethel, Ph.D., *Blood Lead Concentration and Delayed Puberty in Girls*, NEW ENGLAND JOURNAL OF MEDICINE, Volume 348:1527-1536 (April 17, 2003), Number 16.
279. Office of the Governor, *Governor's Budget Summary 1997–98* (Sacramento, CA; Jan. 1997) at 112.
280. 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.

281. *Sinclair Paint Co. v. State Board of Equalization*, 15 Cal. 4th 866 (1997).
282. Zev Ross, Bill Walker, Richard Wiles, *Lead Astray: California's Broken Promise to Protect Children from Lead Poisoning*, Environmental Working Group (Washington, D.C.; April 2000).
283. *Id.*
284. *Id.*
285. 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.
286. *Id.*
287. Leslie Zellers, Children's Advocacy Institute, *Using Medicaid for Case Management in Lead Poisoning Cases* (Apr. 22, 1993).
288. *Healthy Children Organizing Project, et al. vs. DHS, et al.*, San Francisco County Superior Court, No. 313012, filed June 19, 2000. For more information, see <http://www.youthlaw.org/docket.htm>.
289. See 17 CCR Section 37000 et seq., see also CHILDREN'S REGULATORY LAW REPORTER, Vol. 3, No. 2 (2002) at 15.
290. 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.
291. *County of Santa Clara v. Atlantic Richfield*, Santa Clara County Superior Court Case No. CV788657.
292. See *State v. Lead Industries Association*, No. 99-5226; see Molly McDonough, *Poisoned by Paint*, ABA JOURNAL, July 2002, at 43. Note that California makes available the additional weapon of a broad Unfair Competition Act (Bus. & Profs. Code Section 17200) that applies injunctive remedies (including restitution) wherever an unlawful or unfair act in competition occurs. Further, it allows any person to sue on behalf of the general public in a private attorney-general action to enforce its terms. Much of the difficulty in seeking remedy by nuisance or unfair competition suit rests with the extension of liability beyond the acts of current defendants.
293. Chapter 931, Statutes of 2002.
294. See *Our Children at Risk*, *supra* note 266.
295. 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.
296. *Our Children at Risk*, *supra* note 266, at v.
297. 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.
298. See National Academy of Sciences, *Pesticides in the Diets of Infants and Children* (1993).
299. Pub. L. No. 104-170, the Food Quality Protection Act of 1996.

300. AB 2260 (Shelley) (Chapter 718, Statutes of 2000).
301. U.S. Environmental Protection Agency, *Environmental Health Threats to Children* (EPA 175-F-96-001) (Washington, D.C.; September 1996).
302. 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.
303. *Our Children at Risk*, *supra* note 266, at vi, 80-91.
304. *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).
305. 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).
306. *Governor's Budget Summary 2001-02*, *supra* note 158, at 143 and 145.
307. 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).
308. Assembly Committee on Transportation, *Committee Analysis, AB 2997 (Firebaugh), as Introduced* (Sacramento, CA; April 2004).
309. *Id.*
310. *Our Children at Risk*, *supra* note 266, at vii.
311. *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.
312. 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).
313. The Dental Health Foundation, *Selected Findings and Recommendations from the California Oral Needs Assessment of Children, 1993-94* (Sacramento, CA; September 18, 1997).
314. 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).
315. *Oral Health in America*, U.S. Surgeon General, May 25, 2000.
316. *UCLA Child Health 2001*, *supra* note 3, at x-xi. As discussed in the "illness" discussion at the beginning of this chapter, the study found that "over 6% of young children are sleeping with a bottle—greatly increasing risk of dental problems and indicating lack of parental knowledge about dental health." *Id.*
317. Lorraine Jones, *et al.*, *Denti-Cal Denied: Consumers' Experiences Accessing Dental Services in California's Medi-Cal Program*, Health Consumer Alliance, December 2002 at 3-6.

318. *Id.*, at 12. Note that juvenile periodontitis exists in children as young as age 12, see note 13.
319. *Id.*, at 13.
320. *Id.*, at 14.
321. Chapter 675, Statutes of 2000.
322. For summary of research and status of federal policy, see C. Tab Turner and Susan Lister, *The Forgotten Child— The Failure of Motor Vehicle Manufacturers to Protect 4- to 8- Year Olds in Crashes*, Public Citizen (Washington, D.C.; April 2002) seriatim (see www.citizen.org).
323. 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 256, at 2.
324. *Governor's Budget Summary 2001–02*, *supra* note 158, at 142–43.
325. 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) (portions of which were invalidated in *American Lung Association, et al. v. Wilson*, 51 Cal. App. 4th 743 (Dec. 13, 1996)).
326. See analysis of Lynn Kersey, Lucy Quacinella, and Manjusha Kulkarni, Letter Statement to MRMIB, Re: R-3-01 (AIM), Maternal and Child Health Access Foundation, July 11, 2002 at 1-7.
327. *Id.*
328. For more information, see www.consumernet.org/lazyeye/.
329. 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.
330. 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?*").
331. *Id.*
332. California Health and Human Services Agency, *California's Healthy Families SCHIP 1115 Demonstration Project* (Sacramento, CA; December 2000) at 3-4.
333. *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.
334. 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.
335. 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.
336. Office of the Governor, *May Revision 2002* (Sacramento, CA; May 2002) at 35.
337. Dr. Susan Lambe, *Emergency Room Visits 1990-99*, ANNALS OF EMERGENCY MEDICINE, April 2002.
338. See *On the Brink: How the Crisis in California's Public Hospitals Threatens Access to Care for Millions*, California Association of Public Hospitals and Health Systems (Oakland, CA; May, 2003) Appendix B at 31 (available at www.caph.org) (hereinafter, "*On the Brink*").
339. See Table App. - A, last row.
340. *On the Brink*, *supra* note 338, at 7.
341. Data provided by the Division of Accounting, State Controller's Office (Apr. 1993) (available at the Children's Advocacy Institute).
342. Office of the Legislative Analyst, *LAO 1995-96* (Sacramento, CA; 1995) at Fig. 1.
343. Senate Rule Committee, *Analysis of AB 1457 (Assembly Budget Committee), as amended April 21, 2004*.
344. Legislative Analyst's Office, *Analysis of the 2004-05 Budget Bill* (Sacramento, CA; Feb. 2004) at F-119.
345. Helen Gao, *'Poison Pill' Is Costing Counties \$90 Million*, SAN DIEGO UNION-TRIBUNE, Apr. 29, 2004.
346. Legislative Analyst's Office, *Analysis of the 2004-05 Budget Bill* (Sacramento, CA; Feb. 2004) at F-119.
347. *Governor's Budget Summary 2001-02*, *supra* note 158, at 28 and 142.
348. See mixed findings in initial studies of managed care impact on the clinic infrastructure relied upon by uninsured populations, discussed above.
349. Health and Human Services Release, dated March 12, 2004.
350. 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*").
351. CAL. WELF. & INST. CODE § 14087.325.
352. *Medi-Cal Managed Care Has Not Had an Adverse Effect*, *supra* note 350, at 1.
353. Each of these counties is now part of the Two-Plan Model.
354. University of California at San Francisco, Institute for Health Policy Studies, *Medi-Cal Managed Care Clinic Impact in Sacramento County* (San Francisco, CA; 1997).
355. See Dorsey Griffith, *Medi-Cal Plan Hurting Clinics*, SAC. BEE, Nov. 4, 1997 at A-1.
356. See Leaf quote in Anderson, *Los Angeles Health Director Proposes Steep Service Cuts to County Health System*, (January 29, 2002).
357. See Charles Ornstein and Daren Briscoe, *Health Cutbacks to Curtail Immunizations for Children*, LOS ANGELES TIMES, August 22, 2002 at B-1.

358. Legislative Analyst's Office, *Analysis of the 2004–05 Budget* (Sacramento, CA; Feb. 2004) at C-128.
359. Elizabeth Kersten, Senate Office of Research, *Emergency Room Response Shortage* (Sacramento, CA; May 28, 2003) at 1–4.
360. Charles Levin, *County Health Cuts Would Hit Thousands*, VENTURA COUNTY STAR, July 24, 2002, at 1.
361. See e.g., *Orange County Supervisors Agree to Cut Funds for Health Services in County Budget*, ORANGE COUNTY REGISTER, June 11, 2003.
362. See *On the Brink.*, *supra* note 338, at 1–5.
363. 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).
364. "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," MRMIB, March 1, 2001; and "Quick Summary Comparison of Administration's Initial Waiver and Modified Waiver," Senate Budget Committee, March 3, 2001.
365. *Id.*
366. *Field Institute Survey*, *supra* note 66.
367. Managed Risk Medical Insurance Board, *Retention in Healthy Families* (as of 3/12/01) (see www.mrmib.gov).
368. Health Status Assessment Project, University of California at San Diego and Children's Hospital of San Diego, November, 2002, at 1-3.
369. Governor Gray Davis, *Governor Davis Announces Improvement in California Children's Health/Social Skills*, Press Release, Office of the Governor, 11-20-02, at 1-2.
370. Carole Gresenz and Jacob Kierman, *Beyond Medi-Cal: Health Insurance Among Former Welfare Recipients*, Rand Institute (September 2002) at 1–3 (see www.rand.org).
371. See *Children Losing Health Coverage*, SPECIAL REPORT, Families USA, Revised September 19, 2002, Figure 2 at 3 displaying the OMB estimate of 4.3 million enrollees in 2003 falling to 3.4 million by 2006.
372. Kristen Testa, Larissa Mohamadi, Dawn Horner, Wendy Lazarus, Jayleen Richards, Len Finocchio, *Children Falling Through the Cracks*, 100% Campaign, funded by the California Endowment, January 2003, at 1, 9-14.
373. To further exacerbate the problem, a negative credit report is commonly issued impacting parental debt in general. Credit card companies commonly offering the bait of from zero to 7% interest on borrowing have clauses that allow the switch to over 20% where credit report "scores" decline.
374. 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.
375. California Health and Human Services Agency, *California's Healthy Families SCHIP 1115 Demonstration Project* (Sacramento, CA; December 2000).
376. Office of the Governor, *May Revision 2002* (Sacramento, CA; May 2002) at 42.
377. See discussion in Stephen Robitaille, *Healthy Families Effort Continues, Despite Giveback*, California HealthCare Foundation, Oakland, 2003, at 1.

378. Medicaid remains an “entitlement” program, with federal monies payable upon enrollment of qualified children. The \$2 billion estimate uses an average enrollment shortfall of 500,000 children over 8 years, at a \$1,000 average cost per enrollee.
379. See *Losing Health Insurance: The Unintended Consequences of Welfare Reform*, Families U.S.A., May 1999; *One Step Forward, One Step Back: Children’s Health Coverage after CHIP and Welfare Reform*, Families U.S.A., October 1999; 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; Judith Feder and Sheila Burke, *Options for Expanding Health Insurance Coverage*, Henry J. Kaiser Foundation, October 1999; 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; 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.
380. 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) (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.
381. 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;
 - (g) Cover transitional Medi-Cal recipients to 235%;
 - (h) Drop all advance premiums beyond the \$5 co-payment;
 - (i) Remove the partial pay provisions of Medi-Cal which limit benefits where parents have even minor income (see discussion above);
 - (j) Increase incentive payments to \$100 per new member—with \$25 going to the child’s parent;
 - (k) Increase outreach;
 - (l) Replace earned income disregards with a standard income deduction;
 - (m) 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).
382. 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. 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.

383. 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. 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. Significantly, California's 1999 dispensation for 2000 was only a reprieve. The state continues to engage in incremental strategies to cover children, and has now lost \$1.9 billion through 2002, with a \$3 billion conservative estimate in foregone available federal monies to 2006 (see discussion and itemization above).
384. *The State of Health Insurance, supra* note 9, at 18, Ex. 11.
385. 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; and (4) coverage costs \$1,000 per year per child.
386. 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.
387. 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.
388. 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 158.
389. 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.
390. 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.

