Joint Hearing on Proposition 67:
Emergency and Medical Services. Telephone Surcharge.

Assembly Committee on Health
Assembly Committee on Utilities and Commerce
Assembly Committee on Elections, Redistricting and Constitutional Amendments
Senate Committee on Health and Human Services
Senate Committee on Energy, Utilities and Communication

August 10, 2004
1:30 p.m.
State Capitol, Room 4202

This hearing will examine whether uncompensated health care and emergency services should be financed through an increase in the telephone surcharge and the use of portions of Prop 99 funds and criminal and traffic penalties.

On November 2, 2004 voters will consider Proposition 67, which provides funding for emergency personnel training and equipment, uncompensated emergency care, uncompensated community clinic care, and emergency telephone system improvements through a 3% surcharge on intrastate telephone calls, use of Proposition 99 (tobacco tax) funds, and use of criminal and traffic penalties. The measure caps the surcharge at 50 cents per monthly phone bill for residential phone lines, but has no cap on mobile telecommunication services and commercial telephone lines. Revenues from the increased surcharge would be deposited in a new 911 Emergency and Trauma Care Fund established and will be allocated as follows:

- 0.75% to the 911 Account.
- 3.75% to the Emergency and Trauma First Responders Account.
- 5% to the Community Clinics Urgent Care Account.
- 30.5% to the Emergency and Trauma Physician Uninsured Account.
- 60% to the Emergency and Trauma Hospital Services Account.

The Maddy Emergency Services Fund was created to provide supplemental financing for local emergency services. California law permits, but does not require, each county to levy a $2 penalty assessment to each $10 of traffic fines, and directs monies to be deposited in the fund. Up to ten percent of the total revenue is deducted annually for administration. Of the remaining revenues, 58% goes to reimburse physicians for uncompensated emergency room (ER) costs, 25% is allocated to trauma centers and hospitals, and 17% is allocated for county emergency

medical services. In addition to new revenues through the surcharge, the initiative transfers a portion of the local Maddy Emergency Services Fund revenues to the state for emergency physician and surgeon reimbursements. However, a county may obtain authority to administer its existing Maddy funds for reimbursement to physicians and any additional funding for uncompensated emergency and trauma care provided by physicians. The measure would also require all counties to levy the aforementioned penalty to traffic fines. Finally, the proposition locks in the amount of Proposition 99 funding allocated in the FY 2003-04 budget for uncompensated care provided by physicians and community clinics.

Background: The Warren 911 Emergency Assistance Act and the Emergency Telephone Users Surcharge Act were enacted to ensure that 911 emergency assistance was implemented in each public safety answering point (PSAP) while also ensuring that the State provide adequate funding to maintain the service through a surcharge. The Department of General Services (DGS) has oversight authority for the 911 program, which currently serves approximately 500 PSAPs in law enforcement, fire, and emergency medical services agencies in California's 58 counties.

Public safety agencies are funded and reimbursed for costs approved by the 911 Program Office from the Emergency Telephone Number Account (ETNA). Revenue for the 911 Account is generated by a surcharge on all intrastate telephone communication services and deposited in the ETNA. Under California statute, the surcharge is capped at 0.75% of a customer's phone bill, and is currently set at 0.72% by DGS. There has been no increase in this surcharge since 1995. The surcharge generates approximately $130 million annually. Approximately half of the funds pay for database services, which identify incoming 911 calls by a telephone number and street address. One quarter pays for carrying the telephone call and one quarter pays for telecommunications equipment housed in public safety dispatch centers. The surcharge does not pay for public safety personnel to respond to 911 calls.

Telecommunication Surcharges and Taxes: California law provides for several programs to support universal telephone service, such as Universal Lifeline, High Cost Fund A, High Cost Fund B, and Teleconnect. Each of those programs is funded through a surcharge on telephone bills. The CPUC assesses the needs of the programs supported by the surcharges and adjusts the rates annually. These surcharges are itemized on phone bills and calculated as a percentage of the customer's total intrastate phone charges. Calls made to other states (interstate calls) are not subject to the CPUC surcharges. In addition to state surcharges, there are two interstate access charges imposed by the Federal Communications Commission (FCC). There are also three taxes charged to a customer's local phone bill. They are the Emergency Telephone Users Surcharge Tax (to support 911 services), City and County Utility Tax, and Federal Excise Tax. The local and federal taxes apply to all services on the telephone bill regardless of whether they are intrastate or interstate. The total taxes and fees on telephone bills vary throughout the state because of variations in local taxes and ranges from 8.09% to 19.09%. Several local jurisdictions have also imposed telephone taxes to pay for 911 service and other localities are considering such taxes.

The Uninsured: According to the UCLA Center for Health Policy Research, over six million children and nonelderly adults in California were uninsured for all or part of the year in 2001. Of the 6.3 million Californians who lacked insurance, over 1.3 million were children. Over half

the uninsured (3.3 million people), were uninsured for more than a year. There are substantial disparities in coverage stability across ethnic and racial groups. About 86% of whites and African Americans were insured all year in 2001 compared with lower proportions for Asian Americans and American Indians/Alaska Natives. Latinos are the least likely to be insured all year (64.1%) and the most likely to be uninsured all year (22.8%). Coverage stability varies even more by family income. Among nonelderly persons with family incomes of at least 300% FPL ($56,550 annual income for a family of four), 89.9% were insured all year compared with just 61.3% of those below poverty. Just 3.7% of those with incomes at or above 300% FPL were uninsured all year, less than one-sixth the proportion (24.8%) of those below poverty.

Health Care for the Uninsured: According to a July 2004 report by the California Medical Association, uninsured persons with chronic diseases such as asthma, high blood pressure, diabetes or heart disease often delay treatment until they are in crisis, and many times become hospitalized as a result. The uninsured also seek emergency room care for problems as an earache or flu, which should be treated by a primary care doctor. In 2001, over $35 billion in uncompensated care was provided nationwide according to the Kaiser Commission on Medicaid and the Uninsured. Physicians' donated time and foregone profits and hospital philanthropy and profit margins were responsible for $7.5 to $9.8 billion in private funding of uncompensated care. The federal government provided $19.9 billion, primarily through payment to hospitals by the Medicare and Medicaid programs and through the Veterans Administration. State and local governments spent $10.7 billion, allocated primarily to hospitals, mainly through tax appropriations and indigent care programs. According to the California Healthcare Association, California hospitals provided $5 billion dollars in uncompensated care in 2003.

Emergency Services: California's hospitals have an obligation under existing law to provide health care services to any person seeking that care, regardless of their ability to pay. ERs are designed to provide emergent and trauma care, and are the most costly location in which to receive health care services. Frequently, uninsured patients are seen in the ER for non-urgent needs due to their inability to pay for services elsewhere. This has caused great strain on California's ERs and has led to a temporary suspension of the provision of services in many cases. Ambulance diversion occurs when a hospital closes its ER to incoming ambulances because it is full and is measured in the hours that an ER must remain closed. Diversion rates have become alarmingly high due to hospital closings and overcrowded ERs. According to the California Medical Association, Sacramento hospitals experienced more than 6,000 hours of ambulance diversion in 2003. Ambulances are diverted 25% of the time in Los Angeles County. According to a January 2004 study in the Annals of Emergency Medicine, hospitals with the longest diversion times in Los Angeles turned away ambulances from one-third to more than two-thirds of the time during a 12-month study period.

Community Clinics: Primary care clinics provide comprehensive health care, including primary, dental, and mental health services. In 2002, California primary care clinics reported 9.5 million patient encounters to over three million patients. Clinics serve primarily low-income, underserved patients: approximately 80% have incomes below 200% of the federal poverty level (FPL); 45% speak a primary language other than English; and 53% are Latino. Medi-Cal accounts for 43% of all clinic revenue, Medicare accounts for 11% of revenue, and other publicly funded health programs account for 21% of revenue. According to Office of Statewide

Health Planning and Development (OSHPD) data, community clinics saw 2.8 million uninsured and indigent patients in 2001. While they received partial compensation for a portion of these patients through self pay and publicly funded programs such as Expanded Access to Primary Care (EAPC), County Medical Services Program (CMSP), and Medically Indigent Services Program (MISP), clinics received no compensation at all for over 524,000 (19%) of their uninsured patient encounters.

LAO Fiscal Analysis: According to the Legislative Analyst's Office (LAO), based upon the current number of residential and commercial landlines and cellular phone subscribers, increasing the existing surcharge by 3% would raise about $500 million annually. However, the number of residential users affected by the monthly cap is difficult to estimate and would depend on variations in monthly phone usage. Based on 2001-02 data, the LAO estimated that Prop 67 would result in about $32 million to the state from the county Maddy Emergency Medical Services Funds to reimburse physicians and surgeons for uncompensated emergency care. The measure also would allocate about $32 million per year in Prop 99 funds to reimburse physicians and surgeons and community clinics for uncompensated emergency care. These funding allocations would provide a fixed continuing source of revenue for uncompensated medical services, but could cause a reduction in funding for programs reliant on Proposition 99 funds, because tobacco levies are a declining source of state revenues.

The LAO estimates that one-time and ongoing administrative costs incurred by state departments would probably amount to several million dollars, which would be offset by the additional revenues generated under the measure. Finally, this measure would also result in minor administrative expenditures at the local level, that would be paid for by the revenues generated under the proposition.

Support: According to the proponents, which include the California Medical Association, California Primary Care Association, and the California Chapter of the American College of Emergency Physicians, this measure will ensure emergency care is available when the citizens of California need it the most. California is currently facing an emergency care crisis. There are 64 fewer emergency rooms and trauma centers in California than just a decade ago. Children, families and seniors continue to lose access to doctors, nurses, critical medical equipment, medicines and essential emergency care. This measure will help keep emergency rooms, trauma centers and health clinics open by preventing long lines in emergency rooms and diversion of ambulances during overcrowding. It will support local health clinics that treat non-emergency patients and preserve our emergency rooms for real emergencies. Further, this measure will enable emergency rooms to provide critical medical equipment and technology.

Opposition: According to opponents, which include the California State Sheriffs' Association, local Chambers of Commerce, the California NAACP, and the District Attorneys of Sacramento and Solano counties, this measure is a $540 million direct tax on consumers, with no cap on cell phone, small business or business phone taxes. More than one million seniors will be affected. Additionally, this proposition is a regressive tax which gives a huge windfall to for-profit hospitals, while putting the bulk of the burden on those who can least afford to pay: people of color, young people, and small businesses. Finally, proponents of the proposition have sold it as the “save 911” initiative, yet less than 1% of the proceeds actually go to the 911 system.