California Budget Watch (Part 4 of 4): The Legislature Implements Major Healthcare Reforms in Trailer Bills SB 78 and SB 104

Last month, we recapped the appropriations allocated to healthcare reform in the 2019 California Budget. These budget allocations, however, do not provide much guidance on how the money should be spent. Trailer bills provide the statutory language to implement the budget. With the enacted 2019 budget, the Governor signed two healthcare trailer bills passed by the Legislature, SB 78 and SB 104. In this post, we dissect these trailers bills which create and implement various programs impacting healthcare access and costs.

What are Trailer Bills?

SB 78 and SB 104 are known as "trailer bills," which are bills that clarify how some of the budget appropriation should be used. The authority to implement trailer bills comes from Article IV, Section 12(e) of the California Constitution, which allows the Legislature to pass "the budget bill and other bills."

Critics have argued that trailer bills have been used to pass unpopular legislation. Trailer bills do not need to go through the regular legislative process of committees and wait until January 1 to be implemented. Rather, trailer bills are

introduced and passed quickly with immediate effect. While trailer bills make policy making easy for the majority party, the evasion of regular legislative process may make some uneasy.

That said, trailer bills have helped speed up health reform in California. The individual mandate and California's all-payer claims database (APCD), both politically difficult to coalesce around, have owed their existence to the trailer bill. Additionally, the Medi-Cal expansion and increased Medi-Cal benefits have been given life this budget cycle through the trailer bill.

Breaking Down SB 78 and SB 104

The trailer bills regarding health include several provisions relating to health care delivery systems. In this post, we focus on seven of them, most of which have been previously introduced in our four-part series on the 2019 budget.

1. ***Directing Healthy California For All Commission to Explore Single Payer Option***

As an example of how a previous trailer bill can be completely altered by another trailer bill, SB 104 repurposed the Council on Health Care Delivery System, established under 2018's AB 1810, as the Healthy California for All Commission. The newly formed Commission is to develop a plan for a single payer system. As seen in the chart below, this is not California's first attempt to develop a single payer plan that future legislatures could adopt. The challenge here will be the next steps after a plan is developed.

	Health Care Options Project (1999)	Council on Health Care Delivery Systems (2018)	Healthy California for All Commission (2019)
Bill #	S.B. 480 (1999)	AB 1810 (2018)	SB 104 (2019), amending AB 1810
Goal	To develop "[1] the options for financing universal health coverage[;] [2] [t]he institutional mechanism or mechanisms by which universal health coverage may be delivered[;]][3] [t]he extent and scope of the health coverage which all California residents may have."	To "develop a plan that includes options for advancing progress toward achieving a health care delivery system in California that provides coverage and access through a unified financing system for all Californians."	To "develop a plan that includes options for advancing progress toward achieving a health care delivery system in California that provides coverage and access through a unified financing system, ***including, but not limited to, a single-payer financing system,*** for all Californians." [*emphasis highlights difference from AB 1810*]
Agency	California Health and Human Services Agency (CHHS)	Independent Body	Independent Body but chaired by Secretary of CHHS

Deadline	Summer 2002 for nine coverage options including single payer	Jan. 1, 2020 for update; Oct. 1, 2021 for options and timeline for "universal financing system"	Jan. 1, 2020 for update; July 1, 2020 for options; Feb. 1, 2021 for "key design considerations"
Membership	N/A	Five[i]	Thirteen[ii] now including CalPERS, Covered California, and CHHS

2. ***Implementing Individual Mandate***

The Legislature codified the Minimum Essential Coverage Individual Mandate under SB 78. Starting on January 1, 2020, a California resident must have minimum essential coverage each month or face a penalty. Under the legislation, Covered California must also provide nine exemptions for all who qualify and seek an exemption,[iii] including individual hardship or religious conscience, [iv] among others.

Additionally, the Franchise Tax Board can pass on to Covered California the names of those who did not have minimum essential coverage or sought an exemption. Covered California is then authorized to reach out to those individuals to encourage them to obtain minimum essential coverage.

To speed up the process of adopting and clarifying the individual mandate, the legislation allows both Covered California and the Franchise Tax Board to adopt emergency regulations until January 1, 2022. An emergency regulation will only receive ten days of review but is meant to be only

temporary. As an extra level of review, the legislation requires the regulation to be discussed "during at least one properly noticed board meeting before the [Covered California] board meeting at which the board adopts the resolution." Additionally, the emergency regulation must be repealed after five years if it does not go through normal rulemaking processes.

Finally, to insulate the mandate from federal preemption, the Legislature included the following language: "[e]nsuring the health of insurance markets is a responsibility reserved for states under the federal McCarran-Ferguson Act (15 U.S.C. Sec. 1011 et seq.) and other federal law."

3. ***Implementing Premium Assistance Subsidies for Covered California***

As discussed in previous posts, the Individual Market Assistance program under the new budget will provide subsidies to California residents who have household incomes at or below 600% federal poverty level (FPL) and who are also eligible for the federal premium tax credit. To maximize eligibility, SB 78 provides that any premium assistance subsidies received would not count toward the gross household income in terms of eligibility determination.

The subsidy will be advanced to program participants for use on the Covered California marketplace. Interestingly, an individual may either receive a refund or incur a liability depending on whether the allowed premium assistance subsidies for the taxable year exceed the program participant's advanced premium assistance subsidies or vice versa.

How the subsidies can be used and which groups will get more of the subsidies will be based on Covered California's program

design. The program design is dependent on legislative appropriation, which can include "provisional language directing the Exchange to provide a certain proportion of the funds to specified income ranges as determined by the Legislature and may provide other parameters guiding the design of the program." These subsidies are to end after the 2022 coverage year ends. Additionally, the statute authorizing the Individual Market Assistance program will be repealed on January 1, 2023.

Notably, the premium assistance subsidies program's additional rules and regulations will not be subject to the Administrative Procedure Act, which would have required notice and comment before a regulation or rule takes effect.

4. ***Convening of Pharmacy Benefits Advisory Group***

When Governor Newsom first took office in January 2019, he ordered the Department of Health Care Services (DHCS) to transition all pharmacy services from managed care to fee for service (FFS) by January 1, 2021. He also ordered DHCS to review all pharmaceutical purchasing initiatives and consider additional options to maximize the state's bargaining power by July 12, 2019.

While DHCS has not publicly released an official review by the July 12 deadline, it has announced that Medi-Cal pharmacy benefits and services administered by DHCS in the FFS delivery system will be identified collectively as "Medi-Cal Rx." DHCS also updated its progress on July 24.

SB 78 now orders DHCS to "convene an advisory group to receive feedback on the changes, modifications, and operational timeframes regarding the implementation of pharmacy benefits offered in the Medi-Cal program." The membership was not clear

but should include “hospitals, clinics, health plans, and consumer advocates.”

Additionally, DHCS must “provide regular updates” regarding “changes in the division of responsibilities between the department and managed care plans as a result of a transition of the outpatient pharmacy benefit to fee-for-service . . . [and] anticipated changes, if any, to beneficiary access to prescription medications.”

5. ***Expanding Medi-Cal Eligibility for Aged and Disabled Individuals and Undocumented Young Adults***

SB 104 codifies the Medi-Cal expansion for 1) aged and disabled individuals and 2) undocumented young adults, which was discussed in previous posts. In the first instance, the elimination of the Medi-Cal senior penalty would expand Medi-Cal eligibility to 138 percent of FPL, starting January 1, 2020. However, because such expansion requires federal approval, the Legislature included an additional $230 for an individual or $310 for a couple in the countable income. In this indirect manner, the countable income could exceed the previous 100% FPL limit. Since FPL is always changing, this is a temporary measure. With federal approval, all countable income up to 138% FPL will be disregarded for Medi-Cal purposes. Additionally, SB 104 requires that the income level be no less than the Supplemental Security Income/State Supplementary Payment (SSI/SSP) level a disabled or blind individual or couple may receive. To implement all of this, DHCS will be required to adopt regulations by July 1, 2023.

In the second instance, all young adults from ages 19 to 25, regardless of immigration status, will be eligible for the full scope of Medi-Cal benefits. This provision will be implemented

as soon as DHCS programs the systems for implementation. The legislation requires DHCS to maximize federal financial participation, and if no federal funds can be allocated, states funds will be used.

6. ***Creating the Medi-Cal Drug Rebate Fund***

SB 78 creates the Medi-Cal Drug Rebate Fund, which will pool the nonfederal money collected as part of the "state's share of state and federal supplemental Medi-Cal drug rebates." According to the trailer bill, the Fund shall be used for "funding the nonfederal share of health care services for children, adults, seniors, and persons with disabilities enrolled in the Medi-Cal program."

7. ***Implementing Value-Based Payment for Medi-Cal Managed Care***

SB 78 appropriates some of the Proposition 56 ("cigarette tax") proceeds to fund a new Value-Based Payment (VBP) program for Medi-Cal managed care plans. The Legislature intends for the VBP program to "help improve care for some of the most vulnerable or at-risk populations in the Medi-Cal managed care delivery system." To accomplish this, VBP programs would "offer financial incentives to health care providers that improve their performance on predetermined measures or meet specified targets that focus on quality and efficiency of care."

The VBP program targets four areas to improve: (1) behavioral health integration, (2) prenatal and postpartum care, (3) chronic disease management, and (4) quality and outcomes for children. In all these instances, Medi-Cal managed care plans shall make incentive payments at different levels depending on the integration or the standard they achieve.

The VBP program is to last at least three years and will be suspended on December 31, 2021 if expenditures exceed revenue estimates in the May 2021 Budget Revise. To implement the VBP program, DHCS may use either contracts or plan letters and does not have to enact regulations. However, DHCS is not mandated to implement the VBP program with a county mental health plan contracted with the department or a county Drug Medi-Cal organized delivery system authorized in the California Medi-Cal 2020 Demonstration.

Conclusion

Because budget numbers are not often clear on how a program should be implemented, a trailer bill provides a process or guidance in implementation. To wrap up the 2019 budget season, SB 78 and SB 104 created and implemented various programs, including the Healthy California for All Commission, the individual mandate, premium subsidies for those up to 600% FPL, the pharmacy benefits advisory group, Medi-Cal expansion for the aged, disabled, and undocumented young adults, the Medi-Cal Drug Rebate Fund, and value-based payment programs for Medi-Cal managed care.

These budget proposals have an impact on prices. In the instance of the individual mandate and premium subsidies, the implementation would result in a healthier risk pool in the insurance market, which in turn prevents spikes in premiums. Additionally, value-based payment programs should provide higher quality of care and reduce expenditures that may result from poor outcomes. We'll be keeping watch on the Healthy California for All Commission and its plan for single payer as well as the other initiatives' impact on healthcare prices and the healthcare market. Next month, we'll look at specific healthcare

bills (like balancing billing and air ambulances) that are of note during this legislative cycle. Stay tuned!

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[i] “(c) (1) The council shall be comprised of five members as follows:

(A) Three members who shall be appointed by the Governor.

(B) One member who shall be appointed by the Senate Committee on Rules.

(C) One member who shall be appointed by the Speaker of the Assembly.”

[ii] “(c) (1) The commission shall be comprised of 13 members as follows:

(A) The Secretary of California Health and Human Services, or the secretary’s designee, who shall serve as the chairperson.

(B) Eight members who shall be appointed by the Governor.

(C) Two members who shall be appointed by the Senate Committee on Rules.

(D) Two members who shall be appointed by the Speaker of the Assembly.

(2) There shall also be five ex officio, nonvoting members of the commission who shall be the Executive Director of the California Health Benefit Exchange, the Director of Health Care Services, the Chief Executive Officer of the Public Employees’ Retirement System, and the chairs of the health committees of the Senate and the Assembly, or their officially designated

representatives."

[iii] As stated in SB 78, the following are exempted from the individual mandate requirement: "(1) An individual who has in effect a certificate of exemption for hardship or religious conscience issued by the Exchange under Section 100715 for that month; (2) An individual who is a member of a health care sharing ministry for that month. "Health care sharing ministry" has the same meaning as the term was defined in Section 5000A(d)(2)(B) of the Internal Revenue Code on January 1, 2017; (3) An individual who is incarcerated for that month, other than incarceration pending the disposition of charges; (4) An individual who is not a citizen or national of the United States and is not lawfully present in the United States for that month; (5) An individual who is a member of an Indian tribe, as defined in Section 45A(c)(6) of the Internal Revenue Code of 1986, during that month; (6) An individual for whom that month occurs during a period described in subparagraph (A) or (B) of Section 911(d)(1) of the Internal Revenue Code of 1986 that is applicable to the individual; (7) An individual who is a bona fide resident of a possession of the United States, as determined under Section 937(a) of the Internal Revenue Code of 1986, for that month; (8) An individual who is a bona fide resident of another state for that month; (9) An individual who is enrolled in limited or restricted scope coverage under the Medi-Cal program or another health care coverage program administered by and determined to be substantially similar to limited or restricted scope coverage by the State Department of Health Care Services for that month."

[iv] The individual, for that month, has to be either: "(1) A member of a recognized religious sect or division thereof, as described in Section 1402(g)(1) of the Internal Revenue Code of 1986, and is an adherent of established tenets or teachings of that sect or division. (2) A member of a religious sect or

division thereof that is not described in Section 1402(g)(1) of the Internal Revenue Code of 1986, who relies solely on a religious method of healing, for whom the acceptance of medical health services would be inconsistent with the religious beliefs of the individual, and who includes an attestation that the individual has not received medical health services during the preceding taxable year. For purposes of this paragraph, the term “medical health services” does not include routine dental, vision, and hearing services, midwifery services, vaccinations, necessary medical services provided to children, services required by law or by a third party, and other services as the Secretary of United States Department of Health and Human Services may provide in implementing Section 1311(d)(4)(H) of the federal Patient Protection and Affordable Care Act. An individual who claims this exemption, but received medical health services during the coverage year, shall lose eligibility for the religious conscience exemption, is liable for the cost of the care, and is liable for the Individual Shared Responsibility Penalty.”