# CALIFORNIA LEGISLATURE

**Informational Hearing of the**

**Senate Committee on Health and Human Services**

**Senator Deborah V. Ortiz, Chair**

# "A COST EFFECTIVE AGENDA FOR HEALTH ACCESS FOR CHILDREN AND FAMILIES"

**Wednesday, January 16, 2002**
**Upon adjournment of bill hearing**
**State Capitol, California Room 4203**
**Sacramento, CA**

1144-S

COMMITTEE ADDRESS
STATE CAPITOL, ROOM 2191
SACRAMENTO, CA 95814

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California Legislature

# SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

DEBORAH V. ORTIZ
CHAIR

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## Agenda

I. **Welcome**
*Senator Deborah Ortiz*

II. **Barriers to Access Health Care and the State of Uninsurance**
***Speranza Avram,*** Executive Director, Northern Sierra Rural Health Network
***Yolanda Vera,*** Attorney, San Fernando Valley Legal Services
***Yesenia Zolarzano,*** PICO representative
***Larry Levitt,*** Vice-President, Henry J. Kaiser Family Foundation
***Lucien Wulsin,*** Executive Director, Insure the Uninsured Project

III. **Recommendations from the Foundation Community to Increase Access to Health Care**
***Judith K. Chynoweth,*** Executive Director, Foundation Consortium
***Dr. Robert K. Ross,*** CEO/President, The California Endowment
***Alicia Procello,*** Program Director, The California Wellness Foundation
***Bonnie Armstrong,*** Director, Regional Advocacy and Community Development, Casey Family Programs
***Mookie Abdullah***, youth representative
***Len McCandliss,*** President, Sierra Health Foundation
***Amy Studdieford,*** Coordinator, Cordova Community Collaborative for Healthy Children and Families

IV. **The Role of Safety Net Providers and Access to Health Insurance**
***Denise K. Martin,*** President and CEO, California Association of Public Hospitals
***Carmela Castellano,*** Executive Director, California Primary Care Association
***Lucien Wulsin,*** Executive Director, Insure the Uninsured Project
***Michael Mahoney,*** CEO, St. Rose Hospital

V. **The Role of Data in Policymaking**
***Theodore Lobman,*** President, Stuart Foundation.
***Judith K. Chynoweth,*** Executive Director, Foundation Consortium

# BACKGROUND

# INFORMATION

California Legislature

SENATE COMMITTEE
ON
HEALTH AND HUMAN SERVICES

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# "A COST EFFECTIVE AGENDA FOR HEALTH ACCESS FOR CHILDREN AND FAMILIES"

## *Background*

The facts are well known. A large number of Californians lack access to a regular source of health care services and almost 7 million Californians lack health insurance. These individuals suffer significant economic and health consequences due to their lack of health care services. Californians' lack of access to health care is the product of a wide array of factors including but not limited to the state's high rates of uninsurance, shortage of providers, limited availability of linguistically appropriate care, lack of transportation, particularly in rural areas, and lack of information about available services.

California has historically operated a variety of public health insurance programs, including Medi-Cal, Healthy Families and Access for Infants and Mothers, to provide access to health care services for the state's low-income population. Over the last two years the Governor and the Legislature have provided increased access to health coverage through expanded use of federal funds for health care purposes and easing access to these programs by eliminating administrative burdens. The state also dedicates significant funds to increase provider availability and sustain safety net providers who deliver critical services to the state's low-income populations. Private foundations also dedicate a significant amount of resources to address California's access to health care challenges. Foundations have funded alternative models of health care coverage, the direct provision of health care services to the state's vulnerable populations, efforts to increase the availability of providers in shortage areas, campaigns to increase participation in existing health care programs, studies to gain a better understanding of the challenges California's health care delivery system faces and other interventions to increase access to care.

Despite the state and private efforts, many of the California's significant access to health care challenges persist. A significant number of the state's safety net providers argue that their financial challenges are worsening and that these challenges threaten their ability to serve low-income Californians. Hospitals argue that the rate of managed care penetration and the imposition of new requirements, such as the seismic safety standards, have resulted in significant health care costs for the state's hospitals and threaten the long term financial viability of many of the state's hospitals. Reports document a shortage of providers in many of the state's rural and low-income communities which negatively affect Californians' access to health care. The state's

high rate of uninsurance persists even at a time of record economic growth and when the government has undertaken significant initiatives to increase access to health coverage.

This year's economic downturn and the state's economic downturn is likely to increase the pressure on California's health care delivery system and may result in decreased access to health care for the state's most vulnerable populations. The Senate Health and Human Services Committee and the Foundation Consortium have organized an informational hearing to assess the current state of California's health care delivery system, the challenges the system is likely to face and to explore potential models that may increase access to health care services for the state's most vulnerable populations.

***Defining the Uninsured Population:***

Two thirds of Americans receive health insurance coverage through their employers. Yet the number of uninsured non-elderly adults in California persists at 6.8 million. Even among adults who work full time for a full year, one in five remains uninsured. Generally, the uninsured population of California is comprised of those people who lack the resources to afford private health care coverage, but do not meet the requirements for publicly funded health care coverage or do not know how to obtain that coverage.

The poor and the near-poor (below 200% of the federal poverty level) account for two thirds of the uninsured population. More than half of low-income non-elderly adults are uninsured. Disproportionately more adults are uninsured relative to children and the elderly. The rate of uninsurance among adults is due in part to the orientation of government programs, which tend to focus on children and the elderly. Nearly all the elderly are covered through Medicare, so most uninsured Americans are individuals under the age of 65. Non-elderly adults must meet stringent income eligibility standards. Many of California's low-income individuals are ineligible for public health insurance because existing programs tend to target children and families.

There are large ethnic disparities in health care coverage, with generally lower rates of insurance coverage among people of color compared to non-Latino whites (13%). Uninsured rates are particularly high among Latinos (36%) and among Koreans (45%). The poor and the near-poor (below 200% of the federal poverty level) account for two thirds of the uninsured population.

The uninsured are more likely than those with insurance to be hospitalized for conditions that could have been avoided, such as pneumonia and uncontrolled diabetes. The uninsured with various forms of cancer are more likely to be diagnosed with late-stage cancer. Death rates for uninsured women with breast cancer are significantly higher compared to women with insurance. The financial impact of being uninsured is often substantial. Nearly 30 percent of uninsured adults say that medical bills have had a major effect on their families' lives.

***The Role of Community Health Centers:***

Community clinics and health centers grew out of the efforts of neighborhood groups to improve the availability of health care services in communities where there was little or no access to primary or preventive health care. In 1999, community clinics and health centers served more than 2.7 million patients across California. Community health centers have become a crucial

component of a low-income person's ability to access health care. One of every ten uninsured persons in California uses a community clinic or health center. Eighty eight percent of the clients of community health centers have incomes at or below 200 percent of the federal poverty level. Seventy percent of those served by clinics come from ethnic or racial minorities. Community health centers are a particularly important source of health care services for individuals whose primary language is not English. Limited English speakers amount to 44 percent of the clients of community health centers. Community clinics and health centers are the major provider of health care for rural Californians.

Community health centers receive funding from a variety of state and federal sources. Some of the state programs that support community health centers include the Rural Health Service Development Program, the Expanded Access to Primary Care Program and the Seasonal Agricultural Migratory Worker Program. The Rural Health Service Development (RHSD) Program provides funds to community clinics and health centers serving low income, geographically isolated populations. There are 97 RHSD sites. The Seasonal Agricultural Migratory Worker (SAMW) Program provides funds to community health centers to serve California's farmworker population. These health centers serve as the main source of health services to the farmworker population. The Expanded Access to Primary Care (EAPC) Program provides funding to community clinics and health centers to care for California's uninsured populations, including pharmacy, laboratory, x-ray, and case management services. EAPC, which was implemented in 1989 utilizing Proposition 99 funding, serves populations that would otherwise seek costly care in California's overburdened emergency rooms.

***The Financial Condition of California's Hospitals:***

California's hospital system is the largest and most complicated hospital system in the nation. In 1999, California's 409 acute care hospitals employed more than 300,000 people, discharged more than 3 million patients, had an available bed capacity of more than 80,000, and generated more than $35 million in total revenue. But more than half of California's hospitals lost money from operations in 1999. By comparison, the national median hospital's operating margin was positive.

The operating margin disparity between the top and bottom performing hospitals widened significantly during the mid-1990's. Of the hospitals that were in the worst-performing quartile in 1995, 53 percent were in the same quartile in 1999, while 70 percent remained in one of the two bottom quartiles in 1999. Conversely, among the strong hospitals performing in the top quartile in 1995, 53 percent remained in the top quartile in 1999 and 78 percent remained in one of the top two quartiles in 1999. The weaker hospitals are finding it increasingly difficult to obtain debt financing for the necessary and/or mandatory capital and information systems investments required to survive. Given that the bottom quartile of California's hospitals handled 17 percent of the state's hospital discharges, this group is large enough to create a serious hospital access problem in California, if large numbers of them fail to survive.

Categories of hospitals that were over-represented among the bottom quartile hospitals occurred within the following groups:

- Small
- Rural
- City- or county-owned
- Disproportionate share hospitals
- Non-members of health care system
- District-owned

Over-represented among the top quartile hospitals occurred within the following groups:

- Urban
- Medium-large
- Medium-small
- Investor-owned
- Members of a health care system

Regulatory mandates imposing substantial demands on hospitals:

- The federal Balanced Budget Act of 1997 contains mandated Medicare payment reductions that by 2002 will cut net Medicare payments to California hospitals by a projected $4.9 billion.
- California Senate Bill 1953, enacted in 1994, requires all hospitals in California to meet stringent guidelines for structural resilience to earthquakes, with graduated levels of conformance required in 2008 and 2030. Costs could include retrofitting, business interruption and, in some cases, complete hospital replacement. Failure to meet these deadlines can mean the loss of licensure. The California Healthcare Association has estimated the seismic retrofit cost to the state's hospitals at $24 billion.
- The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires providers to adopt electronic transaction standards, data security protocols, and privacy measures to protect confidential patient information that is stored or transmitted electronically. The American Hospital Association estimates an average annual cost per hospital of approximately $4.6 million for the first five years of program implementation.
- Medi-Cal instituted managed care programs in 20 California counties by 1999, which generally resulted in reduced reimbursement to hospitals for Medi-Cal services.
- California Senate Bill 1875, enacted in 2000, requires most hospitals to create technology-based systems to reduce medication errors by January 2005.

Today's hearing will provide the Committee with valuable information to assess the current state of California's health care delivery system, the challenges the system is likely to face, and to explore potential models that may increase access to health care services for the state's most vulnerable populations.

# Health Insurance, Access, and Use: California

Tabulations from the 1999
National Survey of
America's Families
SP-02

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State Profiles

Assessing the New Federalism

*An Urban Institute Program to Assess Changing Social Policies*

# Assessing the New Federalism

*Assessing the New Federalism* is a multiyear Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states. It focuses primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. Alan Weil is the project director. In collaboration with Child Trends, the project studies changes in family well-being. The project provides timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states and a database with information on all 50 states and the District of Columbia. Publications and database are available free of charge on the Urban Institute's Web site: http://newfederalism.urban.org/. This paper is one in a series of papers analyzing information from these and other sources.

The project received funding form The Annie E. Casey Foundation, the W.K. Kellogg Foundation, The Robert Wood Johnson Foundation, The Henry J. Kaiser Family Foundation, The Ford Foundation, The John D. and Catherine T. MacArthur Foundation, the Charles Stewart Mott Foundation, The David and Lucile Packard Foundation, The McKnight Foundation, The Commonwealth Fund, the Stuart Foundation, the Weingart Foundation, The Fund for New Jersey, The Lynde and Harry Bradley Foundation, the Joyce Foundation, and The Rockefeller Foundation.



Publisher: The Urban Institute, 2100 M Street, N.W., Washington, D.C. 20037

The following set of tabulations presents detailed descriptive information on health insurance coverage, access to care, and health care utilization in California and the nation. These tabulations are based on the 1999 National Survey of America's Families (NSAF) and are an update of similar tabulations developed using the 1997 NSAF (the 1997 data are available online at http://newfederalism.urban.org/pdf/State_profile_CA.pdf)[i]. Although detailed comparisons between 1997 and 1999 are not available in these tabulations, Table A presents an overview of changes in the distribution of health insurance coverage for California and the nation as a whole.

***Table A. Health Insurance Coverage of Nonelderly Population by Age, California and the U.S., 1997-1999.***

| | California | | | U.S. | | |
|---|---|---|---|---|---|---|
| | **1997** | **1999** | | **1997** | **1999** | |
| **All** (0-64) | | | | | | |
| Employer-Sponsored | 61.1 | 63.4 | | 69.7 | 70.5 | * |
| Medicaid/SCHIP/State | 12.5 | 11.1 | ** | 8.8 | 8.5 | |
| Other | 7.3 | 6.8 | | 6.1 | 5.9 | |
| Uninsured | 19.1 | 18.8 | | 15.4 | 15.1 | |
| **Children** (0-17) | | | | | | |
| Employer-Sponsored | 56.6 | 60.1 | ** | 66.7 | 66.6 | |
| Medicaid/SCHIP/State | 24.2 | 20.7 | ** | 17.4 | 16.8 | |
| Other | 5.4 | 6.0 | | 4.1 | 4.2 | |
| Uninsured | 13.8 | 13.2 | | 11.8 | 12.3 | |
| **Adults** (18-64) | | | | | | |
| Employer-Sponsored | 63.1 | 64.9 | | 71.1 | 72.2 | ** |
| Medicaid/SCHIP/State | 7.1 | 6.7 | | 5.1 | 4.9 | |
| Other | 8.2 | 7.2 | | 6.9 | 6.6 | |
| Uninsured | 21.6 | 21.3 | | 17.0 | 16.3 | |

**Source:**
Urban Institute tabulations of the National Survey of America's Families (NSAF), 1997 and 1999.
**Notes:**
* Indicates change from 1997 to 1999 is statistically significant at the 0.10 confidence level.
** Indicates change from 1997 to 1999 is statistically significant at the 0.05 confidence level.
*** Indicates change from 1997 to 1999 is statistically significant at the 0.01 confidence level.

The remaining tables presented in this State Profile focus only on 1999. Further details on changes by state and nationally between 1997 and 1999 are available in other publications (Kenney, Dubay, and Haley 2000; Zuckerman, Haley, and Holahan 2000).

Tables 1 through 10 present the distribution of insurance coverage (Employer-Sponsored, Medicaid/SCHIP/State, Other Coverage, and Uninsured[ii]) by selected subgroups, including age, family income, gender, race/ethnicity, family structure, family work status, worker's firm size, community type, and country of origin. Table 11 presents characteristics of the uninsured, and Table 12 summarizes estimates of uninsurance rates for each of the subgroups shown in Table 11. Tables 13 and 13a describe characteristics of enrollees in Medicaid, SCHIP, or other state insurance programs, overall and separately for poor and

near-poor enrollees. Tables 14 through 17a present indicators of access to and utilization of health care for children and adults by type of insurance coverage, overall and separately for the low-income population (defined as those with family incomes below 200 percent of the federal poverty level, or $33,060 for a family of four in 1998).

***The National Survey of America's Families***

The NSAF is a household survey conducted as part of the Urban Institute's *Assessing the New Federalism* (ANF) project, which was designed to analyze the devolution of responsibility for social programs from the federal government to the states. The first round of the NSAF was fielded in 1997, the second round was fielded in 1999, and a third round will be fielded in 2002. Along with providing a nationally-representative sample of over 44,000 households in each round, the NSAF has large, state-representative samples in 13 selected states (Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin) and over-samples the low-income population. Comparable State Profiles for each of these 13 states in 1997 and 1999 are available on the ANF Web site (http://newfederalism.urban.org). Extensive information about the survey, including the design features, response rate, weighting procedures, and treatment of nonresponse, is available in a series of online methodology reports (http://newfederalism.urban.org/nsaf/methodology.html).

Readers should note that NSAF estimates of the number of uninsured children and non-elderly adults are lower than those based on the Census Bureau's Current Population Survey (CPS). There are many differences between these two surveys, including the surveys' approaches to measuring insurance coverage. First, prior to March 2000, the CPS approach to measuring coverage has been to ask a series of questions about insurance coverage and assume that any person not designated as being covered through any type of health plan is uninsured. NSAF uses a series of questions similar to CPS in wording but added a question that confirms whether people who appear not to have coverage are, in fact, uninsured. A substantial number of respondents used this opportunity to designate a particular type of coverage for those who initially appeared to be uninsured.

For the March 2000 survey, the CPS also added a confirmation question. Revised estimates for 1999 that used information collected through the confirmation question suggested a lower uninsurance rate from the CPS than was originally estimated (Nelson and Mills 2001). A detailed analysis of the implications of the confirmation question in NSAF is available in Rajan, Zuckerman, and Brennan (2000). In addition, CPS measures insurance coverage during the calendar year prior to the survey (which occurs in March), while NSAF measures insurance coverage at the time of the survey. As a result,

the CPS uninsurance rate would not be directly comparable to the statistics reported in these tables.

### *Public use files*

Researchers can access the NSAF data through public use files available on the ANF Web site. Files based on both the 1997 and 1999 rounds of data are available to download. In addition, custom tabulations using either year of data are available using a Windows-based program, the NSAF CrosstabMaker. The CrosstabMaker is easy to use and requires no knowledge of the survey or statistical software packages. These resources are available at no charge to users who register at http://newfederalism.urban.org/nsaf/cpuf/index.htm.

### *References*

Kenney, Genevieve, Lisa Dubay, and Jennifer Haley. October 2000. "Health Insurance, Access, and Health Status of Children," In *Snapshots of America's Families II.* Washington, D.C.: The Urban Institute.

Nelson, Charles T. and Robert J. Mills. 2001. "The March CPS Health Insurance Verification Question and its Effect on Estimates of the Uninsured." http://www.census.gov/hhes/hlthins/verif.html. [Accessed September 13, 2001.]

Rajan, Shruti, Stephen Zuckerman, and Niall Brennan. 2000. "Confirming Insurance Coverage in a Telephone Survey: Evidence from the National Survey of America's Families." *Inquiry* 37: 317-327.

Zuckerman, Stephen, Jennifer Haley, and John Holahan. October 2000. "Health Insurance, Access, and Health Status of Nonelderly Adults," In *Snapshots of America's Families II.* Washington, D.C.: The Urban Institute.

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[i] Note that different categories of insurance coverage are used in the 1997 and 1999 State Profiles. The tabulations using the 1997 NSAF classified coverage into five categories: Employer, Other Private, Medicaid/State, Other Public, or Uninsured. In 1999, coverage was grouped into four slightly different categories: Employer-Sponsored, Medicaid/SCHIP/State, Other, and Uninsured. Thus, direct comparisons within coverage groups between the two rounds of data are not possible using these reports. See notes following the tables for further details on the categorization of insurance coverage.

[ii] To create mutually exclusive coverage categories, people reporting multiple types of insurance coverage are classified according to a hierarchy that looks first for employer coverage and then for Medicaid/SCHIP/State coverage.

## Table 1: Health Insurance Coverage of Nonelderly California Population by Age, 1999[1]

| | Employer-Sponsored[2] | | | Medicaid/SCHIP/State[3] | | | Other Insurance[4] | | | Uninsured[5] | | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number |
| **California** | | | | | | | | | | | | | |
| **All** | 18,830,188 | 63.4 | (1.1) | 3,292,993 | 11.1 | (0.6) | 2,016,808 | 6.8 | (0.5) | 5,573,960 | 18.8 | (0.9) | 29,713,949 |
| **Children** | 5,617,386 | 60.1 | (1.4) | 1,938,765 | 20.7 | (1.3) | 559,578 | 6.0 | (0.6) | 1,233,026 | 13.2 | (0.9) | 9,348,756 |
| 0-10 | 3,572,949 | 59.6 | (1.9) | 1,327,833 | 22.2 | (1.8) | 408,682 | 6.8 | (0.9) | 685,589 | 11.4 | (0.9) | 5,995,054 |
| 11-17 | 2,044,437 | 61.0 | (2.3) | 610,932 | 18.2 | (2.0) | 150,896 | 4.5 | (1.0) | 547,437 | 16.3 | (1.7) | 3,353,702 |
| **Adults** | 13,212,802 | 64.9 | (1.4) | 1,354,228 | 6.7 | (0.5) | 1,457,230 | 7.2 | (0.6) | 4,340,934 | 21.3 | (1.2) | 20,365,193 |
| 18-34 | 5,109,803 | 60.3 | (2.0) | 576,097 | 6.8 | (0.7) | 584,709 | 6.9 | (0.9) | 2,207,016 | 26.0 | (1.6) | 8,477,626 |
| 35-64 | 8,102,999 | 68.2 | (1.6) | 778,131 | 6.6 | (0.7) | 872,521 | 7.3 | (0.8) | 2,133,918 | 18.0 | (1.4) | 11,887,567 |
| **U.S. Total** | | | | | | | | | | | | | |
| **All** | 168,214,977 | 70.5 | (0.4) | 20,254,895 | 8.5 | (0.2) | 14,056,048 | 5.9 | (0.2) | 36,063,311 | 15.1 | (0.4) | 238,589,231 |
| **Children** | 47,951,280 | 66.6 | (0.6) | 12,096,953 | 16.8 | (0.4) | 3,032,462 | 4.2 | (0.2) | 8,883,455 | 12.3 | (0.5) | 71,964,150 |
| 0-10 | 28,560,386 | 64.3 | (0.8) | 8,707,580 | 19.6 | (0.5) | 1,819,164 | 4.1 | (0.3) | 5,300,798 | 11.9 | (0.6) | 44,387,927 |
| 11-17 | 19,390,894 | 70.3 | (0.8) | 3,389,373 | 12.3 | (0.6) | 1,213,298 | 4.4 | (0.3) | 3,582,658 | 13.0 | (0.6) | 27,576,223 |
| **Adults** | 120,263,697 | 72.2 | (0.4) | 8,157,942 | 4.9 | (0.1) | 11,023,586 | 6.6 | (0.2) | 27,179,855 | 16.3 | (0.4) | 166,625,081 |
| 18-34 | 42,487,694 | 66.2 | (0.8) | 3,932,261 | 6.1 | (0.3) | 3,652,598 | 5.7 | (0.3) | 14,094,559 | 22.0 | (0.7) | 64,167,112 |
| 35-64 | 77,776,003 | 75.9 | (0.5) | 4,225,681 | 4.1 | (0.2) | 7,370,988 | 7.2 | (0.3) | 13,085,296 | 12.8 | (0.4) | 102,457,969 |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

## Table 2: Health Insurance Coverage of Nonelderly California Population by Income, 1999[1]

| | Employer-Sponsored[2] | | | Medicaid/SCHIP/State[3] | | | Other Insurance[4] | | | Uninsured[5] | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) |
| **California** | | | | | | | | | | | | |
| **All** | 18,830,188 | 63.4 | (1.1) | 3,292,993 | 11.1 | (0.6) | 2,016,808 | 6.8 | (0.5) | 5,573,960 | 18.8 | (0.9) |
| Less than 100 percent | 1,209,774 | 24.3 | (2.5) | 1,782,657 | 35.8 | (2.2) | 306,886 | 6.2 | (1.2) | 1,686,964 | 33.8 | (2.4) |
| 100-200 percent | 2,202,942 | 40.4 | (2.4) | 965,763 | 17.7 | (1.6) | 372,408 | 6.8 | (1.2) | 1,918,429 | 35.1 | (2.2) |
| 200-399 percent | 3,647,791 | 71.9 | (2.7) | 276,395 | 5.5 | (1.0) | 275,436 | 5.4 | (1.1) | 874,815 | 17.2 | (2.3) |
| 400 percent or higher | 11,769,681 | 82.9 | (1.4) | 268,178 | 1.9 | (0.5) | 1,062,078 | 7.5 | (0.8) | 1,093,753 | 7.7 | (1.3) |
| **Children** | 5,617,386 | 60.1 | (1.4) | 1,938,765 | 20.7 | (1.3) | 559,578 | 6.0 | (0.6) | 1,233,026 | 13.2 | (0.9) |
| Less than 100 percent | 327,999 | 16.7 | (2.4) | 1,089,401 | 55.6 | (3.7) | 67,326 | 3.4 | (1.5) | 474,741 | 24.2 | (2.9) |
| 100-200 percent | 842,801 | 40.9 | (3.7) | 626,231 | 30.4 | (3.0) | 132,341 | 6.4 | (1.8) | 459,781 | 22.3 | (3.1) |
| 200-399 percent | 1,314,648 | 77.0 | (3.1) | 120,346 | 7.1 | (2.0) | 73,575 | 4.3 | (1.4) | 198,468 | 11.6 | (2.1) |
| 400 percent or higher | 3,131,939 | 86.5 | (1.7) | 102,788 | 2.8 | (1.1) | 286,336 | 7.9 | (1.2) | 100,036 | 2.8 | (0.8) |
| **Adults** | 13,212,802 | 64.9 | (1.4) | 1,354,228 | 6.7 | (0.5) | 1,457,230 | 7.2 | (0.6) | 4,340,934 | 21.3 | (1.2) |
| Less than 100 percent | 881,775 | 29.1 | (3.0) | 693,256 | 22.9 | (1.9) | 239,560 | 7.9 | (1.5) | 1,212,222 | 40.1 | (3.0) |
| 100-200 percent | 1,360,141 | 40.0 | (2.3) | 339,532 | 10.0 | (1.3) | 240,067 | 7.1 | (1.6) | 1,458,648 | 42.9 | (2.3) |
| 200-399 percent | 2,333,143 | 69.3 | (3.2) | 156,049 | 4.6 | (1.0) | 201,861 | 6.0 | (1.4) | 676,347 | 20.1 | (2.8) |
| 400 percent or higher | 8,637,743 | 81.7 | (1.7) | 165,391 | 1.6 | (0.4) | 775,743 | 7.3 | (0.9) | 993,717 | 9.4 | (1.6) |
| **U.S. Total** | | | | | | | | | | | | |
| **All** | 168,214,977 | 70.5 | (0.4) | 20,254,895 | 8.5 | (0.2) | 14,056,048 | 5.9 | (0.2) | 36,063,311 | 15.1 | (0.4) |
| Less than 100 percent | 7,811,916 | 24.6 | (0.9) | 11,500,333 | 36.3 | (1.0) | 2,167,503 | 6.8 | (0.5) | 10,222,507 | 32.3 | (1.1) |
| 100-200 percent | 22,547,559 | 52.1 | (1.1) | 5,824,835 | 13.5 | (0.4) | 2,875,344 | 6.6 | (0.4) | 12,029,333 | 27.8 | (0.9) |
| 200-399 percent | 31,074,302 | 74.2 | (0.8) | 1,733,835 | 4.1 | (0.3) | 2,643,519 | 6.3 | (0.4) | 6,436,909 | 15.4 | (0.7) |
| 400 percent or higher | 106,781,200 | 87.7 | (0.4) | 1,195,893 | 1.0 | (0.1) | 6,369,682 | 5.2 | (0.3) | 7,374,562 | 6.1 | (0.4) |
| **Children** | 47,951,280 | 66.6 | (0.6) | 12,096,953 | 16.8 | (0.4) | 3,032,462 | 4.2 | (0.2) | 8,883,455 | 12.3 | (0.5) |
| Less than 100 percent | 2,652,611 | 20.6 | (1.1) | 6,927,463 | 53.7 | (1.4) | 362,981 | 2.8 | (0.4) | 2,965,349 | 23.0 | (1.3) |
| 100-200 percent | 8,617,805 | 52.4 | (1.3) | 3,624,867 | 22.0 | (1.0) | 720,980 | 4.4 | (0.5) | 3,489,029 | 21.2 | (1.2) |
| 200-399 percent | 10,902,631 | 77.9 | (1.0) | 996,798 | 7.1 | (0.6) | 617,707 | 4.4 | (0.5) | 1,477,623 | 10.6 | (0.7) |
| 400 percent or higher | 25,778,233 | 90.1 | (0.5) | 547,825 | 1.9 | (0.2) | 1,330,794 | 4.7 | (0.3) | 951,454 | 3.3 | (0.3) |
| **Adults** | 120,263,697 | 72.2 | (0.4) | 8,157,942 | 4.9 | (0.1) | 11,023,586 | 6.6 | (0.2) | 27,179,855 | 16.3 | (0.4) |
| Less than 100 percent | 5,159,305 | 27.5 | (1.1) | 4,572,870 | 24.3 | (1.0) | 1,804,522 | 9.6 | (0.7) | 7,257,158 | 38.6 | (1.2) |
| 100-200 percent | 13,929,754 | 51.9 | (1.2) | 2,199,968 | 8.2 | (0.4) | 2,154,364 | 8.0 | (0.5) | 8,540,304 | 31.8 | (1.0) |
| 200-399 percent | 20,171,671 | 72.3 | (1.0) | 737,037 | 2.6 | (0.3) | 2,025,812 | 7.3 | (0.6) | 4,959,286 | 17.8 | (0.9) |
| 400 percent or higher | 81,002,967 | 87.0 | (0.5) | 648,068 | 0.7 | (0.1) | 5,038,888 | 5.4 | (0.3) | 6,423,108 | 6.9 | (0.5) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

## Table 3: Health Insurance Coverage of Nonelderly California Population by Gender, 1999[1]

| | Employer-Sponsored[2] | | | Medicaid/SCHIP/State[3] | | | Other Insurance[4] | | | Uninsured[5] | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) |
| **California** | | | | | | | | | | | | |
| **All** | 18,830,188 | 63.4 | (1.1) | 3,292,993 | 11.1 | (0.6) | 2,016,808 | 6.8 | (0.5) | 5,573,960 | 18.8 | (0.9) |
| Female | 9,263,104 | 63.3 | (1.4) | 1,894,605 | 12.9 | (0.9) | 1,028,353 | 7.0 | (0.6) | 2,453,283 | 16.8 | (1.1) |
| Male | 9,567,084 | 63.5 | (1.4) | 1,398,388 | 9.3 | (0.7) | 988,454 | 6.6 | (0.7) | 3,120,677 | 20.7 | (1.1) |
| **Children** | 5,617,386 | 60.1 | (1.4) | 1,938,765 | 20.7 | (1.3) | 559,578 | 6.0 | (0.6) | 1,233,026 | 13.2 | (0.9) |
| Female | 2,705,432 | 59.4 | (2.1) | 975,611 | 21.4 | (1.9) | 262,333 | 5.8 | (0.9) | 609,714 | 13.4 | (1.2) |
| Male | 2,911,955 | 60.7 | (1.8) | 963,154 | 20.1 | (1.8) | 297,245 | 6.2 | (1.0) | 623,312 | 13.0 | (1.2) |
| **Adults** | 13,212,802 | 64.9 | (1.4) | 1,354,228 | 6.7 | (0.5) | 1,457,230 | 7.2 | (0.6) | 4,340,934 | 21.3 | (1.2) |
| Female | 6,557,672 | 65.0 | (1.7) | 918,995 | 9.1 | (0.7) | 766,020 | 7.6 | (0.7) | 1,843,568 | 18.3 | (1.3) |
| Male | 6,655,130 | 64.8 | (1.7) | 435,233 | 4.2 | (0.6) | 691,209 | 6.7 | (0.9) | 2,497,365 | 24.3 | (1.5) |
| **U.S. Total** | | | | | | | | | | | | |
| **All** | 168,214,977 | 70.5 | (0.4) | 20,254,895 | 8.5 | (0.2) | 14,056,048 | 5.9 | (0.2) | 36,063,311 | 15.1 | (0.4) |
| Female | 83,907,600 | 69.8 | (0.4) | 11,521,220 | 9.6 | (0.3) | 7,022,888 | 5.8 | (0.2) | 17,786,994 | 14.8 | (0.4) |
| Male | 84,307,377 | 71.2 | (0.5) | 8,733,675 | 7.4 | (0.2) | 7,033,160 | 5.9 | (0.2) | 18,276,317 | 15.4 | (0.4) |
| **Children** | 47,951,280 | 66.6 | (0.6) | 12,096,953 | 16.8 | (0.4) | 3,032,462 | 4.2 | (0.2) | 8,883,455 | 12.3 | (0.5) |
| Female | 23,368,843 | 66.5 | (0.7) | 5,904,759 | 16.8 | (0.6) | 1,383,419 | 3.9 | (0.3) | 4,499,691 | 12.8 | (0.6) |
| Male | 24,582,437 | 66.8 | (0.7) | 6,192,194 | 16.8 | (0.5) | 1,649,043 | 4.5 | (0.2) | 4,383,765 | 11.9 | (0.5) |
| **Adults** | 120,263,697 | 72.2 | (0.4) | 8,157,942 | 4.9 | (0.1) | 11,023,586 | 6.6 | (0.2) | 27,179,855 | 16.3 | (0.4) |
| Female | 60,538,757 | 71.2 | (0.5) | 5,616,461 | 6.6 | (0.2) | 5,639,469 | 6.6 | (0.3) | 13,287,303 | 15.6 | (0.4) |
| Male | 59,724,940 | 73.2 | (0.5) | 2,541,482 | 3.1 | (0.2) | 5,384,117 | 6.6 | (0.3) | 13,892,553 | 17.0 | (0.5) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

## Table 4: Health Insurance Coverage of Nonelderly California Population by Race/Ethnicity, 1999[1]

| | Employer-Sponsored[2] | | | Medicaid/SCHIP/State[3] | | | Other Insurance[4] | | | Uninsured[5] | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) |
| **California** | | | | | | | | | | | | |
| **All** | 18,830,188 | 63.4 | (1.1) | 3,292,993 | 11.1 | (0.6) | 2,016,808 | 6.8 | (0.5) | 5,573,960 | 18.8 | (0.9) |
| White Non-Hispanic | 9,835,997 | 71.0 | (1.4) | 1,027,111 | 7.4 | (0.8) | 1,366,018 | 9.9 | (0.9) | 1,629,369 | 11.8 | (1.0) |
| Black Non-Hispanic | 1,210,112 | 58.5 | (4.5) | 524,878 | 25.4 | (3.3) | 97,633 | 4.7 | (1.4) | 235,372 | 11.4 | (3.0) |
| Hispanic | 5,164,344 | 50.6 | (1.8) | 1,571,154 | 15.4 | (1.3) | 235,641 | 2.3 | (0.5) | 3,245,297 | 31.8 | (1.7) |
| Other Non-Hispanic | 2,619,736 | 73.4 | (3.7) | 169,849 | 4.8 | (1.6) | 317,516 | 8.9 | (1.9) | 463,922 | 13.0 | (2.9) |
| **Children** | 5,617,386 | 60.1 | (1.4) | 1,938,765 | 20.7 | (1.3) | 559,578 | 6.0 | (0.6) | 1,233,026 | 13.2 | (0.9) |
| White Non-Hispanic | 2,681,829 | 72.2 | (2.2) | 479,982 | 12.9 | (1.7) | 364,869 | 9.8 | (1.3) | 190,456 | 5.1 | (0.9) |
| Black Non-Hispanic | 310,611 | 47.5 | (5.8) | 276,224 | 42.2 | (5.8) | 28,911 | 4.4 | (1.6) | 38,859 | 5.9 | (2.7) |
| Hispanic | 1,913,795 | 47.1 | (2.4) | 1,088,648 | 26.8 | (2.2) | 109,188 | 2.7 | (0.9) | 955,008 | 23.5 | (2.0) |
| Other Non-Hispanic | 711,151 | 78.1 | (5.0) | 93,911 | 10.3 | (3.8) | 56,610 | 6.2 | (2.4) | 48,703 | 5.4 | (2.2) |
| **Adults** | 13,212,802 | 64.9 | (1.4) | 1,354,228 | 6.7 | (0.5) | 1,457,230 | 7.2 | (0.6) | 4,340,934 | 21.3 | (1.2) |
| White Non-Hispanic | 7,154,168 | 70.5 | (1.6) | 547,129 | 5.4 | (0.6) | 1,001,149 | 9.9 | (1.1) | 1,438,913 | 14.2 | (1.2) |
| Black Non-Hispanic | 899,500 | 63.6 | (5.5) | 248,655 | 17.6 | (3.0) | 68,722 | 4.9 | (1.6) | 196,513 | 13.9 | (4.1) |
| Hispanic | 3,250,550 | 52.9 | (2.0) | 482,505 | 7.9 | (1.1) | 126,452 | 2.1 | (0.7) | 2,290,289 | 37.2 | (2.0) |
| Other Non-Hispanic | 1,908,584 | 71.7 | (4.2) | 75,939 | 2.9 | (1.0) | 260,906 | 9.8 | (2.3) | 415,219 | 15.6 | (3.5) |
| **U.S. Total** | | | | | | | | | | | | |
| **All** | 168,214,977 | 70.5 | (0.4) | 20,254,895 | 8.5 | (0.2) | 14,056,048 | 5.9 | (0.2) | 36,063,311 | 15.1 | (0.4) |
| White Non-Hispanic | 128,165,235 | 76.8 | (0.5) | 8,863,879 | 5.3 | (0.2) | 11,086,300 | 6.6 | (0.2) | 18,874,066 | 11.3 | (0.4) |
| Black Non-Hispanic | 17,341,382 | 56.0 | (1.3) | 6,248,536 | 20.2 | (1.0) | 1,241,635 | 4.0 | (0.4) | 6,111,394 | 19.8 | (1.0) |
| Hispanic | 14,635,209 | 49.6 | (1.0) | 4,384,723 | 14.9 | (0.6) | 945,534 | 3.2 | (0.3) | 9,545,969 | 32.4 | (0.9) |
| Other Non-Hispanic | 8,073,151 | 72.4 | (1.6) | 757,757 | 6.8 | (0.9) | 782,578 | 7.0 | (0.9) | 1,531,882 | 13.7 | (1.3) |
| **Children** | 47,951,280 | 66.6 | (0.6) | 12,096,953 | 16.8 | (0.4) | 3,032,462 | 4.2 | (0.2) | 8,883,455 | 12.3 | (0.5) |
| White Non-Hispanic | 34,879,259 | 75.6 | (0.7) | 4,803,953 | 10.4 | (0.4) | 2,252,037 | 4.9 | (0.3) | 4,209,425 | 9.1 | (0.7) |
| Black Non-Hispanic | 5,317,271 | 48.3 | (1.6) | 3,803,466 | 34.6 | (1.6) | 282,836 | 2.6 | (0.4) | 1,600,033 | 14.5 | (0.9) |
| Hispanic | 5,231,095 | 46.0 | (1.2) | 3,023,882 | 26.6 | (1.0) | 335,251 | 3.0 | (0.4) | 2,787,252 | 24.5 | (1.0) |
| Other Non-Hispanic | 2,523,656 | 73.4 | (2.4) | 465,652 | 13.5 | (2.1) | 162,337 | 4.7 | (1.2) | 286,745 | 8.3 | (1.1) |
| **Adults** | 120,263,697 | 72.2 | (0.4) | 8,157,942 | 4.9 | (0.1) | 11,023,586 | 6.6 | (0.2) | 27,179,855 | 16.3 | (0.4) |
| White Non-Hispanic | 93,285,977 | 77.2 | (0.4) | 4,059,926 | 3.4 | (0.2) | 8,834,263 | 7.3 | (0.3) | 14,664,641 | 12.1 | (0.4) |
| Black Non-Hispanic | 12,024,111 | 60.3 | (1.5) | 2,445,070 | 12.3 | (0.9) | 958,799 | 4.8 | (0.5) | 4,511,360 | 22.6 | (1.4) |
| Hispanic | 9,404,115 | 51.9 | (1.1) | 1,360,841 | 7.5 | (0.5) | 610,283 | 3.4 | (0.4) | 6,758,717 | 37.3 | (1.1) |
| Other Non-Hispanic | 5,549,495 | 72.0 | (1.7) | 292,105 | 3.8 | (0.6) | 620,241 | 8.1 | (1.1) | 1,245,137 | 16.2 | (1.8) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

## Table 5: Health Insurance Coverage of California Adults Aged 18-64 by Family Structure, 1999[1,6]

| | Employer-Sponsored[2] | | | Medicaid/SCHIP/State[3] | | | Other Insurance[4] | | | Uninsured[5] | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) |
| **California** | | | | | | | | | | | | |
| **All Adults** | 13,212,802 | 64.9 | (1.4) | 1,354,228 | 6.7 | (0.5) | 1,457,230 | 7.2 | (0.6) | 4,340,934 | 21.3 | (1.2) |
| Married, with Children | 4,909,391 | 72.6 | (1.4) | 247,736 | 3.7 | (0.6) | 423,097 | 6.3 | (0.9) | 1,182,382 | 17.5 | (1.4) |
| Married, without Children | 3,476,221 | 78.4 | (2.7) | 169,549 | 3.8 | (1.1) | 249,224 | 5.6 | (1.7) | 541,353 | 12.2 | (2.1) |
| Single, with Children | 876,227 | 43.4 | (2.5) | 514,839 | 25.5 | (2.7) | 75,218 | 3.7 | (0.9) | 553,082 | 27.4 | (2.9) |
| Single, without Children | 3,950,963 | 55.3 | (2.6) | 422,104 | 5.9 | (0.9) | 709,690 | 9.9 | (1.4) | 2,064,117 | 28.9 | (2.3) |
| **U.S. Total** | | | | | | | | | | | | |
| **All Adults** | 120,263,697 | 72.2 | (0.4) | 8,157,942 | 4.9 | (0.1) | 11,023,586 | 6.6 | (0.2) | 27,179,855 | 16.3 | (0.4) |
| Married, with Children | 42,826,652 | 79.9 | (0.5) | 1,267,701 | 2.4 | (0.2) | 2,455,433 | 4.6 | (0.2) | 7,065,699 | 13.2 | (0.5) |
| Married, without Children | 36,869,789 | 82.4 | (0.7) | 746,778 | 1.7 | (0.2) | 2,945,973 | 6.6 | (0.5) | 4,184,780 | 9.4 | (0.6) |
| Single, with Children | 6,699,011 | 48.0 | (1.1) | 2,619,409 | 18.8 | (0.8) | 563,509 | 4.0 | (0.4) | 4,069,486 | 29.2 | (1.0) |
| Single, without Children | 33,868,245 | 62.4 | (0.8) | 3,524,054 | 6.5 | (0.4) | 5,058,671 | 9.3 | (0.5) | 11,859,891 | 21.8 | (0.8) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

## Table 6: Health Insurance Coverage of California Children Aged 0-17 by Family Structure, 1999[1,7]

| | Employer-Sponsored[2] | | | Medicaid/SCHIP/State[3] | | | Other Insurance[4] | | | Uninsured[5] | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) |
| **California** | | | | | | | | | | | | |
| **All Children** | 5,617,386 | 60.1 | (1.4) | 1,938,765 | 20.7 | (1.3) | 559,578 | 6.0 | (0.6) | 1,230,057 | 13.2 | (0.9) |
| No parents | 83,207 | 20.3 | (5.6) | 232,995 | 56.7 | (8.5) | 39,682 | 9.7 | (4.3) | 54,843 | 13.4 | (4.9) |
| One parent family | 998,387 | 42.3 | (3.2) | 905,042 | 38.3 | (3.4) | 127,678 | 5.4 | (1.4) | 330,941 | 14.0 | (2.1) |
| Two-parent family | 4,535,792 | 69.0 | (1.6) | 800,728 | 12.2 | (1.1) | 392,218 | 6.0 | (0.8) | 844,273 | 12.8 | (1.2) |
| **U.S. Total** | | | | | | | | | | | | |
| **All Children** | 47,900,589 | 66.6 | (0.6) | 12,080,601 | 16.8 | (0.4) | 3,029,327 | 4.2 | (0.2) | 8,880,486 | 12.4 | (0.5) |
| No parents | 831,444 | 29.7 | (2.5) | 1,263,605 | 45.1 | (2.6) | 169,042 | 6.0 | (1.4) | 537,319 | 19.2 | (2.0) |
| One parent family | 8,133,383 | 45.7 | (1.0) | 6,259,316 | 35.2 | (1.0) | 611,564 | 3.4 | (0.3) | 2,794,305 | 15.7 | (0.9) |
| Two-parent family | 38,935,762 | 75.9 | (0.7) | 4,557,680 | 8.9 | (0.4) | 2,248,721 | 4.4 | (0.3) | 5,548,861 | 10.8 | (0.6) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

## Table 7: Health Insurance Coverage of Nonelderly California Population by Family Work Status, 1999[1,8]

| | Employer-Sponsored[2] | | | Medicaid/SCHIP/State[3] | | | Other Insurance[4] | | | Uninsured[5] | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) |
| **California** | | | | | | | | | | | | |
| **All** | 18,830,188 | 63.4 | (1.1) | 3,292,993 | 11.1 | (0.6) | 2,016,808 | 6.8 | (0.5) | 5,573,960 | 18.8 | (0.9) |
| Full-Time Worker(s) | 17,175,906 | 71.1 | (1.1) | 1,655,940 | 6.9 | (0.5) | 1,440,757 | 6.0 | (0.5) | 3,894,563 | 16.1 | (0.9) |
| Part-Time Worker(s) only | 918,778 | 38.7 | (4.7) | 326,703 | 13.8 | (2.1) | 269,620 | 11.4 | (2.3) | 856,902 | 36.1 | (4.5) |
| No Workers | 735,504 | 23.2 | (3.2) | 1,310,349 | 41.3 | (3.1) | 306,430 | 9.7 | (2.1) | 822,495 | 25.9 | (3.3) |
| **U.S. Total** | | | | | | | | | | | | |
| **All** | 168,214,977 | 70.5 | (0.4) | 20,254,895 | 8.5 | (0.2) | 14,056,048 | 5.9 | (0.2) | 36,063,311 | 15.1 | (0.4) |
| Full-Time Worker(s) | 154,635,701 | 76.6 | (0.4) | 10,127,488 | 5.0 | (0.2) | 9,501,412 | 4.7 | (0.2) | 27,541,261 | 13.7 | (0.4) |
| Part-Time Worker(s) only | 6,098,616 | 44.6 | (1.7) | 2,423,126 | 17.7 | (1.1) | 1,492,394 | 10.9 | (0.9) | 3,676,615 | 26.9 | (1.6) |
| No Workers | 7,480,660 | 32.4 | (1.1) | 7,704,282 | 33.4 | (1.0) | 3,062,241 | 13.3 | (0.8) | 4,845,435 | 21.0 | (1.0) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

**Table 8: Health Insurance Coverage of Nonelderly Working California Population by Firm Size, 1999[1,9]**

| | Employer-Sponsored[2] | | | Medicaid/SCHIP/State[3] | | | Other Insurance[4] | | | Uninsured[5] | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) |
| **California** | | | | | | | | | | | | |
| **All Working Adults** | 8,198,552 | 75.3 | (1.6) | 322,454 | 3.0 | (0.4) | 294,304 | 2.7 | (0.6) | 2,079,003 | 19.1 | (1.2) |
| 0-99 Employees | 4,285,069 | 68.0 | (2.0) | 218,656 | 3.5 | (0.6) | 219,767 | 3.5 | (0.9) | 1,577,274 | 25.0 | (1.7) |
| 100-999 Employees | 2,615,586 | 80.6 | (2.8) | 94,419 | 2.9 | (0.8) | 70,247 | 2.2 | (1.0) | 465,897 | 14.4 | (2.2) |
| 1000 Employees or More | 1,297,897 | 96.3 | (1.5) | 9,378 | 0.7 | (0.4) | 4,290 | 0.3 | (0.3) | 35,832 | 2.7 | (1.3) |
| **U.S. Total** | | | | | | | | | | | | |
| **All Working Adults** | 73,268,162 | 80.4 | (0.5) | 2,072,326 | 2.3 | (0.2) | 2,666,728 | 2.9 | (0.2) | 13,144,968 | 14.4 | (0.4) |
| 0-99 Employees | 38,087,994 | 73.8 | (0.6) | 1,586,840 | 3.1 | (0.2) | 1,935,097 | 3.8 | (0.2) | 9,969,296 | 19.3 | (0.6) |
| 100-999 Employees | 24,578,838 | 87.1 | (0.8) | 380,729 | 1.4 | (0.2) | 590,366 | 2.1 | (0.3) | 2,666,551 | 9.5 | (0.7) |
| 1000 Employees or More | 10,601,330 | 93.4 | (0.9) | 104,757 | 0.9 | (0.4) | 141,265 | 1.2 | (0.4) | 509,121 | 4.5 | (0.7) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

## Table 9: Health Insurance Coverage of Nonelderly California Population by Community Type, 1999[1,10]

| | Employer-Sponsored[2] | | | Medicaid/SCHIP/State[3] | | | Other Insurance[4] | | | Uninsured[5] | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) |
| **California** | | | | | | | | | | | | |
| **All** | 18,830,188 | 63.4 | (1.1) | 3,292,993 | 11.1 | (0.6) | 2,016,808 | 6.8 | (0.5) | 5,573,960 | 18.8 | (0.9) |
| **MSA** | 18,263,891 | 64.0 | (1.2) | 3,130,987 | 11.0 | (0.6) | 1,927,920 | 6.8 | (0.5) | 5,217,480 | 18.3 | (1.0) |
| Children | 5,406,190 | 60.4 | (1.5) | 1,856,403 | 20.7 | (1.4) | 552,700 | 6.2 | (0.6) | 1,140,939 | 12.7 | (0.9) |
| Adults | 12,857,701 | 65.7 | (1.4) | 1,274,584 | 6.5 | (0.5) | 1,375,220 | 7.0 | (0.6) | 4,076,541 | 20.8 | (1.2) |
| **Non-MSA** | 566,298 | 48.3 | (9.6) | 162,006 | 13.8 | (3.9) | 88,888 | 7.6 | (3.6) | 356,480 | 30.4 | (6.9) |
| Children | 211,197 | 53.8 | (9.7) | 82,362 | 21.0 | (7.2) | 6,878 | 1.8 | (1.2) | 92,087 | 23.5 | (8.4) |
| Adults | 355,101 | 45.5 | (10.0) | 79,644 | 10.2 | (2.9) | 82,010 | 10.5 | (5.3) | 264,393 | 33.9 | (8.6) |
| **U.S. Total** | | | | | | | | | | | | |
| **All** | 167,913,425 | 70.5 | (0.4) | 20,230,596 | 8.5 | (0.2) | 14,040,509 | 5.9 | (0.2) | 35,939,357 | 15.1 | (0.4) |
| **MSA** | 136,151,817 | 71.9 | (0.4) | 15,581,219 | 8.2 | (0.2) | 10,697,985 | 5.7 | (0.2) | 26,988,845 | 14.3 | (0.4) |
| Children | 38,587,130 | 68.3 | (0.6) | 9,310,066 | 16.5 | (0.5) | 2,324,112 | 4.1 | (0.2) | 6,246,629 | 11.1 | (0.3) |
| Adults | 97,564,688 | 73.4 | (0.4) | 6,271,153 | 4.7 | (0.2) | 8,373,873 | 6.3 | (0.2) | 20,742,216 | 15.6 | (0.4) |
| **Non-MSA** | 31,761,608 | 65.2 | (0.9) | 4,649,377 | 9.6 | (0.5) | 3,342,524 | 6.9 | (0.4) | 8,950,512 | 18.4 | (1.0) |
| Children | 9,269,317 | 60.3 | (1.6) | 2,768,069 | 18.0 | (1.1) | 708,350 | 4.6 | (0.4) | 2,620,641 | 17.1 | (1.7) |
| Adults | 22,492,291 | 67.5 | (0.8) | 1,881,307 | 5.6 | (0.4) | 2,634,174 | 7.9 | (0.5) | 6,329,871 | 19.0 | (0.8) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

## Table 10: Health Insurance Coverage of Nonelderly California Population by Place of Birth, 1999[1]

| | Employer-Sponsored[2] | | | Medicaid/SCHIP/State[3] | | | Other Insurance[4] | | | Uninsured[5] | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) |
| **California** | | | | | | | | | | | | |
| **All** | 18,830,188 | 63.4 | (1.1) | 3,292,993 | 11.1 | (0.6) | 2,016,808 | 6.8 | (0.5) | 5,573,960 | 18.8 | (0.9) |
| US-born | 14,956,534 | 66.6 | (1.2) | 2,854,363 | 12.7 | (0.7) | 1,604,866 | 7.2 | (0.5) | 3,043,967 | 13.6 | (0.9) |
| Foreign-born | 3,873,655 | 53.4 | (2.4) | 438,630 | 6.1 | (0.8) | 411,942 | 5.7 | (1.0) | 2,529,993 | 34.9 | (2.4) |
| **U.S. Total** | | | | | | | | | | | | |
| **All** | 168,214,977 | 70.5 | (0.4) | 20,254,895 | 8.5 | (0.2) | 14,056,048 | 5.9 | (0.2) | 36,063,311 | 15.1 | (0.4) |
| US-born | 155,363,461 | 72.1 | (0.4) | 19,012,204 | 8.8 | (0.2) | 12,708,815 | 5.9 | (0.2) | 28,344,684 | 13.2 | (0.4) |
| Foreign-born | 12,851,516 | 55.5 | (1.2) | 1,242,691 | 5.4 | (0.4) | 1,347,233 | 5.8 | (0.5) | 7,718,627 | 33.3 | (1.2) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

## Table 11: Characteristics of the Uninsured in California, 1999[11]

| | California | | | U.S. Total | | |
|---|---|---|---|---|---|---|
| | Number | Percent | (S.E.) | Number | Percent | (S.E.) |
| **All** | 5,573,960 | 100.0 | — | 36,063,311 | 100.0 | — |
| **Age** | | | | | | |
| 0-10 | 685,589 | 12.3 | (0.9) | 5,300,798 | 14.7 | (0.6) |
| 11-17 | 547,437 | 9.8 | (1.0) | 3,582,658 | 9.9 | (0.4) |
| 18-34 | 2,207,016 | 39.6 | (1.8) | 14,094,559 | 39.1 | (0.8) |
| 35-64 | 2,133,918 | 38.3 | (1.9) | 13,085,296 | 36.3 | (0.9) |
| **Gender** | | | | | | |
| Female | 2,453,283 | 44.0 | (1.6) | 17,786,994 | 49.3 | (0.8) |
| Male | 3,120,677 | 56.0 | (1.6) | 18,276,317 | 50.7 | (0.8) |
| **Race/Ethnicity** | | | | | | |
| White Non-Hispanic | 1,629,369 | 29.2 | (2.0) | 18,874,066 | 52.3 | (1.2) |
| Black Non-Hispanic | 235,372 | 4.2 | (1.1) | 6,111,394 | 17.0 | (0.8) |
| Hispanic | 3,245,297 | 58.2 | (2.3) | 9,545,969 | 26.5 | (0.8) |
| Other Non-Hispanic | 463,922 | 8.3 | (1.7) | 1,531,882 | 4.3 | (0.4) |
| **Income** | | | | | | |
| Less than 100 percent | 1,686,964 | 30.3 | (2.5) | 10,222,507 | 28.4 | (1.0) |
| 100-200 percent | 1,918,429 | 34.4 | (2.3) | 12,029,333 | 33.4 | (1.0) |
| 200-300 percent | 874,815 | 15.7 | (2.0) | 6,436,909 | 17.9 | (0.8) |
| 300 percent or higher | 1,093,753 | 19.6 | (2.9) | 7,374,562 | 20.5 | (1.1) |
| **Community Type**[12] | | | | | | |
| MSA | 5,217,480 | 93.6 | (2.1) | 26,988,845 | 75.1 | (1.3) |
| Non-MSA | 356,480 | 6.4 | (2.1) | 8,950,512 | 24.9 | (1.3) |
| **Place of Birth** | | | | | | |
| US-born | 3,043,967 | 54.6 | (2.6) | 28,344,684 | 78.6 | (0.9) |
| Foreign-born | 2,529,993 | 45.4 | (2.6) | 7,718,627 | 21.4 | (0.9) |
| **Health Status** | | | | | | |
| Fair/Poor Health | 1,152,545 | 20.7 | (1.8) | 6,042,118 | 16.8 | (0.6) |
| Excellent/Very Good/Good Health | 4,421,415 | 79.3 | (1.8) | 30,021,192 | 83.3 | (0.6) |
| Has a Limiting Disability[13] | 528,374 | 9.5 | (1.1) | 4,441,810 | 12.3 | (0.5) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

## Table 12: Uninsurance Rates in California, 1999[11]

| | California | | U.S. Total | |
|---|---|---|---|---|
| | Percent | (S.E.) | Percent | (S.E.) |
| **All** | 18.8 | (0.9) | 15.1 | (0.4) |
| **Age** | | | | |
| 0-10 | 11.4 | (0.9) | 11.9 | (0.6) |
| 11-17 | 16.3 | (1.7) | 13.0 | (0.6) |
| 18-34 | 26.0 | (1.6) | 22.0 | (0.7) |
| 35-64 | 18.0 | (1.4) | 12.8 | (0.4) |
| **Gender** | | | | |
| Female | 16.8 | (1.1) | 14.8 | (0.4) |
| Male | 20.7 | (1.1) | 15.4 | (0.4) |
| **Race/Ethnicity** | | | | |
| White Non-Hispanic | 11.8 | (1.0) | 11.3 | (0.4) |
| Black Non-Hispanic | 11.4 | (3.0) | 19.8 | (1.0) |
| Hispanic | 31.8 | (1.7) | 32.4 | (0.9) |
| Other Non-Hispanic | 13.0 | (2.9) | 13.7 | (1.3) |
| **Income** | | | | |
| Less than 100 percent | 33.8 | (2.4) | 32.3 | (1.1) |
| 100-200 percent | 35.1 | (2.2) | 27.8 | (0.9) |
| 200-399 percent | 17.2 | (2.3) | 15.4 | (0.7) |
| 400 percent or higher | 7.7 | (1.3) | 6.1 | (0.4) |
| **Community Type**[12] | | | | |
| MSA | 18.3 | (1.0) | 14.3 | (0.4) |
| Non-MSA | 30.4 | (6.9) | 18.4 | (1.0) |
| **Place of Birth** | | | | |
| US-born | 13.6 | (0.9) | 13.2 | (0.4) |
| Foreign-born | 34.9 | (2.4) | 33.3 | (1.2) |
| **Health Status** | | | | |
| Fair/Poor Health | 31.2 | (2.9) | 25.7 | (1.0) |
| Excellent/Very Good/Good Health | 17.0 | (0.9) | 14.0 | (0.3) |
| Has a Limiting Disability[13] | 15.6 | (1.7) | 15.6 | (0.7) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

**Table 13: Characteristics of Medicaid/SCHIP/State Enrollees in California, 1999[14]**

| | California | | | U.S. Total | | |
|---|---|---|---|---|---|---|
| | Number | Percent | (S.E.) | Number | Percent | (S.E.) |
| **All** | 3,292,993 | 100.0 | — | 20,254,895 | 100.0 | — |
| **Age** | | | | | | |
| 0-10 | 1,327,833 | 40.3 | (2.5) | 8,707,580 | 43.0 | (0.8) |
| 11-17 | 610,932 | 18.6 | (1.7) | 3,389,373 | 16.7 | (0.7) |
| 18-34 | 576,097 | 17.5 | (1.6) | 3,932,261 | 19.4 | (0.7) |
| 35-64 | 778,131 | 23.6 | (1.9) | 4,225,681 | 20.9 | (0.7) |
| **Gender** | | | | | | |
| Female | 1,894,605 | 57.5 | (2.3) | 11,521,220 | 56.9 | (0.9) |
| Male | 1,398,388 | 42.5 | (2.3) | 8,733,675 | 43.1 | (0.9) |
| **Race/Ethnicity** | | | | | | |
| White Non-Hispanic | 1,027,111 | 31.2 | (2.6) | 8,863,879 | 43.8 | (1.2) |
| Black Non-Hispanic | 524,878 | 15.9 | (2.1) | 6,248,536 | 30.9 | (1.2) |
| Hispanic | 1,571,154 | 47.7 | (2.9) | 4,384,723 | 21.7 | (0.8) |
| Other Non-Hispanic | 169,849 | 5.2 | (1.8) | 757,757 | 3.7 | (0.5) |
| **Income** | | | | | | |
| Less than 100 percent | 1,782,657 | 54.1 | (3.2) | 11,500,333 | 56.8 | (1.2) |
| 100-200 percent | 965,763 | 29.3 | (2.7) | 5,824,835 | 28.8 | (1.0) |
| 200-300 percent | 276,395 | 8.4 | (1.6) | 1,733,835 | 8.6 | (0.7) |
| 300 percent or higher | 268,178 | 8.1 | (2.1) | 1,195,893 | 5.9 | (0.5) |
| **Community Type[12]** | | | | | | |
| MSA | 3,130,986 | 95.1 | (1.8) | 15,581,219 | 77.0 | (1.1) |
| Non-MSA | 162,006 | 4.9 | (1.8) | 4,649,377 | 23.0 | (1.1) |
| **Place of Birth** | | | | | | |
| US-born | 2,854,363 | 86.7 | (1.7) | 19,012,204 | 93.9 | (0.5) |
| Foreign-born | 438,630 | 13.3 | (1.7) | 1,242,691 | 6.1 | (0.5) |
| **Health Status** | | | | | | |
| Fair/Poor Health | 739,172 | 22.5 | (2.2) | 4,376,390 | 21.6 | (0.7) |
| Excellent/Very Good/Good Health | 2,553,821 | 77.6 | (2.2) | 15,878,505 | 78.4 | (0.7) |
| Has a Limiting Disability[13] | 895,893 | 27.2 | (2.0) | 5,964,709 | 29.5 | (1.0) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

## Table 13a: Characteristics of Low-Income Medicaid/SCHIP/State Enrollees in California, 1999[14]

| | Less than 100% of Poverty | | | | | | 100 to 199% of Poverty | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | California | | | U.S. Total | | | California | | | U.S. Total | | |
| | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) | Number | Percent | (S.E.) |
| **All** | 1,782,657 | 100.0 | — | 11,500,333 | 100.0 | — | 965,763 | 100.0 | — | 5,824,835 | 100.0 | — |
| **Age** | | | | | | | | | | | | |
| 0-10 | 686,382 | 38.5 | (3.1) | 4,955,902 | 43.1 | (1.3) | 468,521 | 48.5 | (4.1) | 2,583,562 | 44.4 | (1.4) |
| 11-17 | 403,018 | 22.6 | (2.6) | 1,971,561 | 17.1 | (1.1) | 157,711 | 16.3 | (2.4) | 1,041,304 | 17.9 | (1.2) |
| 18-34 | 334,598 | 18.8 | (2.1) | 2,264,571 | 19.7 | (0.9) | 127,026 | 13.2 | (2.4) | 1,028,239 | 17.7 | (1.2) |
| 35-64 | 358,658 | 20.1 | (2.1) | 2,308,299 | 20.1 | (0.9) | 212,506 | 22.0 | (4.0) | 1,171,729 | 20.1 | (1.4) |
| **Gender** | | | | | | | | | | | | |
| Female | 1,091,696 | 61.2 | (3.0) | 6,806,614 | 59.2 | (1.1) | 532,739 | 55.2 | (3.9) | 3,258,648 | 55.9 | (1.6) |
| Male | 690,961 | 38.8 | (3.0) | 4,693,719 | 40.8 | (1.1) | 433,024 | 44.8 | (3.9) | 2,566,187 | 44.1 | (1.6) |
| **Race/Ethnicity** | | | | | | | | | | | | |
| White Non-Hispanic | 475,973 | 26.7 | (4.1) | 4,402,261 | 38.3 | (1.7) | 241,656 | 25.0 | (4.3) | 2,749,107 | 47.2 | (2.0) |
| Black Non-Hispanic | 331,233 | 18.6 | (3.2) | 3,966,081 | 34.5 | (1.8) | 148,515 | 15.4 | (3.2) | 1,625,838 | 27.9 | (1.8) |
| Hispanic | 891,800 | 50.0 | (4.7) | 2,742,011 | 23.8 | (1.1) | 556,311 | 57.6 | (4.8) | 1,283,258 | 22.0 | (1.6) |
| Other Non-Hispanic | 83,651 | 4.7 | (2.0) | 389,980 | 3.4 | (0.5) | 19,282 | 2.0 | (1.0) | 166,631 | 2.9 | (0.6) |
| **Community Type**[12] | | | | | | | | | | | | |
| MSA | 1,668,859 | 93.6 | (3.3) | 8,640,880 | 75.3 | (1.9) | 954,070 | 98.8 | (0.9) | 4,588,308 | 78.9 | (1.5) |
| Non-MSA | 113,798 | 6.4 | (3.3) | 2,842,651 | 24.8 | (1.9) | 11,693 | 1.2 | (0.9) | 1,229,029 | 21.1 | (1.5) |
| **Place of Birth** | | | | | | | | | | | | |
| US-born | 1,566,204 | 87.9 | (2.3) | 10,838,554 | 94.3 | (0.5) | 781,071 | 80.9 | (3.7) | 5,408,409 | 92.9 | (0.9) |
| Foreign-born | 216,453 | 12.1 | (2.3) | 661,779 | 5.8 | (0.5) | 184,692 | 19.1 | (3.7) | 416,425 | 7.2 | (0.9) |
| **Health Status** | | | | | | | | | | | | |
| Fair/Poor Health | 349,131 | 19.6 | (3.3) | 2,601,670 | 22.6 | (1.1) | 241,267 | 25.0 | (4.3) | 1,201,794 | 20.6 | (1.5) |
| Excellent/Very Good/Good Health | 1,433,526 | 80.4 | (3.3) | 8,898,663 | 77.4 | (1.1) | 724,496 | 75.0 | (4.3) | 4,623,041 | 79.4 | (1.5) |
| Has a Limiting Disability[13] | 382,640 | 21.5 | (3.0) | 3,303,029 | 28.7 | (1.3) | 286,220 | 29.6 | (4.6) | 1,723,504 | 29.6 | (1.8) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

**Table 14: Access to Health Care by Insurance Status: California Children, 1999[15]**

| | Employer-Sponsored/ Other Insurance[16] | | Medicaid/ SCHIP/State[17] | | Uninsured[18] | | All Children | |
|---|---|---|---|---|---|---|---|---|
| | Percent | (S.E.) | Percent | (S.E.) | Percent | (S.E.) | Percent | (S.E.) |
| **California** | | | | | | | | |
| Usual Source of Care[19] | | | | | | | | |
| None | 4.2 | (0.8) | 6.9 | (1.9) | 27.4 | (3.3) | 7.8 | (0.7) |
| ER | 0.8 | (0.3) | 3.0 | (1.2) | 2.6 | (1.2) | 1.5 | (0.4) |
| Doctor's Office | 69.8 | (1.5) | 41.3 | (3.7) | 21.7 | (3.3) | 57.6 | (1.3) |
| Other | 25.2 | (1.6) | 48.8 | (3.7) | 48.2 | (4.7) | 33.1 | (1.3) |
| Unmet Need[20] | | | | | | | | |
| Medical/Surgical | 2.7 | (0.6) | 3.8 | (1.3) | 3.2 | (1.4) | 3.0 | (0.5) |
| Dental | 5.7 | (0.8) | 8.6 | (2.0) | 11.9 | (2.0) | 7.1 | (0.6) |
| Prescription Drug | 1.1 | (0.4) | 2.5 | (0.9) | 3.6 | (1.1) | 1.7 | (0.3) |
| ANY | 8.3 | (1.0) | 12.2 | (2.2) | 15.0 | (2.4) | 10.0 | (0.8) |
| Not Confident in Access to Care[21] | 4.2 | (0.7) | 17.3 | (2.3) | 31.1 | (3.6) | 10.5 | (0.8) |
| Not Satisfied with Quality of Care[22] | 9.6 | (1.1) | 14.6 | (2.8) | 15.3 | (3.0) | 11.3 | (1.1) |
| **U.S. Total** | | | | | | | | |
| Usual Source of Care[19] | | | | | | | | |
| None | 3.7 | (0.2) | 5.4 | (0.6) | 18.1 | (1.3) | 5.8 | (0.2) |
| ER | 0.5 | (0.1) | 2.6 | (0.5) | 4.4 | (0.6) | 1.3 | (0.1) |
| Doctor's Office | 76.2 | (0.5) | 52.3 | (1.3) | 44.2 | (2.3) | 68.2 | (0.5) |
| Other | 19.6 | (0.5) | 39.8 | (1.3) | 33.4 | (1.8) | 24.7 | (0.5) |
| Unmet Need[20] | | | | | | | | |
| Medical/Surgical | 2.1 | (0.2) | 3.4 | (0.5) | 6.4 | (0.7) | 2.8 | (0.2) |
| Dental | 5.4 | (0.3) | 7.2 | (0.6) | 13.9 | (1.0) | 6.7 | (0.3) |
| Prescription Drug | 1.2 | (0.2) | 2.6 | (0.4) | 3.3 | (0.5) | 1.7 | (0.1) |
| ANY | 7.7 | (0.4) | 11.0 | (0.7) | 17.6 | (1.2) | 9.5 | (0.3) |
| Not Confident in Access to Care[21] | 3.9 | (0.2) | 12.2 | (0.9) | 22.9 | (1.6) | 7.6 | (0.3) |
| Not Satisfied with Quality of Care[22] | 8.8 | (0.4) | 11.2 | (0.9) | 20.4 | (1.7) | 10.5 | (0.3) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

## Table 14a: Access to Health Care by Insurance Status: Low-Income California Children, 1999[15,23]

| | Employer-Sponsored/ Other Insurance[16] | | Medicaid/ SCHIP/State[17] | | Uninsured[18] | | All Low-Income Children | |
|---|---|---|---|---|---|---|---|---|
| | Percent | (S.E.) | Percent | (S.E.) | Percent | (S.E.) | Percent | (S.E.) |
| **California** | | | | | | | | |
| Usual Source of Care[19] | | | | | | | | |
| None | 6.9 | (2.0) | 7.1 | (2.1) | 27.3 | (4.4) | 11.7 | (1.4) |
| ER | 3.0 | (1.4) | 3.1 | (1.4) | 3.5 | (1.6) | 3.1 | (0.8) |
| Doctor's Office | 52.9 | (4.1) | 39.7 | (4.4) | 15.9 | (3.0) | 38.7 | (2.4) |
| Other | 37.2 | (3.9) | 50.1 | (4.2) | 53.4 | (5.6) | 46.5 | (2.4) |
| Unmet Need[20] | | | | | | | | |
| Medical/Surgical | 3.4 | (1.3) | 3.6 | (1.4) | 2.6 | (1.2) | 3.3 | (0.8) |
| Dental | 5.4 | (1.7) | 8.9 | (2.2) | 11.8 | (2.4) | 8.4 | (1.2) |
| Prescription Drug | 1.0 | (0.8) | 2.7 | (0.9) | 2.8 | (0.9) | 2.1 | (0.5) |
| ANY | 8.8 | (2.1) | 12.2 | (2.4) | 13.2 | (2.6) | 11.3 | (1.4) |
| Not Confident in Access to Care[21] | 4.3 | (1.1) | 18.3 | (2.6) | 27.9 | (4.1) | 15.7 | (1.5) |
| Not Satisfied with Quality of Care[22] | 8.3 | (1.8) | 15.1 | (3.1) | 13.9 | (3.1) | 12.5 | (1.7) |
| **U.S. Total** | | | | | | | | |
| Usual Source of Care[19] | | | | | | | | |
| None | 5.6 | (0.5) | 5.3 | (0.7) | 18.5 | (1.5) | 8.4 | (0.4) |
| ER | 1.2 | (0.2) | 2.7 | (0.5) | 4.9 | (0.8) | 2.5 | (0.3) |
| Doctor's Office | 67.0 | (1.2) | 50.5 | (1.5) | 40.6 | (2.7) | 55.2 | (0.8) |
| Other | 26.2 | (1.2) | 41.5 | (1.4) | 36.0 | (2.1) | 33.9 | (0.8) |
| Unmet Need[20] | | | | | | | | |
| Medical/Surgical | 3.0 | (0.4) | 3.4 | (0.5) | 5.8 | (0.7) | 3.7 | (0.3) |
| Dental | 8.1 | (0.8) | 7.2 | (0.6) | 13.6 | (1.2) | 9.0 | (0.5) |
| Prescription Drug | 2.0 | (0.3) | 2.6 | (0.4) | 2.9 | (0.4) | 2.4 | (0.2) |
| ANY | 11.4 | (0.9) | 11.0 | (0.8) | 16.6 | (1.3) | 12.4 | (0.5) |
| Not Confident in Access to Care[21] | 5.1 | (0.5) | 12.7 | (0.9) | 22.7 | (1.7) | 11.7 | (0.5) |
| Not Satisfied with Quality of Care[22] | 10.3 | (0.8) | 11.2 | (1.0) | 19.4 | (2.1) | 12.5 | (0.6) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

**Table 15: Access to Health Care by Insurance Status: California Adults, 1999[15]**

| | Employer-Sponsored/ Other Insurance[16] | | Medicaid/ SCHIP/State[17] | | Uninsured[18] | | All Adults | |
|---|---|---|---|---|---|---|---|---|
| | Percent | (S.E.) | Percent | (S.E.) | Percent | (S.E.) | Percent | (S.E.) |
| **California** | | | | | | | | |
| Usual Source of Care[19] | | | | | | | | |
| None | 10.8 | (0.8) | 14.3 | (2.3) | 40.3 | (2.4) | 17.3 | (0.8) |
| ER | 2.5 | (0.5) | 3.1 | (1.3) | 2.8 | (0.8) | 2.6 | (0.4) |
| Doctor's Office | 62.9 | (1.2) | 37.6 | (3.9) | 19.5 | (1.8) | 52.0 | (1.1) |
| Other | 23.8 | (1.2) | 44.9 | (4.0) | 37.3 | (2.1) | 28.1 | (0.9) |
| Unmet Need[20] | | | | | | | | |
| Medical/Surgical | 8.2 | (0.7) | 8.7 | (1.9) | 13.6 | (1.9) | 9.4 | (0.7) |
| Dental | 13.1 | (0.9) | 19.7 | (2.8) | 20.7 | (2.3) | 15.1 | (0.8) |
| Prescription Drug | 4.1 | (0.6) | 10.3 | (1.9) | 6.5 | (1.2) | 5.0 | (0.6) |
| ANY | 19.9 | (1.2) | 30.1 | (3.5) | 27.8 | (2.8) | 22.3 | (1.0) |
| Not Confident in Access to Care[21] | 5.4 | (0.6) | 14.3 | (3.0) | 27.9 | (2.8) | 10.8 | (0.8) |
| Not Satisfied with Quality of Care[22] | 10.4 | (0.9) | 18.6 | (3.0) | 17.8 | (2.7) | 12.4 | (0.9) |
| **U.S. Total** | | | | | | | | |
| Usual Source of Care[19] | | | | | | | | |
| None | 10.7 | (0.4) | 10.6 | (0.9) | 33.4 | (1.2) | 14.4 | (0.4) |
| ER | 1.6 | (0.2) | 6.0 | (1.1) | 6.3 | (0.5) | 2.6 | (0.2) |
| Doctor's Office | 66.1 | (0.5) | 43.0 | (1.4) | 31.4 | (1.4) | 59.3 | (0.4) |
| Other | 21.6 | (0.4) | 40.4 | (1.4) | 28.9 | (1.0) | 23.7 | (0.4) |
| Unmet Need[20] | | | | | | | | |
| Medical/Surgical | 6.1 | (0.2) | 10.3 | (1.0) | 13.8 | (0.8) | 7.6 | (0.2) |
| Dental | 11.3 | (0.3) | 18.8 | (1.0) | 22.8 | (1.0) | 13.5 | (0.3) |
| Prescription Drug | 4.3 | (0.2) | 11.2 | (0.8) | 10.4 | (0.6) | 5.7 | (0.2) |
| ANY | 16.9 | (0.4) | 29.1 | (1.2) | 30.5 | (1.1) | 19.7 | (0.3) |
| Not Confident in Access to Care[21] | 5.9 | (0.2) | 12.0 | (1.0) | 22.7 | (1.0) | 8.9 | (0.3) |
| Not Satisfied with Quality of Care[22] | 9.4 | (0.3) | 14.2 | (1.2) | 18.9 | (1.2) | 11.1 | (0.3) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

## Table 15a: Access to Health Care by Insurance Status: Low-Income California Adults, 1999[15,23]

| | Employer-Sponsored/ Other Insurance[16] | | Medicaid/ SCHIP/State[17] | | Uninsured[18] | | All Low-Income Adults | |
|---|---|---|---|---|---|---|---|---|
| | Percent | (S.E.) | Percent | (S.E.) | Percent | (S.E.) | Percent | (S.E.) |
| **California** | | | | | | | | |
| Usual Source of Care[19] | | | | | | | | |
| None | 17.8 | (2.4) | 14.4 | (2.5) | 42.6 | (3.1) | 27.6 | (1.9) |
| ER | 2.0 | (0.9) | 3.4 | (1.7) | 3.1 | (1.0) | 2.7 | (0.6) |
| Doctor's Office | 44.9 | (3.3) | 33.9 | (3.8) | 15.6 | (2.1) | 31.0 | (2.0) |
| Other | 35.3 | (2.7) | 48.3 | (3.8) | 38.7 | (2.6) | 38.8 | (1.7) |
| Unmet Need[20] | | | | | | | | |
| Medical/Surgical | 9.3 | (1.9) | 9.0 | (2.2) | 10.4 | (1.7) | 9.7 | (1.1) |
| Dental | 17.2 | (3.0) | 20.6 | (3.0) | 18.6 | (2.6) | 18.3 | (1.7) |
| Prescription Drug | 5.5 | (1.7) | 8.2 | (1.9) | 6.6 | (1.5) | 6.4 | (1.0) |
| ANY | 24.5 | (2.6) | 31.0 | (4.0) | 25.9 | (3.3) | 26.1 | (1.9) |
| Not Confident in Access to Care[21] | 8.0 | (1.3) | 16.0 | (3.7) | 29.6 | (3.4) | 18.3 | (1.7) |
| Not Satisfied with Quality of Care[22] | 10.9 | (2.0) | 17.7 | (3.1) | 20.4 | (3.1) | 15.8 | (1.7) |
| **U.S. Total** | | | | | | | | |
| Usual Source of Care[19] | | | | | | | | |
| None | 12.5 | (0.7) | 10.6 | (1.1) | 33.7 | (1.2) | 19.6 | (0.6) |
| ER | 2.9 | (0.4) | 6.4 | (1.3) | 7.0 | (0.6) | 4.8 | (0.3) |
| Doctor's Office | 55.4 | (1.3) | 41.7 | (1.6) | 27.2 | (1.4) | 43.6 | (0.9) |
| Other | 29.1 | (1.3) | 41.3 | (1.5) | 32.2 | (1.2) | 32.0 | (0.8) |
| Unmet Need[20] | | | | | | | | |
| Medical/Surgical | 7.6 | (0.5) | 10.1 | (1.0) | 13.5 | (1.0) | 10.0 | (0.4) |
| Dental | 14.7 | (0.9) | 18.8 | (1.2) | 20.9 | (1.0) | 17.5 | (0.6) |
| Prescription Drug | 7.4 | (0.6) | 10.4 | (0.9) | 10.4 | (0.6) | 8.9 | (0.4) |
| ANY | 21.6 | (0.9) | 29.1 | (1.4) | 29.9 | (1.1) | 25.6 | (0.7) |
| Not Confident in Access to Care[21] | 9.5 | (0.7) | 12.5 | (1.2) | 23.8 | (1.2) | 14.9 | (0.6) |
| Not Satisfied with Quality of Care[22] | 12.2 | (0.6) | 13.4 | (1.2) | 18.9 | (1.4) | 14.6 | (0.6) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

## Table 16: Utilization of Health Care by Insurance Status: California Children, 1999[15,24]

| | Employer-Sponsored/ Other Insurance[16] | | Medicaid/ SCHIP/State[17] | | Uninsured[18] | | All Children | |
|---|---|---|---|---|---|---|---|---|
| | Percent | (S.E.) | Percent | (S.E.) | Percent | (S.E.) | Percent | (S.E.) |
| **California** | | | | | | | | |
| Any Doctor Visit | 77.6 | (1.4) | 71.2 | (3.0) | 44.2 | (3.4) | 71.9 | (1.2) |
| If Any, Average Number of Visits | 3.1 | (0.1) | 3.6 | (0.2) | 2.5 | (0.2) | 3.2 | (0.1) |
| Any Health Professional Visit | 38.6 | (1.9) | 33.2 | (3.6) | 21.6 | (2.6) | 35.2 | (1.6) |
| If Any, Average Number of Visits | 2.6 | (0.1) | 2.8 | (0.3) | 2.7 | (0.4) | 2.6 | (0.1) |
| Any Dental Visit | 84.7 | (1.5) | 72.0 | (3.3) | 45.2 | (4.1) | 76.7 | (1.3) |
| If Any, Average Number of Visits | 2.5 | (0.1) | 2.7 | (0.3) | 1.9 | (0.1) | 2.5 | (0.1) |
| Any Mental Visit | 3.6 | (0.5) | 7.4 | (1.7) | 0.5 | (0.3) | 4.0 | (0.5) |
| If Any, Average Number of Visits | 7.9 | (1.5) | 19.1 | (5.8) | 2.1 | (0.4) | 12.1 | (2.5) |
| Any ER Visit | 18.8 | (1.4) | 29.9 | (3.4) | 10.2 | (2.0) | 20.0 | (1.3) |
| If Any, Average Number of Visits | 1.6 | (0.1) | 1.9 | (0.2) | 1.4 | (0.2) | 1.7 | (0.1) |
| Any Well-Child Doctor Visit | 64.6 | (1.6) | 75.0 | (2.9) | 41.8 | (3.6) | 63.8 | (1.4) |
| If Any, Average Number of Visits | 1.9 | (0.1) | 2.2 | (0.1) | 1.7 | (0.1) | 1.9 | (0.1) |
| Any Hospital Stay | 4.5 | (0.7) | 7.5 | (1.9) | 2.2 | (1.0) | 4.9 | (0.6) |
| **U.S. Total** | | | | | | | | |
| Any Doctor Visit | 80.1 | (0.5) | 77.7 | (1.2) | 48.2 | (1.9) | 75.7 | (0.5) |
| If Any, Average Number of Visits | 3.2 | (0.0) | 4.0 | (0.1) | 2.7 | (0.1) | 3.3 | (0.0) |
| Any Health Professional Visit | 35.3 | (0.5) | 35.2 | (1.2) | 24.3 | (1.4) | 33.9 | (0.5) |
| If Any, Average Number of Visits | 2.6 | (0.1) | 3.4 | (0.2) | 2.4 | (0.1) | 2.7 | (0.1) |
| Any Dental Visit | 84.8 | (0.4) | 75.7 | (1.3) | 50.0 | (1.6) | 78.9 | (0.4) |
| If Any, Average Number of Visits | 2.4 | (0.0) | 2.2 | (0.1) | 2.1 | (0.1) | 2.4 | (0.0) |
| Any Mental Visit | 5.0 | (0.3) | 10.4 | (1.0) | 3.2 | (0.5) | 5.7 | (0.3) |
| If Any, Average Number of Visits | 9.7 | (1.0) | 14.7 | (1.6) | 11.3 | (2.6) | 11.4 | (0.9) |
| Any ER Visit | 22.9 | (0.6) | 36.1 | (1.2) | 20.5 | (1.4) | 24.8 | (0.4) |
| If Any, Average Number of Visits | 1.6 | (0.0) | 2.3 | (0.1) | 1.8 | (0.1) | 1.8 | (0.0) |
| Any Well-Child Visit | 67.2 | (0.6) | 74.8 | (1.1) | 43.7 | (1.6) | 65.5 | (0.6) |
| If Any, Average Number of Visits | 1.8 | (0.0) | 2.3 | (0.1) | 1.7 | (0.1) | 1.9 | (0.0) |
| Any Hospital Stay | 6.6 | (0.3) | 10.8 | (0.8) | 3.8 | (0.5) | 7.0 | (0.3) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

## Table 16a: Utilization of Health Care by Insurance Status: Low-Income California Children, 1999[15,23,24]

| | Employer-Sponsored/ Other Insurance[16] | | Medicaid/ SCHIP/State[17] | | Uninsured[18] | | All Low-Income Children | |
|---|---|---|---|---|---|---|---|---|
| | Percent | (S.E.) | Percent | (S.E.) | Percent | (S.E.) | Percent | (S.E.) |
| **California** | | | | | | | | |
| Any Doctor Visit | 73.9 | (3.1) | 69.3 | (3.5) | 41.3 | (3.8) | 64.3 | (2.1) |
| If Any, Average Number of Visits | 3.3 | (0.2) | 3.5 | (0.3) | 2.5 | (0.3) | 3.3 | (0.2) |
| Any Health Professional Visit | 34.2 | (3.8) | 32.1 | (3.9) | 22.1 | (3.1) | 30.5 | (2.4) |
| If Any, Average Number of Visits | 2.7 | (0.2) | 2.8 | (0.3) | 2.8 | (0.5) | 2.8 | (0.2) |
| Any Dental Visit | 75.9 | (3.7) | 71.6 | (3.5) | 43.8 | (5.0) | 66.0 | (2.5) |
| If Any, Average Number of Visits | 2.2 | (0.1) | 2.8 | (0.3) | 1.9 | (0.2) | 2.4 | (0.2) |
| Any Mental Visit | 2.4 | (1.3) | 7.4 | (1.9) | 0.4 | (0.3) | 4.1 | (0.9) |
| If Any, Average Number of Visits | 1.3 | (0.2) | 21.4 | (6.3) | 1.4 | (0.4) | 16.9 | (5.1) |
| Any ER Visit | 19.3 | (2.8) | 29.7 | (3.7) | 9.2 | (2.5) | 21.4 | (2.2) |
| If Any, Average Number of Visits | 1.9 | (0.3) | 1.9 | (0.2) | 1.5 | (0.2) | 1.8 | (0.1) |
| Any Well-Child Doctor Visit | 65.3 | (3.3) | 73.7 | (3.1) | 40.5 | (4.3) | 63.1 | (2.3) |
| If Any, Average Number of Visits | 2.2 | (0.2) | 2.2 | (0.1) | 1.7 | (0.1) | 2.1 | (0.1) |
| Any Hospital Stay | 4.3 | (1.6) | 7.5 | (2.1) | 1.0 | (0.6) | 4.9 | (1.1) |
| **U.S. Total** | | | | | | | | |
| Any Doctor Visit | 74.0 | (1.0) | 76.8 | (1.3) | 45.8 | (2.2) | 68.8 | (0.9) |
| If Any, Average Number of Visits | 3.2 | (0.1) | 4.0 | (0.1) | 2.6 | (0.1) | 3.4 | (0.1) |
| Any Health Professional Visit | 33.4 | (1.1) | 34.3 | (1.4) | 24.0 | (1.6) | 31.6 | (0.9) |
| If Any, Average Number of Visits | 2.7 | (0.1) | 3.3 | (0.2) | 2.3 | (0.1) | 2.9 | (0.1) |
| Any Dental Visit | 76.6 | (1.0) | 75.8 | (1.4) | 46.9 | (1.7) | 69.4 | (0.8) |
| If Any, Average Number of Visits | 2.2 | (0.1) | 2.3 | (0.1) | 2.1 | (0.1) | 2.2 | (0.1) |
| Any Mental Visit | 5.2 | (0.5) | 10.3 | (1.1) | 3.2 | (0.6) | 6.6 | (0.4) |
| If Any, Average Number of Visits | 10.3 | (1.3) | 14.5 | (1.7) | 11.0 | (3.1) | 12.8 | (1.2) |
| Any ER Visit | 26.8 | (1.3) | 35.9 | (1.3) | 19.2 | (1.5) | 28.4 | (0.8) |
| If Any, Average Number of Visits | 1.7 | (0.1) | 2.3 | (0.1) | 1.8 | (0.1) | 2.0 | (0.1) |
| Any Well-Child Visit | 63.4 | (1.2) | 74.3 | (1.3) | 43.9 | (1.8) | 63.0 | (1.0) |
| If Any, Average Number of Visits | 1.9 | (0.0) | 2.3 | (0.1) | 1.7 | (0.1) | 2.0 | (0.0) |
| Any Hospital Stay | 6.9 | (0.6) | 10.8 | (0.9) | 3.4 | (0.6) | 7.5 | (0.4) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

## Table 17: Utilization of Health Care by Insurance Status: California Adults, 1999[15,24]

| | Employer-Sponsored/ Other Insurance[16] | | Medicaid/ SCHIP/State[17] | | Uninsured[18] | | All Adults | |
|---|---|---|---|---|---|---|---|---|
| | Percent | (S.E.) | Percent | (S.E.) | Percent | (S.E.) | Percent | (S.E.) |
| **California** | | | | | | | | |
| Any Doctor Visit | 73.2 | (1.3) | 73.7 | (3.0) | 40.2 | (2.6) | 66.2 | (1.2) |
| If Any, Average Number of Visits | 4.3 | (0.3) | 7.9 | (1.4) | 2.7 | (0.2) | 4.4 | (0.3) |
| Any Health Professional Visit | 31.5 | (1.3) | 32.1 | (3.5) | 19.7 | (2.0) | 29.0 | (1.0) |
| If Any, Average Number of Visits | 3.0 | (0.2) | 5.0 | (0.8) | 2.7 | (0.5) | 3.1 | (0.2) |
| Any Dental Visit | 79.2 | (1.3) | 62.6 | (3.7) | 46.0 | (3.5) | 71.0 | (1.1) |
| If Any, Average Number of Visits | 2.4 | (0.1) | 2.6 | (0.2) | 2.5 | (0.4) | 2.4 | (0.1) |
| Any Mental Visit | 8.0 | (0.7) | 17.5 | (2.4) | 5.0 | (1.1) | 8.0 | (0.5) |
| If Any, Average Number of Visits | 14.6 | (4.9) | 13.6 | (2.4) | 9.1 | (2.3) | 13.7 | (3.5) |
| Any ER Visit | 20.8 | (1.3) | 32.9 | (3.8) | 12.1 | (1.5) | 19.7 | (1.1) |
| If Any, Average Number of Visits | 1.7 | (0.1) | 2.7 | (0.8) | 1.9 | (0.5) | 1.8 | (0.1) |
| Any Breast Exam (women only) | 59.7 | (2.1) | 48.4 | (4.9) | 33.4 | (3.3) | 53.9 | (1.5) |
| Any Pap Smear (women only) | 66.4 | (2.0) | 68.5 | (4.4) | 47.5 | (3.6) | 63.1 | (1.6) |
| Any Hospital Stay | 8.0 | (0.8) | 17.4 | (2.7) | 4.8 | (0.9) | 8.0 | (0.6) |
| **U.S. Total** | | | | | | | | |
| Any Doctor Visit | 75.3 | (0.4) | 75.9 | (1.5) | 45.8 | (1.0) | 70.5 | (0.4) |
| If Any, Average Number of Visits | 3.9 | (0.1) | 7.6 | (0.4) | 3.5 | (0.2) | 4.1 | (0.1) |
| Any Health Professional Visit | 28.6 | (0.5) | 30.5 | (1.3) | 19.6 | (0.9) | 27.2 | (0.4) |
| If Any, Average Number of Visits | 2.9 | (0.1) | 6.1 | (0.7) | 2.8 | (0.2) | 3.1 | (0.1) |
| Any Dental Visit | 75.3 | (0.4) | 55.8 | (1.5) | 42.7 | (1.3) | 69.0 | (0.4) |
| If Any, Average Number of Visits | 2.3 | (0.0) | 2.4 | (0.1) | 2.3 | (0.1) | 2.3 | (0.0) |
| Any Mental Visit | 6.2 | (0.2) | 20.0 | (1.2) | 5.1 | (0.5) | 6.7 | (0.2) |
| If Any, Average Number of Visits | 10.1 | (0.9) | 15.8 | (1.9) | 8.0 | (1.0) | 10.7 | (0.8) |
| Any ER Visit | 20.5 | (0.4) | 43.8 | (1.5) | 22.2 | (0.8) | 21.9 | (0.4) |
| If Any, Average Number of Visits | 1.7 | (0.0) | 2.9 | (0.2) | 1.8 | (0.1) | 1.8 | (0.0) |
| Any Breast Exam (women only) | 63.2 | (0.8) | 48.9 | (1.6) | 33.4 | (1.0) | 57.6 | (0.6) |
| Any Pap Smear (women only) | 68.6 | (0.7) | 62.8 | (2.1) | 45.0 | (1.2) | 64.5 | (0.6) |
| Any Hospital Stay | 9.0 | (0.3) | 26.0 | (1.3) | 6.9 | (0.5) | 9.5 | (0.3) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

## Table 17a: Utilization of Health Care by Insurance Status: Low-Income California Adults, 1999[15,23,24]

| | Employer-Sponsored/ Other Insurance[16] | | Medicaid/ SCHIP/State[17] | | Uninsured[18] | | All Low-Income Adults | |
|---|---|---|---|---|---|---|---|---|
| | Percent | (S.E.) | Percent | (S.E.) | Percent | (S.E.) | Percent | (S.E.) |
| **California** | | | | | | | | |
| Any Doctor Visit | 66.0 | (2.7) | 73.7 | (3.2) | 36.1 | (3.0) | 54.8 | (2.1) |
| If Any, Average Number of Visits | 5.3 | (1.1) | 6.8 | (0.8) | 2.8 | (0.3) | 5.0 | (0.6) |
| Any Health Professional Visit | 28.6 | (2.8) | 32.4 | (4.0) | 15.9 | (2.1) | 23.9 | (1.5) |
| If Any, Average Number of Visits | 3.3 | (0.3) | 5.3 | (1.0) | 3.5 | (0.7) | 3.8 | (0.4) |
| Any Dental Visit | 61.9 | (3.7) | 63.8 | (3.1) | 38.8 | (3.5) | 52.6 | (2.3) |
| If Any, Average Number of Visits | 2.5 | (0.1) | 2.7 | (0.2) | 2.3 | (0.2) | 2.5 | (0.1) |
| Any Mental Visit | 5.5 | (1.8) | 13.7 | (2.6) | 6.8 | (1.7) | 7.4 | (1.1) |
| If Any, Average Number of Visits | 46.0 | (38.0) | 13.1 | (4.0) | 8.0 | (2.0) | 21.6 | (11.9) |
| Any ER Visit | 21.3 | (2.6) | 34.5 | (3.8) | 13.1 | (1.4) | 20.0 | (1.5) |
| If Any, Average Number of Visits | 2.0 | (0.3) | 2.9 | (1.0) | 2.2 | (0.8) | 2.3 | (0.4) |
| Any Breast Exam (women only) | 46.5 | (3.8) | 48.3 | (5.4) | 33.7 | (4.2) | 42.3 | (2.3) |
| Any Pap Smear (women only) | 60.3 | (3.0) | 66.6 | (5.7) | 42.3 | (4.2) | 56.2 | (2.2) |
| Any Hospital Stay | 10.6 | (1.6) | 18.2 | (2.9) | 5.2 | (1.0) | 9.6 | (0.9) |
| **U.S. Total** | | | | | | | | |
| Any Doctor Visit | 71.6 | (1.1) | 75.9 | (1.6) | 42.6 | (1.3) | 62.2 | (0.7) |
| If Any, Average Number of Visits | 4.4 | (0.2) | 7.4 | (0.4) | 3.8 | (0.2) | 4.8 | (0.1) |
| Any Health Professional Visit | 29.3 | (0.8) | 30.6 | (1.4) | 17.9 | (1.1) | 25.5 | (0.6) |
| If Any, Average Number of Visits | 3.4 | (0.2) | 6.2 | (0.7) | 3.2 | (0.2) | 3.8 | (0.2) |
| Any Dental Visit | 63.1 | (1.2) | 54.1 | (1.6) | 37.0 | (1.4) | 52.7 | (0.8) |
| If Any, Average Number of Visits | 2.3 | (0.1) | 2.5 | (0.1) | 2.3 | (0.2) | 2.3 | (0.1) |
| Any Mental Visit | 7.4 | (0.7) | 19.6 | (1.2) | 5.7 | (0.6) | 8.6 | (0.4) |
| If Any, Average Number of Visits | 11.3 | (3.4) | 15.9 | (2.2) | 7.8 | (1.2) | 12.1 | (1.7) |
| Any ER Visit | 27.1 | (1.0) | 44.3 | (1.5) | 24.2 | (1.0) | 28.7 | (0.7) |
| If Any, Average Number of Visits | 2.0 | (0.1) | 3.0 | (0.2) | 1.9 | (0.1) | 2.2 | (0.1) |
| Any Breast Exam (women only) | 55.1 | (1.5) | 48.6 | (1.9) | 31.9 | (1.3) | 46.4 | (0.9) |
| Any Pap Smear (women only) | 61.6 | (1.5) | 63.0 | (2.2) | 44.4 | (1.3) | 56.3 | (0.9) |
| Any Hospital Stay | 12.8 | (0.9) | 26.4 | (1.4) | 8.2 | (0.6) | 13.2 | (0.6) |

Source: Urban Institute tabulations of the National Survey of America's Families (NSAF), 1999.
Standard errors for each percent are given in parentheses.
See further notes following last table.

**Notes for Tables 1 - 10**

1. Insurance coverage is measured at the time of the survey. Excludes persons ages 65 and over and those living in institutions or group quarters.
2. Employer-Sponsored coverage includes those who receive coverage directly from a current or former employer or union, those who receive coverage as dependents, those who receive coverage under the Consolidated Budget Reconciliation Act of 1986 (COBRA), and those who receive coverage under CHAMPUS, Veterans Affairs (VA), or other military program.
3. Medicaid/SCHIP/State coverage includes those who receive coverage through the Medicaid program, through state-specific programs, or, for children less than 18, through separate State Children's Health Insurance Programs (SCHIP).
4. Other Insurance includes those who receive coverage through Medicare, through privately-purchased coverage that is not obtained through an employer or union, and through coverage that cannot be definitively classified as employer-sponsored, privately-purchased, Medicaid/SCHIP/State, Medicare, or CHAMPUS, Veterans Affairs (VA), or other military program.
5. Uninsured includes those who report no type of health insurance coverage at the time of the survey or who report coverage under the Indian Health Service Program. Rather than defining uninsurance as a residual, the NSAF confirms uninsurance with a question that verifies whether people who appear not to have coverage are, in fact, uninsured (Rajan, Zuckerman, and Brennan 2001).
6. The family structure of adults is defined in terms of whether or not they are married and whether or not they have any of their own children in the household. "Married" adults are defined as those who report being married or have a spouse in the household. Those who are widowed, divorced, separated, or never married, or whose marital status was not ascertained but who did not report having a spouse in the household, are classified as "single." Those "with children" have at least one biological, adoptive, or stepchild under age 18 living in the household at the time of the survey; all other adults are classified as "without children."
7. Family type for children is defined in terms of their relationship with the adults with whom they live. The category "no parents" means that the child lives with relatives other than parents or with unrelated adults. Children classified as living in "one-parent families" live with a single biological or adoptive parent (the household may contain this parent's unmarried partner). Children living with two biological or adoptive parents (married or unmarried) or one biological or adoptive parent and one stepparent (parents must be married) are classified as living in "two-parent families."
8. Family work status is a hierarchy. Individuals who work fewer than 35 hours per week are considered part-time workers, and those who work 35 or more hours per week are considered full-time workers. Families with at least one full-time worker are classified as "full-time worker" families. Families with no full-time workers but one or more part-time workers are classified as "part-time worker(s) only" families, and those with no full-time or part-time workers in the family are classified as "no workers" families.
9. Firm size is the number of people who are employed at the location of the worker's main job. Based on those who work for an employer. "Working for an employer" includes those who are also self-employed part of the time but work for an employer as their main job. Excludes those who work in the public sector.
10. Based on those for whom geographic location is known (county-level information is not available for residents of Alaska). MSAs are Metropolitan Statistical Areas as defined by the U.S. Office of Management and Budget and as used by the U.S. Census Bureau (see http://www.census.gov/ population/www/estimates/aboutmetro.html).

**Notes for Tables 11 - 13a**

11. Insurance coverage is measured at the time of the survey. Interviewers asked respondents about family members' current enrollment in private and public insurance and followed up with a confirmation question when no coverage was specified. Uninsured includes those who reported no type of health insurance coverage at the time of the survey or who reported coverage under the Indian Health Service program. Excludes persons ages 65 and over and those living in institutions or group quarters.
12. Based on those for whom geographic location is known (county-level information is not available for residents of Alaska). MSAs are Metropolitan Statistical Areas as defined by the U.S. Office of Management and Budget and as used by the U.S. Census Bureau (see http://www.census.gov/ population/www/estimates/aboutmetro.html).
13. For children, indicates that the child has a physical, learning, or mental health condition that limits participation in the usual kinds of activities done by most children the child's age or limits his or her ability to do schoolwork. For adults, indicates a physical, mental, or other health condition that limits the kind or amount of work the person can do.
14. Insurance coverage is measured at the time of the survey. To create mutually exclusive coverage categories, people reporting multiple types of insurance coverage are classified according to a hierarchy that looks first for employer-sponsored coverage and then for Medicaid/SCHIP/State coverage. Thus, for instance, those with both employer-sponsored coverage and Medicaid would be classified as having employer-sponsored coverage and would not be included in these estimates. Medicaid/SCHIP/State coverage includes those who receive coverage through the Medicaid program, through state-specific programs, or, for children less than 18, through separate State Children's Health Insurance Programs (SCHIP). Excludes persons ages 65 and over and those living in institutions or group quarters.

**Notes for Tables 14 - 17a**

15. Insurance coverage is measured at the time of the survey. Excludes persons ages 65 and over and those living in institutions or group quarters.
16. Employer-Sponsored/Other Insurance includes those who receive coverage directly from a current or former employer or union, those who receive coverage as dependents, those who receive coverage under the Consolidated Budget Reconciliation Act of 1986 (COBRA), those who receive coverage under CHAMPUS, Veterans Affairs (VA), or other military program, those who receive coverage through Medicare, those who receive coverage through privately-purchased coverage that is not obtained through an employer or union, and those who receive coverage that cannot be definitively classified in any other category.
17. Medicaid/SCHIP/State coverage includes those who receive coverage through the Medicaid program, through state-specific programs, or, for children less than 18, through separate State Children's Health Insurance programs (SCHIP).
18. Uninsured includes those who report no type of health insurance coverage at the time of the survey or who report coverage under the Indian Health Service Program. Rather than defining uninsurance as a residual, the NSAF confirms uninsurance with a question that verifies whether people who appear not to have coverage are, in fact, uninsured (Rajan, Zuckerman, and Brennan 2001).
19. The NSAF asks, "Is there a place where [person] usually goes when he/she is sick or needs advice about his/her health?" If yes, the interviewer asks, "What kind of place is it that [person] usually goes to?" The response choices are a doctor's office (including an HMO), a hospital emergency room, a clinic or hospital outpatient department, or some other place. "Other" includes those whose usual source of care is a clinic or hospital outpatient department, a naturopathic/herbal provider, a family member or friend who is in the medical profession, dial-in or phone service, or other providers.
20. Unmet need estimates are based on responses to a series of questions asking, "In the past 12 months, did [person] not get or postpone [type of care] when he/she needed it?" "Any" unmet

need indicates that a person had one or more types of unmet need among medical/surgical, dental, and prescription drug need.

21. Based on respondent's answer to the question "How confident are you that your family members can get care if they need it?" "Not confident" includes those respondents who say they are "not too confident" or "not confident at all" that their family can get needed medical care.
22. Based on respondent's answer to the question "How satisfied are you with the quality of medical care your family has received during the last 12 months?" "Not satisfied" includes those respondents who say they are "very dissatisfied" or "somewhat dissatisfied" in the quality of care their family receives.
23. "Low-income" is defined as below 200 percent of the federal poverty level.
24. Health service utilization questions in the NSAF ask whether the sampled person received specific types of care in the 12 months prior to the survey and, if so, how many times.

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# Children Eligible for Medicaid but Not Enrolled: How Great a Policy Concern?

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*In the mid-1990s, children eligible for, but not insured by, Medicaid were almost four times more likely than Medicaid-enrolled children to lack a regular source of health care.*

Approximately one of every five children eligible for Medicaid coverage is medically uninsured, despite great interest in reducing the number of children without health insurance. Since these Medicaid-eligible children account for up to a quarter of all uninsured children (Lewis, Ellwood, and Czakja 1997; Selden, Banthin, and Cohen 1998), many states have launched outreach and enrollment initiatives to attract them. But is underenrollment really a public policy concern? If these children have sufficient access to primary care and can enroll in Medicaid when serious health problems strike, for example, does further outreach represent a cost-effective use of public funds?

Children who are eligible for but not enrolled in Medicaid do, in fact, encounter greater obstacles to care than their Medicaid-covered counterparts, according to National Health Interview Survey (NHIS) data.[1] Medicaid-eligible uninsured children are somewhat healthier than enrolled children, but not all are healthy. If uninsured Medicaid-eligible children are compared with Medicaid-covered children with the same health status, family income, and other characteristics, the uninsured are more likely to report unmet medical need and less likely to use health care services. Also, their families are more likely to be burdened with out-of-pocket health costs.

Medicaid-eligible children with *private* health insurance also face barriers to access. When health status and other non–insurance-related differences are taken into account, these children are more likely than Medicaid-enrolled children to have a regular source of care. However, they are also more likely to report financial barriers (out-of-pocket expenses) to seeking care. Furthermore, those who saw a provider in the past year had fewer visits, on average, than Medicaid-enrolled children. For these reasons, the public interest in enrolling more Medicaid-eligible children is justified.

## Differences between Eligible Uninsured and Medicaid-Enrolled Children

A nationally representative sample of 18,462 Medicaid-eligible children ages 0 to 17 in the 1994 and 1995 NHIS forms the basis for

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the analysis reported here.[2] This group represents 32 percent of U.S. children nationwide. Of these Medicaid-eligible children, 56 percent were enrolled in Medicaid, 27 percent had private insurance, and 17 percent were uninsured.[3]

The uninsured and Medicaid-enrolled groups of Medicaid-eligible children differ demographically, socially, and economically (table 1). The uninsured are slightly older than the Medicaid-covered group, more likely to be white non-Hispanic, and less likely to be African American non-Hispanic. Their families are better educated on average than their Medicaid-covered counterparts, less likely to be very poor (below 50 percent of the federal poverty level [FPL]), more likely to have two resident parents, more likely to have resident parents working full-time, and less likely to have at least one parent out of the labor force (neither working nor looking for work).

What about their relative health? Most children in both groups are healthy (table 2). More than 9 out of 10 reported no activity limitations, and less than 6 percent reported fair or poor health. The typically small health differences between the groups are statistically significant, however, with Medicaid-covered children slightly less healthy than the uninsured. This is to be expected because eligible children often are enrolled in Medicaid when they seek care for a health problem. Both providers and parents are strongly motivated to enroll eligible uninsured children in such circumstances. Still, it is conspicuous that about 4 percent of the uninsured were limited in a major activity, and 11 percent had some chronic health condition. Thus, it is not uni-

*TABLE 1: Characteristics of Medicaid-Eligible Children: Uninsured versus Enrolled (Percent Distribution)*

| | Uninsured | Enrolled |
|---|---|---|
| Age | | |
| 0–6 years | 51.0*** | 54.9 |
| 7–13 years | 36.9*** | 32.9 |
| 14–17 years | 12.0 | 12.2 |
| Race/Ethnicity | | |
| White, non-Hispanic | 48.3*** | 38.8 |
| African American, non-Hispanic | 17.4*** | 31.5 |
| Hispanic | 28.7*** | 24.9 |
| Other | 6.0 | 4.9 |
| Family Type | | |
| Two parents | 60.8*** | 42.2 |
| Single parent, female | 35.3*** | 55.2 |
| Single parent, male | 3.8** | 2.6 |
| Parental Education[a] | | |
| Less than high school | 29.3*** | 34.2 |
| High school graduate | 45.8** | 42.4 |
| Some college | 18.0 | 18.3 |
| College graduate or more | 7.8*** | 5.0 |
| Family Income (% FPL)[a] | | |
| <50 | 42.0*** | 63.1 |
| 50–100 | 41.4*** | 20.8 |
| 100–150 | 14.4*** | 6.3 |
| 150–200 | 2.1** | 3.2 |
| >200 | 0.1*** | 3.7 |
| Parental Work Activity[c] | | |
| Full-time (one or both as relevant) | 31.9*** | 20.1 |
| Part-time (at least one) | 17.0 | 15.8 |
| Not in labor force (at least one) | 50.7*** | 64.0 |

*Source:* Urban Institute tabulations of NHIS data, 1994 and 1995.

a. Of responsible adult.

b. In previous month.

c. Resident parent(s) in previous two weeks.

*** Different from Medicaid enrollees at the 99 percent level of statistical significance.

** Different from Medicaid enrollees at the 95 percent level of statistical significance.

* Different from Medicaid enrollees at the 90 percent level of statistical significance.

*TABLE 2: Health Status of Medicaid-Eligible Children: Uninsured versus Enrolled*

| | Uninsured | Enrolled |
|---|---|---|
| Fair or Poor Health (%, self-reported) | 3.5*** | 5.8 |
| Activity Limitations (% distribution) | | |
| None | 85.2*** | 91.3 |
| In a major activity | 3.5*** | 6.8 |
| In other activity | 1.4** | 2.0 |
| Restricted Activity Days (number in a year)[a] | 7.9*** | 11.3 |
| Bed Days in a year[b] | | |
| Any (%) | 38.6* | 40.9 |
| Number (if at least one) | 6.3*** | 6.6 |
| Chronic Conditions | | |
| Any (%) | 10.7*** | 15.4 |
| Number (if at least one) | 1.3*** | 1.4 |

For source and statistical significance notes, see table 1.

a. As reflected in a two-week recall.

b. As reflected in a 12-month recall.

versally true that Medicaid-eligible children are enrolled if they have health needs.

Access to care is clearly more of a problem for eligible uninsured than for Medicaid-covered children (table 3). Almost one-quarter (23 percent) of these uninsured children lacked a regular source of care, compared with about 6 percent of the Medicaid-enrolled. In fact, only 28 percent of the uninsured reported lack of need as their main reason for not having a regular source of care, while 56 percent cited lack of insurance. For those *with* a regular source of care, the type of provider used for that care was similar for both groups. However, the eligible uninsured were less likely to see a specific provider or to be satisfied with how long they had to wait to be seen—suggesting that the perceived quality of care they get from their regular source may be lower. Finally, Medicaid-eligible uninsured children were almost three times as likely to have an unmet health care need during the year as Medicaid-enrolled children—and more than four times as likely to delay care due to cost.

Consistent with their better health and more limited access to providers, health care use by eligible uninsured children was lower than use by Medicaid-enrolled children (table 4). Uninsured children were less likely to have seen a provider in the past 12 months, for example, and less likely to have been hospitalized. If they had a provider visit, the eligible uninsured children were less likely to have had it in a physician's office. They were more likely than Medicaid-enrolled children to have had a telephone contact, however, suggesting that the parents of uninsured children may be substituting free telephone consultations for physician visits (this is particularly likely for those who do have a regular source of care). About one-third of both groups reported less-than-adequate immunization,[4] suggesting that the preventive care delivery system may be failing some low-income children, even those with health insurance. Finally, families of the uninsured children spent substantially more out-of-pocket on medical care, with almost 30 percent spending over $500 a year, while only 13 percent of the families of Medicaid-enrolled children spent this much.

*TABLE 3: Health Care Access for Medicaid-Eligible Children: Uninsured versus Enrolled*

| | Uninsured | Enrolled |
|---|---|---|
| No Regular Source of Care (%) | 23.0*** | 5.6 |
| Main Reason for No Regular Source (% of total without) | | |
| No need | 28.0*** | 40.7 |
| Moved, don't know where to go | 9.7*** | 22.5 |
| No insurance | 56.2*** | 18.6 |
| Other | 6.1*** | 18.2 |
| Regular Source of Care (% of total with) | | |
| Physician's office | 73.0 | 75.7 |
| Outpatient | 21.2 | 22.0 |
| Hospital emergency room | 2.6* | 1.4 |
| Military/VA | 1.7*** | 0.1 |
| Other | 1.6* | 0.7 |
| Characteristics of Regular Source (%) | | |
| Satisfied with wait time for appointment | 87.1 | 90.9 |
| Satisfied with wait time to be seen | 78.6** | 85.3 |
| Evening/weekend availability | 82.5 | 86.1 |
| Specific provider seen | 68.2*** | 77.2 |
| Unmet Need in a Year (%)[a] | | |
| Any | 17.9*** | 6.2 |
| Medical | 5.9*** | 1.5 |
| Dental | 13.6*** | 3.7 |
| Other | 5.6*** | 2.4 |
| Delayed Seeking Care Due to Cost | 11.3*** | 2.5 |

For source and statistical significance notes, see table 1.

a. As reflected in 12-month recall.

*TABLE 4: Health Care Used by Medicaid-Eligible Children: Uninsured versus Enrolled*

| | Uninsured | Enrolled |
|---|---|---|
| Use in a Year[a] | | |
| Any provider (%) | 69.2*** | 84.1 |
| Number of visits (if at least one) | 3.2*** | 4.5 |
| Any acute hospital stay (%) | 2.3*** | 4.5 |
| Family Out-of-Pocket Spending in a Year (%) | | |
| None | 15.2*** | 41.5 |
| $1–500 | 55.8*** | 45.6 |
| Over $500 | 28.9*** | 12.9 |
| Visits to Primary Care Provider (% of total visits)[b] | 77.3 | 70.7 |
| Provider Location (% of total visits)[b] | | |
| Physician's office | 48.1* | 55.0 |
| Nonhospital outpatient | 19.6 | 19.6 |
| Hospital outpatient | 9.9 | 8.7 |
| Hospital emergency room | 9.1 | 8.7 |
| Home | 0.0** | 0.4 |
| Telephone | 13.3* | 8.6 |
| Adequacy of Immunizations (%)[c] | 64.8 | 70.0 |

For source and statistical significance notes, see table 1.

a. As reflected in 12-month recall.

b. If any visits in previous two weeks.

c. For children ages 19 to 35 months.

*Changes since the mid-1990s may have narrowed access gaps. For example, CHIP requires states to inform potentially eligible families about coverage availability.*

## Effects of Medicaid Coverage on Health Care Access and Use

These differences between eligible uninsured and Medicaid-enrolled children provide a useful measure of how much greater the unmet need for care is among uninsured Medicaid-eligibles. However, these differences do not reflect how much of that unmet need could be eliminated if all Medicaid-eligible uninsured children were enrolled. Many factors affect access and use, irrespective of insurance coverage.

Estimating the effect of lack of Medicaid coverage per se requires statistical adjustment for demographic, social, economic, and health differences between the two groups, the results of which are shown in table 5. The first column of the table shows the observed differences between eligible uninsured and Medicaid-covered children on a range of health care access and use measures. The second column shows how much of the differences are attributable to lack of Medicaid coverage. For example, Medicaid-eligible uninsured children were 17.4 percent more likely than Medicaid-covered children to have no regular source of care. Yet, when health and other differences are eliminated from the comparison, the uninsured group was just 7.7 percent more likely to have no regular source of care—this is the gap that Medicaid coverage could close. Similarly, Medicaid-eligible uninsured children were 11.7 percent more likely to have had an unmet health need in the previous year. When health and other differences are taken into account, however, those without insurance were only 7.0 percent more likely to have had an unmet health need—again, the gap Medicaid could fill.

All the observed differences in health care access and use are smaller but remain statistically significant when the effect of Medicaid enrollment per se is the focus. Therefore, expanding Medicaid enrollment could reduce but not totally eliminate the health care access and use gaps between the two groups. Interestingly, there is no statistically significant difference in immunization adequacy overall. When the effects of health and other differences between the two groups are taken into account, however, lack of insurance has a significant negative impact on immunization adequacy. The Medicaid-enrolled population is more likely to have very low income and less family education, reducing the likelihood of adequate immunization, other things being equal. The lack of statistical significance for the observed difference results from the positive impact of Medicaid counteracted by the negative impact of low income and less education. Removing the effect of these other factors reveals the benefits of Medicaid coverage.

*TABLE 5: Effect of Being Uninsured on Health Care Access and Use by Medicaid-Eligible Children*

| | Difference between Uninsured and Enrolled | |
|---|---|---|
| | Unadjusted Difference[a] (Uninsured vs. Medicaid) | Effect of Being Uninsured (Adjusted Difference)[b] |
| No Regular Source of Care (%) | 17.4*** | 7.7*** |
| Unmet Need in a Year (%)[c] | | |
| Any | 11.7*** | 7.0*** |
| Medical | 4.4*** | 2.1*** |
| Dental | 5.8*** | 4.6*** |
| Other | 3.2*** | 1.9*** |
| Delayed Seeking Care Due to Cost (%) | 8.8*** | 4.7*** |
| Use in a Year[c] | | |
| Any provider(%) | −14.9*** | −9.2*** |
| Number of visits (if at least one) | −1.24*** | −1.16*** |
| Received Adequate Immunizations (%)[d] | −5.2 | −6.2* |
| Family Out-of-Pocket Spending in a Year More Than $500 (%) | 16.0*** | 12.4*** |

For source, see table 1.

a. First column minus second column of tables 3 or 4.

b. Group difference adjusted for a variety of noninsurance factors affecting access and use (see text note 5.)

c. As reflected in 12-month recall.

d. For children ages 19 to 35 months.

*** Difference statistically significant at the 99 percent level.

** Difference statistically significant at the 95 percent level.

* Difference statistically significant at the 90 percent level.

## Medicaid-Eligible Children with Private Insurance

Medicaid-eligible children with private coverage are not generally the focus of

public policy concerns except for the concern that Medicaid expansions, rather than attracting the uninsured, may be attracting enrollees who otherwise would have private insurance. In addition, privately insured Medicaid-eligible children may be relevant to policy in the context of access barriers, especially if the copayments and deductibles associated with private coverage reduce children's use of care. This may be an issue particularly for preventive or other services less likely to be covered by private insurance plans than by Medicaid.

Privately insured Medicaid-eligible children resemble their uninsured counterparts: they have better health, higher family incomes and education levels, and a greater likelihood of having two resident and employed parents than Medicaid enrollees. They are also less likely to be Hispanic or African American.

Without adjusting for different characteristics of the two populations, patterns of health care access and use among privately insured Medicaid-eligible children are different from those among the Medicaid-eligible uninsured (table 6). The privately insured were less likely than Medicaid enrollees to lack a regular source of care, slightly less likely to report unmet medical need (although slightly more likely to report unmet dental need), and more likely to report delay in care due to cost. The family spending burdens of privately insured children were very similar to those of the uninsured and significantly greater than for Medicaid enrollees, with an unadjusted difference of 21 percent in the proportion of privately insured and Medicaid enrollees with family out-of-pocket spending over $500.

How much of these access and use variations are due to the difference in insurance coverage? Removing the differences in health and other noninsurance characteristics between the two groups changes the picture in several ways. The privately insured were even less likely to lack a regular source of care, the (small) difference in unmet dental need is reduced, and the difference in unmet medical need loses significance. Additionally, privately insured children who made at least one provider visit in a year made even fewer visits than Medicaid enrollees (from 0.49 fewer to 0.73 fewer visits on average). The difference in family out-of-pocket spending burden was reduced but still was substantially larger than for Medicaid-enrolled children. Because of their private insurance, 11.7 percent more families had out-of-pocket spending burdens of over $500 in a year compared with their Medicaid-covered counterparts.

*TABLE 6: Effect of Private Insurance on Health Care Access and Use by Medicaid-Eligible Children*

| | Difference between Privately Insured and Enrolled | |
|---|---|---|
| | Unadjusted Difference[a] (Private vs. Medicaid) | Effect of Being Privately Insured (Adjusted Difference)[b] |
| No Regular Source of Care (%) | -2.3*** | -2.6*** |
| Unmet Need in a Year (%)[c] | | |
| Any | 1.2 | 0.9 |
| Medical | -0.4* | -0.4 |
| Dental | 1.8*** | 1.0* |
| Other | -0.1 | 0.3 |
| Delayed Seeking Care Due to Cost (%) | 1.0** | 0.7*** |
| Use in a Year[c] | | |
| Any provider | -1.9 | -1.3 |
| Number of visits (if at least one) | -0.49*** | -0.73*** |
| Received Adequate Immunizations (%)[d] | -0.7 | -1.5 |
| Family Out-of-Pocket Spending in a Year More Than $500 (%) | 21.0*** | 11.7*** |

For source, see table 1; for statistical significance notes, see table 5.

a. Difference in group means (privately insured–Medicaid).

b. Group difference adjusted for a variety of noninsurance factors affecting access and use (see text note 5).

c. As reflected in 12-month recall.

d. For children ages 19 to 35 months.

## Removing Barriers to Medicaid Enrollment: Next Steps

A useful way to summarize health and health care access differences among the two eligible nonenrolled groups and Medicaid enrollees is to compare the proportions with some health or access problem. Among Medicaid-enrolled children, 40 percent reported at least one of the following: fair or poor health, activity limitations, chronic conditions, no regular source

of care besides an emergency room, unmet care needs or care delays due to cost, and family out-of-pocket health care spending over $500 a year. Among eligible children with private insurance, 49 percent reported at least one problem. Among those with no insurance, 58 percent did.[5]

Parents whose children face health and health care access problems that Medicaid coverage could ease would be expected to enroll their children so long as time, hassle, stigma, or lack of knowledge were not barriers. That almost three out of five Medicaid-eligible children who were uninsured faced at least one health or access problem in 1994 and 1995—problems even when health and other differences are excluded from the comparison—strongly suggests that such barriers exist.

*Increasingly older children in poor families have become eligible for Medicaid, and many states have expanded coverage to children higher up the income scale.*

Recent policy initiatives have begun to address them. First, the 1997 Balanced Budget Act allows states to implement presumptive eligibility for Medicaid. Under this option, any qualified provider (whether WIC programs, Head Start, or agencies determining eligibility for subsidized child care, in addition to traditional health care providers) may deem children eligible for Medicaid, facilitating temporary enrollment when medical care is needed.[6] Second, Medicaid enrollment has become easier as the Children's Health Insurance Program (CHIP) has been implemented, since CHIP requires states to inform potentially eligible families about coverage availability and enrollment processes. The new emphasis on outreach has affected children who were already eligible for Medicaid prior to CHIP: For all applicants, many states have shortened application forms, dropped asset tests, permitted application by mail, used media outreach, placed eligibility workers in agencies that deal with low-income families with children in other contexts, and involved schools and employers (NGA 1998).

What about Medicaid-eligible children whose families have private insurance? Although private insurance has some advantages over Medicaid—including greater likelihood of full family coverage, a wider range of providers, no stigma, and greater satisfaction with various aspects of care—our results indicate some Medicaid-eligibles with private insurance may not seek care because it is too expensive. To the extent that this is true, choosing Medicaid when both options are available may improve health care access overall (Holahan 1997).

Two other developments since 1994–1995 probably have changed the pool of Medicaid-eligibles and their insurance options. First, increasingly older children in poor families have become eligible for Medicaid. Many states have also expanded coverage to children higher up the income scale, either through Section 1115 waivers or through CHIP. The Medicaid impact results reported here indicate that extending Medicaid coverage to new groups of uninsured children will narrow gaps in access and use. Second, many states have implemented CHIP programs that resemble private insurance more than traditional Medicaid. Such CHIP coverage should enhance access to providers relative to CHIP programs that operate as Medicaid expansions. Indeed, private CHIP programs may have greater positive impacts than private coverage because out-of-pocket expenses—a major access barrier—are far lower.

Have these developments narrowed the access gaps that existed in 1994–1995 between Medicaid-enrolled children as a group and Medicaid-eligible children who were uninsured or privately insured? And if so, to what extent? These pressing questions can be answered as more recent data become available.

## Endnotes

1. The NHIS is a large, nationally representative sample of the U.S. noninstitutionalized civilian population. The analysis presented here uses data from the core instrument as well as three supplemental files and a special study of immunization adequacy among 19- to 35-month-olds in the NHIS. This database was supplemented with data on federal and state regulations for the Aid to Families with Dependent Children (AFDC) and Medicaid programs.

2. They were identified as Medicaid-eligible on the basis of family structure, child age, family income, assets, and out-of-pocket medical spending, all compared with age, state, and year-specific thresholds. Children with Medicare or Supplemental Security Income were excluded because they are

likely to have substantial health problems and could skew comparisons across groups.

3. This estimate from 1994–1995 shows a smaller proportion who are uninsured, relative to estimates for 1996 by Selden et al. (1998). Part of the explanation could be that Medicaid enrollment decreased in anticipation of welfare reform, which increased the numbers of Medicaid-eligibles who were uninsured. Dual Medicaid and privately insured children were counted in the privately insured category. Because we suspect the NHIS underreports Medicaid enrollment, we counted all children on AFDC in the Medicaid-covered group. Cash welfare recipients were automatically enrolled in Medicaid until AFDC was replaced by Temporary Assistance for Needy Families (TANF) in 1996.

4. Adequate immunization (for 19- to 35-month-olds) consists of the recommended four diphtheria/polio/tetanus vaccines, three oral polio vaccines, one measles-containing vaccine, and three hemophilus influenza bacteria vaccines.

5. The Medicaid-eligible uninsured children reporting at least one health status or access problem are somewhat different from those without any problem. They are, for example, less likely to be in the youngest age group, less likely to be African American, and more likely to live in two-parent families. The differences are too small to be of much use in targeting outreach efforts, however.

6. The child's parent must submit the completed application by the end of the following month if the child is to continue in enrollment status.

## References

Holahan, J. 1997. "Crowding Out: How Big a Problem?" *Health Affairs* 16 (1): 204–6.

Lewis, Kimball, Marilyn Ellwood, and John L. Czajka. 1997. *Children's Health Insurance Patterns: A Review of the Literature.* Cambridge, Mass.: Mathematica Policy Research.

National Governors' Association (NGA). 1998. "How States Can Increase Enrollment in the State Children's Health Insurance Program." Issue Brief. May 11.

Selden, Thomas M., Jessica S. Banthin, and Joel W. Cohen. 1998. "Medicaid's Problem Children: Eligible but Not Enrolled." *Health Affairs* 17 (3): 192–200.

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Issues and Options for States

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# Medicaid-Eligible Adults Who Are Not Enrolled: Who Are They and Do They Get the Care They Need?

Amy Davidoff, Bowen Garrett, and Alshadye Yemane

*Uninsured Medicaid-eligible adults are more likely to report unmet need, lack a usual source of care, and make less use of physician services.*

There is unprecedented interest in extending public insurance eligibility to greater numbers of low-income parents and other adults. This effort follows on the heels of the latest expansions of eligibility for children through the State Children's Health Insurance Program (SCHIP). Supporters note preliminary evidence that extending Medicaid eligibility to adults may increase the likelihood of enrollment among children (Dubay and Kenney forthcoming; Ku and Broaddus 2000) and that covering adults may have a positive effect on access to care for children. Perhaps more important than potential spillover effects is that insurance coverage is likely to have a positive effect on access to health care and on health status for the adults themselves. Relatively little is known about the characteristics of Medicaid-eligible adults and the potential effects of insurance coverage on their access to care.

In a recent brief (Davidoff et al. 2000), we examined the characteristics, health status, and access to care for children who were eligible for Medicaid, comparing those who enrolled with those who were uninsured or privately insured. We found that those who were uninsured were generally healthier than the enrollees but that they faced greater constraints on access to needed health care. In this brief we analyze adults who are eligible for Medicaid, also comparing those who are uninsured or privately insured with those enrolled in Medicaid. We focus on adults eligible for Medicaid prior to the recent round of expansions. This group is likely to be more economically disadvantaged than the newly eligible, and the uninsured among them are least able to obtain needed health care.

Adults who are eligible for Medicaid but not enrolled encounter greater obstacles to care than their Medicaid-covered counterparts, according to data from the 1997 National Health Interview Survey. The Medicaid-eligible uninsured adults are less likely to have chronic medical conditions and are in better overall health than their enrolled counterparts, but not all are free of health problems. When uninsured Medicaid-eligible adults are compared with Medicaid-covered adults with the same health status, family income, and other characteristics, the uninsured are more likely to report unmet need, to lack a usual source of care, and to make less use of physician services. Families of the uninsured are more likely to be burdened with out-of-pocket health care costs.

Medicaid-eligible adults with private health insurance coverage do not report barriers to access more often than Medicaid-covered adults. In fact, when health status and other characteristics potentially related to health insurance are taken into account, these adults are less likely to report unmet medical needs than their Medicaid-enrolled counterparts. They are more likely, though, to be burdened by substantial out-of-pocket health care costs.

## The National Health Interview Survey—Data and Methods

The primary source of data for this report is the 1997 National Health Interview Survey (NHIS), a large, nationally repre-

sentative sample of the U.S. noninstitutionalized civilian population.[1] The NHIS collects data on individual demographics, selected acute and chronic medical conditions, general health status, income, current insurance coverage, and access to and use of health care services. We identified adults likely to be eligible for Medicaid through Section 1931 family coverage, the medically needy program, and Section 1115 waiver programs by creating an algorithm that mimics the eligibility determination process.[2] The algorithm was applied to each adult in the NHIS. Eligibility determination was unaffected by reported insurance coverage.[3] Enrollment in Medicaid among nonelderly adults eligible for Medicaid was relatively low; only slightly more than half (51.4 percent) of adults eligible for Medicaid through Section 1931 family coverage, the medically needy program, or Section 1115 waivers were enrolled in 1997. Private coverage was held by 21.6 percent, and an additional 27.0 percent were uninsured. For our eligible adult sample, we compared the characteristics, health status, and access to and use of health care services for those enrolled in Medicaid with those uninsured and those privately insured. We report basic (unadjusted) comparisons of access and use across insurance groups, which describes the experience of the populations of interest. We also estimate the effect of insurance coverage adjusted for a variety of demographic and health status characteristics, which indicates what portion of any gap in access and use is related to insurance coverage.

## Differences between Eligible Uninsured and Medicaid-Covered Adults

The uninsured and Medicaid-enrolled groups of Medicaid-eligible adults differ demographically, socially, and economically (table 1). Compared with eligible adults with Medicaid, the uninsured are older and are more likely to be non-Hispanic white or Hispanic, immigrants, married, and male. They are less likely to be very poor (below 50 percent of the federal poverty level [FPL]), and they have fewer children. There are no differences in education, but the uninsured are almost twice as likely to work full-time, though half still remain unemployed or out of the labor force.

When we compare health status for uninsured Medicaid-eligible adults and Medicaid enrollees (table 2), we find that most report no health problems, but the uninsured are less likely to have health problems than those enrolled in Medicaid. Among the uninsured, only 13.0 percent report being in fair or poor health and 11.3 percent report limitations in activity, compared with 21.0 percent and 20.9 percent, respectively, for Medicaid enrollees. There are no significant differences in patterns of work loss days (among those who are employed) or bed disability days between the two groups. Surprisingly, we find no difference in the prevalence of some chronic conditions such as heart disease, cancer, and diabetes, but the uninsured are less likely than the Medicaid-covered to have other conditions such as hypertension, asthma, ulcer, sinusitis, and chronic bronchitis. The differences in health status are to be expected, because eligible adults are more likely to get enrolled if they seek medical care for a health problem. However, it is clear that not all eligible adults who have health needs are enrolled in Medicaid.

Access to care is clearly more of a problem for the population of eligible uninsured than for Medicaid-covered adults, as the unadjusted comparisons in table 3 show. Almost 42 percent of these uninsured adults lack a usual source of care, compared with about 12 percent of Medicaid-enrolled adults. For those who did have a usual source of care, the type of provider identified is similar for both groups, except that the uninsured are more likely to use a hospital emergency department (5.8 percent vs. 1.8 percent for the Medicaid-enrolled; data not shown in table). The eligible uninsured are much more likely to report unmet need for medical care, dental care, and prescription drugs, and 26.3 percent report delaying seeking care because of the cost, compared with 9.8 percent of those enrolled in Medicaid.

Consistent with their better health and more limited access to providers, fewer eligible uninsured adults use health care than

*TABLE 1. Characteristics of Medicaid-Eligible Adults: Uninsured vs. Enrolled (percentage distribution)*

| Characteristic | Uninsured N = 1,731,000 | Medicaid-Enrolled N = 3,233,000 |
|---|---|---|
| **Age (%)** | | |
| 19–24 | 23.1 | 25.6 |
| 25–30 | 25.3 | 26.1 |
| 31–40 | 28.6 | 31.2 |
| 41+ | 21.4*** | 14.4 |
| **Sex:** Female (%) | 69.8*** | 89.6 |
| **Race and Ethnicity (%)** | | |
| White, non-Hispanic | 47.8** | 41.7 |
| Black, non-Hispanic | 20.6*** | 33.4 |
| Hispanic | 27.2*** | 20.8 |
| Other | 4.3 | 4.1 |
| Immigrant | 25.3*** | 14.6 |
| **Poverty Level (%)** | | |
| <50% of FPL | 73.8*** | 86.4 |
| 50–100% of FPL | 24.2*** | 12.6 |
| 100–150% of FPL | 2.0 | 1.0 |
| **Marital Status (%)** | | |
| Married | 33.5*** | 13.1 |
| Divorced/sep/widowed | 34.2 | 34.1 |
| Never married | 32.3*** | 52.7 |
| **Education (%)** | | |
| Less than high school | 43.1 | 43.1 |
| High school graduate | 34.9 | 34.3 |
| Some college | 19.5 | 20.1 |
| College graduate or more | 2.5 | 2.6 |
| **Employment Status (%)** | | |
| Works full-time | 30.4*** | 15.9 |
| Works part-time | 14.5* | 11.5 |
| Not employed | 55.2*** | 72.6 |
| **Number and Age of Children (%)** | | |
| Number of children | 1.7*** | 2.0 |
| 0–1 years | 23.4*** | 30.0 |
| 2–6 years | 43.2*** | 54.4 |
| 7+ years | 53.8 | 56.4 |

*Source:* Urban Institute Analysis of the National Health Interview Survey, 1997.
Number (N) of adults is nationally weighted, rounded to the nearest thousand.
T-tests were performed to compare uninsured to Medicaid enrollees:
*** $p < 0.01$; ** $p < 0.05$; * $p < 0.10$.
FPL = Federal poverty level.

do Medicaid-enrolled adults. Uninsured adults are less likely to have any physician visit within a 12-month period (60.9 percent compared with 87.4 percent for Medicaid-enrolled adults), and they have somewhat fewer visits, if they have any. They are less likely to see a medical specialist (32.4 percent vs. 61.5 percent) or a dentist (35.6 percent vs. 51.2 percent), although there are no differences in the likelihood of vision care or mental health visits (data not shown). They are less likely to have surgery or any overnight hospital stay.[4] Finally, families of eligible but uninsured adults are much more likely to be burdened by out-of-pocket health care costs. More than 21 percent report spending between $500 and $2,000, compared with fewer than 10 percent of families of Medicaid-enrolled adults (data not shown), and more than 11 percent of families of the eligible uninsured report spending more than $2,000 out-of-pocket.

## Effects of Medicaid Coverage on Health Care Access and Use

The differences between eligible uninsured and Medicaid-enrolled adults provide a useful measure of how much greater the unmet need for care is among uninsured Medicaid-eligibles. The groups differ in their characteristics, though, and thus these differences do not reflect how much of that unmet need could be eliminated if all

*TABLE 2. Health Status of Medicaid-Eligible Adults: Uninsured vs. Enrolled*

| Characteristic | Uninsured | Medicaid-Enrolled |
|---|---|---|
| **Self-Reported Health Status (%)** | | |
| Excellent–good | 87.0*** | 79.0 |
| Fair–poor | 13.0*** | 21.0 |
| **Activity Limitations (%)** | | |
| No limitations | 88.7*** | 79.1 |
| Limited in major and other activity | 11.3*** | 20.9 |
| **Work Loss Days (12 months) (%)** | | |
| 0–9 days | 71.9 | 74.7 |
| 10–19 days | 11.5 | 10.0 |
| 20+ days | 16.7 | 15.2 |
| **Bed Days (12 months) (%)** | | |
| 0–9 days | 71.5 | 69.1 |
| 10–19 days | 12.8 | 11.7 |
| 20+ days | 15.7 | 19.2 |
| **Chronic Conditions (%)** | | |
| Hypertension (on at least 2 visits) | 8.1** | 13.1 |
| Heart disease (ever) | 5.7 | 7.7 |
| Cancer (ever) | 4.8 | 3.9 |
| Asthma (attack in 12 months) | 4.2*** | 10.4 |
| Ulcer (12 months) | 2.9** | 6.6 |
| Diabetes (current treatment with medication) | 2.2 | 2.0 |
| Sinusitis (12 months) | 11.4** | 16.4 |
| Chronic bronchitis (12 months) | 6.2* | 10.2 |

*Source:* Urban Institute Analysis of the National Health Interview Survey, 1997.
T-tests were performed to compare uninsured to Medicaid enrollees:
*** $p < 0.01$; ** $p < 0.05$; * $p < 0.10$.

Medicaid-eligible uninsured adults were enrolled.[5]

Estimating the effect of lack of Medicaid coverage per se requires statistical adjustment for demographic, social, economic, and health differences between the two groups, the results of which are shown in the third results column in table 3. This column shows how much of the difference in access to care or use of services is attributable to lack of Medicaid coverage. For example, Medicaid-eligible uninsured adults are 26.5 percentage points less likely to have a physician visit in 12 months. Yet, when health and other differences are eliminated from the comparison, the uninsured group is just 17.7 percent less likely to have a physician visit. This is the gap that Medicaid coverage could fill.

All the observed differences in health care access and use remain statistically significant when the (adjusted) effect of Medicaid is the focus, with the exception of the proportion with 10 or more physician visits. Many of the adjusted effects of Medicaid coverage are equal to or larger than the unadjusted effects. For example, uninsured adults are 12.8 percentage points more likely to report unmet dental needs than their Medicaid-enrolled counterparts. When characteristics of the two groups are taken into account, the effect of Medicaid coverage on unmet dental care needs is 15.0 percent. Therefore, increasing Medicaid enrollment among eligible adults would eliminate many gaps in health care access and use for this group.

## Medicaid-Eligible Adults with Private Insurance

Medicaid-eligible adults with private insurance are not generally the focus of public policy concerns. However, low-income persons are more likely to be enrolled in less expensive health plans, either health maintenance organizations (HMOs, which have less cost-sharing but tighter restrictions on access to providers) or less comprehensive fee-for-service plans (where the premiums may be lower but out-of-pocket requirements may be greater). The cost-sharing requirements associated with the fee-for-service plans may create financial barriers to access. This may be an issue particularly for preventive or other services that are less likely to be

*TABLE 3. Health Care Access and Use by Medicaid-Eligible Adults: Uninsured vs. Enrolled*

| Characteristic (%) | Unadjusted Mean Value | | Adjusted Difference in Mean Value [Medicaid-Enrolled minus Uninsured] |
|---|---|---|---|
| | Medicaid-Enrolled | Uninsured | |
| **No usual source of care** | 11.6 | 41.7*** | -25.6*** |
| **Unmet need (UN) due to cost (12 months)** | | | |
| Medical | 8.9 | 22.7*** | -15.9*** |
| Mental health | 5.0 | 6.3 | -1.9 |
| Dental | 18.8 | 31.6*** | -15.0*** |
| Prescription | 13.7 | 25.8*** | -13.3*** |
| **Delayed seeking care due to cost** | 9.8 | 26.3*** | -18.5*** |
| **Any physician/other provider visit** | 87.4 | 60.9*** | 17.7*** |
| **10 or more physician visits** | 26.9 | 19.4* | 4.5 |
| **Any surgery** | 17.7 | 9.0*** | 7.0** |
| **Any overnight hospital stay** | 23.1 | 13.8*** | 3.7* |
| **Family spending ≥ $2,000** | 4.1 | 11.1*** | -6.0*** |

*Source:* Urban Institute Analysis of the National Health Interview Survey, 1997.
T-tests were performed to compare unadjusted means for uninsured and Medicaid enrollees; adjusted differences controlled for age, race, gender, marital status, education, number of children, health status, income, size of metropolitan statistical area, and region of the country.
*** $p < 0.01$; ** $p < 0.05$; * $p < 0.10$.

covered by private insurance plans than by Medicaid. On the other hand, low reimbursement rates under Medicaid and resulting low levels of physician participation may result in constrained access for Medicaid enrollees compared with those who have private coverage.

Privately insured Medicaid-eligible adults resemble their uninsured counterparts in some ways but not others (data not shown). Compared with the Medicaid-enrolled population, they are somewhat older and more likely to be male. They are even more likely than the eligible uninsured to be non-Hispanic whites, but much less likely than either of the other groups to be Hispanic or immigrants. They have higher incomes than the Medicaid enrollees, they are more likely to be married, and, unlike the uninsured adults, they have higher educational attainment than Medicaid enrollees. They are much more likely to work full-time (40.2%) than are the Medicaid-enrolled (15.9%). Privately insured eligible adults are also more likely to report no health problems than Medicaid enrollees, with fewer in fair or poor health (10.6% vs. 21.0% among enrollees), with activity limitations (13.6% vs. 20.9%), and with heart disease, asthma, ulcer, or chronic bronchitis.

When no adjustment is made for different characteristics of the two populations, patterns of health care access and use among privately insured Medicaid-eligible adults are similar to those of Medicaid-enrolled adults, as shown in table 4. For example, there is no significant difference in the likelihood they will lack a usual source of care; have unmet needs for mental health services, dental care, or prescription drugs; or delay care because of the cost. For those with a usual source of care, the privately insured are more likely to use a doctor's office or HMO (73.5 percent vs. 53.7 percent; data not shown in table), and there is actually less reported unmet medical care need. The privately insured eligible adults are somewhat less likely to have any physician visit. They are less likely to see a medical specialist (43.8 percent vs. 61.5 percent; data not shown). The biggest burden on the privately insured is in out-of-pocket spending. Nearly 15 percent of privately insured families spend at least $2,000, compared with 4 percent of Medicaid enrollee families.

As indicated by the adjusted differences presented in table 4, the effect of private coverage in reducing unmet medical need and the positive effect on out-of-pocket spending persist after adjusting for demographic and health status characteristics. The differences in the likelihood of a physician visit and an overnight hospital stay are explained by differences in health status and demographic characteristics, and are not associated with differences in insurance.

TABLE 4. *Health Care Access and Use by Medicaid-Eligible Adults: Privately Insured vs. Enrolled*

| Characteristic (%) | Unadjusted Mean Value | | Adjusted Difference in Mean Value |
|---|---|---|---|
| | Medicaid-Enrolled | Privately Insured | [Medicaid-Enrolled minus Privately Insured] |
| **No usual source of care** | 11.6 | 16.7 | -5.5 |
| **Unmet need (UN) due to cost (12 months)** | | | |
| Medical | 8.9 | 5.0*** | 3.4*** |
| Mental health | 5.0 | 4.4 | -0.5 |
| Dental | 18.8 | 17.1 | 1.0 |
| Prescription | 13.7 | 12.0 | 2.7 |
| **Delayed seeking care due to cost** | 9.8 | 11.7 | -2.4 |
| **Any physician/other provider visit** | 87.4 | 80.8* | 3.4 |
| **10 or more physician visits** | 26.9 | 22.8 | 1.5 |
| **Any surgery** | 17.7 | 17.0 | -2.7 |
| **Any overnight hospital stay** | 23.1 | 14.7*** | 0.1 |
| **Family spending ≥ $2,000** | 4.1 | 14.9*** | -8.0*** |

*Source:* Urban Institute Analysis of the National Health Interview Survey, 1997.
T-tests were performed to compare privately insured and Medicaid enrollees; adjusted differences controlled for age, race, gender, marital status, education, number of children, health status, income, size of metropolitan statistical area, and region of the country.
*** $p < 0.01$; ** $p < 0.05$; * $p < 0.10$.

*The eligible uninsured are much more likely to report unmet need for medical care, dental care, and prescription drugs.*

## Implications for Policy

Medicaid-eligible adults who do not enroll and are uninsured face substantial barriers to access, and as a result they use fewer health care services than adults with Medicaid coverage. Although our analysis does not address the health effects associated with reduced access, other researchers have shown links between being uninsured and the prevalence of serious but preventable medical conditions and events (e.g., Bindman et al. 1995). Thus, the reduced use of services likely reduces the general health of these low-income adults. Efforts to increase enrollment in Medicaid, when private insurance alternatives are not available, are essential to maintaining and improving the health of these adults. Our results suggest that covering the uninsured eligible adults (on the margin) would be less expensive because they are healthier than those currently enrolled in Medicaid, though they may have pent-up demand for health care that would need to be served in the short term.

Why would eligible adults who face health problems and high expenses and perceive that they have inadequate access to health care fail to enroll in Medicaid? Time, hassle, stigma, or lack of knowledge may present substantial barriers. The fact that a large proportion of Medicaid-eligible adults who are uninsured face unmet need and delay seeking care because of its cost strongly suggests that such barriers exist. There have always been uninsured Medicaid-eligible adults. However, barriers to Medicaid enrollment were likely exacerbated by implementation of the federal Personal Responsibility and Work Opportunity Reconciliation Act, which began in 1996 (Families USA 1999; Ku and Garrett 2000).

Since 1997, children's eligibility for Medicaid has expanded substantially through the State Children's Health Insurance Program (SCHIP). In addition, states have made efforts to reverse the effects that welfare reform had on administrative practices associated with Medicaid enrollment. Nevertheless, Medicaid enrollment among adults continued to decline through 2000 (U.S. Census Bureau 2001), even as child enrollment increased, suggesting that greater numbers of very low-income adults are faced with barriers to access. More recent efforts have attempted to expand eligibility for Medicaid or SCHIP coverage to higher-income adults. But if barriers to enrollment cannot be reduced for persons with the lowest income, their access to care will not improve.

Our comparison of privately insured and Medicaid-enrolled adults suggests that private insurance coverage is providing access to care that is comparable to access provided by Medicaid. However, the large out-of-pocket spending associated with these policies represents a substantial

financial burden to these low-income adults. Relieving them of this burden may further enhance their access to care and free up family resources to meet other basic needs.

## Endnotes

1. By using data from 1997 we create a snapshot of Medicaid-eligible adults prior to more recent expansions.

2. The algorithm uses information on family structure, employment, income, assets, and out-of-pocket medical spending to compute countable income and assets. These quantities are compared with federal- and state-specific income and asset thresholds to determine eligibility. The algorithm did capture eligibility for medically needy programs through spend-down. However, most of those identified as medically needy eligible met the higher income thresholds without spend-down. Adults with Medicare or Supplemental Security Income (SSI) were excluded because they have substantial health problems that could skew comparisons across groups. Adults reporting that they had "other public" insurance were also excluded from the analysis, because it was not possible to determine whether they had Medicaid or some other program.

3. Approximately half of adults who reported Medicaid coverage were not deemed eligible through our algorithm and were excluded from this analysis. Some of these individuals may have been pregnant women who are eligible through the poverty-related expansions, but we were not able to model their eligibility through our algorithm. Others may have had transitional Medicaid coverage, available for up to 12 months to families leaving welfare. Ineligible reporters were more likely to be male, above 150 percent of the federal poverty level (FPL), married, and working full-time. These characteristics are consistent with transitional eligibility for two-parent families who left welfare.

4. Some of this difference can be explained by the fact that persons who need these services often come in contact with providers who can enroll them in Medicaid. Some of the difference is likely a consequence of differences in access to care.

5. It is possible that current patterns of coverage reflect selection based on unobserved preferences for care. Thus, the estimated effect of Medicaid on use of services may overstate the true response of the currently uninsured to being enrolled in Medicaid. However, the access constraints faced by the uninsured eligible population suggest that the main reason for failure to enroll is perceived or actual barriers to enrollment rather than preferences for medical care.

## References

Bindman, Andrew, Kevin Grumbach, Dennis Osmond, Miriam Komaromy, Karen Vranizan, Nicole Lurie, and Julie Billings. 1995. "Preventable Hospitalizations and Access to Health Care." *Journal of the American Medical Association* 274(4): 305–311.

Davidoff, Amy, Bowen Garrett, Diane Makuc, and Matthew Schirmer. 2000. "Children Eligible for Medicaid but Not Enrolled: How Great a Policy Concern?" Washington, D.C.: The Urban Institute. *Assessing the New Federalism* Policy Brief A-41.

Dubay, Lisa, and Genevieve Kenney. Forthcoming. "Covering Parents through Medicaid and SCHIP: Potential Benefits to Low-Income Families." Kaiser Commission on Medicaid and the Uninsured.

Families USA. 1999. "Losing Health Insurance: The Unintended Side Effects for Medicaid." Washington, D.C.: Families USA.

Ku, Leighton, and Matthew Broaddus. 2000. "The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms." Washington, D.C.: Center on Budget and Policy Priorities.

Ku, Leighton, and Bowen Garrett. 2000. *How Welfare Reform and Economic Factors Affected Medicaid Participation, 1984–96.* Washington, D.C.: The Urban Institute. *Assessing the New Federalism* Discussion Paper 00-01.

U.S. Census Bureau. 2001. "Health Insurance Historical Table 2." http://www.census.gov/hhes/hlthins/historic/hihistt2.html. [Accessed October 2001.]

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CALIFORNIA HEALTHCARE FOUNDATION

February 4, 2002

Senate Health and Human Services Committee
State Capitol, Room 2191
Sacramento, CA 95814

**TO WHOM IT MAY CONCERN:**

The Senate Health and Human Services Committee has our permission to reprint in their January 16, 2002 transcript on *"A Cost Effective Agenda for Health Access for Children and Families"* the following issue brief:

**ARTICLE:** "Financial Challenges for California Hospitals"

**PUBLISHED IN:** CHCF Issue Brief, September 2001

**SIGNED,**

**Sally Mudd, Communications Officer**
**California HealthCare Foundation**
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HOSPITALS

# Financial Challenges for California Hospitals

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CHCF Issue Brief

## Background

When it comes to hospital systems, the state of California is a behemoth. California contains more hospital beds that generate more net patient revenue and expense than any other state in the nation. In 1999 the state's 409 acute care hospitals employed more than 300,000 people, discharged more than 3 million patients, recorded more than 23 million adjusted patient days, had an available bed capacity of more than 80,000, and generated more than $35 billion in total revenue.

California hospitals also operate in one of the most competitive health care markets in the nation. This unique, heavily managed-care marketplace has resulted in a hospital system with relatively low cost, low utilization, and competitive costs to payers for hospital services. However, the very characteristics that have contributed to California's health care success also have helped create a serious and growing financial vulnerability among the state's hospitals.

When compared to hospitals across the nation, California hospitals function in a marketplace that poses a more formidable challenge to financial health. They operate in a highly competitive pricing environment for commercial patients, and federal budget reductions on Medicare payments have further exacerbated revenue pressures.

On the expense side of the equation, California hospitals confront a challenging climate relative to other hospitals in the nation. They have a higher patient acuity than the national average, due to the impacts of managed care on patient treatment patterns; higher wages for hospital employees; a growing nursing shortage; and the third-largest uninsured population in the nation.

In addition, state and federal regulatory measures on such issues as seismic retrofitting of hospital facilities, new data security rules on patient information, minimum nurse staffing ratios, and medication error reduction have increased financial pressures on the state's hospital industry.

Collectively, these market forces have caused a substantive weakening of operating margins among California's hospitals, with more than half losing money from operations in 1999. This weakening has not affected all hospitals equally, but rather has widened the historical gap between "have" and "have-not" hospitals. The highly vulnerable "have-not" hospitals are not only losing money, but are finding it increasingly difficult to obtain debt financing for the necessary and/or mandatory capital and information systems investments required to survive.

Any single factor or a combination of forces has the potential to accelerate the weakening of the financial health of California's hospitals. Extended or worsening operating losses, coupled with legislative requirements that contain potentially adverse financial consequences, could create a cumulative set of impacts that would cause hospital closures throughout California.

## The Methodology

This study was conducted by Shattuck Hammond Partners, and was commissioned by the California HealthCare Foundation. The study examined hospital financial performance for 1995 through 1999; it is exhaustive in scope, analyzing data for all 409 hospitals in California that submitted disclosure reports in those years to state and federal agencies. It sought to raise important questions facing health care industry leaders and policymakers:

- What is the current financial health of California's hospitals?
- What are the recent trends in financial performance, in terms of margins, revenues, expenses, and capital?
- Are the trends in financial performance consistent across various typologies of hospitals?
- How large is the gap between strong and weak hospitals?
- What are the public policy implications of the financial health of California's hospitals?

The study analyzed hospitals by size, location (both geographic and urban/rural), type of control, and patient mix, as well as by the following characteristics:

- Small (150 or fewer available beds)
- Medium-small (151–250 available beds)
- Medium-large (251–350 available beds)
- Large (more than 350 available beds)
- Rural
- Urban
- Northern/southern
- Investor-owned
- Nonprofit
- District-owned
- City- or county-owned
- Member of a health care system
- Non-member of a health care system
- Academic medical center
- Seismic Zone Status
- Disproportionate Share Hospitals

The study used these main data sources for its analyses:

- *Selected Hospital Financial Data* from California's Office of Statewide Health Planning and Development (OSHPD)
- *The Comparative Performance of U.S. Hospitals: The Sourcebook* from HCIA-Sachs and Deloitte & Touche
- *Hospital Statistics* and the *AHA Guide to the Health Care Field* from the American Hospital Association
- *The Almanac of Hospital Financials and Operating Indicators* from the Center for Healthcare Industry Performance Studies

In addition Shattuck Hammond Partners conducted a "MegaTrends Survey," which polled leaders of 13 leading hospital and health system organizations in California on issues raised by the study. This research will help policymakers, health care professionals, and the public better understand the issues contributing to the serious financial predicament looming before California's hospital industry.

The California HealthCare Foundation has funded additional research to further identify the specific characteristics that distinguish the state's profitable from the financially vulnerable hospitals.

## Major findings from the Study

The years 1995 through 1999 were indisputably a period of weakening financial health for California's hospitals. The deteriorating financial condition of California's hospitals is a legitimate and growing concern for California residents, planners, and policymakers. The potential for a significant portion of California's hospitals to face closure is now greater than ever. Due to the diversity of the state's hospitals, it is likely there will be few communities that are spared the fallout of this potential scenario.

It should be noted that this study covers the years 1995 through 1999. There is anecdotal evidence to suggest an improvement in the financial position of a portion of California hospitals since 1999, making their fiscal status less precarious than during the years covered by the study. These improvements, however, may not have major impacts on the overall findings or conclusions of the study.

## The California Market

California is a highly competitive market for hospitals in terms of revenues. This environment is the result of a particularly aggressive combination of the following factors.

- Strong business and purchasing alliances, such as CalPERS and Pacific Business Group on Health, maintain a high degree of premium pricing pressure on payers.
- High managed care market penetration—54 percent of HMO penetration, compared to 34 percent nationwide—combined with a high concentration of managed care patients among relatively few payers. In 1999, 85 percent of HMO enrollment was concentrated among five HMOs: Kaiser Foundation Health Plan, Blue Cross of California, PacifiCare of California, HealthNet, and Blue Shield of California. This consolidated payer purchasing power for hospital services.
- Competition for premium revenues not only with other hospitals but also with large, sophisticated medical group organizations.
- California hospital patients have a higher severity of illness as measured by the Health Care Financing Administration (HCFA) case mix index (CMI): 1.34 versus 1.22 nationwide in 1999.
- A higher median salary per full-time hospital employee: $40,984 versus $32,893 nationwide in 1999.
- A nursing shortage in which California has the lowest number of nurses per capita in the nation.
- A larger uninsured population than the national average: 21 percent versus 16 percent nationwide.

## Expense Issues

The study found that operating expenses per unit of service have trended at levels below medical inflation rates over the last several years in spite of some rapidly rising components, such as pharmacy expenses. Moreover, utilization has been managed, with median adjusted acute average length of stay (ALOS) falling.

The data in Table 1 show risk-adjusted revenue, expense, utilization, and discharge statistics to illustrate the competing trends that drive operating margins.

The difference between revenue and expense, both in the per-day and per-discharge categories, eroded substantially for the average California hospital between 1995 and 1999. Remarkably, operating expenses in both the per-day and per-discharge categories were generally stable over that time period, with per-day expenses actually showing a slight decline. The compound annual rate of growth for both per-day and per-discharge expenses were significantly below the rate of inflation for the study period.

TABLE 1. CALIFORNIA HOSPITAL AVERAGE REVENUE, EXPENSE, AND UTILIZATION TRENDS, 1995 AND 1999

| | 1995 | 1999 | Compound Annual Growth Rate |
|---|---|---|---|
| Daily operating revenue, per day | $ 1,222 | $ 1,189 | -0.67% |
| Daily operating expenses, per day | $ 1,219 | $ 1,212 | -0.14% |
| **Difference** | $ 3 | $ (23) | NA |
| Operating revenue per discharge | $ 7,347 | $ 7,638 | 0.98% |
| Operating expenses per discharge | $ 7,523 | $ 8,077 | 1.79% |
| **Difference** | $ (176) | $ (439) | 25.64% |
| Acute average length of stay | 4.55 | 4.24 | -1.74% |
| Acute days as % of total inpatient days | 72.6% | 70.4% | -0.75% |
| Acute inpatient discharges as % of total inpatient discharges | 89.8% | 88.3% | -0.41% |

Source: Shattuck Hammond Partners. *The Financial Health of California's Hospitals.* July 2001.

Notwithstanding hospitals' success in managing expenses in the past, there is grave concern about the future. The majority of respondents to the MegaTrends survey indicated a fear that operating margins will continue to decline as a result of rapidly rising expenses, particularly pharmacy and labor costs. OSHPD data for 1995 through 1999 suggests that the overall rate of expense growth has been largely controlled. Median salaries and wages per adjusted patient day in California actually declined slightly in that time, from $458 per day to $446 per day, a drop of 0.69 percent.

Despite these positive trends, expense projections show some adverse signs. Salary and wage expenses, which have been contained by staffing reductions and changes in skill mix, may be poised for an increase. The combined factors of unionization, the minimum nurse staffing ratio legislation of state Assembly Bill 394 (AB 394), and general shortages of skilled patient care and information technology workers are creating expectations for increasing wage expenses, the largest single component of hospital operating expenses.

California hospitals also incur expenses that are complex and, at times, difficult to control. For example, if new, more expensive cardiovascular technology allows cardiologists to implant stents into arteries to prevent occlusion, and this procedure is safer and more effective than the angioplasties that had been performed in the past, the procedure likely would be implemented. The majority of payment structures in place for California hospitals would not provide additional revenue to the hospital to offset such increases in expense, because hospitals are typically paid either a fixed per-diem rate or a fixed per-case rate, regardless of resources consumed. Any additional reimbursement from health plans would have to be negotiated at the time the hospital's current contract expires. Revenue increases from public programs may also not be responsive to current trends.

Information technology comprises another expected area of steep cost increases. Hospitals are faced with needed upgrades to information systems technology, which will allow them to better manage patient care and expenses. Although some of these technology investment requirements have both capital and operating cost implications, many have a direct operating cost impact.

While expenses trended at a rate well below the rate of medical price inflation, revenues trended at an even lower rate, leading to an erosion of operating margin. This finding reinforces the notion that competitive and regulatory forces have been very successful at containing California hospital pricing. Further, although the California hospital industry has kept per-unit cost trends well below the rate of inflation, it has not been successful enough in reducing those costs so as to maintain or improve operating margins.

## Regulatory Mandates

State and federal regulatory measures have imposed substantial revenue drains and capital demands on the industry:

- The federal Balanced Budget Act of 1997 contains mandated Medicare payment reductions that by 2002 will cut net Medicare payments to California hospitals by a projected $4.9 billion.
- California Senate Bill 1953 (SB 1953), enacted in 1994, requires all hospitals in California to meet stringent guidelines for structural resilience to earthquakes, with graduated levels of conformance required in 2008 and 2030. Costs could include retrofitting, business interruption and, in some cases, complete hospital replacement. Failure to meet these deadlines can mean the loss of acute hospital licensure. The California Healthcare Association has estimated the cost to the state's hospitals at $24 billion.
- The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires providers to adopt electronic transaction standards, data security protocols, and privacy measures to protect confidential patient information that is stored or transmitted electronically. The American Hospital Association estimates an average annual cost per hospital of approximately $4.6 million for the first five years of program implementation.
- Medi-Cal (California's Medicaid program) instituted managed care programs in 20 California counties by 1999, which generally resulted in reduced reimbursement to hospitals for Medi-Cal services.
- California Senate Bill 1875 (SB 1875), enacted in 2000, requires most hospitals to create technology-based systems to reduce medication errors by January 2005.

## Deteriorating Operating Margins

A financially healthy organization is one that produces an operating margin sufficient to finance the current and future capital that is required for the maintenance and growth of its business. For most California hospitals, this capital comes from two primary sources: operating cash flow and debt financing.

Operating margin is an "early warning" indicator of financial health because it provides access to the capital required to sustain and/or grow a business in the future. Particularly in the capital-intensive hospital industry, access to capital, or lack thereof, determines future viability.

Although generalizing about healthy levels of operating margin may be misleading in some circumstances, an industry rule of thumb is that an operating margin of 3 percent to 5 percent would be considered healthy.

Given the pricing and expense environment of California hospitals relative to the nation, it is

not surprising to find that median California hospital operating margins are well below national figures (see Table 2). In 1999, California hospitals were reporting a negative median operating margin, at –0.33 percent; more than half of California's hospitals were losing money from operations that year. Nationally, the median operating margin was 0.4 percent. The most precipitous decline occurred from 1996 to 1997, with a decline of 1.5 percent of the 2 percent total drop over the entire five-year period.

## Hospital Types: The Haves versus the Have-nots

Another potential risk factor facing California's hospitals is the differential financial health of its hospitals. Analysis of hospital types found that California possesses a highly vulnerable group of hospitals at the "have-not" end of the spectrum—a group that includes 25 percent or more of the state's hospitals. California also possesses a group of "have" hospitals, which are strong financially and are in a position to dominate the highly competitive private marketplace for hospital services.

The operating margin disparity between the top and bottom performing hospitals widened significantly from 1995 to 1999 for both California and the nation as a whole, as illustrated in Table 3.

It is troubling that the bottom quartile of California's hospitals had an operating margin of –7.76 percent in 1999. These most vulnerable hospitals had a deteriorating credit profile that in 1999 reached levels that would likely preclude them from accessing capital through debt financing in the public markets.

For these hospitals, any one or a combination of adverse financial developments could result in insolvency and possible closure. Given that the bottom quartile of California's hospitals handled 17 percent of the state's hospital discharges, this group is large enough to create a serious hospital access problem in California, if large numbers of them fail to survive. Furthermore, hospitals in other operating margin performance quartiles may be vulnerable to the same risk factors.

In a significant finding of this study, analysis of California's diverse array of hospital types yielded some patterns of over-representation in the lowest quartile of operating margin based on typology. Most evident was the state's rural hospitals. An analysis of rural versus urban hospitals revealed a widening gap in performance between 1995 and 1999, with rural hospitals showing a consistently negative and worsening median operating margin. Quartile distribution showed that rural hospitals are under-represented in the top quartile, comprising only 7 percent of the top quartile hospitals versus 18 percent of all hospitals, and are largely distributed below the median, with their highest representation, 26 percent, in the lowest quartile.

TABLE 2. MEDIAN OPERATING MARGINS, CALIFORNIA VERSUS THE NATION, 1995–1999

| | 1995 | 1996 | 1997 | 1998 | 1999 | Change 1995–1999 |
|---|---|---|---|---|---|---|
| California hospitals | 1.65% | 1.59% | 0.09% | 0.10% | –0.33% | –1.98% |
| National hospitals | 2.8% | 2.6% | 2.8% | 1.2% | 0.4% | –2.4% |

Source: Shattuck Hammond Partners. *The Financial Health of California's Hospitals*. July 2001.

TABLE 3. OPERATING MARGIN QUARTILES, CALIFORNIA VERSUS THE NATION, 1995 AND 1999

| | California | | | National | | |
|---|---|---|---|---|---|---|
| Quartile | 1995 | 1999 | Change | 1995 | 1999 | Change |
| 75th percentile | 6.84% | 5.72% | –1.12% | 7.0% | 5.0% | –2.0% |
| Median | 1.65% | –0.33% | –1.98% | 2.7% | 0.4% | –2.3% |
| 25th percentile | –3.96% | –7.76% | –3.80% | –1.5% | –5.1% | –3.6% |
| 75th minus 25th percentile | 10.82% | 13.48% | | 8.5% | 10.1% | |

Source: Shattuck Hammond Partners. *The Financial Health of California's Hospitals.* July 2001.

Other categories of hospitals that were over-represented among the bottom quartile hospitals occurred within the following groups:

- Small
- District-owned
- City- or county-owned
- Rural
- Disproportionate Share Hospitals
- Non-members of a health care system

Over-representation among the top quartile hospitals occurred within the following groups:

- Medium-large
- Medium-small
- Investor-owned
- Urban
- Members of a health care system

Notably, all hospital types have significant representation between both the top and bottom operating margin quartile hospitals, with the exception that city/county, district, and rural hospitals comprise an insignificant share of the top quartile.

Other observations include:

- Investor-owned hospitals had the highest median operating margin among all categories between 1995 and 1999, but were not immune to the overall trend of declines in operating margin. While this was the strongest group in terms of type of control, the median operating margin decline of 2.26 percent exceeded the 1.98 percent median decline for all hospitals in this time period.
- Statewide, 18 of the 19 hospitals that were closed or had their licenses suspended from 1997 to 1999 had fewer than 200 beds, suggesting that small size had an influence on viability.
- While small and medium-small hospitals showed weaker operating margin trends, these two types also comprised 72 percent of all California hospitals in 1999, as well as 69 percent of top quartile hospitals and 79 percent of bottom quartile hospitals.
- Between 1995 and 1999, the proportion of medium-large and large hospitals above the median grew from 27 percent to 32 percent. In four of the five years studied, median operating margins for medium-large hospitals exceeded the median operating margins for all other size categories (i.e., small, small-medium, and large).
- Southern California hospitals' operating margins showed that in 1995 and 1999,

58 percent of its hospitals were below the statewide median operating margin. The region's hospitals could be modestly characterized as "have-nots."

- System member hospitals had much higher median operating margins between 1995 and 1999, and experienced a smaller decline in median operating margin during that time frame than non-system members. System hospitals' median operating margin went from 4.37 percent in 1995 to 1.77 percent in 1999; non-system margins slipped from –0.27 percent to –4 percent.
- Some hospital migration was observed among operating margin quartiles between 1995 and 1999. Of the hospitals that were in the worst-performing quartile in 1995, 53 percent remained in the same quartile in 1999, while 70 percent remained in one of the two bottom quartiles in 1999. Of the hospitals in the best-performing quartile in 1995, 53 percent remained in the top quartile in 1999 and 78 percent remained in one of the two top quartiles in 1999.
- In 1999 California's top quartile hospitals out-performed the nation's top quartile—a reversal from the 1995 relationship.
- From 1995 to 1999, California's bottom quartile hospitals fared worse than the nation's bottom quartile hospitals, experiencing a median operating margin decline of 3.8 percent, compared to a decline of 3.6 percent nationally.
- The gap between California's top and bottom quartile grew from 10.82 percent in 1995 to 13.48 percent in 1999.

## Capital Access Woes Threaten Hospitals' Future

Capital for maintenance, replacement, and new technology is a critical need for hospitals in California. The industry is particularly dependent on capital because its ability to provide quality service and produce operating revenue is heavily dependent on tangible assets such as land, facilities, medical equipment and, increasingly, information technology.

California hospitals rely heavily on debt financing as a source of capital. In 1999 California's median and weighted average hospital debt ratio statistics showed that its hospitals financed approximately 44 percent of their total capital with debt.

Table 4 shows financial ratios data for California hospitals, calculated from OSHPD data. These ratios, which lenders use to evaluate a hospital's creditworthiness, are compared to Moody's national median ratios for "Baa" credit ratings, which are the lowest investment grade rating the agency offers. A rating below "Baa" moves a borrower into "junk bond" territory, where debt financing is often very expensive and difficult to obtain.

*Liquidity/Days Cash* is a ratio that measures the number of days of operating expense that could be funded by a hospital's liquid reserves. A hospital's investment reserves not only provide it with a direct source of capital, but also influence the amount of debt financing a hospital can obtain. Lenders look to this ratio as a "comfort factor" in assuring timely debt repayment; low liquid reserves can limit a hospital's access to capital.

*Debt Service Coverage* is a ratio that measures the hospital's cash flow, divided by its existing annual debt service payments. It shows debt-financing levels at a given hospital; higher ratios create greater comfort for lenders.

*Debt to Capital* is a ratio that examines a hospital's debt in comparison to its total assets or capital. A hospital's access to debt financing is often limited by its ratio of debt to capital.

While the credit ratio data does not appear to evidence significant change in debt service coverage and debt to capital ratios, liquidity shows a

TABLE 4. CALIFORNIA HOSPITAL CREDIT RATIOS, 1995 AND 1999

| Ratio | | OSHPD DATA 1995 | OSHPD DATA 1999 | Moody's "Baa" Median 1999 |
|---|---|---|---|---|
| Liquidity/Days Cash | System | 119.5 | 108.2 | |
| | Median | 81.1 | 50.9 | 92.7 |
| Debt Service Coverage | System | 2.52 | 2.21 | |
| | Median | 2.34 | 2.43 | 2.62 |
| Debt to Capital | System | 43% | 43% | |
| | Median | 47% | 44% | 44% |

Source: Shattuck Hammond Partners. *The Financial Health of California's Hospitals.* July 2001.

weakening trend. Liquidity decline is an alarm for investors and credit analysts, which indicates an unsustainable combination of financial performance and capital investment.

Based on this data, California's hospital system as a whole would likely receive a weak "Baa" rating based on liquidity, coverage, and leverage ratios.

The strong link between operating margin and access to debt capital is readily apparent in observing California hospital trends. By 1999 the credit quality of California's hospitals had fallen dramatically:

- Moody's Investors Service (Moody's) and Standard & Poor's Corporation (S&P), two national credit rating agencies, had ratios of downgrades to upgrades for California hospitals of 4 to 1 and 11 to 1, respectively, for the period of 1997 to 1999.
- In financial profiles of California hospitals, 38 percent of Moody's and 30 percent of S&P's reports carried a qualifier of "negative outlook."

With the exception of a minority of California hospitals, California's hospital system overall has experienced and will likely continue to experience significant credit deterioration, putting many hospitals in the position of being challenged to fund current much less future mandated capital expenditures.

Capital funding issues present the highest risk factor in accelerating a financial crisis among California hospitals. Study findings indicated significant credit erosion of California hospitals' overall financial profile. Furthermore, the rating agencies observed a deferral of capital spending among many rated California hospitals—an indication of capital inadequacy. If unchanged, this fragile state of capital access will likely lead to an increasing prevalence of hospital failures.

Primary among the risk factors facing California's hospitals are the seismic upgrade requirements of SB 1953. Although public, hospital-specific SB 1953 data is not available yet, it is the conclusion of this study that a significant portion of California's hospitals may not possess sufficient capital access to fund SB 1953 requirements. SB 1953 has great potential to accelerate potential financial non-viability for California's hospitals.

Virtually all MegaTrends survey participants believed that California's hospitals, on a systemwide

basis, could not afford to meet the requirements of SB 1953. Respondents anticipated increased debt levels and reduced liquidity from the combination of increasing capital needs and financial performance pressures, and overwhelmingly predicted an increase in the rate of closure of California hospitals in the future. Participants also ranked information technology first in priority and patient care facilities last, which is not surprising, given the pressures on the hospital industry to become more productive. Ironically, patient care facilities are ranked first in expected future magnitude of capital expenditures, due to SB 1953.

## Policy Implications of California Hospitals' Financial Challenge

One Chinese translation for the word "crisis" is "dangerous opportunity." This translation aptly describes the broader historical perspective on California's hospitals in light of the current environment. California has led the nation in the constructive adaptation of its health care system. It has also led to a highly competitive managed care market, making much of hospital revenue subject to tough negotiation. The results have yielded a highly competitive hospital infrastructure that provides quality care and at the same time has seen hospital expenses remain at levels below the rate of inflation.

What threatens to alter the success of California's hospitals is not necessarily competition alone, but rather the explosive confluence of competition and new governmental mandates. Historically, a quasi-public good like health care has been influenced by government, which has sought to achieve greater efficiency and the benefits of market-based adaptation through competition, while protecting the public and achieving social policy goals through regulation. Indeed, the "invisible hand" of health care policy, in tandem with market competition, has shaped the evolution of California's health care environment.

Given the current financial situation among California hospitals, the marketplace has the potential to spark needed reforms in the structures and service delivery methods of the state's hospital system, or to introduce serious dislocations and disruptions into that system.

Numerous studies have concluded that California has more hospital beds than are necessary for its current and future health care needs. The hospital beds currently in place in California are more appropriate, both in terms of geography and facility type, to the financial and health care needs of 30 years ago. The medical practices and technologies available today require significantly fewer inpatient beds, as well as different types of facilities. The ongoing redevelopment and modernization of inpatient services is likely to result in consolidation of services and closure or relocation of some hospitals, regardless of SB 1953's seismic retrofit mandates.

In addition to these changes to inpatient services delivery, there also has been an historical under-investment in new or upgraded hospital buildings in California. This has made for an obsolescence problem among the state's hospital facilities that also is unrelated to the seismic retrofit issue, particularly in rural areas.

Given the aging inventory of inpatient buildings and the need to comply with modern seismic standards, there is a golden opportunity to recast the distribution of inpatient services in a way that more closely matches California's current and projected needs, and the changing approaches to health care delivery.

However, this is where the danger in "dangerous opportunity" could come into play. As the study has shown, many if not most of California's hospitals do not have the resources to finance their own modernization. Should the health care marketplace be allowed to proceed in unfettered fashion, there could be a series of closures and consolidations that could benefit the state's healthy hospital systems, but which have the risk of creating serious gaps in hospital access among

communities served by financially vulnerable hospitals.

In this situation, the market could tend to reward those hospitals in areas with the greatest potential for return on investment, while denying investment in the health care needs of potentially underserved communities. In addition to the potential for disruption from closures and relocation, consequences could include the continued use of obsolete or seismically unsafe facilities, and more consolidated control of hospital services, thanks to the absorption of vulnerable hospitals into enlarging systems.

Hospital closures could create regional capacity shortages. The MegaTrends survey suggests that many hospitals already are encountering capacity shortages in critical care units. While the overall hospital occupancy rate for California hospitals rose to 59 percent in 1999, this occupancy is not evenly distributed on a facility-by-facility or regional basis. Therefore, the potential for wide geographic distribution of vulnerable hospitals could result in similarly widespread hospital supply dislocations.

In addition, while there are a variety of viewpoints on how to ensure that the state's hospital system provides all Californians with high-quality medical care and appropriate access to services—and does so in cost-effective fashion—there is currently no systematic process in place to provide objective information, develop standards, or help resolve conflicts about the type and number of hospital facilities and services needed by each community.

Finally, communities tend to be very loyal to their existing hospitals. Reconfiguration, closure, and resizing of hospitals are significant political issues, and can prompt substantial public resistance to such proposals, even if experts agree that such steps are needed.

The fundamental policy questions that emerge from the study revolve around whether there is a need to seek preventive solutions to this challenge facing the state's hospitals, or whether California's market forces should be allowed to shape the system's future. Considerations include:

- Should the public bear any or all of the responsibility for covering the costs of physical facility upgrades to California's hospitals, through such methods as state grants to hospitals or state underwriting of hospital construction bonds?
- If the state provides fiscal relief to the state's hospitals, what should taxpayers receive in return as a public benefit?
- Should consideration be given to providing financial support to hospitals in areas where closure or consolidation would result in significant gaps in service?
- Should financial assistance for modernization include criteria for support for projects other than seismic upgrades?
- Should delays be granted to hospitals for implementation of the seismic standards under SB 1953? If so, what conditions should be attached to such delays?
- Should facilities that fail to meet SB 1953 seismic standards be closed, or allowed to remain open?
- Should the state develop standards for acceptable access and appropriate sizing of inpatient facilities statewide and, if so, which agencies should develop and administer them?
- How would local communities and the general public be included in this decision-making process?

This substantial challenge to the state's hospital industry calls for the coordinated review and analysis of legislative requirements, in the context of the current highly competitive market environment. Such a review could allow California to convert its pending hospital challenge into an opportunity.

## For More Information

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To receive the full report by Shattuck Hammond Partners, and for additional copies of this issue brief and other publications, contact the California HealthCare Foundation's publications line at 1-888-430-2423 or visit us online (www.chcf.org).

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## Mission

The California HealthCare Foundation, a private philanthropy based in Oakland, California, focuses on critical issues confronting a changing health care marketplace by supporting innovative research, developing model programs, and initiating meaningful policy recommendations.

# THE STATE OF HEALTH INSURANCE IN CALIFORNIA: RECENT TRENDS, FUTURE PROSPECTS

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# EXECUTIVE SUMMARY summary

## OVERVIEW

In 1999, 6.8 million nonelderly Californians were uninsured, down from 7.3 million the previous year. This drop in the number of uninsured was the result of a 2.3 percentage-point gain in employment-based health insurance coverage and a slower decline in Medi-Cal coverage compared to the previous several years. California's recent upturn in coverage follows years of persistent and rising rates of uninsurance, despite the booming economy during this period.

Between 1994 and 1999, coverage from job-based insurance and public programs changed significantly.

- The rate of job-based coverage rose faster between 1998 and 1999 (from 58.3% to 60.6%) than between 1994 and 1998 (from 56.4% to 58.3%). This pattern reflects the state's recovery from the recession of the early 1990s, and a strengthening economy in subsequent years.
- Privately purchased health insurance has remained statistically unchanged between 1994 (4.3%) and 1999 (4.7%).
- Medi-Cal fell dramatically from 14.4% in 1994 to 12.8% in 1996, and continued to drop to 11.0% in 1998. This may have been in part due to the direct, anticipated and perceived effects of public policy changes that restricted Medicaid eligibility among immigrants during this period. However, this decline is slowing, with no significant drop between 1998 and 1999 in reported coverage from Medi-Cal or Healthy Families, California's State Children's Health Insurance Program initiated in mid-1998.

## CALIFORNIA'S UNINSURED POPULATION

California's uninsured rate dipped from 24.4% in 1998 to 22.4% in 1999, but this rate is still no lower than in 1996. Moreover, compared to the United States as a whole, California's nonelderly population has a higher uninsured rate (22.4% vs. 17.4%). California has the fourth highest uninsured rate in the nation.

- Over eight in 10 of the uninsured — a total of 5.8 million Californians — are workers and their family members.
- Over two in three had family incomes under 250% federal poverty level in 1999, an income too low to make health insurance coverage affordable without substantial assistance from an employer and/or government.
- Large ethnic and racial disparities in coverage are reflected in the generally higher uninsured rates among people of color compared to non-Latino whites (13%). Uninsured rates are particularly high among Latinos (36%) and among Koreans (45%).
- Within the state, regions and counties also differ markedly in their coverage rates, with Southern California having lower job-based coverage and higher uninsurance than the other regions.

Economically vulnerable groups of Californians are far less likely to have job-based health insurance coverage

## CHILDREN'S COVERAGE

Among California's children, 1.85 million have no private or public health care coverage of any kind. Children in California have a higher uninsured rate than in the nation as a whole (19% versus 14% in 1999). Although children's uninsured rate declined between 1998 and 1999, it remains higher than in 1995.

Uninsurance among children remained high during this period of sustained economic growth. This occurred because the gains in their coverage through a parent's job-based insurance, which rose from 50% in 1994 to 56% in 1999, was offset by plummeting Medi-Cal coverage, which fell from 25% in 1994 to 19% in 1999. Between 1998 and 1999, children's uninsured rate declined significantly as job-based coverage increased and the decline in public coverage slowed.

- Nine in 10 uninsured children are in working families.
- Seven in 10 uninsured children are in low- to moderate-income families with incomes below 250% the poverty level, an income too low for most families to afford health insurance coverage for their children without a substantial subsidy from an employer and/or government.
- Latino children continue to have the highest uninsured rate (28%), a rate that has not improved since 1994. Between 1994 and 1999, uninsured rates worsened for Asian-American and Pacific Islander children and for African-American children, while they improved among non-Latino white children.
- Children experience large disparities in health insurance coverage related to family immigrant and citizenship status. Four in ten noncitizen children and three in ten U.S.-citizen children with noncitizen parents were uninsured in 1999. These are three to four times the uninsured rate for citizen children with U.S.-born parents.
- There is a growing disparity between children in single-parent and married couple families. Uninsurance rose for children in single-parent families (from 22% in 1994 to 25% in 1999), while it declined for children in married couple families (from 18% in 1994 to 16% in 1999). The rise in uninsurance for children in single-parent families is due to a dramatic drop in Medi-Cal coverage (from 43% in 1994 to 35% in 1999), which was only partially offset by gains in job-based coverage (from 32% in 1994 to 36% in 1999).
- Uninsured rates and job-based coverage among children vary widely throughout the state. As with the nonelderly population overall, the Southern California region has higher rates than all other regions.
- More than two-thirds of California's 1.85 million uninsured children are eligible for either Medi-Cal or Healthy Families. A total of 535,000 uninsured children (range: 455,000 to 614,000) are eligible for Healthy Families, and 726,000 (range: 633,000 to 817,000) are eligible for Medi-Cal.[1] An estimated 343,000 uninsured children (range: 279,000 to 407,000) are citizens or legal immigrants who have family incomes that exceed the Medi-Cal and Healthy Families limits.



Californians lag behind the U.S. in job-based health insurance coverage

## COVERAGE OF NONELDERLY ADULTS

Nonelderly adults, ages 19 to 64, face an even greater risk of being uninsured than do children. Although they are more likely than children to have job-based health insurance coverage, they are less likely to be eligible for public programs that protect children and the elderly.

- The 5 million uninsured adults account for three-fourths of the state's uninsured population.
- Young adults, ages 19-24, have the highest uninsured rates (38%) and lowest job-based insurance (48%), though coverage as dependents is high for this group (28%).
- Even among adults who work full-time for the full year, one in five remains uninsured.
- More than half (51%) of poor nonelderly adults are uninsured.
- Latinos are less likely than non-Latino whites to receive job-based coverage (45% versus 72%) regardless of how much they work, the size firm in which they work, or their educational attainment.
- Seven in 10 U.S.-born citizens had job-based insurance in 1999, compared to 64% of naturalized citizens, 46% of noncitizens who are legal residents, and 31% of undocumented immigrants.
- Opportunities for both employment-based health insurance and for Medi-Cal coverage also vary depending upon family composition.
  - One in three (32%) single adults is uninsured as a result of a moderate rate of job-based insurance (55%) and few opportunities for coverage through Medi-Cal (6%). Single adults account for half of the state's nonelderly adult uninsured population — a total of 2.5 million.
  - Just 16% of married couples without children are uninsured — half the rate for single adults. Married couples without children have higher rates of job-based insurance as a result of more opportunities to obtain dependent coverage.
  - Married couples with children also have substantial opportunities to be covered as a dependent, resulting in a relatively low uninsured rate.
  - Single parents have few opportunities to obtain job-based insurance as a dependent. Although their generally lower family incomes result in one in four depending upon Medi-Cal coverage, they still have a high rate of uninsurance (30%).
- We estimate that 685,000 nonelderly adults (range: 595,000 to 775,000) are uninsured but eligible for Medi-Cal coverage, about 14% of the nearly 5 million uninsured adults in the state. Many groups of adults have few options for receiving assistance to obtain coverage; this is particularly true for low-income single adults without children, those with no disabling condition, new legal immigrants, and the undocumented.

1 Reported numbers are estimates based on small sample sizes, which reduce the estimate's precision and reliability. The range (called, a "95% confidence interval") provides a more reliable estimate of the numbers of persons in the population who fit that category. It means that the "true" estimate has a 95% probability of falling within the range.

Latinos are far less likely to have job-based coverage, and they comprise 28% of the California population, compared to 11% nationally

## EMPLOYMENT-BASED HEALTH INSURANCE COVERAGE

Job-based health insurance coverage rose both in California and nationally from 1994 to 1999, with particularly fast growth in California during the 1998-1999 period. Nevertheless, California still lags far behind the United States as a whole. One of the major reasons is that California employers are less likely to offer such coverage to their employees. Furthermore, although certain economically vulnerable subgroups in California have shown improvement over this time period, they still lag behind other groups in obtaining health insurance coverage from employment.

- The gap between California and the national average has lessened over time, but in 1999 Californians were still 6.6 percentage points less likely to receive health insurance through employers than the average American (62.8% vs. 69.4%).
- Whereas Californians overall have a 63% chance of obtaining job-based coverage, rates for particular groups are much lower. These include young adults age 19-24 (48%), Latinos (45%), non-citizens (40%), those without a high school degree (34%), those with low incomes (18% for those below the poverty line, and 43% for those between 100%-249% of poverty), part-time workers (55%), full-time workers employed part of the year (57%), and single parents (43%).
- To have coverage through one's own job, three things must take place: the employer must offer coverage, the employee must be eligible for it, and he or she must "take up" or enroll. Eligibility rates and take-up rates are roughly similar in California and in the United States as a whole, but offer rates are substantially lower in California. In 1999, 80.5% of California employees worked for an employer who offered health insurance coverage to at least some workers, compared to 85.6% of Americans. This 5.1% difference was somewhat lower than the 6.1% disparity five years earlier.

Further improvements in job-based coverage depend on continued economic growth as well as steady health insurance costs. If there is an economic downturn in California, or if there is a resurgence in health insurance premium inflation, recent gains will be jeopardized, since fewer employers would be able to afford to offer coverage, and fewer employees could afford to enroll.

- Already, the majority of families in many economically vulnerable California groups cannot afford the out-of-pocket premium costs of family coverage. For example, we calculate that 66% of uninsured Latinos would have to pay 5% or more of their income to afford employer-based family coverage, and 23% would have to pay 10% or more of their income. Given the other necessities of living, this is far beyond the means of most California residents.

## THE GOAL IS UNIVERSAL COVERAGE

The state should fully fund the study mandated by SB 480 to analyze alternative approaches to achieve universal coverage, and it should adopt a state policy related to this goal.

### POLICY RECOMMENDATIONS

- Fully fund the study mandated by SB 480 to examine and identify cost-effective ways to extend health insurance coverage to all Californians.



California and the U.S. show similar trends over time in job-based coverage

- Enact a state policy committing California to achieve affordable health care coverage providing good access to quality care that enhances people's health.

Until the United States achieves universal coverage, it will be important to find ways to shore up the nation's eclectic arrangements of voluntary employment-based health insurance and public coverage programs.

## EXPANDING EMPLOYMENT-RELATED HEALTH INSURANCE COVERAGE

The costs of health insurance and limited financial resources of most uninsured Californians and many employers underscore the necessity of providing financial assistance and other policies to expand health insurance coverage.

### Policy Recommendations

- To help mid-sized firms offer affordable coverage, firms with up to 200 employees should be included in California's purchasing cooperatives.
- To encourage more employers to offer health benefits, both the federal government and the state of California could offer financial assistance to low-wage firms that provide and help pay for the costs of health insurance for their employees and spouses and dependent children.
- To help more workers accept health benefits for which they are eligible, the state of California should provide financial assistance for workers in low-income families to defray part of the costs of purchasing employer-based health insurance coverage.

## EXPANDING PUBLIC PROGRAMS TO COVER UNINSURED CALIFORNIANS

The federal government has provided many opportunities for California to draw down federal matching dollars for a number of options to expand coverage for children and for their parents and some other adults.

The Governor's proposed expansion of Healthy Families could benefit up to 412,000 uninsured parents (range: 342,000 to 482,000) with income eligibility up to 200% of poverty. If the Governor raised income eligibility to 250% of poverty — the same as for children — 518,000 uninsured parents (range: 440,000 to 597,000) would be eligible for Healthy Families.

California could cover more uninsured children and their parents by raising Healthy Families' income eligibility to 300% of the poverty level.

### Policy Recommendations

- Expand the Healthy Families Program eligibility to parents on the same eligibility basis as for their children.
- Increase income eligibility for the Healthy Families Program to 300% of the poverty guidelines.

## ENHANCING ENROLLMENT OF ELIGIBLE PERSONS IN MEDI-CAL AND HEALTHY FAMILIES

The number of uninsured children and adults who are eligible for Medi-Cal or Healthy Families suggests that efforts to enroll eligible residents in these programs — and retain eligible beneficiaries once they are enrolled — ought to be enhanced. Although the state has improved its outreach and enrollment efforts, these efforts could be made more effective by several policy changes.

Economically disadvantaged Californians show the most improvement in coverage

**Policy Recommendations**

- The state should more fully engage community-based organizations, churches and schools in culturally sensitive outreach and expand funding for these efforts. Outreach should emphasize locally targeted media, use expanded federal authority and funds to enroll children in community settings away from the welfare office, and mobilize community leaders in these efforts.
- Fully implement Express Lane Eligibility to expedite enrollment in health programs for children who are participating in Food Stamps, the School Lunch Program, and WIC.
- Simplify the application and eligibility process for Medi-Cal and the Healthy Families Program by replacing income documentation with a "paperless" system used by many other states.
- Further simplify the application and eligibility process for Medi-Cal and the Healthy Families Program for children and adults by replacing the allowed expense deductions with an expanded income disregard as allowed under federal law.
- Reduce fragmentation for families by (1) integrating Medi-Cal and Healthy Families into a new program, or (2) creating an administrative overlay that retains separate program eligibility and funding but makes the programs seamless for enrollees, or (3) establishing a "bright line" between the programs so that all children and adults in a family are in the same coverage program.
- To avoid dumping eligible children out of Medi-Cal, vigorously implement the 12-month continuous eligibility for children, the elimination of the quarterly status report, and new procedures for retaining Medi-Cal for eligible persons when welfare ends.
- Take the eligibility determination process for California's public health care programs out of the welfare system.

## 3.7 MILLION ADULTS HAVE NO CURRENT OR PLANNED COVERAGE OPTIONS

At least 3.7 million uninsured adults would not qualify for Medi-Cal or the proposed expansion of Healthy Families. About seven in every 10 of these uninsured adults — a total of 2.6 million persons — are citizens or legal immigrants.

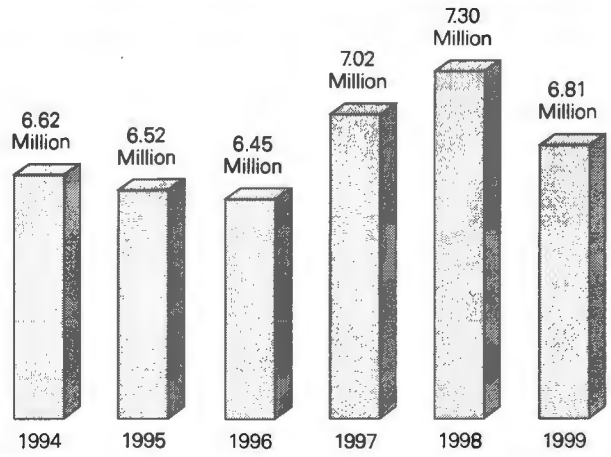
**Policy Recommendations**

- Apply for a section 1115 waiver to restructure the Medi-Cal and Healthy Families Programs to open them to people who do not meet traditional categorical requirements.
- The state of California should increase subsidies to MRMIP to expand opportunities for low-income persons who have been denied coverage in the private health insurance market.
- Local jurisdictions can mobilize community leadership, encourage or require contractors to offer health benefits to their employees, and generate local resources to expand coverage of their residents.
- Health care "safety net" providers will continue to need federal, state and local financial support to meet the needs of those who remain uninsured.

# introduction

The number of uninsured Californians dipped to 6.8 million in 1999, down from 7.3 million in 1998 (Exhibit 1). One in six of the nation's 42 million uninsured persons lives in California.

EXHIBIT 1. UNINSURED NONELDERLY CALIFORNIANS, AGES 0-64, CALIFORNIA, 1994 TO 1999




Source: March 1995, 1996, 1997, 1998, 1999, and 2000 Current Population Surveys

Despite the good news, more than one in five (22.4%) of the state's nonelderly residents have no health insurance coverage, about the same rate as in 1996, when California had not yet fully recovered from the recession of the early 1990s. This report provides information and analysis intended to help answer a series of policy questions:

- Does the most recent positive change represent a reversal of the previous long-term negative trend? How great an improvement does this represent? How long is it likely to last?
- Who has benefited from this improvement? Who continues to bear a disproportionate share of the risk of being uninsured?
- How does employment-based health insurance coverage in California differ from coverage nationally?
- What opportunities are there for uninsured children and adults to be covered through Medi-Cal and the Healthy Families Program?
- What public policies might stabilize or strengthen health insurance coverage?

The number of uninsured Californians dipped to 6.8 million in 1999, down from 7.3 million in 1998

The report examines the health insurance coverage of nonelderly Californians in 1999, as well as trends in coverage from 1994 to 1999. In Part 1, we provide an overview of the population's coverage. We look at coverage from a variety of sources and focus especially on the uninsured. In Part 2, we examine health insurance coverage of children, followed in Part 3 by an examination of coverage of adults. We look carefully at disparities in coverage — by race and ethnicity, citizenship and immigration status, age, family composition, and other factors. In these sections, we examine current opportunities for uninsured children and adults to obtain public coverage through Medi-Cal and the Healthy Families Program.[2] In Part 4, we dig deeper into access to employment-based health insurance, the primary source of coverage for most nonelderly adults and children, including disparities within California and differences between California and the nation as a whole. In this section, we also consider how trends in the recent past might inform our understanding of future trends — whether very recent improvements will turn into a trend. Finally, in Part 5, we look to the future and suggest policy options that would be most useful to enhance Californians' coverage and build a foundation for universal coverage.

The data used in this report are taken from several sources. Estimates of the health insurance coverage of the population are based on the March 1995, 1996, 1997, 1998, 1999, and 2000 Current Population Surveys, in which respondents were asked about coverage during the previous calendar year (i.e., 1994, 1995, 1996, 1997, 1998, and 1999, respectively). Estimates of working adults' access to health insurance through employment are based on the February 1995, 1997, and 1999 Current Population Surveys. In these surveys, employed respondents were asked a series of questions about whether, at the time of the survey (i.e., not the previous calendar year) their employer offers health insurance to any of their workers, whether the respondent is eligible for health benefits that are offered, and whether the respondent accepts health benefits when eligible.

All references in the text to differences in proportions between groups are statistically significant ($p \leq .05$) unless otherwise stated.

2 Medi-Cal is California's Medicaid program, a joint state and federal program that provides matching funds to states to cover families with children, disabled adults, and the elderly with income eligibility set by the states at or above a federal floor. The Healthy Families Program is California's version of the State Children's Health Insurance Program, which provides federal matching funds to states to cover children with family incomes above the limits for "no-share-of-cost" Medicaid.



**Despite the recent decline, more than one in five of the state's nonelderly residents are uninsured**

# 1. AN OVERVIEW OF HEALTH INSURANCE COVERAGE 1

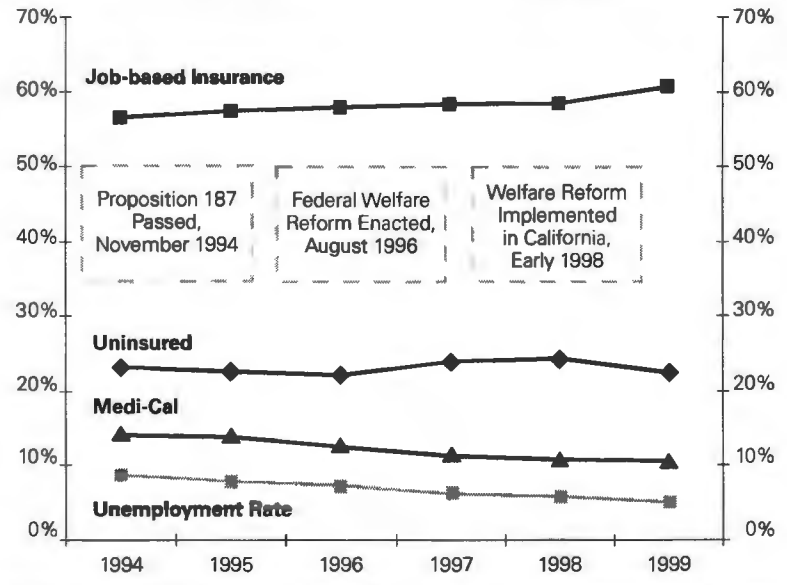
The drop in the number and proportion of Californians who are uninsured between 1998 and 1999 is due to new growth in employment-based health insurance coverage, aided by a slower decline in Medi-Cal coverage.

## OVERVIEW IN CONTEXT

Employment-based insurance rose gradually from the intractable recession of the early 1990s, which was reflected in the low rate of job-based coverage in 1994 when unemployment was high (Exhibit 2). But job-based insurance rates did not visibly respond to the unprecedented period of economic growth until 1999. Meanwhile, Proposition 187 in 1994 and the enactment of federal welfare reform in 1996 engendered widespread fear among noncitizens, including legal permanent residents, that enrollment in public programs would jeopardize their immigration status. This fear preceded the actual implementation of welfare reform in California, but it discouraged participation in Medi-Cal. The combination of relatively flat or slow growth in employment-based coverage and falling Medi-Cal enrollment resulted in a persistent and rising rate of uninsurance, despite the booming economy.

In this part of the report, we examine health insurance coverage of the nonelderly population in more detail, including how it changed over time, who benefited from the change — and who did not.

**EXHIBIT 2. HEALTH INSURANCE COVERAGE OF NONELDERLY CALIFORNIANS AND UNEMPLOYMENT RATE, AGES 0-64, CALIFORNIA, 1994-1999**




Source: March 1995, 1996, 1997, 1998, 1999 and 2000 Current Population Surveys and California Employment Development Department, Labor Market Information

**Until the most recent year, California experienced a persistent and rising rate of uninsurance despite the booming economy**

## EMPLOYMENT-BASED HEALTH INSURANCE

The proportion of nonelderly Californians who received health insurance through their own employment or that of a family member rose 2.3 percentage points between 1998 and 1999, from 58.3% to 60.6% — a greater increase in one year than in the four-year period from 1994 to 1998 (Exhibit 3).

This welcome improvement in health insurance coverage was a result of significant gains in employment, not an expansion of job-based coverage among working families. The proportion of nonelderly Californians in families in which no adult worked fell to its lowest level (9.7%) in six years, a strong gain that came only after several years of unparalleled economic growth. In 1999, the proportion whose families had at least one adult worker employed full time for the full year reached 66%, up from the 62%-63% level where it had hovered from 1995 (when California was beginning to emerge from the recession of the early 1990s) to 1998 (when the state was already well into the current economic boom). This is an important employment gain because full-time, full-year employees are the most likely to receive health benefits.

## PRIVATELY PURCHASED HEALTH INSURANCE

Health insurance purchased in the nongroup market ("privately purchased") is an option for employees who do not obtain coverage through an employer and for self-employed adults — if they qualify and can afford it. Privately purchased insurance remained flat, covering 4.3% of nonelderly Californians in 1994 and 4.7% in 1999 (Exhibit 3).

**EXHIBIT 3. HEALTH INSURANCE COVERAGE OF NONELDERLY CALIFORNIANS, AGES 0-64, CALIFORNIA, 1994, 1996, 1998, AND 1999**

| | 1994 | 1996 | 1998 | 1999 | CHANGE 1994-1999 | CHANGE 1998-1999 |
|---|---|---|---|---|---|---|
| UNINSURED | 23.3% | 22.3% | 24.4% | 22.4% | –0.9 | –2.0* |
| JOB-BASED INSURANCE | 56.4% | 57.8% | 58.3% | 60.6% | +4.2* | +2.3* |
| PRIVATELY PURCHASED | 4.3% | 5.7% | 4.5% | 4.7% | +0.4 | +0.2 |
| MEDI-CAL/ HEALTHY FAMILIES** | 14.4% | 12.8% | 11.0% | 10.5% | –3.9* | –0.5 |
| OTHER PUBLIC | 1.7% | 1.5% | 1.8% | 1.7% | — | –0.1 |
| TOTAL | 100% (POPULATION: 28,370,000) | 100% (POPULATION: 28,940,00) | 100% (POPULATION: 29,870,000) | 100% (POPULATION: 30,400,000) | | |

* Change is statistically significant at p ≤.05.

** Includes persons reporting enrollment in Medi-Cal (1994-1999) or the Healthy Families Program (1998-1999). Such estimates derived from surveys are generally lower than those derived from administrative data.

Note: Population estimate is based on March 2000 Current Population Survey, which may differ from population estimates derived from other sources.

Source: March 1995, 1997, 1999 and 2000 Current Population Surveys



The proportion of nonelderly Californians who received job-based insurance rose between 1998 and 1999

## MEDI-CAL AND THE HEALTHY FAMILIES PROGRAM

For those who do not obtain coverage through employment and cannot purchase it privately, Medi-Cal (California's Medicaid program) or the Healthy Families Program (California's version of the State Children's Health Insurance Program, or CHIP) may be an option — but only for those who have low incomes and meet other stringent requirements. Medi-Cal is restricted to persons who fit into one of the program's eligibility categories. In addition, only persons in these groups whose family incomes and financial assets are low enough to meet the requirements specified for that group will be eligible. In general, only citizens and noncitizens legally residing in the United States are eligible for Medi-Cal,[3] but the noncitizens among this group have been further discouraged from enrolling in Medi-Cal. The implementation of some federal laws and California's Proposition 187, along with the debates over some provisions of federal welfare reform legislation, created an anti-immigrant climate.

Children may be eligible for Medi-Cal if their family incomes do not exceed specified limits (children are not subjected to an asset test), which vary depending on the age of the child. For infants under age 1, family income may not exceed 200% of the federal poverty guidelines; for children ages 1-5, up to 133% of poverty; and for children ages 6-18, up to 100% of poverty. Income deductions allowed for childcare and work expenses may enable children in families above the specified income level to be determined eligible for the program. Children who meet these requirements are eligible for no-share-of-cost Medi-Cal; that is, the child's family pays no premiums.

Children are eligible for the Healthy Families Program if their family income exceeds the Medi-Cal income eligibility level but does not exceed 250% of the poverty guidelines (after deducting allowed expenses). Unlike Medi-Cal, the Healthy Families Program, which was enacted in 1997 and began enrolling children in 1998, charges families modest premiums for health insurance coverage, ranging from $4 to $9 per month (up to $27 per family).

Adults may qualify for Medi-Cal if they are in a family with eligible children or are either a pregnant woman, a disabled nonelderly adult, an elderly adult (age 65 or over), or part of some other limited categories — and meet stringent income and asset limits set for the particular eligibility code under which they might qualify. Pregnant women may qualify for Medi-Cal with incomes up to 200% of poverty, and women with incomes between 200% and 300% of poverty are eligible for the Access for Infants and Mothers (AIM) Program. Those who are parents of Medi-Cal-eligible children may also be eligible if their family incomes do not exceed 100% of the poverty level, with a higher limit for those transitioning off of welfare. Adults without children may qualify for no-share-of-cost Medi-Cal if they are disabled and if their family incomes do not exceed 133% of poverty.[4] Other than these provisions, adults have few options for coverage through Medi-Cal.

The proportion of the nonelderly population that reported receiving Medi-Cal coverage tumbled from 14.4% in 1994 to 12.8% in 1996 (Exhibit 3). It continued to fall as the new Healthy Families Program was getting started — to 11.0% in 1998 despite a relatively flat rate of job-based insurance. Medi-Cal and Healthy Families coverage together

3 This includes PRUCOL aliens (those "permanently residing under color of law") who are eligible for full-scope Medi-Cal, but undocumented aliens not legally residing in the U.S. are eligible for pregnancy-related and emergency Medi-Cal.

4 For information on Medi-Cal eligibility, see Page C, Ruiz S, *The Guide to Medi-Cal Programs: A Description of Medi-Cal Programs, Aid Codes, and Eligibility Groups*, Oakland, CA: Medi-Cal Policy Institute, 1999.

dipped further to 10.5% in 1999, but this decline was offset by a larger increase in job-based coverage.[5] It should be noted that despite these continuing declines in Medi-Cal coverage based on CPS survey data, Medi-Cal enrollments based on administrative data have recently shown an increase. The administrative data indicate that California's Medi-Cal enrollments rose 1.3% from a low point in December 1997 to December 1999, although the end-of-1999 figure was still below the level earlier in 1997.[6]

The decline in Medi-Cal enrollment reported in the Current Population Survey between 1994 and 1996 may have been due, in part, to more people obtaining employment-based or other private health insurance, but most of the decline was due to changes in public policy, especially welfare reform, that occurred at the end of this period. First, welfare reform weakened the historical tie between Medi-Cal and federally funded public assistance programs. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 separated eligibility for Medi-Cal from eligibility for cash assistance to families with children.[7] Although families leaving welfare could remain eligible for transitional Medi-Cal, many were not informed of their eligibility and did not receive it.[8] Other low-income working families who had not received welfare were also potentially eligible but were not widely informed of this option. However, all these policy changes were not to take effect until 1998 in California, and even then many families were entitled to remain covered until a special review was conducted. But the enactment of these reforms and their anticipation created confusion about who was eligible, concern about lifetime eligibility for public assistance benefits, and fear among immigrants.

Welfare reform greatly restricted immigrant noncitizens' eligibility for public assistance — a change that disproportionately affected California residents. The federal legislation restricted Medicaid to citizens and to legal immigrants who were in the United States when welfare reform was signed (August 22, 1996). It also led to more widespread application of the "public charge" classification — as used by the State Department, someone who is, or is likely to become, dependent on public benefits. This policy generated widespread fear among noncitizens that enrolling themselves or their children in Medicaid might jeopardize their re-entry into the United States, accounting for much of the drop in Medi-Cal coverage during the period 1996-1998. A modification of the policy issued by the Immigration and Naturalization Service (INS) in May 1999 and widely disseminated by community-based organizations may have eased these fears during the past year.

5 Persons identified in this report as covered by Medi-Cal or the Healthy Families Program are those who reported being covered by one of these programs (or were classified as such by the Current Population Survey) and who did not report having either employment-based health insurance or privately purchased insurance during the year. These estimates, as well as those of other surveys, are generally lower than estimates derived from the programs' administrative data. Note that only estimates for 1998 and 1999 include Healthy Families enrollees. See the Appendix for a fuller discussion of differences between estimates of Medi-Cal and Healthy Families enrollment based on administrative vs. survey data.

6 Ellis R, Smith VK, and Rousseau DM, *Medicaid Enrollment in 50 States, June 1997 to December 1999*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2000.

7 Known nationally as Temporary Assistance for Needy Families, or TANF, and in California, as "CalWORKs."

8 Guyer J, *Health Care After Welfare: An Update of Findings from State-Level Leaver Studies*, Washington, DC: Center on Budget and Policy Priorities, 2000; Garrett B, Holahan J, "Health Insurance Coverage After Welfare," Health Affairs 2000; 19(1): 175-184. Although the majority of women who left welfare were working, only 33 percent of these women obtained health coverage through their jobs. Rates of uninsurance increased with the number of months since leaving welfare and with declines in Medicaid coverage. A year or more after leaving welfare, 49 percent of women and 30 percent of children were uninsured.



The proportion of persons covered by Medi-Cal fell between 1994 and 1999

The combination of welfare reform's limits on receipt of public assistance and added restrictions on immigrants pushed many recipients into entry-level jobs that paid low wages and did not offer health benefits. Additionally, for many potential Medi-Cal recipients the stigma of the welfare office interview, required for eligibility determination, has kept them from seeking Medi-Cal coverage even when they are eligible.[9]

## THE UNINSURED

The uninsured rate in 1994 (23.3%) appeared to decline slightly (but not significantly) by 1996 (22.3%) as the state's economy began to recover from the recession (Exhibit 3). It then climbed to 24.4% in 1998 following the enactment and implementation of welfare reform. It finally fell back to 22.4% in 1999 as economic gains brought improved employment, especially for those who previously had been unemployed or not in the labor force. It is noteworthy that this lower uninsured rate is higher than it was early in the economic recovery.

## HEALTH INSURANCE COVERAGE IN CALIFORNIA COMPARED TO THE NATIONAL AVERAGE

Compared to the United States as a whole, California's nonelderly population has lower rates of job-based insurance and higher uninsured rates.[10] This is true in spite of the fact that employer-sponsored health insurance is less expensive in California, and that employees foot a lower portion of the premiums. In 1999, California had a significantly higher uninsured rate than the nation as a whole (22.4% in California vs. 17.4% nationally, Exhibit 4) — although the difference has declined somewhat since 1994. If California had the same uninsured rate as the national average, it would have only 5.3 million uninsured residents — 1.5 million fewer than it has.

This higher rate of uninsurance was largely driven by California's lower rate of employment-based coverage (60.6% vs. 68.1%).

California's uninsured rate would be even higher if the state's Medi-Cal income eligibility policies were less generous. In California in 1999, even after several years of decline, 10.5% of the nonelderly population obtained coverage through Medi-Cal or the Healthy Families Program, compared with only 8.0% in the United States overall.[11] If California covered only the national average in its Medi-Cal and Healthy Families programs and if these residents had no other health insurance alternative — which is likely for most enrollees — it would have 7.6 million uninsured residents, 768,000 more than it has.

Among the 50 states and the District of Columbia, California has the second lowest proportion of nonelderly residents with job-based insurance coverage exceeded by New

9 Perry MJ, Stark E, Valdez RB, *Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment: Findings from Eight Focus Groups in California with Parents of Potentially Eligible Children*, Menlo Park, CA: Henry J. Kaiser Family Foundation, 1998.

10 Throughout this report we compare health insurance coverage in California to coverage in the United States as a whole. An alternative would have been to compare California to the average of all other states. We chose the former method because the national average is easier to comprehend than the average for all other states, and it facilitates comparison to other data sources. It is important to note, however, that including California in the U.S. figures reduces any differences reported between California and the nation as a whole. Thus, any such differences reported are on the conservative side.

11 As noted above, Medicaid estimates derived from surveys are generally lower than those derived from administrative data.

**The proportion who are uninsured declined in 1999 but it was still no lower than in 1996**

Mexico and tied for second lowest with seven other states. This low rate accounts for the state having the fourth highest uninsured rate (exceeded by New Mexico, Texas, and Louisiana, and tied for fourth highest with Arizona, Florida, Nevada, and Idaho).

Californians have had higher uninsured rates than the U.S. average for at least two decades. However, the 1999 gap of 5.0 percentage points is narrower than in 1994, when California's uninsured rate (23.3%) was 6.1 percentage points higher than the nation's as a whole (17.2%). This improvement is due to California's expanding employment-based health insurance; the current 7.5 percentage-point gap in that category is narrower than the 9.2 percentage-point difference (56.4% vs. 65.6%) in 1994.

It is noteworthy that during this same period, Medi-Cal coverage declined more rapidly in California than did Medicaid coverage nationally. In the United States as a whole, nonelderly residents' Medicaid coverage fell 1.8 percentage points between 1994 and 1999 (from 9.8% to 8.0%), while in California, Medi-Cal coverage fell 3.9 percentage points (from 14.4% to 10.5%). (Administrative data show less of a decline; for a discussion of the reasons for differences between estimates of Medi-Cal coverage from population-based surveys and those from administrative data, see the Appendix.)

**EXHIBIT 4. HEALTH INSURANCE COVERAGE OF NONELDERLY PERSONS, AGES 0-64, CALIFORNIA AND U.S., 1994 AND 1999**

| | CALIFORNIA | | U.S. | |
|---|---|---|---|---|
| | 1994 | 1999 | 1994 | 1999 |
| UNINSURED | 23.3% | 22.4% | 17.2% | 17.4% |
| JOB-BASED INSURANCE | 56.4% | 60.6% | 65.6% | 68.1% |
| PRIVATELY PURCHASED | 4.3% | 4.7% | 5.0% | 4.3% |
| MEDI-CAL/ HEALTHY FAMILIES* | 14.4% | 10.5% | 9.8% | 8.0% |
| OTHER PUBLIC | 1.7% | 1.7% | 2.4% | 2.3% |
| TOTAL | 100% | 100% | 100% | 100% |

* Includes persons reporting enrollment in Medi-Cal or the Healthy Families Program in California, and in Medicaid or the State Children's Health Insurance Program nationally. Such estimates derived from surveys are generally lower than those derived from administrative data.

Source: March 1995 and 2000 Current Population Surveys



**Californians are persistently disadvantaged in their health insurance coverage, driven by a low rate of job-based insurance**

## UNINSURED CALIFORNIANS ARE LOW-AND MODERATE-INCOME WORKING FAMILIES

Well over eight in 10 (85%) of the uninsured are workers and their spouses and children (Exhibit 5) — for a total of 5.8 million uninsured Californians in working families. Half (51%) are in families headed by at least one employee who works full time all year round — a total of 3.5 million uninsured full-time, full-year employees and their family members.

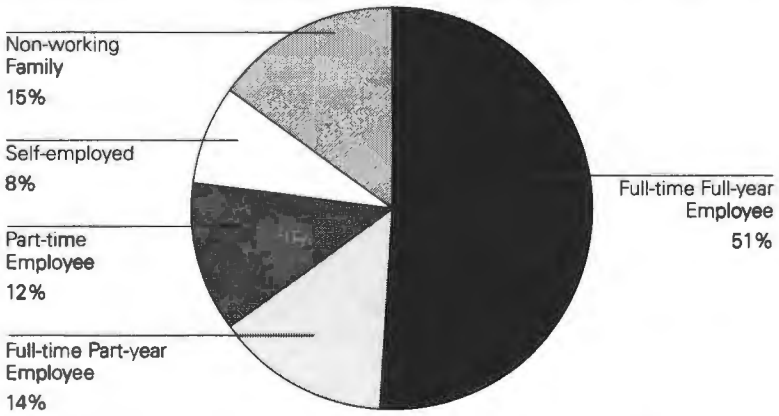
Many of these adults and children are in working families whose breadwinners do not have access to employment-based health insurance. As we will see in Part 4 of this report, this can be because their employer does not offer health benefits to any of its workers or because the employee is not eligible under the employer's rules. In other cases, individuals work for employers that do offer health benefits, but the employee finds the required premium contribution unaffordable.

## FAMILY INCOMES OF UNINSURED CALIFORNIANS

The uninsured are a disproportionately low-income group — a characteristic with important implications for efforts to expand coverage. Among California's uninsured population, one-fourth (26%) had incomes below the federal poverty level and another 41% had family incomes between 100% and 249% of the federal poverty level in 1999 (Exhibit 6).[12] Thus, two-thirds of the uninsured have family incomes so low that they are unlikely to be able to afford any substantial contribution toward the costs of health insurance premiums. To make health insurance affordable for them, an employer or the government will need to pay most, if not all, of the cost. Only 17% of the uninsured had family incomes four times the poverty threshold or greater.

This distribution of the uninsured by family income is quite different from the income distribution of the state's nonelderly population — underscoring the higher risk of being uninsured among low- and moderate-income

**EXHIBIT 5. UNINSURED NONELDERLY PERSONS BY FAMILY WORK STATUS, AGES 0-64, CALIFORNIA, 1999**




Source: March 2000 Current Population Survey

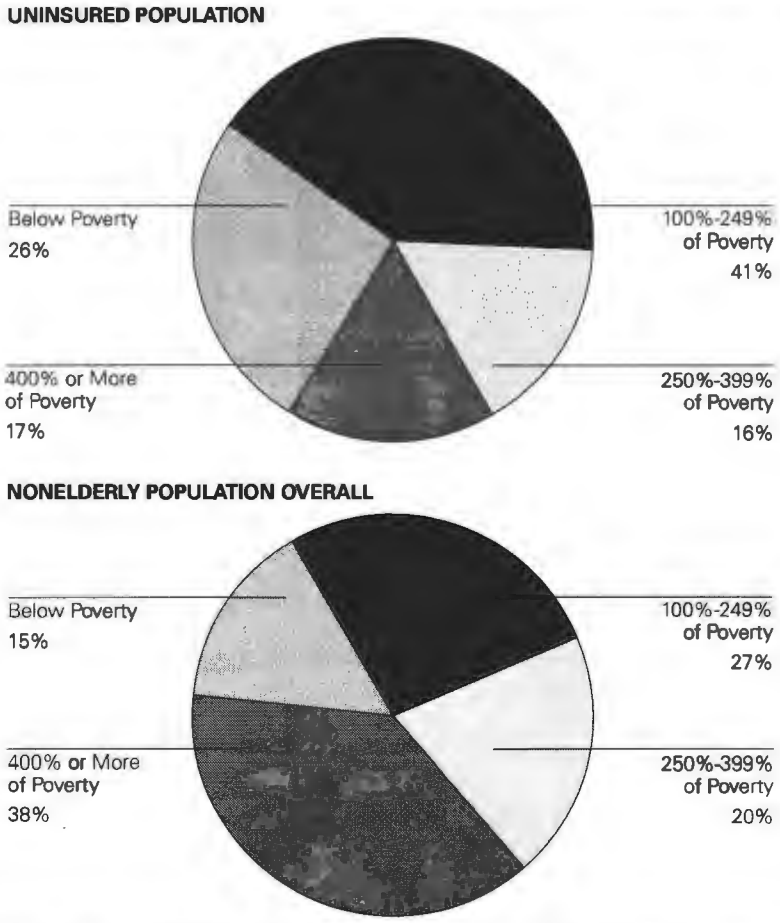
12 In 1999, the poverty threshold was $8,667 for one person under age 65, $11,214 for a family of two under age 65, $13,290 for a family of three, and $17,029 for a family of four, etc.

Over eight in 10 of the uninsured are workers and their family members

persons. In 1999, 15% of nonelderly residents were poor, compared to 26% of the uninsured (Exhibit 6). Another 27% of the population was near poor, compared to 41% of the uninsured. On the other hand, 38% of nonelderly residents had incomes of at least 400% of the poverty level, compared to just 17% of the uninsured.

Children and nonelderly adults with family incomes below poverty experienced a sharp increase in their uninsured rate between 1994 and 1999. This is the only income group in California whose uninsured rate grew during this period. The percentage of poor residents who are uninsured appeared to rise in California from 38% to 40% (not a statistically significant increase), while nationally it

**EXHIBIT 6. DISTRIBUTIONS OF UNINSURED AND NONELDERLY CALIFORNIANS OVERALL BY POVERTY LEVEL, AGES 0-64, CALIFORNIA, 1999**




Source: March 2000 Current Population Survey



**Two-thirds of the uninsured have very low family incomes**

climbed from 31% to 35%. This apparent growth in uninsurance is particularly disconcerting because these very low-income adults and children experienced increased employment-based insurance coverage during this period: from 12% to 18% in California, and from 18% to 21% nationally.

For this poverty population, falling Medicaid coverage was responsible for their rising uninsured rate. In California, Medicaid coverage fell 8 percentage points (from 46% of poor children and adults in 1994 to 38% in 1999), while nationally Medicaid coverage fell 7 percentage points (from 43% to 36%).

## ETHNIC AND RACIAL DIFFERENCES IN HEALTH INSURANCE COVERAGE

Latinos continue to have the lowest health insurance coverage of any ethnic group. Just 43% of Latinos had employment-based coverage in 1999, compared with 72% of non-Latino whites (Exhibit 7). Both groups' rates were up from 1998, when 40% of Latinos and 70% of non-Latino whites ("whites") had job-based insurance.

Latinos' low rate of job-based coverage is partially offset by Medi-Cal, although Medi-Cal covered 17% of Latinos in 1999 (and 1998), far lower than in 1994 (22%). Latinos' rise in job-based insurance between 1994 and 1999, together with a slight increase in privately purchased insurance, offset the erosion in Medi-Cal coverage. As a result, 36% of Latinos remained uninsured in 1999 (the same as in 1994), compared to 13% of whites (3 percentage points lower than in 1994).

Asian Americans and Pacific Islanders (AAPIs) also have a lower rate of job-based insurance than do whites, but their rate in 1999 (63%) reflects a fairly steady improvement over 1994 (52%). But between 1994 and 1999, AAPIs' Medi-Cal coverage fell from 18% to 7%, equal to the rise in job-based coverage; this left 22% uninsured in 1999, the same as in 1994.

African Americans gained from the economic growth in the latter 1990s, with their job-based coverage climbing from 52% in 1994 to 59% in 1999 — a rate still far below that of whites. As with other ethnic groups, falling Medi-Cal coverage, from 24% in 1994 to 15% in 1999, left 22% still uninsured in 1999.

American Indians and Alaska Natives (AI/ANs) also have a very low rate of employment-based health insurance, just 53% in 1997-1999. Medi-Cal only partially offsets this low rate of job-based coverage, leaving 20% of AI/ANs uninsured. (The small number of American Indians and Alaska Natives in the California sample of the Current Population Survey necessitated our using three-year averages for their estimates.)

The United States government has a trust responsibility to provide health care to American Indians and Alaska Natives who are members of federally recognized tribes.[13] To obtain Indian Health Service care, the individual would have to travel to his or her home reservation. While 554 tribes are currently recognized by the federal government, other tribes are recognized solely by their home states or are "self-recognized" and not recognized by the federal government, leaving their members ineligible for IHS

13 The relationship between the federal government and American Indian and Alaska Native people is based on treaty obligations, case law, the Snyder Act of 1921 (PL 83-568), the Indian Health Care Improvement Act (PL 94-437), and other public policies. (Pevar SL, *The Rights of Indians and Tribes: The Basic ACLU Guide to Indian and Tribal Rights*, 2nd ed. Carbondale, IL. Southern Illinois University Press, 1992).

## EXHIBIT 7. HEALTH INSURANCE COVERAGE OF NONELDERLY PERSONS BY ETHNIC GROUP, AGES 0-64, CALIFORNIA, 1994 AND 1999

| | 1994 | 1999 |
|---|---|---|
| **UNINSURED** | | |
| NON-LATINO WHITE | 16% | 13% |
| LATINO | 36% | 36% |
| ASIAN AMERICAN/PACIFIC ISLANDER | 22% | 23% |
| AFRICAN AMERICAN | 20% | 22% |
| AMERICAN INDIAN/ALASKA NATIVE* | — | 20% |
| **JOB-BASED INSURANCE** | | |
| NON-LATINO WHITE | 69% | 72% |
| LATINO | 39% | 43% |
| ASIAN AMERICAN/PACIFIC ISLANDER | 52% | 63% |
| AFRICAN AMERICAN | 52% | 59% |
| AMERICAN INDIAN/ALASKA NATIVE* | — | 53% |
| **PRIVATELY PURCHASED** | | |
| NON-LATINO WHITE | 6% | 7% |
| LATINO | 1% | 2% |
| ASIAN AMERICAN/PACIFIC ISLANDER | 5% | 5% |
| AFRICAN AMERICAN | 2% | 2% |
| AMERICAN INDIAN/ALASKA NATIVE* | — | 2% |
| **MEDI-CAL/HEALTHY FAMILIES**** | | |
| NON-LATINO WHITE | 7% | 6% |
| LATINO | 22% | 17% |
| ASIAN AMERICAN/PACIFIC ISLANDER | 18% | 7% |
| AFRICAN AMERICAN | 24% | 15% |
| AMERICAN INDIAN/ALASKA NATIVE* | — | 20% |

* Estimates for American Indians/Alaska Natives are three-year averages reflecting coverage in 1997-1999 because they are averages of the March 1998, 1999, and 2000 Current Population Surveys. These are more stable than one-year estimates.

** Includes persons reporting enrollment in Medi-Cal (1994 and 1999) or the Healthy Families Program (1999). Such estimates derived from surveys are generally lower than those derived from administrative data.

Source: March 1995 and 2000 Current Population Surveys



**Despite increases in job-based insurance coverage, there was no improvement in the uninsured rates for people of color**

services.[14] In California, there are an estimated 292,000 AI/ANs and 105 federally recognized tribes, whose members are eligible for health care services — but only from their own tribe's facilities. Another 40 tribes in California are state-recognized, but not federally recognized, and their members are thus ineligible for services, with some exceptions.[15]

IHS services are usually located on or near reservations and thus are not very accessible to urban Indians who constitute a majority of the AI/AN population. The limited resources of programs serving urban Indians are reflected in the absence of even a single AI/AN health clinic in Los Angeles County, the urban area with the greatest number of AI/ANs.[16] The very restricted access to health care of many Indians who are officially eligible for services is sufficient reason not to count IHS eligibility as a type of health insurance coverage.[17]

## ASIAN AMERICAN AND PACIFIC ISLANDER SUBGROUPS

Aggregate health insurance statistics for the Asian American and Pacific Islander (AAPI) groups mask the heterogeneity across AAPI subgroups. Exhibit 8, which presents information on coverage for 10 AAPIs subgroups, [18] demonstrates this heterogeneity. Third-plus generation AAPIs, who are more acculturated and more integrated into the U.S. labor and health insurance markets, have higher rates of job-based coverage and lower rates of uninsurance. Filipinos, Japanese and South Asians also exhibit this health insurance advantage, related to higher levels of educational attainment.

Southeast Asians also have a lower uninsured rate (19%) than the aggregate AAPI category, but they have abysmally low job-based coverage (34%) that is augmented by very high Medi-Cal participation. Vietnamese, like most other Southeast Asians (Cambodians, Lao, Hmongs, and Mien), have refugee status that gives them greater access to Medi-Cal, although growing labor force participation, in part, has reduced their Medi-Cal participation rate to 17%, a much lower rate than the Southeast Asian group. Yet the rise in Vietnamese employment-based health insurance has not offset the drop in Medi-Cal coverage and therefore puts this group at higher risk of being uninsured than the AAPI group as a whole.

The uninsured rates for those originating from China, Hong Kong, Taiwan and Singapore are also higher than the average AAPI group. The most at-risk group for being uninsured is the Korean subgroup (45%), whose rate is even higher than that of Latinos. High rates of self-employment and employment in small firms continue to limit Koreans' access to job-based insurance.

14 Department of the Interior, Bureau of Indian Affairs.

15 Information generously provided by Delight Satter, Program Manager, American Indian and Alaska Native Program, UCLA Center for Health Policy Research, December 21, 2000. The small sample size for American Indians/Alaska Natives in the California sample of the CPS makes it statistically infeasible to generate an estimate of eligibility for IHS services — a problem that should be ameliorated when data from the California Health Interview Survey are available late in 2001.

16 Information generously provided by Delight Satter, Program Manager, American Indian and Alaska Native Program, UCLA Center for Health Policy Research, December 21, 2000.

17 Beginning in 1998, the U.S. Census Bureau ceased counting IHS eligibility as health insurance coverage.

18 The CPS collects, but does not report, national subgroups for AAPIs. We developed a proxy ethnic classification of AAPIs into ethnic subgroups based on the birthplace of the AAPI respondent or his/her parents. If both parents were U.S.-born, we labeled these individuals as "third-generation AAPI." All others were assigned to Filipino, Chinese (China, Hong Kong, Taiwan, Singapore), Japanese, Korean, Vietnamese, South East Asian (Cambodia, Laos), South Asian (India, Pakistan, Bangladesh), Pacific Islanders, and Other AAPI.

There are large differences in health insurance coverage across Asian American and Pacific Islander subgroups

There were too few observations of Pacific Islanders in the CPS sample to provide an estimate for uninsurance. We do, however, estimate that only 55% of Pacific Islanders (which includes Native Hawaiians) are covered through their own or a family member's employment-based insurance. This rate is lower than the AAPI group as a whole, whites and African Americans.

The "Other AAPI" category encompasses a group with a high uninsured rate (36%) and low job-based coverage (45%). This group includes individuals from all other countries, notably those from Thailand, one of the fastest growing AAPI communities in California.

Finally, we urge caution in interpreting these subgroup estimates because they approximate AAPI ethnic subgroups. Our place-of-birth proxy method for ethnicity has limitations that cannot disentangle the diaspora of ethnic groups across Asia (which is considerable among the Chinese and Indians), and cannot differentiate the ethnicity of third-generation AAPIs. Although this approach has limitations, until CPS releases codes for these ethnic subgroups, it is the only alternative to detect disparities that may be missed within this aggregate AAPI group.

**EXHIBIT 8. HEALTH INSURANCE COVERAGE OF NONELDERLY PERSONS BY ASIAN AMERICAN AND PACIFIC ISLANDER ETHNIC SUBGROUP, AGES 0-64, CALIFORNIA, 1997-1999 (3-YEAR AVERAGE)***

| | UNINSURED | JOB-BASED INSURANCE | PRIVATELY PURCHASED | MEDI-CAL |
|---|---|---|---|---|
| AAPI OVERALL[1] | 23% | 63% | 5% | 7% |
| THIRD-PLUS GENERATION AAPIs | 15% | 68% | 5% | 9% |
| FILIPINO[2] | 16% | 72% | 4% | 3% |
| CHINESE[2] | 28% | 60% | 9% | ** |
| JAPANESE[2] | 18% | 71% | ** | ** |
| KOREAN[2] | 45% | 40% | 13% | ** |
| VIETNAMESE[2] | 29% | 48% | 4% | 17% |
| SOUTHEAST ASIAN[2] | 19% | 34% | ** | 45% |
| SOUTH ASIAN[2] | 15% | 73% | 8% | ** |
| PACIFIC ISLANDERS[2] | ** | 55% | ** | ** |
| OTHER AAPI[2] | 36% | 45% | 3% | 15% |

1 March 2000 Current Population Survey estimates for 1999.

2 First- and second-generation immigrants

* Estimates for Asian American and Pacific Islander subgroups are three-year averages reflecting coverage in 1997-1999 because they are based on averages of the March 1998, 1999, and 2000 Current Population Surveys. These are more stable than one-year estimates.

** Estimates are not statistically reliable.

Source: March 1998, 1999 and 2000 Current Population Surveys

## DIFFERENCES ACROSS COUNTIES

Counties are responsible, under the state's Welfare and Institutions Code section 17000, for meeting the health care needs of their low-income uninsured residents. They, therefore, have a strong interest in knowing their residents' health insurance status and how their coverage compares to that of other counties. County-level data on health insurance coverage are, however, very limited. In Exhibit 9, we present estimates of uninsurance and job-based coverage by region and for each county or group of counties. The prospects for receiving employment-based health insurance coverage and the risk of being uninsured are not evenly spread across the state. Counties with high uninsured rates have low rates of employment-based health insurance, reflecting regional differences in industry, occupations, and workforce characteristics. To capture one dimension of workforce characteristics, we supplement our health insurance data in Exhibit 9 with a three-year average of unemployment rates at the county level.

Like health insurance coverage, employment opportunities, a prime indicator of economic prosperity, vary widely throughout California. In general, Southern California counties have the highest unemployment and uninsured rates, with the exception of Ventura County, which has a relatively lower uninsurance rate (Exhibit 9). In contrast, the Bay Area and Sacramento tend to have low unemployment rates and low uninsurance rates — except for San Francisco, which has a high uninsured rate and a low unemployment rate. High unemployment rates and medium to high uninsured rates characterize the Central Valley counties. Northern counties do not fall into such clear patterns.

Due to limitations of the data, we can present only 6 county groups (including Los Angeles and "all others") and 22 counties, out of California's 58 counties. Moreover, while the regional rates are one-year estimates, for the county-level rates we average three years of data to increase the precision of the estimates. It is important to note that the range estimates give a more reliable picture of coverage in each locale. For example, while San Francisco has the highest estimated uninsurance rate (34%), this ranges from 29% to 38%, a much wider range than the Los Angeles uninsurance rate (32%, ranging from 31%-33%). Hence, particularly for the smaller counties, interpretation of our estimates should consider both rates and ranges. More precise county-level health insurance coverage rates will be available when data from the California Health Interview Survey (CHIS) are released toward the end of 2001.

This section provided an overview of the health insurance of California's non-elderly population, how it compares with the U.S. and how it has changed recently and since 1994. Our discussion centered on the uninsured, as we identified vulnerable groups and regions with high uninsured rates and low-job-based health insurance. The following sections delve deeper into the issues as we focus on the state of health insurance for specific groups: coverage of children and their eligibility for Medi-Cal and Healthy Families in Part 2; coverage of nonelderly adults and their eligibility for Medi-Cal in Part 3; and employment-based health insurance for workers and their families in Part 4. Finally, in Part 5, we offer policy recommendations for the state to expand and improve coverage options for California's 6.8 million uninsured residents.

**The prospects for receiving job-based insurance and the risk of being uninsured are not evenly spread across counties**

**EXHIBIT 9. UNINSURED AND JOB-BASED INSURANCE RATES OF NONELDERY PERSONS BY COUNTY OF RESIDENCE, AGES 0-64, CALIFORNIA, 1997-1999 (3-YEAR AVERAGE)**

| | UNINSURED[1] | | JOB-BASED INSURANCE[1] | | UNEMPLOYMENT | POPULATION AGES 0-64 |
|---|---|---|---|---|---|---|
| **COUNTY/COUNTY GROUP[5]** | **RATE** | **RANGE[2]** | **RATE** | **RANGE[2]** | **RATE[3]** | **1999[4]** |
| **NORTHERN CALIFORNIA[6, 7]** | 16% | | 62% | | — | — |
| BUTTE | 27% | 21%-32% | 44% | 38%-50% | 7.9% | 163,291 |
| PLACER | 13% | 6%-20% | 70% | 60%-79% | 3.9% | 195,629 |
| SACRAMENTO | 16% | 13%-19% | 61% | 56%-65% | 4.9% | 1,046,539 |
| YUBA, SUTTER | 29% | 23%-34% | 47% | 41%-53% | 13.9% | 120,930 |
| **GREATER BAY AREA[7]** | 17% | | 72% | | — | — |
| ALAMEDA | 17% | 14%-20% | 72% | 69%-76% | 4.0% | 1,278,919 |
| CONTRA COSTA | 11% | 8%-13% | 82% | 78%-85% | 3.6% | 810,069 |
| MARIN | 13% | 7%-19% | 68% | 60%-76% | 2.4% | 211,358 |
| MONTEREY | 29% | 22%-36% | 45% | 37%-52% | 10.3% | 345,290 |
| NAPA, SOLANO | 10% | 7%-14% | 71% | 65%-76% | 5.2% | 455,159 |
| SAN FRANCISCO | 34% | 29%-38% | 53% | 48%-59% | 3.6% | 671,705 |
| SAN MATEO | 15% | 11%-19% | 75% | 70%-79% | 2.4% | 628,629 |
| SANTA CLARA | 16% | 14%-18% | 72% | 69%-75% | 3.1% | 1,540,921 |
| SONOMA | 17% | 11%-22% | 75% | 69%-81% | 3.2% | 382,796 |
| **CENTRAL VALLEY[7]** | 19% | | 56% | | — | — |
| FRESNO, MADERA | 18% | 15%-22% | 54% | 50%-59% | 13.5% | 805,703 |
| MERCED | 22% | 16%-27% | 50% | 43%-56% | 14.6% | 185,309 |
| STANISLAUS | 17% | 13%-22% | 58% | 52%-64% | 11.9% | 385,273 |
| SAN JOAQUIN | 22% | 17%-26% | 60% | 53%-67% | 10.0% | 489,138 |
| TULARE | 26% | 20%-31% | 43% | 37%-49% | 15.8% | 323,671 |
| **SOUTHERN CALIFORNIA[7, 8]** | 21% | | 63% | | — | — |
| RIVERSIDE, SAN BERNARDINO | 23% | 21%-25% | 58% | 56%-61% | 6.0% | 2,763,336 |
| KERN | 23% | 18%-27% | 60% | 55%-65% | 11.9% | 573,562 |
| ORANGE | 23% | 21%-25% | 64% | 62%-67% | 2.9% | 2,500,853 |
| SAN DIEGO | 22% | 20%-24% | 56% | 52%-61% | 3.6% | 2,518,119 |
| SAN LUIS OBISPO | 21% | 15%-27% | 60% | 57%-62% | 4.0% | 202,181 |
| SANTA BARBARA | 26% | 21%-32% | 64% | 58%-70% | 4.4% | 355,022 |
| VENTURA | 16% | 12%-20% | 73% | 68%-77% | 5.6% | 663,161 |
| **LOS ANGELES** | 32% | 31%-33% | 50% | 49%-52% | 6.4% | 8,716,230 |
| **ALL OTHER COUNTIES[7]** | 11% | | 52% | | — | — |

Source: March 1998, 1999 and 2000 Current Population Surveys

1 These estimates of health insurance coverage are three-year averages, which are more stable than one-year estimates.

2 Reported rates are estimates. The true rate is likely to fall in this range (95% confidence interval). Estimates for regions are more precise.

3 The unemployment rates are three-year averages computed from data published by the California Employment Development Department, Labor Market Information Division, Information Services Group. These rates are not seasonally adjusted.

4 The population numbers are California State Department of Finance estimates for each county for January 1, 1998.

5 Counties not shown fall into two categories: (1) the county was not sampled in the March Current Population Survey (CPS) — for example Santa Cruz county; (2) estimates for both the uninsured and job-based insurance rates were not statistically stable. Additionally, county groups displayed in the exhibit reflect CPS sampling of the area — for example Riverside, San Bernardino.

6 The Northern California rate includes El Dorado and Yolo counties, but these counties are not shown because of unstable rates.

7 Regional rates are one-year estimates for 1999, data source March CPS 2000.

8 The Southern California rate excludes Los Angeles county.

# 2. CALIFORNIA'S CHILDREN: HIGH UNINSURED RATES, RECENT IMPROVEMENTS AND OPPORTUNITIES FOR EXPANDED COVERAGE

2

A total of 1.85 million of California's children have no private or public health care coverage of any kind — more than one in six of the nation's 10.7 million uninsured children. This large number of uninsured children in California is an improvement over 1998, when more than 2 million were uninsured.

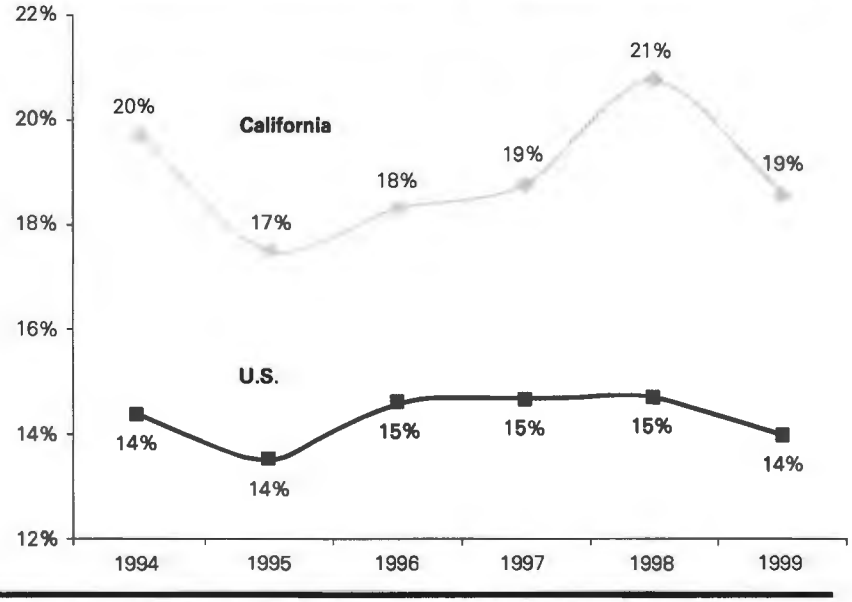
## CALIFORNIA'S CHILDREN ARE AT HIGHER RISK OF BEING UNINSURED

One in five California children is uninsured, a larger proportion than in the United States as a whole. In 1999, 19% of the state's children up to age 18 were uninsured, compared to 14% nationally (Exhibit 10). If California's children were uninsured at the same rate as the national average, only 1.39 million children would be uninsured — 457,000 fewer.

This disadvantage for California's children has persisted throughout the 1990s. The uninsured rate in 1999 was lower than in 1998 when 21% of California's children were uninsured — a peak uninsured rate that reflected the enactment and implementation of welfare reform. However, the lower rate in 1999 was still higher than in 1995 when the state was climbing out of the recession, which had produced an especially high uninsured rate for children in 1994.

California children's higher rate of uninsurance is due to their lower rate of health insurance coverage obtained through a parent's employment: 56% in California

**EXHIBIT 10. PERCENT OF CHILDREN WHO ARE UNINSURED, AGES 0-18, CALIFORNIA AND U.S., 1994 TO 1999**




Source: March 1995, 1996, 1997, 1998, 1999 and 2000 Current Population Surveys

One in five California children is uninsured, a larger proportion than in the United States as a whole

**EXHIBIT 11. HEALTH INSURANCE COVERAGE OF CHILDREN, CALIFORNIA AND U.S., AGES 0-18, 1999**

| | CALIFORNIA | U.S. |
|---|---|---|
| UNINSURED | 19% | 14% |
| JOB-BASED INSURANCE | 56% | 65% |
| PRIVATELY PURCHASED | 4% | 4% |
| MEDI-CAL/HEALTHY FAMILIES AND MEDICAID/CHIP* | 19% | 15% |
| OTHER PUBLIC | 2% | 2% |
| TOTAL | 100% (POPULATION: 9,961,000) | 100% (POPULATION: 76,330,000) |

* Includes persons reporting enrollment in Medi-Cal or the Healthy Families Program in California and in Medicaid or the State Children's Health Insurance Program nationally. Such estimates derived from surveys are generally lower than those derived from administrative data.

Note: Numbers may not add to 100% due to rounding. Population estimate is based on March 2000 Current Population Survey, which may differ from population estimates derived from other sources.

Source: March 2000 Current Population Survey

compared to 65% in the nation as a whole (Exhibit 11). The state's Medi-Cal and Healthy Families programs have more generous income eligibility than those in many states (although not as generous as some), but they only partially offset California's lower rate of employment-based insurance for children.

Children's health insurance obtained through a parent's employment has hovered around 54% to 56% from 1996 through 1999, an improvement over the low recession-related rate in 1994 (Exhibit 12). However, between 1994 and 1999 Medi-Cal coverage plummeted from 25% to 19%, a direct result of the enactment and implementation of welfare reform.

**EXHIBIT 12. HEALTH INSURANCE COVERAGE OF CHILDREN, AGES 0-18, CALIFORNIA, 1994-1999**

| | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | CHANGE 1994-1999 |
|---|---|---|---|---|---|---|---|
| UNINSURED | 20% | 17% | 18% | 19% | 21% | 19% | –1 |
| JOB-BASED INSURANCE | 50% | 53% | 54% | 56% | 54% | 56% | +6* |
| PRIVATELY PURCHASED | 3% | 3% | 4% | 3% | 4% | 4% | +1* |
| MEDI-CAL/ HEALTHY FAMILIES** | 25% | 25% | 22% | 21% | 20% | 19% | –6* |
| OTHER PUBLIC | 2% | 1% | 1% | 2% | 2% | 2% | — |
| TOTAL | 100% | 100% | 100% | 100% | 100% | 100% | |

* Change is statistically significant at $p \leq .05$.

** Includes persons reporting enrollment in Medi-Cal (1994-1999) or the Healthy Families Program (1998 and 1999). Such estimates derived from surveys are generally lower than those derived from administrative data.

Note: Numbers may not add to 100% due to rounding.

Source: March 1995, 1996, 1997, 1998, 1999 and 2000 Current Population Surveys



**Children's health insurance has improved slightly in California**

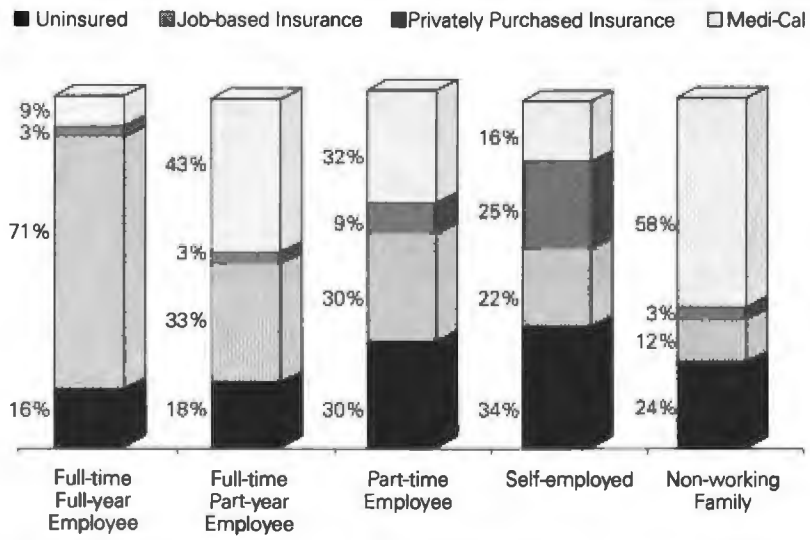
If the proportion of children in California's Medi-Cal and Healthy Families programs had not declined since 1994 and the proportions with job-based and privately purchased insurance had risen as they have, about 600,000 fewer children would have been uninsured in 1999. Thus, substantial further gains in children's coverage could be made by maintaining and expanding enrollments in these programs.

## CHILDREN'S COVERAGE AND THEIR FAMILY'S WORK STATUS

Job-based coverage is highest (71%) for children in families with at least one parent who is a full-time, full-year employee (Exhibit 13) — the family work status that includes two-thirds of the state's children. But this job-based coverage declines dramatically when looking at other family employment status categories: 33% for children with at least one parent who is a full-time employee for at least part of the year; 30% for those with part-time employment; and 22% for those in families supported by self-employment (for whom privately purchased insurance covers one in four).

The expanding economy enabled more families to obtain more and better employment, increasing the proportion of California's children whose parents were full-time, full-year employees from 59% in 1994 to 65% in 1998 and finally to 68% in 1999. During this same period, the proportion of children in nonworking families fell from 18% in 1994 to 11% in 1998 and to just 9% in 1999. This

**EXHIBIT 13. HEALTH INSURANCE COVERAGE OF CHILDREN BY FAMILY WORK STATUS, AGES 0-18, CALIFORNIA, 1999**




Note: Includes persons reporting enrollment in Medi-Cal or the Healthy Families Program. Such estimates derived from surveys are generally lower than those derived from administrative data.

Source: March 2000 Current Population Survey

Nine in 10 uninsured children are in working families

improvement in the economy increased these families' incomes and their access to job-based insurance coverage for their children.

Medi-Cal and the Healthy Families Program form a safety net for many children in both nonworking and working families. Among those in families in which no adult worked during the year, 58% received Medi-Cal or Healthy Families coverage in 1999. This proportion is statistically the same as in 1998, when 54% of children in nonworking families had Medi-Cal or Healthy Families coverage, but it is far below the proportion in 1995 (76%), the year before welfare reform was enacted and three years before Healthy Families even began to accept enrollees.[19] One in four (24%) children in nonworking families was uninsured in 1999, an improvement over the previous year (33%), but a rate that is somewhat higher (although not significantly) than in 1994 before the enactment of welfare reform (19%).

Part of this improvement may be due to Los Angeles, San Francisco, Alameda and some other counties leaving many children on Medi-Cal longer than expected after their families left welfare. Children who initially had been enrolled through public assistance programs (that is, the former Aid to Families with Dependent Children or its CalWORKs replacement) were supposed to have their cases reviewed to determine whether they continued to be eligible for Medi-Cal after their post-welfare transition period ended. The delayed implementation of this policy benefited thousands of individuals who might have lost their Medi-Cal coverage had the "re-determination" been done immediately.

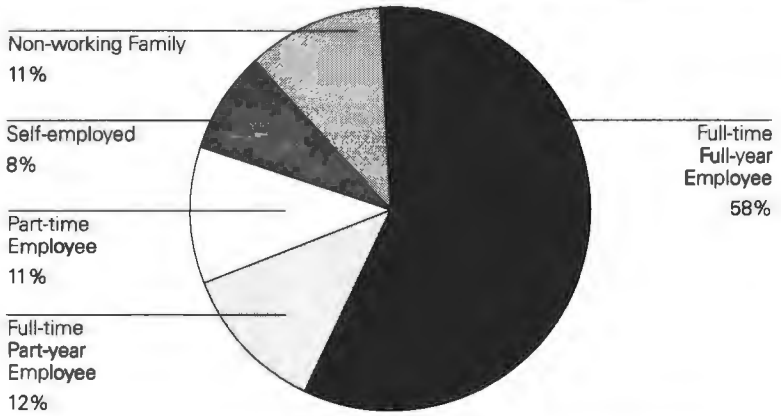
Children in working families also benefit from these programs, which covered 43% of those in full-time, part-year employee families in 1999 and 32% of those in families headed by a part-time employee.

As a result of their high rate of job-based coverage, children in full-time, full-year employee families have the lowest uninsured rate — 16% in 1999 — a rate that has changed little since 1994 (17%). Children in full-time, part-year employee families have a comparable uninsured rate (18%) due more to Medi-Cal coverage than to employment benefits. About one in three children whose parents are part-time employees (30%) or self-employed (34%) is uninsured.

Nine in 10 (89%) uninsured children are in working families (Exhibit 14) — a total of 1.6 million children. More than 1 million uninsured children are in families with at least one parent who is employed full-time for the full year — nearly six in 10 (58%) of all uninsured children in the state.

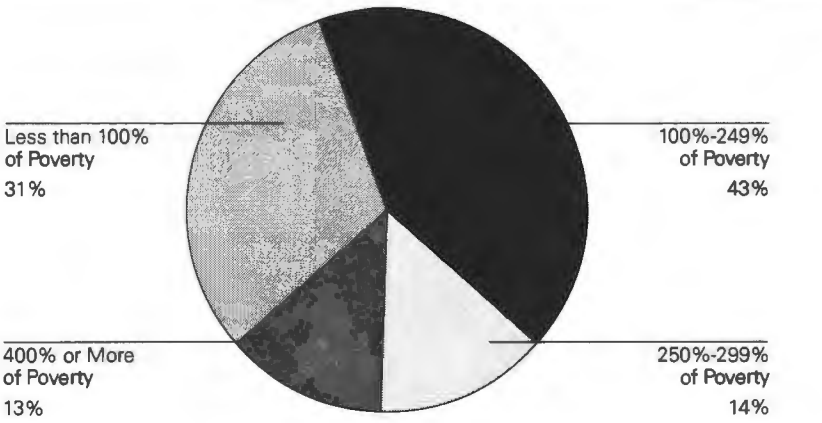
19 Medi-Cal/Medicaid and Healthy Families/CHIP estimates derived from surveys are generally lower than those derived from administrative data.

**EXHIBIT 14. UNINSURED CHILDREN BY FAMILY WORK STATUS, AGES 0-18, CALIFORNIA, 1999**




Source: March 2000 Current Population Survey

**EXHIBIT 15. UNINSURED CHILDREN BY FAMILY INCOME RELATIVE TO POVERTY THRESHOLD, AGES 0-18, CALIFORNIA, 1999**




Note: Numbers may not add up to 100% due to rounding.
Source: March 2000 Current Population Survey

## HEALTH INSURANCE COVERAGE OF CHILDREN BY FAMILY INCOME

Three in 10 (31%) uninsured children live below poverty (below 100% of the federal poverty threshold) and another four in 10 (43%) have family incomes that are near the poverty level (100%-249% of poverty; Exhibit 15).[20] The low incomes of these uninsured children's families make the private purchase of health insurance unaffordable. These family incomes are also so low that required premium contributions for employer-provided family coverage are often unaffordable as well. Thus, any efforts to provide them with health insurance coverage will require substantial subsidies.

Fortunately, most of these children have options for receiving coverage through either Medi-Cal or the Healthy Families Program, as we will see. However, one in four (27%) uninsured children has a family income at least 250% of the poverty level, putting most of them out of range for public coverage programs. Unless income eligibility for public programs is raised to more generous levels, these children will have to depend on voluntary employer contributions for family coverage (reversing a long-established downward trend) or private charitable efforts.

20 In 1999, the poverty threshold was $8,667 for one person under age 65, $11,214 for a family of two under age 65, $13,290 for a family of three, and $17,029 for a family of four, etc.



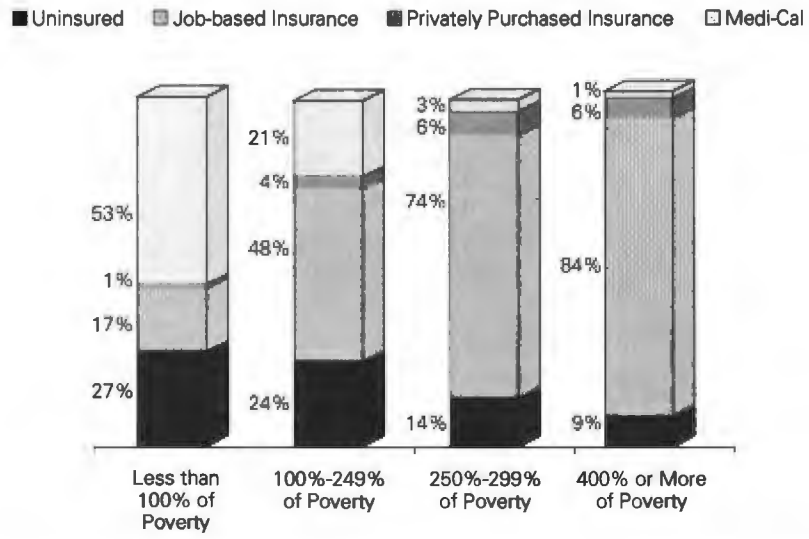
Seven in every 10 uninsured are in low- to moderate-income families

About one in four (27%) children living in families with incomes below the federal poverty level is uninsured (Exhibit 16) — the result of very low rates of job-based insurance (17%) that are only partially offset by high rates of coverage from Medi-Cal or the Healthy Families Program (53%). This group has lost ground since 1995, the year before welfare reform was enacted, when 62% were covered by Medi-Cal.

One in four (24%) near-poor children (those with family incomes 100%-249% of the poverty level) is also uninsured. Compared to those with family incomes below poverty, these children are more likely to receive employment-based health insurance (48%), but they are much less likely to receive Medi-Cal or Healthy Families coverage (21%).

Children in somewhat more affluent families (those with incomes between 250% and 399% of poverty) are far more likely to have job-based coverage (74%), resulting in a lower uninsured rate (14%). Children above that level are least likely to be uninsured (9%) because of their higher rates of job-based coverage (84%).

**EXHIBIT 16. HEALTH INSURANCE COVERAGE OF CHILDREN BY FAMILY INCOME RELATIVE TO POVERTY THRESHOLD, AGES 0-18, CALIFORNIA, 1999**




Note: Includes persons reporting enrollment in Medi-Cal or the Healthy Families Program. Such estimates derived from surveys are generally lower than those derived from administrative data.

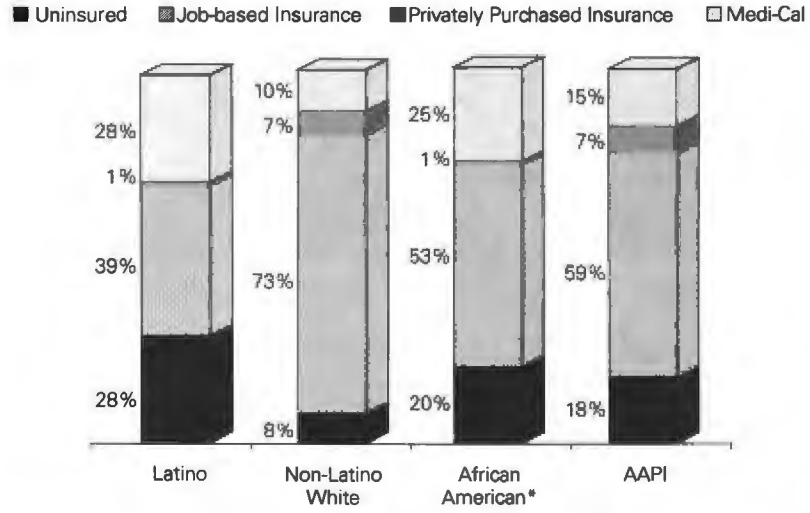
Source: March 2000 Current Population Survey

## HEALTH INSURANCE COVERAGE OF CHILDREN BY RACE AND ETHNICITY

Latino children have the highest uninsured rates (28%) and lowest rates of job-based coverage (39%) of all major ethnic groups (Exhibit 17). African-American and Asian-American/Pacific Islander children also have uninsured rates that are more than twice the rate for whites. For all these groups, having health insurance obtained through parents' employment is the primary determinant of whether the child is uninsured, but Medi-Cal and the Healthy Families Program partially offset low rates of job-based insurance.

Overall, the uninsurance rate for children in California was 1 percentage point less in 1999 than in 1994 (not a statistically significant change), but that improvement reflected the substantial gains experienced by white children, who account for 40% of the state's children. Their uninsured rate fell from 14% to 8% during this period (Exhibit 18), as their coverage through parent's employment rose with the economic recovery and expansion (from 66% to 73%), despite an apparent (but not statistically significant) decline in Medi-Cal coverage (from 13% to 10%).

**EXHIBIT 17. HEALTH INSURANCE COVERAGE OF CHILDREN BY ETHNIC GROUP, AGES 0-18, CALIFORNIA, 1999**




* Estimates for African-American children are two-year averages of March 1999 and 2000 Current Population Surveys, which are more stable than one-year estimates. Sample sizes for American Indian/Alaska Native children are too small to provide a statistically acceptable estimate.

Note: Includes persons reporting enrollment in Medi-Cal or the Healthy Families Program. Such estimates derived from surveys are generally lower than those derived from administrative data.

Source: March 2000 Current Population Survey



**Racial and ethnic disparities remain, despite improvements for some groups**

Latino children ended the 1990s with the same uninsured rate as in 1994 (28%) — despite a seeming (but not statistically significant) increase in job-based insurance coverage.

Even among children in families headed by at least one employee who works full time year round, Latino children are less likely to receive job-based insurance and more likely to be uninsured than white children. In 1999, only 51% of Latino children in full-time, full-year employee families were covered by job-based insurance (compared to 85% of white children) and 28% of Latinos were uninsured (compared to 6% of whites).

Uninsured rates worsened for Asian-American and Pacific Islander children (14% in 1994 and 18% in 1999) and for African-American children (13% in 1994 and 20% in 1999). Gains in overall coverage were made among non-Latino white children, whose uninsured rate dropped from 14% in 1994 to 8% in 1999.

**EXHIBIT 18. HEALTH INSURANCE COVERAGE OF CHILDREN BY ETHNIC GROUP, AGES 0-18, CALIFORNIA, 1994 AND 1999**

| | NON-LATINO WHITE | | LATINO | | ASIAN AMERICAN/ PACIFIC ISLANDER | | AFRICAN AMERICAN* | |
|---|---|---|---|---|---|---|---|---|
| | 1994 | 1999 | 1994 | 1999 | 1994 | 1999 | 1994 | 1999 |
| UNINSURED | 14% | 8% | 28% | 28% | 14% | 18% | 13% | 20% |
| JOB-BASED INSURANCE | 66% | 73% | 36% | 39% | 51% | 59% | 43% | 53% |
| PRIVATELY PURCHASED | 6% | 7% | 1% | 1% | 3% | 7% | 1% | 1% |
| MEDI-CAL/ HEALTHY FAMILIES** | 13% | 10% | 35% | 28% | 27% | 15% | 38% | 25% |
| OTHER PUBLIC | 2% | 2% | <1% | 3% | 4% | 2% | 4% | 1% |
| TOTAL | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| POPULATION IN 2000 | 4,021,000 | | 4,011,000 | | 1,203,000 | | 580,000 | |

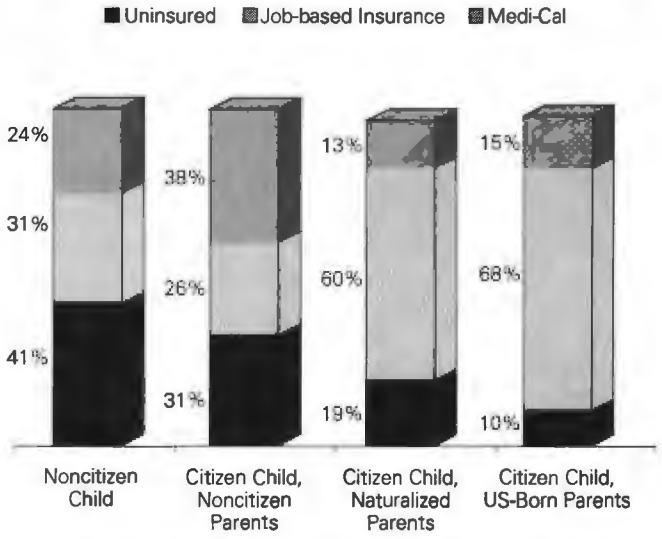
* Estimates for African-American children are two-year averages of March 1995-1996 and March 1999-2000 Current Population Surveys, which are more stable than one-year estimates. Sample sizes for American Indian/Alaska Native children are too small to provide a statistically acceptable estimate.

** Includes persons reporting enrollment in Medi-Cal (1994 and 1999) or the Healthy Families Program (1999) in California. Such estimates derived from surveys are generally lower than those derived from administrative data.

Note: Numbers may not add to 100% due to rounding. Population estimate is based on March 2000 Current Population Survey, which may differ from population estimates derived from other sources.

Source: March 1995 and 2000 Current Population Surveys

**EXHIBIT 19. HEALTH INSURANCE COVERAGE OF CHILDREN BY FAMILY IMMIGRANT AND CITIZENSHIP STATUS, AGES 0-18, CALIFORNIA, 1999**




Note: Includes persons reporting enrollment in Medi-Cal or the Healthy Families Program. Such estimates derived from surveys are generally lower than those derived from administrative data.

Source: March 2000 Current Population Survey

## WELFARE REFORM AND IMMIGRANT FAMILIES

Health insurance coverage of children varies greatly by their parents' and their own immigrant and citizenship status. Four in 10 (41%) noncitizen children and three in 10 (31%) U.S.-citizen children with noncitizen parents were uninsured in 1999 — three to four times the uninsured rate for citizen children with U.S.-born parents (10%; Exhibit 19). Thus, being a noncitizen increases a child's risk of being uninsured, but even citizen children in "mixed status" families (that is, with one or more parents who are noncitizens) bear several times the risk of being uninsured compared to those with U.S.-born parents. Citizen children with naturalized parents fare better (19% uninsured), but their uninsured rate is nearly twice that of citizen children with U.S.-born parents.

Most of the disparities in uninsured rates are driven by differences in children's access to employment-based health insurance. Job-based insurance coverage ranges from 26% and 31% for U.S.-citizen children with noncitizen parents and noncitizen children, respectively, (rates that are not significantly different from each other) to 60% for citizen children with naturalized parents and 68% for those with U.S.-born parents (Exhibit 19).



**Four in 10 noncitizen children and three in 10 U.S.-citizen children with noncitizen parents were uninsured in 1999 — three to four times the rate for those with U.S.-born parents**

**EXHIBIT 20. MEDI-CAL/HEALTHY FAMILIES COVERAGE** OF CHILDREN BY FAMILY IMMIGRANT AND CITIZENSHIP STATUS, AGES 0-18, CALIFORNIA, 1994, 1998 AND 1999**

| | 1994 | 1998 | 1999 | CHANGE 1994-1999 | CHANGE 1998-1999 | POPULATION IN 2000 |
|---|---|---|---|---|---|---|
| NONCITIZEN CHILD | 40% | 18% | 24% | –16* | +6* | 789,000 |
| CITIZEN CHILD, NONCITIZEN PARENTS | 42% | 35% | 38% | –4 | +3 | 1,584,000 |
| CITIZEN CHILD, NATURALIZED PARENTS | 10% | 15% | 13% | +3 | –2 | 2,374,000 |
| CITIZEN CHILD, US-BORN PARENTS | 19% | 16% | 15% | –4* | –1 | 5,041,000 |

* Estimates for African-American children are two-year averages of March 1995-1996 and March 1999-2000 Current Population Surveys, which are more stable than one-year estimates. Sample sizes for American Indian/Alaska Native children are too small to provide a statistically acceptable estimate.

** Includes persons reporting enrollment in Medi-Cal (1994-1999) or the Healthy Families Program (1998 and 1999) in California. Such estimates derived from surveys are generally lower than those derived from administrative data.

Note: Population estimate is based on March 2000 Current Population Survey, which may differ from population estimates derived from other sources.

Source: March 1995, 1999 and 2000 Current Population Survey

This disparity by immigrant and citizenship status is very important in California, where 24% of all children are noncitizens or in mixed-status families, and another 24% are in families with naturalized parents. Immigration and citizenship issues affect Latino and Asian American/Pacific Islander children more than other groups. Among Latino children, about half (49%) are noncitizens or are citizens but have at least one noncitizen parent, and another one-fourth (28%) have naturalized parents. Among Asian American/Pacific Islanders, 21% are noncitizens or have at least one noncitizen parent, and two-thirds (68%) have naturalized parents. But this does not adequately explain Latino children's very high uninsured rate because even among children with U.S.-born parents, Latino children are much less likely than whites to receive job-based insurance (56% vs. 75%) and more likely to be uninsured (16% vs. 7%).

Policy makers have expanded Medi-Cal and enacted the Healthy Families Program to increase coverage for low- and moderate-income children who do not have access to employment-based health insurance. But welfare reform created a countervailing force that decreased public coverage of many children in immigrant families. Welfare reform imposed more stringent eligibility policies that discouraged many noncitizens from applying for Medi-Cal, resulting in a 16 percentage-point drop in Medi-Cal coverage between 1994 and 1999, although their coverage rose significantly between 1998 and 1999 (Exhibit 20). Medi-Cal coverage also declined (albeit not significantly) among U.S.-citizen children with noncitizen parents, from 42% in 1994 to 38% in 1999, and among citizen children with U.S.-born parents, from 19% in 1994 to 15% in 1999 (a statistically significant decline).

During this same period, Medi-Cal coverage for citizen children with naturalized parents rose from 10% in 1994 (when 68% had employment-based coverage) to 15% in 1998 and declined to 13% in 1999 (when 60% had

**EXHIBIT 21. HEALTH INSURANCE COVERAGE OF CHILDREN BY FAMILY COMPOSITION, AGES 0-18, CALIFORNIA, 1994 AND 1999**

| | MARRIED-COUPLE FAMILY | | | SINGLE-PARENT FAMILY | | |
|---|---|---|---|---|---|---|
| | 1994 | 1999 | CHANGE 1994-1999 | 1994 | 1999 | CHANGE 1994-1999 |
| UNINSURED | 18% | 16% | –2* | 22% | 25% | +3 |
| JOB-BASED INSURANCE | 59% | 64% | +5* | 32% | 36% | +4* |
| PRIVATELY PURCHASED | 4% | 5% | +1* | 2% | 2% | – |
| MEDI-CAL/HEALTHY FAMILIES** | 17% | 13% | –4* | 43% | 35% | –8* |
| OTHER PUBLIC | 2% | 2% | – | 1% | 2% | +1 |
| TOTAL | 100% | 100% | | 100% | 100% | |
| POPULATION IN 2000 | 7,218,000 | | | 2,569,000 | | |

* Estimates for African-American children are two-year averages of March 1995-1996 and March 1999-2000 Current Population Surveys, which are more stable than one-year estimates. Sample sizes for American Indian/Alaska Native children are too small to provide a statistically acceptable estimate.

** Includes persons reporting enrollment in Medi-Cal (1994 and 1999) or the Healthy Families Program (1999) in California. Such estimates derived from surveys are generally lower than those derived from administrative data.

Note: Numbers may not add to 100% due to rounding. Population estimate is based on March 2000 Current Population Survey, which may differ from population estimates derived from other sources.

Source: March 1995 and 2000 Current Population Survey

employment-based insurance), resulting in an increase in their uninsured rate from 13% in 1994 to 19% in 1999. Based on changes in the reported status of parents, it is likely that some of this increase in Medi-Cal coverage was due to noncitizen parents becoming U.S. citizens.

## WELFARE REFORM AND FAMILY COMPOSITION

People who had the fewest alternative options for obtaining health insurance suffered the most from the adverse effects of welfare reform. Children living in families headed by a married couple have two chances of obtaining health insurance through a parent's employment, while children in single-parent headed families have only one chance.[21] Although Medi-Cal coverage of children in married-couple families fell 4 percentage points between 1994 and 1999, the economic recovery and boom pushed up their employment-based health insurance from 59% to 64%, with a net reduction in their uninsured rate of 2 percentage points (Exhibit 21).

21 This general pattern may be qualified in some instances. Children in married-couple families have two chances of obtaining job-based insurance if both parents are working, but only one chance if just one parent is employed. Children in single-parent headed families have two chances of obtaining job-based insurance if a step-parent outside the household is able to provide it.



**Children living with two parents experienced an increase in employment-based insurance between 1994 and 1999 and a decrease in their uninsured rate**

Children in single-parent families did not fare so well. Their Medi-Cal coverage plummeted 8 percentage points between 1994 and 1999. Although economic growth increased their job-based coverage by 4 percentage points, the proportion who are uninsured increased (but not significantly) 3 percentage points.

As a result of welfare reform and these changes in Medi-Cal and employment-based health insurance, there is a growing disparity between children in single-parent and married-couple families. One in four (25%) children who live with one parent is uninsured, compared to 16% of those who live with two parents (data not shown).

Latino children are somewhat less likely than non-Latino whites to live with two parents (71% vs. 77%), which might partly explain their higher uninsured rate. However, even among those in two-parent families, Latino children are less likely than white children to receive employment-based health insurance (46% vs. 78%) and more likely to be uninsured (27% vs. 6%).

**Children in single-parent families also gained employment-based insurance but their Medi-Cal coverage fell so fast that their uninsured rate increased**

## EXHIBIT 22. UNINSURED AND JOB-BASED INSURANCE RATES OF CHILDREN BY COUNTY OF RESIDENCE, AGES 0-18, CALIFORNIA, 1997-1999 (3-YEAR AVERAGE)

| | UNINSURED[1] | | JOB-BASED INSURANCE[1] | | UNEMPLOYMENT | POPULATION AGES 0-18 |
|---|---|---|---|---|---|---|
| **COUNTY/COUNTY GROUP[5]** | **RATE** | **RANGE[2]** | **RATE** | **RANGE[2]** | **RATE[3]** | **1998[4]** |
| **NORTHERN CALIFORNIA[6, 7]** | 12% | | 56% | | — | — |
| BUTTE | 22% | 13%-32% | 36% | 25%-46% | 7.9% | 51,755 |
| SACRAMENTO | 13% | 9%-17% | 57% | 51%-64% | 4.9% | 345,922 |
| YUBA, SUTTER | 26% | 19%-34% | 43% | 33%-52% | 13.9% | 46,042 |
| **GREATER BAY AREA[6, 7]** | 12% | | 71% | | — | — |
| ALAMEDA | 9% | 4%-13% | 75% | 69%-82% | 4.0% | 388,592 |
| CONTRA COSTA | 9% | 4%-13% | 83% | 77%-89% | 3.6% | 247,619 |
| MONTEREY | 18% | 8%-27% | 41% | 29%-53% | 10.3% | 120,604 |
| NAPA, SOLANO | * | | 67% | 59%-76% | 5.2% | 147,970 |
| SAN FRANCISCO | 27% | 18%-37% | 50% | 39%-61% | 3.6% | 157,126 |
| SAN MATEO | 14% | 6%-21% | 78% | 68%-87% | 2.4% | 183,152 |
| SANTA CLARA | 13% | 9%-17% | 71% | 66%-76% | 3.1% | 461,762 |
| **CENTRAL VALLEY[7]** | 15% | | 50% | | — | — |
| FRESNO, MADERA | 11% | 6%-16% | 52% | 44%-59% | 13.5% | 303,909 |
| MERCED | 15% | 8%-21% | 50% | 41%-59% | 14.6% | 73,553 |
| SAN JOAQUIN | 13% | 7%-19% | 47% | 38%-56% | 10.0% | 174,985 |
| STANISLAUS | * | | 54% | 43%-64% | 11.9% | 140,037 |
| TULARE | 25% | 17%-32% | 33% | 25%-42% | 15.8% | 126,178 |
| **SOUTHERN CALIFORNIA[7, 8]** | 19% | | 59% | | — | — |
| KERN | 21% | 14%-27% | 54% | 46%-63% | 11.9% | 214,181 |
| ORANGE | 19% | 16%-23% | 63% | 58%-67% | 2.9% | 801,376 |
| RIVERSIDE, SAN BERNARDINO | 20% | 17%-23% | 56% | 52%-60% | 6.0% | 1,012,826 |
| SAN DIEGO | 19% | 15%-22% | 57% | 52%-61% | 3.6% | 804,872 |
| SAN LUIS OBISPO | 19% | 10%-29% | 53% | 40%-66% | 4.0% | 55,894 |
| SANTA BARBARA | 33% | 21%-44% | 48% | 36%-60% | 4.4% | 108,804 |
| VENTURA | * | | 79% | 71%-86% | 5.6% | 216,224 |
| **LOS ANGELES** | 27% | 25%-29% | 46% | 44%-48% | 6.4% | 2,919,064 |
| **ALL OTHER COUNTIES[7]** | * | | 52% | | — | — |

Source: March 1998, 1999 and 2000 Current Population Surveys

1 These estimates of health insurance coverage are three-year averages, which are more stable than one-year estimates.

2 Reported rates are estimates. The true rate is likely to fall in this range (95% confidence interval).

3 The unemployment rates are three-year averages computed from data published by the California Employment Development Department, Labor Market Information Division, Information Services Group. These rates are not seasonally adjusted.

4 The population numbers are California State Department of Finance estimates for each county for January 1, 1998.

5 Counties not shown fall into two categories: (1) the county was not sampled in the March Current Population Survey (CPS) — for example Santa Cruz county; (2) estimates for both the uninsured and job-based insurance rates were not statistically stable. Additionally, county groups displayed in the exhibit reflect CPS sampling of the area — for example Riverside, San Bernardino.

6 The Northern California rate includes El Dorado, Placer and Yolo counties and the Greater Bay Area rate includes Marin and Sonoma. These counties are not shown individually because of unstable rates.

7 Regional rates are one-year estimates for 1999, data source March CPS 2000.

8 The Southern California rate excludes Los Angeles county.

* Does not meet minimum standards for precision.

## CHILDREN'S HEALTH INSURANCE COVERAGE DIFFERS FROM COUNTY TO COUNTY

Health insurance coverage of children varies markedly from county to county. Exhibit 22 provides three-year averages of county-level estimates for children ages 0-18.[22] Despite averaging three years of data, the range for each county-specific health insurance estimate for children is more reliable than the point estimate. More precise county-level health insurance coverage estimates will be available from the California Health Interview Survey (CHIS).

The relationship between job-based coverage and unemployment for children is similar to that of the nonelderly overall. The Bay Area, except San Francisco, has low unemployment and high job-based coverage, while the Central Valley has higher unemployment and lower job-based health insurance. San Francisco, Los Angeles, and other Southern California counties reflect a different pattern: low unemployment yet low coverage rates for their workers. Employment-based coverage for children spans a wide range across counties — from 33% in Tulare County to a high of 83% in Contra Costa County (again, with a wide margin of error for most counties).

Children's uninsured rates vary from Santa Barbara, Los Angeles and San Francisco at the high end to Alameda and Contra Costa at the low end. (We emphasize that these estimates for children may be unreliable due to small sample sizes.)

## UNINSURED CHILDREN: A POSITIVE TURN IN A LONGER DISMAL TREND

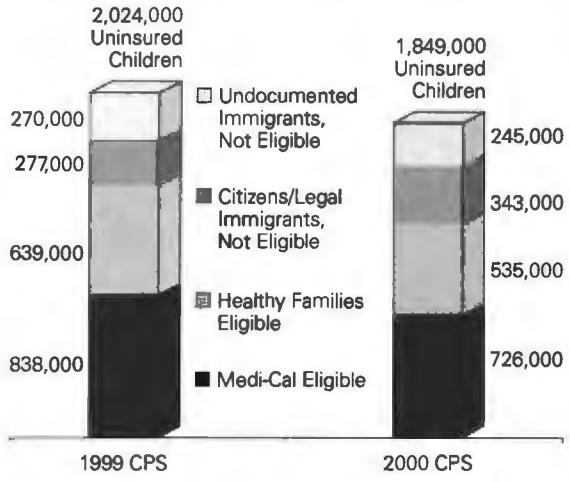
To sum up, the number and proportion of children in California who are uninsured declined in the past year, as has been the case nationally. This positive change is a result of expanding employment-based health insurance due to the booming economy, together with a slower decline in public coverage. Stabilized public coverage appears to be due to extensive efforts to enroll children in Medi-Cal and Healthy Families and perhaps to diminished concern about the "public charge" issue. This is a very welcome change from the trend between 1995 and 1998, when Medi-Cal coverage significantly declined while job-based insurance, privately purchased insurance, and other sources showed little change — despite the strong economic recovery.

This good news should be weighed together with the recognition that California's children are at higher risk of being uninsured than children in the nation as a whole due to their families' poorer access to employment-based health insurance. Furthermore, children of color — African Americans, Asian American/Pacific Islanders, and especially Latinos — have uninsured rates that are much higher than the most advantaged group, non-Latino whites. Their higher rates are due both to lower rates of job-based insurance — a consequence of the labor market in the U.S. voluntary coverage system — and dramatic declines in coverage through Medi-Cal, a consequence of public policy.

22 As with the nonelderly estimates in Exhibit 9, we present three-year estimates of children's health insurance coverage to obtain more precise estimates for counties.

**Health insurance coverage of children varies widely from county to county**

**EXHIBIT 23. UNINSURED CHILDREN BY ELIGIBILITY FOR MEDI-CAL AND HEALTHY FAMILIES, AGES 0-18, CALIFORNIA**




Source: Estimates of eligibility calculated by the UCLA Center for Health Policy Research based on data from the March 1999 and 2000 Current Population Survey

## OPPORTUNITIES TO COVER UNINSURED CHILDREN: THE HEALTHY FAMILIES AND MEDI-CAL PROGRAMS[23]

California has enormous opportunities to expand health insurance coverage for its uninsured children through its public programs. More than two-thirds of the state's 1.85 million uninsured children are eligible for either Medi-Cal or the Healthy Families Program. As the number of uninsured children has declined, the numbers who are eligible for these programs has fallen from 1.5 million based on 1999 CPS data to 1.3 million based on 2000 CPS data — a change that is not statistically significant.

Based on the most recent data available, 29% of uninsured children are eligible for Healthy Families — a total of 535,000 children (range: 455,000 to 614,000; Exhibit 23).[24] This is an apparent (but not statistically significant) decrease from the estimate of 639,000 (range: 543,000 to 736,000) based on the previous year's data. Not enrolling a

23 Hongjian Yu, Ph.D., performed the complex modeling of Medi-Cal and Healthy Families eligibility, with extensive collaboration by Jennifer Kincheloe, M.P.H.

24 Reported numbers are estimates based on small sample sizes, which reduce the estimate's precision and reliability. The range (called, a "95% confidence interval") provides a more reliable estimate of the numbers of persons in the population who fit that category. It means that the "true" estimate has a 95% probability of falling within the range.



**More than two-thirds of California's 1.85 million uninsured children are eligible for either Medi-Cal or the Healthy Families Program**

sufficient number of children in Healthy Families cost California $590 million in federal matching funds that had been available to the state but remained unspent by the deadline of September 30, 2000.[25]

Another 39% of uninsured children are eligible for Medi-Cal — a total of 726,000 children (range: 633,000 to 817,000). This also is an apparent (but not statistically significant) change from the previous year's estimate of 838,000 (range: 728,000 to 949,000).

Approximately three-fourths of all uninsured children who are eligible for Medi-Cal are in working families, and about half of these children are in families headed by at least one full-time, full-year employee. An even larger proportion of children who are eligible for the Healthy Families Program have working parents; three-fourths have at least one parent who works full-time, full-year for an employer without getting employment-based health benefits.

Although none of the differences between 1999 and 2000 are statistically significant, there does appear to be a small shift. The lower numbers in the most recent data may be due to a combination of three factors. First, continuing improvements in the economy enhanced children's coverage through their parents' employment, reducing the number who are uninsured. The number of children with job-based insurance rose about 300,000 between 1998 and 1999, while the number who are uninsured fell by 176,000.

Second, these economic improvements have also led to growing family incomes, even for some uninsured children. The proportion of all children with family incomes below poverty fell from 24% to 21% between 1998 and 1999 while those with incomes of 400% of poverty or more increased from 24% to 27%; the proportion with family incomes between 100% and 250% of poverty remained flat at about one in three. These higher family incomes reduced the proportion of uninsured children with Medi-Cal income eligibility. As earnings rose, however, the proportion and the number of uninsured children whose family incomes exceeded the Healthy Families limit also grew, from 14% of all uninsured children — a total of 277,000 (range: 214,000 to 341,000) based on 1999 CPS data — to 19% of all uninsured children — 343,000 (range: 279,000 to 407,000) based on 2000 CPS data (a statistically significant increase).

Third, expanded outreach and enrollment efforts have paid off with growing enrollments in the Healthy Families Program. The number of enrollees in Healthy Families rose from 53,000 in December 1998 to 206,000 in December 1999 to 355,000 in December 2000.[26] Approximately 2.7 million children (under age 21) were enrolled in Medi-Cal in January 2000, only slightly changed from the 2.8 million one year earlier.[27] (The Medi-Cal enrollees data include all children of those ages, not just the ones who were enrolled through the children's percent-of-poverty program.) All three of these explanations are welcome news, bringing benefits for California's children.

25 Pear R, "40 States Forfeit Health Care Funds for Poor Children," *New York Times*, September 23, 2000.

26 The numbers of Healthy Families enrollees were provided by Sandra Shewry, Executive Director, California Managed Risk Medical Insurance Board, personal communication, Dec. 20, 2000.

27 Based on administrative data from the Monthly Medi-Cal Eligibility File (MMEF), table with data for January 1996 to June 2000 (http://www.dhs.ca.gov/mcss/RequestedData/Ages/age.htm). The number of enrollees based on Medicaid administrative data are generally higher than estimates derived from the Current Population Survey or other surveys.

**Declining uninsurance of children in the last year appears due to growing employment opportunities for their parents, rising family incomes, and improved outreach and enrollment in Medi-Cal and Healthy Families**

We estimate that, based on 2000 CPS data, another 245,000 (range: 191,000 to 300,000) uninsured children were undocumented immigrants (about 13% of the total) and therefore not eligible for either program, except for emergency medical services and prenatal care under Medi-Cal if they have very low income. (This estimate is not statistically different from the estimate of 270,000, which falls within the range of 214,000 to 341,000, based on 1999 CPS data. Undocumented status is not available in the CPS; we imputed it using a method described in the Appendix.)

California has worked to improve its outreach to families of uninsured eligible children and to enroll them in one of these programs. These efforts were initially hampered by many flaws:

- an incredibly lengthy and unnecessarily complicated application (a 28-page application booklet since reduced to 10 pages),
- an unnecessarily complex application process (e.g., burdensome and unnecessary documentation requirements),
- uncertainty among noncitizens about whether enrolling their children would jeopardize their status in this country (partially resolved by new federal policy statements about "public charge" classification, issued in May 1999),
- recertification procedures in Medi-Cal that dropped out large numbers of eligible children (with quarterly recertification now being replaced for children by 12-month continuous eligibility — although the success of this policy change will be determined by its implementation),
- a lingering stigma related to Medi-Cal's welfare system procedures (only partially addressed by the use of mail-in applications since welfare office interviews still may be required), and
- a weak outreach campaign that relied too much on traditional media and too little on experienced community-based organizations (whose roles are gradually being increased).

In Part 5 of this report, we offer a number of recommendations that could dramatically improve outreach and enrollment of children.



The number of uninsured children who are citizens or legal immigrants and whose family incomes exceed the Healthy Families limit grew to 343,000 — 19% of all uninsured children — in the most recent year

# The Uninsured in California: Causes, Consequences, and Solutions

**E. Richard Brown, PhD**
**Roberta Wyn, PhD**
**Rebecka Levan, MPH**

**Final Report**
**to the**
**California HealthCare Foundation**

**December 1, 1997**

**UCLA Center for Health Policy Research**

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# Executive Summary

## Who Are the Uninsured?

For nearly two decades, uninsurance has risen among all nonelderly Californians and other Americans. In 1995, approximately 6.5 million Californians—22.7% of the population under the age of 65—had no public or private health insurance coverage. One-fourth (25%) of the population ages 18-64 and 17% of all children under age 18 were uninsured.

The percent of uninsured residents varies considerably by region. Southern California counties had the highest uninsured rates while counties in the northernmost regions had the lowest uninsured rates.

The largest portion of the uninsured are single adults without children (40%), but one-fourth of the uninsured are children. In recent years, Medicaid expansions have reduced the percentage of uninsured children but the percentage of uninsured adults has risen somewhat. Uninsurance affects single-parent and two-parent families equally though two-parent families are more likely to have job-based coverage and single parents are more likely to have Medi-Cal coverage.

Over 60% of the uninsured have total family incomes less than 200% of the poverty level, making it difficult or impossible to afford privately purchased health insurance. Latinos constitute the largest portion of the uninsured among ethnic groups and have the highest uninsured rates.

Eighty-five percent of the uninsured live in families with one or more working adults. Among uninsured working adults, over half work for firms with fewer than 25 employees and 20% work in retail trade. Five major economic sectors account for over half of uninsured employees: retail, business services, agriculture, construction, and wholesale trade. Private household employees, farm workers, and employees in forestry and fishing occupations had the highest uninsured rates among all employee groups. Four occupational groups account for over half of the uninsured work force: service workers (excluding household help and protective service), precision production, sales, and administrative support.

In industries in which a large proportion of employees are immigrant workers—such as agriculture, the garment industry, and private households—between half and two-thirds of employees are uninsured. Non-citizens (both undocumented and legal residents) are highly unlikely to have either job-based insurance or Medicaid coverage and thus have an uninsured rate of 44%.

## Reasons for Uninsurance

Six out of every ten uninsured persons in California report that they lack coverage because it is unaffordable. An additional 11% report that they lack coverage because it is not offered by their employer.

Three-fourths (73%) of California employers who do not offer health benefits to their employees cited high premium costs as a very important reason for their not providing health insurance. Other critical issues include the firms' own financial problems or concerns related to its profits or inability to afford health benefits.

## Access to Health Services Among The Uninsured

Insurance coverage makes a meaningful difference in individuals' access to health care services. The uninsured are much less likely to have a regular connection to the health care system than those with coverage. Among children, 29% of the uninsured have no usual source of care compared to 4% of insured children. More than half of uninsured adults report that they have no usual source of care compared to 10% of insured adults. Among those who do report a usual source of care, the uninsured are much more likely than the insured to use public hospitals and community clinics for care.

The number and recency of physician visits a person receives provides a relative standard of access, permitting comparisons of access across population groups that differ by insurance coverage or other characteristics. In general, those without insurance are less likely to seek medical care on a timely basis. The uninsured are less likely to have seen a physician within the last year and have longer intervals since the last visit. Uninsured children are consistently less likely to use health services, even after considering differences in reported health status. Among adults, the uninsured are far more likely than the insured to go an entire year without a doctor visit and far less likely to report four or more visits in one year.

Lack of insurance coverage affects receipt of preventive screenings. Uninsured adults are two to three times as likely as their insured counterparts to report that they have not had their blood pressure checked in the past two years. Uninsured women ages 30 to 64 are much less likely to receive clinical breast examinations than insured women. Among women ages 50-64, almost half of uninsured women reported that they never received a mammogram, compared to 8% of insured women in that age group. One-fourth (26%) of uninsured women ages 18-45 report that they have not received a Pap smear in three or more years, compared to 14% of insured women in the same age group.

Approximately 13% of uninsured children and 23% of uninsured adults reported that they delayed seeking care because of cost. By comparison, only 2% of insured children and 6% of insured adults reported treatment delays due to cost.

## Solving the Problem

A variety of solutions have been proposed to insure the uninsured in California. The very low income of the majority of uninsured persons suggests the importance of providing some form of financial assistance to help cover the cost of health insurance. If a voluntary strategy, designed to encourage people to purchase health insurance coverage, is to be successful in covering virtually all the population, it must attract enrollees by offering coverage that people feel is affordable and worthwhile.

There are opportunities to expand Medi-Cal to provide subsidized health insurance coverage to the uninsured. More than 500,000 children and perhaps thousands of adults are already eligible and not enrolled. Medi-Cal could extend coverage to this group through administrative reforms and outreach to eligible people. In addition, California could choose to implement the section 1902(r)(2) federal Medicaid option that would enable it to extend eligibility to all children, ages 18 and under with family incomes below 300% of poverty. If this option were available for children up to 300% of poverty, 1.45 million currently uninsured children would be eligible. Finally, California could use Medi-Cal as a vehicle to provide coverage to even more of its currently uninsured population through a section 1115 waiver which has been successfully used by other states to extend coverage to uninsured adults as well as children.

Market reforms may help make health insurance more available and more affordable to small firms and individuals if such reforms address their concerns: high premium costs and lack of affordability. One proposal is to expand the Health Insurance Plan of California (HIPC) to employers with more than 50 employees or to directly offer coverage to individuals. However, the HIPC has had only a very marginal effect on the number of uninsured and any expansion that does not include subsidies is also likely to have little effect on the overall number of uninsured.

California's extensive health safety net—comprised of county hospitals and clinics, community and migrant health centers, homeless health services, school-based clinics, and private hospitals, especially their emergency rooms—could increase the volume of services they provide to the uninsured if they had additional funding with which to do so. Although such subsidies would not provide coverage to the uninsured and therefore would not reduce uninsurance, additional funding would help sustain agencies that currently meet the needs of the low-income uninsured population, a role that will continue to be important in the absence of universal coverage.

# TRANSCRIPT OF

# HEARING

# SENATE HEALTH & HUMAN SERVICES COMMITTEE

## Senator Deborah Ortiz, Chair

## "A Cost Effective Agenda for Health Access for Children and Families"

**Wednesday, January 16, 2002**
**State Capitol, Room 4203**

**SENATOR DEBORAH ORTIZ:** We will now transition into the informational hearing today. I would encourage Members who are within earshot to join us.

I know that we are starting a bit earlier than our participants had anticipated, but I do want to welcome those of you who are here and encourage others to join us. This is a very important committee hearing. It is informational. The challenge is always having Members attend a hearing that is informational, but I can't think of more important information than that which will be provided today on the question of access to health care and health disparities in our existing system.

As I mentioned earlier, I welcome you here. I appreciate your participation in this important hearing and your willingness to share your expertise with the committee.

Today's hearing was born of a partnership between the committee and the Foundation Consortium, which started last year, when I attended an institute held by the Foundation Consortium to discuss health access and health disparities. The report from the institute is included in your hearing materials.

The partnership between the committee and the Foundation Consortium mirrors our ongoing public and private partnerships to provide access to health care for California's most vulnerable populations. As you know, a large number of Californians lack access to a regular source of health care services, and almost 7 million, out of our roughly 33 million population of Californians, lack health insurance. These Californians suffer the economic and health consequences of lack of healthcare services. They're often hard-working Californians who delay necessary care. They seek care when their conditions are advanced and require more serious intervention. They frequently experience decreased productivity.

Over the last two years, we've taken some significant steps to increase access to health care for California's vulnerable populations. Despite our public and private efforts to improve access to health care for many Californians, significant access to health care challenges persist.

Many of our safety-net providers face significant financial challenges that threaten their ability to serve Californians. Our rural areas and our urban, low-income communities are experiencing a serious shortage of providers. Our high rate of uninsurance persists even at a time, at least until recent history, of record economic growth.

The current downturn, of course, in our state's economic situation is likely to increase the challenge that our system faces. It is essential that we overcome these challenges and protect access to health care for our most vulnerable populations.

Today's hearing will help us to do just that. Our purpose is to assess the state of our healthcare system, the challenges it is likely to face, and to explore ways to increase access to healthcare services for the state's most vulnerable populations.

With us today are a group of experts on health insurance, the status of the safety net, county health delivery systems, and barriers, of course, that those vulnerable populations face when accessing health care. Also with us are representatives of various foundations who will share with the committee their expertise based on funding a wide variety of innovative models and initiatives to improve health access.

I'm confident that our witnesses will identify the barriers to accessing health care that Californians face. They'll give us a sense of what the uninsurance picture will look like this year, which is very critical, because we have some guesstimates, some projections. As we move forward in the budget process and we're trying to make very difficult decisions, the projections of what that uninsurance population and estimates look like are critical to help and guide us through that budget process.

They will share with us information on the link between health insurance and access to health care. They'll discuss the status of the safety net and the challenges it is likely to face. Hopefully, they'll provide us with some concrete recommendations, and then, of course, we have the difficult task of working those recommendations in the context of the fiscal situation as well as the inherent political nature of our jobs;

and, hopefully, again, those examples and models that we should consider to ensure that Californians can access the healthcare services they need.

Thank you again for joining us. I'm going to allow my colleagues to share some opening comments and move forward with the hearing.

Senators, opening comments? Senator Chesbro?

**SENATOR WESLEY CHESBRO:** Just briefly, I commend you for calling the hearing. This remains a timely topic. I know the conventional wisdom is when you've got a budget crisis, you forget about moving forward on very crucial needs of human beings, and I commend you for not getting knocked off of the course here. I think we need to have this discussion, so I appreciate it and am looking forward to hearing the testimony.

**SENATOR ORTIZ:** Thank you, Senator Chesbro. I want to thank Members because it's very difficult to hold Members here. We're running from committee to committee and meetings to meetings, and the fact that they are here shows you that they really do care about this issue.

I believe we're going to change our agenda around a bit. Our first panel, which, of course, deals with barriers to access health care for the state's vulnerable populations, as well as uninsurance, and the third panel, the role of health insurance and access to health care, will be sort of combined. I'm going to ask our first speaker, Speranza Avram, who is the executive director of Northern Sierra Rural Health Network, to please join us at the committee table up here. Also, others who are part of this panel discussion should feel free to come and have a seat and learn how to work our mikes at the same time. Those include Yolanda Vera, who is an attorney from the San Fernando Valley Legal Services. Also, Mr. Larry Levitt, who is the vice president of the Henry J. Kaiser Family Foundation. And, of course, many of us who are familiar with his great work – Lucien Wulsin, who's the executive director of Insure the Uninsured Project.

Welcome. Please feel free to begin.

**MS. SPERANZA AVRAM:** Thank you.

**SENATOR ORTIZ:** I want to thank Senator Polanco for joining us, and Senator Escutia and Senator Chesbro.

**MS. AVRAM:** Thank you very much for the opportunity to speak with you today. My name is Speranza Avram. I'm the executive director of the Northern Sierra Rural Health Network.

We're a nonprofit organization that works with rural healthcare providers in the northeastern part of California. Our service area is 27,000 square miles. We work with providers on a variety of issues, including operating a Regional Telemedicine Network, working to integrate mental health services into primary care practices, and providing resources to our members to help pay for the costs of health care for the uninsured.

I currently live and work in Nevada County, and prior to that in Sierra County, population 3,300 people, which is probably less than what are in the State Capitol today.

The healthcare system that currently exists in rural California is challenged to meet the needs of the older, poorer, and sicker residents that we serve. As more elderly and ethnic minority residents move into rural communities, the systems that we currently have in place are going to be challenged to provide quality health care, particularly if the safety-net services are not maintained. California's rural healthcare system is fragile, and unless we are mindful of this fragility, rural residents throughout California could be left without any healthcare services at all.

Over 75 percent of California's land mass is considered rural. It's home to over 4.3 million people and visited by millions more throughout the year. We are characterized by our distance from urban areas, our limited economic resources, our low population density, and our fragile healthcare systems that survive very close to the margin.

Overall, rural residents are less well off than their urban counterparts. Of the twenty-nine California counties that exceeded the statewide rate for people living in poverty, twenty-two of those counties were rural counties in 1998.

Rural California is in transition, with some rural communities seeing large increases in population. Between 1990 and 1996, California's rural population increased by 14 percent. Rural residents are also getting older. The number of people over age 85 living in rural Northern California increased by 35 percent over the past ten years, compared to a statewide increase of only 25 percent.

Rural California is home to an increasingly diverse population. In 1996, one-third of residents in rural California were ethnic minorities, compared to only one-fifth of the population in 1990. Rural California is home to more than 1.3 million farmworkers and over 70,000 Native Americans.

There are a number of underlying structural factors associated with providing care in rural areas that are important to remember as the state contemplates how to allocate its healthcare resources. These structural factors are what distinguish California's rural healthcare system from the system that exists in urban areas.

First of all, California's rural healthcare system consists primarily of public sector providers. There are a very limited number of private family physicians or privately operated hospitals that still practice in rural California. Instead, California's rural safety net consists mostly of rural health clinics, federally qualified health centers, small rural hospitals, and public health departments. These providers offer services to all residents regardless of their abilities to pay, and they are increasingly challenged as the number of uninsured patients increase.

The dominant payers are Medicare and Medi-Cal. For example, 59 percent of the inpatients in California's seventy-one rural hospitals are either Medicare or Medi-Cal. Thus, any reductions in Medi-Cal payments will have a tremendous impact on the safety-net provider's ability to maintain services.

Secondly, a lack of healthcare resources within rural communities limits the use of competition as a method for reducing healthcare costs. One of the key characteristics of rural areas is the absence of competition within the healthcare sector. The overall small numbers of residents in most rural areas limit the number of healthcare providers that are able to practice in a given community. While some of the larger rural communities are able to support multiple providers, most rural towns have only one primary care clinic or one physician practice or one rural hospital. These providers offer a range of services, and there are no other healthcare providers with which to compete.

I'm sure most of you have heard about the Medicare-HMO plans pulling out of rural areas, and one of the primary reasons is because of this lack of competition which makes it impossible for providers to compete in rural communities.

The lack of overall healthcare resources also contributes to the fragility of the system. Because, generally, rural communities can only support one primary care

provider, there are few alternatives if this provider is forced to shut his or her practice. For example, in Fall River Mills, in Eastern Shasta County, the privately owned physician practice was considering closing their doors because of financial considerations. If this had happened, pregnant women would have been forced to drive more than ninety minutes over winding mountain roads to deliver their babies in Redding. Closing the practice would have also jeopardized the continued operation of the local hospital. Instead, this private practice will be converting to a federally qualified health center in order to maintain services to the community.

The third structural factor that characterizes the delivery of rural health in California is the chronic shortage of primary care specialty and ancillary providers of all kinds. An overwhelming majority of California's rural communities qualify for at least one type of federal health provider shortage designation. The overall shortage of doctors, nurses, dentists, mental health workers, and specialty providers is exacerbated by the dearth of providers in rural areas who are culturally and linguistically competent. For example, a mid-level provider such as nurse practitioners and physicians' assistants are commonly used to provide health care in rural clinics and hospitals; yet, statewide, in 1998, only 6 percent of nurse practitioners and 13 percent of PAs were Hispanic. California's Hispanic population at that time was 30 percent, and I know it's increased since then.

Finally, rural providers operate so close to the margin that even minimal reductions in public funding can have devastating consequences. In order to recruit and retain, medical providers maintain adequate healthcare facilities and keep up with the rising cost of operations such as increased energy costs and insurance costs. Rural health providers are paying more than ever to provide needed services; yet, the population growth in rural California will never be enough to make most healthcare facilities self-sufficient.

For example, in Fiscal Year 2000, California's rural hospitals had an average operating margin of -3.9 percent. It was only through the infusion of a variety of state and federal operating programs that the hospitals reached a fragile .7 percent margin.

Rural health providers are extremely limited in their ability to increase volume or decrease costs to make ends meet. This is one of the main reasons why the new Prospective Payment System (PPS) being implemented by the state is so worrisome to rural providers. Their ability to do more with less is extremely limited, and unless

care is taken to implement PPS in a way that recognizes the structural factors facing rural health providers, PPS has the potential to destabilize a fragile rural healthcare system.

Cuts in the foundation of the rural safety net will inevitably impact access to care for rural residents. I hope I have demonstrated that California's rural health system is based on the foundations of public program support. Medi-Cal payments, Healthy Families reimbursement, expanded access to care for the uninsured, rural demonstration projects, and many other state programs are all part of an intricate safety net that protects healthcare access to California's most geographically isolated residents.

If the public programs that form the foundation of the rural safety net are reduced to the extent that the facilities are forced to close, then rural residents will just be without health care, period. There are no alternatives for the heart attack victim, except perhaps a three-hour drive to the nearest urban emergency room. Once the safety net is gone, there will be nothing left to take its place, and millions of rural residents and migrant farmworkers will be without health care.

Thank you for the opportunity to speak, and I'm happy to answer any questions you may have.

**SENATOR ORTIZ:** Thank you. Let me see if there are other members of the committee that have questions.

Senator Chesbro.

**SENATOR CHESBRO:** You just said it very well. I held two hearings in my district, which runs parallel to the area you serve, one in Santa Rosa and one in Eureka. Everything that's wrong with the system statewide is just that much more wrong in rural counties. So, I appreciate your very succinct description of the rural problem. You did a good job.

**MS. AVRAM:** Thank you.

**SENATOR ORTIZ:** Other questions or comments from Members?

Let me quickly ask, and I assume that you've taken a glance at the proposed budget as we know it today and have formed some thoughts, because part of your presentation, of course, addressed that. One of the things that I'm grappling with is we saw an infusion of about $17 million proposed to be shifted over to clinics, which is a good thing but a proposed elimination of the Child Health and Disabilities Program

(CHDP). I guess what I am confounded with is there are many places that have a really elaborate and developed clinic system of delivery and other areas that clearly don't. So, the gap of, particularly, undocumented children that are served under CHDP--there is the notion that they will, in fact, be picked up in the clinic systems, which I think that's probably not a sound assumption or opinion on that piece of the budget. Of course, proposed to be eliminated is the rural health program, I believe. I don't have my notes in front of me at the moment, but I know that one of the programs that was proposed to be eliminated – there's a yes now.

**MS. AVRAM:** I actually, honestly, have not studied the budget that carefully because it's overwhelming. I wait for emails to come to my box, and I did just hear yesterday that there is a proposed cut in the Managed Risk Medical Insurance Board (MRMIB) rural demonstration projects. Actually, I have one of those contracts to help support our Telemedicine Network which provides access to specialty care. I'm interested to see what the outcome will be because it's a two-year program and the second year will be cut. So, we're concerned about that.

In terms of CHDP, you're right: For children that aren't going to a clinic system and are going to private providers, it does provide a means of funding for preventive care and for screening. Again, I haven't studied the issue. There's probably an assumption that those kids were picked up either by Medi-Cal or by Healthy Families or some other way, and I think that's always dangerous to assume that patients will go from one program to another.

**SENATOR ORTIZ:** Any insight you can lend as we go through that process will be greatly appreciated. Anyone, certainly, in the group.

**SENATOR CHESBRO:** Madam Chair?

**SENATOR ORTIZ:** Please.

**SENATOR CHESBRO:** Can I follow up on what you just asked? My guess, what I read into the chair's question, and I'm as concerned about too, is the question of whether or not the potential shift of providers was going to leave inadequate coverage of the programs and services for rural California.

**MS. AVRAM:** I can't speak to all of California, quite honestly. I'm always uncomfortable doing that. It's a very diverse region of the state, just like urban areas are. I know that in rural Northeastern California there's actually a pretty strong coverage network of, if not community clinics, primary care clinics that may not be

designated yet. In fact, as I mentioned in Shasta County, a private practice is converting to a Federally Qualified Health Clinic (FQHC) because that's the only way they can maintain services in that community. That may be the fallout in rural areas, that if a private practice can't make ends meet, they may shift over. Philosophically, I don't think that's a bad thing. I think that will ensure that coverage is there. I don't know how the private provider may feel about that.

In other areas of the state, it could be problematic. Actually, I know in the valley there is some counties that don't have community clinics. I'm thinking like Tehama and Glenn and that part of the world. That's a good question: What will happen to people who are relying on private providers, and if their ability to provide care is limited, what will happen to those children?

**SENATOR ORTIZ:** Thank you. It gives us all a feel for placeholders as we go back and look at the budget more closely.

I want to let Members know that Ms. Avram's testimony is in your packet, I believe. Should you want a copy of that, we do have that available.

We're going to be a little creative with our panels as they're proposed in the agenda and ask Ms. Yolanda Vera to speak next. I understand Ms. Zolarzano is here from PICO, so please join everyone else and we'll build you into this panel. Ms. Zolarzano is a constituent of mine, so it's always good to see you. Welcome.

Ms. Vera.

**MS. YOLANDA VERA:** Good afternoon. My name is Yolanda Vera, and I'm a senior health policy attorney at Neighborhood Legal Services.

We were founded in 1965, and we do a variety of legal services – Welfare to Work, domestic violence, immigration law – and I wanted to talk about two particular health projects I work on, as I talk about barriers that we face in Los Angeles County.

One of those projects is the Health Consumer Center, which is a California Endowment-funded, independent ombudsman center. We help low-income residents below 200 percent of the federal poverty level, which is almost $30,000 a year for a family of three, who experience healthcare problems. We have eight hotline counselors, five attorneys, and two outreach workers who are bilingual in Spanish, Armenian, Turkish, Khmer, Mandarin, Vietnamese, French, and Arabic. We're partners with other health consumer sites in San Francisco, San Mateo, San Diego, Orange, Fresno, as well as a health rights hotline in Sacramento.

Our office alone – to give you an idea of the demand – we get 25,000 calls a year from health consumers experiencing problems. Seven out of every ten of those people call because they have an eligibility problem. Either they're calling because they're wondering if they're eligible for a particular program, but they don't know that they're eligible for Medi-Cal or charity care – they've been denied; they're too afraid to apply; their application was delayed; their benefits were terminated – or they're having some kind of problem with cost-sharing obligations. The rest of the 25,000 people that call a year have a particular problem with service. They need a particular service, but it's been denied. They are covered, but they can't access that service.

The second project our office has is called the VIDA Project, which is also funded by The California Endowment. VIDA is really more of a strategy to help uninsured persons in the San Fernando and San Gabriel areas deal with this feeling of helplessness over not being insured and not being able to access health care. We partner with LA Metro and the Industrial Areas Foundation, and we have twenty-four public-private partners. What we do is we focus on 2,000 families and have regular meetings with them at local churches to talk to them about how they can access available resources, what problems they're experiencing, and really learn directly from them what we can do to improve our system together.

We're learning that a lot of these kinds of consumers face a huge number of problems. L.A. County is home to approximately 2.8 million uninsured persons. Eighty percent of them are, in some way, connected with the workforce. Two million of them are in households under 200 percent of poverty. One-point-seven million of these persons are uninsured adults who just don't qualify for any other type of healthcare coverage. Those all rely on our very frayed county healthcare system, and because of this, our county healthcare system is overwhelmed and plagued by long waits in both the emergency room and the specialty care clinics.

As an example, in October of last year, a patient at Martin Luther King with eye problems would have to wait nine months before they could get the next available appointment at the ophthalmology clinic to see a doctor about a cornea problem. And the same problems, three-month waits, for an appointment at the gastroenterology clinic.

The emergency rooms also experience problems, and our VIDA participants tell us about those experiences. One VIDA participant told me last night that he took his

father in who had a stroke and had to wait twelve hours before he was seen in the emergency room by a doctor. Another VIDA participant told me about her thirty-year-old, full-time working son who went to a community clinic because he was experiencing severe abdominal pains, and the clinic sent him by ambulance over to the emergency room. He had to wait ten hours before he was screened, and they determined that he had appendicitis. Fortunately, he was seen before his appendix burst.

While they're in the waiting rooms, they meet other people who are there: a diabetic grandmother who brings her diabetic grandson, and they're waiting for eight hours. All of this makes all of these participants feel helpless, and they want to do something.

Even if they are eligible, the VIDA participants and the other clients we see at our office experience many problems getting onto the programs for which they're eligible because they face huge enrollment and retention difficulties. Unfortunately, Medi-Cal and other survival programs are so complicated, it's hard to qualify even if you're eligible. In L.A. County, we spent over $150 million on a computer system called LEADER, which does eligibility determinations for Medi-Cal and other programs. Unfortunately, the computer program is so cumbersome, it hasn't been updated to take into account the changes that have taken place in the last three years. So, it doesn't automate major programs like 1931 and the Aged and Disabled Program.

Just to give an example of the impact of that, the Aged and Disabled Program was implemented starting January of last year. It was meant to, by last year, help 52,000 aged and disabled people qualify for free Medi-Cal care. Given that four out of every ten Medi-Cal beneficiaries are from our county, we thought that by the end of the year approximately 19,550 seniors and disabled persons should qualify for this program. We started to take a look at the numbers on enrollment, and the June 2000 numbers, which is the last reliable numbers, show that of the 24,000 people who had enrolled so far in the program, only 204 – or .009 percent – were from our county.

Now, L.A. County is ultimately responsible for accurately screening people for Medi-Cal, but underlying this is the problem that Medi-Cal has become so complicated, we need to spend millions and millions of dollars on a computer system because normal human beings can't do it anymore.

So, what do we do to overcome some of these barriers? We can't even begin to address the long waits that we experience in emergency rooms and specialty clinics without additional revenue. As one county official put it very eloquently, "Virtual loan isn't enough to fix this system." L.A. County, even if it did everything right, we'd still have a huge problem. Given the current budget situation, it seems unlikely that we'll have a huge infusion of funds, so we need to make some smaller, simpler steps towards fixing it.

We can take some more modest steps. Some require legislation, some do not. I feel like every time we come, we keep talking about the elimination of the Asset Test, which will take large strides towards simplifying the Medi-Cal program, making it easier for people to get on; as well as elimination of old AFDC rules affecting two-parent working families. They're simple improvements that will net cost savings and help us cement some of the improvements we have already taken in the Medi-Cal and Healthy Families programs.

Other things we can do are streamlining verification procedures. In the Healthy Families mail-in process, as well as in the express lane process – express lane is ... (tape turned – portion of text missing) ... a new bill which makes it easier for kids who qualify for free school lunch to quickly get onto Medi-Cal. We've been working in our county with LA Unified, that wants to be one of the first counties out there getting people enrolled, working on the application, but we're stymied because of some of the verification obstacles. We're hoping administrative improvements can be made so that we can more quickly get people on.

The other types of steps we can take are simple steps to keep families on Healthy Families at their year-end review. We get people enrolled into Healthy Families, get the outreach out there, and then they drop off at their annual review. There's some steps we can take to make it easier for them to stay on so it's not so burdensome for them to stay on.

Until programs are simplified, what our experience over at Health Consumer Center, with our amazing volume of calls we can't keep up with, is we have to continue to focus efforts and funding on community-based strategies, which include skilled assistance and trainings and community materials. We cannot keep up with the demand from doctors, from clinics, from community groups, from consumers, who ask us, "Please try to explain these rules to us. We don't understand them. We want to

claim funding to access the funding but we don't know how to do it." We could take it in small bits. There could be efforts to do training just on services that foster care kids are eligible for or simply preparing updated materials on Medi-Cal managed care enrollment.

VIDA has taught us that when it comes to sensitive health decisions, the consumers want to know, but they trust their neighbors and they trust other parishioners for information on where to go for services, what works, what doesn't work, what should work, and what to do if it doesn't work.

Thank you.

**SENATOR ORTIZ:** Thank you, Ms. Vera. Again, many of us have heard this and have tried to remedy many of these pieces. We just have to come back each year and make the case again. I do appreciate it.

Questions from Members on Ms. Veda's presentation?

I'm going to deviate a bit. Ms. Zolarzano is here, representing a consumer perspective from my local PICO project, the Sacramento Area Congregations Together.

Welcome.

**MS. YESENIA ZOLARZANO:** I'm Yesenia Zolarzano. I'm a leader with Sacramento Area Congregations Together, and we represent 35,000 families. We're also a part of PICO, which is Pacific Institute for Community Organization. We all represent 350,000 families statewide.

The reason I'm here is to tell you a little bit about how it is to be with no insurance. I'm a parent of six girls. My oldest is seventeen and my youngest is six years old. My husband and I both struggle very much to make a living and to support our children.

My oldest daughter, who is seventeen, has severe allergies. She gets a lot of hives, a lot of itching. The last time that she got them, it got to the point where I had to take her to a dermatologist. Dermatologists are very expensive. Usually, when it comes to that bottom of the line where you have to decide whether you eat, you pay your rent or you take care of your children, we struggle with that on a monthly basis. On top of just paying for the dermatologist, then you have to pay for the medicine, which is outrageous too.

My ten-year-old has asthma. The very first time she had an asthma attack, we had to rush her to the hospital. It took us I don't know how long just to pay that

emergency bill on top of her medications. She needs two inhalers – one at home and one at school. Whenever it's time to get the new inhaler, it's another struggle to decide which bill is going to be set aside.

I'm just one of the thousands of families that are out there struggling with the same situation that I'm struggling. People in Sacramento Area Congregations Together, or ACT, we've been working on this for a long time with our families and our leaders. It's very unfortunate that we have to go through all of this. It's very hard for us parents to have to decide whether you feed your children or you have a house or you pay your electricity bill or you take care of the health issues. It's very important to have a healthy family because we need our kids in school, and if they're not healthy, they can't learn. It's our priority in my house and with a lot of the families who we all represent.

I think we need greater access to health care. It's very important for our families to have access to all these health cares and to be able, like you were saying, just to know how it works. For years we were on and off of Medi-Cal because we qualified, then we didn't qualify. My husband would take two jobs just to have a better life and then we wouldn't qualify for Medi-Cal anymore, so there went our effort to get a better life for our children. If you make too much, you don't know what to do anymore. Should I make more? Should I just stay where I'm at just to have that insurance? You have to debate between that access to the Medi-Cal.

Three months ago I got a job as an assistant administrator. I have insurance for all my children and my family. I'm very proud of that. For the first time in years, I don't know how long, I can sleep at night now. But there's so many other families just like me that are still struggling. They're still in the same situation that I was three months ago, and that's why I'm here.

I keep on coming back, Ms. Ortiz, just to be here and tell a little bit of my struggles and how hard it is for our families to go uninsured and be able to sleep, thinking about "What bill am I going to pay tomorrow?" or "How important is it? Is it serious? Can I just go over the counter?" That kind of decision. I just think the health of our children is so important. They're the future, and if we don't have healthy children, they can't learn.

Thank you very much.

**SENATOR ORTIZ:** Thank you so much. I do appreciate each time you tell that story. We have to be reminded of the face of the uninsured. They're not only homeless or persons who don't work. They're all primarily, unfortunately, falling between the gaps, people who do work and are a paycheck away from eligibility for Medi-Cal, or working poor, and that's the face. As we try to get through the difficult time in our economy, it's that very sector of workers that will get us through and have to be insured.

So, thank you. I do appreciate it.

Questions from Members? I know that there's lots of valuable testimony. I'm going to encourage, so that we're being fairly creative with the proposed agenda, and I know that there are others who have time commitments, so I'm going to ask the participants to try to move through their testimony fairly quickly so we have time for questions and comments. We'll finish this panel and go directly into the next one.

Welcome, Mr. Levitt. I do appreciate your being here, and please begin your testimony.

**MR. LARRY LEVITT:** Thank you, Chairwoman Ortiz, and members of the committee, for the opportunity to testify.

I'm Larry Levitt, from the Kaiser Family Foundation. We're a national organization based in Menlo Park that provides information and analysis on health issues. For better or for worse, depending on your perspective, we have no affiliation with the Kaiser Permanente health plan.

I know you're not facing particularly good news this week on state finances, and I don't mean to pile it on but I, unfortunately, bring little good news today on the uninsured as well. As many of you know, we're facing a whole confluence of negative forces that put health insurance coverage for Californians in jeopardy – those with the fewest financial resources that are especially vulnerable.

The economic recession puts workers not only at risk for losing their jobs but their health insurance as well, and our economic difficulties come at the same time that health insurance costs are rising at the fastest rate in almost a decade. This combination of rising costs and weak demand for labor, for workers, means employers are likely to cut back on coverage for their workers and shift costs to their employees.

Finally, budget pressures not only compromise the state's ability to expand coverage for the uninsured but also offer a real danger of retrenchment. Unlike in

recent years when many states, including California, were making improvements in their public health insurance system, growing numbers of states across the country are now talking about cutbacks instead.

At last count, over 6 million Californians were uninsured; about 1 in 5 of all people under age 65. This lack of health insurance certainly threatens access to care, as you've heard. The uninsured, across a wide range of measures, have poorer access to preventive services and poorer access to services when they're sick. They're more likely to be hospitalized for preventable conditions, and they're less likely to have a regular source of health care.

Importantly, lack of health insurance also threatens the uninsured's financial security. Lack of health insurance is now a significant factor in personal bankruptcies, and the growing uninsured population is a real—

**SENATOR ORTIZ:** Can I ask you to repeat that? Because I think it's very critical when persons with health insurance go and get critical health care and they're not eligible for Medi-Cal. They're hit with huge bills, and there's data that suggests that is the number one or primary means of bankruptcy.

**MR. LEVITT:** Exactly. The uninsured are many times more likely than people with insurance to say they have trouble paying a medical bill. You're right, it is a major factor in personal bankruptcies.

**SENATOR ORTIZ:** Thank you. I just wanted Members to focus on that, because I read that a couple of times and I thought, "This has to be told; the story has to be told."

**MR. LEVITT:** My pleasure, in a manner of speaking.

To be sure, California is not alone in this problem, but while California is a leader in the nation for many positive things, unfortunately, it also has an uninsured crisis that is among the worst in the country.

As we've heard, this problem cuts across all demographic and geographic boundaries. In fact, most of the uninsured are working Californians, but it hits hardest among some populations and communities. I've prepared a few charts, which I believe you have in the back of my testimony.

Chart 1 shows, for example, that low-income Californians – those earning less than 200 percent of the poverty level; about $29,000 a year for a family of three – are more than three times as likely as people with higher incomes to be uninsured. On

Chart 2 you can see that communities of color are also much more likely to lack health insurance. For instance, over one-third of Hispanics under age 65 in California are uninsured compared to 16 percent of African Americans and 12 percent of whites.

**SENATOR ORTIZ:** Let me stop you for a moment. If we have, roughly, 33 million Californians, and about 11 million of them Hispanic – Latino – so about one-third of those 11 million, roughly, what? What's one-third of eleven? About 4 million, and we have roughly 6.8 million uninsured in California?

**MR. LEVITT:** Yes. The numbers are sliding because many of the 33 million mentioned are elderly who have near-universal coverage through Medicare. This is among people under age 65, which is probably about more like 30 million people. But I can get you the numbers.

**SENATOR ORTIZ:** About 11 million Hispanics though.

**MR. LEVITT:** Right, but many of them have Medicare coverage because they're over age 65. The numbers I was presenting were for people under age 65. But you're close, it's in the millions.

**SENATOR ORTIZ:** It's a significant part of the total uninsured in California though, and mostly children, I suspect.

**MR. LEVITT:** Many children, and mostly working as well.

**SENATOR ORTIZ:** Thank you. Please continue.

**MR. LEVITT:** Current economic recession and the end-of-the-boon economy are likely, unfortunately, to make a bad problem even worse. The number of uninsured, as we've been discussing, was last measured by the federal government at the end of the year 2000. These figures, positively, had showed a drop in the number of uninsured for two years in a row, both in California and across the country. Unfortunately, these decreases were modest, and they came at the end of an unprecedented ten years of economic prosperity.

Of course, much has changed in the last year since these numbers were last put out. In December 2000, for example, the unemployment rate in California was 4.7 percent. Figures released just last week show that it had climbed to 6 percent in California. An analysis that we recently put out show that for every 100 people losing their jobs, the number of uninsured goes up by approximately 85. So, if you translate these figures to California, where the number of unemployed workers has increased by

more than 200,000 within the last year, the number of uninsured, just based on the economic recession alone, has likely increased by at least 150,000.

I know these figures are a cause for concern. Unemployment remains well below the levels we saw in previous recessions where it hit, for example, nearly 10 percent in 1992. While economists continue to debate over how long this current recession is likely to last, it's clear that the weakened economy will leave low-income California families increasingly vulnerable.

Let me describe briefly a number of ways in which the economic downturn is likely to lead to lack of availability of health insurance. First, clearly, is workers lose their jobs; their ability to maintain their health insurance coverage is diminished. As you can see on Chart 4, California families with no workers in the household are twice as likely to be uninsured as families with one or more full-time employees, and this problem is not limited to people who are out of work. In fact, families with only part-time workers are just as likely as the unemployed to be uninsured. As employers continue to shift work from full-time to part-time work, we're likely to see the uninsurance problem expand.

Now, the plight of the unemployed and underemployed highlights the importance both in California and nationally of employer-provided health insurance. Most nonelderly Californians get their health coverage through an employer, and by pooling risk, this group coverage through employment protects people who have higher-than-average healthcare needs. If forced to buy insurance on their own through what's known as the nongroup insurance market, people with even relatively mild health conditions can find themselves denied coverage, imposed with benefit limitations, or have their premiums surcharged.

For laid-off workers who had insurance on their job, there are some protections both here in California and nationally. In companies with twenty or more employees, the federal COBRA law guarantees people access to their former group insurance plan, and a California law, known as Cal-COBRA, extends similar but somewhat weaker protections to workers in small businesses. However, workers using COBRA to maintain their health insurance are likely to be shocked at how much that health insurance costs.

In California, employers on average contribute about 90 percent of the premium for single employees and 80 percent for families; in fact, better than in most other

states. But unemployed workers buying their health insurance, even through the protections of COBRA, would obviously have to pay the entire premium out of their own pockets. Again, costs are lower in California than in the rest of the country – a positive story – but even in California the cost of a typical family insurance policy exceeds $6,000 a year. With the lost income from a job and only modest financial support from unemployment insurance, which I believe for some unemployed workers was recently increased to $333 a week, a $6,000 insurance premium is obviously out of reach.

Unfortunately, the cost of health insurance is rising more rapidly than it has in almost a decade, which you can see on Chart 5. We do an annual survey of employers, and that survey shows that the average cost of employer-provided health insurance increased by 11 percent in 2001, more than three times the rate of inflation and twice the growth in workers' wages, putting health insurance increasingly out of reach of working families. These cost increases, combined with a weak economy, mean that employer-sponsored coverage is likely to become less available and more expensive for workers. This, of course, was all before the tragedy of September 11th and the escalating economic downturn.

In recent years, California's made significant gains in the availability of health coverage, with increasing numbers of employers, for example, offering insurance to their workers. But the combination of rising costs and a declining economy will likely lead some employers to restrict coverage for part-time and temporary workers and lead others to drop coverage entirely.

Historically, the effect of economic downturns on health insurance coverage has been cushioned, to some extent, by increased enrollment in public programs, like Medi-Cal. As jobs losses mount, families lose income, forcing them below the eligibility guidelines for these programs; yet, of course, the needs for such state funding tend to grow at the same time that state budgets become strained. Not an unknown story to you all.

Recent expansions in eligibility under Medi-Cal and the creation of the new Healthy Families program put the state, I think, in a very strong position to provide a safety net for people who lose private insurance coverage. Particularly noteworthy is the recent expansion of Medi-Cal to cover families with incomes under a hundred percent of the poverty level. Simplification of the enrollment process, as Yolanda

mentioned, also helps to ensure that people eligible for this coverage are able to enroll more quickly and with fewer administrative hurdles.

Of course, significant gaps still exist. For example, childless adults who are not disabled, no matter how poor they are, are ineligible for any form of publicly sponsored insurance here in California. Until expanded coverage for uninsured parents under Healthy Families is funded and implemented, many low-income families will remain partially uninsured, with their children able to obtain insurance but the parents not able to.

The bottom line is that we will be unable to make a dent in the problem of the uninsured without providing substantial subsidies to make that coverage more affordable. While there are a variety of approaches for doing this, our analysis shows that expansions and programs like Medi-Cal and Healthy Families are the most effective at targeting assistance to those who need it the most: the low-income, uninsured population.

But just as expansions and public programs could cushion the effects of the current economic recession, cutbacks in these programs could do just the opposite. Reductions in eligibility for Medi-Cal or Healthy Families, or curtailment of the recent reforms that have made it easier for the low-income uninsured to enroll, would both leave more people without health insurance, put greater pressure on those public and private providers who traditionally serve the uninsured, and potentially even exacerbate the current economic recession. It's important to remember that Medi-Cal, with the federal government paying approximately half the costs, provides an important economic stimulus to a state like California.

While the Governor's recent budget proposal avoided these cutbacks in eligibility, it's certainly important to keep our eyes on those issues as the budget process continues.

Thanks for the opportunity to testify, and I'd be happy to answer any questions.

**SENATOR ORTIZ:** Thank you. Questions from Members? Comments?

Senator Polanco.

**SENATOR RICHARD POLANCO:** From any of the presenters – are there any recommendations as to what could be done, either through policy change at the Legislature, to really look to maybe producing a different product that gets us services at a lower cost and thereby allows us to redirect a strategy in another direction versus

where we're headed, given the economic uncertainties that we're faced with, with the certainty being $12 million for sure? Any of the studies come out with any proposed recommendations?

**MR. LEVITT:** Well, I'll start. I welcome any company.

First of all, it simply takes money to deal with this problem. As I said, health insurance is tremendously expensive. Even a typical employer insurance policy, which is less comprehensive than what Medi-Cal provides to low-income families because the need for services is greater, is $6,000 a year. It's difficult to attack this problem cheaply.

I think there are a whole combination of strategies, particularly if there is some money available, that could help. Expansions in programs like Medi-Cal and Healthy Families are the easiest, fastest, and most direct way to get at the problem, but those can certainly be supplemented with other, more limited approaches – like providing tax credits or subsidies to small businesses who are least likely to offer insurance – to encourage them to do so. That enables state money to be matched by small employer money and money out of workers' pockets to get the insurance, which, for a non-low-income population, it's certainly a viable strategy.

**SENATOR POLANCO:** What about the pooling? I know that years ago then-Assembly Member Burt Margolin moved legislation that was to allow for workforce or sectors of the workforce to be able to pool the workers together and then leverage that in terms of some purchasing powers. Are we doing that?

**SENATOR ORTIZ:** Like an insurance pool essentially.

**SENATOR POLANCO:** Exactly.

**MR. LEVITT:** Right. Certainly, Assemblyman Margolin at the time – and Lucien can certainly speak to this, I think – one of the products of that was the creation of the HPIC, which is a purchasing pool for small businesses.

**SENATOR POLANCO:** Is there enough being done there? We know where the low-wage earner is. We know where they're located. If you have this mechanism, it appears there ought to be some impacts. The question is: Is it being implemented? If not, why not? If so, to what degree, and what can we do to expand that?

**MR. LEVITT:** I think it's certainly reasonable to look at these private approaches, particularly in the context of a state budget problem. One of the big holes in that strategy was individuals buying coverage on their own, which, of course, is

where the uninsured is left if their employer doesn't offer coverage. Those reforms provided this purchasing pool for small businesses, but individuals buying coverage on their own are faced with this nongroup market where they're not guaranteed access and premiums vary based on your health status and your age. I think that's an area where certainly progress could be made is extending these pooling approaches to individuals buying coverage on their own.

**MS. AVRAM:** I'm actually one of those individuals, and my small nonprofit cannot afford healthcare insurance for our employees. We explored the HPIC, and I will say it's about four years ago, and we looked at the small business purchasing pool. There were so many restrictions and so many eligibility things we didn't qualify.

I've been buying my own Blue Cross for probably the past seven or eight years and my premiums have gone up. Luckily, we're only two people. We're paying probably about $4,000 a year. I just heard on the news yesterday that the premiums in Sacramento are going to go sky high, and what about those thousands of people like me who are buying their own insurance? Why can't we get into a pool? I think it's regulatory issues primarily and then, of course, funding.

I think we need to look at creative solutions. The rules are sometimes made in absence of reality, or they're made twenty-five years ago, and today it's a different world. So, I would encourage you, if we can't use the funding, let's use some of the regulatory mechanisms and make it easier to have creative solutions to these problems.

**MR. LUCIEN WULSIN:** Senator, if I might. What happened initially was that the pool was associated with a decline in premiums in the small business market, and that was very positive. The pool never amassed sufficient purchasing power that it really began to become able to fully negotiate with plans with a lot of clout over price. There was never, really, an expectation that pooling, in and of itself, would significantly reach most of the uninsured, because it doesn't make enough of a difference on price, and you really have to do something else. In other words, some additional money has to come in, in order to make that coverage affordable for that small business who has a lot of low-wage workers at a very high premium cost.

So, the challenge, I think, is to think of ways that you can tie the pool into some of the public programs in ways that you creatively use those to increase coverage of some of the small businesses and low-wage workers.

**SENATOR ORTIZ:** And I think some of those proposals have floated through the Legislature, with my colleagues and I trying to have, essentially, the state play a role in subsidizing part of that as well as accessing the pool and minimizing the cost to the employer and, ideally, to the employee's ability to pay. There's always the debate that we come back to by designing these models for, particularly, the nonparent, uninsured working poor, but also to the working poor in general is the crowd-out debate. There are certainly those who will argue if we do this and we create the pool and we subsidize it further, we're going to have employers drop employees that they're currently covering through their employer plans. That is a political debate that we have to continue to drive home and have the data. Some of those before us have done the studies that suggest that those assumptions are incorrect.

Senator Polanco is absolutely trying to get at the core of this issue, and it's a new creation for all us mired in politics as well as fiscal realities this year.

I believe, Mr. Wulsin, you have a presentation. I do know we have an individual who has a time commitment, so I would ask you to go ahead and then we're going to deviate a bit for the next panel and ask one of our participants to come forward out of order.

Welcome.

**MR. WULSIN:** My name's Lucien Wulsin. I'm with the Insure the Uninsured Project. Thank you very much, Madam Chair, for convening this hearing and for inviting us to testify.

I think my goal in talking at this point is to talk a bit about the funding streams that are there for the safety net to try to take care of the uninsured. As you know, we have 6.8 million uninsured in California and going up.

**SENATOR ORTIZ:** Although, I recently heard we had a huge improvement, and numbers are awaiting us in a study from UCLA.

**MR. WULSIN:** Last year's study in the height of a very strong economy showed that we actually had a drop from about 7.1 to about 6.8. The projections are that that's really a few-years-out-of-date data. The projection is that we're going to have an increase, and the increase is due to a weakening economy, combined with the premium increases that employers are facing, which is going to cost some employers to drop and some employees to drop.

I thought I would address my comments first to the issue of community clinics and their funding; and secondly, to the counties and the different kinds of counties and the funding that they're dependent upon.

We are just completing a study that will be released pretty soon on the community clinics.

(Interruption.)

**SENATOR ORTIZ:** We're having a little bit of technical difficulties, in that we're changing the agenda a bit.

**MR. WULSIN:** Sure.

**MS. ANA MATOSANTOS:** Mr. Wulsin, in the changing of the panel, the question that we're primarily interested in having you address in your role in this panel is to talk about the health consequences of the uninsurance problem and the system consequences of California's large uninsurance rates.

**MR. WULSIN:** Certainly.

**SENATOR ORTIZ:** Thank you.

**MR. WULSIN:** Yesterday, when I spoke to your consultant, she said that you had lost one of your key witnesses, and I did prepare some testimony that pulls the data from the Urban Institute Study, which indicates what the use patterns are for the uninsured because of their lack of health insurance.

Is that the issue that we're going to talk about?

**SENATOR ORTIZ:** Correct.

**MR. WULSIN:** That data is pretty frightening. When you take a look at usual source of care, what you see is the uninsured have 300 times the lack of a usual source of care. In the data here that's done by the Urban Institute, they take a look at the patterns of care used by the uninsured. They compare it to patterns of use by the private insurance folks who have Medicaid, and I added in the comparison between uninsured in California and uninsured in the United States. What you find there is, in terms of people who have no usual source of care, in California, if you're uninsured, 42 percent of the uninsured have no usual source of care. That is three times the rate at which someone who is on Medicaid has no usual source of care.

Moving down the chart to the indicator for any physician visit, what you will see is that for the uninsured in California, only 36 percent in a given year had any physician visit. That's about half the rate of people with Medicaid or private

insurance. If they do have a physician visit, they use doctors about half the rate of people who have Medicaid or who have private insurance visits. The same thing applies to dental visits. We would have expected that, because they have access to nothing else, that they would have a very high rate of emergency room use. Their emergency room visits are half to a third that of the insured populations. The same thing applies to hospital visits.

Despite all of our excellent programs to provide coverage of pap smears and breast exams, even for those women who are low-income, women are using it at one-third the rate of insured women.

That's what it means to be uninsured in California, at least according to the recent study that came out from the Urban Institute in terms of access to services.

**SENATOR ORTIZ:** When you see the data that shows that women of color, poor women, who are more likely to have delayed diagnoses for breast cancer – and we even have a mechanism in place for poor women to have annual mammograms – and/or cervical cancer rates, and you look at the data here, it's pretty evident. It's quite alarming.

This has been quite helpful. This concludes our first panel. Unless there are questions, I'm going to invite the next group of speakers forward. I want to thank all of the participants for your presentation and your materials, and, hopefully, Members will take advantage of your expertise and call upon you as we move forward in our policymaking, as limited as it may be, in this fiscal situation. Thank you all.

We do have a second panel that I'm going to invite, but I am actually going to invite you to come forward but allow Deni Martin, from the California Association of Public Hospitals, to actually speak first. But if the second panel, that includes the following individuals, would please come forward and be prepared to begin after Ms. Martin: Ms. Chynoweth, who will be joining us; Dr. Bob Ross, who is here, I know; Alicia Procello; Bonnie Armstrong; and Len McCandliss. I will ask you to bear with us and allow Denise Martin to present first, because I understand there's a commitment for this evening that we want to accommodate.

Welcome, Ms. Martin.

**MS. DENISE MARTIN:** Thank you so much, Senator Ortiz, for accommodating my schedule, and I do apologize to the rest of the panelists about this.

Let me introduce myself. I'm Deni Martin. I'm president and CEO of the California Association of Public Hospitals, and I'm very grateful to you, Senator Ortiz, for the opportunity to testify today about the role and status of the public healthcare safety net.

My comments today, just for members of the audience and the panel, is I'm going to concentrate more on the delivery system. We've been hearing a great deal of testimony this morning about what these problems mean for the uninsured, what it means for health insurance, underinsurance, etc. I'm going to switch gears a little bit for you, and I hope that will be okay with you, to really talk about things in terms of how the delivery system is impacted by some of these very major problems.

For purposes of my presentation, I will be speaking to you about the challenges and issues facing the public hospitals in California, and by that I mean the public hospitals that are owned or operated by the counties. There are twenty-one public hospitals that I'll speak to in this data, three University of California hospitals at Davis, Irvine, and San Diego, and the University Medical Center in Fresno, which was the formerly owned public hospital. Together, these hospitals provide the core of services to the indigent populations. They are distinguished from their private sector safety-net counterparts, actually, by law. Again, I'm only speaking about the public safety net today. There certainly is an extensive private safety net as well which another panelist will speak to.

Section 17000 of the Welfare and Institutions Code mandates that all counties must serve as the provider for the indigent. They are open-door providers and treat all-comers, whether they arrive through the emergency rooms, through community-based clinics, or through their own network of outpatient clinics. Once stabilized in the emergency room, our patients are either admitted for their care or they're referred to our outpatient clinics for follow-up care. I think this does distinguish their role in the community from their private sector counterparts.

There are just a few significant facts I'd like to highlight for you about these systems before I get into the challenges they face. Again, I'll be very brief, but I think you'll see pretty quickly the scope of their work in vulnerable communities up and down the state.

Again, taken together, these twenty-five hospitals represent just 6 percent of all hospitals in the state – only 6 percent – yet, they provided 40 percent of all inpatient

care to the uninsured in the entire state of California. Now, that's an enormous amount of care concentrated in a very small number of hospitals.

The data indicate that the numbers of uninsured in our facilities is actually growing, not shrinking. For example, in 1993, 22 percent of our patients were uninsured. By 1998, that number had climbed to 29 percent, and we expect that number is only going up. When you think about this data, you think that 30 percent of the patients that receive their care in our systems are uninsured. Now, another, almost 40 percent are on Medi-Cal. So, we are heavily, heavily reliant on a combination of county, state, and federal funding to keep our doors open.

Just so that you know, too, on the outpatient side, these very same systems provided over 11 million outpatient visits per year. Almost half of all of the hospital-based outpatient care to the state's Medi-Cal and uninsured populations occur in these healthcare systems. This, too, is a really important statistic for you to think about because many people, when they think about public hospitals, they think about beds, and they think about bricks and mortar, and that simply is not the case. Nothing could be further from the truth these days. These systems have developed very large and extensive outpatient clinic systems in recent years in response to Medi-Cal managed care and the growing shift of primary and preventive care. In addition to primary care services, in many communities these outpatient clinics also provide the only access to specialty services for many special needs uninsured populations.

We all tend to think primary care when we think about patient clinics, but the fact of the matter is that, in many cases, specialty care is very difficult to find for patients without insurance.

Other services, just very quickly, that these systems offer, include training, roughly, one-half of the entire state's physicians. Almost half of the docs are trained in these twenty-five hospitals I just mentioned. They provide two-thirds of all of the level one trauma centers and 60 percent of the state's burn care. These critical services naturally benefit entire communities, in addition to serving as the only access point for many of the state's uninsured.

Now, in terms of our patients, what do they look like? What is their profile? Our patients are almost 70 percent nonwhite, and I think in the packet that we've given to you, you'll see how that demographic breaks down. As a result of that, we have developed extensive cultural and language-based assistance to help meet the

needs of patients from these diverse backgrounds. Many of our patients suffer from chronic, expensive, and difficult-to-treat healthcare problems which, as we all know, are often rooted in social and economic inequalities in our system.

While we have a long way to go, and we'll be the first to admit this, in overcoming adverse health outcomes for people of color, we strive to provide the best quality of care to our patients. We pride ourselves in recruiting and retaining a diverse workforce, work hard to improve minority representation in our systems, and continually aim to enhance the cultural competences of our organizations and staff.

Let me switch gears a little bit now to talk with you about some of the extraordinary environmental pressures that these providers are experiencing; and again, these aren't a mystery to you all because this is what you have to live with every day. We have a huge state budget crisis; we have an ongoing recess; we have the rising number of uninsured and the concentrations in our system. Now we have to be prepared to respond to threats of bioterrorism. We have horrible workforce shortages, seismic safety requirements, rising cost of pharmaceuticals, and an underfunded emergency room and trauma system. And to make matters worse, we're looking at large cuts in two federal Medicaid Disproportionate Share Hospital (DSH) funding mechanisms for us, which is the lifeblood for our hospitals.

When California last faced a recession in the early '90s, the state largely balanced the budget on the backs of the counties, if you'll recall, through the Property Tax Transfer. We, in turn, as providers, went to the federal government through the DSH programs to help us pay for care to the Medi-Cal and uninsured. We did this because we didn't have any other choices, quite frankly. Without the DSH program, many of our hospitals – and I include here both public and private safety net hospitals – would have closed their doors. Today, the situation that we face is really extremely different than it was at that period of time. I was here back then, unfortunately, and I'm here now.

But at the federal level, we can't go there anymore. We're facing a reduction in federal funding for our core DSH program of $184 million in our basic DSH program as a result of the Balanced Budget Act of 1997 that mandated a 20 percent cut in federal DSH funding over five years.

To make matters worse, we're also, right now, in the process of losing additional Medi-Cal supplemental funds of at least a billion dollars over the next seven years,

followed by a loss of $300 million per year after that due to the proposed federal rule change in the Medicaid upper payment limit issue. That's the UPL issue that some of you have been hearing about. With the help of the Davis Administration, with the help of our entire California delegation in Washington, and several key representatives here in Sacramento, we fought very hard in a very coordinated effort, with the private sector as well, to prevent this rule change with the Bush Administration. Unfortunately, so far we have lost that battle to maintain the upper payment limit at 150 percent.

The issue again is a nonpartisan one for California, as we've enjoyed the full support of all of our elected officials, but I can't underscore the importance to you of what the loss of these funds will mean to our hospitals, both public and private again. We're not optimistic that when Congress resumes next week we're going to win on this issue.

If you could just indulge me for a moment, there is a historical footnote to this issue. We developed these so-called UPL programs over a decade ago, and we did that in 1990 exactly because the emergency room and the trauma system and the OB system down in Los Angeles County was in meltdown. We went and we developed this program because we had the state recession and we knew we couldn't get any money at the state level. This program has since grown to over $700 million a year in federal funding. Now we're being asked to have this program ripped out from under our feet at the same time we again have a trauma and emergency room crisis, which you've heard about in other hearings, at the same time we need to be prepared in case there is any more bioterrorism attacks – we have to be ready in terms of being able to defend ourselves against them – and, of course, we're back to a budget crisis and a recession. Where once we looked to the federal government to bail us out, we now no longer can look there for that. That's a real issue for us that we're really concerned about.

Let me go back to the state level really briefly. Again, as I mentioned earlier in my comments, we're extremely reliant on public sources of funding at all levels of government. All of these funding sources are declining and, of course, some faster than others. Proposition 99 for indigent care again, for example, it dropped from a record high of $336 million in 1989 to [19]90 to this year to a meager $71 million. So, think 336 to 71 million. Again, those funds are targeted to indigent health care.

In terms of our basic core DSH program, our SB 855 program, as many of you know, we successfully stabilized this essential source of funding for both public and private safety-net providers over the course of four or five years of serious compromise and negotiations within the hospital industry. Not an easy struggle but we stabilized the program and we all feel very good about that. However, as you know, in the Governor's budget for Fiscal Year 2002-2003, the Governor proposes that we take the DSH rake-off up another $55 million. It's $30 million now. The Governor proposes to take it up to $85 million.

Again, we ask you, because of all the pressures that I have outlined on the safety net, we ask you to carefully consider the impact of increasing the DSH fee for our critical systems and to not use these funds to help balance the state budget. I know you face really tough decisions, but our safety net simply can't afford this level of cuts, given the environmental pressures I've outlined.

In closing, let me say that I believe we are facing a meltdown in the public safety net, and I suspect that's true for the private safety net as well. There are not a lot of options available to our systems that don't include large reductions in services and in some cases could lead to closure of some of our hospitals.

I say this without meaning to be an alarmist, but because I've never experienced this confluence of events in my years working on these issues – and my years on these issues total twelve years, so I've seen where this pendulum goes and I'm extremely worried about it – this would be a tragedy for the millions of Californians that rely on these systems as the only source for their health care.

Thank you so much for the opportunity to testify, and I'd be happy to answer any questions.

**SENATOR ORTIZ:** Thank you. Members, questions of Ms. Martin?

Great testimony, sobering as it is. Thank you so much for getting through it very quickly.

We now are switching around, and I think we're back in order here. This is the second, sort of quasi-second, panel here of speakers. I believe the first speaker is Ms. Chynoweth, from the Foundation Consortium.

Welcome.

**MS. JUDITH K. CHYNOWETH:** Thank you very much, Senator, and committee members.

I'm the executive director of the Foundation Consortium. The Foundation Consortium is a ten-year-old nonpartisan resource on what works for California's children. In this particular hearing, our members will be talking to you about what innovative practices work to reduce healthcare disparities. We've just heard a pretty bleak picture about what's happening with the basics of health care in California, and our job is to talk about what innovative practices we're engaged in that work that might help.

The Foundation Consortium's mission is to find ways to bring policymakers together to seek innovation, to foster partnerships, so that all California children are safe, healthy, and ready to learn each day. As our name suggests, we are funded and governed by sixteen of California's leading foundations. Each member is independent; yet, they come together to fund this collaborative effort and to share common goals.

You will hear from five of our members today about the kinds of community innovation they are supporting – what they have learned about programs that work. They include Dr. Robert Ross of The California Endowment; Alicia Procello of the California Wellness Foundation; Bonnie Armstrong of the Casey Family Programs, and with her is Ms. Mookie Abdullah; Len McCandliss of the Sierra Health Foundation, and with him is Amy Studdieford. Ted Lobman will be speaking at the end of this hearing.

The Foundation Consortium believes in accountability, uses data to make decisions on what is working, and, as in any partnership, everyone takes accountability for achieving results. Individuals, families, different government agencies, nonprofits, foundations – we are all responsible.

We believe in sustainability. That means if it works, fund it. Find a way to keep it going, even if it means funding that crosses categorical and jurisdictional boundaries.

We believe in looking long-term. As you know, many of the problems facing children and families are complex and may require reorganization of government efforts at the local, state, and federal level. We're always trying to keep our eye on the needs of the whole child. That is what is important.

We believe in unified, simplified funding. We believe in collaboration, and inclusion, focusing on individual communities and involving families and nonprofits, schools, and government.

Part of the Consortium's mission is to connect these various elements and find common ground. We sponsor educational events. We are also an impartial resource. For example, we partner with others to produce three websites that have information for policymakers: the Promising Practices Network, the Results Accountability Guide, and the website of the Foundation Consortium itself.

Today, we are focusing, in part, on one of our recent activities, the California Policymakers Institute. A hundred and twenty-five education, nonprofit youth and government leaders shared ideas in the fourth of an ongoing series of dialogues. Our topic was the elimination of healthcare disparities and how linking health and education can reduce these disparities. It was cosponsored with Lieutenant Governor Bustamante and his Commission for One California, and we were delighted to have Senator Ortiz as one of our presenters. As we plan other such efforts in the future, we'd like to invite all of you to participate.

You each have a copy of our journal for the community approach. This issue highlights the recommendations of the Institute. Let me comment very briefly on a few desired outcomes and ideas.

The desired outcomes discussed at the Institute included children born healthy; children and families with access to health care – obviously, what we've just spent the last hour discussing – school-age children ready to learn every day; children and families with good mental health; children and families in rural areas with equal access; and adequate supply of providers with diverse cultural and language competencies; and adolescents practicing healthy behaviors.

Looking broadly at this set of goals, we have evidence that programs have worked well. School-linked approaches work. Healthy Start works. After-school programs work. We have statewide evidence and local program evidence about after-school programs; evidence from L.A.'s best, from LA Unified School District, from San Francisco Beacon, from Sacramento Start, from programs in Calexico, Monrovia, Tulare, from all over. Other programs like family and community resource centers also show promise to achieve these goals.

These are just a few examples of programs that work. They are also successful collaborations; resources coming together from a variety of sources. Some of the presenters this afternoon may touch on some of these issues. They may share other findings from the Institute, their own analyses and successes.

Before I introduce the presenters, I would like to thank the Senator and this committee for this opportunity today. And I would also ask you to look at the foundation community perhaps in a new way. Sometimes – I can't think why – when government leaders think of philanthropy, they think of money; deep pockets they can go to when times are tough. Frankly, that is not how the Consortium sees our role. I would like to suggest something different. Think of us as a source of information, as an organization that seeks out innovation in social policy, that invests in it, experiments with it, and searches for what works.

The Foundation Consortium is eager to partner with you to make California a better place for children and families. I believe the Foundation Consortium and its individual members, indeed all the speakers today, have much to offer.

At this point, I would to introduce our speakers, members of the Consortium, who all have deep experience in funding creative programs in communities around the state. They will look at some of the broad policy issues that came out of the Institute as well as share their unique views.

I'd like to start with Dr. Robert Ross, who is the CEO and president of The California Endowment.

**SENATOR ORTIZ:** Thank you. Welcome, Dr. Ross.

**DR. ROBERT K. ROSS:** Good afternoon, and thank you, Senator, and members of the committee, for having us out. I know you're under time constraints, so I'll be brief and get to the point fairly quickly.

I think Judith summarized it very well about the role that we can play. These are tough times. I think we all should be reminded that this is somewhat closer to a set of events that we had in the late 1980s, very early 1990s, that led to the Clinton reform. We had rising numbers of uninsured in combination with increased costs, really putting a focus on the screaming from families throughout America about the inadequacies of our healthcare delivery system, and we find ourselves there yet again; except, as Deni Martin has gone through, I think the situation is actually worse than at that time.

There are a whole bunch of reasons why it's worse than even ten years ago. As a foundation leader, I think the scariest thing is that we've actually seen fewer new ideas about how to address the health system issues that face us. I think everyone agrees that there's a lot more reason for a lot more hammering, but to be perfectly

honest, I certainly haven't seen – there are bits and pieces of ideas that have been coming from certain counties, and we'll talk a little bit about that – but visionary, compelling ideas that we, as a foundation community, could all get behind, that the Legislature could get behind, and pick up a couple of areas in a couple of counties and try them, I really haven't seen them.

I think one of the Senators mentioned the question – I think it was Senator Polanco – what happened to the pooling idea? At least back then we had an idea called pooling. We had an idea called managed competition that was part and parcel of the Clinton reform plan, but we've been there, done that now. We've squeezed all the savings we can out of managed care. That's gone now. We don't have those dollars to squeeze out anymore.

I think Judith said it well: Think of philanthropy as a partner in three areas. Judith did touch on them, but I'll summarize them again quickly. One is to model and demonstrate new ideas. Secondly is a source of information and education for the public and for policymakers. And then, thirdly, the issue of advocacy – strengthening the ability of organizations like PICO, who have been marvelous at moving public opinion and educating the public and policymakers, and supporting their ability to educate and inform the public on these issues. Those are the three areas where I think philanthropy can play a role, and there may be other areas as well. There's a foundation representative here today that we as The California Endowment don't have a partnership with.

Very quickly, I'll just go through some of the things that we at The California Endowment are supporting that give you a sense of some of the ideas that we're testing and modeling. Many of them work. Number one, we believe that this issue of disparities in health care, of the health status gaps that primarily impact communities of color but other groups as well – the gay and lesbian community, the elderly, other kinds of communities across this wonderfully diverse state – is really a significant issue. It plays out economically, it plays out in educational outcomes, and we really have to get at this issue. Access is the bottom line in terms of getting at the issue of reducing some of these disparities in health status gaps.

We believe at The Endowment that the formula is that access to health care plus, in California, culturally competent approaches to health care, including diversifying the health workforce, will equal and lead to a reduction in health

disparities across the state. We're going to be in this battle for a long time. It's really not a battle; it's a war. It's not a sprint; it's a marathon. It's going to take us ten to twenty years to begin to get there and see the differences, but there are things out there that are working right now.

We are looking at nursing in diversifying the workforce. We have a major initiative getting ready to roll out, looking at the Central Valley and the San Joaquin Valley around their nursing shortages, among the worst in the state, and that we share the diversity of the workforce as a priority with our sister foundation, The Wellness Foundation. Alicia Procello is here today, and she'll probably talk more about what they're doing.

We also have creative welcome-back centers for internationally trained healthcare workers who've trained in other communities, in other foreign lands, and are radiologists and pharmacists and x-ray technicians and nursing assistants and are driving cabs and working at Burger King and at McDonald's because they can't get the kind of resources and support to become healthcare workers here. We have centers working with Charles Drew University, with Cal State University Long Beach, with Mt. San Antonio College, Cal State University, setting up centers to attract these workers and get them into the workforce by giving them the kind of supports and pointing them in the right direction.

Increasing access to health care. It was mentioned earlier, expressly eligibility, which I think this committee wholeheartedly supported. We, as a foundation – and also the California Health Care Foundation is working with us – we want to jump on this opportunity with both feet. We'd love to make resources available to local coalitions of school districts and community leaders to get schools to sign kids up through the reduced lunch program and also through the Food Stamp Program as well. It's a great move by the Legislature. The Governor signed it, and we think it's a terrific opportunity. We need to make it work on behalf of kids so we can reduce the number of uninsured but eligible children and families in the system.

We've also helped seeded, along with other foundations, efforts in Alameda County and in Santa Clara County. They had managed to, at the local level, using local resources, to try and have a vision of all children being insured and all families that are eligible for programs being insured. That is beginning to work. In fact, I know it's working because they're hitting us up for more money for more subsidies

because they're getting so many families in through the door so quickly, which is partially a good sign and partially a bad sign as well, but for the families and kids, it's great. We need more of those kinds of efforts. We have fifty-eight counties, which means we have fifty-eight possibilities of laboratories and demonstrations at the local level to make this issue move and to educate the rest of the state on what works.

We also have, as an important area of investment, cultural competency of the healthcare workforce. We have a wonderful program going on at White Memorial Center in East Los Angeles to train medical residents to become more culturally competent and to become better physicians when they finish those programs. We're also very interested in moving the language access issue and medical interpretation services. We are in conversations and dialogue with the California Medical Association about how to move that issue forward.

Finally, no former public health official can get through a presentation like this without underscoring the need for prevention. I know I want to extend – I know she was here earlier – but extend congratulations to Senator Escutia on the obesity issue in schools and snacks. A very important victory for kids in California in dealing with the skyrocketing issue of obesity. We have interest in diabetes and cancer. We've got a number of partnership programs under a partnership for the public's health. Community-based organizations and local public health departments are partnering to address issues such as cancer, diabetes, obesity, and other kinds of issues. We're seeing a lot of terrific models coming in that area that are working as well.

With that, I'll close. As Judith said, please use us as a partner. Again, we don't like to fund stuff. The worst thing a foundation leader likes to hear is "The state cut this program, can you write us a check?" It pains us to hear the story, but it also pains us to tell them no because we don't like saying no, but in those areas we try not to do what the state ought to be doing. We are partners in information and education, in testing new models, and in advocacy as well.

Thank you.

**SENATOR ORTIZ:** Thank you.

**MS. CHYNOWETH:** Alicia Procello.

**MS. ALICIA PROCELLO:** Thank you, Senator Ortiz, for convening this hearing. My name is Alicia Procello. I'm a program director at The California Wellness Foundation.

Our foundation has recently changed one of its goals to be very explicit in the communities in which we plan to serve. We have now specified that low-income individuals, people of color, youth, and residents of rural areas are part of our target populations, clearly defining who are the traditionally underserved populations in California.

Our grant making has also changed the way in which we do business, in that we've gotten rid of RFPs and deadlines. We're trying now to be a little more responsive to people saying "There are too many hoops to jump through when you approach foundations. What is one way you can make it easier?" I think our foundation is trying, just as many foundations are, to make money more accessible to communities that are savvy at getting grant funds and who are also in the game for the first time.

One of the things that we've particularly focused on is access. We have funded over the past five years urban and rural clinic associations. Supporting the infrastructure of clinics and groups of clinics to work together to provide services to individual residents and funding clinic associations has translated into, actually, 106 community clinics in counties such as Alameda, Orange, Santa Clara, San Diego, and Sacramento, particularly focusing on some of the ones in Mendocino, Humboldt, Shasta, and the Central Valley.

We also are focused on getting access for residents of rural areas. As you may know, to give an example, California's American Indians live in rural areas, getting their primary health care on reservations. A grant to the California Rural Indian Health Board, which is a consortia of travel clinics, has strengthened not only the infrastructure of each clinic, providing more services, but also is giving them the opportunity to give scholarships to increase the number of providers from those ethnic groups.

I think one of the major things the foundation has made a statement of supporting is a new priority called diversity in the health professions, which is what I manage. It really says, looking at the numbers of providers from underrepresented groups, these are the people that actually go out and then practice in these communities, particularly in inner-city and rural communities. Our strategy is to increase the number of providers from those communities; hopefully, it will then increase access and will affect health disparities.

I want to share a quote with you from a student from USC School of Medicine who's on a full scholarship from the foundation. He told me that "Growing up in an environment where little was expected of me, I didn't know a single person outside of my teachers who went to college, let alone medical school. The fact that I received a scholarship of this magnitude not only acknowledges my hard work but my mother's and brother's and sister's, who are responsible for getting me here." I think these are the kind of people that will go out and make a difference by practicing in the communities in which he's from.

We've also supported statewide initiatives such as the American Public Health Association and the California HHS [Initiative] to Eliminate Racial and [Ethnic] Disparities [in Health]. Really, the starting point, hopefully, of this multisector initiative will look at California-specific Healthy People 2010 goals.

A lot of the good state programs that we have now overlap with education. As a health funder, I think we are working on how do you define that and make it a specific health concern? When you look at the workforce, they have to be trained somewhere. We are trying to promote strategies that look at the education and training of enough providers to meet the demands of the field, particularly strategies looking at how do the transitions between community colleges to CSU systems, to UC systems, how do you push students all the way through this trajectory? And then, how do you strengthen the academic preparedness of students of color? Without this, there's a disadvantage when applying to get into these kind of health professional schools. Strategies such as post-back programs, summer enrichment programs, and standardized test preparation are things that we're trying to fund.

I leave at least three priorities that I can suggest to consider and which I hope we can be a partner in in funding. One is to make the reduction and elimination of health disparities an explicit state priority. I think by establishing measurable statewide objectives, which we can look at programs year to year as to how they're achieving their goals, is one of the ways we can do that.

Another one is develop strategies that address workforce diversity, emphasizing the elite professions like doctors and nurses; but also looking at allied health professions, like lab technicians and medical assistants, where a lot of people enter their field and then can advance from there.

Finally, to replicate models that address health disparities based upon their track record to underserved communities. There are a lot of individuals, organizations, and coalitions – many in this room – who have been doing this work and addressing health disparities for many years, and these are the people which we need to tap into and support.

Thank you.

**SENATOR CHESBRO:** Thank you. Senator Ortiz has stepped out of the room for a moment. I'll make a comment – got to keep the discussion going – and then we'll move on to the next speaker.

First of all, I really appreciate the focus on rural California. As I said earlier, there's a crisis all over the state, but I think it's particularly in rural areas. Because of the numbers, it doesn't get the attention that it deserves, we welcome any focus and attention on those particular issues.

The other thing I wanted to mention is I've been talking to the Workforce Investment Board folks and Employment Training Panel folks about the idea of these healthcare professions – the less elite is the term you used – as career ladders in trying to get the education and the training folks and the employers thinking. It might be hard to attract some folks to be stable in some of those lower rungs of the ladder, but if they're viewed that way as rungs that can help people climb up and get training as they work through community colleges or through training programs, then it can provide upward mobility as well as an incentive for talented younger people to go into those professions.

I'm not sure exactly how that looks, except I want to get those folks talking to each other, and I just want to plant that seed since you're the sort of catalyst foundation-type folks. That's something I encourage you to be thinking about as well.

**MS. CHYNOWETH:** Thank you.

I'd like to introduce our next speaker, which would be Bonnie Armstrong, from the Casey Family Programs.

**MS. BONNIE ARMSTRONG:** I'm Bonnie Armstrong, from Casey Family Programs. Casey Family Programs is maybe the least well-known of the Foundation Consortium members, so I'll give you a quick understanding of who we are.

I'm the director of Advocacy and Community Development for our west regional office which is located here in Pasadena, California, but we cover the states of Arizona, California, and Hawaii. I figure I got the real hardship post in the organization.

We're a national foundation, established in 1966 by the founder of United Parcel Service, but we are sort of the other Casey, the one most folks don't know as much about because we are an operating foundation. We actually work with our own money and the communities in which we operate, rather than being primarily a grantmaker. We are primarily an operating foundation. Our mission is to support families, youth, and children to reach their full potential. In more than thirty locations nationally we provide an array of direct services to children and youth and their families who either are in foster care or have emancipated from foster care. The child welfare system is really the area of the world that we work most closely with. That includes foster care, it includes other permanency options, and, most specifically, it includes transition services; services to those young people who are transitioning out of care into a successful adulthood.

Much of our work is accomplished through collaborations with the public sector and other private sector organizations. In California we happen to have operations in San Diego, in Los Angeles County, and in Sacramento, where Mookie works, and also in the Bay Area. As I say, the regional office is in Pasadena.

I'm here with my colleague, Mookie, to bring forward the issues that have to do with children in the child welfare system that were addressed at the California Policymakers Institute, and then to describe a couple of service delivery models that we have found are working quite well to improve access to health and mental health services to kids and youth who are in the system.

The Institute discussed data that clearly demonstrated the disproportionate prevalence of African American children and Native American children in the child welfare system in California, and we have found this same phenomenon across the country. In fact, it is one of the priority issues that Casey nationally is addressing. We aren't exactly sure what's causing it. The research is not conclusive, so we are working with researchers across the country to get a better handle on what is causing it. Of course, we will be working with the child welfare system in California in that process.

In July 2000, in California, you were five times more likely as an African American child to be in foster care than the norm. You were six times more likely than if you were a white child, and twice as likely if you were Native American. Interestingly enough, if you were a Latino child, you were just under the norm. All the numbers are in the testimony that you have before you, so I won't go through all the numbers.

Kids come into the system. African American young people come into the child welfare system at about twice the rate of other children, so that doesn't answer why they're five times more likely to be in it later on. We've got a lot of work to do on figuring out why that is. We're ready to work with you and with your state department, as well as people across the country, to figure that one out.

The disproportionate representation of children of color in the system is important to today's discussion about health care because we all know that children and youth who are in the child welfare system are very likely to be children whose healthcare status and mental healthcare status is poorer than children who are in the general population. It is for that reason that we bring it to your attention.

**SENATOR ORTIZ:** It really calls for specialized, focused kinds of things beyond the entry kind of health care, but rather, ongoing counseling, mental health services, etcetera.

**MS. ARMSTRONG:** Exactly right. Most of these children will have experienced various forms of childhood trauma, and most of them will not have been well served while they were in our care as a system. We have lots of work to do in this realm.

Then, of course, we put all of that before this wonderfully diverse group of folks at the California Policymakers Institute, and they came out with some very interesting recommendations, which you have before you. School-based and community collaborative services were highly valued by that group of people, and I find that very interesting, that the common theme among the recommendations that were made by that group was that existing resources needed to be strengthened and made more accessible – "accessible" meaning linguistically, culturally, affordably, transportation-wise; all of those ways – and then be well coordinated to be utilized within the community where the children live.

People were, by and large, not asking for "We need a whole bunch of new programs. What we need is what we have to be done better and better coordinated

and closer to home." I think that we really need to listen carefully to the themes that came out of the Policymakers Institute from that standpoint because it's a lot less expensive to do it the way they're asking us to do it than it is to try to reconstruct a whole new infrastructure.

I want to suggest comprehensive, school-based mental health services and comprehensive, school-based health services as one of the things that we have worked with, one of the kinds of modalities that we have worked with, that are meeting these needs in some school districts. As I say, our regional office is in Pasadena. We have worked with the Pasadena School District to provide mental health services there. The Los Angeles County Department of Mental Health and several local nonprofits are providing school-based mental health services in that school system. There happen to be about 1,300 children in out-of-home placements in that school district at the same time, so it's a way of providing easily accessible services to those children in out-of-home placements as well.

The clinicians are located on the school site, although they're paid through county mental health contracts and through local nonprofit organizations. There happens to be an article about it in the same journal, so you can get more detail there.

Again, back to the testimony from earlier this morning, the funding of the indigent child, who is most often the child of a working poor family, is a dilemma. It is difficult to look to philanthropy to fund those children because they are, clearly, a long-term sustainability issue. We raise that for you. This particular program has clearly shown that students improve attendance, improve behavior, and improve class work when they have that kind of support available to them right there and accessible.

Now, as they go through the system and age out of the child welfare system at age 18 – I know the California Youth Connection has spent time with you. I know that you're familiar with all the statistics about homelessness and the various ways in which we don't meet the needs of youth as they transition out of the system. We won't go back over those things. We will congratulate you for having acted as a good parent, an appropriate parent in this case, providing the Medicaid option to students up to age 21 and stipends as long as they're involved in their emancipation plans. Thank you very much. But it does take very special service delivery models to keep those kids involved and getting access to their services.

I'd like to introduce Mookie Abdullah, who used to be one of the people who came out of care, who is now working with us at Casey here in Sacramento, and has been involved with our Pasadena Alumni Center in Pasadena and with the work we're doing here in Sacramento.

**SENATOR ORTIZ:** Thank you, and welcome.

**MS. MOOKIE ABDULLAH:** I'd like to let you know that I do appreciate the opportunity to speak to all of you today.

My name is Mookie Abdullah, and I'm a 21-year-old former foster child of Sacramento County. I was in care from age 4 to 18.

My experience with health care, living in over thirty-seven different homes, which is a high number, so don't think that that's the norm – probably half of that would be the norm – I did, however, manage to receive health care. However, being a foster child, I had to advocate often for myself to receive health care, even though health care was provided to me through Medi-Cal.

One of the benefits that has been offered to me, or has been made available to some youth, as the youth in the Pasadena School District, is health care and mental health services. Those are definitely a wonderful opportunity for foster youth. Being that I did live in over thirty-seven different homes, I only went to four high schools. These are numbers, but the fact is that I managed to make it to school. I did graduate with my class and on time. So, the opportunity to go to school every day, which is something I will do – I may not have the same bed every night, but I would have gone to school every morning – and school-based health care was really important for me as a foster child moving through transitions.

Also, many foster parents are single-parent homes. They have numbers of children of different ages and different schools and they do not have the opportunity to transport a youth. Having the health care at the school also made it an advantage to a foster child with limited transportation.

Also, it provided healthcare education. As we do know, some parents tend not to speak to their children about health care and health-related issues. Foster parents really don't think to speak to their not-biological children about those issues. Having it available and confidential, youth-friendly, and accessible at school makes it a lot easier for a foster child to be educated on their own health care in which they have to advocate for themselves very often.

Also, health services assist us in care. I was in care and then I emancipated at age eighteen, having Medi-Cal health care to being not eligible for Medi-Cal health care, due to the fact that I was employed at a job. I do not have children so it put me just over into share of cost. I was very grateful to know that the former foster children behind me have now been offered the opportunity to extend Medi-Cal with no-share cost. That's definitely wonderful.

However, even now, as I am an employed person with benefits, there still are a lot of things that are needed for other transitioning foster youth, ages 18 to 21 – or 24, for that matter. It's necessary that we still have them educated about the insurance and those kinds of things. It's very difficult that if we don't learn it in school, it becomes twice as hard when you're out of school. You have no parents at all to advocate for you or to even help you understand how medical is supposed to work.

One of the other services that is definitely needed and would assist youth, both in care and out of care, is case management. As I said, I was in care from four to eighteen. Thirty-seven of those homes have been during that time, so at age four, if I was allergic to oranges, which I am, my foster mom may know it tomorrow but the next one may not. So, case management is definitely necessary with doctors and those kind of things, providing the kind of health care that will stay attached to the foster youth.

I would like to speak to you about how the transitional services centers have been able to help foster youth get over the barriers that I have explained regarding the uneducation about insurance or health care, the no share of cost, and case management. Pasadena Alumni Support Center, which is a Casey-designed program, designed by former foster youth with Casey and partners, has been able to help foster youth get the needed health care or understand the needed health care by providing youth mentors or youth advocates who are also former foster youth to help them go through the loops of the healthcare system. They also have a part-time Medi-Cal staff there on site and computer information, along with social events and cooking classes and other things to help health education. This system seems to work very well. It's very youth-friendly. Youth do not have a problem going to these centers because they are youth-friendly.

As an employee of the Sacramento Employment Training Agency, which is a collaboration with Casey Family Programs here, I am a member of the Great

Start/Young Adult Program, and that is a program very similar to the Pasadena Alumni Support Center, which we also help make sure that youth are aware of the Medi-Cal extension with no share of cost. We're trying to get youth aware of what services are out there, and it's made it a lot easier for youth to walk into the welfare office or the appropriate buildings with the understanding of what they need to do and how to do it. It has made it very easy for youth to utilize health care.

**SENATOR ORTIZ:** Quite impressive. I know that you've been profiled a couple of times here locally and pretty impressively. I've heard you before committee, and there's no better voice for the challenge that foster youth have while in the system and at that point where they have had to drop off in the past with no support base. I know the statistics are so incredibly sobering when you look at within six months most foster youth are homeless. Statistics of having graduated from high school, you are the best person to deliver that message, that it's difficult. I commend the Foundation for establishing the centers. I'm real curious, just in terms of locally, the Great—?

**MS. ABDULLAH:** Great Start/Young Adult.

**SENATOR ORTIZ:** And that's a local model through SETA?

**MS. ABDULLAH:** Yes. There are four sites that we utilize through the Sacramento Employment Training Agency, which has collaborated with Casey Family Programs, Department of Human Assistance, Department of Human Health Services, and Sacramento Housing and Redevelopment Agency. Basically, we are employment-based services that provide healthcare assistance, educational opportunities, and housing opportunities to transitioning foster youth, with youth specialists.

**SENATOR ORTIZ:** How do you track to assure that those youth who are in Sacramento County who are entitled to this, how do you track them before they fall off?

**MS. ABDULLAH:** We have collaborated with the Department of Human Health Services which runs the Independent Living Program, which has already been assigned to hold and case manage foster youth, ages 15½ to age 21. Our program, however, extends to age 24. So, we do collaborate with them, and when they get a youth, they're co-enrolled with our program so that we can help them in summer job programs or employment when they transition.

**SENATOR ORTIZ:** Please have someone in my office or someone in your office invite me over there. I'd love to see the on-hands operation.

**MS. ABDULLAH:** We have four sites throughout Sacramento.

**SENATOR ORTIZ:** Let's look at all of them. Thank you so much.

Questions? Senator Kuehl.

**SENATOR SHEILA KUEHL:** Thank you so much.

I also wanted to express my praise. I apologize for coming in late on your testimony. We keep being called out to talk to people that are far less interesting.

The foster youth in Los Angeles County have also organized. I think it's one of the most effective new movements in terms of grassroots organizing. The Liberty Hill Foundation in L.A., on whose board I'm pleased to serve, just gave a grant, albeit small, to a group of – I don't know if you'd say formerly foster youth or foster home graduates, I guess is the way we say it nicely—

**MS. ABDULLAH:** Alumni.

**SENATOR KUEHL:** Yes, alumni. Exactly. To do the kind of organizing that's necessary to bring all of these different sets of issues – not only the healthcare issues – to the attention of the appropriate groups and places.

Is there a grassroots organization of foster youth alumni in Sacramento as well?

**MS. ABDULLAH:** I am also a member of the California Youth Connection, which is built for and by foster youth, current and former, ages 14 to 24. We also have adult supporters too. We are a legislation and policymaking group of young people who try to help and better and support the foster care system throughout the state. Our headquarters is in San Francisco. We do have a chapter here in Sacramento. Also, we have a number of chapters in Los Angeles County.

Even though I am an employee of the Sacramento Employment Training Agency, Casey Family Programs, as an operating foundation, does believe in instilling their theories and philosophies in all of their employees, whether they're collaborative partners or not. One of the things that is unique to both of our partnerships, Pasadena Alumni Center and the Great Start/Young Adult Program, is they were both formed with and by foster youth on the beginning decision-making and the end decision-making. I am an active member and partner in the Great Start/Young Adult Program as are the youth in Pasadena.

**SENATOR KUEHL:** Thank you.

Madam Chair, is the issue of the portability of health information of foster youth still a burning issue and unresolved?

**SENATOR ORTIZ:** I don't know specifically. I know we've had some good news this year with maintenance of some of the bridge programs, especially to health. I don't know about the portability issue. Maybe Ms. Abdullah can speak to that.

**SENATOR KUEHL:** I don't mean of health care coverage so much as I mean of health records.

**MS. ARMSTRONG(?):** I don't think the news is all that good, but they are testing in Los Angeles – as you know, the Smart card – which hopefully will improve things greatly.

**MS. ABDULLAH:** Locally, the Sacramento Office of Education—

**SENATOR ORTIZ:** Sacramento County Office of Education?

**MS. ABDULLAH:** Sacramento County Office of Education, along with a lot of other partners, has been working ... (inaudible).

**SENATOR ORTIZ:** And I'm sure Youth Connection is going to visit us once again, as they always do and which you should. (Response inaudible). Wonderful. I look forward to it. It's always impressive to see.

**MS. ARMSTRONG:** May I let Senator Kuehl and Senator Vincent also know that ... (tape turned – portion of text missing) ... program that the board of supervisors in Los Angeles County has just voted to pursue is a wonderful example of taking something that philanthropy did on a small experimental basis, like the Pasadena Alumni Support Center. The board has now decided that this model is a good one, as a delivery model, for this kind of service countywide, and so these kinds of centers now will be created across the county. We're working next on one in Long Beach, as a matter of fact, which may well be opened by the end of this year, and then they will be opened across the county. We're working in partnership with the county.

**SENATOR ORTIZ:** Thank you.

I was out of the room and was unaware that Mr. McCandliss had yet to speak, and I apologize. I thought we were going to move into the next panel, but I really think it's important that we hear from Mr. McCandliss.

We're going to close with "The Role of Data in Policymaking." I think we've run a bit out of time, but I don't want us to lose Members, and so I would encourage everybody to try to be brief. I've been a very bad chair because I haven't moved people along.

Welcome, and please, those of you who are yet to present, keep that in mind.

**MR. LEN McCANDLISS:** Good afternoon. I'd like to echo my colleagues by saying thank you for this opportunity. In some ways this is a breakthrough opportunity, I think, for foundations to address the Senate and may hold promise for us in ways we can work together in the future, and I hope that turns out to be the case. Thank you for your leadership, Senator, in this.

**SENATOR ORTIZ:** You're more than welcome. Thank you.

**MR. McCANDLISS:** My name is Len McCandliss. I'm the CEO of Sierra Health Foundation.

We are a foundation that concentrates in northeastern California. We fund in twenty-six counties of northeastern California – a very rural area in the main, as Senator Chesbro mentioned – and we support the notion of the importance of this part of California.

We've been in business since 1984, and we have found a variety of ways to try to fund and support access and insurance issues, often through the support of clinics, through capacity building efforts such as capital expenditures, business practices, and other kinds of developmental activities. But we also have moved into a community development strategy which we think can help address access issues. Our program is called Community Partnerships for Healthy Children. It's been a long-term – in fact, we're now in our ninth year – commitment of $20 million to this activity. While we believe and support all the continuing issues with regard to clinic services and access issues, we think that this can be a complement to things that are going on. Community building is a constructive and promising approach which capitalizes on the resources and social capital that are in the communities that we care about.

Several references to the current economy have been made. This program was started also in the early '90s when the California economy was a mess, health funding issues were extent and under national debate, and we were looking for a way to do something that we thought could be inexpensive and utilize the existing resources in communities. So, we crafted this strategy and have struggled to perfect it.

I'd like to point out that we think the strategy itself has no particular boundaries. We think it works in rural areas; we think it works in urban areas; we think it can work in all of our communities, and we have one community in particular we'd like to have focus on today. Amy Studdieford is the coordinator of the Cordova Community Collaborative for Healthy Children and Families. She's a leader in her

community, and she can best describe how they've taken this program and translated it into better access there.

**MS. AMY STUDDIEFORD:** Thank you, Len.

Thank you for this opportunity to speak. My name is Amy Studdieford, and I'm from Rancho Cordova, which, if you're not familiar, is eight miles east of the Capitol, and it's a community that's very diverse and has a lot of low-rent apartments. We have an area that has its own share of problems that affect the health of the people that live there.

When I first became involved with the Collaborative, the group was focusing on preventive dental care and increasing immunizations for children. We were really looking at the children, and we did a needs assessment and found that it was really important that we look at the whole family. That would be the central issue that we needed to address, and we began the process of identifying resources and gaps and then collecting data.

Besides our community members, the White Rock Clinic, funded by Mercy Health Care, was identified as our number one resource in our community. It became our bridge between the community and resources. White Rock is a free clinic for the uninsured and has been serving the Rancho Cordova community since 1994. It is located next to White Rock Elementary, which is also a Healthy Start site. It started out as Healthy Start and is now sustained through private funds. It has a multicultural client base. Forty percent are Spanish speaking, and 10 percent are African American, and 5 percent are Russian/Ukrainian. The clinic did a survey and found that 40 percent of their clients that they serve were eligible for county services, and another survey that we did as a collaborative was at our annual Kids Day event. We interviewed 158 residents, and 51 percent had used the emergency room in the last year, and 32 percent had used it twice in the last year. Also, they reported that 20 percent had difficulty in obtaining transportation to their medical care. As you're aware, that can be a barrier to care.

The Collaborative decided it was time to take action on behalf of its residents and invite decision-makers to a problem-solving discussion to try to create a partnership that would improve clinic access in the community. It was a fruitful discussion. We're currently negotiating with Sacramento County Health officials and Mercy Health Care to start a pilot project that would expand our current community

resources and increase the number of people served at the clinic. I was glad to hear what you were saying about building on existing resources, because this would increase the level of staffing at that clinic and the hours of operation to accommodate those who work during the day. We're in the very beginning stages but are glad to have the opportunity to speak about it today.

The Collaborative's role is to bring those partners to the table. It's an essential role in our community, and we act as a facilitator and a vehicle to bring that voice out in front so people will listen and create an impetus for something to happen. We are continuing to work on this partnership and need the continued cooperation and flexibility as we combine large organizations to work together. We're very appreciative of Mercy Health Care and the county in being flexible in persuading them to make adjustments.

I thank you for this opportunity to tell our story today.

**MR. McCANDLISS:** Thanks, Amy.

I will close by saying that a key element of these kinds of community development strategies is evidence, and those of us who care deeply about this are looking for that compelling evidence to prove the case. This fall we will be having a national conference around community-building strategies and the outcomes associated with them. You all will be hearing more about that because we think the critical issue in producing and promoting these programs is demonstrating their effectiveness. So, we'll have another chance at that.

**SENATOR ORTIZ:** Great. I look forward to visiting the Collaborative. It's a new part of my district that I'm picking up. I'm picking up part of Rancho Cordova. I look forward to it. I was out there for the bond kickoff for the school bond. It's a great community, and I would welcome visiting the Collaborative with my district staff so we can help be part of your collaborative efforts.

Thank you so much for your presentation. This is so valuable. I wish we had more Members to look at the innovation. I just thank you for all that you're doing. It is the gap that we look to, not just for funding but also for new ideas and resources. So thank you, all, for your presentation. Please, let's schedule my visit to the program here locally.

We have our last group of speakers before the closing last panel, essentially the second to the last, and it's really focusing on the role of the safety net. I would

welcome the participants who have been so patient to wait until the end of a very long informational hearing: Ms. Castellano, from the California Primary Care Association; Mr. Wulsin will be joining us once again on insuring the uninsured; as well as Mr. Michael Mahoney, from the St. Rose Hospital.

Welcome.

I apologize. It's late in the afternoon. I hope we can move through your presentation quickly so we at least have Members here besides myself to raise questions. Lots of valuable information for us.

Ms. Castellano, I believe you'll be first.

**MS. CARMELA CASTELLANO:** Thank you, and thank you for convening this hearing today. It was very impressive to see the major foundations in California represented at this table. Thank you for doing that.

**SENATOR ORTIZ:** I thank them.

**MS. CASTELLANO:** I'm going to speak today on the role of community clinics and health centers in the California safety net in providing access and healthcare insurance in our state.

The California Primary Care Association is a statewide association of 500 nonprofit community clinics and health centers that serve as a safety net for the medically uninsured and underserved communities in our state. CPCA was founded to create a unified voice for community clinics and health centers, and our members are comprised of urban and rural health providers, migrant health centers, free clinics, federally qualified health centers, and look-alike clinics.

Regarding federally qualified health centers, or FQHCs, these clinics were established specifically to provide health care to low-income and underserved, uninsured individuals that are located in areas with few providers and with the high low-income and underserved population. What's important to know about community clinics in general, and FQHCs in particular, is that they serve all individuals who come to their door, regardless of their ability to pay, regardless of their immigration status, their insurance status, their language, etc.

Ms. Avram already spoke to some of the funding streams for community clinics, principally in terms of health insurance: Medicare and Medi-Cal, Healthy Families, and a little bit of private insurance – our key insurance programs – and then there's more categorical funding like CHDP, the Expanded Access to Primary Care Program,

and then a sliding fee scale which allows us to provide a minimal fee based on a person's ability to pay.

In terms of our capacity, in 1999 community clinics provided over 2 million encounters just for the uninsured alone. In 1999, in terms of our total patients, there were 2.7 million patients served, totaling 9.2 million encounters throughout the state of California.

Just some quick demographic factors: 44 percent of clinic patients speak a language other than English. We serve over a million low-income children. Maternity care and delivery services are over 11 percent of all our patient visits. And in terms of the minority population, over 70 percent of clinic patients are racial or ethnic minorities, with 53 percent of clinic patients being of Latino origin, which I think goes with what you were pointing out earlier about the uninsured numbers. The disproportionate share of Latinos is also reflected in the disproportionate numbers of Latinos served at our community clinics, which are a key access point for those uninsured families.

In terms of major challenges that our community clinic system is facing, of course, the persistent numbers of uninsured were already mentioned. The issue of the phase-out of cost-based reimbursement, which Ms. Avram mentioned, is a major issue for our FQHC clinics in the state in transitioning to a Perspective Payment System. Of course, the provider shortage crisis already mentioned affects us significantly. And then the whole issue of infrastructure and information technologies for our health centers. Many have been in buildings for over thirty years and are facing major challenges in that arena. Then, of course, the downturn in the economy. We've heard today from several speakers how this is affecting our safety-net providers.

I'd like to briefly touch upon some recent investments in clinics that we have seen with the support of the Legislature and some of the leaders here on this panel. The Expanded Access to Primary Care Program, we secured a $10 million augmentation last session, which I think was a really key recognition by the Legislature and the Governor of the critical role that we play in care to the uninsured which this program provides. The Cedillo-Alarcon Community Clinic Investment Act was a $50 million investment in the infrastructure and capital expansion for our health centers, with grants to be coming out this month. All that money will already be out the door.

**SENATOR ORTIZ:** I was going to say, is there any money available in that fund to date? It's pretty much all been committed at this point?

**MS. CASTELLANO:** Yes. The final round of notices of grant awards are going out this month.

**SENATOR ORTIZ:** So that fifty million was used very quickly.

**MS. CASTELLANO:** It was spent very quickly, and that speaks very well to the efficiency of the Treasurer's Office in getting that funding out quickly.

And then the rural demonstration projects and the rural and farm-worker funding that we have in the state have been augmented in recent years. It bears mentioning, at the federal level, the President's initiative to expand health centers by 1,200 sites over the next five years is a very significant federal commitment and has resulted in, this year, a $175 million appropriation in the federal budget for health center service expansion. As a primary care association, I want you to know we are doing our best to make sure California gets its fair share of those dollars to aid in all these efforts.

Since we were having foundations here today, I did want to highlight a key role that one foundation, in particular, is playing in the state supporting clinics, and that's The California Endowment, who are certainly to be commended for recognizing the valuable role of clinics and making a significant investment. A couple of highlights are: They have committed over $40 million, and already $20 million has gone out the door from The California Endowment through the Tides Foundation for the Community Clinic Initiative, which supports the development of information technology in our community clinics. A more recent investment, their board just approved a $45 million Sustainable Solutions Initiative, and this will assist community clinics in financing their capital needs as well as looking at how to improve their operations. Finally, last year a $10 million commitment was made by the Endowment to support the development of networks in our community clinic consortia at the local level.

So, I think they've really been exemplary in defining clinics as a key piece of our safety net and making an investment. I think, down the line, we'll be able to really see some tremendous outcomes in expanding access.

Ultimately, I think the investments by the Legislature and the foundations are acknowledgement of the potential of community clinics and our role. We are available

to provide preventive care for families. We provide a full scope of services in a cost-effective manner and in the local environment where the communities live. We are a primary point of access for enrollment in the public coverage programs such as Medi-Cal and Healthy Families – involvement with outstation workers, with certified application assisters, onsite enrollment. That's what happens at our community health centers.

When we look at proposals for insurance reform, we, of course, focus on the public programs, such as Medi-Cal, and the issues of the single point of entry, the continuous eligibility for adults, elimination of the assets test, coverage of parents, and Healthy Families. Those are obvious things that we need to support to help health centers serve their population.

Finally, in terms of the long-term viability of clinics, we look to the Legislature and the Governor for making a continued investment in our health centers and their expansion and growth. We need support for important clinic programs and this Perspective Payment System. Transition is something we need to continue to look at, and Senator Chesbro has truly been a champion for us on that issue. We need to look at the continued expansion and improvement of public health programs in general. We are part of the public health safety net and concerned about public health. And finally, raising the awareness of the uninsured and the overall role of safety-net providers is going to be critical as we move forward.

Thank you.

**SENATOR ORTIZ:** Thank you so much. Questions? Comments, Members? We had quite a succinct presentation and I appreciate that.

Next we have Mr. Mahoney. Welcome.

**MR. MICHAEL MAHONEY:** Thank you. I would like to echo the sentiments, I think, of all the speakers of thanking you for having this hearing. I've been saying for some time, as the administrator of an urban hospital in a very diverse community in Alameda County, that health care is in crisis, and indeed, it's in crisis from funding, that you've heard from Deni Martin. I'm not going to go over those figures that she's talked about but to tell you that the situation that we face in Alameda County and the recognition that, in addition to the public providers, there are many private providers that make up crucial elements of the safety net, and if any one of those, either private or public, falls, then I think a lot of people fall.

I know the situation at St. Rose Hospital is not dissimilar from other private providers that serve Medi-Cal. I'm going to concentrate my comments, in light of the hour and time, perhaps just on telling you a story of our community.

Hayward is an extremely diverse community, like the state of California. There is no majority. We suffer from many of the problems that have been talked about. We have over 30,000 emergency room visits every year. Over one-third of those visits, those people have no insurance. We continue to suffer with concerns about disproportionate share, the upper payment limit. Our hospital has lost money for the last four years in a row. We are a small, 175-bed hospital. We are independent. We have a community board of directors. We are owned by a religious order out of Kansas. We are not part of one of the mega not-for-profit systems that exist in California.

While there are threats to us, there are also opportunities, and I would like to touch briefly on some of these opportunities that I think the collapse of the safety net threatens. We've been able to work with our community to decrease the number of children seen in our emergency room over the last six years by establishing a pediatric clinic that has almost 10,000 visits a year. We expanded that two years ago to provide dental services; dental services in a state-of-the-art facility in partnership with rotary clubs and local organizations. It is located in the community in which these people live.

We have established a mobile clinic in partnership with the Hayward Unified School District; a clinic that now goes to eleven different elementary schools, a continuation school, that links with our pediatric clinic to provide access for those on Medi-Cal, for those on Healthy Families, to help enroll people – like others have talked about – to look at what happens in a community.

Many of the speakers before talked about lack of access in rural communities. In Hayward and Alameda County, we're fortunate to have an excellent public facility, Highland Hospital, located in Oakland. But on public transportation from Hayward, it's a three-hour to a four-hour bus ride. So, transportation, while it's certainly an issue in rural counties, is also an issue in urban counties. Health care is often impacted by the inability of people to get adequate transportation. I don't believe anyone here on the committee or in the audience actually believes that a pregnant

woman who's going to deliver can depend on public transportation to take her from thirty-five miles away, where she might live, on to a public hospital.

St. Rose Hospital is threatened, and I would ask all of us here: What happens when our hospital, if it has to, closes? Where do those thirty-some-odd thousand emergency room visits go? Where do those 10,000 pediatric visits go? They certainly cannot go to our public system. It's already at the breaking point. You've heard that from Deni and others.

Funding remains a critical issue. Recently, I was interviewed by members of the board of supervisors in San Mateo County, and I was asked a question that I think we all need to ask ourselves. We don't acknowledge it enough. I was asked a very simple question: Is health care for citizens and residents of California, regardless of their status, a right or is it a privilege? It's funded as if it is a privilege, but many of the legislations I hope move it more toward a right.

We need to look at a comprehensive review. I hope this hearing is but a first. There are solutions we can look to many of our problems. We have an obstetrical staff of twelve doctors. Three of them are under the age of fifty, the others are all over the age of sixty. Physicians will tell you that to come to practice in California is now being called "the Kosovo of medicine." It's not a place that doctors choose to come practice. We know that that also includes shortages of nurses, pharmacists – all of the necessary healthcare professionals.

But there are solutions. Recently, our hospital, with our limited resources, sought out a partnership with the Hayward Adult School. We put advertisements in the local newspaper and local cable access TV to look if there were people in our community who were interested in becoming trained to become a certified nurse assistant. We had, in three community meetings, over a hundred people come and ask if they could participate. We have already graduated our first class of over thirty. We were able to hire ten of them at our own hospital. The other twenty were also able to get jobs.

As Senator Chesbro talked about, there is a need for a career ladder. We're now talking with both Chabot College and Cal State Hayward about how we might expand to LVNs and, hopefully, on to RNs. There are creative solutions.

In addition to being the CEO of St. Rose, I serve on the board of the Alameda Alliance for Health. I've served two terms as chair, and I currently serve as chair of

the Finance Committee and serve on the Strategic Planning Committee. I think you will find no more managed care organization in the state of California that has been innovative in finding ways to provide better access for people and expanding insurance coverage. That is a key.

I'm getting older. I've been around since 1982 and the Medi-Cal Reform Act. I think we have to acknowledge – and I think, Senator Ortiz, in a sense this hearing acknowledges it – that we cannot depend on marketplace solutions to solve the healthcare problems and the people in California. We need to look at how we fund all the safety-net providers and how you can encourage us to reach out and provide even more innovative partnerships.

I'm glad you've had this hearing because I can tell that I know from Senator Figueroa, whom I know very well because she represents us and represents us well, that we are one or two hospitals in our county from having the EMS system collapse. We are in a situation where we have to deal with seismic retrofitting. In the event of a seismic event, one or two freeway collapses, and nobody has access to health care, depending on your location. Health care for the poor, the vulnerable, the dispossessed, happens in their community, and as the administrator of a hospital in such a community, I can tell you that we can't even do that on our hospital site. We've had to reach out in our clinics and in a youth center. We've had to look at mobile responses to work with the school districts. The state of California energy crisis last year, not to be withstanding, we are on the verge of a healthcare crisis that I think would make the energy crisis look rather mild.

Thank you, and I appreciate the opportunity to talk to you. I would like to stress that I'm really here on the behalf of all the private hospitals – and public hospitals – that make up the safety net, and I'm actually, in some respects, inspired by much of the other testimony and the work that goes on, but we need your continued leadership to find solutions to these very difficult problems.

Thank you.

**SENATOR ORTIZ:** I do appreciate your testimony. I actually have a question or two, but I just want to give my colleagues an opportunity.

Let me ask you a question. The system is so overwhelmed and there's so much to do. Based on the presentation, there's good things that are happening with some of the innovation and the models of local programs, but we're also hearing testimony that

there's likely to be a breakdown very easily, particularly in the Alameda model. Two questions for you: One, how long has the Alameda initiative for children been in place?

**MR. MAHONEY:** The Alameda Alliance for Health was started when Governor Wilson and the Legislature passed the managed Medi-Cal reform of some years ago. I think we've now been in existence over six years, so we've been able to expand access. We have about 70,000 members, but in addition to that, through recent studies, we know that there are over 50,000 people in Alameda County who are either eligible for Medi-Cal or Healthy Families and are not enrolled.

Again, there are some innovative ideas being talked about. Supervisor Gail Steele in Alameda County is pushing for the creation of a department of Medi-Cal in the county and to get some of our people in social services to work in teams to go into the community. So, I think there are some solutions, but they need to happen on a faster basis than they've been happening to date.

**SENATOR ORTIZ:** And then the second question: What is the percentage of Medi-Cal population you serve at St. Rose?

**MR. MAHONEY:** Forty-eight percent of our discharges are Medi-Cal.

**SENATOR ORTIZ:** That's not unlike some of the other private and public hospitals, whether you're in the six percent of the system that are public hospitals that are serving or the privates.

I struggle with the DSH model right now and a request by, for example, one hospital who's serving less than 25 percent to ask for an exemption under DSH. The notion of DSH funding is to prevent these hospitals from being financially insolvent. I think it's really important that we tell the story of well above 25 percent that most of these hospitals are absorbing and serving and doing it incredibly well with limited resources. Whatever limited resources are available ought to go to those hospitals.

I appreciate that data and that information. I may come back to you at certain points to make the case with some of my colleagues.

**MR. MAHONEY:** I'd be happy to come back to Sacramento at any time.

**SENATOR ORTIZ:** Thank you for doing a great job.

Mr. Wulsin. You are the last on this panel, and then we're going to have a wrap-up with a couple of speakers. I'm going to apologize to them for the lateness of

the afternoon. Senator Vincent has been incredible staying here, and I do appreciate that because it's valuable information.

**SENATOR VINCENT:** If I could—

**SENATOR ORTIZ:** Please. Are you going to leave? You can't leave.

**SENATOR VINCENT:** No, I'm not leaving. I'm just amazed and dumbfounded by so much of what I've been hearing. I think it's been an excellent presentation by members of the panels who've been here. I'm very impressed by that.

There's a lot of problems. I'm particularly interested in the funding of the indigent child. We've talked about the child welfare system in general – I was a probation officer for many years – and just health access in general. Bonnie Armstrong, director of Regional Advocacy and Community Development and the Casey Family Programs, she made a statement. She said all these problems, we have lots of work to do. Well, that's like an understatement.

Let me say this. We have a chair of this committee in Senator Ortiz that has the interest, the desire, the knowledge, and the leadership, and she's going to make things better leading this thing. I mean, she's very serious about this. So, I want to take my hat off to her for setting this informational hearing up. As a matter of fact, I didn't know anything about it. I think that it should have been mandatory that our whole committee should have heard this. It's very important. The work you're doing, and the work I know you're going to do, we appreciate it. You just lead, and we'll follow.

**SENATOR ORTIZ:** Thank you, Senator. I appreciate those words.

**MR. WULSIN:** Madam Chair, again, thank you very much. I'll be very brief, and you can give me the high sign anytime you want.

I want to make a couple of brief points about a couple of pieces of work we've been doing. The first is with respect to clinics, and this will come out a little bit later this month. The point on the clinics that we're seeing is that over a five-year period of time, the number of uninsured visits are growing very dramatically. The number of Medi-Cal visits have been fairly constant. They don't have a good funding stream to pay for uninsured visits. About the only thing they have at the state level that's significant is the EAPC Program, and that really only pays for about 10 percent of their uninsured visits. That's the point that I think we need to keep in mind about the primary care clinics.

**SENATOR ORTIZ:** So, 90 percent of their uninsured visits continue to be the deficit the clinics are running.

**MR. WULSIN:** They do have some money from the counties to help. The patients put in a little bit. I'm just saying at the state level, in terms of a real funding stream, to support them. They've got about 10 percent of their visits paid for by EAPC.

**SENATOR ORTIZ:** Is that even with the $17 million that's being proposed? Is it seventeen that's being proposed?

**MR. WULSIN:** That's not with the augmentation proposed in the Governor's budget.

**SENATOR ORTIZ:** So, that might make things a little easier?

**MS. CASTELLANO:** That would allow for a significant number of more visits to be seen of uninsured individuals under the EAPC Program, most definitely.

**SENATOR ORTIZ:** Hopefully, this testimony is going to come back when Senator Chesbro convenes our Budget subcommittee hearings on Health and Human Services, because we're going to be looking very closely at the shifting around that's proposed by the Governor to see if it comes anywhere near the demand.

Thank you. Please continue.

**MR. WULSIN:** I want to make a couple of comments with respect to the county programs. What we have to keep in mind is, number one, realignment in a recession is not growing. Prop. 99 has been a declining revenue source. The counties with public hospitals have been heavily dependent upon DSH funding, which is not exactly a growth revenue source. SB 1255 has been the only place that they've been able to make up for it.

Now, there really are three different types of counties here in California, and they're facing very different experiences. The first that I want to mention is the CMSP, or County Medical Services Program, which are primarily the very small rural counties with less than 300,000 population. In most of those counties, you are facing a program which has been an excellent program but has not been able to reach much in the way of primary care and has no DSH funding supporting it. At least in the ten counties we looked at in Northern California, we could find no evidence that the hospitals in that region were getting any DSH funding to help pay for their care to the uninsured.

**SENATOR ORTIZ:** Was that because they weren't applying? They hadn't met the 25 percent?

**MR. WULSIN:** It was because they don't meet the thresholds. If you don't have enough concentration, and it's spread out amongst all the other hospitals, you don't have that as a funding stream.

Secondly, there's another set of counties – the counties such as your own – which don't have a public hospital. They, again, are dependent upon realignment and Prop. 99. What you're seeing in the two counties that we've looked most closely at, which are Orange and San Diego, is they're reaching about 40 percent of their target population.

**SENATOR ORTIZ:** So, 60 percent of their target population is not being served?

**MR. WULSIN:** Is not enrolled in their programs in getting care and services.

**SENATOR ORTIZ:** Anywhere, or through ER.

**MR. WULSIN:** Those counties do have significant DSH funding that goes through the University of California hospitals and some of the others, so they do have some DSH funding to really make up for this. So, there is some federal money there that's not available in a lot of the small rural counties.

**SENATOR ORTIZ:** Let me state that another way. In Sacramento County, we don't have a very developed clinic system by any means. We have the UCD Med Center, which used to be our county hospital, but it is our primary provider of indigent care. You're saying their major sources of funding are—?

**MR. WULSIN:** Are realignment, Prop. 99, and DSH; all of which have serious problems.

**SENATOR ORTIZ:** Right.

**MR. WULSIN:** In the public hospital counties, the data we've seen says that they're able to reach a much larger percentage of their uninsured population in terms of delivering care and services than the others, and that they're able to stretch the dollars much farther. That is, in large part, because they're able to get the DSH funding and the SB 1255 funding.

**SENATOR ORTIZ:** So, that's Los Angeles, San—

**MR. WULSIN:** Los Angeles, Alameda, Kern, San Joaquin, San Bernardino, Riverside. Those counties are facing exactly the same problems as the others are in

terms of realignment, DSH, and Prop. 99, but on top of it, they're dependent upon their success in competing for Medi-Cal patients because much of the money is driven, associated with their ability to compete. They frequently are not able to compete effectively, so that adds another set of pressures that are unique and different to these set of counties than the others.

So, I'm saying that there are three types of counties. Each of them faces severe problems, but they're different kinds of problems, and you have to look at somewhat different solutions.

**SENATOR ORTIZ:** And you're going to give us the three different solutions here today?

**MR. WULSIN:** No. I'm going to say that over a longer period of time we need to look at the possibility of asking the federal government for an 1115 waiver to cover this unlinked to Medicaid population through Medicaid. Massachusetts has one; New York has one; Oregon has one; Arizona has one. California could think about applying. You've had a bill on this. Assemblyman Richman and Senator Figueroa had a bill on this. It requires a lot of work for us all to think through these problems. I'm not saying this is a solution for anybody this year, but it is something we have to look at over a longer period of time to see if it does provide some answers for some of these difficulties.

Thanks very much.

**SENATOR ORTIZ:** Thank you for your testimony. I do appreciate it. We'll all be coming back to – I know I will – for more information, so thank you.

We are at the last group of speakers, essentially the role of data in policymaking, and I'm going to invite Ms. Chynoweth back, of course, as well as Mr. Theodore Lobman. Thank you for being so patient. I know it's been a long afternoon. Hopefully, you've gathered more information and more data that will help bring innovation to other applicants and grantees.

**MS. CHYNOWETH:** I'd just like to say, in addition to being – well, Ted will introduce himself – but Ted is also the chair of the board of the Foundation Consortium.

**SENATOR ORTIZ:** Wonderful. We're honored to have you here. It's a pretty powerful group that you're chairing.

**MR. THEODORE LOBMAN:** Well, that's a matter of opinion. (Laughter.) I figure maybe it's all right to be a little lighter than some of the others.

**SENATOR ORTIZ:** Please do.

**MR. LOBMAN:** I'll do my best.

**SENATOR ORTIZ:** We've had too much sobering information throughout the day.

**MR. LOBMAN:** I grew up in New York, so if there's a little edge to the humor—

**SENATOR ORTIZ:** That's a good thing.

**MR. LOBMAN:** First, I wanted to say that the Consortium itself is a diverse group. The one thing that holds us together is the belief that collaboration, not just among ourselves but across the various helping systems, is essential, and that's part of the introduction to this problem of data and good analysis to make decisions about how to create these programs across the systems.

I'll also say, in expectation that you're not as familiar with the foundations as you might be, foundations normally don't collaborate. Foundations are large bodies of money, surrounded by people who want that money, and such institutions don't naturally collaborate with each other. It's very different from politics. Foundation people focus on ideals – what's right. It's full of people with fire in their belly, which is not unlike the Legislature, but our disposition to cooperate and share and shave this, it's much weaker in our system. Yet, we're all on the same page because of the kinds of changes we want for children and family and the services to children and family and also the ways the communities organize themselves to help children and families apart from services. It's quite a bit of consistency but we take a very different approach. As a couple of the other speakers said, we don't have a whole lot of money. What we like to do is think of ourselves as a source of capital for innovation. Innovation is nearly useless, except for the information that the innovation provides, which is another introduction.

In 1985, when I joined the Stuart Foundation, I had two experiences almost right next to each other, and I'm going to juxtapose them because they help me make the case that the condition of data and information for decision-making and health is so much better than it is in social services and even in education – and even in education when the Governor's accountability system is complete.

I went to a meeting where an individual was talking about value added in hospitals. He was talking about liver diseases. He said that his particular consulting organization had studied liver disease in a number of hospitals and discovered, of course, that some hospitals got much better results than others. But when they accounted for the age of the patient and the severity of the presenting condition, hospitals that were thought to be really quite weak in terms of overall outcomes were actually producing the most value for patients.

A few days later – this is a true story – I visited an elementary school in San Francisco and said, "Is this is a good school?"

"Yes. Our test scores have risen."

It was also a school with quite a bit of mobility. You can imagine a great many of the schools that lead the public to think that the public education system is not good enough – or, worse, failing – have high fractions of mobile students. That kind of goes with poverty.

This woman had never thought – a distinguished principal, I must say – this woman had never thought to ask the question, What's the probability that children that start at a particular point, whether it's reading, math, or even behavior, if you will, end up at a certain point when they leave the care of that faculty?

Another consideration: With so many schools, and particularly the schools that are helping shape public opinion, full of mobile kids, and then you have this other question – Should you hold schools accountable the same way when the children in those schools are differentially in that school? – mobility is not only a risk factor for children. You change the curriculum, maybe you change friends, maybe there's a difficult family situation at home. Mobility is a risk factor for a school. It's much harder to run a classroom, as you can imagine, when kids are coming in and out.

By the way, I'm emphasizing education here. Health is not my field; education more so.

The accountability systems we have need to account for the resources that people have at their disposal to work on these problems. One of the things you find in education is this amazing gap between powerful advocacy based on intuition and emotion for certain programs – I'm sorry Senator Vasconcellos isn't here because he lived through this in the self-esteem age – and the actual sources of information that might lead you to believe that program X, Y, or Z, whether it's an academic program, a

social program, or a clinical services program, actually contributes in some fashion to outcomes for these kids.

If you go way back, you find these terribly powerful but tiny studies of early childhood education done under the Head Start rubric. Powerful findings you know because the business community jumped on them in the mid-'80s and helped make it possible for committees like yours to create a very large state – and, of course, a huge federal – program. And what did they find? They found that the academic benefits of these Head Start programs attenuated by fourth grade. "Let's cut them," say some, but they also learned, because the studies were longitudinal, that these very same kids had far fewer Special Ed. placements and, longer term, they were graduating. And given all of that, guess what? Lower divorce rates, higher marriage rates, less time on welfare.

**SENATOR ORTIZ:** That's true in _____.

**MR. LOBMAN:** Right. All of the sequelae from a good start.

So, instead of learning from the great power of these longitudinal studies and building in to our health, our social, and our education service systems the capacity to produce that information when somebody says, "This intervention works," we haven't done it.

Len McCandliss said that he really wants to show that these community development approaches to getting people adequate health care actually work. Well, guess what? Those very same approaches should help reduce crime, and there are a fair number of people who might not care much about health access but who might care about spending on the criminal justice system. Do we have the capacity, either locally or through state-managed systems, to produce that information? We don't.

So, what happens is foundations like ours that get interested in innovation, and then a smaller fraction of foundations who might be interested in innovation who are also willing to spend a lot of money on evaluation, step in. What do we find? In order to create a decent evaluation, first of all, I have to spend more on the evaluators than you do on the intervention sometimes – boards don't like that – and second, you find that these guys have to recreate data that social services, health services, and education services ought to have right [snapping sound] like that, encrypted for privacy and ready to package. This isn't there.

I guess what I'd like to close with is a simple statement that all of us talk about how much we want to decide what works and then replicate it. We can't do that in an efficient way without better data systems and that those data systems need not only to be sufficient within child welfare, within juvenile justice, education, and so on. It's not only that we need, right at our fingertips, to be able to see whether programs like Casey Family Programs in schools are actually producing higher graduation rates and later on we ought to be asking good questions about how these kids fared in postsecondary education, but we also need to create these systems in a way that make it possible for the practitioners inside the systems to use them.

Accountability is all the rage today. People have been, for many years, sufficiently frustrated with government that they're calling for more accountability, and the light has shown off of the use of data for purposes of continuous improvement. People inside these systems need the data. They need the data to diagnose, to decide treatments, and, of course, to purchase treatments.

I'll just close with the thought that the medical system, the health system, in our country, for all of the problems we heard about today and for all of the aspirations that are unmet, has a much higher level of confidence and prestige than the social and the educational systems, and I believe that's not simply a political matter. I think that has considerably to do with the extent to which there's a scientific culture in those systems. We've been doing it from the heart and from the gut in social services and education for too long. We've got to catch up. Although this is not the year to spend a couple hundred million dollars on building a data system, I would hope that members of this committee, and, of course, others in our own foundation community, will become advocates so that this might become possible, at least within a generation.

Thank you for your time and, again, for the opportunity you afforded the Consortium to speak with you.

**SENATOR ORTIZ:** Thank you. I'll save my comments on your presentation until Ms. Chynoweth finishes.

**MS. CHYNOWETH:** I just want to say thanks again, Senator, and to the committee members, especially those that were able to stay with us. I understand why others have to go.

I think, in closing, I just want to say what I've heard today is that there's nothing that foundations can do with the amount of resources that we have at our

disposal to replace the fundamentals – the fundamentals of good health care, access to insurance, and funding the safety net. Those are things that I think we count on to be in place.

However, the foundation community can add value, can stretch dollars, through innovation, through collaboration, and build on the assets of the fundamentals that a state puts in place, and link those assets to populations that are the hardest hit. That brings me back around to the disparity issue and the role that foundations and private dollars have to play, linking and holding hands with public dollars to try to make these outcomes better for populations of color and other special populations in California.

Thank you so much for your time and attention.

**SENATOR ORTIZ:** Thank you.

Before I do my closing comments in general, I want to share with Mr. Lobman that I think there actually is a greater focus with the policymakers – and unfortunately, we are the policymakers as politicians – in the areas of education and health care in general. There's a greater focus on that data and the outcomes and the measurement even if it isn't apparent to the outside world. Primarily, it's a function of our need to leverage scarce dollars and a bit, I think, of cynicism with the old models.

I know when I was in the Assembly and introduced the legislation to establish the statewide after-school program funding, and it was a very strong bipartisan measure and it presented the model of then K through 6 – it's now middle school year – in order to get that bipartisan commitment and in order to get further along than traditional models of after-school programs that may have been local models, we knew that we had to build in measurement mechanisms to measure. Of course, how do you measure the success of after-school programs for children who are defined? Fifty percent or more of the children are in free or reduced lunch programs, and that was our demographic target. It was things like reducing truancy. It was things like higher attendance rates. It wasn't going to be right away – you know, simply improvement in reading scores in six months – but all those factors.

I think we as a Legislature have an obligation to continue to look at the data and the outcomes and the measurement of these models in ways differently because we have very scare dollars and we're making the case for long-term committed investments. Another area that I'm really hopeful I can get that last vote on a two-

thirds vote majority is on preschool for our at-risk children because it brings them up to pace. That is so critical when they enter kindergarten. We absolutely have to look to the means of measuring the success however we choose to define it in these programs. It's essential to the programs, it's essential to the integrity of the policymaking process, and, quite frankly, it's essential to the success of California.

I'm going to look closely at some of the recommendations on that data gathering, and, hopefully, we can come a little closer to making that the norm.

With that, unless there are other questions or comments, I want to thank everybody for being a part of such valuable information. I know I'm going to take it away and hopefully read through most of it. I thank the Members who were here today and certainly Senator Vincent. He's been just a prince in this. Thank you all.

This meeting is adjourned.

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# WRITTEN TESTIMONY

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# PARTICIPANTS

**Northern Sierra Rural Health Network**

**Testimony for the Senate Health and Human Services Committee Hearing on a Cost Effective Agenda for Health Access**

**January 16, 2002**

**Presented by Speranza Avram, MPA**
**Executive Director**

Thank you for the opportunity to speak with you today about the health care access barriers faced by rural Californians. My name is Speranza Avram and I am the Executive Director of the Northern Sierra Rural Health Network. We are a non-profit organization that works with primary care providers in clinics, hospitals, and public health departments to improve health care services for residents in eight rural northeastern counties. Our service area is over 27,000 square miles. The Network's major activities include the operation of a regional telemedicine network, the promotion of integrated mental health services in primary care practices and providing resources to our members to help cover the costs of providing health care for the uninsured in our region. I currently live and work in Nevada County and prior to that, in Sierra County, which has a population of 3,300 residents

The health care system that currently exists in rural California is challenged to meet the needs of the older, poorer, and sicker residents that we serve. As more elderly and ethnic minority residents move into rural communities, the systems that are in place will face even greater challenges to provide quality health care, particularly if existing safety net services are not maintained. California's rural health care system is fragile, and unless we are mindful of this fragility, rural residents throughout California could be left without any health care services at all.

Over 75% of California's landmass is considered "rural". It is home to over 4.3 million people and visited by millions of urban residents each year. Rural California is characterized by its distance from urban areas, limited economic resources, and fragile health care systems that survive very close to the margin. Overall, rural residents are less well off than their urban counterparts,. Of the 29 California counties that exceeded the statewide rate for persons living in poverty in 1998, 22 counties, or 75%, were rural counties. [1]

The region is also in transition, with some rural communities seeing large increases in population. Between 1990 and 1996, California's rural population increased by 14%. [2] Rural residents are also getting older. The number of people over age 85 living in rural Northern California increased by 35% over the past ten years, compared to a statewide increase of only 25%.[3] Rural California is home to an increasingly

diverse population. In 1996, 1/3 of residents in rural communities were ethnic minorities, compared with only 1/5 in 1990.[4] Rural California is home to more than 1.3 million farm workers and over 70,000 Native Americans.

There are a number of underlying, structural factors associated with providing care in rural areas that are important to remember as the state contemplates how to allocate health care resources. These structural factors are what distinguish California's rural health care system from the health care system that exists in many urban areas.

- **First, California's rural health care system consists primarily of public sector providers.** There are a very limited number of private family physicians or privately operated hospitals that still practice in rural California. Instead, California's rural health safety net consists mostly of rural health clinics, federally qualified health centers, small rural hospitals and public health departments. These providers offer health care services to all residents, regardless of ability to pay. As the number of uninsured patients increase, safety net providers are increasingly challenged to maintain services. The dominant payers are Medicare and Medi-cal. For example, 59% of the in-patients at California's 71 rural hospitals are either Medicare or Medi-Cal.[5] Thus any reductions in Medi-Cal payments will have a tremendous impact the ability of rural safety-net providers to maintain services.
- **Second, a lack of health care resources within rural communities limits the use of competition as a method for reducing health care costs.** One of the key characteristics of rural areas is the absence of competition within the health care sector. The overall small numbers of residents in most rural areas limit the number of health care providers that are able to practice in a given community. While some of the larger rural communities in California are able to support multiple providers, most rural towns can only support one primary care clinic, or one physician practice or one rural hospital. Rural health care providers offer a range of services to all residents, with or without insurance, and there are usually no other health care providers with which to compete. I'm sure most of you already know about the pull-out of Medicare HMO plans from many of California's rural counties. Lack of competition among providers is one of the primary reasons that managed care does not work in rural communities.

The lack of overall health care resources contributes to the fragility of the rural health care system. Because generally, rural communities can only support one primary care provider, there are few alternatives if this provider is forced to shut his or her practice. For example, in Fall River Mills, in eastern Shasta County, the privately owned physician practice was considering closing their doors. If this had happened, pregnant women would have been forced to drive more than 90 minutes over winding mountain roads to deliver their babies in Redding. Closing the practice would also have jeopardized the continued operation of the local rural hospital. Instead, the private practice will be converting to a Federally Qualified Health Center in order to maintain services to the community.

- **The third structural factor that characterizes the delivery of rural health in California is the chronic shortage of primary care, specialty and ancillary providers of all kinds.** An overwhelming majority of California's rural communities qualify for at least one type of federal health provider shortage designation.[6] The overall shortage of doctors, nurses, dentists, mental health workers and specialty providers of all types is exacerbated by the dearth of providers in rural areas who are culturally and linguistically competent. For example, mid-level providers such as nurse practitioners and physician assistants are commonly used to provide health services in rural clinics and hospitals. Yet, statewide, in 1998, only 6% of nurse practitioners and 13% of physician assistants were Hispanic. California's Hispanic population at that time was 30%, and I know it has increased since then. [7]
- **Finally, rural providers operate so close to the margin that even minimal reductions in public funding can have devastating consequences.** In order to recruit and retain medical providers, maintain adequate health care facilities, and keep up with the rising cost of operations such as increased energy and insurance costs, rural heath providers are paying more than ever to provide needed services. Yet the population growth in rural California will never be enough to make most rural health care facilities self-sufficient. For example, in fiscal year 2000, California's rural hospitals had an average operating margin of –3.9 percent. It was only through the infusion of a variety of state and federal operating programs that the hospitals reached a fragile .7 percent margin. [8] Rural health providers are extremely limited in their ability to increase volume or decrease expenses to make ends meet. This is one of the main reasons why the new Prospective Payment System being implemented by the state is so worrisome to rural providers. Their ability to "do more with less" is extremely limited, and

unless care is taken to implement PPS in a way that recognizes the structural factors faced by rural health providers, PPS has the potential to destabilize a fragile rural health system.

Cuts in the foundation of the rural safety net will negatively impact access to care for rural residents. As I hope I have demonstrated in my testimony today, California's rural health system is based on a foundation of public program support. Medi-cal payments, Healthy Families reimbursement, Expanded Access to Care for the uninsured, Rural Demonstration Projects, and many other state programs are all part of an intricate safety net that protects health care access to California's most geographically isolated residents. If the public programs that form the foundation of rural safety-net providers are reduced to the extent that facilities are forced to close, then rural residents will just be without health care – period. Remember, there are no alternatives for the MI victim, except perhaps a three-hour drive, to the nearest urban emergency room. Once the safety net is gone, there will be nothing left to take its place, and millions of rural residents and migrant farm workers will be without health care.

Thank you very much for the opportunity to speak with you today. I will be happy to answer any questions you may have.

Speranza Avram, MPA, Executive Director
Northern Sierra Rural Health Network

**DATA SOURCES**

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[1] U.S. Census Bureau, "County Estimates for People of All Ages in Poverty for California: 1998", Table A-98-06, December 2001, www.census.gov.
[2] Office of Statewide Health Planning and Development (OSHPD) Rural Medical Service Study Area (MSSA) data between 1990 and 1996. www.oshpd.ca.gov.
[3] Jensen, Warren, "Age Distribution Table", California Center for Economic Development, California State University, Chico.
[4] Office of Statewide Health Planning and Development (OSHPD) Rural Medical Service Study Area (MSSA) data between 1990 and 1996. www.oshpd.ca.gov.
[5] Avery, Sharon, "Rural Health Care at Risk: California Small and Rural Hospitals", CHA Special Report, September 2001.
[6] California Rural Health Policy Council, Shortage Designation Maps, www.ruralhealth.ca.gov.
[7] Office of Statewide Health Planning and Development and the Center for California health Workforce Studies at UC San Francisco, "Nurse Practitioners, Physician Assistants and Certified Midwives in California", Spring 2000.
[8] Avery, Sharon, "Rural Health Care at Risk: California Small and Rural Hospitals", CHA Special Report, September 2001.

# Testimony of Yolanda Vera

Good afternoon, my name is Yolanda Vera and I am a senior health policy attorney at Neighborhood Legal Services of Los Angeles County (NLS). Founded in 1965, NLS provides a full range of legal assistance to low-income residents throughout the county in a variety of areas including health, housing, family/domestic violence, welfare-to-work, education, immigration, consumer and employment. I work on two particular projects, the Health Consumer Center and the VIDA project.

The Health Consumer Center (HCC) is a California Endowment funded, independent, county wide ombudsman program that helps low-income residents (below 200% FPL) obtain quality health care from HMO's and other public and private health care providers. Our office's eight hotline counselors, five attorneys and two outreach workers are bilingual in Spanish, Armenian, Turkish, Khmer, Mandarin, French and Arabic. We are a collaborative with other HCC sites in Fresno, Orange, San Diego, San Francisco and San Mateo counties. The 25,000 annual calls our Los Angeles HCC site receives provide a rich source of data regarding the types of health problems that low-income Los Angeles County residents face. Seven out of every 10 persons who call us have an eligibility problem. That is, they are eligible for programs -- whether it is government funded health care or charity care -- but don't know it, they are afraid to apply, their application was denied or delayed, their benefits were terminated or they can't afford their Medi-Cal cost sharing or deductibles (share of cost). The rest call us with health service problems. For example, they are on benefits and need a particular type of health care service, but they have been denied or they need language appropriate care and cannot find it.

The VIDA project is a California Endowment-funded, focused strategy to help our community learn more about how to get better access to health care and become more active in public life. We are partnering with LA Metro/Industrial Areas Foundation (IAF) and approximately 24 public/private providers. VIDA is not health insurance, but we work closely, and meet regularly with, uninsured low-income families to help them learn healthy lifestyles and the health care resources that are already available to them. We have enrolled approximately 2000 persons in VIDA from various churches throughout the San Fernando Valley and we are expanding into the San Gabriel Valley.

First, a little background on health care barriers faced by Los Angeles residents.

Los Angeles County is home to approximately 2.8 million uninsured persons. Over 80% of these uninsured men, women and children are workers and their families, with nearly 2 million struggling in households which earn less than 200% of the federal poverty level ($34,000 a year for a family of four). Over 1.7 million of these uninsured persons are uninsured adults who do not have, and do not qualify for, any type of public health coverage. These County residents depend on local physicians, clinics, and hospitals, which comprise the public/private safety net for access to health care services, made possible by the current 1115 Medicaid waiver.

Given these numbers, Los Angeles County's health care system is overwhelmed. It provides nearly 3 million outpatient visits a year, however, it is plagued by long waits, in particular at the specialty care clinics and emergency rooms. For example, according to the LA County Waiver Office's most recent wait time reports, in October 2001, a patient at Martin Luther King Drew Medical Center with cornea problems had to wait 273 days (or 9 months) for the next available appointment at the ophthalmology clinic.

. The emergency rooms suffer the same problem. One VIDA participant complained that his father had to wait 12 hours at a County hospital emergency room after being rushed there because he suffered a stroke. Another VIDA participant took her employed (full-time), uninsured, 30-year-old son to another County facility because he was suffering severe abdominal pain. He had to wait 10 hours in the emergency room before he was diagnosed with appendicitis. Fortunately, his appendix didn't burst while he was waiting.

Indeed, the San Fernando Valley, where these VIDA participants reside, experiences an extremely high rate of emergency service demand in the face of shrinking trauma care resources. According to a recent motion by Los Angeles County Board Supervisors Antonovich and Yaroslavsky (December, 2001), Olive View Medical Center -- a major provider of emergency services in the San Fernando Valley-- experienced over 64,000 emergency room visits last year. The 2001 Community Needs Assessment for the San Fernando and Santa Clarita Valley conducted by not-for-profit hospitals found that local hospital emergency departments were on diversion 32,032 hours in 2000, compared with 12,395 hours in 1997 (a more than 250% increase)!

Most every VIDA participant tells us that once they get into the door to see a county provider, the care they receive is excellent. But the problem is getting in the door.

Even if uninsured persons like our VIDA participants qualify for Medi-Cal, they face huge enrollment difficulties. Medi-Cal and other survival programs remain so complicated, that all counties, urban and rural, need expensive computer systems to calculate eligibility. In LA County, we have spent more than 150 million dollars on a computer system called LEADER, which has not been programmed to screen for Medi-Cal eligibility under the Medi-Cal programs implemented within the last three years, including Section 1931(b) and the Aged and Disabled program. As a result, thousands of children, families, seniors and disabled persons are denied the free Medi-Cal for

which they are eligible. For example, on January 1, 2001, California implemented the Aged and Disabled Medi-Cal program. This program saves impoverished senior citizens hundreds of dollars in out-of-pocket expenses for medicines and doctor's visits and instead allows them to spend their few dollars on rent and food. According to the Governor's 2001-02 Budget summary, the Aged and Disabled program was expected to benefit approximately 53,800 people in 2001-02. Four out of every 10 Medi-Cal beneficiaries, statewide, are from LA County. That *should* mean that last year, even conservatively, approximately 19,550 seniors and disabled persons in Los Angeles County would/should be eligible for this new program. Instead, in June, 2001 (the latest reliable numbers), of the approximate 24,000 people so far enrolled in the program, only 204 (or .009% of the total) were from Los Angeles County! Our County is responsible for accurately screening persons for Medi-Cal eligibility and must be faulted, but also underlying the LEADER problem is the fact that Medi-Cal eligibility and application rules are so complicated, counties must spend millions of dollars on computer programs to determine eligibility. Workers and normal human beings can no longer do it.

What do we need to overcome these barriers:

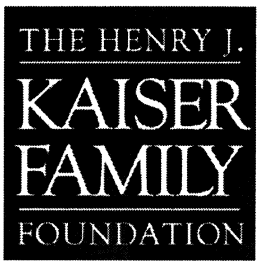
1. We cannot begin to address the long waits at the emergency rooms and specialty clinics without additional revenue. As one county official put it, "Virtue alone is not enough to fix our county's health care system." As flawed as our county system is, it is simply not true to say that there would be no uninsured, and health care wouldn't cost anything, if only our county had "done it right." The system needs a massive infusion of funds.

2. It cannot be cost effective to define eligibility for services in a manner that is so complicated that you need multimillion dollar computers you cannot control, and attorneys, to navigate the system. Yet, the LEADER computer problems, and the volume of calls that HCC

receives each month, confirm that this is, in fact, the reality. Eligibility must be simplified. Eliminating the asset test is just one example of a simplification which will net savings. Other modest steps include streamlining the recertification process in the Healthy Families program just as we did with Medi-Cal in SB87, so that burdensome forms do not result in families losing health care.

3. Until it is simplified, we need to continue to focus on community based strategies which include assistance and training regarding how to access the system, available resources, rights and responsibilities and preventive health measures families can take. VIDA has taught us that when it comes to sensitive health decisions, people trust their neighbors and fellow parishioners on what works, what doesn't work and what should work. The Health Consumer Center has taught us that many persons do not understand the programs for which they are eligible. Resources should continue to be allocated to community-based education and representation efforts which utilize health promoters developed from within the community to both educate patients and help them navigate the system. Funding could be allocated, for example, to develop a pilot project in which health promoters are trained to conduct house meetings regarding healthy lifestyle changes to combat diabetes, high blood pressure, and other preventable chronic diseases. In return, these health promoters could be offered affordable health insurance. A modest education improvement could include requiring hospitals to advise patients regarding their charity care program eligibility requirements so that huge hospital debts can be avoided. Finally, resources must continue to be allocated so that community groups can develop simple and culturally appropriate outreach materials which describe eligibility rights and retention rights.

Thank you for this opportunity to comment and your commitment towards improving the health of all Californians.




# Prospects for the Uninsured in the Economic Recession

**Larry Levitt**
**Vice-President**
**Henry J. Kaiser Family Foundation**

**for**

**Committee on Health and Human Services**
**California State Senate**

**January 16, 2002**

Thank you Chairwoman Ortiz and members of the Committee for the opportunity to testify today on the important issue of the prospects for those who lack health insurance in the current economic recession. I am Larry Levitt, Vice-President of the Kaiser Family Foundation, where I direct our work on health policy issues in California and health care marketplace issues nationally. We are a national organization, based in Menlo Park, dedicated to providing information and analysis on health issues to policymakers, the media, and the general public. We have no affiliation with the Kaiser Permanente health plan.

I unfortunately bring little good news today. We are facing a confluence of negative forces that puts health insurance coverage for Californians in jeopardy. Those with the fewest financial resources are especially vulnerable.

The economic recession puts workers at risk for losing not only their jobs, but their health insurance as well. And our economic difficulties come at the same time that health insurance costs are rising at the fastest rate in almost a decade. This combination of rising costs and weak demand for labor means that employers are likely to cut back on coverage and shift costs to workers. And finally, budget pressures not only compromise the state's ability to expand coverage for the uninsured, but also offer a real danger of retrenchment. Unlike in recent years, growing numbers of states across the country are talking about cutbacks in public programs serving the uninsured, rather than improvements.

At last count, over six million Californians were uninsured, about one in five of all people under age 65 in the state. This lack of health insurance threatens not only their access to care, but also their financial security. Indeed, health insurance is now a significant factor in the risk of bankruptcy. And, a growing uninsured population is also a real threat to the finances of public and private "safety net" health providers, who are likely to see a growing caseload of people unable to pay their medical bills.

To be sure, California is not alone in this problem. But, while California is a leader in the nation for many positive things, it also has an uninsured crisis that is among the worst in the country.

This problem cuts across demographic and geographic boundaries, but hits hardest among some populations and communities. For example, low-income Californians – those in families earning less than 200% of the poverty level, about $29,000 a year for a family of three – are more than three times as likely as people with higher incomes to be uninsured (see Chart 1). People of color are also much more likely to lack health insurance – for instance, over one-third of Hispanics under age 65 in California are uninsured (see Chart 2).

The current economic recession and the end of the boom economy threaten to make a bad problem even worse. The number of uninsured was last measured by the federal government in the year 2000. Those figures showed a drop in the number of uninsured

for two years in a row, both in California and across the country. But these decreases were modest, and they came after a decade of unprecedented economic prosperity.

And, of course, much has changed in the last year. In December 2000, the unemployment rate in California was 4.7%. Figures released last week show that by December 2001, it had increased to 6.0%. Analysis prepared recently by researchers at the Kaiser Family Foundation and the Massachusetts Institute of Technology (MIT) shows that for every one percentage point increase in the unemployment rate, the number of uninsured nationally goes up by 860,000. Put another way, for every 100 people who lose their jobs, the uninsured count rises by 85. Translating these figures to California, where the number of unemployed workers has increased by more than 200,000 in the last year, the number of uninsured has likely grown by more than 150,000. Though these figures are a cause for concern, unemployment remains well below the levels seen in the previous recession – when it hit 9.7% in 1992 -- and may continue to rise (Chart 3). While economists continue to debate over how long the current recession is likely to last, it is clear that the weakened economy leaves low-income families increasingly vulnerable.

An economic downturn and rising unemployment jeopardize the availability of health insurance in a number of ways.

As workers lose their jobs, their ability to maintain health insurance coverage is diminished. California families with no workers in the household are almost twice as likely to be uninsured (32%) as families with one or more full-time employees (18%). And, this problem is not limited to people who are out of work. Families who have only part-time work available – an increasingly common occurrence as the economic downturn continues – are just as likely (33%) as the unemployed to lack health insurance (Chart 4).

The plight of the unemployed and underemployed highlights the importance of employer-provided health insurance. Most non-elderly Californians get their health coverage through an employer. By pooling risk, group coverage through employment protects people who have higher than average health care needs. If forced to buy insurance on their own through the non-group insurance market, people with even relatively mild health conditions can face denial of coverage, benefit limitations, and premium surcharges.

For laid off workers who had insurance on the job, there are some protections. In companies with 20 or more employees, the federal COBRA law gives most workers leaving a job-based health insurance plan guaranteed access to continued coverage at the group premium plus a 2% administrative fee. A California law, known as Cal-COBRA, extends somewhat weaker protections to workers in small businesses.

However, workers using COBRA to maintain their health insurance are likely to be shocked to learn how much that coverage costs. When people get health insurance through an employer, the employer typically shares in the cost. In California, employers

on average contribute about 90% of the premium for single employees and about 80% for families. But, unemployed workers buying insurance through COBRA must pay the entire premium out of their own pockets. Costs are lower on average in California than in the rest of the country, but health insurance is still quite expensive, with the average cost of a family policy exceeding $6,000 a year. With the loss of income from a job and modest financial support from unemployment insurance, most unemployed workers cannot afford premiums that high.

And, unfortunately the cost of health insurance is rising more rapidly than it has in almost a decade. According to the annual nationwide Kaiser/HRET health benefits survey, the average cost of an employer-provided health insurance plan rose by 11% in 2001, more than three times the rate of inflation and twice the growth in worker wages (Chart 5). These cost increases, combined with the weak economy, mean that employer-sponsored health coverage is likely to become less available and more expensive for workers. In our national survey of employers last year, 75% of large firms and 42% of small businesses said they were likely to ask workers to pay more for health insurance in the coming year.

And this was before the tragedy of September 11th and the escalating economic downturn. In recent years, California has made significant gains in the availability of health coverage, with increasing numbers of employers offering insurance to their workers. But the combination of rising costs and a declining economy will likely lead some employers to restrict coverage for part-time and temporary workers, and others to drop coverage entirely.

Historically, the effect of economic downturns on health insurance coverage has been cushioned to some extent by increased enrollment in public programs like Medi-Cal here in California. As job losses mount, the lost income means that more families fall below the eligibility guidelines for public health insurance programs. Yet, the needs in these programs tend to grow at the same time that state budgets become strained.

Recent expansions in eligibility under Medi-Cal, and the creation of Healthy Families for uninsured children with incomes too high to qualify for Medi-Cal, put the state in a strong position to provide a safety net for people who lose private health insurance coverage. Particularly noteworthy is the recent expansion of Medi-Cal to cover all families with children under the poverty level. Simplification of the enrollment process for Medi-Cal and Healthy Families also helps to ensure that people eligible for public coverage are able to enroll more quickly and with fewer administrative hurdles.

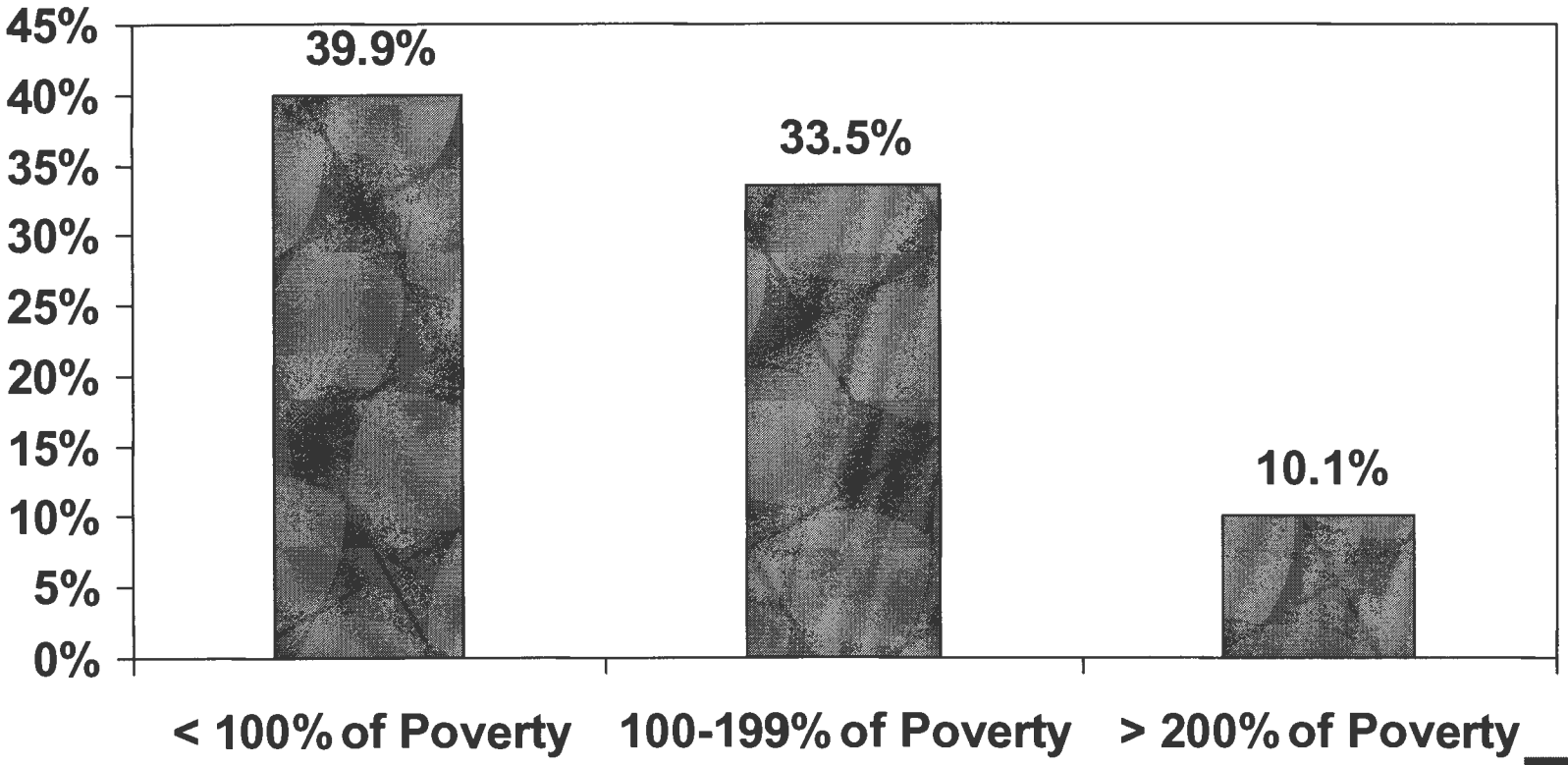
Yet, significant gaps still exist. Childless adults who are not disabled, regardless of how poor they are, are ineligible for any form of publicly-subsidized health coverage in California. And, until expanded coverage for uninsured parents under Healthy Families is funded and implemented, many low-income families will remain partially uninsured. The bottom line is that we will be unable to make a dent in the problem of the uninsured without providing substantial subsidies to make coverage affordable. While there are a variety of approaches available for doing this, our analysis shows that expansions in

programs like Medi-Cal and Healthy Families are most effective at targeting assistance to those who need it most: the low-income uninsured. And, because state spending on these programs is matched by the federal government, they provide an important economic stimulus within the state.

But, just as expansions in public programs could cushion the effects of the current recession on the uninsured and stimulate the economy, contractions in these programs due to state budgetary pressures could exacerbate the problems. Reductions in eligibility for Medi-Cal or Healthy Families – or curtailment of the recent reforms that have made it easier for the low-income uninsured to enroll – would both leave more people without health insurance coverage and put greater financial pressure on those public and private providers who traditionally serve the uninsured.

Thank you for the opportunity to testify before the Committee. I would be pleased to answer any questions.

## Chart 1
# Percentage of Non-Elderly Californians Who Are Uninsured, by Poverty Level (1999-2000)




Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of the Current Population Survey

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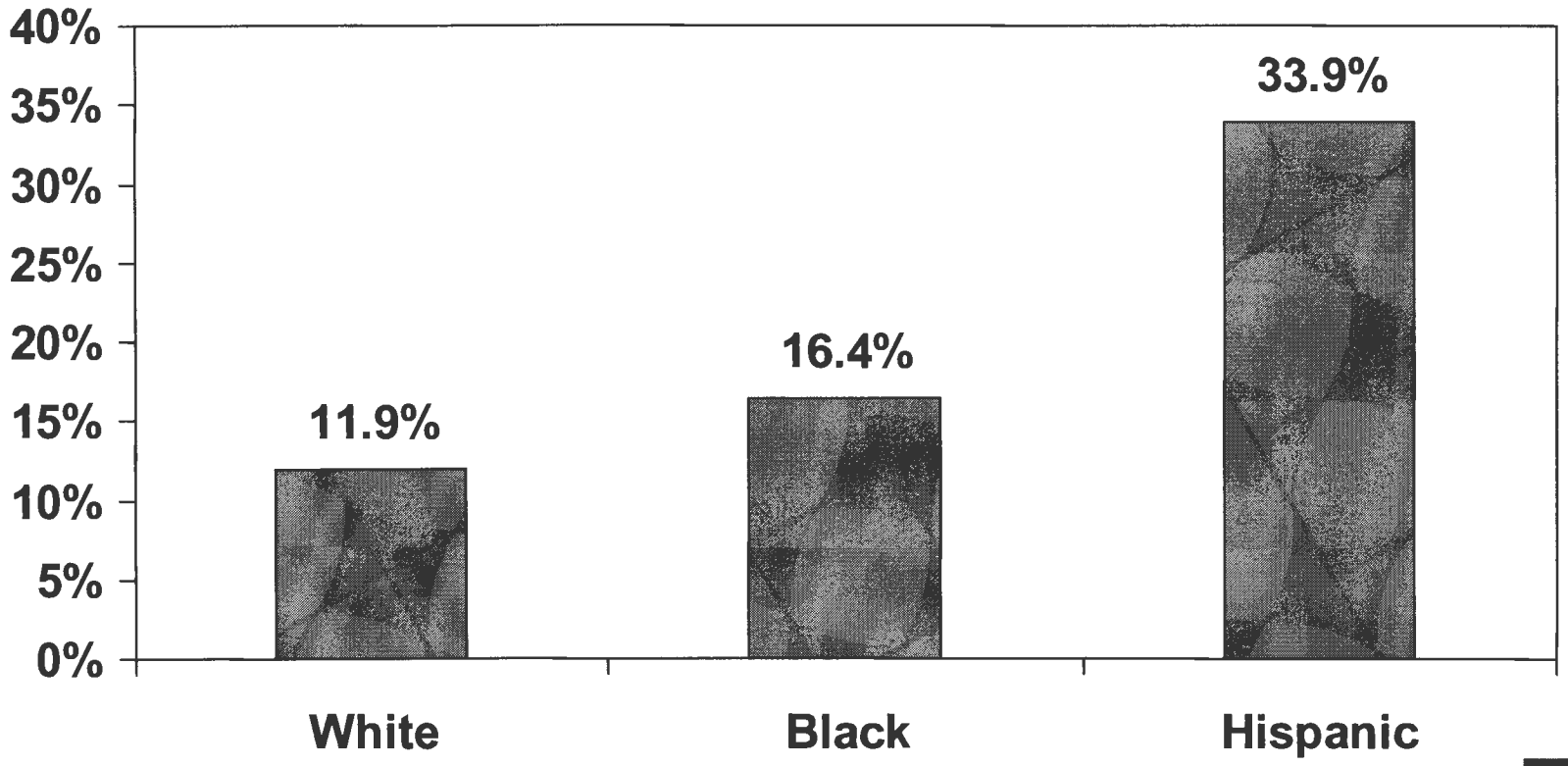
## Chart 2
# Percentage of Non-Elderly Californians Who Are Uninsured, by Race/Ethnicity (1999-2000)




Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of the Current Population Survey

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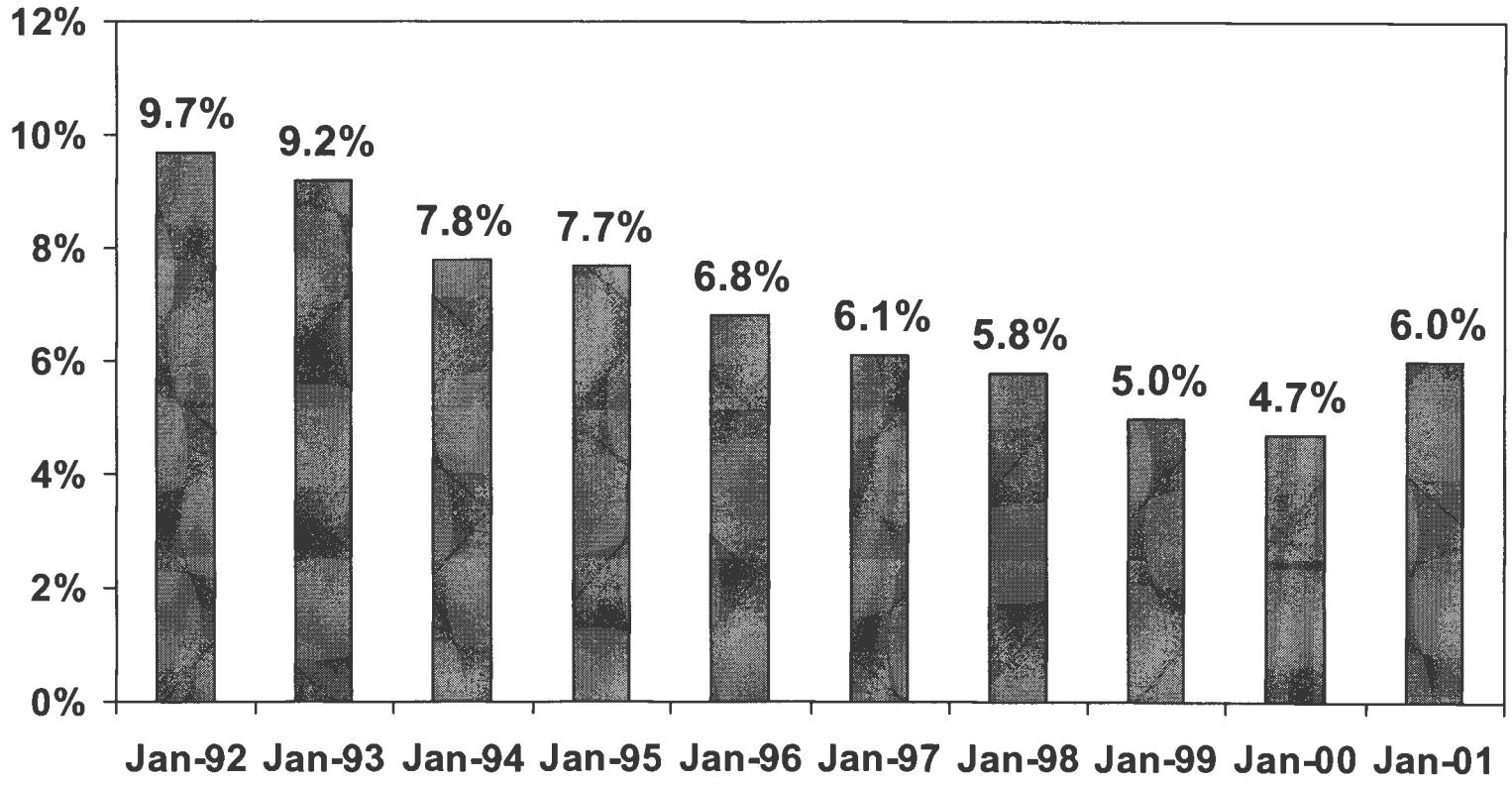
# Chart 3
# Unemployment Rate in California




Source: California Employment Development Department

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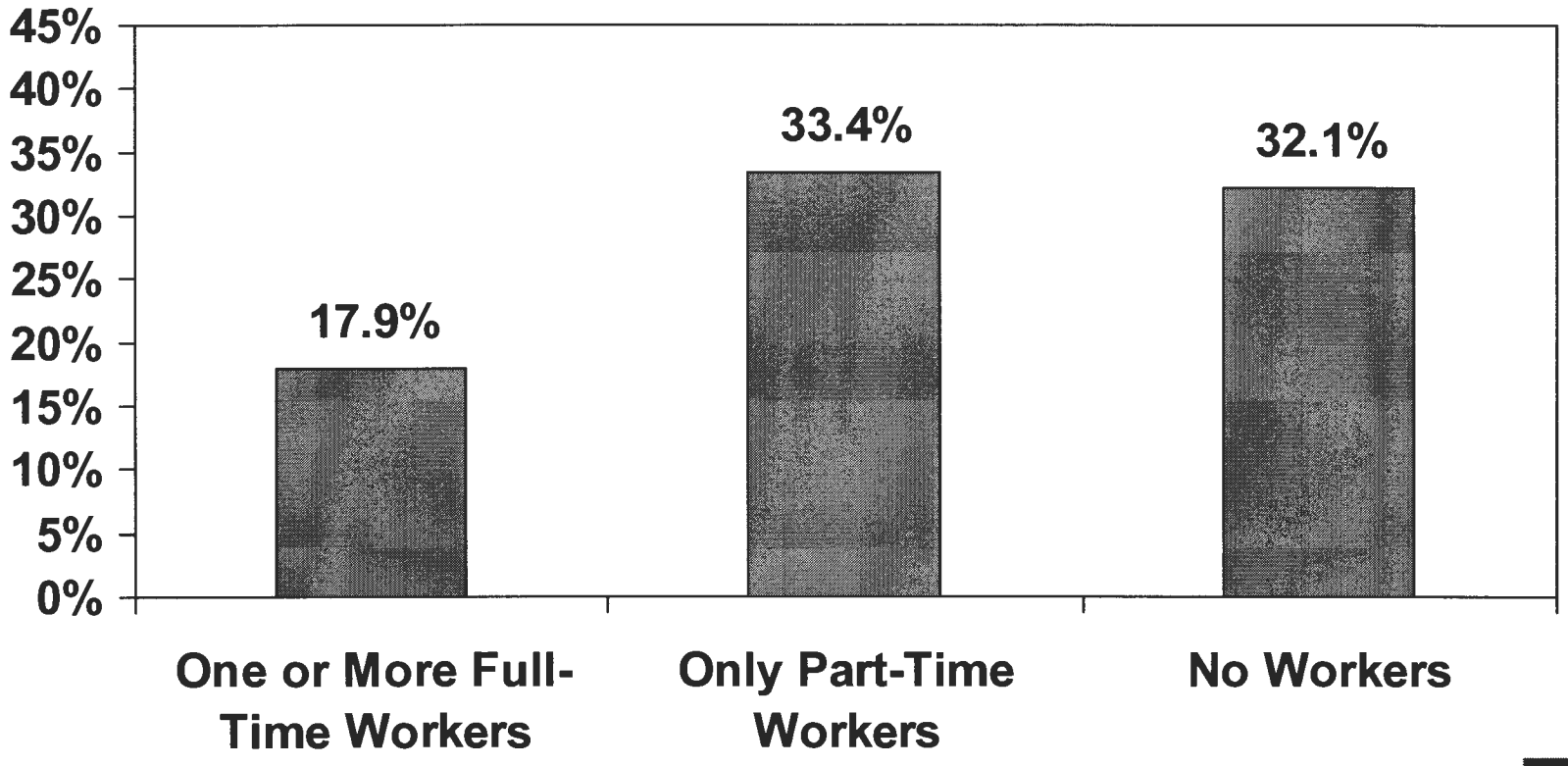
## Chart 4
# Percentage of Non-Elderly Californians Who Are Uninsured, by Family Work Status (1999-2000)




Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of the Current Population Survey

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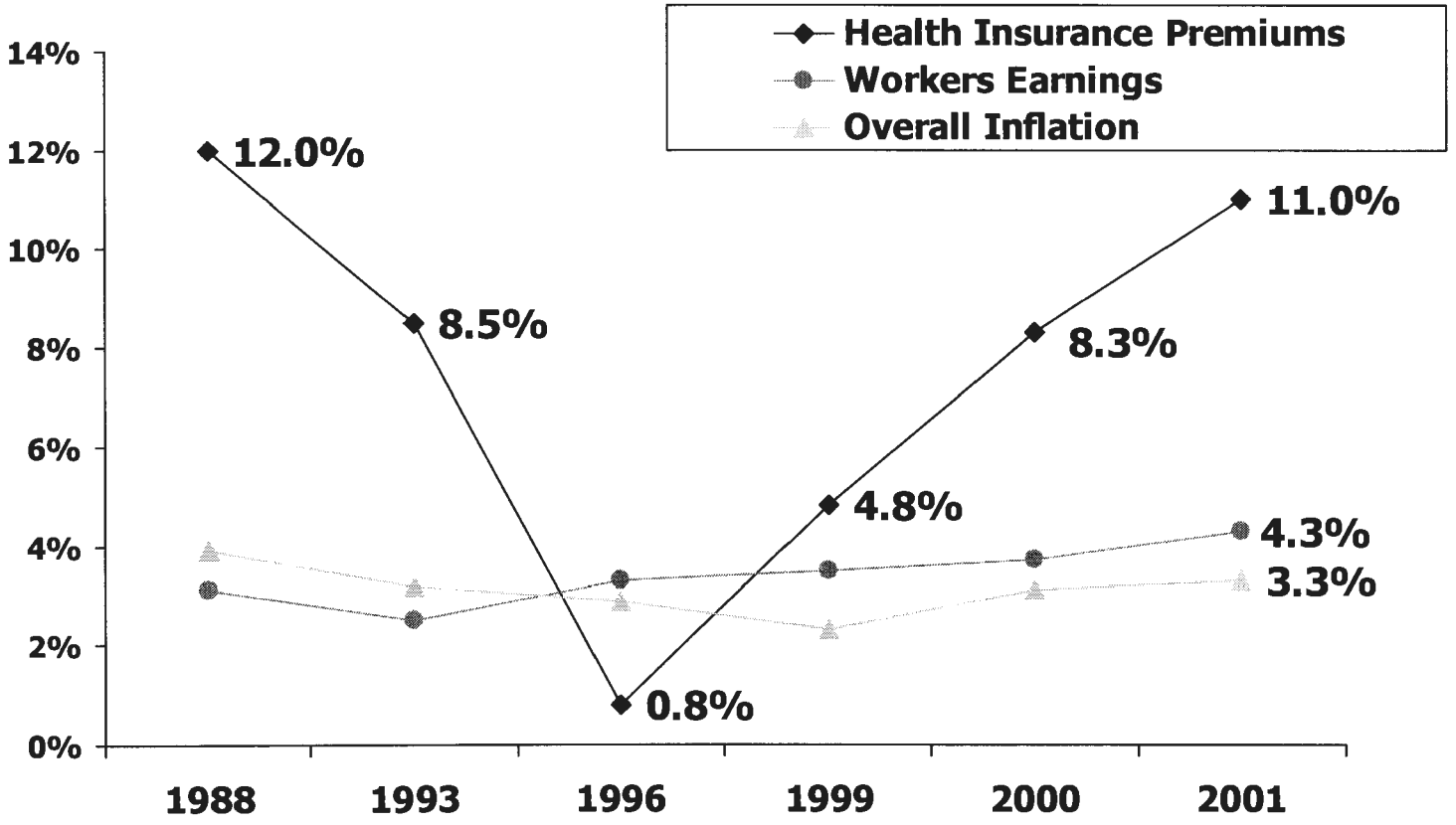
# Chart 5
# Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2001




Source: Kaiser/HRET Employer Health Benefits Survey

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WORKING WITH
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MENTAL HEALTH
AND FAMILY
WELL-BEING

Senate Health & Human Services Committee
January 16, 2002

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THE BROTMAN FOUNDATION OF CALIFORNIA

THE CALIFORNIA ENDOWMENT

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THE SAN FRANCISCO FOUNDATION

SIERRA HEALTH FOUNDATION

STUART FOUNDATION

ZELLERBACH FAMILY FUND

Thank you Senator and committee members. My name is Judy Chynoweth and I am the Executive Director of the Foundation Consortium.

The Foundation Consortium is a ten year old, non-partisan resource on what works for California's children.

Our mission is to find ways to bring policy makers together, to seek innovation, to foster partnerships, so that all California children are safe, healthy, and ready to learn each day.

As our name suggests, we are funded and governed by 16 of California's leading foundations. Each member is independent, yet they come together to fund this collaborative effort and share common goals.

You will hear from five of our members today -- on different panels -- about the kinds of community innovation they are supporting, what they have learned and about programs that work.

They include:

Dr. Robert Ross of The California Endowment, Alicia Procello of The California Wellness Foundation, Bonnie Armstrong of The Casey Family Program, Len McCandliss of Sierra Health Foundation, and Ted Lobman of the Stuart Foundation. Ted is also Chair of the Foundation Consortium Board of Directors.

The Foundation Consortium believes in accountability. We use data to make decisions on what is working. And as in any partnership, everyone takes accountability for achieving results: individuals, families, different government agencies, non-profits, and foundations. We are all responsible.

We believe in sustainability. That means if it works, fund it. We need to find a way to keep it going. Even if it means funding that crosses categorical and jurisdictional boundaries.

We believe in looking long term. As you know, many of the problems facing children and families are complex and may require re-organization of government efforts at a local, state and federal level.

We try to always keep our eye on the needs of the whole child. That is what is important.

We believe in unified, simplified funding.

We believe in collaboration, inclusion, focusing on individual communities and involving families, non-profits, schools and government. Part of our mission is to help connect these various elements and find common ground.

We sponsor educational events, convening decision makers to share ideas, to learn from one another, to seek innovation and find examples of what works.

We also are an impartial resource. For example, we partner with others to produce three websites with information for policymakers: promising practices network (www.promisingpractices.net), results accountability guide (www.raguide.org), and the website of the Foundation Consortium (www.foundationconsortium.org).

Today, we are focusing -- in part -- on one of our recent activities, the California Policymakers Institute where 125 community, education, non-profit, youth and government leaders shared ideas in our fourth of an on-going series of dialogues.

Our topic was the elimination of health care disparities and how linking of health and education can reduce these disparities. It was co-sponsored with Lt. Governor Bustamante and his "Commission For One California".

We were delighted to have Senator Ortiz as one of our presenters. As we plan other such efforts in the future, we invite all of you to participate.

You each have a copy of our *Journal for the Community Approach.* This issue highlights the recommendations of the Institute.

Let me comment very briefly on a few desired outcomes and ideas.

Desired outcomes discussed at the California Policymakers Institute included:

- Children born healthy,
- Children and families with access to health care,
- School age children ready to learn each day,
- Children and families with good mental health,
- Children and families in rural areas with equal access to health care,
- An adequate supply of providers with diverse cultural and language competencies, and
- Adolescents practicing healthy behaviors.

Looking broadly at this set of desired goals, we have statewide evidence and local program evidence that some have worked well. School-linked approaches work! Healthy Start programs work. After school programs work. Examples include: LA's

Best, LA Unified School District, S.F. Beacon, Sacto Start, Calexico, Monrovia, Tulare County.

Other programs, like family/community resource centers are showing promise.

These are a few examples of programs that work. They are also successful collaborations with resources coming together from a variety of sources.

Some of the various presenters this afternoon may touch on some of these issues. They may share other findings from the California Policymakers Institute, and their own analyses and successes.

Before I introduce our next two presenters, I would like to thank Senator Deborah Ortiz and this committee for this opportunity today. I would also ask you to look at the foundation community perhaps in a new way.

Sometimes when government leaders think of philanthropy they think of money, of deep pockets they can go to when times are tough. Frankly, that is not how we see our role.

I would like to suggest something different. Think of foundations as sources of information, as organizations that seek out innovation in social policy, invest in it, experiment with it and search for what works.

The Foundation Consortium is eager to partner with you to make California a better place for children and families. I believe the Foundation Consortium and its individual members, indeed, all the speakers today, have much to offer.

Our next two speakers, members of the Foundation Consortium, have deep experience in funding creative programs in communities around the state. They will look at some of the broad policy issues that came out of the California Policymakers Institute as well as share their own unique views.

Dr. Robert Ross is the Chief Executive Officer and President of The California Endowment. Alicia Procello is a Program Director for The California Wellness Foundation.

Dr. Ross.

# SENATE HEALTH & HUMAN SERVICES COMMITTEE HEARING

**A Cost Effective Agenda For Health Access For Children & Families**
**January 16, 2002**

## Testimony by
## BONNIE ARMSTRONG
## CASEY FAMILY PROGRAMS

Thank You. I am Bonnie Armstrong, Director of Advocacy and Community Development in the West Region of Casey Family Programs. Established in 1966 by the founder of United Parcel Service, we are an operating foundation with a mission to support families, youth and children in reaching their full potential. In more than 30 locations nationally, Casey provides an array of direct services for children and youth who are in, or emancipated from, the child welfare system. These include foster care and other permanency options, as well as services designed to assist youth in making a successful transition to adulthood. Much of our work is accomplished through collaborative working arrangements with the public sector and other nonprofit organizations. In California, we have operations in San Diego, Los Angeles County, Sacramento, and the Bay Area. Our West Regional Office is located in Pasadena.

I am here with my colleague, Mookie Abdullah, to bring forward the issues that were addressed at the California Policymakers Institute with regard to the child welfare system, and to describe some service delivery models that work to improve access to health and mental health services to youth in the system, and also those leaving the system.

The Institute discussed data that clearly demonstrated the disproportionate prevalence of African-American and Native American children and youth in California's child welfare system, and this same phenomenon exists across the country. In July, 2000, African-American children were almost five times more likely to be living in foster care in California than the average (9.5 per 1,000), and six times more likely than white children. (The rate for African American children was 44.2 per 1,000, compared to 7.6 per 1,000 for white children. Native American children were found in foster care at 18.8 per 1,000, which was twice the average of 9.5 per 1,000 in the total population.) Statistics on abuse and neglect also are striking (the number of substantiated reports among African Americans was 2.3 times what might be expected), but do not explain this difference.

The disproportionate representation of African American and Native American children in the child welfare system is important to today's discussion in part because we also know that the health and mental health status of the children who are now in the child welfare system, and those who have left the system at age 18, is generally poorer than children in the rest of the population. A 1990 study at the University of Maryland found that the incidence of emotional, behavioral, and developmental problems among children in foster care was three to six times greater than the incidence of these problems among children not in care. The American Academy of Pediatrics estimates that 30% of children in foster care have severe emotional, behavioral or developmental problems. These problems may stem both from the fact

that these children have virtually all suffered various levels of childhood trauma and that they are chronically underserved.

As you can see from the recommendations made by the diverse group of policymakers at the CPI, school-based and community collaborative services were highly recommended to meet these needs. A common theme is that existing resources should be strengthened, made accessible and be well coordinated to be utilized within the community.

Comprehensive, school-based mental health services are meeting some of this need in some school districts, such as the Pasadena Unified School District. The Los Angeles County Department of Mental Health and several local nonprofit agencies have joined together to make their services more accessible and coordinated for local children and youth. In Pasadena, more than 1,300 children in out-of-home placements attend the schools, so it is also a method of increasing access to services for these children within the mainstream. Mental health clinicians are located on school sites and play an integral role on the school team, although they are paid through a county contract for the MediCal eligible children. This takes advantage of the already existing program infrastructure in the community, rather than creating new programs.

Funding for indigent children, who are mainly children of the working poor, has been difficult to sustain through foundations, because this clearly is a long-term and continuing need. Tracking has shown that students in the program have improved attendance, behavior and classwork.

The issues for the older youth who "age out" of the child welfare system at age 18 have been discussed with you by the California Youth Connection, so I am sure you have heard the statistics about the likelihood of their becoming homeless, pregnant, undereducated or unemployed. The California Legislature is to be congratulated on taking the role of an appropriate parent in this case – offering Medicaid coverage to age 21, as well as stipends while the youth is following an approved emancipation plan.

It takes special service delivery models to increase access to health and mental health services to this population. My colleague Mookie Abdullah, recruitment specialist in our Sacramento Transition Services Program, will talk about a model of transition services that works well to increase access and reduce barriers to service for older youths 16 –24.

The Pasadena Alumni Support Center was designed by former foster youth working with Casey and Transition Partners -- a coalition of 25 public and private agencies committed to providing a comprehensive and coordinated system of support for emancipating and former foster youth in the Pasadena/Altadena area. It is a comfortable, homey, drop-in and resource center that opened in May of 2000. Youth come to get help finding housing, a job, or scholarships for education. They come to do their homework in the computer room, or to take a cooking class, or to attend one of the many social events that bring a sense of belonging and comfort. The County Independent Living Program has a worker out-stationed at the Center. There also is a part-time Medi-Cal eligibility worker from the Public Health Department -- and a computer kiosk from the local Workforce Investment Act office.

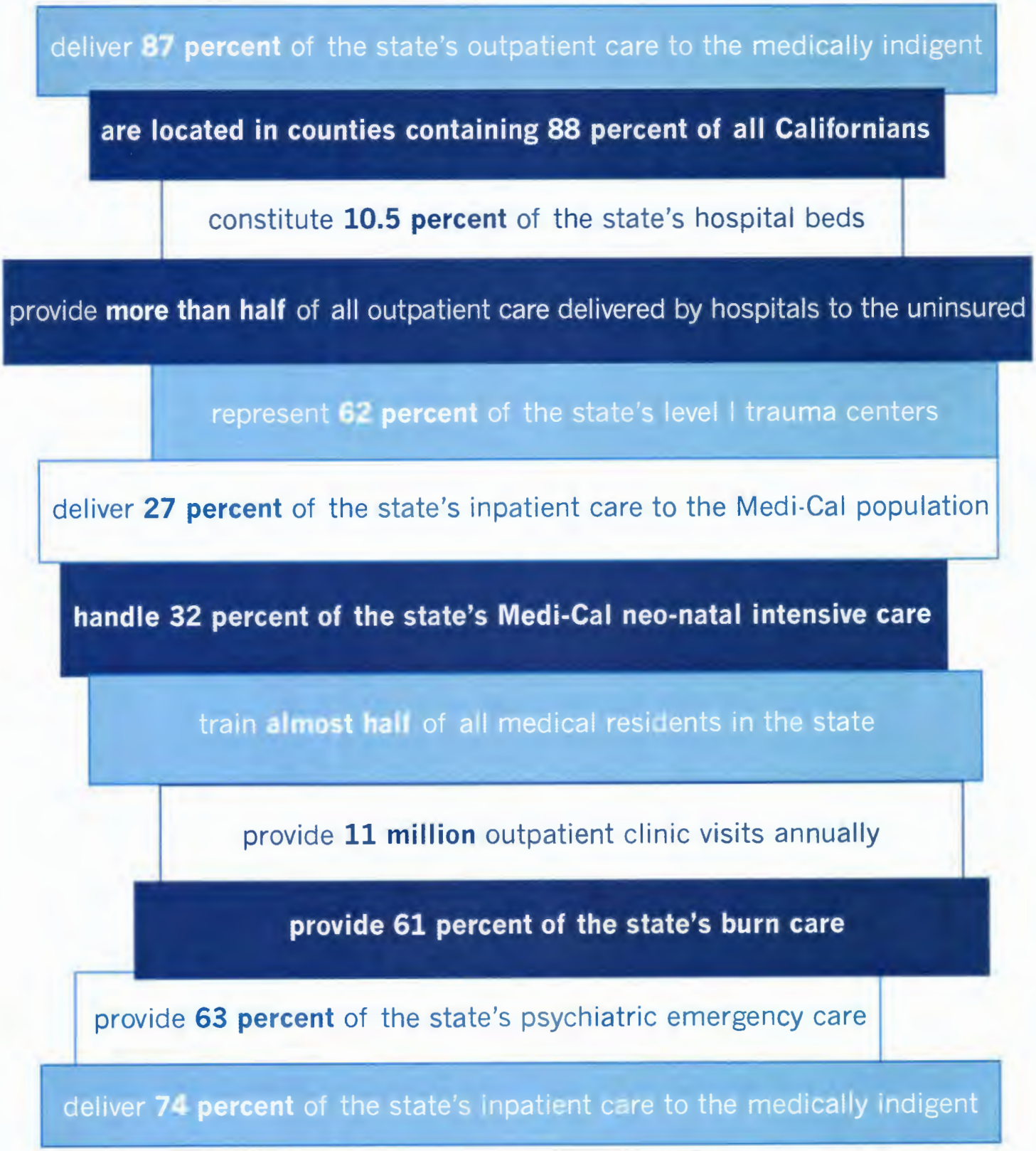
But most importantly there are youth advocates to greet you when you walk in the door. Youth Advocates are former foster youth who can relate to the youth they serve. Because they have lived through it, they play a critical role in connecting young people to the services they require with understanding and respect. Often, youth will come to the center a few times to use the computer or attend a class before they will build up enough trust to ask for the service they really need help with, particularly if it is something sensitive like mental health counseling.

Thank you for providing Medi-Cal coverage for us – but the fact that a young adult has health insurance does not necessarily mean that she has good health care. Even if they can find doctors who will take Medi-cal, people need to know what to ask for, and when to go to the doctor. The key to improved access for youth who use the Alumni Center may be the fact that they have someone to talk it all through with, someone who can help them make the call, and who will know what to ask for. Remember, if you have never had good health care in your life, it is hard to be suddenly expected to know how to work the system to get good care – or even to expect it -- without a little support.

The Pasadena Alumni Support Center was opened in May, 2000 by Casey Family Programs and the local Transition Partners. The Los Angeles County Departments of Children and Family Services, Probation and Mental Health have been part of the planning from the beginning. The County Chief Administrative Office and Board of Supervisors have now decided that this is a delivery model that should be brought to scale, and we will work with them to develop more centers around the county with increased coordination from more county agencies. We already have begun planning for a center in Long Beach, which is scheduled to open later this year. We are very pleased with this example of philanthropy testing an idea in a small way and then partnering with government to bring it to scale once it has shown efficacy. Several other counties, including Sacramento, have visited the Center and are in the process of adapting this model to their own localities. Our Sacramento Great Start Collaborative is currently using a case management model which emancipated youth access through the offices of our partner, the Sacramento Employment Training Agency.

Thank you for your attention, and for this opportunity to discuss the needs of young adults who are transitioning out of the child welfare system. We look forward to continuing strong relationships with the State of California and its counties on behalf of vulnerable children, youth and families.

# California's public hospitals & health systems:




Source: Office of Statewide Health Planning and Development

CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS
2000 Center Street, Suite 308, Berkeley, CA 94704 phone (510) 649-7650

# MEMBERS

**ALAMEDA COUNTY**
Alameda County Health Care Services
Alameda County Medical Center

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Contra Costa Health Services
Contra Costa Regional Medical Center

**FRESNO COUNTY**
University Medical Center

**KERN COUNTY**
Kern Medical Center

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Ventura County Health Care Agency
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CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

# ABOUT CAPH

## Our Mission

The California Association of Public Hospitals and Health Systems, a non-profit trade organization representing California's public hospitals and health systems since 1983, works to strengthen the capacity of its members to advance community health, ensure access to comprehensive, high-quality, culturally sensitive health care services for all Californians and educate the next generation of health care professionals. Our passionate belief that everyone deserves an equal opportunity to enjoy good health—regardless of their insurance status, immigration status or ability to pay—drives our policy and advocacy agenda.

## Our Members

CAPH represents more than two dozen hospitals, health care systems and academic medical centers in 18 counties—including each of the 15 most populated counties—throughout California. Also called "open door providers" because no one is denied access to the essential health care services they provide, CAPH members share a mission and mandate to provide care to all residents, regardless of their ability to pay. Among the members of CAPH are county-owned and operated facilities, University of California medical centers, and private, not-for-profit facilities sharing a common commitment to serving all people.

## What is an "open door provider"?

An open door provider is a hospital, academic medical center, community-based health center or other entity dedicated to assure the accessibility of cost-effective, high quality and culturally appropriate health care services for low-income and uninsured populations, *beyond those emergency and stabilization services required by law.* Open door providers also ensure the availability of critical public goods, such as trauma and burn care, essential to the health and well-being of the public-at-large.

## How can CAPH help you?

The intricacies of public health care policy and legislation are often complex and confusing. CAPH is pleased to serve as a resource for information and assistance on a variety of state and federal health care policy issues. Our highly trained professional staff is available to respond to inquiries from legislators and their staffs, administration officials, members of the media, healthcare stakeholders, the general public and, of course, our members and their staffs on a wide range of issues, especially those affecting California's low-income and uninsured populations. Key areas of expertise include:

- Public hospitals
- Primary care & prevention
- Tertiary services
- Trauma systems
- Public & community health
- Graduate medical education (GME)
- Medically indigent
- The uninsured
- Outpatient services
- Vulnerable populations
- Medi-Cal
- Medi-Cal managed care
- Healthy Families
- County organized health systems (COHS)
- Health care financing
- Charity care
- Medicaid Disproportionate Share Hospital (DSH) funding program
- State financial data
- Health care workforce
- Public-private partnerships

**For information on these or other issues,**
**call CAPH at (510) 649-7650 or visit our Web site at www.caph.org.**

ISSUEbrief

# Removing the Medicaid DSH Cliff

## Preserving Health Care Access for Low-Income Californians

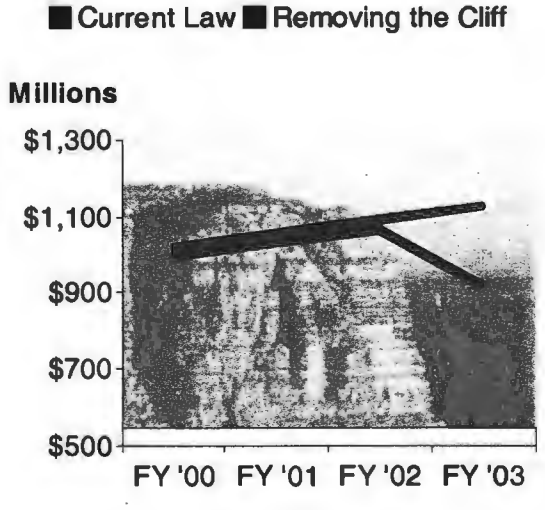
### Summary

The California Association of Public Hospitals and Health Systems supports legislation to remove the "cliff" in federal Medicaid disproportionate share hospital (DSH) allotments that will result in significant cuts to safety net hospitals after FY 2002. Ensuring stable funding in the Medicaid DSH program is essential to protect the viability of the public health care safety net and assure access to needed health care services for low-income populations.

### Background

Over the last two years, Congress passed important legislation to help stabilize funding to health care providers. These measures did not focus significantly on the Medicaid program, which serves low-income patients. Although the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA") *postponed* until 2003 severe reductions in Medicaid DSH funding, this legislation provided only a stopgap to a looming fiscal crisis. Under current law, deep reductions in the Medicaid DSH program will take place in fiscal year 2003 and beyond. Without further legislative action, federal Medicaid DSH payments to California will be cut an estimated $184 million in FY 2003.

**Federal Medicaid DSH Allotments to California**




The scheduled cliff in funding in the Medicaid DSH program will result in a loss of tens of millions of dollars for California's "open door providers"—the hospitals and health systems that share a mission and mandate to serve all Californians, regardless of insurance status, immigration status or ability to pay. Although California's open door providers comprise only six percent of hospitals statewide, they provide nearly 40 percent of the inpatient care to California's low-income and uninsured patients and more than half of all outpatient care delivered by hospitals to the uninsured. In addition to providing access to extensive inpatient and outpatient services for low-income populations, these essential institutions also play a critical role in delivering high-cost specialty services—such as trauma and burn care—and other public goods that

August 2001

benefit all members of the community. For example, they operate more than 60 percent of all Level I trauma centers statewide and train almost half of California's medical residents.

The Medicaid DSH program is one of the critical funding sources that has maintained the fiscal viability of open door providers and allowed them to deliver needed health services to low-income and uninsured populations. Many open door providers in California are under severe financial distress and face significant budget deficits. This situation is the result of an increasing concentration of uninsured patients being served by open door providers; intense marketplace changes, such as the rise of Medicaid managed care; and declining patient revenues and subsides that have historically supported these vital institutions.

Unless the Medicaid DSH funding improvements enacted under BIPA are extended permanently beyond FY 2002, public hospitals and health systems will be severely challenged to provide access to health care for many of the low-income patients they currently serve. Removing the cliff in Medicaid DSH funding scheduled for 2003 would support the efforts of California's open door providers to continue to meet the growing health care needs of the communities they serve.

**Removing the cliff in Medicaid DSH funding is needed to ensure health care access for California's low-income and uninsured populations.**

## Federal Action

Two bills have been introduced that would extend changes contained in BIPA regarding Medicaid DSH allotments and remove the cliff in funding currently scheduled for 2003: H.R. 854, the "Medicaid Safety Net Hospital Continued Preservation Act of 2001," sponsored by Representatives Whitfield and DeGette, and S. 572, the "Medicaid Safety Net Hospital Preservation Act of 2001," sponsored by Senators Chafee, Graham, Helms, Feinstein, Hutchison, and Lincoln. These legislative efforts will safeguard essential funding to states to support access to care for low-income individuals through the Medicaid program.

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P.E.A.C.H., INC.
Private Essential Access Community Hospitals

CALIFORNIA HEALTHCARE ASSOCIATION

CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

# MAINTAIN THE UPPER PAYMENT LIMIT
# PRESERVE CALIFORNIA'S SAFETY NET

## Overview

- The Centers for Medicare and Medicaid Services (CMS) has issued a proposed rule that will devastate California's Medi-Cal program and eliminate the ability of public and private safety net hospitals to meet the health care needs in their community and respond to a natural or other disaster.

- The proposed rule completely undermines last year's bipartisan compromise adopted as part of the Benefits Improvement and Protection Act (BIPA) and final regulations that recognized and protected California's program.

- The proposed rule provides no protection for California's safety net hospitals. The transition period in the proposed rule neither extends nor eases the transition period that was already in place and agreed to in BIPA.

- Over the course of the transition outlined in the rule, California will lose *at least $1 billion* in federal Medicaid payments to safety net hospitals. Once the rule is fully implemented, the loss to California will be *at least $300 million* per year.

- The magnitude of this loss will result in major reductions in health care services and could force some hospitals to close.

- Access to health care services for California's increasingly diverse, working poor and uninsured populations, as well as access to highly specialized health care services such as emergency, trauma and pediatric care for all community residents, will be seriously jeopardized.

***The Issue***
CMS has issued a proposed rule to reduce from 150% to 100% the Medicaid Upper Payment Limit for public hospitals, a move that will significantly cut funding for health care services to low-income populations and destabilize California's entire health care industry.

***The Impact***
California will lose *at least $1 billion* in federal Medicaid payments to safety net hospitals over the course of the transition outlined in the rule. Once the rule is fully implemented, the loss to California will be *at least $300 million* per year, jeopardizing access to vital health care services for communities throughout the state.

***The Solution***
Preserve the 150% UPL for California and ensure that the state's program is held harmless from CMS's proposed rule.

## Background on the Upper Payment Limit Agreement

- The draft rule undermines a carefully crafted bipartisan agreement reached last year regarding the "Medicaid Upper Payment Limit (UPL)"—the maximum amount the federal government will pay states and specified groups of providers for Medicaid services.

- The agreement safeguards federal dollars by setting more stringent limitations on states' use of Medicaid funding while protecting states, like California, with legitimate programs that use the funds exclusively to support access to care for low-income populations.

- The agreement was incorporated in legislation enacted at the end of 2000 in BIPA and regulations that became effective in March 2001.

- For more than 10 years, California has consistently directed these supplemental Medicaid funds to safety net hospitals that care for the greatest numbers of low-income, uninsured and medically needy Californians. These funds have become an integral part of the patchwork of funding that supports safety net hospitals. The loss of these funds pushes this fragile and unstable financing system to the brink of collapse.

## Status of Proposed Rule

- CMS published the proposed rule in the November 23, 2001, *Federal Register*. A 30-day comment period is provided. CMS has indicated that it plans to finalize the rule by February 2002.

## Impact of Draft Rule: Devastating Losses to California

- ***The proposed rule will reduce or eliminate access to high quality, essential health care services used by all community residents.*** While over 5 million Medi-Cal beneficiaries and 7 million uninsured Californians rely on the safety net to meet their health care needs, the entire community uses services, such as emergency room and trauma care, provided by safety net hospitals. It is critical that communities not lose access to these vital, life-saving services.

- ***The proposed rule will jeopardize the ability of safety net hospitals to prepare for and respond to a natural or other catastrophe.*** These hospitals provide emergency care to thousands of Californians every day and are the first place people turn to in a health care crisis. At a time when hospitals are being asked to redouble their efforts to prepare to respond to a potential terror attack, the proposed rule will only further erode an already weakened safety net system.

- ***The proposed rule will devastate California's Medi-Cal program.*** Although the higher payment limit applies only to public hospitals, the structure of California's Medi-Cal program intrinsically links public- and private-sector hospitals. Private safety net hospitals, children's hospitals and teaching hospitals—as well as public hospitals—all receive supplemental Medi-Cal payments and all would be seriously harmed by the proposed change.

## Policy Recommendation

Congress must act immediately to preserve the 150% UPL for California and ensure that the state's program is held harmless from CMS's proposed rule.

# California's Public Hospitals and Health Systems: Heart of the Health Care Safety Net

*Presented by*

Denise K. Martin
President and CEO
California Association of Public Hospitals and Health Systems

*Before the*

Senate Health and Human Services Committee
Informational Hearing: Cost Effective Agenda for Health Access for Children and Families

January 16, 2002
Sacramento, CA

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# Public Hospitals & Health Systems

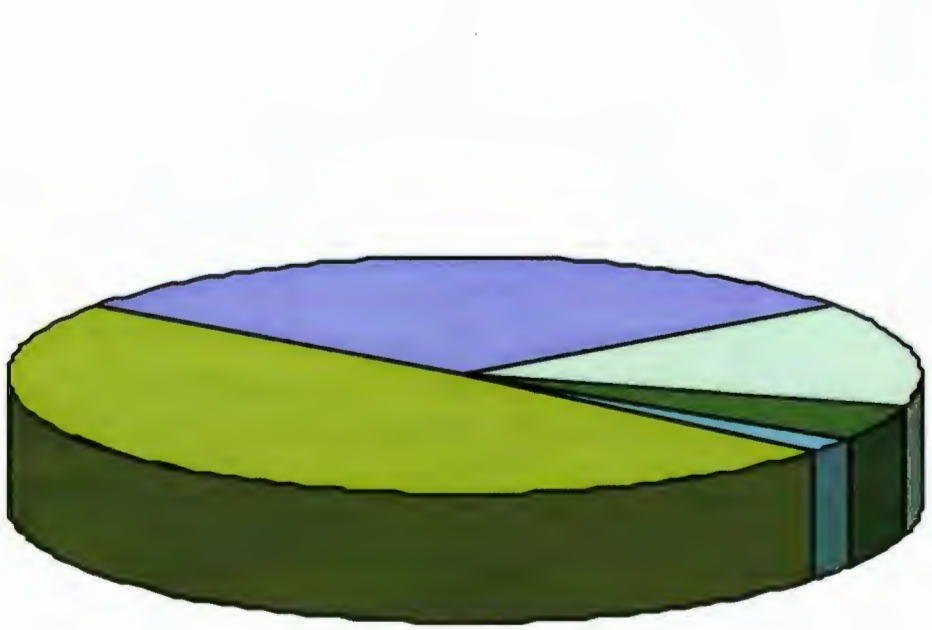
## *Providing Public Goods for the Whole Community*

- ✔ Inpatient Services
- ✔ Outpatient Care
- ✔ Emergency Servies
- ✔ Trauma Care
- ✔ Poison control
- ✔ Burn treatment centers
- ✔ Psychiatric services (emergency and chronic)
- ✔ Environmental health
- ✔ EMS coordination
- ✔ Hazmat monitoring and response
- ✔ Disaster response (e.g., bioterrorism, earthquakes)
- ✔ Substance abuse services
- ✔ Communicable disease surveillance
- ✔ Graduate medical education
- ✔ Correctional medicine (prisons and jails)

## *Caring for Vulnerable Populations*

- ✔ Medi-Cal
- ✔ uninsured
- ✔ Healthy Families
- ✔ poor elderly
- ✔ low-income populations
- ✔ high risk OB/infants
- ✔ victims of violence
- ✔ mentally ill
- ✔ migrant populations and undocumented immigrants
- ✔ CCS children
- ✔ refugees
- ✔ non-English speaking populations
- ✔ HIV-infected individuals
- ✔ drug resistant TB and newly emerging pathogens
- ✔ substance abusers
- ✔ homeless

# Public Hospitals: Patient Mix by Race

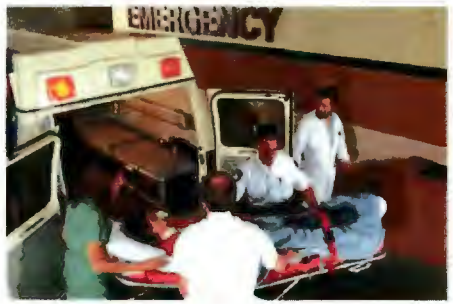


- Latino (49%)
- White (30%)
- African American (14%)
- Asian (5%)
- Other (2%)

70% of inpatients are people of color

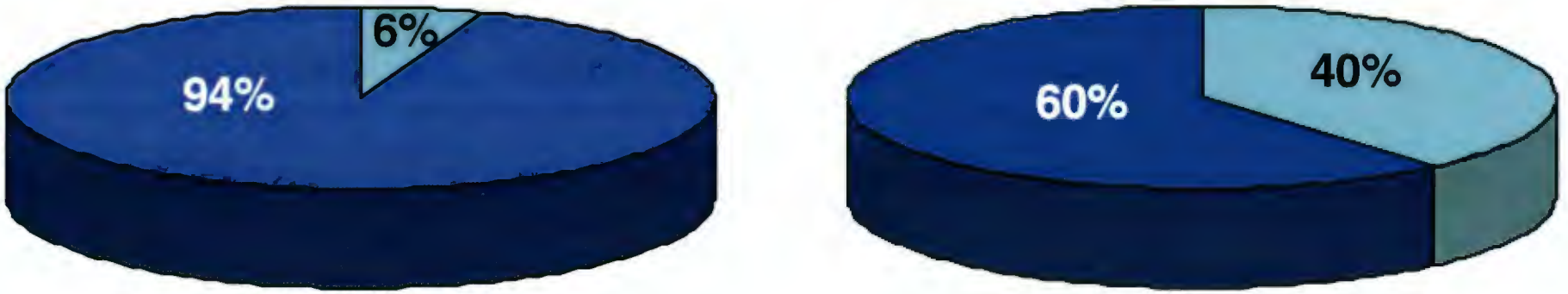
# Public Hospitals & Health Systems: By the Numbers

- ✔ **87%** of outpatient care to medically indigent
- ✔ **74%** of inpatient care to the medically indigent



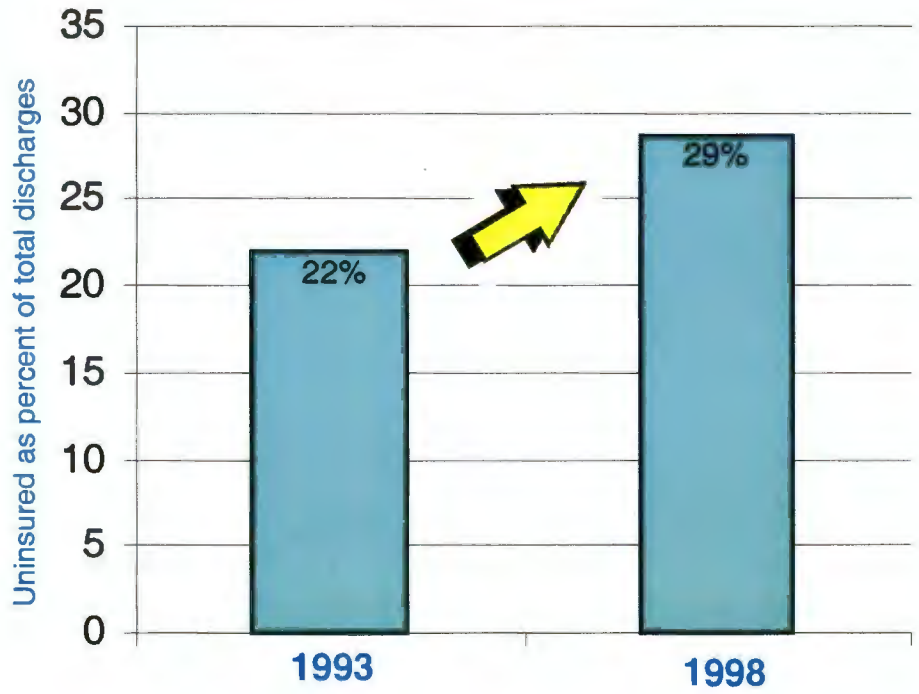

- ✔ **64%** of level I trauma centers
- ✔ **63%** of psychiatric emergency care
- ✔ **61%** of the burn care
- ✔ **50%** of all medical residents in the state
- ✔ **47%** of hospital-based outpatient care to the Medi-Cal and uninsured populations
- ✔ **32%** Medi-Cal neonatal intensive care
- ✔ **11 million** outpatient clinic visits annually
- ✔ **10.5%** of all hospital beds in state

# Public Hospitals: Disproportionate Share of Care to Uninsured



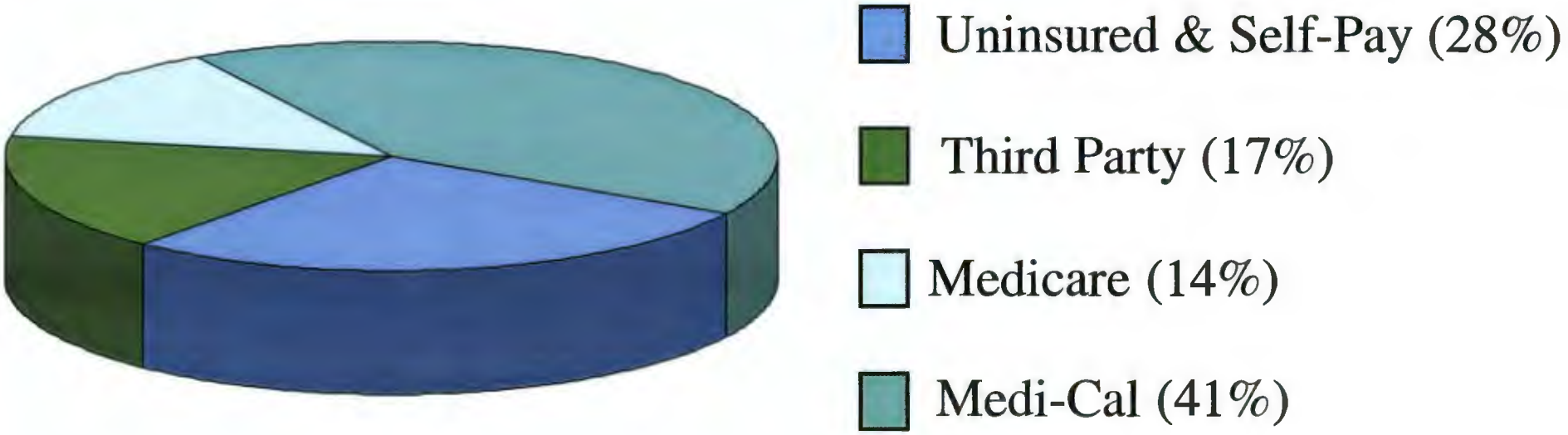

Although public hospitals represent only 6% of hospitals statewide, they account for 40% of uninsured discharges

# Rising Concentration of the Uninsured in Public Hospitals



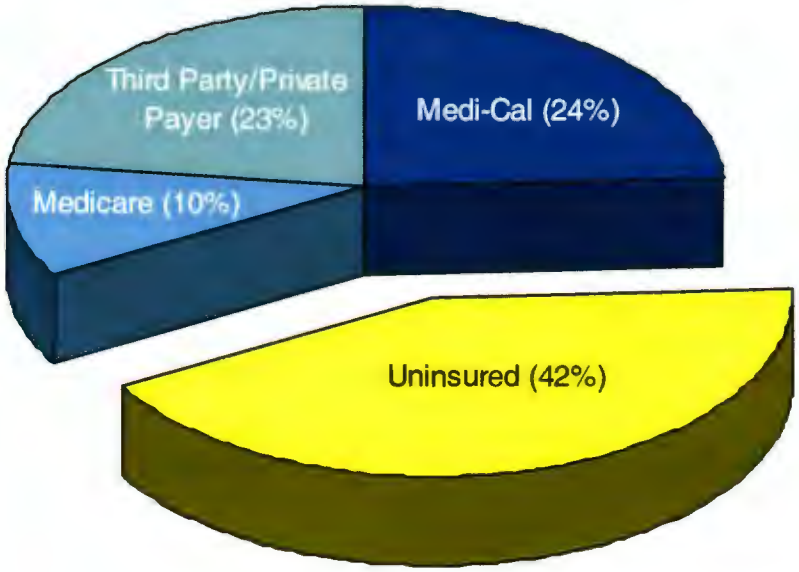

Uninsured patients are increasingly concentrated in public hospitals

# Public Hospitals: Average Payor Mix

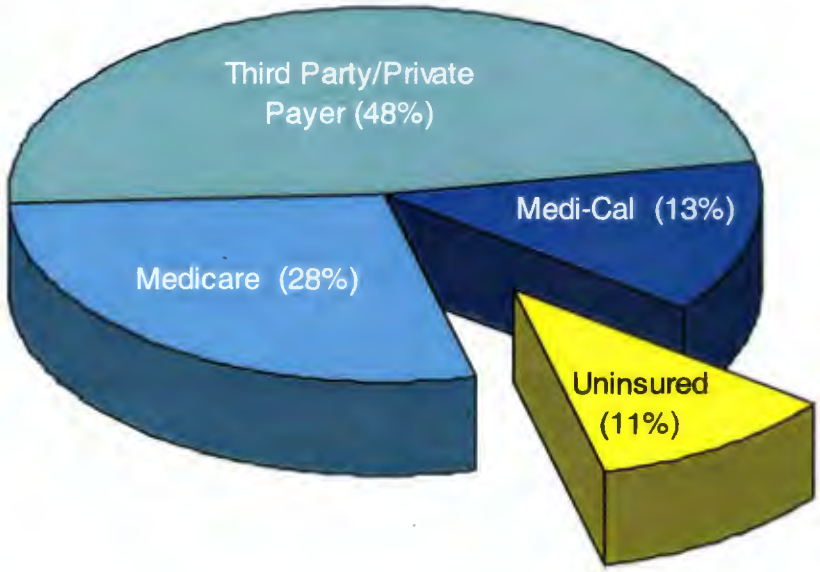



69% of inpatients are low-income or uninsured

# Outpatient Visits to California Hospitals By Payor




Public Hospitals & Health Systems




Other California Hospitals

Hospital outpatient care for uninsured patients is heavily concentrated at public hospitals & health systems

# Environmental Pressures Squeezing Public Hospitals

- ✔ Federal Medicaid DSH "cliff" ($184 million loss)
- ✔ Elimination of 150% inpatient UPL ($300 million annual loss)
- ✔ Proposed increase in DSH administrative fee ($30 million→$85 million)
- ✔ Declines in Prop. 99/tobacco tax ($336 million in FY 89-90 →$71 million in FY 01-02)
- ✔ Underfunded ER/trauma

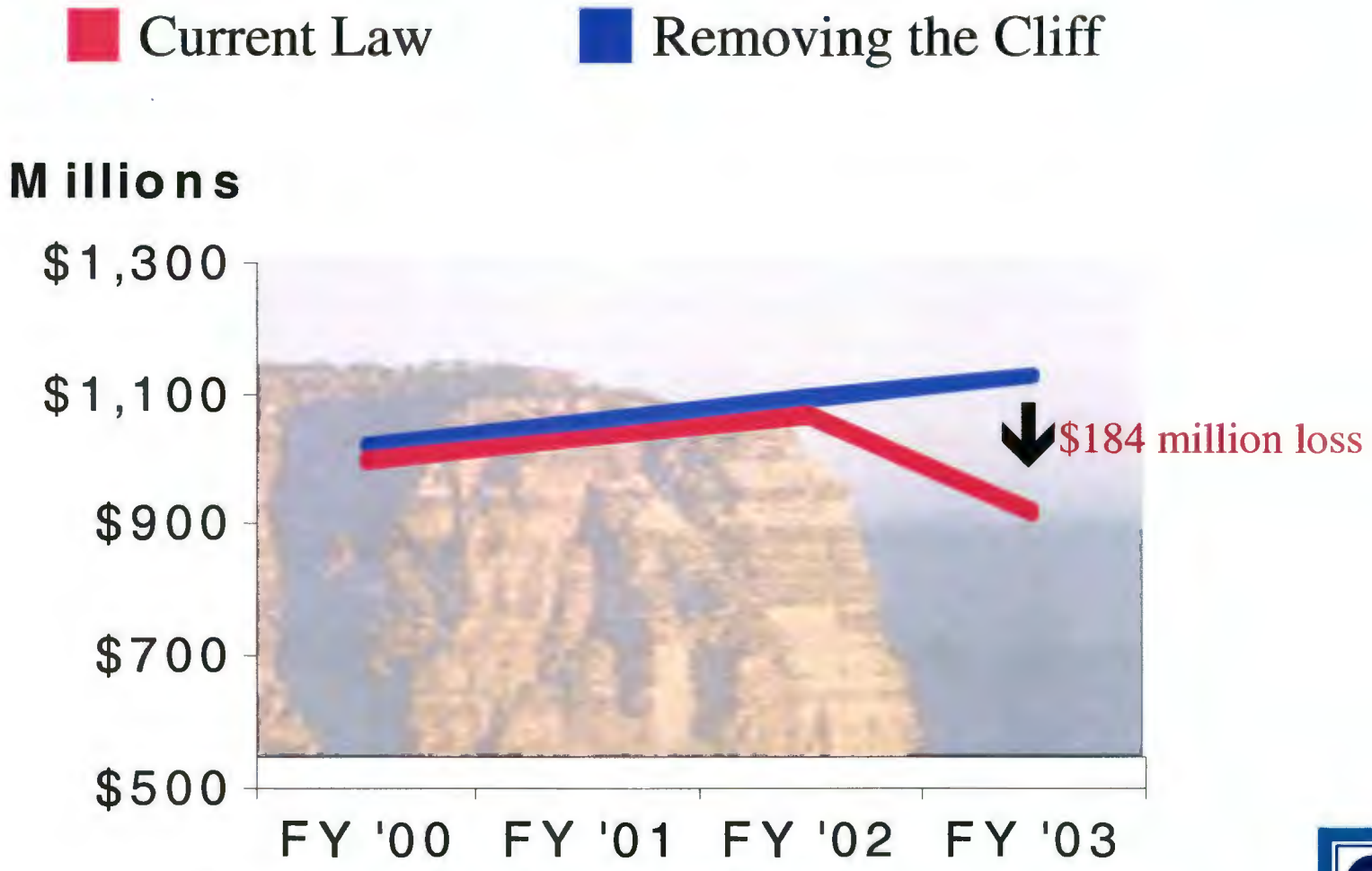
- ✔ Rising concentration of uninsured patients
- ✔ Workforce shortages (esp. nursing)
- ✔ Seismic safety
- ✔ Rising drug costs

- ✔ State budget crisis
- ✔ Economic recession
- ✔ Rising number of uninsured (approx. 7 million +)
- ✔ Bioterrorism

# Major Federal Threat #1: Elimination of the 150% Medicaid UPL

- ✔ Devasting reductions in federal Medicaid payments to California's safety net hospitals
- ✔ Loss of *at least* $300 million annually once rule is fully implemented
- ✔ Loss of *at least* $1 billion over the course of the transition to the new limit
- ✔ CMS plans to finalize rule in February 2002

# Major Federal Threat #2: Medicaid DSH "Cliff"




Federal Statewide Medicaid DSH Allotments to California

# Major State Threat: Increase in the DSH Administrative Fee

- ✔ Governor's budget proposes to increase "administrative fee" for the Medi-Cal disproportionate share hospital (DSH) program from $30 million (FY 01-02 level) to $85 million
- ✔ Represents a loss of $55 million in Medi-Cal DSH funds to safety net hospitals
- ✔ Impacts safety net hospitals that treat the most vulnerable patients, including uninsured
- ✔ May increase federal scrutiny of the Medi-Cal program, inadvertently harming California's efforts in Washington, DC, to address DSH "cliff" and UPL matters

TESTIMONY OF: CARMELA CASTELLANO

CALIFORNIA PRIMARY CARE ASSOCIATION

# The Role of Community Clinics and Health Centers in California's Safety Net

# California Primary Care Association

The California Primary Care Association (CPCA) is a statewide association representing a network of over 500 non-profit community clinics and health centers that serve as a safety net for the medically uninsured and underserved.

# CPCA's Membership

- CPCA was founded to create a unified, statewide voice for community clinics and health centers.
- Members are comprised of urban and rural health providers, migrant health centers, free clinics, federally qualified health centers (FQHCs), and look-alikes.

# FQHCs

- Federally Qualified Health Centers were established to provide health care to low-income and uninsured individuals.

- They are located in areas with few providers and low-income, uninsured populations.

# CLINICS AS SAFETY NET PROVIDERS

- Clinics serve clients through Medicare, Medi-Cal, Healthy Families, CHDP, EAPC, Private Insurance and Sliding Fee Scale.

- In 1999, California community clinics provided 2,043,551 encounters for the uninsured.

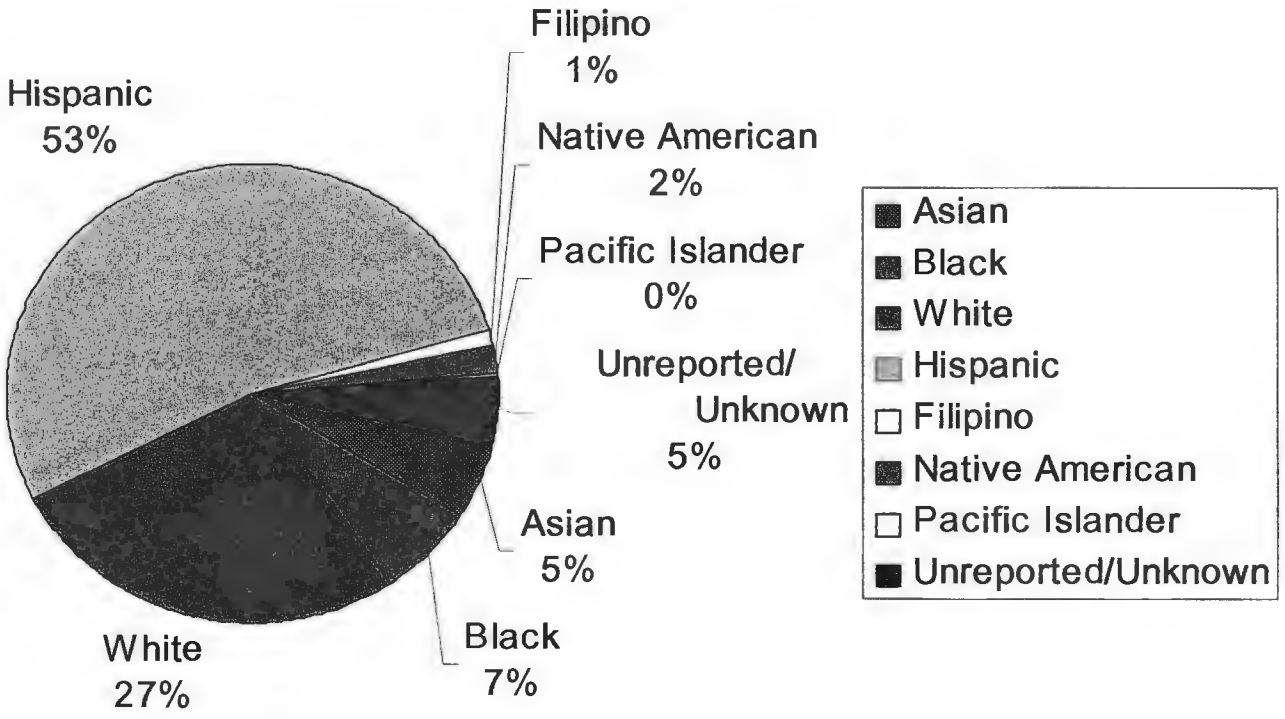
# Clinics' Patient Profile

| | |
|---|---|
| Patients | 2,769,659 |
| Female | 66% |
| Male | 34% |
| Encounters | 9,284,807 |

# Other Demographic Factors

- **Language**: 44% of Clinic Patients Speak a Primary Language Other Than English
- **Children**: Clinic Serve Over One Million Low-Income Children
- **Pregnant Women**: Maternity Care and Delivery Services Account for 11.5% of all Patient Visits
- **Minority Populations**: 70% of Clinic Patients are Ethnic or Racial Minorities

# PATIENTS BY ETHNICITY



# Major Challenges

- Persistent Number of Uninsured
- Phase-out of cost-based reimbursement and transition to a Prospective Payment System
- Provider Shortage Crisis
- Infrastructure and I.T.
- Downturn in the Economy

# Recent Investments In Clinics

- Expanded Access to Primary Care
- Cedillo-Alarcon Community Clinic Investment Act
- Rural Demonstration Projects
- Rural Health Service Development Program and the Seasonal Agricultural Migratory Worker Program

# The Role Of Foundations

- $40 million total made available for a Community Clinic Initiative for the Development of Information Technology from the Tides Foundation
- $45 million for a Sustainable Solutions Initiative to Assist in Clinic Financing and Improvement in Operations from the California Endowment
- $10M for Network Development at the local level

# The Potential Of Clinics

- Availability of Preventive Care for Families
- Full-Scope Services Offered in a Cost-Effective and Local Environment
- A Primary Point of Access for Enrollment in Public Coverage Programs

# Important Proposals For Reform

- Single Point of Entry
- Continuous eligibility for adults for the Medi-Cal program
- Elimination of the Asset Test for adults for the Medi-Cal program
- Coverage for Parents in Healthy Families

# CLINICS' LONG-TERM VIABILITY

- Continued Investment
- Support for Important Clinic Programs
- Continued Expansion and Improvements for Public Health Programs
- Raising Awareness of Uninsured and the Overall Role of Safety Net Providers

# Testimony to the Senate Health Committee

**Senator Deborah Ortiz, Chair**
**by Lucien Wulsin Jr.**
**Insure the Uninsured Project**

## COUNTY PROGRAMS FOR INDIGENT ADULTS
**January 16, 2002**

California covered indigent adults (MIAs) through MediCal with no federal matching funds until 1983. MediCal coverage was terminated because the state was in recession and no federal matching funds were available for their care. A reduced amount of state funding was transferred to the counties, which took on the responsibility for operating health systems for indigent adults pursuant to their obligations under Welfare and Institutions Code §17000. County programs provide care for a mix of chronically ill adults and individual medical emergency episodes for healthy adults.

In California there are about 1.2 million indigent adults with incomes below the federal poverty line and another 2 million with incomes between 100% and 250% of FPL.[1] Professor E. Richard Brown estimates that thirty eight percent are parents with children who can be covered under MediCal or under the state's §1115 waiver to cover the parents of Healthy Families children. Over 60% are adults, who are not parents of minor children and thus not eligible for either the MediCal or Healthy Families absent a federal Medicaid §1115 waiver to cover *unlinked adults.*[2] 75% of uninsured adults are citizens or legal permanent residents and thus are not disqualified for MediCal by immigration status.[3] We therefore estimate there are 730,000 uninsured unlinked adults below 100% of FPL and 1.2 million uninsured unlinked adults between 100% and 250% of FPL.

California counties are funded through realignment, Prop 99 and a county match to care for indigent adults (MIAs). They report spending at least $1.5 billion on care for 1.5 million indigent uninsured.[4] Counties with county hospitals also receive SB 855 (Disproportionate Share Hospital -- DSH) and SB 1255 funding.

Counties have developed very different local delivery systems and funding, some of which are excellent models to cover the uninsured while other are not.[5] California counties divide into three groups: CMSP (County Medical Services Program for small counties), payor and provider MISP (Medically Indigent Services Program) counties.

### <u>County Medical Services Program for 34 Small Counties</u>

County Medical Services Program pays for care to indigent adults in 34 mostly rural counties with small populations. CMSP counties operate a fee for service system of care for the uninsured indigent through the state Department of Health Services. It is similar to MediCal, but with no federal matching funds and fewer benefits.

CMSP counties spent $176.4 million in FY 2000 on care for 63,000 users of services (a cost per user of $2800).[6] Of that total, 54% was spent on hospital inpatient services, 14% on hospital outpatient care, 19% on pharmacy and 13% on medical care (this includes both community clinic services and physician visits).[7] The program appears to provide comparatively little funding for out of hospital care to uninsured indigent adults. In a recent ITUP study of 10 Northern California counties, we found that CMSP paid for approximately half of hospital care to the uninsured; while it paid for only about 15% of community clinics' uninsured visits.[8] Clinics' uninsured visits were paid in part through CMSP, EAPC, other state programs, other county programs and the patients themselves.[9]

We estimate that reported users of CMSP services are 80% of uninsured, unlinked indigent adults below the federal poverty line in the 34 CMSP counties and 37% of uninsured, unlinked indigent adults below 200% of FPL.[10] In using the term uninsured, unlinked indigent adults we refer to individuals who could not qualify for either MediCal or Healthy Families due to linkage -- a term which includes families with children, the disabled and aged and excludes single individuals and couples without minor children.

For 1998-9, CMSP was funded as follows: realignment $124 million, state general fund $20 million, Proposition 99 $10 million, and county funds $5.5 million.[11] At recent workgroups we conducted in Redding and Eureka, California, participants pointed to the difficulties they experience in enrolling eligible patients in the MediCal and CMSP programs in rural areas due to the inaccessibility of county social services offices and the enrollment hassle factors of excessive verifications and the asset test.

## Medically Indigent Services Program (MISP) Payor Counties

Payor counties such as Orange and San Diego, Sacramento, Santa Barbara and Fresno pay private providers for their care to medically indigent adults. Their care to the uninsured is financed through realignment, Prop 99 and county matching funds. These counties have no access to federal matching funds for their MISP programs for the county indigent.

Individual private hospitals in these counties may receive significant DSH (Disproportionate Share Hospital) and SB 1255 funding to defray their costs of caring for the uninsured.[12] University of California hospitals in Orange, San Diego and Sacramento contribute the required state/local match. By contrast, in the 10 small Northern California counties we studied, few or none of the hospitals reported receiving any DSH funding.[13]

Eligibility rules and the eligibility process for the payor county programs are roughly the same as for MediCal. Covered services are somewhat less. Provider payments are typically a modified fee for service within a capped allocation.[14]

In San Diego County for example, there are an estimated 541,000 uninsured -- about 19% of the county's population under age 65. San Diego County covered 22,000 indigent adults at a cost of $40 million in the year 1997-8 through its CMS (County Medical Services) program. We estimated there are 54,000 uninsured unlinked adults in the

county with incomes below 100% of FPL; about 40% of this eligible population uses the county program.

- The county reports spending 49% of its CMS budget on inpatient services, 37% for specialty care and 12% on primary care clinics.
- The county's CMS program pays for 19,700 (274 bed days per 1000 uninsured unlinked adult with incomes below 100% of FPL) inpatient days and 31,000 (574 visits per 1000) emergency room visits and 133,000 medical visits (2.4 visits per uninsured unlinked adult with incomes below 100% of FPL).[15]
- San Diego County private hospitals receive about 60% of the DSH funding levels of Orange County private hospitals.

In Orange County for example, there are 667,000 uninsured -- about 23% of the county's population under age 65. Orange County covered 26,000 indigent adults at a cost of $52 million in the year 1998-9 through its MSI (Medical Services to Indigents) program. We estimate there are 67,000 uninsured unlinked adults in the county with incomes below 100% of FPL; about 40% of this eligible population use the county's MSI program.

- The county spends 74% of its MSI budget on hospital services, 20% for specialty care and 3% on primary care clinics.
- The county MSI program pays for 28,800 inpatient days (430 bed days per 1000 uninsured unlinked adults with incomes below 100% of FPL) and 9,400 emergency room visits (140 visits per 1000) and 100,000 medical visits (1.5 visits per unlinked, uninsured county indigent adult).[16]

Provider networks in payor counties such as San Diego and Fresno are quite restricted. In San Diego, primary care is reimbursed only in community clinics, and clinics are reimbursed for only 1 in 8 uninsured visits through the CMS program.[17] In Fresno, the county's indigent program is concentrated in a private hospital, the Fresno Community/University Medical Center, and the network of care needs to be expanded.

Reported payment rates for care to the uninsured are less than or comparable to MediCal levels in these counties. In San Diego and Orange counties, private hospitals report to OSHPD that their inpatient reimbursements through the county program for the medically indigent are approximately the same as under the MediCal program; Orange hospitals, however, report their outpatient reimbursement under the county program is half of their reimbursement under the MediCal program. Fresno private hospitals report their county program payments per inpatient day and per outpatient visit are about half of the MediCal program. Sacramento private hospitals report their county program payments per inpatient day and per outpatient visit are about 10% less than MediCal program payments. [18] We noted large disparities in a number of counties between the county spending reported to the state Department of Health Services -- the Medically Indigent Care Reporting System and the hospital reports to the Office of Statewide Health Planning and Development (OSHPD) of revenues received from the counties for care to county patients.

Financing of county health care in payor counties is a mix of realignment, Prop 99 and county General funds:

- For example in San Diego County in 1998-9, county health was financed by $74 million in realignment, $8 million from Prop 99 and county General Funds.[19]
- In Orange in 1998-9, county health was financed by $69 million in realignment, $8 million from Prop 99 and county General Funds.[20]
- County health departments provide more health services than care to uninsured adults; for example, they provide public health services. Less than half of available county health revenues in San Diego and Orange Counties are devoted to their county programs for the uninsured indigent adults.

The biggest service deficit in payor counties' health programs for uninsured adults is the lack of access to primary and outpatient care.[21] The chronically ill uninsured in payor counties could benefit from a better managed delivery system. Orange County has considered merging its MSI (Medical Services to Indigents) program for uninsured adults into CalOptima, its MediCal managed care system; health officials in Orange conducted extensive studies, but concluded the MSI program's funding was insufficient.

## Medically Indigent Services Program (MISP) Provider Counties

"Provider" counties such as Los Angeles, San Bernardino, Santa Clara, Kern and San Francisco provide care to the medically indigent adults through public hospitals and clinics.[22] Provider counties' care to the uninsured is financed through realignment, Prop 99, county matching funds, and federal funding though the DSH (SB 855) and SB 1255 programs.

Provider counties' eligibility levels are typically broader than the MediCal program, the CMSP counties and the payor counties. In Alameda and Santa Clara Counties, indigent uninsured adults are eligible for care with incomes up to 200% of FPL; those with incomes between 100 and 200% of FPL are expected to pay on a sliding fee scale basis. In Los Angeles County, sliding fee scale contributions are expected for those with incomes over 133% of FPL. Provider counties do not typically exclude uninsured patients based on age, immigration status or categorical linkage to MediCal and Healthy Families as the payor and small CMSP counties do.[23]

Provider counties do not use a MediCal or Healthy Families style enrollment process, but typically assess patient eligibility on an encounter basis. In Los Angeles, a patient's eligibility is assessed on admission or at the first visit, then re-assessed monthly for inpatient and semi-annually for outpatient care. In San Francisco, eligibility is reassessed monthly or on each visit. In Alameda County eligibility is redetermined annually.[24]

Provider counties rely on a shifting mix of federal MediCal matching through DSH (SB 855) and SB 1255 programs, state realignment and Prop 99 funding and county General Funds to support their care to the uninsured. The respective contributions are constantly shifting with recent declines in SB 855 and Prop 99 and recent increases in realignment and SB 1255 funding. Counties use only a portion of their health revenues for care to the uninsured; they also provide public health services and care to many MediCal patients.

Unlike MISP payor counties, provider counties have access to federal matching funds for hospital based care to the uninsured through the DSH and SB 1255 programs.

- Alameda County health was financed in 1998-9 in part with $48 million from realignment, $7 million from Prop 99, $40 million from DSH (SB 855), $12 million from SB 1255 and county General Funds. In Alameda in 1998-9, $69 million was budgeted for care to the uninsured.
- Santa Clara County health was financed in 1998-9 in part by $42 million from realignment, $8 million from Prop 99, $43 million from DSH, $12 million from SB 1255 and county General Funds. Santa Clara County spent $93 million on care to the uninsured in 1998-9.
- Los Angeles County health was financed in 1998-9 in part by $395 million from realignment, $66 million from Prop 99, $237 million from DSH, $172 million from SB 1255, $114 million from the county's §1115 waiver and $160 million in county General Funds. Los Angeles County spent $764 million on care to the uninsured in 1998-9.[25]

The financial status of county hospitals in provider counties is heavily dependent on their success in attracting and retaining MediCal eligible patients within the county system. For example in Los Angeles County with the state's largest and highest percentages of uninsured, the county hospitals' inpatient ratios were roughly 33% uninsured, and 55% MediCal.[26] Many uninsured patients admitted to the county hospital eventually qualify for MediCal due to the efforts of county eligibility staff. Some county hospitals are experiencing declining MediCal participation due to a number of factors including increasing competition from private hospitals and declines in local MediCal enrollment. County hospitals are typically reimbursed for their care to the uninsured at cost.

Delivery systems in provider counties are for the most part based in the county hospital for both historic and financial reasons associated with medical education and state and federal financing rules. The relative emphasis each county places on hospital based care and primary care outside hospital settings is very different.

- In Los Angeles, 85% of spending occurs in the county hospitals; the mix is 53% inpatient, 37% outpatient, and 8% emergency. 3% is spent for primary care through community clinics and other private partners.
- In Alameda, the mix is 35% inpatient, 55% outpatient, and 8% emergency. 10% is spent for primary care through community clinics.
- In Santa Clara, 82% of spending occurs in the county hospital; the mix is 35% inpatient, 49% outpatient, and 14% emergency. 3% is spent for primary care through community clinics.
- In San Francisco, the mix is 50% inpatient, 33% outpatient, and 14% emergency. 0.2% is spent for primary care through community clinics.[27]

Private hospitals and doctors are usually not reimbursed by provider counties for their care to the indigent uninsured, except to a limited degree through Prop 99, SB 12 and DSH.[28] A study in Los Angeles County noted that less than a third of net DSH funds were used for care to the uninsured in private hospitals and over two thirds in public hospitals.[29]

Contra Costa County is the only provider county which uses a public, managed care delivery system for its indigent adults. Its reported managed care enrollment by its indigent adults is quite low and its cost per user is very high: $480 per member per month or $5760 annually.[30] Several provider counties, including Alameda, Los Angeles and San Francisco have considered merging the MediCal and uninsured into a single managed care delivery system, county wide.

Provider counties report their unduplicated users and expenditures to the state of California. While the accuracy of the county reports is highly variable, the reported annual cost per unduplicated users and the reported participation of the county indigent uninsured in county health programs is as follows:

**Provider Counties Eligibles, Users and Spending[31]**

| County | Uninsured | Unlinked uninsured adults below 200% of FPL | County reported unduplicated users | Participation rate | County reported uninsured spending | Spending per unduplicated user |
|---|---|---|---|---|---|---|
| Alameda | 200,000 | 48,000 | 55,000 | 114% | $67 million | $1218 |
| Los Angeles | 2.6 million | 624,000 | 646,000 | 103% | $764 million | $1182 |
| Santa Clara | 258,000 | 62,000 | 68,000 | 110% | $93 million | $1367 |

This indicate that provider counties are doing an excellent job of reaching the uninsured county indigent -- i.e. unlinked, uninsured adults are participating in the provider counties' programs at a much higher rate than in the payor or CMSP counties -- however, it could be distorted by inaccuracies in the count of unduplicated users. Another comparison is to look at bed days, emergency room visits and outpatient visits for the target adult population, which avoids the uncertain accuracy of the county report of unduplicated users. The use of hospital and emergency room care in the provider counties equals or exceeds that of commercially insured populations while use of primary and outpatient services is somewhat less than the commercially insured. This comparison may also be distorted as the provider counties serve a broader group of eligibles than the payor or small counties.

**Provider Counties: Eligibles, Days and Emergency and Outpatient Visits[32]**

| County | Uninsured | Unlinked uninsured adults below 200% of FPL (eligibles) | Hospital days and days per 1000 unlinked uninsured adults below 200% of FPL | Emergency room visits and visits per 1000 unlinked uninsured adults below 200% of FPL | Outpatient visits and visits per uninsured unlinked adult below 200% of FPL | Spending per unlinked uninsured adult below 200% of FPL |
|---|---|---|---|---|---|---|
| Alameda | 200,000 | 48,000 | 12,600 (262 per 1000) | 19,000 (396 per 1000) | 155,000 (3.2 per eligible) | $1395 |
| Los Angeles | 2.6 million | 624,000 | 191,000 (306 per 1000) | 251,000 (402 per 1000) | 1,923,000 (3.1 per eligible) | $1224 |
| Santa Clara | 258,000 | 62,000 | 12,200 (197 per 1000) | 31,000 (500 per 1000) | 154,500 (2.5 per eligible) | $1500 |

## INSURE THE UNINSURED PROJECT RECOMMENDATIONS

We suggest restructuring safety net funding so that is linked to the disproportionate financial burdens of caring for genuinely uninsured patients with no other payment source. Current safety net funding is not linked to care of uninsured patients with no other source of payment; it has become a series of intricate and impenetrable institutional subsidies, reflecting trade-offs negotiated at county and state levels between and among provider associations and state and county governments. Funding is narrowly channeled (silo funding): this amount is for emergency room doctors, this portion is for public and that portion for private DSH hospitals, this pot for community clinics, and that pot for specialists. We suggest that safety net funding be linked to systems of care for the uninsured and be proportionate to their care of the uninsured.

We also suggest seeking federal approval of a §1115 Medicaid waiver; unlinked adult citizens and legal permanent residents (75%) would be eligible for full scope benefits, and undocumented and others without legal permanent residency status (25%) would be eligible for limited scope benefits. Arizona, Oregon, Massachusetts, Tennessee and New York already have federal 1115 waivers to cover indigent adults through Medicaid managed care. Oregon and Tennessee were particularly successful at reducing their numbers of uninsured through waivers.[33] Recent federal guidelines put a severe burden of proof on a state seeking to expand public coverage above 200% of FPL.[34]

County spending on the uninsured could be doubled with a federal Medicaid match, but only if the state and counties are willing to expand coverage. The additional federal matching funds would allow the program to expand eligibility, enrollment and access to medical services quite dramatically. Counties' federal funds through DSH and SB 1255 cannot be used to match other federal funds in meeting the matching requirements for Medicaid and Healthy Families. However county realignment, Prop 99 and county General Fund can be used as local match in the federal MediCal or Healthy Families programs. Some counties already use a portion of these funds as their match for DSH, and SB 1255; more information needs to be gathered on the extent of matching opportunities.

California has substantial federal, state, and county financial commitments to "safety net" providers and barriers that impede efforts to develop systems of coverage for the indigent:

- Multiple, disconnected programs and funding streams dedicated to the care of the indigent uninsured.[35]
- Funding streams, financial incentives and delivery systems for care to the indigent uninsured that are at odds with the managed care approaches for the insured commercial, MediCal and Healthy Families populations.[36]

Some county Local Initiatives operating MediCal managed care plans have been extraordinarily successful. They have strengthened local safety net providers, improved the delivery system for MediCal eligibles, created innovative expansions of coverage and

succeeded in the head to head competition for Healthy Families enrollment.[37] Others have been markedly less successful in these roles.

For the provider counties, instituting MediCal managed care coverage for the MIAs poses challenges: competition with private providers, shifting from episodic to managed care and enrollment of their current uninsured patient populations in MediCal managed care coverage. Important benefits include: increased federal funding for emergency, trauma and primary care, better access to care and a significantly improved delivery system. This approach could also help Los Angeles County's public and private providers avoid the threatened financial meltdown as its federal waiver phases out.

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[1] Brown et al, The State of Health Insurance 2000

[2] Ibid. Those with minor children are eligible for but unenrolled in MediCal and will be eligible once the federal waiver is approved. Brown estimates that half are single adults without minor children and 13% are couples without minor children.

[3] Ibid.

[4] See Wulsin at al: California's Uninsured: Programs, Funding and Policy Options (Insure the Uninsured Project, July 1997) available at www.work-and-health.org/itup.

[5] Counties such as San Francisco, Alameda and Santa Clara are using their Local Initiatives as a building block to cover segments of the uninsured. In San Diego, local managed care organizations such as Sharp and Community Health Group are acting as the focal points of local efforts to cover the uninsured. In Orange and San Mateo Counties, the County Organized Health Systems may serve as the building blocks. See Wulsin et al, Insure the Uninsured Project Conference Binders 1999 and 2001, Tabs on County, Clinic and Local Initiative Efforts to Cover the Uninsured available at www.work-and-health.org/itup.

[6] 2000 Summary of County Medical Services Program Expenditures (CMSP Governing Board, 8/30/01

[7] Ibid.

[8] M. Hickey, An Overview of the Uninsured in Northern Rural California (ITUP, Sept. 28, 2001) available at www.work-and-health.org/itup.

[9] Ibid. Self pay accounted for 27% of clinics' uninsured revenues, EAPC and other state programs for 37%, CMSP and other county programs for 28% and CHDP for 9% of clinics' uninsured revenues.

[10] As a rule of thumb, CMSP counties account for 10% of the state's uninsured.

[11] Peter Long, An Overview of California Financing and Coverage (ITUP, Sept. 28, 2001).

[12] See Wulsin et al, Clinics, Counties and the Uninsured (Insure the Uninsured Project, 1999).

[13] Hickey, An Overview of the Uninsured in Northern Rural California

[14] Wulsin et al, Clinics, Counties and the Uninsured

[15] Wulsin et al. Clinics, Counties and the Uninsured: Phase Two (Insure the Uninsured Project, 2000) Data on county users and county spending derived from county reports to California Department of Health Services. Data on county uninsured and unlinked, uninsured adults derived from Brown, The State of Health Insurance 2000. This use data is from 1998-9 Medically Indigent Care Reporting System reports.

[16] Ibid.

[17] Wulsin, Clinics, Counties and the Uninsured: Phase One

[18] Office of Statewide Health Planning and Development, Individual Hospital Financial Data for California: Report Periods July, 1997-June, 1998.

[19] Clinics, Counties and the Uninsured: Phase Two

[20] Ibid.

[21] The use of outpatient care is far lower than for an insured population, while the use of hospital services is far higher.

[22] Clinics, Counties and the Uninsured: Phase One.

[23] Children comprise roughly 10% of county uninsured spending, and in Los Angeles the undocumented account for an estimated 11-12% of county uninsured spending. Ibid.

[24] Ibid.

[25] Clinics, Counties and the Uninsured: Phase Two
[26] Clinics, Counties and the Uninsured: Phase One
[27] Ibid.
[28] Clinics, Counties and the Uninsured: Phase One
[29] Indigent/Bad Debt Net Surplus or Deficit 1995-6 and SB 855 Revenues (Los Angeles County Dept. of Health Serv. 10/97)
[30] Insure the Uninsured Project, Conference Binder 1999, Counties, Local Initiatives Tab available at www.work-and-health.org/itup/conference.
[31] Data on county users and county spending derived from county reports to California Department of Health Services and reported at Clinics, Counties and the Uninsured. Data on county uninsured and unlinked, uninsured adults derived from Brown, The State of Health Insurance 2000. This use data is from 1998-9 and the budget data from 1999-2000.
[32] Data on county hospital days and visits derived from county reports to California Department of Health Services as revised by the counties and reported at Clinics, Counties and the Uninsured. Data on county uninsured and unlinked, uninsured adults derived from Brown, The State of Health Insurance 2000. This county reported use data is from 1998-9 under the Medically Indigent Care Reporting System.
[33] See R. Kronick et al. Expansion of Health Care to the Working Poor: Lessons from Other States (CA Policy Research Center, 1999)
[34] See Health Insurance Flexibility and Accountability Demonstration Projects at www.hcfa.gov/medicaid/hifademo. These guidelines give strong guidance that the waiver requests should not exceed 200% of FPL and should not tamper with the basic minimum Medical eligibility such as coverage for SSI eligibles and children up to age 6 and up to 133% of FPL.
[35] See Wulsin et al. Clinics, Counties and the Uninsured: Phase Two (Insure the Uninsured Project, 2000). Public safety net providers depend on realignment, Prop 99 and DSH (disproportionate share hospital) funding; non profit community clinics depend on EAPC, CHDP and federal grants and contracts; private hospitals depend on DSH, and private doctors depend on SB 12, Prop 99 and patient copayments. State programs such as Family PACT and Breast Cancer Treatment and stand alone MediCal coverage for perinatal care may need to be merged into the system we are proposing. None of the funding streams are now connected to a coherent delivery and financing system. There are also transitional challenges in coordinating with the MediCal programs for the disabled as county eligibility is often the "waiting room" while MediCal eligibility for disability is being assessed.
[36] MediCal managed care is based on a primary care doctor while care to the uninsured is often funneled and managed through a public hospital emergency room or outpatient department.
[37] Clinics, Counties and the Uninsured: Phase Two

**California Healthcare Association**

**Testimony of**
**Michael P. Mahoney**
**President and Chief Executive Officer**
**St. Rose Hospital**
**Before the**
**Senate Health and Human Services Committee**
**Hearing on**
**Cost Effective Agenda for Health Access**

**January 16, 2002**

My name is Michael Mahoney. I am President and Chief Executive Officer of St. Rose Hospital in Hayward, California. Thank you for the opportunity to testify before the Senate Health and Human Services Committee today. I am testifying today on behalf of the California Healthcare Association, responding to the Committee's request to provide a brief overview of the role that hospitals play as safety-net providers. CHA represents nearly 500 members on a range of issues that directly bear on the subject of today's hearing. CHA also works closely with the California Association of Public Hospitals and Health Systems, California Children's Hospital Association, Private Essential Access Community Hospitals, the University of California, and other interested groups to preserve and protect California's health care safety net and the patients it serves.

CHA's goal is for every Californian to have equitable access to affordable, medically necessary, high-quality health care. Meeting this goal in the long run will require significant expansion of access to private and public health coverage,

balanced by the need to maintain a viable health care safety net. California has made incremental progress toward expanded coverage through enactment of the Healthy Families Program and improvements to Medi-Cal, but continues to see erosion in employment-based coverage and significant threats to the health care delivery infrastructure, including the health care safety net and hospital emergency medical services and trauma care.

Access to health care services for California's increasingly diverse working poor and uninsured populations, as well as access to highly specialized health care services such as emergency, trauma and pediatric care, is increasingly jeopardized by the financial fragility of safety-net hospitals, rural hospitals and other hospitals serving their communities and providing emergency medical or trauma-care services. I will briefly focus on these subjects, none of which will be unfamiliar to the members of this committee.

**1. Protection of the health care safety net**

The core of the health care safety net is formed by California's county health systems; by private and public disproportionate-share Medi-Cal providers; by California's children's hospitals; by California's teaching hospitals; and by critical

access hospitals in rural areas of the state. These facilities are highly dependent on a fragile system of financing that is growing more fragile. The core of the health care safety net is augmented by public and private hospital emergency medical and trauma care services provided without regard to the ability to pay, and by charity care and other services provided by many hospitals throughout the state.

As California grapples with the development and financing of cost-effective approaches to providing access to health care for all Californians, the importance of the health care safety net cannot be over-stated. The solution to cost-effective access to health care should not be an either/or debate between expansion of health care coverage and maintenance of a strong and vital health care safety net. In the long-term, even with vastly expanded health coverage, access barriers will remain, as will a significant role for safety-net providers. In the near-term, as growth in the number of uninsured is likely to outpace significant but incremental expansion of health coverage programs, maintenance of the health care safety net is absolutely critical to access.

The financial condition of the hospitals that form California's health care safety net is at a particularly vulnerable point at this time. At the federal level, the Centers for Medicare and Medicaid Services (CMS) has issued a proposed rule to reduce

from 150% to 100% the Medicaid Upper Payment Limit, a move that will significantly cut funding for health care services to low-income populations and destabilize California's entire health care industry. If implemented, California will lose $1 billion in federal Medicaid payments to safety-net hospitals over the course of the transition. Once the rule is fully implemented, the loss to California will be at least $300 million per year. We cannot withstand a decrease of this size without jeopardizing access to vital health care services for communities throughout the state. (We are working very hard in Washington, D.C., to preserve the 150% UPL for California and ensure that the state's program is held harmless from CMS' proposed rule.) Also at the federal level is the possible decrease in California's disproportionate-share hospital (DSH) program of $184 million, which scheduled to take effective in October of this year if our efforts to freeze the program are unsuccessful.

At the state level, the Governor has proposed increasing the disproportionate-share hospital administrative fee to $85 million. Should this proposal be enacted, it would mean a decrease of $55 million for DSH hospitals, the hospitals at the very core of the safety net.

## 2. Expansion of public and private health care coverage

CHA supports policies and legislation that will expand health coverage to obtain the maximum feasible enrollment of Californians in health insurance that offers at least a standard uniform benefit package to all individuals.

The Balanced Budget Act of 1997 imposed severe Medicare cuts on health care providers, and Medi-Cal underpays most providers of Medi-Cal services. On top of this economic quicksand is a private health insurance/managed care system that has ratcheted down payments to hospitals, physicians and other caregivers to the point that the health care delivery system in California is in meltdown. Bankruptcies of health care providers, particularly physician organizations, have exploded.

The most immediate impact on the growing problem of Californians without health coverage is access to medically necessary services. People without health coverage are less likely to see a physician for preventive or routine care; less likely to get their young children immunized; less likely to receive adequate and timely prenatal care; and less likely to see a physician for serious symptoms. Recent studies have

linked lack of health coverage to a severe decline in health status, particularly among those with chronic health problems.

Individuals without a routine source of health care often use hospital emergency rooms as the entry point to primary care. These services are an expensive point of entry into the system because hospitals must be staffed and equipped to handle serious medical emergencies.

Principles that characterize the health care system should include equitable access to health care for all persons; promotion of individual and community health status; continuous improvement of quality and efficiency within the delivery and financing components of the system; and reasonable predictability and stability.

In order to expand coverage to the largest number of Californians, the foundation described below must be present, assuming a continuing role for private health plans and insurers:

- A standard uniform benefit package that is universally available;
- Individual responsibility and accountability;
- Universal employer participation;

- Governmental support in varying degrees for all persons through tax policies, subsidies and sponsorship; and
- Policies that set the foundation for aligned incentives.

## 3. Emergency medical services and trauma care

Many hospital trauma and emergency departments are in serious jeopardy of closing in California, due primarily to inadequate funding, personnel shortages and lack of coverage by on-call physicians.

California's health care system is struggling with unprecedented financial and workforce challenges. Nowhere can the near meltdown of the health care system be seen more acutely than in hospital emergency and trauma-care services. There are currently 43 trauma centers in California and nearly all acute-care hospitals operate some level of an emergency department. Virtually every trauma center and emergency department in California loses money.

Numerous factors contribute to the crisis in trauma and emergency care, including:

- Inadequate payments from private and governmental sources;

- Rising number of uninsured patients;
- Increased use of hospital emergency services by patients not requiring emergency services;
- Unavailability of specialty on-call physicians;
- Personnel shortages;
- Lack of capacity in many geographic areas; and
- Burdensome federal, state and local requirements.

Not only are the emergency departments and trauma centers in jeopardy, the financial health of entire medical centers is being threatened. Additional closures of hospitals or emergency departments will exacerbate the issue of access to high-quality, timely health care for California's citizens and visitors.

**4. Conclusion**

California hospitals appreciate the leadership of the California Legislature and this Committee in addressing the issues that are the subject of this hearing today. We look forward to working with you to maintain and improve access to health care services through maintenance of California's health care safety net; through expansion of health care coverage; and by addressing the challenges facing

California's emergency medical and trauma-care systems, as well as a myriad of other challenges facing health care providers and the patients we serve.

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