Senate Budget and Fiscal Review—Holly J. Mitchell, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator William W. Monning
Senator Jeff Stone

Thursday, May 3, 2018
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203
PART B

Consultant: Scott Ogus

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4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Mental Health Loan Assumption Program Administrative Resources

Spring Finance Letter. OSHPD requests expenditure authority of $215,000 from the Mental Health Services Fund in 2018-19 and 2019-20. If approved, these resources would support administrative activities to close out all grants awarded through the Mental Health Loan Assumption Program and ensure compliance with program requirements.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20**
3085 – Mental Health Services Fund	$215,000	$215,000
Total Funding Request:	**$215,000**	**$215,000**

Background. OSHPD administers the Health Professions Education Foundation (HPEF), a 501(c)(3) non-profit public benefit corporation established in 1987 through legislation. The HPEF offers scholarships and loan repayments for students and graduates willing to practice in underserved areas. HPEF administers the Mental Health Loan Assumption Program (MHLAP), a loan forgiveness program to help retain qualified mental health professionals working within the public mental health system.

In 2004, voters approved Proposition 63, the Mental Health Services Act (MHSA), to change the way California treats mental illness by expanding the availability of innovative and preventative programs, reduce stigma and long-term adverse impacts for those suffering from untreated mental illness, and hold funded programs accountable for achieving those outcomes. The act directed the majority of revenues to county mental health programs for community services and supports, prevention and early intervention, innovative programs, workforce education and training (WET), and capital facilities and technological needs. For WET programs, Proposition 63 allocated $210 million to counties and $234.5 million to the state over a ten year period beginning in 2008. WET program funds must be expended by June 30, 2018.

MHLAP receives funding from the WET component of Proposition 63. According to OSHPD, $10 million is allocated annually to loan assumption awards for MHLAP recipients. An award recipient may receive up to $10,000 to repay educational loans in exchange for a 12 month service obligation in a hard to fill or retain position within a public mental health system. Each county determines which professions are eligible for awards in that county. Some of the professions that receive MHLAP funding are psychologists, psychiatrists, postdoctoral psychological assistants or trainees, marriage and family therapists, clinical social workers, clinical counselors, clinical counselor interns, and psychiatric mental health nurse practitioners.

According to OSHPD, the WET program budget does not include any administrative resources beyond the expiration of the WET program funding on June 30, 2018. OSHPD reports it reassessed the administrative workload necessary to manage close out activities for the 1,200 MHLAP grant agreements and open grants issued in prior years. OSHPD requests expenditure authority of $215,000 from the Mental Health Services Fund, **equivalent to two Associate Governmental Program**

Analysts, for two years for program management, processing of payments upon recipients' completion of the required service obligation, and permitting recipients to successfully complete the term of service.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested OSHPD to respond to the following:

1. Please provide a brief overview of this proposal.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Proposals for Investment

Stakeholder Proposals. Various stakeholder organizations have submitted the following proposals for investment in Medi-Cal.

Pediatric Primary Care Reimbursement Rate Increase. The American Academy of Pediatrics requests General Fund resources to increase pediatric primary care reimbursement rates to 100 percent of Medicare, consistent with the primary care rate increase authorized for two years under the federal Affordable Care Act.

Whole Genome Sequencing Pilot Project. Illumina, a leading developer, manufacturer, and marketer of life science tools, requests General Fund expenditure authority of $2 million for a clinical pilot project to demonstrate the diagnostic and financial value of clinical whole genome sequencing (cWGS) for the Medi-Cal program. The pilot would test 100 Medi-Cal neonatal and other pediatric patients with undiagnosed diseases that have remain undiagnosed, or had multiple diagnoses over an extended period of time. According to Illumina, the project is intended to demonstrate the value of cWGS as a first line diagnostic test compared to current standards of newborn and pediatric healthcare diagnostic tests.

Restoration of Provider Rate Reduction for Non-Emergency Medical Transportation. The California Medical Transportation Association (CMTA) requests $7.2 million ($3.6 million General Fund and $3.6 million federal funds) to restore the 10 percent provider rate reductions for non-emergency medical transportation (NEMT) imposed pursuant to AB 97 (Committee on Budget), Chapter 3, Statutes of 2011. According to CMTA, seriously ill and chronically disabled Medi-Cal patients are unable to obtain NEMT due to low payment rates and inappropriate transportation broker decisions. Medi-Cal fee-for-service rates do not cover NEMT provider trips costs for trips beyond short distances. Recognizing the inadequacy of fee-for-service NEMT rates, managed care plans pay higher NEMT rates to ensure adequate access. Most NEMT users are dialysis patients dependent on NEMT to access life-sustaining dialysis treatment. Failure to receive timely dialysis care causes complications that require extremely expensive emergency care, hospitalization, or death.

Healthy Start Initiative. United Ways of California and a coalition of several children and other advocacy organizations request conforming actions in the Department of Health Care Services budget to re-establish the Healthy Start Initiative. The Healthy Start Initiative provides comprehensive, school-community integrated services and activities to improve the health and wellness of children, youth, and families including: health, dental, and vision care; mental health and substance use disorder counseling; family support and parenting education; academic support; health education; safety education and violence prevention; youth development; employment preparation; and more. According to United Ways of California, evaluation of the program showed the physical, mental, and emotional health of students and their families were measurably enhanced, and the child's academic success improved greatly.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding these items open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested advocates to present these proposals for investment.

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Proposals for Investment

MHSOAC Proposals. The MHSOAC has proposed the following investments.

Reappropriation of Unexpended Mental Health Triage Funding. MHSOAC requests reappropriation of expenditure authority from the Mental Health Services Fund of $29.4 million ($2.5 million from 2013-14, $8.8 million from 2014-15, $992,408 from 2015-16, and $17.1 million from 2016-17). These funds were originally appropriated under the Investment in Mental Health Wellness Act for triage personnel to provide intensive case management and linkage to services for individuals with mental health disorders at various points of access. The original appropriation was $54 million ($32 million Mental Health Services Fund and $22 million federal funds) for 600 triage personnel. According to MHSOAC, counties experienced challenges hiring triage personnel and were unable to spend all of their allotted funds during the term of their grants. These unspent funds, once reappropriated and available for encumbrance and expenditure through 2020-21, would allow MHSOAC to award more grants to counties during the next grant cycle.

Allocation of Triage Funding. MHSOAC requests trailer bill language to allocate at least one half of funds allocated for triage personnel for programs targeted at children and youth 18 years of age and under.

Stakeholder Contracts To Reduce Criminal Justice Involvement of Mental Health Consumers. MHSOAC requests expenditure authority of $670,000 from the Mental Health Services Fund annually to fund stakeholder advocacy contracts to reduce the involvement of mental health consumers in the criminal justice system. MHSOAC oversees the activities of statewide stakeholder advocacy contracts funded under Welfare and Institutions Code Section 5892(d). These contracts support the needs of mental health clients, family members, children, transition-aged youth, veterans, the LGBTQ community, and organizations working to reduce racial and ethnic disparities through education, outreach and advocacy efforts. MHSOAC awards a total of $4.7 million contracted funds annually.

According to MHSOAC, for too many Californians becoming involved with law enforcement remains the primary avenue to accessing mental health care. As part of a broader strategy to address this challenge, MHSOAC requests expenditure authority of $670,000 from the Mental Health Services Fund state administration account for stakeholder advocacy contracts to reduce the number of mental health consumers who become involved in the criminal justice system.

Children's Mental Health Innovation Incubator. MHSOAC requests expenditure authority of $5 million from the Mental Health Services Fund in 2018-19 to create a Children's Innovation Incubator to support program implementation, provide technical assistance and training and ensure counties are fully leveraging funds to improve outcomes for children within California's mental health system. According to MHSOAC, the incubator will assist MHSOAC and counties in improving the effectiveness of innovative approaches for children's mental health services and provide California the opportunity to develop and test new, unproven mental health models with the potential to become tomorrow's best practices. The $5 million investment would cover start-up and partially cover operations for three years.

AB 114 Technical Cleanup for Treatment of Innovation Funds. The California Behavioral Health Directors Association (CBHDA) requests trailer bill language to clarify the treatment of innovation funds subject to reversion prior to July 1, 2017, pursuant to the provisions of AB 114 (Committee on Budget), Chapter 38, Statutes of 2017. According to CBHDA, the provisions of AB114 are unclear whether counties are required to spend these innovation funds before July 1, 2020, particularly when the timeframe for expending innovation funds is based upon when a county's proposal has been approved by the MHSOAC. CBHDA requests a minor, technical amendment to Welfare and Institutions Code Section 5892.1 (c) to clarify that each county with unspent innovation funds subject to reversion that are deemed reverted and reallocated by AB 114 prepare and receive approval from the MHSOAC before July 1, 2020.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding these items open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested MHSOAC and CBHDA to present these proposals for investment.

4800 CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CALIFORNIA)

Issue 1: Insurance Affordability Proposals

Background. The federal Patient Protection and Affordable Care Act (ACA) implemented significant improvements to health care coverage offered in the individual health insurance market. Beginning in September 2010, ACA individual market reforms:

1. Eliminated lifetime limits on coverage.
2. Prohibited post-claims underwriting and rescission of policies.
3. Required health plans to offer coverage to dependent children up to age 26.
4. Eliminated pre-existing condition exclusions for children.
5. Eliminated copays and other cost sharing provisions for 45 preventive services.
6. Required health plans to spend at least 85 percent of premium dollars on health expenditures or provide rebates to customers (effective January 2012).

According to federal data, by 2013 more than eight million Californians received access to no-cost preventive services and 1.4 million residents with private insurance coverage received $65.7 million in insurance company rebates.

Beginning in January 2014, the ACA implemented additional market reforms and required establishment of health benefit exchanges, which provide federally subsidized health care coverage to individuals between 138 and 400 percent of the federal poverty level (FPL). California established its own health benefit exchange, Covered California, funded by assessments on health plan premiums. Covered California offers several options for individual health care coverage negotiated for cost and quality with health plans. Enrollment occurs during an annual open enrollment period that begins November 1 and ends January 31. The ACA requires all health insurance products, with some exceptions, to cover certain essential health benefits to be considered minimum essential coverage. These benefits include:

- Ambulatory patient services.
- Prescription drugs.
- Emergency services.
- Rehabilitative and habilitative services and devices.
- Hospitalization.
- Laboratory services.
- Maternity and newborn care.
- Preventive and wellness services and chronic disease management.
- Mental health and substance use disorder services, including behavioral health treatment.
- Pediatric services, including oral and vision care.

Metal Tiers for Health Insurance Products in Covered California. Consumers purchasing coverage in the Covered California health benefit exchange may choose from different "metal tiers" that determine the level of coverage and cost-sharing amounts provided by the product. According to Covered California, the metal tiers provide coverage as follows:

- **Bronze:** On average, Bronze health plans pay 60 percent of medical expenses, and consumers pay 40 percent.
- **Silver:** On average, Silver health plans pay 70 percent of medical expenses, and consumers pay 30 percent. Certain income-eligible individuals may qualify for an Enhanced Silver plan, which provides coverage with lower cost-sharing. Individuals in these savings categories get the benefits of a Gold or Platinum plan for the price of a Silver plan. The three categories of Enhanced Silver plans pay 94 percent, 87 percent or 73 percent of medical expenses.
- **Gold:** On average, Gold health plans pay 80 percent of medical expenses, and consumers pay 20 percent.
- **Platinum:** On average, Platinum health plans pay 90 percent of medical expenses, and consumers pay 10 percent.

Figure 1. Metal Tiers of Coverage in Covered California Health Benefit Exchange
Source: *Covered California website: "Coverage Levels/Metal Tiers" https://www.coveredca.com/individuals-and-families/getting-covered/coverage-basics/coverage-levels/*

Advance Premium Tax Credit Subsidies. The ACA subsidizes health care coverage purchased in health benefit exchanges, such as Covered California, for individuals between 138 and 400 percent of the FPL. The subsidies are provided in the form of advance premium tax credits (APTC), which reduce the amount of premium paid by income-eligible consumers purchasing coverage on the exchange. The amount of the APTC is linked to the cost of the second-lowest cost Silver plan in a consumer's coverage region. The APTC is meant to ensure that consumers are required to spend no more than two percent to 9.6 percent of their income for Silver plan premiums. Consumers may use the APTC subsidy amount to purchase other metal tiers of coverage that may be less expensive (e.g. Bronze) or more expensive (e.g. Gold or Platinum). According to Covered California, as of March 2018 nearly 1.3 million individuals covered by exchange products received an average of $452 per month in APTC subsidies. Nearly 167,000 individuals receive exchange-based coverage, but are not eligible for APTC subsidies.

Individual Mandate and Cost-Sharing Reductions. In addition to individual market reforms and new coverage options, the ACA eliminated pre-existing condition exclusions for adults beginning in 2014, and imposed a requirement that individuals enroll in health plans that offer minimum essential coverage or pay a penalty, known as the individual mandate. The individual mandate was designed to stabilize premiums by encouraging healthy individuals to enroll in health coverage and reduce the overall acuity of health insurance risk pools. Because health plans cannot deny coverage based on a pre-existing condition, in the absence of a mandate individuals may delay enrolling in coverage until they are diagnosed with a high-cost health condition, resulting in higher overall plan expenditures which lead to higher premiums. The ACA also limited the amount of cost-sharing that could be required of plan

beneficiaries under 250 percent of the FPL. These cost-sharing reductions result in savings to beneficiaries on deductibles, copayments, coinsurance, and maximum out-of-pocket costs. Until recently, the federal government provided cost-sharing reduction subsidies to health plans to help mitigate the costs of limiting cost-sharing amounts for these beneficiaries. These subsidies were designed to maintain those cost-sharing limits while reducing higher premium costs that would otherwise be required.

Elimination of Cost Sharing Reduction Subsidies and Repeal of Individual Mandate. In October 2017, the federal Administration eliminated cost-sharing reduction subsidies that prevent premium growth due to ACA requirements that limit cost-sharing for health plan beneficiaries under 250 percent of the FPL. According to Covered California, the loss of these subsidies will result in an annual reduction of approximately $750 million of federal funds available to reduce premiums. According to the Kaiser Family Foundation, health plans imposed cost-sharing reduction surcharges ranging from seven to 38 percent on premiums for 2018. In addition, the recently enacted federal tax proposal included the repeal of the individual mandate for purchase of health care coverage. The repeal takes effect beginning in 2019. According to Covered California, the increased premiums in 2019 resulting from elimination of the cost-sharing reduction subsidies and the individual mandate could range between 16 and 30 percent.

Stakeholder Proposals to Improve Health Insurance Affordability. Health Access California and the Care4AllCA Coalition have proposed three specific state investments to improve health insurance affordability and mitigate the negative impacts of recent federal actions. The combined General Fund impact of these proposals would likely be in the low billions of dollars.

Improve Premium Subsidies for Individuals Under 400 Percent of the FPL. The Care4AllCA Coalition proposes to increase premium subsidies for individuals purchasing health insurance in the Covered California health benefit exchange to reduce the costs of obtaining coverage. According to the Coalition, the improved affordability achieved by this proposal will result in between 140,000 and 150,000 newly insured individuals and lower premiums for approximately 1.2 million Covered California enrollees. The proposed premium changes for various income levels are summarized below:

Percent of FPL	Income Range (Single)	Premium as Percent of Income (Current)	Premium as Percent of Income (Proposed)	Approx. Monthly Premium Change
Under 138	Less than $16,800	2.0	0	$0, instead of $47
139-149	$16,800-$18,200	3.4-4.0	0.08-0.95	$15 instead of $61
150-199	$18,200-$24,300	4.0-6.3	0.95-5.0	$101 instead of $127
200-249	$24,300-$30,400	6.3-8.1	5.0-6.6	$167 instead of $204
250-299	$30,400-$36,400	8.2-9.6	6.6-8.2	$248 instead of $288
300-400	$36,400-$48,600	9.6	8.2	$332 instead of $384

Reduce Copays and Deductibles for Individuals Between 200 and 400 Percent of the FPL. The Care4AllCA Coalition proposes to improve cost-sharing requirements, including copays and deductibles, for individuals between 200 and 400 percent of the FPL purchasing coverage in the exchange. According to the Coalition, individuals in this income range get little or no help paying for

copays or deductibles, with one third purchasing Bronze coverage with a $6,300 deductible. This proposal, detailed below, would improve cost-sharing affordability for 500,000 Covered California enrollees.

Cost-sharing improvements	**Current Benefit Design**			**Proposed**
200-300% FPL ($24,300-$36,400 for individual)	**Bronze**	**Silver (200-250%)**	**Silver (250-300%)**	**200-300% FPL**
Avg. % costs paid by insurer	60%	73%	70%	87%
Primary care visit	$75	$30	$35	$10
Specialist visit	$105	$75		$25
Generic drugs	$15 after drug deductible is met			$5 or less
Emergency room	$350	$350		$100
Hospital facility fee	20% coinsurance			15%
Individual medical deductible	$6,300	$2,200	$2,500	$650
Individual pharmacy deductible	$500	$130		$50
Individual out-of-pocket maximum	$7,000	$5,850	$7,000	$2,450
Cost sharing improvements	**Current Benefit Design**			**Proposed**
300-400% FPL ($36,400-$48,600 for individual)	**Bronze**	**Silver**		**300-400% FPL**
Avg. % costs paid by insurer	60%	70%		80%
Primary care visit	$75	$35		$25
Specialist visit	$105			$55
Generic drugs	$15 after drug deductible is met			$15 or less
Emergency room	$350			$325
Hospital facility fee	20% coinsurance			$600/day up to 5 days
Individual medical deductible	$6,300	$2,500		N/A
Individual pharmacy deductible	$500	$130		N/A
Individual out-of-pocket maximum	$7,000	$7,000		$6,000

Limit Premiums to Eight Percent of Income for Individuals Above 400 Percent of the FPL. The Care4AllCA Coalition proposes to limit premiums to no more than eight percent of income for

individuals over 400 percent of the FPL. The limits would be based on the cost of Bronze coverage. According to the Coalition, some individuals in this income range pay more than 20 percent of their income for bronze coverage, which comes with a $6,300 deductible. An individual over age 50 making more than $50,000 could spend between $4,000 and $9,000 on premiums, depending on geographic region, and as much as $6,300 on care. For married couples, premiums could range from $3,600 to $6,400 for a couple aged 24, or $13,700 to $18,600 for a couple aged 62, depending on geography, with both couples subject to a $6,300 deductible for Bronze coverage. The Coalition reports this approach would primarily benefit those with incomes between 400 and 600 percent of the FPL, decrease the number of uninsured by 100,000, and improve affordability for an additional 350,000 individuals.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding these items open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested advocates to present these proposals.