



Health Consumer Alliance

Universal Coverage: Standards to Ensure Low-Income Californians Access to Affordable Quality Care

The Health Consumer Alliance (HCA) is a collaboration of nine local health consumer centers that cover thirteen counties and are home to over three-fifths of California's low-income residents. Last year, HCA collectively assisted over 14,400 low-income consumers. Forty percent (40%) of those consumers were uninsured. Another 35% of HCA consumers were Medi-Cal beneficiaries. HCA offices cover both urban and rural counties, providing a broad picture of the health care needs of people in different health care settings and systems. The local HCA offices are supported by two statewide support centers, the National Health Law Program (NHeLP) and Western Center on Law and Poverty (WCLP).

HCA believes that it is essential to provide health care coverage to all Californians. Providing coverage for individuals and families with the least ability to pay is crucial and long overdue. Any coverage expansion proposal must provide coverage that is affordable, accessible, and culturally and linguistically appropriate for low-income individuals. In addition, any coverage expansion must ensure that Medi-Cal eligible individuals maintain the benefits to which they are currently entitled.

1. Eligibility:

All Californians should have health coverage, regardless of immigration status. Any coverage expansion must include all low-income individuals and retain coverage for those currently eligible for public programs.

- All low-income individuals and families, regardless of immigration status, with income up to at least 300% of the Federal Poverty Level (FPL) should be included in any coverage expansion.
- Publicly-funded health programs should be expanded to the maximum extent allowable under federal law in order to maximize federal dollars available to fund health coverage.
- Policies that result in a lapse or loss of coverage or that discourage people from applying 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, documentation and reporting requirements are not unnecessarily burdensome and are no more restrictive than required by federal law.

2. Affordability:

Health care for low-income individuals and families must be affordable. This means that premiums, cost-sharing and any other out-of-pocket costs must not impede access to necessary care. Low-income individuals must not be forced to choose between basic necessities and health care.

- Deductibles should not apply to low-income individuals because they create barriers to care.

- Cost-sharing and premiums should not be imposed for individuals and families up to 200% FPL as they lack the resources to afford such costs.
- Healthy Families standards should apply for co-payments and premiums for individuals and families who fall within 200-300% of the FPL.
- Medi-Cal beneficiaries should not be subject to additional or higher cost sharing than what current law provides.
- Low-income individuals should not be refused treatment or services if they cannot afford cost-sharing amounts.
- The sharing of risk for the cost of health coverage must not disproportionately fall on the highest users of health care, including those with poor health status or disabilities.

3. Scope of Benefits

Coverage expansion must provide comprehensive benefits for low-income individuals. Specifically, expansion must preserve the existing amount, duration, and scope of benefits for Medi-Cal and Healthy Families beneficiaries.

- Benefits for Medi-Cal and Healthy Families eligible individuals must remain available at existing levels to preserve meaningful access to medically necessary care.
- The benefits package must not differ based on income level.
- When looking to cut costs, efforts should be aimed at reducing waste and managing administrative costs within the program, not at reducing or limiting benefits for beneficiaries.
- Benefits should not be capped on a monthly, annual or lifetime basis in an amount or duration that would unreasonably restrict, compromise the efficacy of, or prevent access to necessary and appropriate health care treatment and services.

4. Financing:

If taxes are used to finance health coverage, income below a certain floor should not be taxed. In addition, the state should expand public programs to the full extent possible to maximize federal funds.

- 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.
- If a payroll tax is used, at a minimum, individuals with income below 200% FPL (\$19,600 a year for a family of one or \$9.42 an hour) should be exempt. The floor for the payroll tax should be tied to FPL to ensure that it increases yearly as costs rise.
- To ensure that all participate, there should be no ability to opt out of financing the coverage expansion, except for those who are exempt based on inability to pay.
- The ceiling for payroll taxes should be no lower than \$200,000.
- Any tax or fee imposed to finance health coverage expansion must not be regressive in design to avoid unfairly burdening low-income individuals and families.

5. Procedural protections:

Health coverage programs must provide due process rights, including notice, appeal, and hearing rights.

- Any coverage expansion must ensure that those currently eligible for Medi-Cal retain the current notice and hearing rights.
- All covered persons must be entitled to the same or better notice as currently provided under state and federal Medicaid law.
- Notices must be culturally and linguistically appropriate.
- For appeals regarding subsidy or eligibility, there must be a right to a fair hearing.
- For appeals of denied services, the appeals process must include an automatic review by the plan, and if it is denied, then there must be an independent medical review.
- For administrative problems, there must be a third party review by the appropriate regulatory agency.
- There must be a set timeframe for the appeals process consistent with either the current Medi-Cal or Knox-Keene rules.
- If an appeal is not decided within 30 days, it must be approved automatically.
- There must be a right to an in-person hearing for all appeals.
- Low-income beneficiaries must be entitled to existing emergency drug supplies and aid pending appeal of disputes regarding eligibility, coverage and benefits denials or delays.
- All beneficiaries must have access to expedited appeals procedures and meaningful review by an independent entity.

6. Access:

Coverage must ensure access to medically necessary care for all. This includes individuals with disabilities, persons residing in rural areas and those with Limited-English proficiency. Any health care expansion proposal must strive to diminish health care disparities.

- All covered persons must be able to access medically necessary care, including preventive 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 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 geographically convenient locations.
- Care management should promote coordination of care and provide routine preventive and screening services.

7. Quality of Care:

Any coverage expansion proposal must promote consistent high quality care across income levels, and geographic locations and populations. Any proposal to expand health coverage should include a mechanism to track and monitor the quality of care and effectiveness of services provided.

- Measurable and enforceable quality of care standards should be developed with a broad range of stakeholder input (e.g. LEP, people with disabilities).
- Services must be designed to address the specific needs of special populations, including seniors, LEP populations, and persons with disabilities.
- Rates must be adequate to ensure a sufficient number of providers in each area of care, including preventive and specialty care services. In addition, reimbursement rates must be adequate to ensure linguistically appropriate providers are available in all areas of care and located in geographically convenient areas.
- Medical necessity criteria must not be overly restrictive.
- Health plans and providers must monitor and track medical and other health outcomes by measuring and publicly reporting on key health outcome indicators and the effectiveness of care.
- 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, comply with clinical quality standards of care, and offer appropriate training and education regarding the needs of special 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 integration and coordination of health care delivery systems to more efficiently and effectively meet the needs of covered persons.
- Any pay for performance proposals must ensure that financial incentives do not result in provider rate cuts, and that access for low-income beneficiaries is not negatively impacted.

8. Choice and Portability:

Coverage expansion must provide for choice of providers and networks, continuity of care and portability of coverage.

- Beneficiaries should be able to choose from a variety of providers and provider networks from whom they can seek care and treatment.
- Health coverage should be portable so that whenever possible, coverage should not depend on changes in life circumstances.
- Health coverage should promote and protect continuity of care to the maximum extent possible.
- For health coverage to be truly portable, it must be affordable.



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Fresno County

Fresno Health Consumer Center
Central California Legal Services
1999 Tuolumne Street, Suite 700
Fresno, CA 93721
(800) 300-1277

Imperial County

Health Consumer Center of Imperial Valley
California Rural Legal Assistance, Inc.
449 Broadway Avenue
El Centro, CA 92243
(800) 935-9288

Kern County

Kern Health Consumer Center
Greater Bakersfield Legal Assistance
615 California Avenue
Bakersfield, CA 93304
(800) 906-3982

Los Angeles County

Health Consumer Center of Los Angeles
Neighborhood Legal Services of Los Angeles
13327 Van Nuys Blvd.
Pacoima, CA 91331
(800) 896-3203

Orange County

Orange County Health Consumer Action Center
Legal Aid Society of Orange County
2101 N. Tustin Avenue
Santa Ana, CA 92705
(800) 834-5001

Sacramento, El Dorado, Placer & Yolo Counties

Health Rights Hotline
Legal Services of Northern California

519 12th Street
Sacramento, CA 95814
(888) 354-4474

San Diego County

Consumer Center for Health Education & Advocacy
Legal Aid Society of San Diego County
1475 Sixth Avenue, 4th Floor
San Diego, CA 92101
(877) 734-3258

San Francisco & Alameda Counties

Community Health Advocacy Project
Bay Area Legal Aid
50 Fell Street, 1st Floor
San Francisco, CA 94102
(415) 354-6360 for San Francisco and
(510) 250-5270 for Alameda

San Mateo County

Health Consumer Center of San Mateo County
Legal Aid Society of San Mateo
521 East Fifth Avenue
San Mateo, CA 94402
(800) 381-8898 and (650) 558-0915

Statewide Support

National Health Law Program

2639 South La Cienega Blvd.
Los Angeles, CA 90034
(310) 204-6010

Western Center on Law and Poverty

3701 Wilshire Blvd., Suite 208
Los Angeles, CA 90010
(213) 487-7211 and
1107 9th Street, Suite 801
Sacramento, CA 95814
(916) 442-0753