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Organizations listed for
identification purposes

The Honorable Richard Pan
Chair, Senate Budget Subcommittee 3 on Health and Human Services
State Capitol, Room 5019
Sacramento, CA 95814

The Honorable Joaquin Arambula
Chair, Assembly Budget Subcommittee 1 on Health and Human Services
State Capitol, Room 6026
Sacramento, CA 95814

RE: Proposed 2019-2020 Budget

Dear Senator Pan and Assemblymember Arambula:

Health Access California, the statewide health care consumer advocacy coalition working for quality health care for all Californians, respectfully offers the following comments and recommendations on the Governor's proposed 2019-2020 budget.

We support the bold steps Governor Newsom took on his first day, which included: proposing to expand full-scope Medi-Cal to undocumented young adults ages 19-25, offering state-funded subsidies for those who buy health insurance through Covered California, establishing a state-specific implementation of the ACA's individual mandate, and using the state's power as a purchaser to rein in the costs of prescription drugs.

Together these proposals are important steps toward the Governor's goal of universal health care in California. However, more investments are needed to meet the health care needs of Californians, and should be considered by the Legislature to best advance a comprehensive approach for helping with the "affordability crisis" in health care in our state, and decreasing the number of the remaining uninsured.

Health4All: Expand Medi-Cal to Low-Income Adults Regardless of Immigration Status

Health Access urges the Legislature to expand Medi-Cal to all income-eligible adults, regardless of immigration status, to ensure that every low-income Californian has health coverage.

We are thrilled to see that Governor Newsom has proposed to invest \$200M from the general fund to expand full-scope Medi-Cal to undocumented young adults up to age 26. Right now, undocumented children covered under Medi-Cal turn 19 with the birthday present of losing health coverage. They are most likely to have parents who are also uninsured, and thus not able to stay on their parents' coverage like many other young adults under the ACA. Providing primary and preventive coverage at any age helps not just the individual and their family, but makes the whole health system work better.

While we appreciate the investment for health care for all young adults, we also urge the Legislature to augment Governor Newsom's proposal with an additional \$1.5-\$2 billion to

expand access to all income-eligible state residents, to ensure no one in our state suffers or dies from lack of access to care simply because of where they were born.

Over the last two years, the federal government has carried out harmful attacks on immigrant communities by separating families, increasing deportations, and undermining our health care system and safety net by attempting to undermine the Affordable Care Act. It is critical that we provide support to our health system, and our immigrant communities, by building on our successes in California, by ensuring access to health care for all low-income residents, regardless of immigration status.

California's 2.2 million undocumented adults have contributed to our economy and social fabric for decades.¹ Many undocumented workers have access to healthcare through employment based coverage, but often low wage undocumented workers are not offered an opportunity to obtain employer sponsored coverage. Under current law, low-income undocumented adults are eligible for emergency-only or Restricted Scope Medi-Cal, but not for primary or preventive care, or even comprehensive hospital care, offered through full-scope Medi-Cal. As a result, most undocumented adults are uninsured, living sicker, dying younger, and being one emergency away from financial ruin because they do not have access to comprehensive health coverage.²

Many undocumented immigrants turn to home remedies when they get sick since they often do not have access to a primary care physician or affordable prescription drugs that could help them thrive. Some individuals with chronic conditions self-impose limits on doctor's visits, ration prescription drugs, or even skip needed tests or screenings. Parents, caretakers, and other undocumented workers are often forced to choose between paying for health care services and other vital necessities.

California already provides near-universal coverage for children, thanks in large part to the Health4All Kids program, which was implemented on May 16, 2016 and provides undocumented children an opportunity to get affordable health coverage. Over 200,000 undocumented children have received comprehensive care under Health4All Kids. Expanding Medi-Cal to low-income adults, regardless of immigration status, would extend eligibility to approximately 1.15 million undocumented adults in 2020.³ Expanding Medi-Cal to low-income undocumented adults would close one of the biggest remaining coverage gaps in the state's health care system, reducing the states uninsured rate by up to 25%.⁴

Health Access urges the Legislature to support Health4All by expanding full-scope Medi-Cal to all income-eligible adults above the age of 19, whose incomes are at or below 138% of the federal poverty level, regardless of immigration status. Providing health coverage for low-income undocumented adults, who are a fundamental part of our workforce and our communities would move California significantly closer to universal coverage. This reality has tremendous health and economic impacts on families and our state where at least 1 in 6 children have at least one undocumented parent.⁵

¹ Pew Research Center, "Unauthorized Immigrant Population Trends for States, Birth Countries and Regions," November 27, 2018, <http://www.pewhispanic.org/interactives/unauthorized-trends/>.

² Dietz, Miranda and Laurel Lucia, et al. November 2018. "California's Health Coverage Gains to Erode Without Further State Action." UCLA Center for Health Policy Research and UC Berkeley Labor Center.

³ Lucia, Laurel. *Towards Universal Health Coverage: Expanding Medi-Cal to Low-Income Undocumented Adults*. Center for Labor Research and Education, University of California, Berkeley. February 2019. <http://laborcenter.berkeley.edu/medi-cal-undocumented-adults>

⁴ Ibid.

⁵ Kenney, Genevieve M., Jennifer M. Haley, and Robin Wang. December 2018. "Proposed Public Charge Rule Could Jeopardize Recent Coverage Gains among Citizen Children." Washington, DC: Urban Institute.

Health Access urges that any clawback or change in county realignment dollars for the medically indigent ensure that the counties that seek to serve the remaining uninsured have the funds to do so.

The Governor also proposes that around \$60 million of the total funding for this expansion would be offset from a reduction of funding to counties to cover medically indigent populations, through the revision of the AB 85 realignment. While some counties provide little care to the remaining uninsured, including the undocumented, others have made an effort to extend medical homes and access to care for the undocumented. Any new formula should ensure a strong safety net at the local level.

We urge the Legislature to make certain that any reduction to county public health and medically indigent care is proportionate to the decreasing costs of fewer remaining uninsured. The Governor's budget proposes to take a third of the realignment funding while covering less than one-tenth of the population: in general, the redirection of realignment funding should be proportionate with the coverage expansion.

Health Access has done extensive work with county advocates and policymakers regarding their safety-net programs for the remaining uninsured. As we have documented in recent studies, some counties have robust programs for the remaining uninsured, while others found use of their safety-net programs mostly disappear during the ACA coverage expansions, given that anyone who fit their tight eligibility requirement were now eligible for Medi-Cal or Covered California coverage. The Governor's proposal would mostly fall on "non-formula" counties, which are a mix of counties: Some, like Stanislaus and Placer, do not serve the undocumented or virtually anybody in their medically indigent program, given their eligibility restrictions. However, others impacted by the Governor's clawback, including Sacramento, Yolo, and the 35 counties in CMSP, are engaged in pilot programs or other efforts. Sacramento's Healthy Partners program now has 3,700 enrollees. CMSP's Path2Health program (which includes Yolo) is just starting a major expansion to potentially provide primary care to more than 20,000.

Ideally, any county realignment would take into account the differences in these efforts. More than just a "use it or lose it" policy, we would want a continued funding and incentive for counties to do more to serve the remaining uninsured in their area, to support those counties who do more and want to do more—up and until the state does a full expansion of coverage that is fully inclusive of all the remaining uninsured, regardless of income, immigration status or any other factor.

Improve Affordability in the Individual Market

Health Access urges the Legislature to improve affordability for Californians who purchase health coverage in the individual market.

Affordability of monthly premiums and out-of-pocket costs, like copays and deductibles, continues to be a top concern for many Californians. While ACA subsidies have helped many people afford health coverage, they may not be enough for some consumers in our high-cost state particularly those who earn too much to qualify for a subsidy but too little to pay for the premiums, or people who cannot afford the premiums even with a subsidy. Low and moderate consumers with individual insurance coverage through Covered California are spending up to 9.6% of their incomes on premiums alone and must pay more to cover copays and deductibles. Over a million Californians, who are citizens or lawfully present remain uninsured, largely because of high health care costs.

Consumers who make less than \$48,000 (under 400% FPL) and who buy their own health insurance as individuals are able to get some federal financial assistance with premiums and out-of-pocket costs, but for many it's not enough. Between 500,000-600,000 Californians with incomes 138%-400% FPL (\$16,000 to 48,000) remain uninsured even though they are eligible for federal subsidies to help pay for premiums.

People who make more than \$48,000 (over 400% FPL) get no financial help at all and end up spending a substantial portion of their income (over 10%) on premiums for coverage with deductibles over \$6,000.

- **Consumers with incomes under 138% FPL (less than \$24,000/family of four)** are asked to spend 2% of income on premiums and pay copays and deductibles. These are a small number of Californians who are not eligible for Medi-Cal because of immigration status or Medicare because they lack enough quarters of work to qualify for Medicare. Spending 2% of income on premiums may not seem like much until you contemplate how anyone can afford to live on \$1400 a month in a state where the average rent often exceeds that amount.
- **Consumers with incomes between 138% and 400% FPL (<\$48,000)** Federal tax subsidies still require those making as little as \$17,000 a year to spend 2% of income on premiums and those making \$36,000-\$48,000 to spend 9.6% of income, or \$3500-\$4800 a year, on premiums. Too many people who get federal subsidies are still buying bronze plans with deductibles of \$6,300 for all services aside from three doctor visits. The Legislature can help these consumers better afford coverage by supplementing federal subsidies for premiums and cost-sharing.
- **Consumers who earn more than 400% FPL (>\$48,000)** In San Francisco, for example, the cheapest Bronze plan available for a 60-year-old person is an HMO for \$730/month, with a \$6300 deductible, which comes out to \$8760/year in premiums. The premiums alone are 13% of income for someone just over 400% FPL. And to get care, the bronze plan requires the consumer to pay the full cost of every service, except for three doctor visits, up to \$6,300 out-of-pocket. In every region in California, people who are over age 50 and over 400%FPL pay more than 10% of their income just on premiums for a bronze plan.

We urge the Legislature to allocate \$2.1-\$2.5 billion additional general fund dollars to establish comprehensive affordability enhancements. The recent estimates done for Covered California indicate that subsidies for premiums and cost sharing for those below 400%FPL and for premiums for those above 400%FPL combined with an individual mandate, would cut in half the number of uninsured who are not excluded due to immigration status. Getting to universal coverage with affordable access to care for those in the individual market requires spending on this scale. While Covered California outlined a buffet of options with lesser price tags, those individual options are insufficient to get California to near-universal levels of coverage comparable to European countries such as France or Germany.

Under the Governor's proposal, California would be the first state in the nation, post-Affordable Care Act, to offer additional help for those between 250-400% FPL while providing financial help to middle-income Californians between 400-600% of the FPL, who get no affordability help now. Unfortunately, this proposal ignores two realities: first, for those 200%-250%FPL, the current federal affordability assistance in the form of cost sharing reductions is utterly insufficient. As a result, many consumers in this income category select bronze coverage with a \$6,300 deductible, something that no one living on \$24,000-\$30,000 a year can afford. Second, while most of those who are over 400% of poverty are between 400% and 600% of poverty, there are those in their late 50s and early 60s who make more than 600% of poverty who need help affording premiums. Cutting off help at 600%FPL just creates a cliff at a different point on the income scale. A married couple in their early 60s living on \$75,000 a year gross income is not poor but not rich either. The Governor's proposal builds on the underlying structure of the ACA, in which the sliding scale for premiums provides greater affordability to those at the end of the income scale and with the most help for those who have the least. Californians who need more help to afford care and coverage in our high cost state would now get that support.

Individual Mandate: Reducing the Number of Uninsured, Lowering Premiums

Governor Newsom has proposed a state-level reinstatement of the federal individual mandate, as a tax penalty to reduce the number of uninsured while raising revenue that the Governor proposes to use for the purpose of affordability subsidies. Health Access supports an individual mandate, as part of a package of greater affordability assistance in Covered California.

We strongly urge that while all the revenue from the individual mandate go to affordability assistance, that the individual mandate penalty should supplement but not be the only or main source of funding for such assistance. Ideally, we should make coverage affordable enough that everyone takes up coverage and few if any pay the penalty. Ideally, as with the tobacco tax, the revenue from the individual mandate should be zero.

Governor Newsom's proposal solely relies on revenue generated from the individual mandate, but we urge the Legislature to add general fund support, because the individual mandate penalty revenue is not sufficient by itself to provide the affordability help Californians in the individual market need.

We also support an individual mandate that uses the tax filing season as an incentive to enroll, and we have other policy recommendations for the structuring of the mandate.

Urge Consideration of Renewal of the Managed Care Organization (MCO) Tax

Renewal of the MCO (Managed Care Organization) Tax was expected to generate about \$1.4 billion in annual savings for the General Fund for the years 2016-2019. The MCO tax passed in 2016 now applies to all managed care plans in the state, and contains provisions that lowered other state taxes assessed on managed care organizations to effectively reduce the net amount of taxes collected from plans. Though the MCO tax must be renewed in 2019 to retain this funding, Governor Newsom's budget did not include a proposal. Health Access urges Governor Newsom and the legislature to consider renewing the MCO tax to shore up healthcare dollars to provide funding for affordability assistance in Covered California or other improvements in Medi-Cal and our health care system.

OTHER IMPROVEMENTS IN MEDI-CAL

Elimination of the Medi-Cal "Senior Penalty"

Health Access strongly supports the proposal to ensure that seniors and people with disabilities up to 138% of the poverty level are eligible for full-scope Medi-Cal. While low-income adults under 65 get full-scope Medi-Cal, a difference in how income is calculated means that the "aged and disabled" population over 123% of the poverty level must pay a share of cost—often hundreds of dollars—to access key medical services. While this was not included in the Governor's budget, we appreciate that the Legislature has prioritized to fix this inequity—a glitch in the law with no policy rationale—over the last few years, and we hope this is the year this is finally rectified for the tens of thousands of seniors and people with disabilities impacted.

We also support other proposals by Western Center on Law and Poverty, Disability Rights California, and Justice in Aging, that seek to further remove eligibility and enrollment barriers for seniors, and align the rules—like the elimination of the assets test—with others in the Medi-Cal program. Combined with the

#Health4All proposal above, we hope we soon say that any Californian under 138% of the poverty level is eligible for full-scope Medi-Cal coverage—without exception, including without regard to age, disability, or immigration status.

Proposition 56 funds

Governor Newsom has proposed to continue investments from the 2018 Budget Act, which includes \$1B from Prop 56 for supplemental payments and rate increases for physicians, dentists, family planning services, Intermediate Care facilities for the Developmentally Disabled, HIV/AIDS waiver services, Home Health, pediatric day health services. Additionally, he proposes new investments of Prop 56 funding which includes: \$30M to provide for early developmental screenings for children to better address social determinants of health, \$22.5M for adverse childhood experiences (ACEs) screenings for children and adults in the Medi-Cal program, and an additional \$50M for family planning services. Governor Newsom has also proposed an investment of \$180 million from Prop 56 to fund a program that encourages Medi-Cal managed care providers to meet goals in critical areas, such as management of chronic disease and behavioral health integration, and supportive housing or other supports through the Whole Person Care Pilot Program.

We support these investments, especially in dental, women’s health, and other areas where there was clear need. We continue to seek data to show that the investments in greater provider rates generally are actually increasing access for Medi-Cal patients, either in greater participation by physicians, reduced waiting times, etc. With such data, we would welcome oversight and efforts to prioritize and structure these payments to achieve the best improvement in access possible. Health Access supports both the continued and new investments that will help expand access to care and make improvements to our state’s Medi-Cal program. Further, we also believe any remaining funding should be used to expand benefits and access to individuals that remain uninsured, including the undocumented and others.

Restoration of Medi-Cal benefits

Health Access continues to seek to restore the Medi-Cal benefits cut in 2009. We opposed the 2009 elimination of eight medically necessary benefits, which were cut during the depths of California’s financial crisis but not for any other policy reason. Ten years into our economic and fiscal recovery, California has yet to restore a majority of these so-called “optional” benefits, that are relatively inexpensive in the context of the Medi-Cal program but would be a big benefit to individual patients in need of podiatry, audiology, psychology, or other services. We appreciate the recent actions to restore dental and acupuncture services, and the scheduled restoration of vision services next year in 2020. Other services merit such restoration as well. Access to podiatry, for example, can serve as an early-warning system for diabetes, and ultimately prevent worse outcomes including amputation. Audiology and speech therapy can help a low-income recipient better function in their community and be more easily employed. These are small investments that can make a big difference.

PRESCRIPTION DRUGS

Governor Newsom's budget proposes steps to use the state's purchasing power to rein in the cost of prescription drugs. Health Access strongly supports steps to impose a single state formulary for all Medi-Cal managed care plans. By creating a single state formulary for Medi-Cal managed care plans, California could maximize its bargaining power as a purchaser, rather than lending its bargaining power to health plans, which may be merely pocketing savings or improving their bottom lines. This concept is similar to requiring the federal government to negotiate for Medicare Part D instead of having health plans and insurers to bargain individually.

While this massive purchasing power has limits—the state will still need to provide medically necessary drug to Medi-Cal patients, CalPERS enrollees, state hospital patients, prisoners, and others, even if they are on patent and sold by one manufacturer—the state would have significant negotiating power, especially with medications that have therapeutic equivalents, and in looking at the growing literature on comparative effectiveness to select drugs for a statewide formulary that provide the greatest efficacy with the least cost.

Right now, the Medi-Cal program contracts with Medi-Cal managed care plans, which each have their own formulary, and who then contracts with a pharmacy benefit manufacturer, who negotiates with the drug companies. To the extent the health plan or PBM are fully incentivized and effective at getting discounts, rebates, or savings, it's unclear at best if that savings comes back to benefit the program or the public. Consolidation of prescription drug purchasing has the potential of providing some savings by simplifying and streamlining the process, for providers and patients and the public.

Currently both state and federal law provide strong consumer protections for those in the Medi-Cal program and those with state-regulated health insurance. The federal Medicaid program requires that consumers have access to medically necessary prescription drugs. Despite this requirement, since the early 1990's, the Medi-Cal program has still saved billions through negotiating supplemental rebates and a Medi-Cal drug formulary. California law which covers the 13 million Californians with coverage regulated by the Department of Managed Health Care, and all of the one million Californians with coverage regulated by the Department of Insurance, all require health plans and insurers to cover all medically necessary drugs, whether on formulary or not. The use of a formulary steers prescribers and consumers to those drugs which have the same, similar or comparable clinical effect at a lower price. But consumers for whom a particular drug or drug formulation is necessary should be able to obtain that drug, even if through an appeal process.

California law also includes numerous consumer protections for those in state-regulated commercial coverage. As we look at a single state purchaser for prescription drugs, we will look to ensure that these important consumer protections apply to consumers when drug prices are negotiated by the single state purchaser.

If a purchaser, either public or private, is not governed by current state consumer protections, we will ask that those protections assuring access to medically necessary drugs are extended to such purchasers. We will also oppose a so-called “closed” formulary in which consumers cannot obtain off-formulary drugs that are medically necessary and appropriate for their condition: whether it is a consumer with multiple sclerosis or one with HIV/AIDS or someone who depends on a particular formulation of insulin, consumers should be able to get a medically necessary drug even if it is off-formulary.

Today most California consumers have access to independent medical review in which clinicians determine whether a medication is medically necessary and appropriate for the individual patient. As policymakers consider carving out Medi-Cal drugs on a fee-for-service basis, we seek to assure that consumers continue to have access to an appeal process that involves clinicians with relevant clinical expertise, rather than administrative law judges who are not selected based on clinical expertise. This could be accomplished by the Department of Health Care Services contracting with the Department of Managed Health Care to review whether a prescription drug is medically necessary and appropriate for that particular patient. DMHC currently contracts with an independent medical reviewer organization to provide this medical necessity review for consumers whether their coverage is through Medi-Cal managed care or commercial plans regulated by DMHC.

In addition, recent articles suggest that health plans are benefitting from deals with pharmacy benefit managers in which the benefit of the rebates and formulary placement accrues the bottom line of the health plan, not the purchaser of coverage.⁶ Taken together, all of this suggests that health plans are putting their bottom line ahead of effectively negotiating lower prices for purchasers, both public and private.

Other Budgetary Requests

We also support the following requests from other organizations:

WIC Express Lane Eligibility to Medi-Cal for Children: We support the request from Children Now and The Children’s Partnership for funding to implement expedited Medi-Cal enrollment for WIC children by using WIC eligibility information and federal Express Lane Eligibility authority, and provide a presumptive eligibility to pregnant women applying for WIC.

Outreach and Enrollment Funding: We support the proposal from the California Pan-Ethnic Health Network, Maternal and Child Health Access, and Community Health Council which seeks funding for community-level outreach and enrollment for health coverage programs for low-income Californians.

Conclusion

In summary, we are excited by the prospect this year of making a major “down payment” to universal coverage, using a fraction of the budget surplus and the natural growth of the economy. California could prevent a predicted rise in the uninsurance rate, and even bring it down below 5% like most developed nations with universal coverage, through key actions. This would include greater assistance to California

⁶ <https://khn.org/news/secretive-rebate-trap-keeps-generic-drugs-for-diabetes-and-other-ills-out-of-reach/>

families to afford health coverage in the individual market through Covered California, both by enhanced subsidies and in reducing premiums through a state-level individual mandate penalty. It also includes removing exclusions in Medi-Cal based on age, disability, or immigration status; and making other improvements in the Medi-Cal program. To help achieve this level of investment, we support revenue proposals like the MCO tax and individual mandate penalty, as well as savings from pooling prescription drug purchasing. We look forward to working with the Legislature toward these goals.

Thank you for your consideration. Please feel free to contact any of our team with any questions, including Anthony Wright, Executive Director, or Ronald Coleman, Director of Policy and Legislative Advocacy at 916-497-0923.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Anthony Wright', written over a horizontal line.

Anthony Wright
Executive Director