ASSEMBLY BILL No. 1296

Introduced by Assembly Member Bonilla

February 18, 2011

An act to add Part 3.8 (commencing with Section 15925) to Division 9 of the Welfare and Institutions Code, relating to public health.

LEGISLATIVE COUNSEL'S DIGEST

AB 1296, as introduced, Bonilla. Health Care Eligibility, Enrollment, and Retention Act.

Existing law provides for various programs to provide health care coverage to persons with limited financial resources, including the Medi-Cal program and the Healthy Families Program. Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers, as specified, and meets certain other requirements. Existing law, the California Patient Protection and Affordable Care Act, creates the California Health Benefit Exchange (Exchange), specifies the powers and duties of the board governing the Exchange relative to determining eligibility for enrollment in the Exchange and arranging for coverage under qualified health plans, and requires the board to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and qualified small employers by January 1, 2014.

This bill would enact the Health Care Eligibility, Enrollment, and Retention Act, which would require the California Health and Human

Services Agency, in consultation with specified entities, to establish a standardized single application form and related renewal procedures for Medi-Cal, the Healthy Families Program, the Exchange, and county programs, in accordance with specified requirements. The bill would specify the duties of the agency and the State Department of Health Care Services under the act, and would require the agency to report to the Legislature by January 1, 2012, regarding policy changes needed to implement the bill, as specified.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Part 3.8 (commencing with Section 15925) is added to Division 9 of the Welfare and Institutions Code, to read:

PART 3.8. HEALTH CARE ELIGIBILITY, ENROLLMENT, AND RETENTION ACT

15925. (a) This part shall be known, and may be cited, as the Health Care Eligibility, Enrollment, and Retention Act.

(b) (1) By January 1, 2014, the California Health and Human Services Agency, in consultation with the State Department of Health Care Services (department), Managed Risk Medical Insurance Board, the California Health Benefit Exchange (Exchange), counties, health care services plans, consumer advocates, and other stakeholders shall undertake a planning process to develop plans and procedures to implement this part and the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), related to eligibility for, and enrollment and retention in, public health coverage programs.

(2) The agency shall submit a report to the Legislature by January 1, 2012, regarding policy changes needed in order to develop the eligibility, enrollment, and retention system for health coverage in compliance with this part.

(c) A single, standardized paper application shall be used by all entities accepting applications for all public health care programs, including Medi-Cal, the Healthy Families Program, the Exchange,

and county programs. An electronic application and a telephone application shall also be developed, using the same eligibility methodologies. All of these applications shall include simple, user-friendly instructions, and require applicants to answer only those questions that are necessary to determine eligibility for their particular circumstances.

(d) All locations, systems, portals, assistors, or entities of any kind accepting applications for the programs identified in subdivision (c) shall use and accept the applications described in subdivision (c) as an application for all of the described programs. An entity processing applications shall enroll an applicant in the most beneficial program for which the applicant is eligible. If an application is forwarded or transferred among entities for processing, this process shall not impose any burden on the applicant. The applicant shall be informed of how to get information about the status of his or her application at any time.

(e) An applicant shall not be required to provide any verification that is not necessary for the purpose of evaluating eligibility or that may be verified using reliable databases approved by the department for the purpose of evaluating eligibility. An applicant shall be given an opportunity to provide his or her own verifications if he or she prefers, but shall not be required to do so. An applicant shall not be denied eligibility for a program specified in this section without being given an opportunity to correct any information provided by a verifying entity.

(f) Applications shall be evaluated so as to provide a real-time determination of eligibility, including applicable cost sharing and subsidies, whenever possible. When a real-time determination is not possible, an applicant shall be granted presumptive enrollment to the fullest extent allowed by federal law. Presumptive enrollment shall continue until the applicant is enrolled in ongoing coverage under Medi-Cal, the Exchange, Healthy Families, or a county health program, or found to be ineligible for all of these programs and informed of the denial of coverage in accordance with all applicable due process requirements. For purposes of this part, "real-time determination of eligibility" means an eligibility determination made at the time the application is submitted.

(g) The eligibility, enrollment, and retention system shall use a consumer-mediated approach, pursuant to which consumers shall receive assistance to understand decisions they may make,

including those concerning subsidies, plan choice, hardship exemptions, and verifications. This approach shall provide consumers with a meaningful opportunity to provide information that ensures their enrollment in, and retention of, health care coverage, in the most beneficial program for which they are eligible.

(h) At application, renewal, or a transition due to a change in circumstances, consumers shall move seamlessly between programs without providing additional verification, application, or other information.

(i) The department shall develop procedures to ensure continuity of coverage at specific transitions, including, but not limited to, all of the following:

(1) When a consumer reaches 65 years of age.

(2) When a qualified alien reaches the five-year bar for receipt of public benefits, as provided in Section 1613 of Title 8 of the United States Code.

(3) When a foster youth reaches the age upon which his or her foster care benefits terminate.

(4) When family income, assets, household composition, or other circumstances change.

(j) The department shall streamline and coordinate eligibility rules and requirements among the programs identified in subdivision (c) to ensure that all applicants whose income is less than 400 percent of the federal poverty level shall be eligible for one of those programs, and all entities processing applications use the same methodologies to determine which program is most beneficial for each applicant. This process shall include coordination of rules for determining income levels, assets, household size, documentation requirements, and citizenship and identity information, so that all applications result in coverage in the most beneficial program and seamless transition between programs.

(k) The department shall maximize coordination and enrollment in other public benefits programs, including, but not limited to, the California Work Opportunity and Responsibility to Kids (CalWORKs) program, the California Special Supplemental Food Program for Woman, Infants, and Children (WIC), and CalFRESH, both by accepting an application and reporting information from those programs as an application for health benefits, and by using

health benefit applications to initiate applications for those programs, to the extent allowed by federal law.

(*l*) Renewal procedures shall be coordinated across all programs and entities that accept and process renewal information, so as to use all available information to renew benefits or transfer beneficiaries seamlessly between programs without placing a burden on the beneficiary. Renewal procedures shall be as simple and user friendly as possible, shall require beneficiaries to provide only that information which has changed, and shall use all available methods for renewal, including, but not limited to, face-to-face, telephone, and online renewal.

(m) All programs shall use standardized forms and notices and notices to ensure that beneficiaries are fully informed and understand what information is required from them for renewal, if any, and are informed of any transfer, and how the transfer will affect the beneficiary's costs access to care, delivery system, and responsibilities.

(n) (1) The requirement for submitting a report imposed under subdivision (b) is inoperative on January 1, 2016, pursuant to Section 10231.5 of the Government Code.

(2) A report submitted pursuant to subdivision (b) shall be submitted in compliance with Section 9795 of the Government Code.

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