



Overview – On May 14th, Governor Schwarzenegger released his May Revision to the proposed 2010-11 California state budget. The state faces a \$17.9 billion shortfall, which the Governor resolves through steep cuts to California's fragile healthcare system and without any measures to increase revenues to ease the budget crisis. Overall, the Revision seeks \$12.4 billion in spending reductions. The national health reform bill's Maintenance of Efforts (MOE) provisions prevented the Governor from making major cuts to Medi-Cal and Healthy Families eligibility by requiring states to uphold current healthcare coverage or forfeit Medicaid funding. However, the Governor proposes to make it even harder for families to access the care they need by placing limits on coverage and increasing cost-sharing. Below is an analysis of many of the May Revision's proposed healthcare cuts and their impact on the state, local communities and families.

PROPOSED CUT	IMPACT ON STATE AND LOCAL COMMUNITIES
<p>Elimination of Vision and Increasing Premiums & Co-payments for the Healthy Families Program</p> <p>General Fund Cut: \$32.9 M</p>	<p>Elimination of Vision</p> <ul style="list-style-type: none"> ▪ 824,630 children would be denied eye exams and glasses. Only medically-necessary vision-related services, such as eye surgery and treatment for eye injuries would be covered.ⁱ ▪ Impaired vision affects an estimated 25% of children in kindergarten through sixth grade in the United States and affects children's ability to learn, thrive and effectively participate in school, sports and other activities.ⁱⁱ ▪ Children who lack vision coverage are 3 times more likely than insured children to go without eyeglasses when needed.ⁱⁱⁱ Regular eye exams are an important part of preventative health care for children and if eliminated would inhibit diagnosis and treatment of vision problems. <p>Premium Increases</p> <ul style="list-style-type: none"> ▪ 552,955 children would be affected by the increased premiums.^{iv} An estimated 120,528 children will lose healthcare coverage due to increased cost-sharing.^v ▪ Premiums were increased twice in 2009 for families between 151 to 200 percent of the federal poverty level. The proposal to increase premiums from \$16 to \$30 per child is an 88% increase since November 1, 2009 and a 233% increase since before the February 1, 2009 premium increase was implemented (from \$9 to \$30). ▪ Families in the 201-250% FPL income category also saw premium increases twice last year. The May Revision proposal to increase premiums from \$24 to \$42 per child is a 75% increase since November 1, 2009 and a 200% increase since before the February 1, 2009 premium increase was implemented (from \$14 to \$42). ▪ Research shows that increasing premiums can drop enrollment if the financial burden is too great for families' incomes. According to the American Public Health Association, a "\$10 increase in monthly premiums would induce 10% of SCHIP children to disenroll, resulting in a 6% increase in public expenditures."^{vi} The Governor's proposals would also place California at the high end of what states charge for premiums.^{vii} ▪ This proposal potentially violates the MOE provision in national healthcare reform. Last year, guidance from CMS on similar language on the MOE in the American Recovery and Reinvestment Act (ARRA) would not allow states to impose new premium increases. States are awaiting direction from CMS for MOE in national health reform. <p>Increase in Co-Payments</p> <ul style="list-style-type: none"> ▪ Research on cost-sharing indicates that it can "depress enrollment and reduce utilization, at times increasing the number of uninsured."^{viii} A 2009 study on cost-sharing in Medicaid in CHIP specifies that "many families would face high health spending burdens even with minimal cost sharing for their publicly funded children."^{ix} ▪ Families currently do not pay hospitalization co-payments, which would jump to \$100 per day with a \$200 maximum for hospital inpatient services under this proposal. This would present an extreme hardship on families, especially those with children who have severe chronic conditions and illnesses such as asthma. ▪ Only 12 states charge family co-payments for inpatient hospital visits. The Governor's proposal would place California at the extreme high-end of these states. ▪ Only 15 states charge family co-payments for emergency room visits and of these states, only four charge \$50 or higher depending on family income.^x It has been just six months since the implementation of the \$15 co-payment for emergency room visits. This extreme proposal represents a 233% increase since November 2009 (from \$15 to \$50).

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<p>Eliminate Medi-Cal Coverage for recent legal immigrants</p> <p>General Fund Cut: \$118 M</p>	<ul style="list-style-type: none"> ▪ 90,000 Californians would lose most of their full-scope Medi-Cal coverage. Decreasing Medi-Cal coverage for newly qualified immigrants and immigrants who permanently fall under the color of law (PRUCOL) will limit access to healthcare to just five services. ▪ These cuts will only increase the number of people receiving care at overstressed and expensive emergency rooms and jeopardize care for those who really need emergency services. Projected cost savings will likely be much lower than anticipated because of increased costs for emergency care. The Department of Health Care Services estimates that 56 percent of the services cut would be billed as emergency services.^{xi} ▪ The Governor’s assumption does not take into consideration the savings associated with disease prevention for these individuals and ignores the California State Legislature’s repeated rejection of the recycled proposal.^{xii}
<p>Increasing Medi-Cal Cost-Sharing</p> <p>General Fund Cut: \$285.5 M</p>	<p>Physician, Clinic, Dental and Pharmacy Visit Co-payments (\$155.4 M General Fund)</p> <ul style="list-style-type: none"> ▪ Loss of \$153.4 million in federal funding by adding mandatory physician and pharmacy co-payments. This proposal requires a federal waiver in order to obtain CMS approval. ▪ Physician co-payments will impact service utilization, preventing thousands from obtaining preventative healthcare. The Department of Health Care Services itself estimates that there will be an 8% reduction in office visits once the copayment is implemented, and a 5% reduction in the number of prescriptions sought.^{xiii} ▪ A recent literature review on cost-sharing by the Center for Children and Families shows that “cost-sharing in CHIP and Medicaid, when even modest can reduce utilization, result in unmet need, cause financial stress, and burden providers.”^{xiv} Co-payments are also particularly troubling for individuals who have serious or chronic healthcare conditions such as diabetes, as consistent care is required and therefore co-payments will increase over the year. ▪ This proposal also does not take into consideration cost shifting to other parts of the healthcare delivery system including emergency rooms and lost revenue for safety net providers such as public hospitals and community health clinics who are already struggling. ▪ Utah’s implementation of \$2 to \$3 co-payments per service on their Medicaid population in 2001 and 2003 reduced utilization of services and access to care. 40% of affected families had to reduce food and housing costs and take less prescribed medications to make ends meet.^{xv} <p>Hospital Stay and Emergency Room Visit Co-payments (\$130.1 M GF)</p> <ul style="list-style-type: none"> ▪ Loss of \$130.2 million in federal funds for adding mandatory hospital stay and ER co-payments. These proposals require a federal waiver to obtain federal CMS approval. ▪ The Department of Health Care Services assumes that hospital inpatient stays will decline by 5% once implemented.^{xvi} This proposal does not account for delayed care and the increase in public healthcare costs as a result of individuals becoming more ill and requiring more healthcare services. ▪ Nearly 80% of Medi-Cal hospitalizations are for more than one day, which reflects a sicker population. Co-payments of \$200 per hospital admission will cause severe financial hardships for families, especially those who have children with special healthcare needs or parents in poor health.^{xvii} ▪ The Department of Health Care Services also assumes an 8% reduction in medically necessary Emergency Room visits with the implementation of \$50 co-payments. The consequences of going without necessary emergency care in some cases will be death.
<p>Utilization Controls for Medi-Cal</p> <p>General Fund Cut: \$129 M</p>	<p>Limiting Drugs and Physician Visits (\$124.4 M GF)</p> <ul style="list-style-type: none"> ▪ Reducing state funding for visits and pharmacy would prompt a loss of \$124.8 million in federal matching funds and would require a Medicaid State Plan Amendment. ▪ Capping prescription drug claims to six per month, except for life saving drugs, will prevent adequate access to vital medications and increase preventable physician visits. In this proposal, if the same drug is dispensed four times a month, it counts as four of the six prescriptions, which is clearly inadequate in providing proper medical care to Medi-Cal beneficiaries, especially those in highest need.^{xviii} ▪ The elimination of coverage for certain over-the-counter drugs including pre-natal vitamins, insulin, nicotine patches, calcium supplements, cough and cold products, acetaminophen containing products, and others will rob beneficiaries of basic preventive alternatives to prescription drugs. Additionally, this proposal will may increase costs as patients seek medical treatment for flu, cold, muscle ache, arthritis, headache, and toothaches at physician offices, clinics or emergency rooms.^{xix} ▪ Restricts access to care by limiting primary and specialty care visits provided by physicians in both Fee-for-Service and Medi-Cal Managed Care programs to 10 per year, excluding children. This limit

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	<p>poses a serious threat as it would lead to loss of 1.3 million or 40% of Medi-Cal office visits per year or more.^{xx} In particular, if the aged, blind and disabled population, many of whom will shortly transition to Medi-Cal Managed Care, is forced to comply with this proposal, their health will be severely compromised as 10 office visits per year is insufficient to meet the demands of this population.</p> <p>Cap on All Remaining Medi-Cal Benefits (\$4.6 M GF)</p> <ul style="list-style-type: none"> ▪ Loss of \$4.6 million in federal matching funds and would require a Medicaid State Plan Amendment. ▪ Establishing a maximum annual benefit dollar cap on hearing aids, durable medical equipment, incontinence supplies, urological supplies, and wound care supplies will further undermine current disease and injury management efforts and may force low-income beneficiaries to make the cruel decision between their personal ability to function and providing for their families. ▪ The annual benefit dollar cap of \$1,604 per year on durable medical equipment will affect approximately 6,773 of the highest need beneficiaries who will have to pay on average over \$3,000 above the benefit cap per year.^{xxi} This will severely hurt and financially break the most medically needy and fragile Medi-Cal beneficiaries who rely on such equipment for access to school, work, and basic quality of life issues. ▪ The hard cap on other medical supplies including wound care, incontinence supplies and urological supplies will additionally impact 10,391 of the highest-risk beneficiaries in serious medical conditions requiring benefits above the cap threshold.^{xxii} Without these medical supplies, it is likely that infections and other more severe medical conditions will occur.
<p>Hospital Rate Freeze & Other Payment Reductions</p> <p>General Fund Cut: \$222.8 M</p>	<p>Hospital Inpatient Rates Freeze (\$84.5 M GF)</p> <ul style="list-style-type: none"> ▪ Loss of \$84.5 million in federal matching funds and would require a State Plan Amendment. ▪ Freezing hospital rates at January 1, 2010 levels will further stress providers of last resort for the low-income and most needy, prompt more closures of facilities and increase barriers to care for Medi-Cal beneficiaries. <p>10% Reduction to Public and Private Hospitals (\$106.2 M GF)</p> <ul style="list-style-type: none"> ▪ Loss of \$175.4 million in federal funds. ▪ A reduction of 10 percent, \$52 million for Private and District Hospitals and \$54.2 million to Designated Public Hospitals, received through the existing Hospital Financing Waiver. ▪ Fewer federal funds will be available for uncompensated care provided to medically needy individuals in Designated Public Hospitals, Disproportionate Share Hospitals and hospitals receiving monies from the South LA Health Services Preservation Fund burdening an already fragile local safety-net and potentially prompting additional closure.^{xxiii} <p>Roll-back Rate Increase for Family Planning Services (\$15.4 M GF)</p> <ul style="list-style-type: none"> ▪ Loss of \$90 million in federal funds due to the high \$9 federal match for every \$1 spent in Family Planning, Access, Care and Treatment Program (FPACT).^{xxiv} ▪ Decreases access to family planning services and increase unintended pregnancy rates and demand on community clinics. According to a 2002 UCSF evaluation, 205,000 unintended pregnancies, which would have cost the public \$2.2 billion up to five years after birth, were averted through the program.^{xxv} ▪ Will force clinics to turn away thousands of patients as prior to the rate increase in 2008, California's clinics were turning away an estimated 10,000 people every month for lack of resources and capacity to serve them.^{xxvi} Additionally, according to community clinics throughout the state that offer family planning services, the current demand for such services already far exceeds their capacity. <p>Reduction to Radiology Rates (\$16.7 M General Fund)</p> <ul style="list-style-type: none"> ▪ Loss of \$19.5 million in federal funds and would require a State Plan Amendment. ▪ A reduction to radiologist rates to eighty percent of Medicare rates will impact over 450 service codes pertaining to radiology services; applies to Medi-Cal Fee-for-Service arrangements.

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<p>Elimination and Cost-Containment of Health Services Programs</p> <p>Prop 99 Diversion: \$ 25.2 M</p>	<p>Eliminate Funding to Expanded Access Primary Care (EAPC)</p> <ul style="list-style-type: none"> ▪ Eliminates the Expanded Access to Care Program (EAPC) by diverting the remaining \$10 million in Prop 99 dollars from the program, which was used to support 580 clinics, further compounding the substantial loss of funding to clinics last year.^{xxvii} ▪ Last year's budget eliminated \$18 million from EAPC, which, in combination with the elimination of the Rural Health Services Development Program, Seasonal Agricultural Migratory Worker Program and the Indian Health Program, contributed to six clinic closures across the state.^{xxviii} This last cut to EAPC will likely result in additional clinic closures, as well as staff layoffs and service reductions. <p>Changes to the Every Woman Counts Program (EWC)</p> <ul style="list-style-type: none"> ▪ Proposes to continue restricting eligibility to women 50 and older on a permanent basis (previously, women between the ages of 40 and 49 were eligible), reduces professional education and regional contracts by \$1.7 million,^{xxix} implements a tiered case management payment system and limits mammograms screenings to once every two years instead of once every year. ▪ The eligibility cuts enacted on January 1, 2010 in addition to the enrollment freeze of this program aimed to reduce monthly EWC recipients to 21,600. Yet less than 10,000 patients have been seen monthly since the changes, severely impacting the lives of many more women than anticipated. Unfortunately, DPH proposes to continue the freeze on new enrollment until cost savings are realized, and to allow limited new enrollment thereafter based on available funds.^{xxx} ▪ These existing cuts and proposed changes shift the financial burden onto local community clinics and county facilities already struggling to serve their own clients. Unfortunately, these cuts will delay diagnosis and treatment, ultimately resulting in dramatically higher long-term spending and unnecessarily risked lives.

ⁱ California Budget Project. Governor's Proposed Budget Could Cause More Than 1 Million Children to Lose Health Benefits or Coverage (February 24, 2010).

ⁱⁱ California Optometric Association. Vision Care for California's Kids at <http://www.eyehelp.org/LinkClick.aspx?fileticket=8MPpYM1E9Gc%3D&tabid=129>.

ⁱⁱⁱ National Commission on Vision & Health. Access to Comprehensive Vision Care Services under SCHIP at

<http://www.visionandhealth.org/documents/FactsheetSCHIP123108M29FINAL.pdf> <http://www.visionandhealth.org/documents/FactsheetSCHIP123108M29FINAL.pdf>.

^{iv} This is the number of kids affected by Healthy Families Category B and C premium increases. This figure reflects the number of kids expected to be enrolled by June 30, 2011. As of June 30, 2011, the estimate number for children from 151-200 FPL will be 376,298 and from 201-250, the number of children is 176,657.

^v 100% Campaign. Premium Increases of Nearly 250% Over the Last 18 Months Proposed for Low-income Children in Healthy Families (June 2010)

^{vi} Tricia J. Johnson et al. The Effects of Cost-Shifting in the State Children's Health Insurance Program. American Public Health Association (April 2006) at <http://ajph.aphapublications.org/cgi/content/abstract/96/4/709>.

^{vii} The Kaiser Commission on Medicaid and the Uninsured. A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009 (See Table 10 Premium Payments for Two Children in A Family of Three at Selected Income Levels). December 2009

^{viii} Center for Children and Families. Cost Sharing for Children and Families in Medicaid and CHIP (March 2009)

^{ix} Selden, Thomas, et al. Cost-Sharing In Medicaid and CHIP: How Does it Affect Out-of-Pocket Spending? Health Affairs (June 2009)

^x Ibid.

^{xi} Assembly Budget Sub-committee No. 1. on Health and Human Services. February 11, 2010 Agenda at <http://www.assembly.ca.gov/acs/subcommittee/frame.asp?subcommittee=1>.

^{xii} California Immigrant Policy Center. The Cost of Cutting Immigrant Programs: Illness, Hunger & Homelessness (2010) at <http://www.caimmigrant.org/>.

^{xiii} California State Senate. Committee on Budget and Fiscal Review Meeting Agenda. May 26, 2010

^{xiv} Center for Children and Families. Cost Sharing for Children and Families in Medicaid and CHIP (page 4). March 2010: [http://ccf.georgetown.edu/index/cms-filesystem-action?file=strategy center/cost_sharing_final.pdf](http://ccf.georgetown.edu/index/cms-filesystem-action?file=strategy%20center/cost_sharing_final.pdf)

^{xv} Ku, Leighton and Wachino, Victoria. The Effect of Increased Cost-Sharing In Medicaid: A summary of Research Findings. Center on Budget and Policy Priorities. July 2005

^{xvi} California State Senate. Committee on Budget and Fiscal Review Meeting Agenda. May 26, 2010

^{xvii} Ibid.

^{xviii} Ibid.

^{xix} Ibid.

^{xx} Ibid.

^{xxi} Ibid

^{xxii} Ibid

^{xxiii} Assembly Budget Subcommittee on Health and Human Services Meeting Agenda. May 27, 2010..

^{xxiv} Ibid.

^{xxv} Ibid.

^{xxvi} Ibid

^{xxvii} Assembly Budget Subcommittee on Health and Human Services, p. 46 (May 27, 2010).

^{xxviii} California Primary Care Association. *Brief Analysis of Governor's May Revision*. May 14, 2010..

^{xxix} Budget Conference Committee on AB 190 Section III Health, June 10, 2010.

^{xxx} Assembly Budget Subcommittee on Health and Human Services, p. 58 (May 27, 2010).