AGENDA
ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

PART 1

Assemblymember Patty Berg, Chair

FRIDAY, MAY 30, 2008, 10 AM
STATE CAPITOL, ROOM 4202

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ITEMS TO BE HEARD

ITEM 4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: MAINTAINING ESSENTIAL HEALTH CARE SERVICES AND ELIGIBILITY

Table 1, below, lists proposed actions to maintain essential health care services, access to those services, and eligibility for coverage in Medi-Cal and Family Health Programs in the Department of Health Care Services (DHCS). These proposed actions assume the availability of additional budget resources above those provided in the Governor's May Revision.

Table 1.
Proposed Actions to Maintain Essential Healthcare Services and Eligibility
(Dollars in millions)

#	Ref.	Description	Amount	Comments
1	PC 147 BBR 278 AB 5 X3	Restore 10% provider rate cut for physicians and other healthcare providers, dentists, outpatient services, dentists, home health, LA Clinics, medical transportation, EPSDT	$172.4	Restores the July 1, 2008 rate reductions for most Medi-Cal fee-for-service providers.
2	PC 147 BBR 278 AB 5 X3	Partially restore Medi-Cal fee-for-service pharmacy rate cut (reduce cut from 10% to 5%). Adopt placeholder Trailer Bill language to allow offset for AMP and UPL drug pricing reform savings enacted last year if those reforms are implemented.	76.3	Restores half of the July 1, 2008 pharmacy cut. Dec. 2007 Myers and Stauffer study found that current Medi-Cal drug pricing averages around 5 percent over cost.
3	PC 151 BBR 284 AB 5 X3	Partially restore long-term care rate reductions enacted in AB 5 X3 (reduce cut from 10% to 5%). Does not adopt May Revision reduction to pediatric subacute rates.	24.6	Restores half of the July 1, 2008 rate cut. AB 5 X3 only reduced rates for distinct-part and certain other facilities that do not pay a qualify assurance fee to assist in financing their rates.
4	PC 178 AB 5 X3	Partially restore Medi-Cal managed care rate cuts to be consistent with reductions in fee-for-service rate cuts.	100.8	Amount estimated based on information provided by DHCS. The partial rate restoration is in addition to the May Revision estimate

				changes for Medi-Cal managed care, including an increase of $278.2 million (total funds) required to provide actuarially sound rates under the "Mercer" methodology adopted last year.
5	PC 169 AB 5 X3	Reject 10% cut to FamilyPACT providers	5.5	This rate cut was rejected in AB 5 X3. Cut would lose enhanced federal match ($12.7 million).
6	PC 175 AB 5 X3	Reject 10% rate cut to Breast and Cervical Cancer Program provider and restore 10% cut to state-only BCCTP services	2.5	This rate cut was rejected in AB 5 X3 for federally-qualified component. Cut would lose enhanced federal match. Restoration of state-only component provides consistency.
7	PC OA 69/70	Restore Medi-Cal CCS and EPSDT case management	2.8	Maintains essential case management staff to enable families to access CCS and EPSDT services to children.
8	AB 5 X3 CCS-PC 13A/B,16 A/B, GHPP-PC5, CHDP-PC2	Restore Family Health (CCS, GHPP, and CHDP) rate cuts and CCS case management.	10.8	Restores Family Health rate cuts in order to remain comparable with Medi-Cal
9	PC 143 BBR 296	Retain adult speech therapy	0.1	
10	PC 144	Retain adult chiropractic services	0.2	
11	PC 148 BBR 292	Retain adult acupuncture services	1.4	
12	PC 149 BBR 304	Retain adult psychology services	0.1	
13	PC 150 BBR 302	Retain adult podiatry services	0.9	
14	PC 153 BBR 290	Retain adult incontinence creams and washes	2.9	
15	PC 154 BBR 298	Retain adult optometrist services	0.5	
16	PC 155 BBR 300	Retain adult optician/optical lab services (eyeglasses)	3.8	
17	PC 156 BBR 296	Retain adult audiology services	1.7	
18	PC 157 BBR 294	Retain adult optional dental services	73.8	
19		*Note:* Total for optional services restorations	(85.5)	These services are not federally required, but they provide crucial services

				and maintain function, particularly for elderly and disabled people, who are the primary users of these services. Dental services are particularly important for maintenance of good general health, functionality, and for reducing costly emergency care.
20	PC 185	Reject 1931(b) rollback. Would roll back applicant eligibility from 100% FPL to 68% FPL and reinstate the 100-hour per month limit on work for married applicants and for applicants and recipients in the family medically needy category.	31.1	Major eligibility reduction for working families and disincentive to marriage. Effective Nov. 08. Reduces caseload by 39,000 average monthly in 08-09 (104,000 unduplicated) and by 434,000 when full impact is realized (August 2011).
21	PC 186	Reject month-to-month eligibility for undocumented immigrants	42.0	Disrupts care (already restricted to emergency services). Savings appear overstated. No provision for increased county eligibility costs due to churning.
22	PC 188	Reject proposal to reduce Medi-Cal services for recent legal immigrants and immigrants with PRUCOL status from full-scope to emergency services only. Note: DHCS now indicates that net GF savings would be $2.5 million less because recent legal immigrant children would shift to state-only coverage in Healthy Families. Savings in Medi-Cal would increase slightly, but be more than offset by increased costs for Healthy Families.	86.7	Affects legal immigrants here less than 5 yrs. and about 9,000 PRUCOLS (generally long-term undocumented immigrants with federal acquiescence in their residency). Assumes 70% of state-only non-emergency services shift to emergency claims and receive federal match). No month-to-month re-qualification (except PRUCOLs).

Note: PC numbers refer to Policy Change numbers in either the Medi-Cal or Family Health May Revision estimate.

The Subcommittee acted on April 14th to reject the proposals to end continuous eligibility for children and to reinstate quarterly status reports for parents.

Staff Recommendation: Approve the proposed actions shown in Table 1.

ISSUE 2: BUDGET TRAILER BILL LANGUAGE PROPOSALS

The following actions are proposed for outstanding DHCS Trailer Bill issues:

1. Elimination of sunset for $1,800 adult dental spending cap.

This language deletes the current sunset and retains the existing cap on benefits that applies to services to adults for optional dental services. The May Revision estimates a General Fund savings of $700,000 from continuing the cap for those services that would have been retained. However, this savings will be larger with the continuation of optional adult dental services.

Proposed Action: Adopt the Administration language.

2. Extend AB 1629 nursing facility rate methodology and quality assurance fee.

This issue was heard on May 5th. The current rate methodology and quality assurance fee provisions sunset at the end of the 2008-09 rate year (July 31, 2009). There is considerable dispute, as the subcommittee heard, as to the efficacy of the higher rates provided by the AB 1629 methodology in improving patient care. The department recently incorporated into its proposal a process for stakeholder input, which should be helpful, but the department also is seeking a two-year extension of the methodology—through 2010-11. The 2009-10 AB 1629 rate adjustment is included in the May Revision estimate approved by the subcommittee on May 21st.

Given the considerable concern and controversy over the impact of the AB 1629 rates, legislative policy review of this program would be advisable next year, when another year of data becomes available. A one-year extension of the methodology is reasonable in order to enable the Department and the nursing homes to plan their budgets and operations for 2009-10 and to operate next summer while legislation is considered. A two-year extension, as requested by the Administration, is not necessary or advisable, given the need for policy review.

Proposed Action: Adopt the Administration's May Revision language, but with an extension for one year only.

3. Reduce Hospital Supplemental Funding.

The Subcommittee heard these issues on April 28th. The Administration is proposing several Trailer Bill language provisions that have the effect of implementing 10-percent reductions in supplemental funds for the public hospitals and private hospitals.

- Safety-Net Care Pool (SNCP) federal waiver funding for designated public hospitals would decrease by $54.2 million, resulting in an equivalent General Fund savings by replacing state funds for the CCS and GHPP programs both in Medi-Cal and Family Health. The designated public hospitals are eligible to receive full-cost-based rates, but they receive no General Fund payments, using their own "certified public expenditures" (from Realignment and other local revenues) to match federal Medicaid funds.

- State General Fund DSH and "Replacement DSH" supplemental payments to nondesignated public hospitals and to eligible private hospitals, respectively, would be reduced by 10 percent ($700,000 and $21.9 million, respectively). There also would be a loss of matching federal funds. The designated public hospitals have the option of retaining the federal funds by using their own funds to match. Private hospitals can seek rate increases from the California Medical Assistance Commission if the reduced funding results in serious financial difficulties.

Together, these reductions result in General Fund savings of $76.8 million. Although these budget-balancing reductions requested by the Governor will have a negative impact on the ability of safety-net hospitals to care for Medi-Cal and uninsured patients, the current budget situation requires spending reductions. Furthermore, other actions on this agenda and to continue optional benefits will assist safety-net hospitals both directly and indirectly and significantly reduce the negative impacts that they would experience under the May Revision budget, as proposed the Governor.

Proposed Action: Adopt the May Revision language and savings.

4. County Administration Budget-Balancing Reductions.

The Administration proposes several Trailer Bill provisions to reduce funding for county administration of Medi-Cal eligibility by 10 percent for a total General Fund savings of $79.1 million as follows:

- Suspend the CNI-based cost-of-doing business adjustment ($22.4 million).

- Suspend funding for caseload workload growth ($33.4 million).

- Permanently reduce base funding by 2.5% ($23.3 million)

At this time, staff recommends adoption of the two suspensions for a savings of $55.8 million (7.1 percent instead of the Governor's 10-percent reduction). Furthermore, the reductions that would be approved are suspensions. Staff recommends rejection of the permanent base reduction in order to mitigate the

impact on counties and to reduce the potential state exposure to federal penalties if county error rates increase. Furthermore, this action would be taken with the understanding that county administration funding requirements should be re-evaluated during Conference in light of Conference actions affecting Medi-Cal eligibility.

Proposed Action: Adopt the COLA and the workload adjustment suspensions and reject the permanent base reduction, subject to review in light of Conference decisions.

5. Fiscal Intermediary transition to electronic media transfer.

This language, requested by the Administration as a budget-balancing reduction, authorizes the phase-out of the issuance of paper provider manuals and most paper provider bulletins. The materials will be provided electronically via the internet. General Fund savings of $700,000 are estimated.

Proposed Action: Adopt the Administration's proposed language and savings.

6. Extend HIV/AIDS Pharmacy Pilot Project

The administration proposed this language as part of the Governor's Budget to extend this program for one year (through June 2009). The program provides an additional $9.50 dispensing fee to a small number of pharmacies that specialize in managing the drug therapy of Medi-Cal patients with HIV/AIDS. A recent study by the San Francisco Health Department has found some preliminary evidence that the drug therapy management provided by pilot pharmacies reduces hospitalizations and results in overall savings. The program cost is $2.6 million (General Fund), which was included in the January Governor's Budget. The administration revised its proposal in the May Revision to reduce the cost to $1 million by limiting the supplemental dispensing fee solely to drugs that treat HIV/AIDS itself or opportunistic infections.

Staff recommends approval of the Governor's Budget proposal at this time to send this issue to Conference and evaluate the potential impact of the proposed restrictions. Many other conditions—such as wasting conditions and mental illness can afflict HIV/AIDS patients, particularly the low-income patients served by this program, and effective drug therapy requires comprehensive management.

Proposed Action: Adopt Trailer Bill Language proposed with the Governor's Budget.

7. Public Assistance Reporting Information System (PARIS) Pilot Project

The May Revision proposes trailer bill language to implement the Public Assistance Reporting Information System (PARIS) pilot project. The primary focus of this proposal is to identify high-cost Medi-Cal enrollees who are also veterans and who may be eligible for VA health services. The DHCS will implement this project within existing resources beginning in 2008-09. As such, there are no General Fund implications for this proposal in 2008-09. DHCS will accomplish the pilot with existing resources.

This proposal would authorize DHCS to operate a two-year pilot program to test the cost effectiveness of the PARIS-Veterans match in three counties. While the DHCS currently identifies veterans enrolled in the Medi-Cal Program, the existing process is paper driven, inefficient and could be enhanced. Improved veteran identification may increase the state's ability to shift health care costs from the Medi-Cal Program to the VA and, just as importantly, provide veterans with a greater set of health care options. No veteran would be forced to stop using Medi-Cal for any service. This DHCS proposal is in response to issues raised by the Legislative Analyst's Office (LAO) in her Analysis of 2007.

PARIS is a federal information sharing system that allows states and federal agencies to verify public assistance beneficiaries and those eligible for veteran's benefits. PARIS would provide the DHCS with an improved method to identify veterans who are enrolled in Medi-Cal.

Proposed Action. Adopt the Administration's language.

8. Part B Premiums for Share-of-Cost Medi-Cal Enrollees

The Subcommittee heard this issue on April 14th.

The language proposed by the Administration would eliminate payment of Medicare Part B premiums (almost $100 per month) for elderly and disabled Medi-Cal enrollees who also qualify for Medicare and have an unmet share of cost. The May Revision estimates a savings of $53.8 million (all General Fund) from this action.

As discussed on April 14th, individuals affected by this proposal with the lowest shares of cost (under $500 per month) have monthly incomes that are about $1,000 or less. Consequently, the Part B premium for these persons represents 10 percent of their income. The Department indicates that exempting those persons with a share of cost under $500 is feasible and would reduce savings by $5.4 million. Also, recent information provided by the Department indicates that some of these individuals may qualify for special federal Medicare Savings Programs (e.g., SLMB and QMB), further reducing the cost of this exemption.

Staff recommends adopting placeholder language to eliminate Part B premium payments only for Medi-Cal enrollees with a share of cost of $500 or more and to ensure coordination with the federal Medicare Savings Programs.

Proposed Action. Adopt the placeholder language.

9. Rural Health Services Delivery

This language implements a 10-percent reduction Governor's budget-balancing reduction to grants under the Expanded Access to Primary Care (EAPC) program and several smaller rural health programs for a General Fund savings of $3.5 million. In addition to EAPC (cut of $1.35 million), the affected programs are Seasonal/Agricultural Migratory Workers (SAMW--$690,000 reduction), Rural Health Services Development (RHSD--$820,000 cut), Indian Health (IH--$650,000 cut), and Grants in Aid (GIA--$44,000 cut).

This reduction will reduce funding for primary care services by these clinics to low-income uninsured persons. However, clinics have a variety of funding sources, including federal and private grants, Proposition 99 funding ($13.5 million for EAPC is maintained in the May Revision), and, most importantly, Medi-Cal. Many of the affected clinics are Federally Qualified Health Clinics (FQHCs) or Rural Health Clinics (RHCs). These clinics treat many Medi-Cal patients, in addition to the uninsured, and receive special rates with automatic inflators tied to Medicare. Consequently, the 10-percent reduction proposed here will result in a much smaller reduction to the clinics' overall funding, although the impact will vary.

Proposed Action. Adopt the Governor's language for a savings of $3.5 million (included in the May Revision).

10. Working Disabled Program

This language proposed by DHCS would extend the Working Disabled Program, which allows low-income disabled persons to remain eligible for Medi-Cal although they work. Traditionally, disability had been defined as being unable to work, but that perception has changed, and federal Medicaid law and state law have been revised to recognize that fact. Furthermore, the budget estimates that this program saves over $6 million annually.

Staff recommends making the program permanent since it has been extended on an ongoing basis and there have not been any issues raised.

Proposed Action. Adopt modified language to eliminate the sunset for the Working Disabled Program.

11. Reduce Non-Contract Hospital Rates

This is a May Revision proposal that encompasses two pieces—one affecting Medi-Cal fee-for-service (FFS) rates paid to noncontract hospitals and the other affecting payments by Medi-Cal managed care plans to noncontracting hospitals. The May Revision includes an estimated General Fund savings of $11.5 million resulting from adoption of these statutory changes.

For FFS Medi-Cal noncontracting means that the hospital does not have a contract agreement to provide discounted rates for Medi-Cal inpatient services. These contracts are negotiated with the California Medical Assistance Commission (CMAC) on behalf of DHCS. Noncontract hospitals receive cost-based payments (less 10 percent as of July 1 under the provisions of AB 5 X3). In the case of managed care plans, a noncontract hospital is one that does not have a contract with the plan. Under federal law, all hospitals must provide emergency treatment and stabilize patients. However, hospitals may choose whether to provide elective and nonemergency care.

Fee-for-Service Provision. The May Revision would change statute to reimburse Non-Contract Hospitals, except Rural Hospitals, the *lower* of: (1) the interim per-diem rate minus 10 percent as is in effect on July 1, 2008; (2) the “regional” average per-diem CMAC contract rate for Non-Tertiary Hospitals minus 5 percent; or (3) a statewide CMAC rate for Tertiary Hospitals, as defined, minus 5 percent. It is assumed that an additional $22.5 million ($11.2 million General Fund) in savings would be achieved from this action.

Medi-Cal Managed Care Provision. This provision limits the amount Medi-Cal Managed Care health plans must pay hospitals that do not contract with them. No 2008-09 savings are assumed from this proposed change, but DHCS states that this proposal will contain or limit growth of hospital costs for Medi-Cal Managed Care plans, thereby reducing pressure on capitation rates and General Fund expenditures. Further, the DHCS notes that if this proposal is enacted, Actuaries will factor this into the rate development process. According to the Department, the language (1) provides an incentive for hospitals to enter into contracts with Medi-Cal Managed Care plans; (2) reduce the costs that health plans pay to Non-Contract Hospitals; and (3) imposes rate limitations for emergency inpatient services that will fully comply with the federal Deficit Reduction Act provision known as the “Rogers Amendment". The proposed language would be effective October 1, 2008.

In addition to compliance with the Rogers Amendment, the Administration indicates that these changes are needed to continue to provide an incentive for hospitals to contract with CMAC or Medi-Cal Managed Care Plans under current hospital market conditions, in which there is no longer a glut of empty hospital beds and in which a few systems operate most of the private hospitals in the state.

Staff recommends adoption of both components of this proposal as placeholder Trailer Bill language. Hospitals and managed care organizations have raised a number of significant questions and issues related to this language that require further discussion between interested parties and the department for clarification and possibly revisions to the language to address specific issues.

Proposed Action. Adopt placeholder language to move this issue to Conference for further development and deliberation.

12. Fiscal Reforms for the Genetically Handicapped Persons Program (GHPP)

The May Revision requests adoption of two provisions of Trailer Bill language related to cost controls in the GHPP program (either in GHPP itself, or via CCS or Medi-Cal), which serves persons with hemophilia and certain other blood disorders. These provisions authorize DHCS to implement blood factor contracting (and contracting for other specialty pharmaceuticals) and would require supplemental rebates from manufacturers of blood coagulation factors. The May Revision includes estimated savings of $250,000 from the rebate provision. Contracting would not begin in time to effect savings in 2008-09.

Patient groups and suppliers have expressed concern and raised issues over specific portions of the language. For example, patient groups have objected to a provision that would allow DHCS to enter into an exclusive contract for provision of blood factor. DHCS has responded that it is willing to drop the exclusive contracting provision, but other issues remain and further discussion is needed to ensure continuation of adequate access and proper patient care while holding down costs. DHCS indicates that it is interested in working with affected parties to resolve these issues.

Staff recommends approval of placeholder language to send these issues to conference and recognize the May Revision savings.

Proposed Action. Adopt placeholder language to move this issue to Conference.

13. Adult Day Health Care Services for ICF-DD-H Residents

The May Revision proposes trailer bill language to clarify that individuals with developmental disabilities who live in Intermediate Care Facilities (ICF-DD-H and ICF-DD-N) are eligible for Medi-Cal Adult Day Health Care (ADHC) services. The clarification is needed because generally ADHC services are not available to persons who reside in a health facility.

The Administration indicates that this clarification will prevent the denial of treatment authorization requests for ADHC services for developmentally disabled persons living in ICF-DD-H and ICFDD- N facilities. With the denial of the Medi-Cal funded ADHC services that receive federal financial participation for 50 percent of the cost, the Department of Developmental Services (DDS) must fund these ADHC services at 100 percent General Fund cost. Therefore, the Administration is seeking to clarify existing statute.

Proposed Action. Approve the May Revision language.

ISSUE 3: FEDERAL DISALLOWANCE FOR FRESNO COMMUNITY MEDICAL CENTER

The Administration is proposing an increase of $9 million (General Fund) in Medi-Cal to pay back the federal government due to an impermissible "intergovernmental transfer" (IGT) made by Fresno Community Medical Center (a Private Hospital under the Hospital Financing Waiver).

Specifically, in 2005-06 the DHCS accepted an IGT from Fresno County in the amount of $18 million to be used as the "non-federal" share of a supplemental Medi-Cal payment to the hospital that was negotiated by the CA Medical Assistance Commission (CMAC). This $18 million IGT was used to draw down federal funds and a payment was made to Fresno Community Medical Center in the amount of $27 million (i.e., $9 million more).

The federal government subsequently determined this IGT to be impermissible for a federal match because Fresno Community Medical Center has an annual contract with Fresno County under which it is paid for providing health care to indigent persons and inmates within the county. The funding the hospital would have received in 2005-06 under this contract (i.e., $18 million) was diverted to the DHCS and used as the IGT. This is considered impermissible by the federal government because it is considered a "provider" donation. Based on federal rules, the penalty for an impermissible provider donation is for the state to pay back half the federal funds claimed, or $9 million, to the federal government. According to the DHCS, if the state was to collect the $9 million from the hospital, they would consider the $9 million to be another impermissible provider donation and the state would owe $13.5 million instead of only $9 million. Therefore, the DHCS contends that the only way for the state to rectify the situation is for the state to pay it back and not recover from the Fresno Community Medical Center.

Criteria as to what is considered a permissible Intergovernmental Transfer (IGT) is clearly articulated under the Hospital Financing Waiver and was discussed at length with the federal government and Administration during the negotiations on the Waiver. Due diligence and scrutiny on the part of all parties should have been made regarding this IGT.

Staff Recommendation: In order to explore other alternatives to General Fund payment of this penalty, the subcommittee could reduce this amount to $1,000 in order to place this issue in Conference. One option to explore, for example, is to use the Private Hospital Supplemental Fund. The Private Hospital Supplemental Fund is a nonfederal source of payments made to Private Hospitals under the Hospital Financing Waiver. It should be noted that there is at least $1 million in unexpended money presently available within this fund.

Proposed Action. Reduce to $1,000 to place in Conference.

ISSUE 4: SUBSTANCE ABUSE SCREENING AND BRIEF INTERVENTION

The May Revision proposes an increase of $1.6 million ($800,000 General Fund) to the Medi-Cal Program to add new reimbursement codes to allow medical providers to routinely screen Medi-Cal patients suspected of non-dependent substance abuse, and provide appropriate intervention services to those patients determined to be at risk of progressing towards drug or alcohol dependency. It is the intent of the DHCS to decrease utilization of more expensive programs specifically targeted to those patients with advanced alcohol and drug dependency. However, no specific information has been provided as to how this would occur. No savings have been scored for this proposal.

An alternative approach that does not require ongoing state funds is provided in AB 2124 (Beall), which would establish the Medi-Cal Alcohol and Drug Screening and Brief Intervention (SBI) Services Program (program) to be administered by DHCS in collaboration with the Department of Alcohol and Drug Programs to authorize counties to use certified public expenditures to obtain federal matching funds for this purpose. AB 2124 is now in the Senate.

Proposed Action. Deny the May Revision request (address issue in legislation instead).

ITEM 4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: SPECIAL FUND LOANS AND GRANTS

The May Revision includes the following requests for loans and transfers to the General from special funds within the purview of the Department of Public Health:

Loan to the General Fund from the Occupational Lead Poisoning Prevention Account (Issue 600)—It is requested that Item 4265-011-0070 be added to authorize a one-time loan of $1.1 million from the Occupational Lead Poisoning Prevention Account to the General Fund.

Loan to the General Fund from the Drinking Water Operator Certification Special Account (Issue 601)—It is requested that Item 4265-011-0247 be added to authorize a one-time loan of $1.6 million from the Drinking Water Operator Certification Special Account to the General Fund.

Budget Bill language would require repayment of the two loans by June 30, 2011. The May Revision indicates that these loans and transfers wound not result in any program impact or require any fee increases. Under existing law, these conditions generally would have to be satisfied for any loan from a fee-supported special fund to the General Fund.

Transfer to the General Fund from the Cancer Research Fund (Issue 603)—It is requested that Item 4265-011-0589 be added to authorize a one-time transfer of $2,119,000 from the Cancer Research Fund to the General Fund.

Note: The original source of these funds was the General Fund.

Transfer to the General Fund from the Drinking Water Treatment and Research Fund (Issue 604)—It is requested that Item 4265-011-0622 be added to authorize a one-time transfer of $8.5 million from the Drinking Water Treatment and Research Fund to the General Fund.

Fee Financing. The source of these funds is regulatory fee revenue in the Underground Storage Tank Cleanup Fund, as specified in the following provisions from the Health and Safety Code:

> 25299.99.1. (a) The [State Water Resources Control] board shall annually transfer five million dollars ($5,000,000) from the Underground Storage Tank Cleanup Fund, created pursuant to Section 25299.50, to the Drinking Water Treatment and Research Fund created by Section 116367, to be expended for the purposes set forth in Section 116367 if a public drinking water well has been contaminated by an oxygenate and there is substantial evidence that the contamination was caused by a release from an underground storage tank.
> (b) This section shall become operative June 30, 1999.
>
> 25299.99.3. In any fiscal year, if the department determines that less than two million dollars ($2,000,000) of unencumbered funds remain in the fund, it shall notify the board and the board shall transfer five million dollars ($5,000,000) from the Underground Storage Tank Cleanup Fund to the Drinking Water Treatment and Research Fund, to be expended for the purposes set forth in Section 116367, if a drinking water well has been contaminated with oxygenate and there is substantial evidence that the contamination was caused by a release from an underground storage tank.

COMMENTS

Transfer from the Drinking Water Treatment and Research Fund to the General Fund Appears Inappropriate. A transfer of regulatory fee revenue to the General Fund for general purposes is not appropriate. There also are inconsistencies in the proposal, since the Governor's Budget Fund Condition Statement for this fund indicates that $5.1 million will be spent in 2008-09 and there is a balance of only $10.6 million, so that the $8.5 million transfer could not be funded without additional transfers from the Underground Storage Tank Cleanup Fund.

Proposed Action. Delete the transfer from the Drinking Water Treatment and Research Fund and approve the other transfer and the two loans

ISSUE 2: EVERY WOMAN COUNTS BREAST CANCER EARLY DETECTION

Because of a reduction in Proposition 99 cigarette and tobacco tax funds, the May Revision reduces Proposition 99 support for the Every Woman Counts Program by $4.2 million. However, the program also receives funding from the Breast Cancer Control Account (funded from a separate 2-cent component of the cigarette tax). The budget estimates that the account will have a reserve of $6.2 million in 2008-09.

COMMENTS

An augmentation of $2 million for the Every Woman Counts Program from the Breast Cancer Control Account would partially offset the reduction in Proposition 99 funding. It should be recognized, however, that backfilling the program now will reduce resources available in future years.

Proposed Action: Augment funding by $2 million from the Breast Cancer Control Account.

ITEM 4280 MANAGED RISK MEDICAL INSURANCE BOARD

The Managed Risk Medical Insurance Board (MRMIB) administers the Healthy Families Program and certain other health coverage programs.

ISSUE 1: GOVERNOR'S HEALTHY FAMILIES PROGRAM REDUCTIONS

The Subcommittee discussed the Governor's Budget-Balancing Reduction proposals for the Healthy Families Program (HFP) on April 14th and held those issues open at that time. The actions proposed below reject or moderate some of the reductions in order to maintain affordable and comprehensive health coverage for children. These proposed actions assume the availability of additional budget resources above those provided in the Governor's May Revision.

1. Reduce HFP Plan Rates by 5 percent.

This proposal, which includes Trailer Bill language, reduces General Fund costs by $14.4 million (and federal funds by $26.2) in 2008-09 by reducing the capitation rates paid to health, dental, and vision plans by 5 percent (from 2007 rates) effective November 1, 2008 (assuming July 1 budget enactment). The board negotiates rates with plans throughout the various regions of the state. The board has delayed its normal annual renegotiation pending budget action. To achieve the 5-percent reduction, plans may restrict provider networks and it is possible that only one plan would be available in some areas.

Staff Recommendation. Due to the need to achieve General Fund savings, staff recommends approval of this proposal with the trailer bill language adopted as a placeholder to consider whether some assurance of continued access and at least a modicum of choice should be included.

Proposed Action. Approve reduction in plan rates with placeholder trailer bill language.

2. Increase in HFP Premiums.

The Governor proposes adoption of Trailer Bill language to increase premiums paid by families for enrollment of their children in the HFP as follows:

A. Subscribers from 100-150 percent of the federal poverty level (FPL). There would be no change due to federal cost-sharing requirements, premiums cannot be raised. The premium is $7 per child with a maximum per family of $14 per month. If the “community provider” plan is chosen the premium is $4 per child with a maximum per family of $8 per month.

B. Subscribers from 151 to 200 percent of FPL. Premiums would Increase from $9 per child per month to $16, an increase of $7 per month. The family maximum amount would increase from $27 to $48 per month, an increase of $21 per month. This is a 77 percent increase.

C. Subscribers over 200 percent FPL. Monthly premiums would increase from $15 per child per month to $19, or by $4 per month. The family maximum amount would increase from $45 to $57 per month, or $12 per month. This is a 27 percent increase.

A total reduction of $48.6 million ($18 million General Fund and $30.6 million federal funds) is assumed. This savings level also includes a reduction of 2.2 percent in caseload due to the premium increases, and families' potential inability to pay. The board notes that the HFP does have "family premium assistance" availability where donations from foundations, the First Five Commission or others can/could contribute to assist families in paying their children's premium. Families with incomes over 200 percent of FPL had their premiums increased in 2005, but other premiums have remained constant since the start of the program.

The board estimates that the proposed premium increases will have the effect of reducing enrollment by 2.2 percent, or almost 20,000 children, which accounts for roughly half of the savings. Also, because HFP receives an enhanced federal match, families must pay $3 in larger premiums in order to save the state $1.

Staff Recommendation. Some premium increase may be warranted because most premiums have remained fixed for years. However, reducing the budgeted savings by half would moderate the impact on families and result in significantly less enrollment decline.

Proposed Action. Reduce the savings estimate to $24.3 million ($9 million General Fund) and adopt placeholder trailer bill language pending an estimate by MRMIB of the premium levels that would achieve this savings with the minimum enrollment impact.

3. Increased Co-Payments

The Governor proposes to increase the co-payments of HFP subscribers from $5 to $7.50 for non-preventive services for families with incomes over 150 percent of FPL. The proposed increase of $2.50 in co-payment for each non-preventive service is a 50 percent out-of-pocket increase. This is in addition to the monthly premium payments. The May Revision assumes that an increase in co-payments will reduce the utilization of services. Therefore, the May Revision includes an additional 1.25 percent rate reduction to health plans due to less services being used. A total reduction of $5.2 million ($1.9 million General Fund and $3.3 million federal funds) is budgeted. This proposal requires a statutory change,

emergency regulation authority, and State Plan Amendment. No federal approval is needed.

Staff Recommendation. For families in the modest income range that qualifies for HFP, a $5 co-pay still represents a meaningful cost that acts as a disincentive to unnecessary utilization. Furthermore, the proposed co-pay structure involves additional complexity because the plans would have to charge different co-pays depending on the income level of each child's family. Accordingly, this proposal should be rejected.

Proposed Action. Reject the increase in co-pays (restore $1.9 million General Fund).

4. Limit on Dental Coverage.

The Governor proposes enactment of Trailer Bill language to institute an annual limit of $1,000 for dental coverage within the HFP for a savings of $8.3 million ($3 million General Fund and $5.3 million federal funds). A November 1, 2008 implementation is assumed. This proposal would limit the annual dental benefit offered to enrolled children to $1,000 annually. Since this proposal reduces total dental benefits, it would reduce dental plan costs, thereby allowing for a reduction in the rates paid to these plans.

The HFP presently contracts with 6 dental plans. According to MRMIB and their contracted actuary, establishing this dental limit would result in an 8.5 percent rate reduction to dental provider organizations and a 3 percent reduction to dental maintenance organizations.

The MRMIB states that if the $1,000 cap is imposed, the dental services offered would remain the same until the cap is reach. Therefore, children with multiple dental needs would likely need to spread services over more than one-year. MRMIB's contracted actuary estimates that 5 percent of enrolled children, or about 46,774 children, would reach the proposed $1,000 annual limit in 2008-09.

Staff Recommendation. Adopt a dental coverage limit within the HFP of $1,500 in lieu of the $1,000 cap proposed by the Administration. An effective date of November 1, 2008 is assumed. The $1,500 dental cap would result in a reduction of about $4 million ($1.1 million General Fund) for 2008-09. Children with significant oral birth defects or other conditions that require extensive dental reconstruction generally would receive those services through the California Children's Services program, which is included in HFP as carved-out coverage which is not subject to any cap.

Proposed Action. Adopt modified trailer bill language establishing a $1,500 annual dental services limit. (Restore $1.9 million General Fund)