

## **Health Consumer Advocates Health Coverage Guiding Principles**

The undersigned diverse group of health consumer advocacy organizations presents this set of Health Coverage Guiding Principles to measure any proposals to expand coverage to health care in California. All health coverage proposals must be measured and evaluated under these Principles to ensure that eligibility, benefits, access, quality of care, choice of providers, and the due process rights of beneficiaries remain fully intact and are not negatively impacted, even if the consequences are unintended, and to ensure affordability of coverage and meaningful access to services that meet the needs of low-income Californians.

Our primary constituencies are low-income Californians who are eligible for publicly-funded health programs, such as Medi-Cal and Healthy Families, as well as low-income individuals who are not currently eligible for public programs. These principles should be read along with the *Working Guidelines for Evaluating Medi-Cal Reform*, which were developed by a number of advocacy organizations in response to the Administration's "Medi-Cal Redesign" proposal.

### **1. Eligibility**

- **Any proposal for health coverage must ensure that groups and individuals currently eligible for public health coverage programs maintain eligibility.**
  - Individuals currently eligible for Medi-Cal and Healthy Families should remain eligible.
  - Persons eligible for and/or enrolled in Medi-Cal should have the option, but not be required to accept other comprehensive health coverage and thereby give up primary coverage under Medi-Cal.
  
- **Any expansion must streamline and simplify eligibility rules and requirements in existing public health coverage programs.**
  - Current policies that result in a lapse or loss of coverage for those eligible for Medi-Cal or other public health programs should be eliminated.
  - Complex rules and requirements should be reduced and/or simplified so that enrollment, retention and documentation and reporting requirements are not unnecessarily burdensome.
  - Eligibility, including application, reporting, and retention rules and requirements, should be no more restrictive than required by federal law.
  - Simplification should include removing barriers that unnecessarily discourage beneficiary participation or impede access to care.
  - Confidentiality of participants' information should be maintained and used only for program purposes as currently provided by law.
  
- **Any proposal to cover children and parents under publicly-funded health programs should be expanded to the maximum extent allowable under federal law in order to maximize all federal dollars available to contribute to the cost of health coverage for Californians.**

- Expansions of coverage through federal Medicaid and SCHIP funds should be pursued to provide coverage for additional low-income families and other vulnerable populations.
  - Expanding eligibility through publicly-funded health programs to additional low-income individuals or groups should not compromise existing categories of eligible individuals or the scope of benefits currently available under these programs.
- **All low-income people with income up to at least 300 percent of the Federal Poverty Level (FPL) should be included in any proposal to expand health coverage.**
    - Low-income parents and their children must be provided health coverage (as parents' health coverage impacts the well-being and self-sufficiency of the entire family).
    - All low-income residents of the state, including low-income adults without children as well as others who are not currently eligible for public programs, must be covered (as they substantially contribute to the economic stability of the state).
- **Any proposal to expand health coverage should maximize portability of coverage and continuity of care and coverage.**
    - Health coverage should be portable so that whenever possible, coverage should not depend on employment status or other changes in life circumstances.
    - Health coverage should promote and protect continuity of care with existing providers to the maximum extent possible.
    - Health coverage should continue for as long as a beneficiary is eligible without imposing new barriers that may interrupt coverage for eligible beneficiaries.

## 2. Scope of Benefits

- **Any proposal to expand health coverage must preserve the existing amount, duration, and scope of benefits for Medi-Cal and Healthy Families beneficiaries.**
  - Benefits for Medi-Cal eligible individuals must remain available at existing levels in order to preserve meaningful access to medically necessary care and must not create differences in access based on income levels.
  - The current scope of benefits available for Healthy Families eligible individuals, including medical, mental health, dental and vision coverage must be preserved.
- **Any proposal to expand health coverage for low-income individuals and families must ensure that a comprehensive benefits package is available, including coverage for medical, mental health, dental and vision services.**
  - Health coverage must include benefits that cover the broad range of (Knox Keene Act covered) inpatient and outpatient medical and mental health services, laboratory and diagnostic services, prescription drugs, specialty care services, family planning, pregnancy-related, and prenatal services, dental services, skilled nursing and long term care services, and medical equipment and supplies.
  - Benefits should not be capped on a monthly, annual or lifetime basis in amount or duration that would unreasonably restrict, compromise the efficacy of, or prevent access to necessary and appropriate health care treatment and services.

### **3. Cost Sharing and Affordability**

- **Any proposal for health coverage must ensure that any deductions, cost sharing, co-payment, premium or similar charges imposed upon Medi-Cal beneficiaries must be nominal in amount and used only as a last resort.**
  - Medi-Cal beneficiaries should not be forced to choose between basic necessities of life and health care.
  - Cost-sharing imposes a real barrier that reduces access to health care for Medi-Cal beneficiaries.
  - Cost savings from imposing cost-sharing will not be realized due to the higher cost of acute care when preventative and on-going care is not sought by low-income beneficiaries.
  - Medi-Cal beneficiaries should not be subject to any additional or higher cost sharing than what the current law provides.
  - Medi-Cal beneficiaries should not be refused treatment or services if they cannot afford even nominal cost-sharing amounts.
  - Monitoring and enforcement against providers or health plans of cost-sharing rules and limitations must be ensured through state regulation by the appropriate agency.
  
- **Any proposal for health coverage through public programs other than Medi-Cal must ensure that total cost sharing imposed upon low-income beneficiaries does not exceed an appropriate amount based upon the individual or family's ability to pay.**
  - Cost sharing mechanisms must be designed to recognize that low-income individuals and families do not have resources to spend on their health care, nor are they financially able to pay cost sharing, even if it later may be reimbursable.
  - Cost sharing should be capped so an individual or family pays no more than a specified percentage based upon the family's income, size, and other relevant factors affecting their ability to pay.
  - Cost sharing, including premiums, imposed upon children with family incomes up to 300% FPL should not exceed amounts currently allowable under the Healthy Families program.
  - Low-income beneficiaries should not be subject to co-payments, premiums, co-insurance or deductibles they cannot afford.

### **4. Access and Choice**

- **Any proposal for health coverage must ensure that beneficiaries currently eligible for public health coverage programs continue to have access to the necessary level of care and services.**
  - Beneficiaries must be able to access medically necessary care, including preventative and specialty care services, in a timely manner.
  - Beneficiaries must have access to appropriate and qualified providers who can ensure that the linguistic and cultural needs of those beneficiaries are adequately addressed.
  - Beneficiaries with disabilities must have physical access to appropriate and qualified health care providers, services and equipment to meet their unique needs.

- Beneficiaries must have meaningful access to appropriate and qualified providers and services that are located in a geographically convenient location.
  - Health care expansion proposals must seek to diminish health care disparities, not exacerbate them.
- **Any proposal to expand coverage for low-income individuals and families must incorporate adequate, enforceable standards for access, medical necessity, care management, and linguistic and cultural needs.**
    - Individuals must have access to medically necessary care, transportation, medical interpreter services, and geographically and physically accessible services.
    - Care management should promote coordination of care and provide routine preventive and screening services.
    - Standards should be developed with a broad range of stakeholder input (e.g. LEP populations, persons with disabilities).
    - Standards should be measurable and enforceable.
    - Services must be designed to address the specific needs of special populations, including seniors, LEP populations, and persons with disabilities.
- **Any proposal to expand health coverage must provide beneficiaries with as much freedom of choice of providers or services as possible.**
    - Beneficiaries should have the choice of a variety of providers and provider networks from whom they can seek care and treatment.
    - Beneficiaries should have a choice among health plans and managed care restrictions should be minimized.
- **Any proposal to expand health coverage to low-income individuals and families should ensure an adequate provider network to meet the needs of beneficiaries in urban and rural communities.**
    - Rates must be adequate to ensure a sufficient number of providers in each area of care, including preventative and specialty care services.
    - Reimbursement rates must be adequate to ensure linguistically appropriate providers are available in all areas of care and located in geographically convenient areas.
- **Any proposal to expand health coverage must ensure providers are able to authorize treatment or make medical decisions with as much clinical autonomy as possible.**
    - Medical necessity criteria must not be overly restrictive, nor may they incorporate financial criteria which may diminish access to necessary care.
    - Limiting beneficiaries' access to care through use of prior authorization or other measures designed for cost containment should be minimized.
    - Requirements that treatment be "evidence based" in order to be covered must not restrict appropriate access to successful medical treatment options which may be considered experimental, investigational or unproven by medical evidence or research on subjects who are similar to the patient.

## 5. Quality of care

- **Any proposal to expand health coverage should provide a mechanism to ensure that the quality of care and effectiveness of services are tracked and monitored.**
  - The health plans and providers must be required to monitor and track medical and other health outcomes by measuring and publicly reporting on key health outcome indicators and the effectiveness of care.
  - The health plans and providers must measure and publicly report on the outcomes concerning patient satisfaction and complaints or grievances filed by beneficiaries.
  - Plans and providers should be required to adhere to specific practice guidelines that ensure timely access, certain quality standards of care, and appropriate training and education regarding the needs of special populations (e.g. LEP and disability access issues), among others.
  - The health plans must ensure that services are culturally and linguistically appropriate to meet the needs of particular populations.
  - Health plans and providers must be appropriately sanctioned, up to and including removal from participation, for providing inappropriate or poor quality of care.
  
- **Any proposal to expand health coverage should promote the integration and coordination of health services delivery systems to more efficiently and effectively meet the needs of beneficiaries.**
  - Health plans should ensure that referral and communication systems between primary care providers and specialists are effective and designed to ensure early intervention and prevention treatment.
  - Health plans and providers should be required to ensure that networks contain an adequate supply of providers to meet the needs and demands of beneficiaries.
  - Health plans should be required to provide effective case management, including disease management services for beneficiaries with special or high health care needs.

## 6. Procedural protections

- **Any proposal to provide health coverage must ensure that due process rights and protections available to Medi-Cal beneficiaries are preserved.**
  - Medi-Cal beneficiaries must be entitled to the same or better notice and hearing rights as currently provided under state and federal law.
  - Medi-Cal beneficiaries must be entitled to existing emergency drug supplies and aid pending appeal of disputes regarding eligibility, coverage and benefits denials or delays.
  - Beneficiaries must have access to expedited appeals procedures and meaningful review by an independent entity.
  
- **Any proposal to expand health coverage to additional low-income populations must include specific complaint and grievance protections to enable beneficiaries to challenge adverse actions or decisions regarding coverage and benefits.**
  - Newly eligible Medi-Cal beneficiaries must be entitled to the same notice and hearing rights as provided under existing state and federal law.

- Beneficiaries must have access to emergency coverage of drugs or other services pending an appeal of coverage.
- Beneficiaries of health plans must have access to independent medical review regarding coverage and benefits disputes.

## 7. **Financing**

- **The government and employers should share the burden of financing health coverage expansion to low-income people.**
  - The government should prioritize and fund health care coverage as a matter of public policy for those California residents with incomes up to and including at least 300% FPL.
  - State and federal funds should be maximized to cover all low-income individuals and families.
  - Large- and medium-size employers must participate in funding health coverage of low-income workers, including any expansions to those not eligible for public health coverage programs.
- **Any tax or fee imposed to finance health coverage expansion must not be regressive in design so that it unfairly burdens low-income individuals and families.**
  - The burden of paying or financing the costs of health coverage expansion must be distributed according to ability to pay and no fee shall be charged that exceeds individuals' and families' ability to pay.
  - The sharing of risks of costs of health coverage must not disproportionately fall on the highest users of health care, including those with poor health status or disabilities.

Health Consumer Alliance  
 Maternal Child Health Access  
 National Immigration Law Center  
 National Health Law Project  
 Fresno Health Consumer Center/Central California Legal Services  
 Health Consumer Center of Los Angeles/Neighborhood Legal Services  
 Orange County Health Consumer Action Center/Legal Aid Society of Orange County  
 Health Rights Hotline/Legal Services of Northern California  
 Consumer Center for Health Education and Advocacy/Legal Aid Society of San Diego, Inc.  
 Health Consumer Center of San Mateo County/Legal Aid Society of San Mateo County  
 Bay Area Legal Aid