AMENDED IN ASSEMBLY APRIL 25, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

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 amended, 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~~ *forms* 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~~ *April* 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, 2012, the California Health and Human Services Agency, in consultation with the State Department of Health Care Services (department), Managed Risk Medical Insurance Board (MRMIB), the California Health Benefit Exchange (Exchange), counties, health care services plans, consumer advocates, and other stakeholders shall have undertaken a planning process to develop plans and procedures to implement this part and the federal Patient Protection and Affordable Care Act (PPACA) (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 health committees of both houses of the Legislature reflecting the process conducted pursuant to paragraph (1) by April 1, 2012, regarding policy changes needed to develop the eligibility, enrollment, and retention system for health coverage in compliance with this part.

(c) 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.

15926. (a) The following definitions apply for purposes of this part:

(1) "Medi-Cal" includes all Medi-Cal programs, both full scope and limited scope benefits, and includes Medi-Cal with a share-of-cost.

(2) "Public health coverage programs" means Medi-Cal, the Healthy Families Program, the Exchange program of premium tax credits and reduced cost sharing, and county health programs.

(3) "Real-time determination of eligibility" means a final determination of eligibility made at the time the application or retention information is submitted online.

(b) An individual shall have the option to apply for public health coverage programs in person, by mail, online, and by telephone.

(c) A single, standardized paper, electronic, and telephone application form for public health coverage programs shall be developed by the department in consultation with MRMIB and the board governing the Exchange and shall be used by all entities authorized to make an eligibility determination for any of the public health coverage programs and by their agents. The application forms shall satisfy all of the following criteria:

(1) Include simple, user-friendly language and instructions.

(2) Require only that information that is necessary to determine eligibility for the applicant's particular circumstances.

(3) May be used for screening, but shall not be limited to screening. The application form instead shall be an application for public health coverage programs at all stages of submittal, receipt, or acceptance at any location authorized to receive or accept an application for any of the public health coverage programs.

(d) All locations of any kind where applications for any of the public health coverage programs are received or accepted, including physical and telephone locations and Internet Web portals or other electronic systems shall treat the applications described in subdivision (c) as an application for all of the public health coverage programs. The entity making the eligibility determination shall enroll the applicant in the most beneficial public health coverage program for which the applicant is eligible.

If an application is forwarded or transferred between or among entities for processing, this process shall not require the applicant to submit any new information that is not necessary to determine her or his eligibility. The applicant shall be informed at the time of application how to obtain information about the status of his or her application at any time and the information shall be promptly provided when requested.

(e) The application form described in subdivision (c) shall be designed to identify infants under the age of one year who are deemed eligible at birth without an application to Medi-Cal under Section 1396a(e)(4) of Title 42 of the United States Code or to the Healthy Families Program under Section 12693.70 of the Insurance Code. An infant who is deemed eligible shall be enrolled upon identification, and the infant's family shall not be required to complete the application process.

(f) Nothing in this section shall preclude the use of a provider-based application form for public health coverage programs that differs from the application form described in subdivision (c) to comply with any of the following:

(1) The form and procedures used by the Child Health and Disability Prevention Program (CHDP) Gateway under Section 14011.7 of the Welfare and Institutions Code and by Medi-Cal's presumptive eligibility program for pregnant women under Section 14148.7 of the Welfare and Institutions Code for children and pregnant women in families with income at or below 200 percent of the federal poverty level shall be modified in the simplest way permitted by federal law to do both of the following:

(A) Serve as an application for ongoing coverage to Medi-Cal, and, for children, to the Healthy Families Program.

(B) Provide for a program of accelerated enrollment through which children and pregnant women screened eligible are immediately enrolled from the medical point of service into coverage with benefits continuing until a final eligibility determination is made.

(2) The department shall adopt a process for prenatal care providers to submit the application form for pregnant women required by paragraph (1) online.

(3) The department shall adopt a process for hospitals to enroll infants deemed eligible for Medi-Cal under Section 1396a(e)(4) of Title 42 of the United States Code or the Healthy Families

Program under Section 12693.70 of the Insurance Code immediately online, without an application.

(g) An applicant or recipient for a public health coverage program shall be given the option, with his or her informed consent, to have the application or renewal form prepopulated or electronically verified in real time, or both, using person information from his or her own public health coverage program or other public benefits case file or that of a parent or child or electronic databases authorized by the PPACA.

(1) An applicant or recipient who chooses a prepopulated application or renewal shall be given an opportunity, before the application or renewal form is submitted to the entity authorized to make eligibility determinations, to provide additional eligibility information and to correct any information retrieved from a database.

(2) An applicant or recipient who chooses electronic real-time verification shall be permitted to provide additional eligibility information and to correct information retrieved from a database any time before or after a final eligibility determination is made. An applicant shall not be denied eligibility for any public health coverage program without being given a reasonable opportunity, at least to the extent provided for under the Medi-Cal program, for citizenship documentation, to resolve discrepancies concerning any information provided by a verifying entity. Applicants shall receive benefits pending this reasonable opportunity period.

(h) (1) Eligible applicants shall be granted eligibility and immediately enrolled into a public health coverage program whenever possible. When granting eligibility immediately is not possible for an applicant who appears to be eligible based on the information provided in the application, both of the following shall apply to the fullest extent permitted by federal law with federal financial participation:

(A) The applicant shall be immediately enrolled into a program of presumptive eligibility for children, pregnant women, and adults.

(B) Presumptive eligibility shall continue until the applicant is enrolled in ongoing coverage through a public health coverage 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.

(2) Notwithstanding paragraph (1), before an online applicant who appears to be eligible for the Exchange with a premium tax credit or reduction in cost sharing, or both, may be enrolled in the Exchange, all of the following shall occur:

(A) The applicant shall be clearly informed of the overpayment penalties under the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (H.R. 4), if the individual's annual family income increases by a specified amount or more, calculated on the basis of the individual's current family size and current income, and that penalties are avoided by prompt reporting of income increases throughout the year.

(B) The applicant shall be fully informed of the penalty for failure to have minimum essential health coverage.

(C) The applicant shall be given the option to decline immediate enrollment while final eligibility is being determined.

(i) The eligibility, enrollment, and retention system shall ensure that applicants and recipients receive assistance to understand decisions they may make, including, but not limited to, those concerning hardship exemptions from the individual mandate, the premium tax credit and cost-sharing reductions for the Exchange, and penalties for overpayments, verifications, and plan choice. Applicants and recipients shall also be given a meaningful opportunity to provide information on their applications and renewal forms that ensures their enrollment in, and retention of, health care coverage, in the most beneficial program for which they are eligible.

(j) At application, renewal, or a transition due to a change in circumstances, eligible applicants and recipients of public health coverage programs shall move seamlessly between programs without any breaks in coverage and without being required to provide duplicative or otherwise unnecessary verification, forms, or other information.

(k) 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 child reaches 19 years of age.

(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 affecting eligibility change.

(l) The department shall, in coordination with MRMIB and the Exchange board, streamline and coordinate all eligibility rules and requirements among Medi-Cal, the Healthy Families Program, and the Exchange premium tax credit and reduced cost-sharing using the least restrictive rules and requirements to ensure that all applicants whose income is less than 400 percent of the federal poverty level shall be determined eligible for Medi-Cal, the Healthy Families Program, or the Exchange when they meet the eligibility requirements and that all entities processing applications use the same least restrictive 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, citizenship and immigration status, and documentation and verification requirements, so that all applications of eligible persons result in coverage in the most beneficial program and seamless transition between programs.

(m) Renewal procedures shall be coordinated across all public health coverage programs and among entities that accept and make eligibility determinations so as to use all relevant information already included in the individual's Medi-Cal, other public benefits, the Healthy Families Program, or Exchange case file, or that of the individual's parent or child, or electronic databases authorized for data sharing by the PPACA to renew benefits or transfer eligible recipients seamlessly between programs without a break in coverage and without requiring a recipient to provide redundant information. Renewal procedures shall be as simple and user-friendly as possible, shall require recipients to provide only information which has changed, if any, and shall use all available methods for reporting renewal information, including, but not limited to, face-to-face, telephone, and online renewal. To the maximum extent allowed under federal law, a recipient shall be permitted to update her or his eligibility information at any point and thereby restart the period for her or his annual redetermination. Eligibility for public health coverage programs shall be automatically renewed whenever any public benefits program renewal is conducted.

(n) The eligibility, enrollment, and retention system shall be both transparent and accountable to the public by complying with, but not limited to, the following:

(1) The department, the California Health and Human Services Agency, MRMIB, and the Exchange board shall provide a forum in which the public, including consumers and their advocates, may on a regular basis, and no less than once a month, give feedback in person on the implementation of the eligibility, enrollment, and retention system, including activities of any public or private entity or individual providing eligibility screening or application or retention assistance, for timely corrective action by the department, MRMIB, and the Exchange board.

(2) In designing and implementing the eligibility, enrollment, and retention system, the department, MRMIB, and the Exchange board shall do both of the following:

(A) Provide for evaluation of information technology (IT) programming by an independent expert before implementation. This evaluation shall be made available to the public sufficiently in advance of implementation to allow for an opportunity for review and comment.

(B) Provide for annual postimplementation evaluation by an independent expert using data points developed in consultation with stakeholders, including consumers and their advocates. This evaluation shall be made available to the public within a reasonable time period.

(3) The duties of the department, the California Health and Human Services Agency, MRMIB, and the Exchange board under this subdivision shall include the duty to monitor and oversee private as well as public entities engaged in screening for eligibility for a public health coverage program to ensure that the correct eligibility rules and requirements are being used by the screener when informing an individual about his or her potential eligibility, that updates to the eligibility rules and requirements used by the screener are made correctly and on a timely basis, and that the screener strictly adheres to the privacy and confidentiality provisions of subdivision (o).

(o) In designing and implementing the eligibility, enrollment, and retention system, the department, MRMIB, and the Exchange board shall ensure that all privacy and confidentiality rights under the PPACA, other federal and California laws and regulations,

the Medi-Cal Program, and the Healthy Families' Program are strictly incorporated and followed. This includes, but is not limited to, adopting and implementing policies and procedures to ensure all of the following:

(1) Only that information that is strictly necessary for an eligibility determination for the individual who is seeking enrollment in or renewal for a public health coverage program shall be requested in the application, retention, and renewal process for that program.

(2) Verification from a third party or database shall be sought only with respect to information required to be obtained or verified under federal law to determine eligibility for the public health coverage program at issue for an individual.

(3) Applicants and recipients shall be given clear, complete, user-friendly information regarding how their personal information will be used, disseminated, secured, verified, and retained by public health coverage programs.

(4) An applicant or recipient shall not be required by the department, MRMIB, the Exchange board, or any public or private entity or individual providing eligibility screening or application or retention assistance to agree to the sharing of his or her personal information without informed consent as a condition of being screened for, applying to, or renewing eligibility for a public health coverage program. Applicants and recipients shall have the option to decline online screening, application, renewal, and electronic verification and instead may apply or renew in person, by mail, or by telephone.

(5) Responses to security breaches shall be conducted according to the strictest requirements of privacy and confidentiality laws, including, but not limited to, implementation of a plan to directly provide information about the breach to anyone whose personal information has been confirmed or suspected to have been compromised, stolen, or viewed by anyone without authorized access.

(p) All programs shall use standardized forms and notices, as appropriate, to timely inform recipients in advance of all of the following:

(1) What information, if any, is required from them for renewal.

(2) Whether transfer to another public health coverage program is to occur.

(3) How the transfer will affect the recipient's cost, access to care, delivery system, and responsibilities.

~~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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