Assembly Bill No. 1296

CHAPTER 641

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

[Approved by Governor October 9, 2011. Filed with Secretary of State October 9, 2011.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1296, 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 Reform Eligibility, Enrollment, and Retention Planning Act, which would require the California Health and Human Services Agency, in consultation with specified entities, to establish standardized single, accessible application forms and related renewal procedures for state health subsidy programs, as defined, 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 provide specified information to the Legislature by July 1, 2012, regarding policy changes needed to implement the bill. The application development requirements of the bill would otherwise be operative January 1, 2014, except as specified.

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 REFORM ELIGIBILITY, ENROLLMENT, AND RETENTION PLANNING ACT

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

(b) (1) 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), the California Office of Systems Integration, counties, health care service plans, consumer advocates, and other stakeholders shall undertake a planning and development process regarding this part and aspects of 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), and regulations or guidance issued pursuant to these acts, related to eligibility for, and enrollment and retention in, state health subsidy programs.

(2) The planning and development process shall provide stakeholders the opportunity to provide meaningful input into the planning and development of the aspects of eligibility, enrollment, and retention identified in this section. This process shall be completed in time for all of the following to occur:

(A) The certification and approval of the eligibility, enrollment, and retention system, as required by PPACA and regulations and guidance issued thereunder.

(B) The approval of enhanced federal funding for Medi-Cal eligibility system development, implementation, and maintenance.

(C) The readiness of the eligibility, enrollment, and retention processes to accept and process applications, as required by federal law.

(3) The planning and development process shall consider issues, including, but not limited to, all of the following:

(A) Whether to use the application developed by the federal Secretary of Health and Human Services, pursuant to Section 1413 of the PPACA (42 U.S.C. Sec. 18083), or whether to develop a separate state form.

(B) What process to use for Medi-Cal eligibility determinations for non-Modified Adjusted Gross Income (MAGI) populations, including whether to develop a supplemental application form and how the applications will be processed.

(C) Whether to 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.

(D) What data collection standards to utilize for the collection of race, ethnicity, primary language, and disability status.

(E) Whether to create a process to allow recipients to provide an update to eligibility information in between renewal dates and to have the option to renew eligibility at the time of the update, resetting the renewal date.

(F) Whether to renew eligibility for a state health subsidy program based on information from a public benefits program, if the recipient is otherwise eligible.

(G) Protections for the confidentiality of personal information.

(H) What process to use to enable applicants determined eligible for and recipients of a state health subsidy program to choose a health plan, if applicable.

(4) The agency shall provide the appropriate fiscal and policy committees of the Legislature with information reflecting the process conducted pursuant to paragraph (1) by July 1, 2012, regarding policy and statutory changes needed to develop and implement the eligibility, enrollment, and retention system for health coverage in compliance with this part.

(c) The information reporting requirement imposed under paragraph (4) of 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) "Accessible" means in compliance with Section 11135 of the Government Code, Section 1557 of the PPACA, and regulations or guidance adopted pursuant to these statutes.

(2) "Limited-English-proficient" means not speaking English as one's primary language and having a limited ability to read, speak, write, or understand English.

(3) "State health subsidy programs" means the programs described in Section 1413(e) of PPACA.

(b) An individual shall have the option to apply for state health subsidy programs in person, by mail, online, by facsimile, or by telephone.

(c) (1) A single, accessible, standardized paper, electronic, and telephone application for state health subsidy programs shall be developed by the department in consultation with MRMIB and the board governing the Exchange as part of the stakeholder process described in subdivision (b) of Section 15925. The application shall be used by all entities authorized to make an eligibility determination for any of the state health subsidy programs and by their agents.

(2) The application shall be tested and operational by the date as required by the federal Secretary of the Health and Human Services.

(3) The application form shall, to the extent not inconsistent with federal statutes, regulations, and guidance, satisfy all of the following criteria:

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

(B) Do not ask for information related to a nonapplicant that is not necessary to determine eligibility in the applicant's particular circumstances.

(C) Require only information necessary to support the eligibility and enrollment processes for state health subsidy programs.

(D) May be used for, but shall not be limited to, screening.

(E) Ask, or be used otherwise to identify, if the mother of an infant applicant under one year of age had coverage through a state health subsidy program for the infant's birth, for the purpose of automatically enrolling the infant into the applicable program without the family having to complete the application process for the infant.

(F) Include questions that are voluntary for applicants to answer regarding demographic data categories, including race, ethnicity, primary language, disability status, and other categories recognized by the federal Secretary of Health and Human Services under Section 4302 of the PPACA.

(d) Nothing in this section shall preclude the use of a provider-based application form or enrollment procedures for state health subsidy programs or other health programs that differs from the application form described in subdivision (c), and related enrollment procedures.

(e) The entity making the eligibility determination shall grant eligibility immediately whenever possible and with consent of the applicant in accordance with the state and federal rules governing state health subsidy programs.

(f) (1) If the eligibility, enrollment, and retention system has the ability to prepopulate an application form for insurance affordability programs with personal information from available electronic databases, an applicant shall be given the option, with his or her informed consent, to have the application form prepopulated. Before a prepopulated renewal form or, if available, prepopulated application is submitted to the entity authorized to make eligibility determinations, the individual shall be given the opportunity to provide additional eligibility information and to correct any information retrieved from a database.

(2) All state health subsidy programs may accept self-attestation, instead of requiring an individual to produce a document, with respect to all information needed to determine the eligibility of an applicant or recipient, to the extent permitted by state and federal law.

(3) An applicant or recipient shall have his or her information electronically verified in the manner required by PPACA and implementing federal regulations and guidance.

(4) Before an eligibility determination is made, the individual shall be given the opportunity to provide additional eligibility information and to correct information.

(5) An applicant shall not have his or her eligibility delayed or denied for any state health subsidy program without being given a reasonable opportunity, of at least the kind provided for under the Medi-Cal program pursuant to Section 14007.5 and paragraph (7) of subdivision (d) of Section 14011.2, to resolve discrepancies concerning any information provided by a verifying entity.

(6) To the extent federal financial participation is available, an applicant shall be provided benefits in accordance with the rules of the state health subsidy program, as implemented in federal regulations and guidance, for

which he or she otherwise qualifies until a determination is made that he or she is not eligible and all applicable notices have been provided.

(g) The eligibility, enrollment, and retention system shall offer an applicant and recipient assistance with his or her application or renewal for a state health subsidy program in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient.

(h) (1) During the processing of an application, renewal, or a transition due to a change in circumstances, an entity making eligibility determinations for a public health coverage program shall ensure that an eligible applicant and recipient of state health subsidy programs that meets all program eligibility requirements and complies with all necessary requests for information moves between programs without any breaks in coverage and without being required to provide any forms, documents, or other information or undergo verification that is duplicative or otherwise unnecessary. The individual shall be informed how to obtain information about the status of his or her application, renewal, or transfer to another program at any time, and the information shall be promptly provided when requested.

(2) An individual screened as not eligible for Medi-Cal on the basis of Modified Adjusted Gross Income (MAGI) household income but who may be potentially eligible for Medi-Cal on another basis shall have his or her application or case forwarded to the Medi-Cal program for an eligibility determination. During the period this application or case is processed for a non-MAGI Medi-Cal eligibility determination, if the applicant or recipient is otherwise eligible for a state health subsidy program, he or she shall be determined eligible for that program.

(3) Renewal procedures shall include all available methods for reporting renewal information, including, but not limited to, face-to-face, telephone, and online renewal.

(4) An applicant who is not eligible for a state health subsidy program for a reason other than income eligibility, or for any reason in the case of applicants and recipients residing in a county that offers a health coverage program for individuals with income above the maximum allowed for the Exchange premium tax credits, shall be referred to the county health coverage program in his or her county of residence.

(i) Notwithstanding subdivisions (e), (f), and (j), 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, both of the following shall occur:

(1) The applicant shall be informed of the overpayment penalties under the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (Public Law 112-9), 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.

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

(j) The department shall, in coordination with MRMIB and the Exchange board, streamline and coordinate all eligibility rules and requirements among state health subsidy programs using the least restrictive rules and requirements permitted by federal and state law. This process shall include the consideration of methodologies for determining income levels, assets, rules for household size, citizenship and immigration status, and self-attestation and verification requirements.

(k) (1) Forms and notices developed pursuant to this section shall be accessible and standardized, as appropriate, and shall comply with federal and state laws, regulations, and guidance prohibiting discrimination.

(2) Forms and notices developed pursuant to this section shall be developed using plain language and shall be provided in a manner that affords meaningful access to limited-English-proficient individuals, in accordance with applicable state and federal law, and at a minimum, provided in the same threshold languages as Medi-Cal managed care.

(*l*) The department, the California Health and Human Services Agency, MRMIB, and the Exchange board shall establish a process for receiving and acting on stakeholder suggestions regarding the functionality of the eligibility systems supporting the Exchange, including the activities of all entities providing eligibility screening to ensure the correct eligibility rules and requirements are being used. This process shall include consumers and their advocates, be conducted no less than quarterly, and include the recording, review, and analysis of potential defects or enhancements of the eligibility systems. The process shall also include regular updates on the work to analyze, prioritize, and implement corrections to confirmed defects and proposed enhancements, and to monitor screening.

(m) 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 and other federal and state laws are incorporated and followed, including responses to security breaches.

(n) Except as otherwise specified, this section shall be operative on and after January 1, 2014.

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