



The True Cost of Living Without Healthcare Coverage

Health Policy Update

March 2004

This policy paper has been produced by OCHNA, a community-based, not-for-profit collaborative created to collect and make available accurate, useful social health data for the communities it serves.

Summary: Access to healthcare is dramatically reduced with a difficult economic environment in the county and an uncertain financial future for the state. Businesses and communities alike face financial hardships which impact an individual's ability to access quality care. If trends continue and no solution is determined, people will be forced to go without healthcare, leading to overwhelming hospital emergency rooms and community clinics with patients unable to pay and with conditions that require expensive treatment due to a lack of preventive care. Communities and policymakers react as healthcare becomes a looming political issue.

What is access to healthcare?

Access to healthcare is the ability to make use of healthcare services. Having that ability allows a person to treat illness, injuries, and chronic diseases, as well as participate in preventive measures to protect future health. A major component of access is *insurance coverage*, which can be separated into the following elements:

- Healthcare coverage
- Behavioral healthcare coverage
- Vision healthcare coverage
- Dental healthcare coverage
- Prescription coverage

Healthcare coverage can refer to a variety of private or public health insurance and sponsorship type programs.

Private coverage includes, but is not limited to, employer-based coverage, coverage provided by a parent's or spouse's employer, COBRA employment coverage, and individually purchased health coverage. In addition, there are several health coverage packages that are designed specifically to meet the needs of low-income children, such as Kaiser Permanente Cares for Kids and California Kids (a privately-sponsored program aimed at providing coverage for low-income children that do not meet the eligibility requirements of either Medi-Cal or Healthy Families and have no source of private coverage).

Public resources include government subsidized healthcare coverage: Medi-Cal (California's version of Medicaid, organized as CalOptima in Orange County), Medicare (provides coverage for most mature adults 65 and over), Child Health and Disability Prevention (CHDP), Medical Services for the Indigent (MSI), Aid to Infants and Mothers (AIM), and Healthy Families (California's version of the federal SCHIP). Eligibility requirements include income limits and may include asset and legal resident status. The scope of services covered also varies among public sector programs.

Those individuals and families without any kind of healthcare coverage, private or public, are considered "uninsured." A person is considered "underinsured" if the coverage they currently have does not provide dental and vision care, behavioral health services or prescription drug coverage, or if they have coverage, but cannot afford the co-pay costs for testing and procedures. Orange County residents without any coverage, or with limited coverage, have substantial challenges to accessing even the most basic necessary healthcare services for themselves and their families and are in danger of incurring overwhelming medical and personal costs.

What are barriers to care?

Coverage is not the only aspect of access; overcoming barriers is another integral aspect of accessing healthcare. Barriers identified by OCHNA focus groups from the 1998 and 2001 OCHNA assessment years and 2001 survey results regarding satisfaction and utilization included:

- Cost, including co-payments and deductibles
- Lack of available transportation
- Difficulty finding acceptable and affordable childcare

- Lack of respect and friendly, helpful customer service attitudes by health providers' front office staff
- An overall system described, by both clients and Application Assistants (acting as key informants), as unfriendly and cumbersome
- A shared belief of participants that they are treated unfairly, or negatively, due to having government-assisted healthcare coverage, or just for being poor
- Long waiting periods to get an appointment and long waits in the waiting room – even with an appointment

Healthcare providers have identified and acknowledged these, along with other issues, as barriers to accessing and utilizing many types of health coverage programs, including free and low-cost healthcare. Although acknowledged, the impact these obstacles have in determining whether or not a person will seek out and use these programs and services may be greatly underestimated.

What costs are involved with healthcare?

Cost to Businesses

- **15.8% increase** in premiums for employer sponsored healthcare benefits in California 2003, a three year increase of almost 42%¹
- **Senate Bill 2**, which is estimated to cost from \$1.3 billion² to \$5.7 billion³ to \$11.3 billion⁴, was passed by the California legislature and signed by the previous governor in 2003. This bill mandates businesses with more than 50 workers to provide coverage to all their employees, with the potential to expand coverage to over 1 million of the uninsured and their dependents. This bill will be subject to voter referendum in November 2004.
- **72%** of Orange County residents with health coverage receive their coverage through their employer or someone else's employer.⁵

Orange County hosts some of the most innovative and recognizable companies in the world, but the business community has recently had to face the challenge of remaining viable in the current economic climate, while providing healthcare coverage to employees. Current surveys assessing the business climate are demonstrating the eroding strength of the Orange County business sector. In 2003, Orange County plummeted to a ranking of 72nd in Forbes magazine's top 200 best places to do business, far from its ranking of 10th in prior years.⁶ The Orange County Business Council's Executive Survey

found that executives rank the cost of housing as the number one reason for the county's negative business climate⁷. Rounding out the issues businesses face are the high cost of energy, workers' compensation coverage premiums, the paid family leave program, and most recently, implementation of mandated health coverage for all employees through Senate Bill 2.

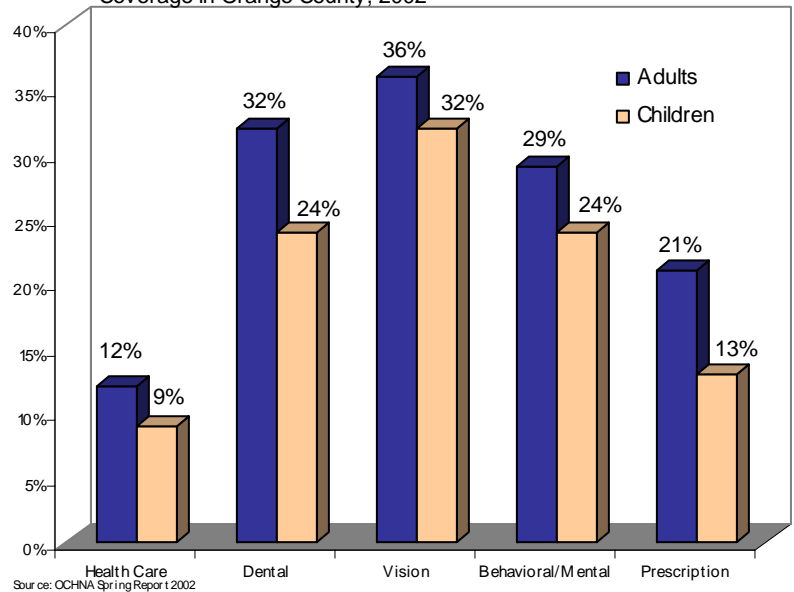
Some businesses are responding to the challenges they face in California by choosing to relocate their offices and future expansion projects. Others may be forced to reduce employee benefits or eliminate jobs.⁸

During tight budget times, it is natural to weigh the costs of providing coverage to workers and families against the cost of an uninsured workforce. The business community acknowledged its role in providing health coverage for their employees as "the right thing to do" and felt it increased loyalty and decreased turnover as was recently found in a survey of small businesses⁹, but are very troubled over rising costs. Many say that if providing health coverage could clearly show an increase in profits, they would be more likely to offer a health plan to their employees. Proponents of expanding coverage through employers cite the benefits of healthy workers who miss work less often and stress the importance of receiving preventative care to reduce costs from lost profits due to lower productivity.

Cost to the Community

- **240,000 adults (12%)** and **69,000 children (9%)** in Orange County lack healthcare coverage.¹⁰
- **664,893 adults (32%)** and **184,439 children (24%)** are without dental coverage in Orange County.¹¹
- **748,005 adults (36%)** and **245,919 children (32%)** in Orange County lack vision coverage.¹²

Graph 1. Percentage of Adults and Children Lacking Types of Coverage in Orange County, 2002



The local health community faces challenges similar to the business community for maintaining viability in Orange County as hospitals and emergency rooms show increases in losses and expenditures. Orange County hospital emergency rooms reported a loss of \$19,620,835 for 2000-2001, up 18% from the previous year.¹³ These losses are potential "leading indicators" of emergency room closures, compounding the issue of reduced access from potential hospital downsizing or closures.

Among other indicators of crisis in the healthcare community, Tenet recently announced its decision to sell 19 hospitals in California, four in Orange County. While the reasons for Tenet's current problems are many, a statement from a representative explains that considering the current economic condition of the 19 California hospitals slated for sale, Tenet could not absorb the \$1.6 billion earthquake retrofit requirements mandated by the State. Tenet has expressed its hope to work with potential buyers in order to minimize the impact on healthcare access in each community.¹⁴ The four Orange County facilities that Tenet has identified for sale operate 760 acute hospital beds and provide vital access to low-income populations.¹⁵

Those in need of services who are without adequate coverage turn to the community's safety-net system. Orange County's healthcare safety-net consists, in part, of hospitals, trauma centers and clinics. Many families depend on emergency rooms and clinics as their "usual source of care" because they either lack coverage or have not established a medical home. In 1999, 39.5% of visits to Orange County emergency rooms were for non-urgent visits.¹⁶ This type of treatment is the most costly to the patient and the hospital, and is on the rise. In Orange County, the number of emergency room visits increased with 25,145 more visits from 1998 to 1999.¹⁷ The overuse of remaining emergency rooms threatens the quality of care that can be provided for serious emergencies, epidemics, major natural disasters such as fires or earthquakes, or terrorist attacks.

The cost to the community cannot be measured only by the dollars and cents lost by healthcare providers; a community's health is measured on many levels. The Institute of Medicine's Committee on the Consequences of Uninsurance estimated the potential economic value to be gained in better health outcomes from uninterrupted coverage for all Americans to be between \$65 and \$130 billion each year.

The loss resulting from interrupted or lack of coverage is captured in:

- Poorer child development
- Less care for chronic diseases
- Less productivity when a person is uninsured or has limited access to healthcare

A lack of health coverage is shown to be associated with:

- Compromised health outcomes for children and adults, leading to poorer health
- Poorer financial security
- Greater accumulation of debt stemming from escalated health issues which could have been avoided with preventative treatment¹⁸

Redefining the Poor

Fact: Many of the poor are families with one or both parents working who struggle to meet basic needs in Orange County.

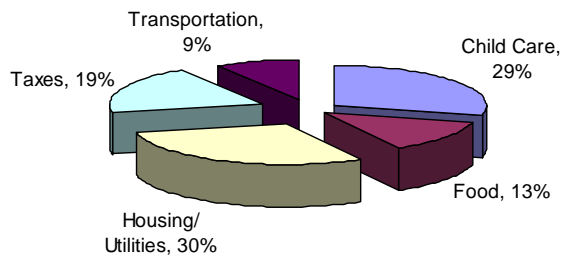
Being poor is not limited to being homeless or completely without resources. In reality, the poor are often dual-income families, who struggle for basic needs and necessities. The high cost of living in Orange County contributes substantially to defining "poor" in our community. Individuals, as well as families with multiple incomes share the same struggle of providing a safe community, nutritious food, education, healthcare, and opportunities to grow and develop into productive citizens. When faced with decisions about what can stay in the budget and what does not fit, people will need to cut expenses like healthcare coverage, which may not be seen as an immediate necessity when compared with the need to provide their families with food or housing.

Cost to Families

- **27%** of Orange County households without coverage report a gross annual income (GAI) between \$25,000 and \$50,000.¹⁹
- **80%** of uninsured adults and children are in working families, which includes families with at least one adult working full-time.²⁰
- Working families with employer-sponsored healthcare coverage pay an estimated **\$2,412** of the \$9,068 annual premium (\$201 per month).²¹

It may be difficult to imagine Orange County residents struggling with issues of poverty when visiting many of our county's beautiful beach communities, but many families find it difficult to cover all of their monthly expenses. In an analysis of the monthly budget for a family of four, an annual income of \$45,250 (250% above the Federal Poverty Level, 2002) was demonstrated to be nearly \$330 short of covering basic household needs such as food, transportation, child care and housing each month (graph 2). As can be seen from the graph, these expenses did not include a cost for healthcare coverage, which although may be provided by an employer, would still most likely

GRAPH 2. Average Monthly Orange County Family Expenses for a Family with Two Adults and Two Children, Ages 2 and 6



Source: Based on rates calculated from the Internal Revenue Service, Fair Market Rate, Consumer Price Index, and child care cost estimates from The 9th Annual Report on the Conditions of Children in Orange County 2003

require a monthly premium to cover a spouse and children, in addition to regular co-pays and “after coverage” costs for services. The family in the analysis would be eligible for Healthy Families¹ for their children, but would likely have a hard time paying the program’s relatively low co-payments required to see a doctor or fill prescriptions. Approximately 35% of all Orange County families fall at or below this income level.²² This example typifies families who qualify for healthcare coverage but still have no access.

A Note on Federal Poverty Level (FPL)

The Federal Poverty guidelines are a set of simplified income levels describing poverty, derived from Federal Poverty Thresholds. The Guidelines are used in determining financial eligibility for certain public programs. The original set of guidelines was created based on an economy food plan developed by the Department of Agriculture intended to be used “for temporary or emergency use when funds are low,” not as an ongoing family income. At that time, a family’s food budget was 1/3 of the total family budget. Therefore, the cost of the economy budget was tripled and set as a base for a poverty income level. These guidelines are adjusted using the Consumer Price Index reflecting price changes only, not changes in the standard of living. Since its development, there has been much debate concerning how to update the FPL, although very little has been done to change the formula over time to account for a variety of issues including regional differences in cost of living across the nation.²³

¹ Healthy Families: The Healthy Families program provides low cost healthcare to children under the age of 19 with family incomes less than 250 percent of the federal poverty level, for children not eligible for no-cost Medi-Cal. Families pay a monthly premium of \$4 to \$9 per child, with a maximum of \$27 for all children in the family.

Income and Access

Families with lower household gross annual incomes (GAI) tend to have less healthcare coverage, but the lowest income group is not the only segment of the community struggling with a lack of coverage. One in ten households with an annual income between \$25,000 and \$50,000 is without coverage; one in four households below \$25,000 GAI lack coverage. Together, households below \$50,000 GAI represent more than 3/4 of the uninsured in Orange County.

Income continues to be a factor when considering dental, vision, prescription coverage, and mental/behavioral healthcare. OCHNA 2001 Survey Data indicated that lower income level groups are significantly less likely to have coverage than groups in higher income categories. Close to 25% of households with incomes between 50,000 and 75,000 have no vision coverage; almost 20% of the same income group is without dental coverage.

In addition to creating a barrier to accessing healthcare services, income levels have been shown to impact quality of life ratings. Only 40% of respondents from the lower income categories reported having “excellent” or “very good” health in the 2001 OCHNA household survey, compared to 70% of those in the highest income category. Low-income households also reported more days of poor physical and mental health that kept them from their usual activities in comparison to higher income level groups.²⁴ While it may be true that money does not buy happiness, it certainly can open the door to greater healthcare access, thereby increasing quality of life.

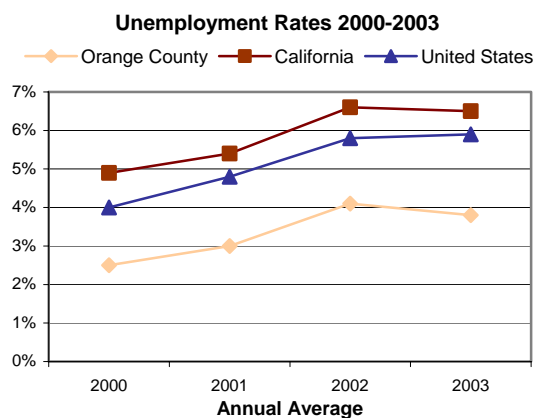
Diminished Affordability

The high cost of living for Orange County further compounds the problem, making healthcare unaffordable for many of our residents. The median price of a home in Orange County increased 21%²⁵ from 2002 to 2003 and rental prices increased 5.4%²⁶ in 2001 for the Orange, Los Angeles, and Riverside Counties. The increase in rental prices is lower than the double-digit increases seen since 1999 but still places apartments beyond the affordability of many individuals and families in Orange County. Thirty percent of the median apartment renter’s income (\$12,135 of \$40,451 in Orange County) would be necessary to afford a median apartment rent.²⁷ Lower income earners, receiving California’s \$6.75 minimum wage, would need to work 115 hours a week to afford a two-bedroom apartment.²⁸ This would require two income earners each working 12 hours a day. As difficult as this may sound, consider that these figures were developed using the Fair Market Rent guidelines, which often fall short of the actual cost of available rentals in Orange County.

The rising cost of goods and services contributes to the high cost of living in Orange County. Overall, the Consumer Price Index rose 1.7% for Los Angeles, Riverside, and Orange Counties combined.²⁹ According to

the 2001 California Health Interview Survey (CHIS), an alarming 25% (approximately 156,000) of Orange County adults below 200% of the FPL were found to be “*food insecure*,” having inadequate or unreliable access to nutritious food. In California, 28% or 2.2 million adults below 200% FPL struggle with food insecurity, with 658,000 suffering from episodes of hunger. CHIS estimates that if children are taken into account, the number of persons experiencing food insecurity in California could be as high as 5,000,000. Food insecurity is often cited as a reason for families not paying for other needs such as rent, utilities, and healthcare as they choose to allocate their funds to feed their families.³⁰

Considering the unemployment rate and available jobs, in conjunction with the measured increase in the cost of living, families will continue to be challenged to pay for healthcare, in addition to meeting basic needs. Unemployment levels have been high at the County, State, and Federal levels since 2001.



Although recently the unemployment rates have begun to decrease, economists describe the Nation’s slow recovery as having “the greatest sustained job loss since the Depression.”³¹ Jobs that are being regained and created are in lower-paying industries at the same time that higher paying jobs continue to disappear.³² Although all work is welcome for the unemployed, a low-wage job may make an employee ineligible for public-sponsored programs while not paying enough to allow the employee to add their families to an employer based coverage plan, if one is offered at all. Illustrating the ebbing access to employer-based coverage, OCHNA data found a 3% drop in employer-based coverage as measured from 1998 to 2001.³³ If this trend persists, people who depend on healthcare coverage from an employer will continue to constitute a greater portion of the uninsured.

Who lacks coverage?

Over half of the uninsured adult population in Orange County is Hispanic. This group is significantly more likely to be uninsured than other ethnic groups.³⁴ The same trend is present statewide, with almost half of the uninsured in California being Hispanic/Latino.³⁵ Vietnamese households in Orange County follow Hispanics with 13% lacking health coverage. In comparison, only 9% of Blacks and 6% of Whites are without coverage. The trend of low healthcare coverage and fractured sources of care for Hispanic/Latino groups is alarming in part because Hispanics/Latinos account for 32.4% of the total population in California, 26% of the total population in Orange County and almost half of the 0-5 population in California. It is estimated that by the year 2020, 60% of new school enrollees in California will be Hispanic. Without good health, success in school and on the job is compromised, having a lasting impact for our communities.³⁶ The continued lack of healthcare coverage for the growing Hispanic/Latino community has the potential to debilitate our state’s future workforce and Hispanic/Latino population’s potential contribution to business and the community at large.³⁷

Younger adults are less likely to have health coverage than are older adults at the national, state, and county levels. Thirty-one percent of Orange County’s population between the ages of 18-24 lack healthcare coverage, a percentage that exceeds both the national and state percentages of 24% and 28% for the same age group. Closing the coverage gap between youth and middle age is an increasingly urgent issue. In addition to chronic diseases such as asthma and congenital heart disease, young adults face the greatest risks for unplanned pregnancies, injuries, and sexually transmitted infections, including HIV.

Perhaps the group with the greatest barrier to accessing healthcare is the one without legal status in the United States. California’s largest foreign-born population, those from Mexico, is considerably more likely to be without coverage than any other ethnic group. Over 40% of all Mexican immigrants 0-64 without legal documentation are without healthcare coverage.³⁸ Not all immigrants without legal status come from Mexico; California has the highest proportion of foreign-born residents in the nation, coming from all over the world and has recorded the greatest increase in foreign-born residents in the past ten years.³⁹ Resident status does not affect a person’s need for regular, quality health services, but it surely impacts their ability to access services.

Services available for immigrants without legal status are primarily for emergencies. Some healthcare organizations, such as Blue Shield, provide employers with an optional benefit for their undocumented employees; these services are primarily provided in Mexico. Regular care in the US is available for pregnant women and children through short-term coverage providing a mother with care through

childbirth and a child through 2 years of age. California Kids, a unique private program, covers children of undocumented status from 2-18 years of age, but has very limited funding, and currently only reaches a fraction of those children in need.⁴⁰

If all other barriers to care were resolved, health-care would not be accessible to all, as those without legal status would still struggle to find access for the basic health needs necessary to maintain health and wellbeing. This group will remain outside of the healthcare community unless public sentiment and policy changes are directed towards their inclusion in the healthcare system.

Update on the Availability of Public Programs

Public programs are struggling more than ever to bear the burden of cuts due to spending reductions implemented by the previous administration. 2003-2004 budgetary and mid-year spending reductions impacted health programs significantly, and additional proposed cuts are included in the Governor's 2004-2005 budget in an effort to balance California's \$17 billion deficit. These cuts have far-reaching effects on all branches of the healthcare community reducing access to many health services and programs.

On January 9, the current Governor presented the 2004-2005 fiscal year budget, which proposes a more than \$900 million dollar reduction of State support for healthcare programs.⁴¹ These proposed reductions are in addition to the cuts in healthcare and education made earlier this year, with specific cuts to the Medi-Cal program, and a cap on enrollment in the Healthy Families program. These reductions are being proposed at a time when the number of beneficiaries is growing and reimbursements fail to keep pace with the growing costs of healthcare provision.

Healthy Families

Despite its name, Healthy Families is a public health coverage program available *only* for children and youth under the age of 19 and pregnant women, whose families have an annual income between 200% and 250% of the FPL guidelines. For children between 1-5 years of age, the eligible income range is 133% to 250% of the FPL and for youth between ages 6-18, the eligible income range is 100% to 250% of the FPL.

Although great gains have been made toward providing healthcare coverage for all children, reduction in outreach through the elimination of

training for new Certified Application Assistants² (CAA) and the proposed enrollment cap, threaten to stifle enrollment growth. Without the guidance and support of the CAA's, barriers such as language, fear regarding immigration issues and the cumbersome application process will once again come between children and the care they are eligible for. As of December 2003, CAA's have been instrumental in the recruitment and enrollment of 686,445 children in California and 67,546 in Orange County⁴², helping communities break down cultural barriers to care and providing the personal assistance so many parents need when completing necessary enrollment paperwork.

The 2004-2005 California budget proposes a cap on total enrollment for the Healthy Families program. The cap will be set at the total enrollment on January 1, 2004. Children who apply and qualify beyond that number will be placed on a waiting list until space permits them to be enrolled. It is estimated that during the first year, 159,000 children will be placed on a waiting list for approximately eight months before being enrolled in the program. The negative impact on this population will increase as the child population continues to grow. It is projected that the age group eligible for Healthy Families will be increased by 13% in 2010 from Census 2000 figures⁴³, severely decreasing the proportion of need reached if the cap remains at the 2004 enrollment level.

Healthy Families was scheduled to expand coverage to the parents of eligible children, but funding restrictions have placed the expansion on hold indefinitely. For now, the program must rely on the current staff of trained CAA's and a new Gateway system for the Child Health and Disability Prevention (CHDP) Program to maintain enrollment.

CHDP, a free, federally-funded program, has estimated that 1.1 million children eligible for Healthy Families or Medi-Cal pass through the program each year. With the Gateway Program, CHDP providers will screen each incoming child to determine eligibility for Healthy Families. Eligible children will receive temporary Medi-Cal coverage for up to 60 days from their initial screening. Parents will then be mailed enrollment forms to complete in order for their child to be permanently entered into the Healthy Families program. The Gateway Program is a needed outreach but with limited access to CAA's, may not be as successful as it relies on parents to complete enrollment forms without assistance and mail them back to the appropriate office. The success of the CAA program hinged on one-on-one assistance for parents with language or immigration concerns. The CHDP program impact would be bolstered with access to needed CAA's;

² Certified Application Assistants are community workers trained to perform outreach in clinics, hospitals, and in the home. Their main role is to help families overcome barriers and complete the necessary paperwork to enroll in the program.

limited access to CAA's may pose the greatest threat to the CHDP reaching its fullest potential.

California Children Services (CCS)

CCS is a program which provides medical care to children with serious chronic or disabling physical conditions or diseases. The 2004-2005 budget proposes an enrollment cap, which will limit the number of children enrolled each year to the total enrolled as of January 1, 2004. As with the cap on Healthy Families, children who are eligible for the program beyond its enrollment limit will be placed on a waiting list and admitted on a first-come, first-served basis. As only children with serious and disabling conditions are eligible for CCS, delays or denials of care could be life threatening.⁴⁴

Medi-Cal

The 2004-2005 budget proposes an \$880 million dollar reduction in spending for Medi-Cal programs, affecting the lowest income groups in the county and eliminating access for many. One of the most significant proposed changes to the program will be a 10% reduction in rates for Medi-Cal providers in addition to the 5% decrease imposed by the State in the 03/04 budget. Providers are currently fighting the rate cut, calling it unconstitutional. At this writing, the Court enjoined the State from implementing the 5% reduction in the Medi-Cal fee for service program pending its decision. However, the Court's order does not apply to the State's Medi-Cal managed care plans such as CalOPTIMA in Orange County. CalOptima has already suffered a diminution in state support as a result. If the additional proposed cut is deemed legal, it will only serve as a disincentive for providers to accept patients with Medi-Cal, thereby significantly reducing access for those who are poor and already have limited access to care.

The following additional changes are also proposed in the California budget⁴⁵:

- Unspecified programmatic changes including eligibility and benefit reductions, which have not yet been determined
- Elimination of non-medical therapy for State residents with developmental disabilities
- Elimination of in-home care services for the elderly and disabled
- Semi-annual eligibility reporting requirements and annual re-evaluations
- Significant expansion of antifraud activities

Medicare

The 65+ age group has comparably lower numbers of persons lacking coverage because Medicare, the country's health coverage program

for seniors, covers most persons 65 years or older. Healthcare coverage for seniors has historically been limited, in that prescription coverage has not been included. In December 2003, the Medicare Reform Bill was signed into law. The new prescription benefit will begin in three years.⁴⁶

It is important to note that although only 1.3% of senior adults 65+ are without coverage, that still accounts for over 3,500 people going without care during a very sensitive time of life. Of even greater concern is the 7.5% of those aged 55-64 who are uninsured. This group is still far from retirement and not yet eligible for Medicare but still in need of quality care. This group is particularly vulnerable to the escalating cost of prescription drugs, which are becoming a considerable proportion of personal healthcare spending in the US.⁴⁷

What action is taking place?

Orange County

The economic climate of Orange County is one with less stability and fund availability than other regions around the State. In comparison to other counties, Orange County has the smallest share of local property taxes returning to its general fund. Only 6% of the property tax dollar is returned via this funding source, which provides for health and human service programs as well as many other county programs and schools. Sales taxes and vehicle license fees, which are a dedicated funding source for county health and mental health programs, also come back to Orange County from the State at very low rates of return. To no avail, the county has proposed changes to the tax code that would increase the return on these locally generated, but State-allocated, taxes for years. With the budget in such a crisis, many lawmakers feel this may be the year to see some change in Orange County's tax allocations. Assemblywoman Lynn Daucher (R - Brea) and Assemblyman Lou Correa (D - Anaheim) secured Senate approval for an increase in property tax returns, bringing Orange County to 11% or an increase of approximately \$4 million.⁴⁸ A coalition of counties led by the County of Orange is also sponsoring legislation to address the sales tax/VLF (Vehicle License Fees) equity issue.

A **Beilenson Hearing** was held on June 10, 2003 by the Orange County Board of Supervisors in Santa Ana, CA, allowing community members to voice their concerns about the budget cuts to healthcare programs – \$13 million in direct services to the public and a like amount in indirect or jail-related services. Specifically, concerns were voiced regarding the reduction of behavioral/mental health services, elimination of 48 behavioral health hospital beds, and public health services.

The concerns expressed by community members are warranted, as the budget cuts include a reduction of substance abuse services, eight community health clinic closures, elimination of vocational services for mentally ill adults, and the reduction of Tuberculosis (TB) skin testing

and the tracking of inactive TB. Although the OC Board of Supervisors voted to approve the cuts, they were able to provide \$1.9 million to restore some services including TB and Chlamydia testing, 16 behavioral/mental health hospital beds, and physical and occupational therapists for disabled children.

It is important to note that an elimination of health services, clinics, and funding does not equate to an equivalent reduction in the need for those services. The question "where do those in need turn when the lowest level of service is gone" needs to be addressed.

The Orange County Health Care Agency has made a number of operational improvements to the Medical Services for Indigents (MSI) program in an effort to make it more responsive to the needs of the patients it serves and to participating providers. Looking towards continued program growth in the future, a Five Year Vision for upgrading this program has also been developed. Thus far, the MSI program has been exempted from the funding reductions affecting the Agency.

California

Express Lane Eligibility — Enacted

In the face of these changes, which will potentially affect thousands of Californians, the government has developed alternative outreach methods and proposed funding for new programs to reach uninsured children. An attempt to soften the blow of these deep cuts is the Express Lane Eligibility (ELE) program, which would help low-income parents sign their children up for Medi-Cal or Healthy Families at the same time they are signing up for the National School Lunch Program. It is estimated that nearly 70% of California's uninsured children (1 million) are enrolled in the school lunch program and that approximately 650,000 of them are eligible for Medi-Cal or Healthy Families.⁴⁹

SB2 — Enacted

On October 5, 2003, Governor Davis signed Senate Bill 2, enacting a controversial piece of legislation that requires all businesses with fifty or more employees to provide healthcare benefits to their employees or pay into an account that will be used to provide care to workers without coverage.⁵⁰ Senate Bill 2, drafted by California State Senator John Burton (D - San Francisco), would potentially reduce the number of uninsured, but the degree of reduction is unknown. SB2 is supported by both the California Medical Association and labor unions. Despite this support, the bill faces strong opposition.

The business community feels strong resistance to the bill with business leaders quoted as stating that the bill will be a "job killer." Alan Zaremborg, president of the California Chamber of Commerce recently said, "Rather than swelling the ranks of the insured, SB 2 will swell the ranks of the unemployed."⁵¹ Businesses may utilize the bill's parameters to avoid the mandated benefit by reducing employee hours, downsizing the size of their business or relocating altogether, reducing the workforce and stifling any future growth in the California business community.

A federal lawsuit that claims the law violates the Employee Retirement Income Security Act of 1974 (ERISA), a federal law pre-empting states from regulating employer benefit plans. The California Chamber of Commerce has submitted a petition for a referendum that would eliminate this bill. The Chamber is part of the coalition called Californians Against Government Run Healthcare (CAGR), who has gathered signatures to place the referendum on the ballot. Altogether, they have gathered over 620,000 signatures and need only 373,816 valid signatures to qualify.⁵² The referendum will appear on the November 2004 ballot. http://www.leginfo.ca.gov/cgi-bin/usweb/postquery?bill_number=sb_2&sess=CUR&house=B&template=California

SB921 — Pending

Senator Sheila Kuehl (D - Santa Monica) has written a bill that would establish a state-run, tax funded universal health coverage program, called the Healthcare for All Californians Act (SB 921). The program, overseen by an elected official, would gather money into an account managed by the State from a payroll tax of about 2%-3% for employees and 5%-6% for employers, taxes on alcohol and tobacco, and additional anticipated revenues generated by projected savings from reducing the administrative costs of the current healthcare systems. The State would manage the allocation of the money by providing a comprehensive benefits plan to all Californians.⁵³ Supporters of the bill feel that many Californians would save on out-of-pocket costs, but not all agree on the efficacy of the program. Kuehl's plan faces opposition similar to that of Senate Bill 2, with many concerned that the mandated costs will impact small businesses, resulting in layoffs and downsizing. Skepticism also exists for any government solution for access to healthcare after the defeat of the Clinton health plan for universal health coverage in the 1990s. Senator Kuehl requested that the bill not be heard in the Assembly Health Committee during this legislative session. While the Legislature's focus remains on the State Budget, SB921 will continue to be revised.

http://info.sen.ca.gov/pub/bill/sen/sb_0901-0950/sb_921_bill_20030710_status.html

AB30 — Pending

Another approach being explored is a voluntary contribution program for all levels of the government, as well as the business sector, taking some of the pressure

off of small businesses. State Assemblyman Keith Richman (R - Northridge), author of Assembly Bill 30, suggests combining funds from the federal, state, and business sectors to voluntarily fund coverage for those workers with an annual income of less than 200% of the poverty level. This plan would utilize an expanded Healthy Families program to reach a more diverse group of uninsured Californians. Richman cites the estimated 7 million uninsured in California, the overburdened trauma and emergency room centers, and the closing of hospitals as evidence for the need of the expansion of coverage.⁵⁴ Recent budget cuts have rescinded plans to expand Healthy Families, making the acceptance of this bill doubtful. Moreover, the bill has not created incentives for businesses to participate voluntarily. This bill is set for its first hearing with the Senate Committee; no hearing has yet been scheduled.

http://www.leginfo.ca.gov/pub/bill/asm/ab_0001-0050/ab_30_bill_20030829_history.html

SB26 — Pending

State Senator Liz Figueroa (D - Fremont) introduced Senate Bill 26 in April 2003, proposing mandating control over rising health costs. SB26 would require insurance companies to receive permission from state regulators before any increases in premiums, deductibles, co-payments, or co-coverage rates were made. The bill is modeled after Proposition 103, which regulates car and homeowners insurance. The Department of Managed Healthcare, State Regulator of HMOs, the Department of Insurance, and State Regulator of Preferred Provider Organizations (PPOs) would oversee all health coverage rates for the state retroactively from April 1, 2000. The bill was introduced after state health plans reported a substantial increase in profits (+64%). Health plans counter that the profit is necessary to account for the unpredictability of health costs. This bill is set for hearing on May 7, 2004.

http://www.leginfo.ca.gov/pub/bill/sen/sb_0001-0050/sb_26_bill_20040202_history.html

Federal Level

Tax Cuts — Ongoing

President George W. Bush's Administration continues to push for tax breaks at the federal level. The administration believes tax breaks will stimulate the economy and boost employment rates by creating jobs. The increase in employment is hoped to increase access to healthcare, as most people receive healthcare coverage through their employer. Despite optimism on the part of tax cut supporters, the opposition is wary of an expanding national deficit. Some economists predict the increased deficit will

worsen the outlook for Social Security and Medicare, while adding little or no actual economic stimulus for the nation.⁵⁵

Medicare Reform-Enacted

After six years of Congressional debate, the Medicare reform bill, including a prescription drug benefit, was signed into law in December 2003. The new drug benefit provides recipients with two options:

1. Purchase of a separate private insurance policy for prescription drugs
2. Join a Preferred Provider Organization (PPO), an HMO, or other private health plan that will also provide coverage for the rest of their care

Either option will require a monthly premium and provide a subsidized drug cost for the recipient for up to three years. Coverage can be extended for those who qualify with "catastrophic" drug expenses.

Opposition to the new reforms express concerns that the prescription coverage benefit will actually force Medicare recipients into HMOs if private healthcare providers do not offer separate drug coverage.

A number of general reforms are included as well as the addition of a prescription drug benefit:

- Health Savings Accounts (HSA), used for payments of long term care premiums, COBRA continuation coverage, and coverage while receiving unemployment
- Increased premiums for higher income recipients
- Increased federal payments to doctors and hospitals
- Federal subsidies for employers that provide health coverage to retirees
- An experimental "Competitive Market Model" which will require some Medicare providers to compete with providers in the private healthcare market

Several politicians have expressed grave doubts about the new law and vow to continue the debate with new bills in the near future.

The Healthcare Assurance Act — Pending

A proposal introduced by Senator Arlen Specter provides an expedited tax deduction of up to 70% for self-employed uninsured Americans who purchase health coverage. A standard benefits package is included as well as extending COBRA coverage for those persons who are uninsured while in-between jobs. The bill would provide an expansion of health services for the disabled, the State Child Health Insurance Program (S-CHIP), and medical coverage for low-income individuals. This bill includes many additional provisions relating to a myriad of issues such as euthanasia and medical errors, which are likely the cause for its languishing on the Senate floor. With so many broad issues, legislators have yet to find a common ground on which to take action for this bill. No Senate action has been taken at this time.

Conclusion

Unaddressed barriers to access to care for all residents will result in negative consequences for businesses, the community, and the individual:

- A wary business community may elect to relocate offices, reduce payroll or limit growth in order to combat rising costs of doing business, both in Orange County and in the State.
- An inability to purchase coverage, or lack of coverage through an employer, will debilitate the future workforce and its potential contribution.
- Increasing healthcare costs will place access to middle- and low-income families farther from reach, placing greater strains on safety net programs, and other programs already stretched beyond their means.
- Susceptible communities left without opportunities to provide themselves and their families with healthcare coverage will not be able to reach their fullest potential and provide their needed contribution to our communities.
- Untreated illness and infection will endanger the future health of everyone, causing unnecessary morbidity and mortality rates for preventable diseases and conditions.

As the cost of healthcare climbs, all of the issues pertaining to increased costs to businesses and the community will trickle down to Orange County families. If fewer businesses maintain affordable healthcare options, the number of families opting out of employer-based care will increase, forcing them to turn to already overburdened emergency health services. These emergency services may not be able to support the need, as the budget cuts for emergency rooms, trauma centers, immunizations, prenatal care and health programs for the low-income and disabled continue to unravel. Forced to go without care, individuals will allow minor illnesses to go unchecked, resulting in more costly care in the future, causing an increase in missed days of work and school, lowering productivity and earnings for family and businesses alike.

“Typically you think of the people without coverage may not be that potent a political force, but if you add in a lot of people that have coverage but are worried about losing it or not being able to continue paying for it, that multiplies the number of citizens concerned with this and it becomes more [of] a potent political issue.”⁵⁶

- Paul Ginsburg, president of the Center for Studying Health System Change

Paul Ginsburg describes how the threat of losing health coverage has become a large enough issue to motivate the community towards political action. The issue of access to healthcare has already gained a great deal of recognition from lawmakers and will continue to demand attention during the upcoming November presidential elections.

It is imperative to find solutions, whether through policy, community or business, to improve access to healthcare that is based on the unique needs of Orange County residents that will provide everyone with the best opportunity to lead a healthy life.



Primary Data Source –OCHNA 2002 Spring Report

The Orange County Health Needs Assessment (OCHNA) is a community based, not-for-profit, collaborative effort created to collect and make available accurate and useful health data for the

community at large and to meet the requirements of the Community Benefits legislation of California Senate Bill 697.

www.ochna.org

Additional Resources

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