(April 1995) is AOR's report to the legislature required by SB 902 (Rogers) (Chapter 760, Statutes of 1993), which granted a temporary, two-year exemption to joint labor management trusts operated by public agencies from the Knox-Keene Health Care Service Plan Act; the bill required AOR to perform a study and make recommendations on the future exemption and/or regulatory status of joint labor management trusts. Approximately 12% of public agencies elect to combine to administer health benefits through joint labor management trusts, which are governed by boards composed equally of management and employee organization representatives. According to AOR, other than a 1993 provision granting the trusts a two-year exemption from Knox-Keene, the trusts are nowhere expressly referred to in California law; however, since 1982, school districts and community college districts have been expressly authorized to join with other districts in providing for the payment of health and welfare benefits.

AOR concluded that no public purpose would be achieved by requiring the trusts to be regulated under Knox-Keene, as long as trusts make health benefits available only to the employees of their member school districts. However, AOR noted that an appropriate statutory framework should be enacted to provide regulatory oversight of the trusts, to assure solvency of the trust arrangements, and to safeguard the rights of employees of school districts who obtain health and welfare benefits for themselves and their dependents through the trusts. AOR also recommended that meetings and records of public agency health and welfare trusts be open to the public; health benefits provided by the trusts be limited to employees and other persons closely related to public agencies, and their dependents; trusts be prohibited from selling health coverage to private individuals and groups unrelated to public agencies; trust enrollees should have the benefit of the same minimum standards and consumer protections as the law currently imposes on regulated health benefits plans; to assure their financial solvency and public accountability, joint labor management trusts should be specifically defined in law as public agency health and welfare trusts; and the trusts should either be expressly recognized in the Insurance Code and be appropriately regulated by the Department of Insurance, or be required to file an annual report of financial transactions with the State Controller, and the Controller should be given the statutory duty to audit and review the financial solvency of trusts.

**Stopping the Violence: Creating Safe Passages for Youth** (April 1995), part of AOR's *California Children, California Families* series *[13:2&3 CRLR 40; 10:2&3 CRLR 59]*, examines the causes of youth violence and programs aimed at reducing or eliminating youth violence. According to AOR, 24,697 reports of child abuse of youth between ages 10–15 were filed in 1992; youth homicides rose from 492 in 1988 to 828 in 1991; juvenile arrests for violent crime increased 64% between 1987 and 1992; and middle and high school officials reported 69,191 assaults at schools and confiscated 5,107 guns and knives during the 1988–89 school year. AOR noted that during the past two years, the federal government, the California legislature, and local governments have increased penalties and redrafted sentencing guidelines for juvenile crimes; however, less attention has been focused on strategies to prevent juvenile violence and stop troublesome predelinquent behavior from escalating into violent crimes. AOR further stated that although additional public funding has been provided for very young children, the state has neglected older children and young adolescents between the ages of 9–15.

According to AOR, the causes of youth violence include victimization and child abuse, domestic violence, unstable and violent neighborhoods, poverty and high unemployment, substance abuse, easy access to guns, and television violence. AOR contended that the few state or federal programs aimed at troubled youth aged 9–15 are generally spread thinly throughout the state, crisis- rather than prevention-oriented, client-specific (offering services only to eligible children and not their families), fragmented, and not held accountable for the results of their services. However, AOR found that two state programs—Healthy Start and the Juvenile Crime Prevention Program—hold promise to prevent high-risk behavior among older children and young adolescents.

AOR also noted that in order to identify the most effective strategies to address youth problems, a focus group of professionals from law enforcement, juvenile justice, education, and community youth programs recently met and formulated five diverse approaches related to schools and state agencies which could help prevent children with troublesome behavior from slipping into violence and delinquency. Specifically, the focus group recommended that the state, local government, and community agencies encourage the creation of community schools with integrated services; provide more individualized attention to troubled children and adolescents; encourage schools, as well as programs serving youth, to implement values and decisionmaking curricula; ensure that schools are safe places for children; and coordinate youth programs among state agencies.

## SENATE OFFICE OF RESEARCH

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Established and directed by the Senate Committee on Rules, the Senate Office of Research (SOR) serves as the bipartisan, strategic research and planning unit for the Senate. SOR produces major policy reports, issue briefs, background information on legislation and, occasionally, sponsors symposia and conferences.

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### ■ MAJOR PROJECTS

**Health Care Reform in California: Options for Further Reform** (February 1995) is a briefing report for the Senate Insurance Committee, chaired by Senator Herschel Rosenthal. The report examines the problems associated with health care reform in California, summarizes health care reforms enacted to date in California (as well as those adopted in other states and under consideration at the federal level), and presents options for further reform for the legislature's consideration during the 1995–96 session.

The SOR report discusses California's problems of declining insurance coverage, rising insurance costs, and increasing cost shifting. The number of Californians covered by job-based insurance or other coverage declined from 73% in 1979 to 63% in 1993. During the same time period, the number of Californians who are uninsured increased from 15% to 20%, and the number of Californians covered by Medi-Cal increased from 12% to 16%. According to SOR, many factors are responsible for the rapid rise in the uninsured population, including shifts in the job base from high-insuring sectors (such as manufacturing) to traditionally low-insuring sectors (such as services and small businesses); shifts in the job base from full-time employment to part-time and seasonal employment; and the economic recession. Additionally, health care costs over the last decade have risen at roughly double the rate of general inflation, causing many employers to shift the responsi-

bility of paying for health care coverage to employees. National studies show that over half of the uninsured live in single-parent families; studies also show that the uninsured population in California is a relatively young, working-age population that is poorer and more ethnically diverse than the general population. The SOR report states that the growth of the uninsured population has increased the uncompensated care burden of hospitals and health care providers; the growing number of uninsureds has also placed severe demands on publicly funded health care programs operated by the state and counties.

The SOR report summarizes several health care reforms enacted in California between 1988 and 1994, and also summarizes comprehensive reforms considered but not enacted during the same period. For example, Proposition 186 on the November 1994 ballot would have established a Canadian-style single-payer system, and Proposition 166 on the November 1992 ballot would have imposed a mandate on employers to provide basic health care coverage to workers and their dependents. Although comprehensive reforms such as these were not enacted, the legislature did enact a number of targeted reforms, including the following:

- ***Small Group Insurance Reforms.*** AB 1672 (Margolin) (Chapter 1128, Statutes of 1992) requires insurers marketing coverage for groups of four to 50 employees (three to 50 after July 1, 1995) to guarantee the issuance and renewal of coverage, and to market coverage without regard to the health status, previous claims experience, or occupation of the group; limits preexisting condition exclusions to a single six-month period; and requires insurers marketing coverage to small groups to develop rates based on age, geographic region, family size, and benefit plan design. According to SOR, the insurance reforms contained in AB 1672 appear to have made health coverage more available and affordable for persons in high-risk occupations and with preexisting medical conditions who work for small employers; they have also been credited with leveling the playing field between carriers operating in the small group market and forcing carriers to compete more on the basis of cost and quality and less on avoidance or segregation of risk.
- ***Health Insurance Plan of California.*** AB 1672 (Margolin) also established the Health Insurance Plan of California (HIPC), through which small employers covered by the small group underwriting and rating reforms are able to collectively buy coverage at more competitive rates. According to SOR, the HIPC concept has enhanced competition and lowered rates in the small group market by offering greater choices of plans to small employers.
- ***Major Risk Medical Insurance Program (MRMIP).*** This program, which is subsidized through an annual allocation of $30 million from Proposition 99 tobacco tax funds, provides subsidized health coverage to persons who are unable to obtain health coverage due to medical conditions or history; the program contracts with health plans to provide comprehensive health coverage and caps the amount that individuals pay for the coverage.
- ***Access for Infants and Mothers (AIM) Program.*** Established by AB 99 (Isenberg) (Chapter 278, Statutes of 1991), this program provides basic coverage for uninsured pregnant women and their infants up to age two. Women enrolling in the program are given a choice from among health plans contracting with the program and must pay 2% of their annual gross family income to participate in the program.
- ***Child Health and Disability Prevention (CHDP) Program.*** AB 75 (Isenberg) (Chapter 1331, Statutes of 1989) expanded eligibility for preventive health screenings to all children under age 19 with incomes below 200% of the poverty level. As a condition to receiving Proposition 99 allocations for uncompensated care, counties and clinics are required to provide treatment for conditions detected through CHDP screens.
- ***Medi-Cal Eligibility Expansions for Pregnant Women and Children.*** SB 2579 (Bergeson) (Chapter 980, Statutes of 1988) adopted the federal option (now a mandate) to extend Medi-Cal coverage for pregnancy-related services to pregnant women and their infants under age one whose family incomes do not exceed 185% of the poverty level. AB 99 (Isenberg) (Chapter 278, Statutes of 1991) extended the income limit for these populations to 200% of the poverty level.
- ***Proposition 99 Allocations for Uncompensated Care.*** AB 75 (Isenberg) (Chapter 1331, Statutes of 1989) established an allocation mechanism for Proposition 99 hospital, physician, and unallocated account revenues to counties, public and private hospitals, and clinics to help cover the unreimbursed costs of treating uninsured patients; due to the continuing drop in Proposition 99 revenues, however, funds available for the allocations have declined since 1989.
- ***Disproportionate Share Hospital Payment Program.*** SB 855 (Robbins) (Chapter 279, Statutes of 1991) established the Disproportionate Share Hospital Payment Program, under which supplemental Medicaid payments are made to public and private hospitals which serve a disproportionate number of Medi-Cal and indigent patients.

The SOR report also summarizes health care reforms adopted in other states; according to SOR, several states—including New York, New Jersey, and Vermont—have adopted more far-reaching small group underwriting and rating reforms than has California. In general, these laws apply to smaller groups and to individuals, and contain tighter rating bands than California's law. A number of states have expanded coverage to pregnant women and children through Medicaid eligibility expansions and to children through the creation of subsidized insurance pools, and have extended coverage to low-income working and non-working uninsured persons currently not eligible for Medicaid through Medicaid research and development waivers. Seven states have enacted bills to allow medical savings accounts (MSAs), which operate similarly to IRAs for retirement savings; MSAs are tax-exempt accounts into which a household is allowed to contribute a limited amount to pay for medical care needs. According to SOR, several states have also undertaken a variety of other reforms which are significantly different from those in California, including employer mandates, subsidies for small employers, exemption of health coverage from state mandates, and insurer/health care provider surcharges used to underwrite uncompensated care and high-risk pools for uninsurable individuals.

The SOR report also summarizes health care reform proposals that are pending in Congress; according to SOR, the proposals are less expansive than those considered by Congress in the previous session, and focus on areas such as health insurance reforms, subsidies for low-income children to obtain coverage, defining a standard benefits plan that employers and insurers would be required to offer, MSAs, tax deductions or credits for individuals who purchase insurance on their own, granting states additional flexibility to structure their Medicaid programs, and setting up commissions to review issues surrounding federal and state health care reform efforts. According to SOR, one of the major issues confronting Congress will be whether to modify the Employee Retirement Income Security Act (ERISA) or grant individual states exemptions from ERISA to allow them to carry on state-based reforms currently preempted by ERISA.

Finally, the SOR report discusses options for further reform, such as expanding the AB 1672 underwriting reforms to cover groups of two and individuals; en-

acting reforms to create a more seamless system of health care services for children; and seeking reforms to ERISA which would give states flexibility to levy assessments on self-insured plans to fund targeted reforms and allow states to bring all employers up to a specified size limit to be subject to community rating reforms.

**Improving Access to Health Care for California Children** (March 1995) is a briefing report that summarizes the health care needs of children and adolescents, examines financial and nonfinancial barriers to children's access to services, and makes recommendations to improve children's access to services.

The SOR report notes that although much attention has been given to health care access problems of the general population, little attention has been given to health care access issues affecting children. For children, access to health care services is intertwined with developmental needs; lack of access to health care and inappropriate care can affect a child's optimal growth and development. Additionally, in contrast to adults, children's access to health care services depends upon the behavior of parents and caregivers who are not always aware of the value and need for preventive care. According to SOR, low-income children, children with chronic illnesses and disabilities, children with complicating social or behavioral needs, and adolescents have special health care needs that often necessitate more extensive services.

According to SOR, 1.6 million of the state's children under age 18, or approximately 19%, have no private or public insurance; the uninsured rate ranges from around 16% for non-Latino, white children to over 30% for Latino children. Children without health insurance or Medi-Cal coverage must rely on indigent health programs or services administered by counties and nonprofit clinics and on hospital emergency room care as their regular source of care. Because funding for these programs has not risen commensurately with the overall growth of the uninsured population, access to outpatient care and preventive care for uninsured adults and children has become severely restricted.

According to SOR, a variety of nonfinancial barriers also hinders the access of low-income children to programs and services for which they are eligible, including fragmentation of programs, cumbersome eligibility and enrollment processes, lack of primary care providers in rural areas and underserved urban areas of the state, low provider participation in programs serving children, and lack of pediatric standards of care in private plans.

The SOR report makes the following recommendations in order to improve children's access to health care:

- The state should implement the recommendations of the AB 99 Steering Committee by developing an integrated and comprehensive health care delivery system for low-income children in the state; this system should ensure that all of California's children with family incomes below 200% of the poverty level have access to a comprehensive set of benefits similar to those recommended by the AB 99 Steering Committee.
- The state should streamline the existing Medi-Cal eligibility process for children and adolescents by seeking waivers to implement presumptive eligibility for preventive and primary care and to waive the use of an assets test for establishing eligibility. In addition, the Medi-Cal eligibility process for children should be decentralized by expanding outstationing of eligibility workers at community sites including health clinics, public hospitals, Women, Infants, and Children Supplemental Food Program sites, and provider offices. Finally, the Department of Health Services (DHS) should develop and seek approval to use a shortened application form for determining the eligibility of children.
- DHS should strengthen the proposed standards in the Medi-Cal managed care expansion plan in several areas, including monitoring and oversight, standards for children with special needs, and linguistic and cultural competency.
- Finally, DHS and the Office of Statewide Health Planning and Development should undertake focused studies to further document gaps in children's access to health care services.

**Teen Pregnancy and Parenting in California: Background** (March 1995) is an SOR briefing paper that discusses the teen pregnancy rate in California, predictors of teen pregnancy, and adverse consequences of teen pregnancy.

According to SOR, California has the highest teen pregnancy rate in the nation, with an average of 154 pregnancies per 1,000 teenagers aged 15–19, as compared to the national average of 111 pregnancies per 1,000 teenagers. The teen birth rate in California has also increased significantly in recent years; births to teenagers in 1993 resulted in a birth rate of 70.6 births per 1,000 teens aged 15–19 and a birth rate of 1.5 births per 1,000 girls aged 14 and younger. From 1987 to 1993, birth rates for teenagers aged 15–19 increased 18.6%.

The SOR report states that only one-third of the fathers of children born to teenagers in 1993 were teenagers themselves. The majority of fathers were age 20 and over, with 42% of fathers between the ages of 20–24 and 14% age 25 and over. The report also states that over 23% of the teens who gave birth in 1993 had given birth at least once before. Of the 70,091 births to teenagers in 1993, 42,199 (60.2%) were to Hispanic women, 16,113 (23%) to white women, 7,913 (11.3%) to African-American women, and 3,866 (5.5%) to Asian and other women. The SOR report states that teen births were somewhat concentrated in selected southern and Central Valley counties, with teenage birth rates highest in rural counties. Recent research indicates that a large majority—two-thirds or more—of pregnant and parenting teenagers have been victims of sexual abuse prior to becoming pregnant; research also indicates that for young women under the age of 15 who have had sexual intercourse, a large majority of them have had sex involuntarily.

According to the Legislative Analyst, state and federal support for pregnant teenagers totals $5–7 billion per year; in 1992, Medi-Cal funded over 50% of the state's total teen deliveries. According to the state Department of Education, 2,118 kindergarten classes costing almost $276 million were needed in September 1993 to serve just the children born to teenage mothers in 1987.

The SOR report also states that poverty, poor school performance, and the early onset of puberty and increased sexual activity for teens are predictors of teen pregnancy. The report notes that the following are adverse consequences of teen pregnancy: Women who began motherhood as teenagers are more likely to have been poor, remain poor, and need welfare in the future; children born to teenage mothers experience adverse health consequences (*e.g.*, low birth weight and premature birth), and adverse effects of teen pregnancy are greater for younger teens and teens with more than one child.

**The Status of Affirmative Action in California** (March 1995) examines issues related to pending California legislation which would repeal affirmative action programs affecting public employment, education, and contracting in California. The report looks at long-term employment trends in California's public and private sectors, reviews the legal history of affirmative action, discusses in detail the state contracting laws aimed at achieving more equity for minority- and women-owned businesses, and explores the potential impacts on public schools, colleges, and universities of repealing affirmative action programs.

Currently pending in the legislature, ACA 2 (Richter) and SCA 10 (Kopp) would

ban the use of race, sex, color, ethnicity, or national origin as a criterion for discriminating against or granting preferential treatment to anyone in public employment, education, or contracting. If either constitutional amendment receives a two-thirds vote from the legislature, it would be placed on the March or November ballot in 1996, depending on when approved. Assemblymember Richter and other legislators have also introduced majority-vote bills to separately dismantle California's affirmative action program.

The proposed constitutional amendments would make exceptions for court-ordered programs or those required to maintain federal funding. According to SOR, it is not likely that local and state welfare and transportation departments, educational institutions, and other entities that receive federal grants and funds would be permitted to abandon their nondiscrimination programs and still receive federal money absent changes in federal law; the degree of affirmative action required to conform to federal civil rights laws, however, remains unclear.

According to SOR, an examination of racial, ethnic, and gender employment data reveals the following:

• Despite gains for women and minorities in public and private job titles reviewed, public salaries overall still show blacks and Hispanics lagging significantly behind whites, and women significantly trailing men.

• State and local government hiring shows that, even though blacks were represented above general labor force parity in the top public jobs in 1993, the median overall income for blacks in public jobs in California was only $33,774, compared with $40,313 for whites.

• In 1975, the median salary for blacks in public jobs in California was 80.5% of the median for whites; by 1993, it had risen to 83.8%.

• The state data echo the finding of the Joint Center for Political and Economic Studies in Washington that affirmative action programs have had "some positive effects" in opening new opportunities for blacks, but measurable benefits in wages have been "quite small."

• Hispanics remain a significantly underrepresented minority in the better-paying public and private jobs in California. In 1975, the median salary for Hispanics in California public service was 80.1% of the median for whites; in 1993, it had edged up to just 81.1%.

• Salary disparities between black and Hispanic women in public service have been even greater than those among minority men. Overall, the median salary for women in public jobs in 1993 was $31,897, or 75% of the male median of $42,566; in 1975, the median public salary for women was 67% of the male median.

• Asian-Americans have fared considerably better than blacks and Hispanics in the public and private sectors; the median salary for Asian-Americans in public jobs in 1993 was $37,925—almost identical to the overall median of $37,863. The Asian-American salary median was 94% of the median for whites.

• Recent studies exploring trends commonly thought to be influenced by affirmative action have found women and minorities falling far short of achieving equal footing at the top of the workplace hierarchy. The bipartisan federal Glass Ceiling Commission on March 15 reported that 87% of senior managers in Fortune 1000 industrial corporations are white males.

• In a new study of census data, the Thomas Rivera Center, a policy research institute at the Claremont Colleges, found Hispanics vastly underrepresented in private sector management jobs in California. Its data sampling, based on the occupations of those who answered census questions, found 77 white managers for every U.S.-born Mexican-American manager, and 29 white managers for every African-American manager. The average annual salary disparity between college-educated young minority managers and young women managers, compared with young white managers, was $10,000–$12,000.