Governor Newsom's Healthcare Budget Proposal for 2024-25

On January 10, 2024, Governor Gavin Newsom released his proposed California state budget for 2024-2025. In a year where the state was expected to struggle financially, the Legislative Analyst's Office had originally predicted that the budget deficit could extend upwards of $68 billion due to 2023's seven month tax filing extension, steep stock market declines, and economic dampening from the Federal Reserve's interest rate hikes. However, to the surprise of many, the released budget projected a significantly smaller budgetary shortfall at $38 billon. The Governor announced plans to close this gap by dipping into California's reserves, delaying and deferring authorized spending from previous years, and bringing new spending cuts in a variety of sectors.

While budget cuts are always concerning, the 2024-25 budget made no significant cuts to healthcare access or coverage. Nevertheless, low-income communities and communities of color are expected to be disproportionately affected due to changes in many other sectors including support services, housing, and workforce supports. When it comes to healthcare spending, the budget is anticipated to continue maintaining CalAIM and MediCal coverage alongside subsidies for purchasing coverage on Covered California. Overall, the 2024-25 budget looks like it will protect investments from prior years without proposing any significant tax changes to increase revenues in the near-term.

Coverage-Related Changes (Medi-Cal and Covered California)

The 2024-25 budget continues to protect major healthcare investments from the past in relation to Medi-Cal and coverage accessibility by improving benefits, rates, access, and eligibility, regardless of age or immigration status. Specifically, the new proposed budget maintains its commitment to expand Medi-Cal eligibility to undocumented immigrants, aged 26 to 49 (which began on January 1, 2024), and seeks to eliminate the Medi-Cal asset test for seniors and people with disabilities.

Medi-Cal

Medi-Cal is California's version of Medicaid and aims to ensure people who have low-incomes and/or other eligibility factors such as age, disability status, or pregnancy receive health coverage. The program is currently estimated to be used by and more than half of California's school-age children. Presently, due to their income and immigration status. Moreover, almost one million Californians lost Medi-Cal coverage during the processing of Medi-Cal renewals beginning during the pandemic. In recent years, immigrants, older adults, and people with

disabilities have been at a higher risk of losing healthcare coverage. The new budget accounts for these changes by expanding full-scope Medi-Cal coverage to all Californians with incomes under 138% of the federal poverty level regardless of immigration status and with no need to count assets. To account for these changes, the budget has made an assumption that the Medi-Cal caseload will increase by 583,000 individuals from the 2023 Budget Act and subsequently allocating an addition $2.3 billion (of which almost $500 million will come from the General Fund) to cover those costs. It is estimated that approximately 14 million Californians from qualifying incomes will receive free or low-cost healthcare through Medi-Cal in the 2024-25 period. Moving forward, the California Budget Center has recommended that the government extend investments towards health navigators and pause procedural terminations to ensure more eligible Californians do not lose their Medi-Cal coverage.

CalAIM

The budget also looks to sustain ambitious Medi-Cal reforms through the California Advancing and Innovating Medi-Cal program (CalAIM). The CalAIM program was first introduced in 2019, and signifies California's long-term commitment to transforming Medi-Cal into a more "equitable, coordinated, and person-centered" program to maximize health and life outcomes. The Governor's budget maintains an allocation of $2.4 billion, of which $811.1 million will come from the General Fund, for CalAIM. At full implementation, the ambitious program will allow upwards of six months of rent or temporary housing to eligible unhoused people or people at risk of homelessness (e.g., individuals transitioning out of institutions or foster care, individuals in need of emergency care).

Covered California

Governor Newsom's proposed budget also continues to focus on lowering out-of-pocket costs for the Covered California program, which has already contributed to increased enrolment by 18% in 2024 compared to the prior year. Covered California is California's health insurance marketplace, where individuals can shop for health insurance plans and apply for subsidies during the open enrollment period. The amount of help someone receives is dependent upon their annual income. The 2024-25 proposal makes no changes to prior plans to lower out-of-pocket health care costs by continuing to eliminate deductibles and cut co-pays for Californians who purchase their care through Covered California and earn under 250% of the federal poverty level.

Maintained Funding for Behavioral Health Initiatives

The newly proposed budget has had a mixed effect on behavioral health initiatives by both maintaining a variety of fundings plans while delaying others. Specifically, the Governor's

2024-25 budget proposal planned to maintain over $8 billion in funds allocated across the Department of Health and Human Services to expand behavioral health treatments while improving the overall system and infrastructure to provide expanded services to children and youth. Services to youth include the Wellness Coach Medi-Cal benefit which will provide wellness education, screening, support coordination, and crisis management in schools and other health settings. The budget also invests in expanded mental health services for all Medi-Cal members through the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT Demonstration). The program currently has $7.6 billion allocated towards it comprised of $350.4 million from the General Fund, $87.5 million from the Mental Health Services Fund, and $2.6 billion from the Medi-Cal County Behavioral Health Fund. The program also anticipates the receipt of $4.6 billion in federal funds, but this is contingent on the availability and federal approval of such funds.

The budget also incorporated some delays in funding plans for other behavioral health programs due to the deficit. Specifically, there will be delays in the amounts of: $235 million for the Behavioral Health Bridge Housing Program for 2024-2026; $189.4 million for improving the behavioral health workforce; and $140.4 million for the Behavioral Health Continuum Infrastructure Program.

Managed Care Organization Tax

The Governor has also demonstrated a desire to receive federal approval to increase the Managed Care Organization (MCO) tax — a provider tax that is imposed by states on healthcare services to reduce or offset state spending from the General Fund on programs like Medi-Cal. Specifically, the Governor's proposal requests early Legislative action to ask the federal government to approve an additional $1.5 billion increase from the amount that was approved by the federal government most recently in December 2023. If the increase is approved, California's MCO tax revenue would total $20.9 billion in funding to the state over three years. Of that amount, an estimated $12.9 billion would be allocated for Medi-Cal, and $8 billion would support provider rate increases to incentivize greater provider participation in Medi-Cal. The proposed increase has received support from the California Association of Health Plans, who has voiced hope that the tax revenue will be used to fund improvements to the Medi-Cal program.

Health Care Worker Minimum Wage "Trigger"

Last year, the Legislature passed SB 525, a bill which sought to incrementally raise healthcare minimum wage to $25/hour by June 2028. The bill which will begin its first pay increases of $18/hour in June 2024 is expected to affect approximately 500,000 health care workers.

However, in an effort to close the budget shortfall, Governor Newsom's new budget seeks to receive early legislative action to supplement the bill with an annual trigger that would make the wage increases subject to the availability of General Fund revenue. It remains to be seen what kind of effect this could have on the healthcare market should this change be accepted.

Reproductive Health Services Waiver

Despite financial challenges, the budget has retained a one-time allocation of $200 million (of which $100 million will come from the General Fund) to fund the California Reproductive Health Access Demonstration Waiver. The proposed waiver would support access to reproductive health services including contraceptive care, sexually transmitted infection prevention and treatment, obstetrical care, and abortion services beginning no later than July 1, 2024.

Next Steps in Budget Process

Following with previous years and the California Constitution, Governor Newsom has included the Budget Bill with the proposed budget for legislative review. The Bill will now go to the Senate Budget and Fiscal Review Committee and the Assembly Budget Committee, where budgetary items will be discussed in their designated sub-committees. In late February, budget hearings within the various committees will begin and the Legislative Analyst's Office will issue a non-partisan analysis of the budget bill. At this point, the Legislative Analyst's Office and the Department of Finance will also issue their recommendations for the Governor's Budget. Following the discussion and recommendation period, a May Revision to the budget with adjustments will be released by the governor on or before May 14. Finally, the Legislature is required to pass a budget bill for the upcoming fiscal year by midnight on June 15, which will go into effect for the period of July 2024 to June 2025.

In the coming months, the Source will continue to report on developments in the California budget process.

Which states have banned noncompetes?

Emanate Health et al v. Optum Health et al

On November 20, 2023, Emanate Health filed an antitrust suit against Optum Health with the US District Court for the Central District of California. Specific causes of action include attempted monopolization, unfair business practices, unlawful business practices, and intentional interference with prospective economic advantage.

Optum is a subsidiary of UnitedHealth, and is the largest employer of physicians in the United States, with nearly 90,000 employed or affiliated physicians after adding nearly 20,000 physicians in 2023. Emanate Health is a nonprofit group of hospitals and physicians providing care in the San Gabriel Valley in California. Emanate has asked for a jury trial in the case.

FTC Succeeds in Thwarting John Muir-Tenet Deal

Cal. Health & Safety Code §§ 127501 through 127501.12: California Health Care Quality and Affordability Act – Office of Health Care Affordability

Establishing within the Department of Health Care Access and Information, the Office of Health Care Affordability. The office shall be responsible for analyzing the health care market for cost trends and drivers of spending, developing data-informed policies for lowering health care costs for consumers and purchasers, creating a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers, and enforcing cost targets.

United Health Subsidiary Optum Sued for Anticompetitive Practices in Federal Lawsuit

Research indicates that concentrating control of healthcare providers and facilities into a handful of massive health systems leads to higher healthcare costs, without improving quality of care. There are often limited possibilities available for smaller marketplace participants who are attempting to compete with the giants in the field, especially when the giants engage in unfair business practices.

On November 20, 2023, Emanate Health filed an antitrust with the US District Court for the Central District of California. The complaint alleges that Optum engaged in unfair and unlawful business practices and anticompetitive practices to monopolize care in the local market, adversely impacting Emanate's ability to compete, causing a decline in revenue for Emanate.

Parties to the case:

Plaintiff Emanate Health is a nonprofit group of hospitals and physicians providing care in the San Gabriel Valley in California. Defendant Optum, a subsidiary of UnitedHealth Group, is a healthcare services provider that includes technology services, a pharmacy benefit manager, and direct healthcare services. UnitedHealth is the largest health insurer in America, based on revenue, but some observers believe that the Optum division directly providing healthcare services represents a greater avenue for profit for UnitedHealth than insurance coverage. As the largest employer of physicians in the United States, Optum has been aggressively acquiring healthcare service groups in recent years, adding nearly 20,000 physicians in 2023, taking its total to nearly 90,000 employed or affiliated physicians nationwide. Additionally, according to the filing, Optum Health Plan of California's market share in Medicare Advantage HMO and Commercial HMO enrollees is close to, or exceeds, fifty percent (50%) in the area where Emanate's patients reside.

Anticompetitive allegations in the suit:

The lawsuit alleges that Optum acted to eliminate Emanate from the local primary care physician market, and to monopolize that market (a violation of Section 2 of the Sherman Act) through unlawful and anti-competitive means, including threatening cancellation of Hospital Service Agreements with Emanate facilities, unless Emanate agreed to new, coercive, anti-

competitive terms. Proposed terms included a requirement that Emanate would not solicit any of Optum's independent physician association participating providers, and if any physician affiliated with Optum Health Plan of California wanted to sell their practice, Optum would have the first privilege to purchase.

Alleged unlawful business practices against providers:

Emanate contends Optum intimidated doctors who want to leave Optum to go to competing medical groups by using unlawful restrictions in the physicians' contracts, and by threatening the physicians and competitors with legal action if the doctors moved to Optum's competitors. Specifically, Emanate claims that Optum contracts with primary care physicians include post-employment non-competition and non-solicitation covenants, preventing providers from working for competing provider networks or health systems. Emanate states these post-employment restrictive covenants are void and unenforceable under California law.

Alleged unlawful and unfair business practices:

The suit also claims that Optum engaged in a concerted effort to prevent patients from contacting their doctors who chose to leave Optum to join competing medical groups. Specifically, Emanate claims that Optum transferred the patients to other Optum physicians without informing them of their treating physicians' departure, lied to the patients who called about where their doctors had gone (claiming that their physicians had either retired or gone on vacation), and instructed Optum's remaining personnel not to reveal to patients where the departed doctors could be found. The complaint also claims that Optum disciplined employees for truthfully responding to inquiries as to why patients were no longer being treated by former Optum providers, and where the provider had moved. The suit claims at least one employee was terminated for truthfully responding to such a patient inquiry. Emanate also contends that Optum failed to comply with continuity of care requirements imposed by the state of California and Medicare by steering patients away from Emanate facilities to geographically remote facilities, including for emergency services.

In context:

Optum has a history of aggressively acquiring healthcare services to increase market power. have been previously accused of using that market power to impede provider competition for financial gain. In March of 2021, a physician group sued United Healthcare Insurance in Colorado and Texas in state courts, alleging the insurance giant violated state antitrust laws, claiming that United Healthcare used its market power to "squeeze" the group out of its insurance network and the marketplace for United's own financial gains. In February 2022, the Department of Justice (DOJ), along with attorneys general of New York and Minnesota,

filed a lawsuit in federal court attempting (although ultimately failing) to block a merger between UnitedHealth Group and Change Healthcare claiming that it would limit competition and innovation in claims processing technology and would give UnitedHealth Group access to healthcare data of competitor insurers and an unfair advantage in health insurance markets. A successful action by Emanate, which has asked for a jury trial, could be encouraging for other small systems attempting to find ways to compete with Optum and other mammoth healthcare systems. The Source will be closely tracking the litigation and be sure to bring the latest developments and analysis in this case.

Recapping the 2023 California Legislative Session (Part 2): Healthcare Services and Pharmaceutical Costs

In the last issue of California Legislative Beat, we examined some significant bills from year one of California's 2023-2024 legislative term. Specifically, we focused on legislation that sought to make changes in healthcare competition, consolidation, and system reform. In part 2 of the 2023 session recap, we turn our attention to bills that aimed to tackle healthcare service and pharmaceutical costs, coverage, and price transparency.

Healthcare Costs and Coverage

Californians can expect to be protected from surprising dental or emergency ground medical transportation bills soon. The legislature approved and signed two bills into action that could help protect the pockets of consumers. One will prevent insurance plans from discriminating against dental patients with pre-existing conditions, while the other will prevent ambulance companies from slapping patients with high costs bills or sending them to connections too quickly. While legislative actions to increase transparency failed to pass, it remains to be seen whether prior authorizations from providers for medical services will be limited in the future.

What Passed

- Dental Benefits and Rate Review (AB 1048)

Despite opposition from dental plans, Governor Newsom recently signed a new bill that will prevent dental benefit plans from denying claims based on a patient's preexisting dental conditions and prevents plans from enforcing capricious waiting periods for patients to access full benefits. The bill, which was sponsored by the California Dental Association, will also require California regulatory agencies to review dental plan premiums with the intent of protecting consumers from high or unfounded rates. Overall, the bill hopes to provide greater oversight over dental plans' rate setting processes and achieve fairer benefits reimbursement for consumers and dentists. AB 1048 is set to take effect starting on January 1, 2025.

- Emergency Ground Medical Transportation (AB 716)

In a move to reduce surprise billing and ensure greater transparency, California passed a new law that would provide protections from large surprise ground ambulance bills. AB 716 prohibits any ground ambulance bill beyond the in-network cost-sharing for consumers with state-regulated plans or greater than the Medi-Cal or Medicare rate for the uninsured. The in-network cost paid will count toward deductibles and out-of-pocket maximums for consumers. Additionally, the new law would prohibit sending the surprise bills to collections for both insured and insured patients, while ensuring ambulance providers are reimbursed similarly to their existing local rate-setting processes without pegging consumers with burdensome costs. Ultimately, Californians will now have more time to address their bills without going through collections.

What Didn't Pass

- Health Care Coverage: Prior Authorization (SB 598)

As proposed by SB 598, health service plans and health insurers could be prevented from requiring health professionals to complete or obtain authorization for health care services that the plan or insurer regularly approves over 90% of the time within the most recent one-year contracted period. SB 598 sets specific standards for denials, recissions, and appeals of this exception, and could help mitigate lengthy and unnecessary wait times to render services to patients. The move, which is sponsored by the California Medical Association, could ensure patients receive more timely and appropriate care in lieu of lengthy insurance disputes. The bill is currently being held in committee and under submission. It remains to be seen whether this bill could possibly go through in the 2024 legislative session.

- Medical Group Financial Transparency Act (AB 616)

Governor Newsom vetoed a bill that would have removed public disclosure exemptions for the financial data of medical groups. AB 616 would have publicized data that was already

collected by the Department of Managed Health Care (DMHC) and the Office of Health Care Access and Information (HCAI). Assemblymember Freddie Rodriguez stated that disclosure of the data would have increased the transparency of reported information and could have been a step towards addressing concerns about gaps relating to medical system spending. Ultimately, AB 616 could have provided more insights to the public about the specifics of their health care spending, particularly how much was being kept as profit, disbursed to shareholders, and used for non-clinical purposes at medical groups.

Prescription Drug Costs & Coverage

The legislature tackled many issues relating to prescription drug costs and coverage and enacted quite a few proposals over the past year. Generally, Californians can expect to see greater affordability for prescription drugs while receiving improved access to services from local pharmacies. With new laws that place or maintain restrictions on health insurance plans, the savings may ultimately be passed down to consumers.

What Passed

- Pharmacist Service Coverage (AB 317)

This new law will require health care service plans and disability insurers to cover and reimburse the cost of services that are rendered by licensed pharmacists at in-network and out-of-network pharmacies. When the law becomes effective, insurance carriers will be required to recognize pharmacists in a similar manner as physicians, physician assistants, and nurse practitioners. By covering services rendered by pharmacists, patients and consumers could receive broader access to care – particularly in communities that presently have physician shortages – and could create more revenue opportunities for community pharmacists to stay in business and subsequently provide quality care.

- Prescription Drugs (AB 948)

California has continued to enhance its efforts in protecting consumers from high prescription drug prices. Presently, Californian laws prohibit copayments, coinsurance, or any form of cost sharing from exceeding $250 for an up to 30-day supply of covered, out-patient prescription drugs. While this requirement is already operational, it was initially set to expire on January 1, 2024. With the passage of this new bill, lawmakers have removed the repeal date on this law, thereby extending the requirement indefinitely. This legislation will ensure that consumers can continue to receive their prescription medications without worrying about soaring prices

and affordability of the costs.

- Health Care Coverage: Cancer Treatment (SB 421)

Similar to AB 948, this newly enacted bill indefinitely extends the timeline of the current California requirement. Under this new legislation, health plan contracts and health insurance policies will not be allowed to require enrollees to pay more than $250 for up to a 30-day supply of prescribed orally administered anticancer medications. The prohibition was set to expire on January 1, 2024, but it will now be extended indefinitely under this bill and could have a significant impact on patients with cancer and their families by improving affordability for drugs that are used for cancer treatment.

- Prescription Drug Pricing (SB 786)

Health care providers and pharmacies will continue to be required to provide affordable care and access to low-cost drugs and services for low-income and uninsured populations, while ensuring that providers fully benefit from purchasing discounted drugs. SB 786, authored by Senator Anthony J. Portantino, prohibits a pharmacy benefit manager (PBM) from discriminating against a covered entity or its pharmacy in connection with dispensing a drug subject to federal pricing requirements or preventing a covered entity from retaining the benefit of discounted pricing for those drugs. These savings could be used to improve access to care and lower prescription prices for vulnerable patients. This new legislation has the potential to protect both providers and their patients by preventing for-profit PBMs from overcharging for life saving drugs and will ensure that patients receive the care that they need.

- Health Care Coverage: Biosimilar Drugs (SB 621)

SB 621 requires that health plans are not prohibited from requiring an enrollee or insured to try a biosimilar before providing coverage for the equivalent branded prescription drug, as provided under existing law, but that the requirement to try biosimilar, generic, and interchangeable drugs does not prohibit or supersede a step therapy exception request. Biosimilars maintain a similar structure and function to reference biologic drugs without meaningful differences but are not considered the same as generic medications since they are not exact replicas of the original drug. SB 621 is predicted to apply to over 14 million Californian enrollees. This bill could greatly impact patients by improving access to some lower-cost medications. Ultimately this bill could result in reduced premiums and access to safer and effective options for patients.

While many bills have become enacted in the 2023 legislative session, it remains to be seen what other changes will come about in 2024, the second half of the legislature's two-year term. Stay tuned to The Source's California Legislative Beat in the new year for the latest legislative action in California.

Thousands face higher medical costs after rift between two California health care giants

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FTC and California AG Jointly Challenge John Muir's Acquisition of San Ramon Regional Medical from Tenet Healthcare

See case page: FTC and California v. John Muir Health and Tenet Healthcare

Update: On December 15, 2023, John Muir announced it would terminate its proposed deal to acquire Tenet's remaining interest in San Ramon Medical Center. On December 18th, the FTC and California moved to dismiss their federal court case and the FTC dismissed its administrative challenge.

Federal antitrust enforcement continues to pick up pace even as we near the year end. On November 17, the Federal Trade Commission sued to block John Muir Health's proposed $142.5 million acquisition of San Ramon Regional Medical Center in California from Tenet Healthcare, citing antitrust concerns that the horizontal merger could eliminate competition and drive up costs for healthcare consumers.

Both John Muir and San Ramon Medical operate in the San Francisco Bay Area, across Contra Costa and Alameda counties. Based in Walnut Creek, John Muir Health is a nonprofit system that currently operates two hospitals and also holds a 49 percent non-operating ownership

interest in San Ramon Medical. According to the administrative complaint, the proposed transaction under review would give John Muir the remaining 51 percent ownership of San Ramon Medical, currently owned and operated by Tenet Healthcare, a for-profit health system based in Texas. The FTC alleges this deal would give John Muir more than 50% of the market for inpatient general acute care (GAC) services in the region. The reduced competition would allow John Muir to demand higher rates at its existing two hospitals as well as San Ramon Medical, which would be its third hospital, leading to higher insurance premiums, co-pays, deductibles, and other out-of-pocket costs.

In addition to initiating administrative proceedings, the FTC expects to file in federal court for an injunction to halt the transaction pending the FTC administrative adjudication. The agency is also joined by the California attorney general in the investigation and litigation. Notably, the AG only has administrative authority over nonprofit healthcare entities in California, which would not cover for-profit entities like Tenet Healthcare. As of December 4, both John Muir and Tenet Healthcare have filed answers in response to the challenge. Stay tuned to The Source Blog for the latest developments in the case.

FTC and California v. John Muir Health and Tenet Healthcare

In November 2023, the FTC and the California AG challenged John Muir Health's proposed acquisition of San Ramon Regional Medical Center from Tenet Healthcare. Both John Muir and San Ramon Medical operate in the San Francisco Bay Area. John Muir Health is a nonprofit system that already operates two hospitals and also holds a 49 percent non-operating ownership of San Ramon Medical. The proposed transaction would give John Muir the remaining 51 percent interest in San Ramon Medical, currently owned and operated by Tenet Healthcare, a for-profit health system based in Texas. The FTC administrative complaint alleges the deal would give John Muir more than 50% of the market for inpatient general acute care (GAC) services in the region and drive up healthcare costs.

On December 15, 2023, John Muir announced it would terminate its proposed deal to acquire Tenet's remaining interest in San Ramon Medical Center. Following this development, the FTC and California moved to dismiss their federal court case and the FTC dismissed its administrative challenge on December 18, 2023.