



Obesity Prevention and Physical Activity

- SB 12 (Escutia) – Establishes nutritional standards for food served or sold in schools.

CPEHN Position: Support

- SB 965 (Escutia) – Bans sodas from being served in high schools or sold in vending machines.

CPEHN Position: Support

Medi-Cal State Budget Issues

- Medi-Cal premiums and cap on adult dental benefits.

CPEHN Position: Oppose cuts to Medi-Cal.

Cultural & Linguistic Access

- AB 775 (Yee) – Prohibits minors from acting as interpreters during medical diagnosis and treatment.

CPEHN Position: Support in concept, but need to ensure that it does not limit access to services.

Refugee Social Services Legislation

- SB 112 (Ortiz) – Provides additional support for counties to support refugee inflows by matching funding more closely to refugee flows and providing counties with incentives to move refugees into employment.

CPEHN Position: Support

Expanded Access to Care

- AB774 (Chan) and SB24 (Ortiz) – Limits hospitals from overcharging the uninsured.

CPEHN Position: Support

- SB 437 (Escutia), and AB772 (Chan) – Provides universal health insurance coverage for all of California's children.

CPEHN Position: Support

SB 12 (Escutia)

School Nutrition Standards

Background

The serious health consequences of poor nutrition and inactivity are reaching epidemic proportions throughout the United States. An estimated 61 percent of U.S. adults are either overweight or obese and alarmingly, the rates for children are also on the rise. An estimated 13 percent of children are now overweight, a three-fold increase since the 1970's. The picture in California mimics this national trend and is more pronounced in communities of color.

- A California survey of children found that nearly one-third were overweight or at-risk for overweight.
- Almost 34 percent of Latino children are overweight, more than any racial/ethnic group.
- 46 percent of African American children are unfit, more than any other racial/ethnic group.
- 18 percent of African American teens are overweight or obese, more than any other racial/ethnic group.

Purpose

SB 12 will implement nutrient standards for competitive foods sold on all public school campuses outside USDA meal programs. Specifically, SB 12 proposes that any food sold or served meet the following standards:

- Not more than 35 percent of its calories from fat (excluding legumes, nuts, nut butters, seeds, eggs, non-fried vegetables and cheese packaged for individual sale).
- Not more than 10 percent of its calories from saturated fat (excluding eggs and cheese packaged for individual sale).
- Not more than 35 percent sugar by weight (excluding fruits and vegetables).
- Food items in vending machines may not exceed 200 calories per item.
- Portion sizes for a la carte sales in the cafeteria should not exceed the serving size of the food served in the National School Lunch Program or School Breakfast Program.

Policy Implications

Related to the rise in overweight and obesity, the number of children and adolescents with Type 2 diabetes is increasing. Previously considered an adult disease, the increase in overweight and obesity among children is directly related to the increase in the prevalence of diabetes. The decline of nutrition and physical activity standards in schools over time have contributed to childhood obesity and overweight.

Proper nutrition can guard against missed days at school due to common ailments and other childhood health problems such as iron deficiency, eating disorders and dental problems.

SB 965 (Escutia) The Soda Ban Bill

Background

A California survey of children found that nearly one-third were overweight or at-risk for overweight. Almost 34 percent of Latino children are overweight, more than any racial/ethnic group. Forty-six percent of African American children are unfit, and 18 percent of African American teens are overweight or obese, more than any other racial/ethnic group. Diabetes has reached epidemic levels primarily as a result of the growing obesity epidemic. Type 2 diabetes, which until recently affected only adults, now affects a growing number of children, accounting for almost 50 percent of new diabetes cases among children in some U.S. communities.

Soft drinks comprise the leading source of added sugar in a child's diet. Each additional daily serving of sugar-sweetened soda increases a child's risk for obesity by 60 percent.

Purpose

SB 965 will expand the restrictions of beverages that can be sold in elementary and middle schools to high schools. The following beverages could be sold in high schools:

- Fruit-based and vegetable-based drinks that are at least 50 percent fruit juice without added sweeteners.
- Drinking water without added sweeteners.
- Milk products including two-percent, one-percent, nonfat, soy, rice and other similar non-dairy milk.
- An electrolyte replacement beverage that contains no more than 42 grams of added sweetener per 20-ounce serving.

Policy Implications

Obesity costs California an estimated \$21.7 billion in medical costs and lost productivity. Since children spend approximately one-third of their day at school, schools play an important role in children's ability to acquire adequate nutrients. Banning sugar-filled drinks on California's campuses will help fight childhood obesity. Health and education leaders agree that one of the most critical steps to helping children practice healthy eating habits is to establish policies and programs that increase access to healthy foods and beverages. SB 965 will help ensure that schools are offering their students beverages that will contribute to making them ready to learn in the classroom.

State Budget and Medi-Cal: The Harmful Impact of Premiums and Dental Benefit Cuts

Background : Medi-Cal, California's Medicaid program, provides vital health care coverage for more than six million low-income children and families as well as elderly, blind, or disabled individuals. Medi-Cal is jointly funded by the state and federal government and administered by the California Department of Health Services. People enroll in Medi-Cal through their county social services department or local clinic. Medi-Cal eligibility is based on a number of factors, such as income, assets, family size, age, and disability, among others. Some groups eligible for Medi-Cal include low-income children and pregnant women, families receiving or eligible for cash aid (CalWORKs), low-income individuals with specific health needs, and individuals who are aged, blind, or disabled according to Social Security rules.

Issue: On January 10, 2005, Governor Schwarzenegger released his budget plan to address the \$9.1 billion deficit for fiscal year 2005-2006. There are some positive aspects in the budget, such as \$5.9 million to restore application assistance to increase enrollment in the Healthy Families and Medi-Cal programs, a proposal to provide technical assistance to counties to establish 'Healthy Kids' programs for children not eligible for Healthy Families or Medi-Cal, and \$6 million to reduce the obesity epidemic. Unfortunately, the Governor's plan also includes cuts to health programs. Medi-Cal takes a big hit, with some of the cuts overlapping with the Governor's Medi-Cal Redesign proposal.

- **Monthly Premiums for persons on Medi-Cal.** Families on Medi-Cal who earn more than the poverty level (\$1,306 a month for a family of three) would have to pay as much as \$27 a month. The premiums would be \$4/month for each child, and \$10/month for each adult covered, with a cap of \$27 per family. The savings to the state in the 2006-2007 budget will be \$5.5 million from the general fund, and California will also lose another \$5.5 million in the federal match.
- **Limits on dental services of \$1,000 for adults on Medi-Cal.** This would result in a savings to the state of \$25 million from the general fund, though California would also lose another \$25 million in the federal match.

Policy Implications: The cuts to Medi-Cal proposed in Governor Schwarzenegger's budget will disproportionately impact communities of color, the very communities that already experience conditions that result in poorer health status. According to the California Health Interview Survey (UCLA Center for Health Policy Research, 2003), approximately one-fourth of Latinos (28%), African Americans (26%), and American Indians (24%), and over 12% of Asians rely on Medi-Cal, while only 8% of Whites are on the program.

Premiums for Medi-Cal recipients and caps on dental benefits are not the way to balance the budget. Requiring monthly premiums for Medi-Cal is asking those who already have very little financial resources to spend money they do not have. In addition, it will require new administrative resources to collect the premiums, thus offsetting some of the savings. The cap for dental benefits ignores the pain and suffering that is caused by dental disease. And the loss of federal matching funds means that California will receive fewer dollars at a time when the Governor is trying to collect more federal funding for the state.

The budget should not be balanced at the expense of the health of low-income communities of color. The budget shortfall should be addressed through progressive revenue enhancements, not cuts to health.

AB 775 (Yee)
Interpreters: Prohibition on Use of Children

Issue: A child should not be the first person to learn about her parent's serious or terminal illness. A child should not be privy to her parent's confidential medical information. A child should not be the first person to tell his parent about that condition or giving complex choices or instructions on a treatment modality or medication.

53% of California's population are from communities of color of whom large numbers speak limited or no English (LEP – limited English proficiency). Studies indicate that health care providers typically use untrained family members and friends to meet their significant language needs. Often, the interpreter is a minor child. Family dynamics can be severely disrupted when the child must convey the doctor's expertise in diagnosing a condition or authority admonishing a parent for his unhealthy lifestyle. A child should not bear the heavy burden for accurately and completely communicating the medical exchange.

The National Council on Interpretation in Health Care articulates six skills required for an effective interpreter. A child interpreter is likely to fail on all or most of these skills. A child is not likely to be able to recognize ethical issues; is not able to recognize cultural misunderstandings from differing cultural assumptions and expectations of providers and patients; would not know health care terminology; and may lack the ability to interpret accurately and completely. Additionally, because the child's language proficiency in English and/or the non-English language is unknown to the provider, it is therefore unreliable. The child is unlikely to have the emotional maturity to convey the substance or severity of a medical encounter of even an average complexity. A parent might withhold relevant sensitive medical information (such as her history of miscarriages) from her child and as a result from her doctor.

Bill Functions: AB775 would prohibit any state or local government agency or state funded agency or organization from using any child, or permitting any child to be used, as an interpreter in any hospital, clinic or physician office for diagnosis and treatment. Such agencies must also have an established procedure for providing competent interpretation services that does not involve children in this manner. There is a 90-day grace period for compliance with the requirement for an established procedure. Violation of these provisions by a non-governmental agency may result in the loss of state funding or cancellation of state contracts and would establish requirements for the reinstatement of that funding.

Policy Implications: Studies repeatedly find that the use of an untrained interpreter results in misdiagnosis, misunderstanding of medications and self-care, misunderstanding of choices of treatment modalities, and miscommunication of the patient's medical complaint. One seminal study found that 63% of the errors in interpretation had clinical implications and the rate of errors was 45% higher for untrained interpreters. These harmful and attendant risks can only be heightened when that untrained interpreter is a child.

According to Title VI of the Civil Rights Act, the health care provider must communicate with his patient in an effective manner comparable to an English-speaking patient. The responsibility begins with the health care industry and government - doctors, hospitals, clinics, and payers - to identify, develop, train and pay for effective medical interpreters. At the same time, they must actively discourage reliance on untrained interpreters, and discontinue reliance on minors as interpreters.

SB112 (Ortiz)

Federal Refugee Grant Allocation Legislation

Issue: In 2004, the U.S. government granted refugee status to approximately 16,000 Hmong who remained in refugee camps in Southeast Asia after the communist take over of Vietnam and Laos. The Hmong feared retribution because some had been recruited by the CIA to assist the U.S. government during the Vietnam war. Since the majority of the new refugees were expected to settle in California, which remains one of the top state destination for other refugees, a Senate hearing was held on the Hmong refugee resettlement. As a result of this hearing, Senator Ortiz authored SB112. The bill will allocate federal refugee funds based on the number of refugees each county receives. By matching federal funding more closely to refugee flows, counties will be able to provide services to refugee populations.

Bill Functions: SB112 will amend Section 13276 of the Welfare and Institution Code relating to public social services. Under existing law, the State Department of Social Services must require that a county's cost in administering employment-related and English language training programs funded by certain program funds derived from the federal Refugee Act of 1980 not exceed the percentage for county administrative costs permitted by the department in administering the Refugee Targeted Assistance Program. Existing law requires the department to allocate all social services funds derived from the act, after setting aside state administrative funds, to each eligible county in the same proportion that the number of refugees on aid in each eligible county bears to the total number of refugees on aid in all eligible counties.

SB112 would revise these provisions to instead require 50% of the money allocated in the same proportion that refugees arrived in each eligible county bears to the total number of refugees that arrived in all eligible counties, during the preceding 60 month period for which the department has data; 50% of the social services funds to be allocated in the same proportion that refugees arrived in each eligible county bears to the total number of refugees that arrived in all eligible counties during the preceding 60 month period for which the department has data.

Policy Implications: California currently receives slightly over \$9 million from the federal Refugee Employment Services funds, distributing \$7 million of that total to eligible counties. Currently, the allocation goes only to 10 – 12 counties that receive the largest numbers of refugees with a formula that is based on the number of refugees on cash assistance. The state does not directly use the actual number of refugees settled in each county when it calculates and allocates the federal funds. This formula results in some counties that receive large share of refugees receiving a much smaller proportion of the funds.

By requiring the state Department of Social Services to allocate the federal refugee funds based on the number of refugees each county receives, it will match federal funding more closely to refugee flows.

Assembly Bill 774 (Chan) and Senate Bill 24 (Ortiz) Hospital Overcharging and Self-Pay Policies for the Uninsured

Background

Hospitals here and across the country routinely charge self-pay and uninsured patient consumers three or four times what insurance companies and government programs pay for the exact same treatments. In many cases, large medical bills are sent directly to collections, to court, and ultimately to bankruptcy. Many families are unaware of their financial options, including public insurance programs and the hospital's own charity care programs. In fact, a Harvard Law Review survey indicated that medical problems and medical bills were cited as a leading cause of personal bankruptcy.

There are numerous cases of uninsured patients who have been billed exorbitant amounts by hospitals or been victims of aggressive collection efforts. According to an article in Investors Business Daily, the uninsured made up 2.6% of all patients for Catholic Healthcare West but accounted for 77% of the total profit. In addition, uninsured patients were 1.5% of Tenet Healthcare's patients, but accounted for 35% of total profits. At Sutter Health, the uninsured were 3.4% of total patients but accounted for 45% of total profits.

AB 774 (Chan) and SB 24 (Ortiz)

These bills would prevent the practice of hospitals overcharging the uninsured. The bill would also ensure that uninsured patients are informed of their consumer rights and financial options, including government programs and the hospital's own "charity care" policy, the circumstances by which they provide care without charge.

These bills ensure that hospitals develop and make available to patients their charity care and reduced payment policies in a language-appropriate manner. It allows public and private coverage options to be exhausted before hospitals refer unpaid bills to collections, and make reasonable attempts to negotiate a payment plan with patients prior to referring the patient's account to a collection agency.

Policy Implications from a Multicultural Approach

People of color are more likely than Whites to be under or uninsured. This is particularly true for Latino, Native American and African American communities. There are a variety of health consequences that are associated with being under and/or uninsured that significantly impact the morbidity and mortality rate within certain health conditions. Uninsured people live sicker and die younger than the insured. The uninsured have worse health outcomes regardless of the type of disease, health need, or emergency that they have. The uninsured are less likely to get preventative care, such as a breast cancer screening; less likely to get ongoing care for an illness such as cancer or diabetes; and less likely to get appropriate treatment even in an emergency trauma situation.

AB 774 (Chan) and SB 24 (Ortiz) are needed to ensure strong consumer and financial protections for self-pay hospital patients.

AB 772 (Chan) and SB 437 (Escutia) Californians for Healthy Kids Program

Background

Health insurance is a critical investment in the state's health and well-being of its future workforce. Children with health insurance are healthier, and are better able to pay attention in school. Uninsured children are more likely to miss out on necessary care and are more likely to have to rely on emergency room care for routine medical treatment.

AB 772 (Chan) and SB 437 (Escutia)

These bills create the California for Healthy Kids Program to provide children living in California from birth to 21 years of age access to affordable health insurance coverage. Specifically, they would:

- Use the local children's health initiatives as a model;
- Offer employers who cannot now afford family coverage for their workers' children the chance to "opt in" to the new program;
- Use outreach efforts to ensure parents all children can qualify;
- Work collaboratively with county leaders already offering insurance to all children or have plans to.

Policy Implications from a Multicultural Approach

The majority of children that do not have a regular source of care and/or are uninsured are children of color. In fact, children without health insurance are three times more likely to lack a regular source of care than children with public insurance coverage. Uninsured children are also more likely to miss out on necessary care and more likely to have to rely on expensive emergency rooms for routine care.

Of the 434,000 children eligible-yet-not enrolled into public health programs, two-thirds are Latino. By enrolling children in public insurance, California gains billions of federal dollars for its health care system. For every dollar the state invests in insuring children, the state receives either \$1 to \$2 from the federal government.

Initiatives that offer coverage to all children are proven successes. Santa Clara County, which launched the first Children Health Initiative (CHI) in 2001, increased its Medi-Cal and Healthy Families enrollment by 28%.

Approximately 75% of uninsured children live in counties with local CHIs. Ten local CHIs already provide health insurance, while another 17 local CHIs are in the planning or development stage. To date, these local programs have cumulatively enrolled more than 50,000 children.

California has a historic opportunity to lead the nation in ensuring that every child has affordable health coverage.