

Date of Hearing: June 11, 2013

ASSEMBLY COMMITTEE ON HEALTH
Richard Pan, Chair
SB 1 X1 (Ed Hernandez) – As Amended: June 4, 2013

SENATE VOTE: 24-7

SUBJECT: Medi-Cal: eligibility.

SUMMARY: Enacts statutory changes necessary to implement the Medicaid (Medi-Cal in California) and the California Children's Health Insurance (CHIP) coverage expansion, eligibility, simplified enrollment, and retention provisions of the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010 (ACA). Specifically, this bill:

I. Expands Medi-Cal coverage as follows:

- 1) Effective January 1, 2014, expands eligibility for Medi-Cal coverage to adults who are under age 65, not pregnant, and not otherwise currently eligible for Medi-Cal coverage, up to 133% of the federal poverty level (FPL) plus a 5% income disregard and provides full-scope Medi-Cal benefits and as supplemented under 2) below.
- 2) Requires the Department of Health Care Services (DHCS) to obtain approval from the U.S. Secretary of Health and Human Services (HHS) to establish a benchmark benefit package that includes the same benefits, services, and coverage that are provided to all other full-scope Medi-Cal enrollees supplemented by any benefits, services, and coverage included in the essential health benefits (EHBs) package adopted by the state applicable to small and individual group insurance markets and approved by the Secretary of HHS for the population eligible for Covered California through the California Health Benefit Exchange (Exchange) and any successor EHB package adopted by the state for the expansion population.
- 3) Requires the transition of persons currently enrolled in a Low-Income Health Program (LIHP) under California's Bridge to Reform Section 1115(b) waiver to the new Medi-Cal expansion program in accordance with the state transition plan that was approved by the federal Centers for Medicare and Medicaid Services (CMS).
 - a) Requires a person enrolled in a LIHP to be simultaneously notified by DHCS, at least 60 days prior to January 1, 2104, of all of the following:
 - i) Which health plan includes his or her current medical home provider;
 - ii) That the LIHP enrollee will be assigned to a plan that includes his or her medical home effective January 1, 2014, unless he or she chooses to change plans and no additional action is required if he or she wants to keep his or her medical home; and,
 - iii) If his or her medical home is not contracted with any of the available Medi-Cal managed care plans (MCPs), he or she will receive informing materials and if a plan is not selected within 30 days, he or she will be automatically assigned to a plan.

- b) Requires, in counties where there is no MCP, LIHP enrollees to be notified that they will be transitioned to Fee-For-Service (FFS) Medi-Cal as of January 1, 2014, informed as to whether their LIHP medical home provider is a Medi-Cal FFS provider, provided instructions on how to access services, given a list of Medi-Cal FFS providers by area of practice and with contact information, and provided any other information required to be sent to new enrollees.
 - c) Requires DHCS to consult with stakeholders, as specified, in developing the notices required and notices to be sent to LIHP enrollees at the time of their 2013 redetermination and again at least 90 days prior to the transition to ensure that no person loses coverage.
- 4) Commencing January 1, 2014, provides, to the extent federal financial participation (FFP) is available, an adolescent who is in foster care on his or her 18th birthday to be deemed eligible without interruption and without requiring a new application, and requires the following:
- a) DHCS to develop procedures to identify and enroll individuals under age 26 who meet the criteria as former foster care youth, including those who lost coverage as result of attaining the age of 21. DHCS to work with counties to identify and conduct outreach to former foster care adolescents who lost coverage as result of attaining the age of 21;
 - b) DHCS to develop and implement a simplified redetermination form and require return of the form only if information known to DHCS is no longer accurate or is materially incomplete;
 - c) DHCS to seek federal approval to institute a renewal process that allows a former foster youth covered under this section to remain on FFS Medi-Cal after a redetermination form is returned as undeliverable and the county is otherwise unable to establish contact, until contact is reestablished;
 - d) Termination of eligibility only after a determination that the individual is no longer eligible and all due process requirements have been met; and,
 - e) DHCS to provide Medi-Cal benefits to individuals under age 26, who were in foster care and enrolled in Medicaid in any state.
- 5) Establishes a premium assistance program for legal immigrants who would otherwise be eligible for Medi-Cal coverage under the expansion for childless adults, but for the five-year eligibility limitations and are eligible for advanced premium tax credit.
- a) Requires DHCS to pay the person's insurance premium, minus the premium tax credit and the cost-sharing expenses, as specified.
 - b) Provides for state-only funded benefits if the person is unable to enroll in the Exchange.
 - c) Provides that the person is to be eligible for services that he or she would have been eligible for under the Medi-Cal program to the extent they are not provided through the Exchange.

- d) Requires DHCS to inform and assist such individuals with enrolling in coverage in the Exchange, with premium assistance, cost-sharing, and benefits in a way that ensures seamless transition.

II. Effective January 1, 2014, provides pregnancy coverage as follows:

- 1) Revises the period of coverage for pregnant women in the Access for Infants and Mothers (AIM) program from 60 days after the end of the pregnancy to the end of the month in which the 60th day occurs, in order to align eligibility with open enrollment in Covered California.
- 2) Provides coverage to children born of women in the AIM program up to age two.
- 3) Provides that pregnant women who are currently eligible for pregnancy-related and postpartum services in the Medi-Cal program are to be eligible for full-scope Medi-Cal services provided to other eligible adults.

III. Converts income eligibility to a Modified Adjusted Gross Income (MAGI)-based standard, effective January 1, 2014, as follows:

- 1) Requires DHCS to convert existing Medi-Cal, CHIP, and AIM income eligibility standards to a MAGI-based income equivalency level for parents of dependent children, caretaker relatives, children, and pregnant women.
- 2) Defines caretaker relative as a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care, and is one of a specified list of relatives such as parent, stepparent, grandparent, sibling, cousin, aunt or uncle, or the spouse or registered domestic partner of one of the listed relatives.
- 3) Provides that the maximum eligibility level is not to be less than the dollar amount that is equivalent to the income level, expressed as a percent of FPL for each eligibility group, plus all applicable income disregards, exclusions, and deductions in effect on March 23, 2010, to ensure that any population eligible for Medi-Cal, AIM, or the Healthy Families Program does not lose coverage.
- 4) Provides that any individual whose income eligibility is determined by means of the MAGI-based standard is not to be subject to a limitation on assets or resources.
- 5) Repeals the provisions establishing eligibility for the Section 1931(b) program that sets the maximum income at 100% FPL, authorizes additional income disregards and deductions, and requires that Medi-Cal eligibility for these families is based on establishing "deprivation" of a child, as defined.
- 6) Applies a standardized 5% income disregard for determining income eligibility for any individual, whose income eligibility is determined by means of the MAGI-based standard, in effect setting the 133% FPL standard at 138%, and sets this as the minimum income eligibility level.
- 7) Requires DHCS to adopt procedures that take into account future changes in income and family size in order to grant or maintain eligibility for those who may become ineligible or would be

ineligible if the determination was based solely on the current income and family size at the point at which eligibility is being determined, as follows:

- a) Requires, for currently eligible individuals, financial eligibility to be based on projected annual household income for the remainder of the current calendar year if an income calculation based on the current monthly income would result in an ineligible income level;
 - b) Requires, for new applicants, financial eligibility to be based on projected annual household income and family size for that year if a determination made solely on current monthly income and family size would result in a determination of income ineligibility; and,
 - c) Requires DHCS to implement a method to account for reasonably predictable decreases in income and increase in family size, based on a history of predictable income fluctuations or other clear indicia of future decrease in income and increase in family size. Prohibits the assumption of potential future increases in income or decreases in family size to make the individual ineligible in the current month.
- 8) For purposes of determining eligibility using the MAGI-bases standard, requires individuals less than 19 years of age, or in the case of full-time students, individuals up to age 21 be included in the household.

IV. Simplifies applications and the redetermination process, effective January 1, 2014, as follows:

- 1) Repeals the requirement that adults file mandatory semiannual status reports regardless of whether there have been any changes in income, family size, or other factors that affect continued eligibility for the MAGI-based categories and eliminates the requirement that a notice of action include the requirement to file this status report.
- 2) Codifies and revises existing regulations that define residency by repealing the requirement that a determination of residency is not to be granted unless the evidence supports intent to remain indefinitely. Authorizes new emergency regulations, and requires that residency is established as follows:
 - a) For an individual 21 years of age or older or under 21 years of age who is capable of indicating intent and is emancipated or married, an attestation that he or she lives in the state and either intends to reside in the state or has entered the state with a job commitment or to seek employment. Specifies that the individual is not required to have a fixed address or to be currently employed;
 - b) An individual under 21 years of age who does not qualify under a) above and is not eligible for Medi-Cal as a foster child, or by virtue of a linkage to other public programs, state residency is established if the child lives in the state, no fixed address is required, or the child resides with a parent, parents, or caretaker relative who meet the requirements of a) above; or,
 - c) For individuals, including those under age 21, who are incapable of stating intent or who are living in an institution, requires that the state of residency be determined by intent to reside, where the parents or guardians reside, whether they are receiving specified

financial assistance or other applicable circumstances.

- 3) Revises provisions relating to an individual who maintains a residence outside the state for at least two months and is terminated due to failure to provide required documentation of continued residence in California and who reapplies, to require the person to be reinstated upon a showing of residence in the state and that no permanent residence has been established in another state, provided other eligibility criteria are met.
- 4) Revises, reenacts, and recasts provisions relating to proof of state residency and requires state residency to be verified electronically using information from specified state databases such as the Franchise Tax Board or the Department of Motor Vehicles. If DHCS is unable to verify state residency using these sources, residency is to be established as follows:
 - a) For an individual 21 years of age or older who is capable of indicating intent;
 - i) Specified documentation, such as recent rent or mortgage receipts; a current California driver's license; evidence of employment or that the person is seeking employment in the state; evidence that the person's children are enrolled in a school in the state; or, a declaration of intent to reside under penalty of perjury, but is without a fixed address; and,
 - ii) A declaration under penalty of perjury that the person doesn't own or lease a principal residence outside the state and is not receiving public assistance outside the state.
 - b) Further allows specified verification for an individual over 21 and incapable of stating intent and living in an institution or is under 21 and living in an institution, consistent with federal regulations, such as declarations under penalty of perjury from parents, caretaker relative, guardians or other specified persons that he or she is a resident or that the person was a resident at the time of institutionalization, as appropriate.
 - c) For an individual under 21 years of age who is capable of indicating intent and is emancipated or married, residency is to be established under 4) a) above.
- 5) Repeals, reenacts, and recasts provisions relating to the annual redetermination of eligibility and a redetermination triggered by a change in circumstances that may affect eligibility and applies uniform rules to all individuals who are eligible for Medi-Cal based on MAGI to do the following:
 - a) Provide that all Medi-Cal enrollees whose eligibility is MAGI-based are to have their eligibility redetermined every 12 months, unless otherwise provided;
 - b) Require the county to gather available relevant information in the beneficiary's file, including but not limited to files opened or closed in the past 90 days for Medi-Cal, the CalWorks, or CalFresh, and if based on this information, the county is able to make a redetermination of eligibility to do so, notify the individual what information has been relied on and that if any information is inaccurate, he/she is required to notify the county, but is not otherwise required to respond; and, include any other related information such as if the individual is in a different Medi-Cal program;

- c) In the case of a change of circumstances that requires a redetermination, but does not affect eligibility, no notice is to be sent unless otherwise required;
 - d) In the case of an annual eligibility redetermination, if the county is unable to determine eligibility pursuant to a) above, requires the beneficiary to be sent an annual renewal form that is prepopulated with the information already available and identifies any additional required information, inform the person that it must be completed and returned within 60 days, in person, by mail, (in either case it must be signed), by telephone, internet, or other commonly available electronic means, and how to obtain more information;
 - i) Requires the county to try to contact the person during the 60 days to collect information;
 - ii) If the person has not responded within the 60 days, the person's eligibility is to be terminated following a timely notice; or,
 - iii) If the person responds, but the information is insufficient, requires the county to follow current procedures that apply when a redetermination is triggered by the receipt of new information by attempting to reach the person in order to obtain the missing information and if unsuccessful to send a form that states what information is still needed, allows the person 20 days to respond and provides an additional 10 days to obtain the missing information before termination of eligibility.
 - e) Requires the renewal form required pursuant to d) above to be developed in consultation with the counties, representatives of eligibility workers, and consumers.
 - f) Revises existing law to allow change of circumstances information to be provided through any modes of submission allowed under federal law, including internet, telephone, mail, in person, and other commonly available electronic means, including signatures by electronic, telephonic, and/or hand written transmitted by electronic means, as authorized by DHCS, and including forms required to be signed under penalty of perjury.
 - g) Revises the period in which a person's eligibility may be reinstated from 30 days to 90 days if the person submits a signed and completed form or otherwise provides the needed information.
- 6) Revises provisions that allow a county to use contact information received from a person's MCP as part of its required efforts to maintain the most current contact information to require the county to attempt to contact the person to confirm accuracy instead of requiring a consent form developed by DHCS developed to be on file and authorizes DHCS to adopt emergency regulations.
- 7) Requires DHCS to develop prepopulated renewal forms, in consultation with specified stakeholders, to also be used for persons whose eligibility is not MAGI-based by January 1, 2015, and allows counties to use existing renewal forms until then.

- 8) Clarifies that blindness and disability are to be considered continuing until a determination is made otherwise, as specified.
- 9) Provides that if a person is found ineligible for Medi-Cal, after a redetermination, the electronic account is to be transferred to another insurance affordability program (Covered California) via secure electronic interface.
- 10) Requires DHCS to provide assistance to any applicant or beneficiary, who requests help with an application or with the redetermination process, requires assistance to be available in person, over the telephone, and online in a manner that is accessible to individuals with disabilities or with limited English proficiency. Requires DHCS to adopt emergency regulations no later than July 1, 2015, to implement this provision, deems the first adoption and one readoption an emergency, and conditions implementation on the availability of FFP.

V. Establishes eligibility protocols and call center operations, effective October 1, 2013, as follows:

- 1) Provides that DHCS is to retain or delegate the authority to perform Medi-Cal determinations, as specified.
- 2) Allows DHCS and the Exchange to electronically determine eligibility for Medi-Cal of an applicant who applies using an electronic or paper application processed by the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) and is completed after an assessment and verification of potential eligibility, using only the information initially provided online or through the written application and using the MAGI-based income standard, without further staff review to verify the accuracy.
- 3) Except for applications pursuant to 2) above, the county of residence is to be responsible for determinations and ongoing case management for the Medi-Cal program.
- 4) Authorizes the Exchange to provide information regarding the available MCP selection options to applicants determined eligible for Medi-Cal based on the MAGI-based income standard; allows those applicants to choose an MCP; and, authorizes the recording of the plan selection into CalHEERS for reporting to DHCS.
- 5) Authorizes implementation by all-county or all-plan letters or other similar instructions in lieu of taking regulatory action, requires reports to the Legislature, conditions implementation on federal approval and provides that it is to be effective from October 1, 2013 until July 1, 2015.
- 6) Requires a workflow transfer protocol to be established so that persons who call the customer center operated by the Exchange to apply for an insurance affordability program are only asked those questions essential to reliably ascertain potential eligibility for Medi-Cal and to determine an appropriate point of referral. Requires after the transfer workflow process:
 - a) If it appears that one or more members of the household are eligible for Medi-Cal on a MAGI-based income standard, the Exchange refer the person to the county of residence or other county resource for completion of the application and, subject to income limitations, review, and approval of DHCS, also refer the caller if the household appears

- to include someone who is pregnant, potentially disabled, over age 65, or in need of long-term care services;
- b) The county to proceed with the assessment and perform any required eligibility determinations and the Exchange to transmit all information relative to the application to the county of residence or other appropriate county resource via secure electronic interface without undue delay;
 - c) If the Exchange determines that the household appears to include only individual(s) not potentially eligible for Medi-Cal benefits, the Exchange is to proceed with the eligibility determination; and,
 - d) Begin coverage immediately upon determination if it subsequently turns out that a member of the household is eligible for Medi-Cal using MAGI-based income standard, with the county of residence responsible for final confirmation.
- 7) Unless otherwise provided, establishes the county of residence as responsible for eligibility determinations and ongoing case management for the Medi-Cal program.
- 8) Requires DHCS, the Exchange, and each county consortia to enter into an interagency agreement specifying operational parameters and performance standards, in consultation with specified interested stakeholders and requires, prior to October 1, 2014, DHCS to review, in consultation with specified stakeholders, the efficacy of the enrollment procedures established by this bill.
- 9) Provides, only during the initial open enrollment period established by the Exchange and in no event after June 30, 2014, if after applying the transfer protocol, the Exchange determines that the household is a mixed household of persons potentially eligible for MAGI-based Medi-Cal and those who are potentially ineligible for Medi-Cal, a process for an initial determination of the Medi-Cal eligibility and a final confirmation by the county of residence, which is to send out notices without imposing any additional burdens on the applicant.

VI. Includes general provisions as follows:

- 1) Makes legislative findings and declarations that the U.S. is the only industrialized country without a universal health insurance system; that 46 million Americans under age 65 do not have health insurance; that 7.1 million nonelderly Californians were uninsured in 2009, amounting to 21.1% of nonelderly and up nearly 2% from 2007; that the ACA was signed into law on March 23, 2010, is the culmination of decades of movement towards health care reform, and is the most fundamental legislative transformation of the U.S. health care system in 40 years; and, that as a result of enactment between 89% and 92% of Californians under 65 years of age will have health coverage and between 1.2 and 1.6 million individuals will be newly enrolled in Medi-Cal. States it is the intent of the Legislature to ensure full implementation of the ACA, including the Medi-Cal expansion for individuals with incomes below 133% of the FPL, so that millions of uninsured Californians can receive health care coverage.
- 2) Requires DHCS, in collaboration with the Exchange, the counties, consumer advocates, and the Statewide Automated Welfare System consortia, to develop and prepare one or more

reports that are issued at least quarterly and are made publicly available within 30 days following the end of each quarter, for the purpose of informing the California Health and Human Services Agency (CHHSA), the Exchange, the Legislature, and the public about the enrollment process for all insurance affordability programs.

- 3) Revises current law to require, instead of authorize, all insurance affordability programs, to accept self-attestation, instead of requiring production of documentation for age, date of birth, family size, household income, state residency, pregnancy, and any other applicable criteria permitted under the ACA.
- 4) Authorizes an individual applying for an insurance affordability program to be accompanied, assisted, and represented in the application and renewal process by individuals or organizations of his or her choice. Provides that that specified persons may apply or renew on behalf of an individual who is unable to apply or renew on their own behalf. Authorizes a person who wishes to challenge an eligibility decision to be represented by herself, himself, legal counsel, or other specified spokespersons of his or her choice, provides that this section is effective October 1, 2013, and may be implemented by emergency regulations.
- 5) Specifies, in furtherance of the intent of the Legislature to protect individual privacy and the integrity of the Medi-Cal program and other insurance affordability programs by restricting the disclosure of personal identifying information to prevent theft, fraud, and abuse where an applicant or enrollee appoints an authorized representative (AR), the following is to be effective October 1, 2013, or when all necessary federal approvals have been obtained:
 - a) DHCS, in consultation with the Exchange, is to implement policies and prescribe forms, notices, and other safeguards and to adopt emergency regulations, as specified;
 - b) A requirement for an AR to be effective, a completed authorization form must be obtained electronically, telephonically or handwritten, with authorization to specify the scope of the authority, what notices are to be sent to the AR, and that it is effective until canceled or modified, or the AR is otherwise replaced;
 - c) Requires that an AR can be canceled or modified at any time for any reason by the program or the enrollee;
 - d) The definition of AR and other relevant terms;
 - e) A requirement that employees or contractors of providers so disclose this relationship;
 - f) Authorizations for an AR at state fair hearings, even if one has not been designated under these provisions; and,
 - g) Authorizes providers, staff members, or volunteers of organizations to be an AR, as long as there is a signed written agreement to adhere to specified federal requirements and a determination that the AR is acting in the person's best interest.

EXISTING LAW:

- 1) Establishes, under state and federal law, the Medicaid program (Medi-Cal in California) as a joint federal and state program offering a variety of health and long-term services to low-income women and children, low-income residents of long-term care facilities, seniors, and people with disabilities.
- 2) Establishes, under federal law, CHIP to provide health coverage to children in families that are low-income, but with incomes too high to qualify for Medicaid.
- 3) Provides under state and pre-ACA federal law that in order to qualify for full-scope Medi-Cal without a share of cost, a pregnant woman must have family income below 100% of the FPL, have assets below the allowable level, meet qualifying immigration status requirements, and must either have another dependent child in the home or be in the third trimester.
- 4) Provides pregnancy-related services to women with family income below 200% FPL, defined as services required to assure the health of the pregnant woman and the fetus. There is no share of cost and no assets limits for this program.
- 5) Establishes the AIM program to provide prenatal care, labor, and delivery coverage for pregnant women with family income between 200% and 300% of the FPL and for children less than two years of age who were born of a pregnancy covered under AIM.
- 6) Provides that citizen and legal immigrant children in foster care are eligible for full scope Medi-Cal benefits regardless of income or assets and upon attaining age 18, remain eligible for full-scope, no share of cost Medi-Cal with no income or assets requirements as former foster care children until age 21.
- 7) Establishes a process for the redetermination of an individual's eligibility for Medi-Cal annually, and whenever the county receives notice of a change in circumstances that may affect eligibility.
- 8) Effective January 1, 2014, requires an individual to have the option to apply for state subsidy programs, which includes the state Medicaid program, the state CHIP, enrollment in a qualified health plan (QHP) through a state exchange and a Basic Health Plan, if there is one, either in person, by mail, online, by telephone, or other commonly available electronic means.
- 9) Effective January 1, 2014, requires development of a single, accessible, standardized application for the state subsidy programs to be used by all eligibility entities and establishes a process for developing and testing the application.
- 10) Creates the Exchange, as an independent state entity governed by a five-member Board, to be a marketplace for Californians to purchase affordable, quality health care coverage, claim available tax credits and cost-sharing subsidies, and one way to meet the personal responsibility requirements of the ACA.

FISCAL EFFECT: According to the Senate Appropriations Committee:

- 1) The Mandatory Expansion. By simplifying the process for determining eligibility for Medi-Cal and enrolling program participants, this bill will increase enrollment in the program. The Legislative Analyst's Office (LAO) projects that the total costs due to increased enrollment of people already eligible for the program will be about \$620 million in 2014-15 (\$290 million General Fund (GF) at traditional cost sharing), rising to about \$1.1 billion in 2020-21 (\$460 million GF). Note that these costs will occur due to changes mandated by federal law.
- 2) The Optional Expansion. By expanding Medi-Cal eligibility to all childless adults under age 65 with household income below 138% of FPL, this bill substantially increases the eligible population, increasing program costs. Under the ACA, FFP will be substantially higher than current practice—starting at 100% and declining to 90% by 2020 and thereafter.
 - a) State Medi-Cal health care costs. The LAO projects that, under reasonable assumptions, about 1.8 million additional people will be eligible for Medi-Cal under this bill and that about 65% of eligible persons will enroll in the program. In 2014-15, total projected costs for medical services under the optional expansion are projected to be about \$3.5 billion per year, entirely funded by the federal government. In 2020-21, the total costs for medical services under the optional expansion are projected to be \$6 billion per year, including about \$605 million per year in GF costs (based on the ultimate 90% federal matching rate for the optional expansion population).
 - b) State Medi-Cal administrative costs. In addition to the direct costs to provide medical services to the expansion population, there will be administrative costs to make eligibility determinations and enroll beneficiaries in Medi-Cal. Due to the changes to eligibility and enrollment processes under this bill, per capita administrative costs associated with the expansion population may be lower than current per capita administrative costs. Administrative costs are subject to the standard 50% federal matching rate. By 2020-21, state GF administrative costs are likely to be in the low tens of millions per year.
 - c) State savings in other health care programs and in corrections. The LAO also indicates that the state will see substantial savings in other state health-subsidy programs, such as the Genetically Handicapped Persons Program, the Breast and Cervical Cancer Treatment Program, and other programs. As Medi-Cal eligibility increases, some participants in these state programs will be eligible for full scope health benefits from Medi-Cal and may no longer need services from these specialized programs. There is a good deal of uncertainty about the impact of the Medi-Cal expansion on these programs, but the LAO indicates that state savings could be in the low hundreds of millions per year. In addition, the state could experience GF savings up to \$60 million per year due to the shift of certain outpatient medical costs for inmates to Medi-Cal under the expansion.
 - d) County health care savings. Under current law, county governments are responsible for providing certain health care services to medically indigent adults who do not qualify for other public health care programs. Under the proposed expansion of Medi-Cal, a portion of that population would transition from county responsibility to the Medi-Cal program. While there is a great deal of uncertainty regarding how many people would transition from county-provided health care coverage to Medi-Cal and the cost savings to the counties, the LAO indicates that the counties are likely to realize cost savings in the range of \$800 million to \$1.2 billion per year. It is important to note that under this bill, all county savings would be retained by the counties and would not be shared with the state.

3) Policies that will impact enrollment and costs. In addition to the general uncertainty in projecting future Medi-Cal enrollment levels and health care costs, there are certain policy issues addressed by this bill that are likely to have impacts on enrollment levels or per capita costs. The fiscal impacts of these policy choices are not fully known at this time. Key policy choices made in this bill include:

- a) The benefit package provided to the expansion population. Federal law provides some flexibility to the state to design a benefit package for the expansion population (although the benefit package must provide the EHBs required under the ACA).

This bill requires DHCS to seek federal approval to provide the same benefit package to the expansion population as is provided under the current Medi-Cal population, as well as providing coverage required under the EHB package. In addition, this bill requires the existing Medi-Cal population to also receive the same essential health benefit benchmark coverage. In general, the existing Medi-Cal benefit package is broader than the EHB benchmark plan the state has selected (the Kaiser Small Group plan), particularly in coverage of long-term services and supports. However, the Kaiser plan provides some additional benefits such as some acupuncture services and more generous substance abuse benefits.

The fiscal projections above assume that the expansion population receives the existing Medi-Cal benefit package. There may be additional costs, for both the existing Medi-Cal eligible population and the expansion population, by requiring both populations to receive benefits equivalent to the Kaiser benchmark plan.

- b) Self-attestation by applicants. Federal law and regulations allow states to accept self-attestation by applicants of certain information, such as age, date of birth, household income, and state residency (not immigration status). This bill requires DHCS to accept self-attestation of this information. By allowing applicants to self-attest (rather than requiring them to provide documentation) this provision simplifies the application process and is likely to increase enrollment.
- c) Full scope pregnancy-related coverage. Under current state law, pregnant women with incomes up to 200% of FPL are eligible for Medi-Cal. Some of these beneficiaries are eligible for full-scope benefits during pregnancy, while other beneficiaries are only entitled to pregnancy-related benefits, depending on a variety of eligibility factors. Draft federal regulations indicate that Medicaid programs must provide full scope benefits to pregnant women, unless the federal government specifically authorizes states to limit such benefits. This bill requires that all pregnant women enrolled in Medi-Cal (up to 200% of FPL) are to be provided with full scope benefits, unless approval is granted by the federal government to provide lesser benefits. (The author indicates that the intent of this bill is to require full-scope benefits to be provided to all pregnant women enrolled in Medi-Cal.)
- d) Elimination of the existing deprivation requirement. Under current state law, the Medi-Cal program covers children and caretaker relatives who are “deprived” of full parental support (i.e. one parent is absent, deceased, disabled, unemployed, or underemployed). Federal law allows states to eliminate this requirement and this bill does so. It is not clear

whether eliminating this requirement would actually increase the number of eligible individuals for the program.

- e) Projection of annual income. Federal guidance to date indicates that projected annual income (rather than an applicant's current monthly income) can be used to determine income eligibility. This bill requires DHCS to allow applicants to use projected annual income to determine income eligibility. The counties (who currently perform eligibility determinations) have indicated that they already allow some projection of income when making eligibility determinations, so it is not clear whether this would actually increase overall enrollment in Medi-Cal.

COMMENTS:

- 1) PURPOSE OF THIS BILL. On January 24, 2013, Governor Brown issued a proclamation to convene the Legislature in Extraordinary Session to consider and act upon legislation necessary to implement the ACA in: a) the areas of California's private health insurance market, rules and regulations governing the individual and small group market; b) California's Medi-Cal program and changes necessary to implement federal law; and, c) options that allow low-cost health coverage through Covered California, California's Exchange, to be provided to individuals who have income up to 200% of the FPL. This bill, along with AB 1 X1 (John A. Perez), address the second of the three areas identified in the Governor's proclamation, that is to adopt the provisions of the ACA related to changes in Medi-Cal.

Specifically, this bill adopts the state option of expanding Medi-Cal coverage to non-disabled citizens and qualified resident childless adults, between the ages of 19 and 65 who are not currently eligible for other full-scope Medi-Cal programs and provides a full scope benefit package, as allowable under federal law. This category is limited to those with income under 138% of the FPL and the person must meet other citizenship and immigration status requirements. This bill also enacts the ACA requirement that the state Medicaid program extend coverage to former foster youth until age 26, without regard to income or assets. The ACA establishes a new simplified income standard for families, children, and the new expansion population based on the MAGI-standard as defined under the Internal Revenue Code (IRC). It does not apply to seniors or person with disabilities. This bill includes provisions necessary to convert to the new MAGI methodology and income standard. Finally this bill includes a number of provisions that implement the goal of the ACA, reducing the number of uninsured by streamlining and simplifying eligibility determinations and increasing reliance on electronically available data.

The author puts forth a number of policy and fiscal reasons in support of the adoption of state options as would be enacted by this bill. For instance, the expansion of Medi-Cal coverage for adults not currently eligible would improve the health status of the newly eligible Medi-Cal recipients; provide significantly enhanced federal funding for California; provide enhanced funding for safety-net health care providers to serve the 3.1 to 4 million remaining uninsured; reduce health care providers' uncompensated care costs; and, prevent lower income individuals from being without access to affordable health care coverage when higher income individuals have access to tax credits that reduce premium and cost-sharing costs in Covered California.

- 2) **BACKGROUND.** Starting in calendar year 2014, the ACA replaces many of the complex categorical groupings and limitations in the Medicaid program and provides eligibility to all nondisabled, non-pregnant individuals between the ages of 19 and 65 with family income at or below 133% FPL, provided that the individual meets certain non-financial eligibility criteria, such as citizenship. Also beginning in 2014, the ACA requires MAGI to be used in determining eligibility for this new Medi-Cal population, as well as for families, children, and caretaker relatives and for subsidized coverage through Covered California. The MAGI is based on the federal IRC. The ACA generally adopts MAGI as a way to count household income and eliminates the existing variety of income disregards and deductions currently used by states. In addition, there are no resource or assets limits under MAGI. Using MAGI methods, household income will be the sum of the income of every individual who is in the household, minus a standard income disregard of five percentage points of the FPL for the applicable household size. The MAGI rule also aligns family size under Medicaid rules with the IRC's MAGI definition. As a result, there are a small number of situations in which the transition from current rules to MAGI rules will result in different household compositions than under the old rules.

According to a model of California insurance markets known as the California Simulation of Insurance Markets, 5.6 million Californians were without health insurance in 2012 or 16% of the population under age 65. A recent study estimates that when California implements the Medi-Cal provisions, more than 1.4 million of these individuals will be newly eligible, of which between 750,000 and 910,000 are expected to be enrolled at any point in time by 2019. This study, "Medi-Cal Expansion under the Affordable Care Act: Significant Increase in Coverage with Minimal Cost to the State," published by UC Berkeley Center for Labor Research and Education and UCLA Center for Health Policy Research in January 2013, also finds that about 2.5 million Californians are already eligible for Medi-Cal but not enrolled, and between 240,000 and 510,000 of them are expected to be enrolled at any point in time by 2019 as a result of implementing the ACA.

- 3) **TRANSITION TO MAGI.** Effective January 1, 2014, states will use the MAGI-based methodology for determining the income of an individual and the individual's household, as applicable, for purposes of eligibility for Medicaid or CHIP where a determination of income is required. Pursuant to the ACA, CMS issued regulations that consolidated eligibility groups currently included in multiple statutory provisions into three simplified groups and established a new group for the low-income adult expansion group. The consolidated groups are: a) Parents and Other Caretaker Relatives; b) Pregnant Women; and, c) Children under 19. According to CMS, to promote coordination and avoid gaps or overlaps in coverage, the new methodology is aligned with the one that will be used to determine eligibility for the premium tax credits and cost sharing reductions available to certain individuals purchasing coverage on the Exchanges starting in 2014. Under the ACA, MAGI-based income methodologies will not apply to determinations of Medicaid eligibility for elderly and disabled populations. As interpreted by CMS regulations, the new MAGI-based methodology includes certain unique income counting and household composition rules.

Currently, states' methodologies for determining Medicaid and CHIP income eligibility vary widely, primarily due to differences in the application of income disregards. To determine eligibility, the state first determines an individual's (or family's) gross income using a combination of state and federal rules on household or family composition, and then applies deductions, or disregards, which are income amounts that are not considered countable, such

as childcare expenses. These income deductions or disregards can vary by state, type of income, and by eligibility group. The resulting net income is then compared to an income eligibility threshold (referred to as the net income standard), expressed as a percentage of the FPL to determine whether the individual is income-eligible for Medicaid or CHIP. By converting to the MAGI rules and collapsing most existing eligibility into three broad categories, this methodology has an impact on how household income is counted. For example, a stepparent with no financial obligation for a child is not counted in the household income under existing rules, but may be under MAGI.

States are required to apply conversion methodologies for two purposes. One is for the purpose of determining the state's applicable Federal Medical Assistance Percentages for each population, including for newly eligible individuals. The second is the conversion of net income standards under existing programs in order to implement the simplified MAGI-based equivalent eligibility income level, under which the minimum eligibility level will be set at 138% FPL for children, parents, and caretaker relatives, and the highest will be based on eligibility standards in effect on March 23, 2010, or December 31, 2013. CMS has two options for states, either a standardized methodology developed by CMS or a state may propose an alternative and demonstrate to CMS how it meets the statutory objectives.

In order to test various methodologies, CMS consulted with states and selected 10 pilot states to test the feasibility of potential conversion methodologies. CMS developed a national model to simulate Medicaid eligibility for use in the recommended standardized MAGI conversion methodology using a data set known as Survey of Income and Program Participation (SIPP). States that choose this methodology may use the SIPP data or state data. CMS is calculating this for each state. The second option is for a state to propose an alternative method because of unusual income disregards or income standards. These states must do their own calculations and seek approval from CMS.

States were required to review the CMS converted MAGI-based standards during April and make corrections by May 31, 2013. States using their own data are required to submit a MAGI conversion plan no later than April 30, 2013, and are supposed to be notified of approval or disapproval by June 15, 2013. DHCS has declined to make the CMS conversion information public.

- 4) ENROLLMENT AND SIMPLIFICATION. Effective January 1, 2014, the ACA envisions a streamlined, simplified, and seamless enrollment system that employs minimal use of paper documentation and relies on modern technology to the greatest extent possible for all the state subsidy programs. For example, CMS states in the Preamble to the March 23, 2012 Rules and Regulations, as follows: whether conducted by a public or private entity, it is anticipated that eligibility determinations using MAGI-based standards will be highly automated, utilizing business rules developed by the State Medicaid agency. In the most simplified cases, which can be determined without human intervention or discretion, we are clarifying that automated systems can generate Medicaid eligibility determinations, without suspending the case and waiting for an eligibility worker to finalize the determinations.

Except for certain specified information such as citizenship and immigration status, the CMS Regulations allow states to accept attestation of needed information. CMS further states that this applies to both financial and non-financial verification and that if self-attestation is not accepted, states must access available electronic databases prior to requiring additional

information or documentation in verifying all factors of eligibility.

With regard to forms, the HHS Secretary is required to develop a single streamlined application. A state may develop its own single, streamlined form, but it must be approved by the HHS Secretary and meet the HHS Secretary-established standards. The ACA also requires that an individual determined to be ineligible for the Medicaid program or the state's CHIP program is to be screened for eligibility for enrollment in the Exchange and if applicable, premium assistance without being required to submit an additional or separate application. Supplemental forms may only be required for individuals whose eligibility cannot be determined through the application of the MAGI standard. States are required to establish procedures that enable individuals to enroll and renew through an Internet website and to consent to enrollment or reenrollment through an electronic signature. States are also required to ensure that the Medicaid program, the CHIP program, and the Exchange utilize a secure electronic interface sufficient to allow for a determination of eligibility for coverage or enrollment, as appropriate. CMS has directed states to analyze current verification procedures to determine the policy and systems modifications that will be needed in order for the state to achieve this streamlined verification process. There are a number of key steps that California has already undertaken, but in other cases new systems or revisions to existing processes will be necessary to ensure that the spirit and intent of the ACA are carried out.

- a) AB 1296 (Bonilla), Chapter 641, Statutes of 2011. AB 1296 codified many of the requirements of the ACA with regard to a streamlined, simplified, and coordinated eligibility system. For instance it selected the option for a state developed single application over the option of using one developed by the HHS Secretary. AB 1296 established a stakeholder process as a forum to review and discuss many of the options and implementation issues and challenges that are created by the ACA with regard to these issues. AB 1296 further advanced the intent of the ACA by requiring that only the information necessary for the eligibility determination could be required and only from the person who was applying for coverage. AB 1296 also required that forms be in simple user-friendly language, and accessible to limited English proficient applicants, as well as others requiring accommodations for accessibility.

AB 1296 laid out a process for streamlining the application and enrollment process by requiring the entity that made the eligibility determination to grant eligibility immediately, to allow prepopulation of forms using information from available data sources and a simplified process for verification, and an opportunity for the applicant to correct information, resolve discrepancies, or to supply additional information as necessary.

- b) CalHEERS Project. CalHEERS is a procurement conducted jointly by the Exchange, DHCS, and Managed Risk Medical Insurance Board to build the Information Technology system to support the consumer application and enrollment process at the Exchange. Following extensive review and stakeholder comment and input, Accenture was hired through a solicitation process for the design, development, and deployment of CalHEERS. The portal will offer eligibility determinations for both Medi-Cal and federally subsidized Covered California coverage through the Exchange. It will allow enrollment through multiple access points including mail, phone, and in-person applications. It is guided by a "no wrong door" policy that is intended to ensure the maximum number of Californians obtain coverage appropriate to their needs. Eligibility

and enrollment functions will be released in September of 2013. The CalHEERS business functions include interfacing with the Medi-Cal eligibility data system. It will also have the capacity to be a secure interface with federal and state databases in order to obtain and verify information necessary to determine eligibility.

- c) MAGI-based eligibility verification. Although states are allowed to accept self-attestation of the individual's information for all factors of eligibility (except citizenship and immigration status), CalHEERS is only currently being programmed to accept it for the Exchange and not for Medi-Cal eligibility. To the extent that information related to Medicaid or CHIP eligibility is available through an electronic data services hub established by the Secretary of HHS, states must use it to do so. Federal regulations detail other sources that should be used to verify wages and earnings such as the Internal Revenue Service, agencies that administer state unemployment compensation laws, and information related to eligibility or enrollment from the Supplemental Nutrition Assistance Program (SNAP). If information provided on the application or renewal form is reasonably compatible with information obtained through these data sources, eligibility is required to be determined without requesting any additional information from the individual. Income information is considered reasonably compatible if both are above, at, or below the applicable income threshold. If the information is not reasonably compatible, states have the option to obtain a statement for the person which reasonably explains the discrepancy or provide a reasonable amount of time for the person to produce documentation or other information. When relying on paper documentation, states are required to consider the administrative costs associated with establishing and using data sources as compared with the administrative costs of relying on paper.
 - d) Income Fluctuations. Under the ACA, Medicaid eligibility remains based on monthly income at the time of application, while eligibility for premium tax credits for Exchange coverage is based on annual income. However, the CMS guidance has been interpreted to provide states new options to assess continuing Medicaid eligibility based on projected annual income or by taking into account anticipated changes in income, which would minimize coverage gaps and transitions between Medicaid and Exchange coverage due to small income fluctuations. Actual changes in income must be reported by applicants and enrollees and acted upon by the state or designated entity.
- 5) RENEWAL AND REDETERMINATION. The ACA goal of reducing the number of uninsured by creating continuum of coverage options for individuals with family incomes up to 400% FPL and the increased reliance on electronically available data has implications for how states process renewals and redeterminations. For instance, unless the individual provides information regarding a change in circumstances, renewal for individuals whose eligibility is based on MAGI can be no more frequently than once every 12 months. Since the individual is obligated to report changes in circumstances, this requires the elimination of semiannual reporting for adults in California. The state agency must have procedures in place to ensure that beneficiaries make timely and accurate reports of any change in circumstances and that enable beneficiaries to report these changes online, by phone, in person, or through other electronic means. For non-MAGI groups, such as those who are blind or disabled, the rule retains the existing provision that eligibility be re-determined at least every 12 months, but allows states to assume that blindness and disability continue until there is a determination otherwise.

For MAGI groups, state agencies will first seek to renew eligibility by evaluating information from the individual's electronic account or from other more current reliable data sources. If the available information is sufficient to determine continued Medicaid eligibility, the state is required to renew coverage based on that information and send an appropriate notice without requiring the individual to sign and return the notice. Enrollees must correct any inaccurate information in the notice online, in person, by telephone, or by mail. If it cannot be determined that the individual remains eligible based on available information, the individual must be provided with a pre-populated form containing the information relevant to renewal that is available to the agency and a reasonable period of time of at least 30 days to provide the necessary information and correct any inaccuracies online, in person, by telephone, or by mail. The state has the option to allow self-attestation and then use information available through electronic data sources for verification. The state cannot require an in-person interview as part of the redetermination process. AB 1296 adopted many of these requirements and this bill makes additional conforming changes.

This bill also implements the provisions that are designed to reduce multiple unnecessary applications by allowing a reconsideration period for individuals who are terminated due to failure to submit a renewal form or information. In such a case, if the individual subsequently submits within 90 days after the date of termination, the state is required to redetermine the individual's eligibility without requiring a new application.

- 6) SUPPORT. Supporters, such as Western Center on Law and Poverty (Western Center), state that this bill is truly a historic piece of legislation which will transform the Medi-Cal program by covering all low-income Californians and modernizing and simplifying the eligibility rules to realize the "no wrong door visions" of the ACA. According to Western Center, many complain that Medi-Cal administration and eligibility determinations are too cumbersome and complicated and states in support that this bill would achieve a more modern, efficient, and streamlined program, as well as align the Medi-Cal rules with the rules in the Exchange. Western Center also points out in support that this bill provides the same scope of benefits to the adult expansion population as to the existing population and also adds the 10 categories of EHBs. The County Welfare Directors Association of California (CWDA) also in support states that this bill moves California closer to the promise of affordable, accessible coverage by implementing a new federal income standard based on tax filings, eliminating the asset test for parents, children, and the newly eligible population, eliminating mid-year status reports, and providing a structure for those enrolled in LIHPs to transition seamlessly into ongoing Medi-Cal coverage. CWDA points out in support, that many of these simplifications have been long sought by county human services departments and that reducing the burden for clients and the amount of time county staff must spend, as well as increasing the use of information electronically will help ensure quick and accurate eligibility determinations. The California Labor Federation states that this bill will enact a central component of the ACA to complement the establishment of the state Exchange by expanding Medi-Cal to ensure that the lowest-income Californians have access to subsidized coverage. The California Labor Federation further argues in support that not only will individuals and families benefit, but the expansion has the possibility of improving public health by increasing access to preventive care and reducing the use of emergency rooms and charity care. These supporters and others also point to the fact that this bill will bring in an estimated \$2.1 to \$3.5 billion in federal funds due to the 100% federal funding for the newly eligible. Health Access California, also in support, points to an analysis conducted by the University of California that found that most of the costs associated with the Medi-Cal

expansion and program changes would be off-set by increased GF revenues and other savings.

Californians for Safety and Justice write in support that this bill will have a positive impact on the justice system and reduce the likelihood of recidivism. These supporters point to data to show that the high rate of chronic medical conditions, mental illness, and substance abuse prevalent in jail and prison populations and left unaddressed contributes to the cycle of crime, making those with low rates of health insurance more likely to be repeat offenders. Other supporters such as the California Pan-Ethnic Health Network, the California Black Health Network (CBHN), the Greenling Institute, and the National Health Law Program also support this bill because of the scope of benefits it provides to the expansion population, to pregnant women, and to former foster youth up to age 26. These supporters also point out that over 60% of the newly eligible are people of color and over one third have limited English proficiency, therefore this bill will improve health outcomes for the lowest-income residents, including communities of color. In addition, CBHN points to the stubbornly high rate of maternal mortality and infant mortality rates of African American women and their infants and the hope that this comprehensive coverage will address these disparities.

7) RELATED LEGISLATION.

- a) AB 1 X1 is substantially similar to this bill. AB 1 X1 is pending in the Senate Health Committee.
- b) AB 2 X1 (Pan), Chapter 1, Statutes of 2013-14 First Extraordinary Session, establishes health insurance market reforms contained in the ACA specific to individual purchasers, such as prohibiting insurers from denying coverage based on preexisting conditions; and, makes conforming changes to small employer health insurance laws resulting from final federal regulations.
- c) SB 2 X1 (Ed Hernandez) Chapter 2 of 2013-14 First Extraordinary Session, applies the individual insurance market reforms of the ACA to health care service plans (health plans) regulated by the Department of Managed Health Care and updates the small group market laws for health plans to be consistent with final federal regulations.
- d) SB 3 X1 (Ed Hernandez), establishes a bridge plan option that allows low-cost health care coverage to be provided to individuals within the Exchange. SB 3 X1 is pending in the Assembly Health Committee.
- e) SB 28 (Ed Hernandez and Steinberg) implements various provisions of the ACA regarding Medi-Cal eligibility and program simplification including the use of the MAGI and expansion of eligibility in the Medi-Cal program. SB 28 is pending in the Assembly Health Committee.
- f) AB 50 (Pan) implements various provisions of the ACA related to allowing hospitals to make a preliminary determination of Medi-Cal eligibility, allows forms for renewal to be prepopulated with existing available information and requires the process for Medi-Cal enrollees to choose a plan to be coordinated with the Exchange. AB 50 is pending in the Senate Health Committee.

8) PREVIOUS LEGISLATION.

- a) AB 43 (Monning) of the 2011-12 Session would have expanded Medi-Cal coverage to persons with income that does not exceed 133% FPL, effective January 1, 2014 and would have required a transition plan for persons enrolled in a LIHP. AB 43 died on the Senate Inactive File.
- b) SB 677 (Ed Hernandez) of the 2011-12 Session would have required DHCS to implement the provisions of the ACA relating to eligibility and benefits in the Medi-Cal program. SB 677 died on the Assembly Inactive File.
- c) SB 1487 (Ed Hernandez) of the 2011-2012 Session would have required DHCS to extend Medi-Cal eligibility to youth who were formerly in foster care and who are under 26 years of age, subject to FFP being available, and to the extent required by federal law. SB 1487 would have also made legislative findings and declarations regarding the ACA, stated legislative intent to ensure full implementation of the ACA, and to enact into state law any provision of the ACA that may be struck down by the U.S. Supreme Court. SB 1487 was held on the Senate Appropriations Committee Suspense file.
- d) AB 1066 (John A. Pérez), Chapter 86, Statutes of 2011, enacts technical and conforming statutory changes necessary to conform to the Special Terms and Conditions required by CMS in the approval of the Bridge to Reform Demonstration, including changing the name of the LIHP from Coverage Expansion and Enrollment Projects to the Medi-Cal Coverage Expansion and Health Care Coverage Initiative.
- e) AB 342 (John A. Pérez), Chapter 723, Statutes of 2010, enacted the LIHP and Coverage Expansion and Enrollment Projects to provide health care benefits to uninsured adults up to 200% of the FPL, at county option through a Medi-Cal waiver demonstration project.
- f) AB 1296, the Health Care Eligibility, Enrollment, and Retention Act, requires CHHSA, in consultation with other state departments and stakeholders, to undertake a planning process to develop plans and procedures regarding these provisions relating to enrollment in state health programs and federal law. AB 1296 also requires that an individual would have the option to apply for state health programs through a variety of means.
- g) AB 1595 (Jones) of 2010 would have required DHCS to expand Medi-Cal eligibility to individuals with family income up to 133% of FPL without regard to family status by January 1, 2014. AB 1595 died on Suspense in the Assembly Appropriations Committee.
- h) AB 1602 (John A. Pérez), Chapter 655, Statutes of 2010, establishes the Exchange as an independent public entity to purchase health insurance on behalf of Californians with incomes of between 100% and 400% FPL and employees of small businesses. Clarifies the powers and duties of the Board governing the Exchange relative to the administration of the Exchange, determining eligibility and enrollment in the Exchange, and arranging for coverage under qualified carriers.
- i) SB 900 (Alquist), Chapter 659, Statutes of 2010, establishes the Exchange. Requires the Exchange to be governed by a five-member Board, as specified.

9) COMMENTS. There are some policy decisions that remain to be decided, as well as a few technical details that need further development. The most significant are as follows:

- a) Pregnant Women. It is the intent of the author, as reflected in this bill, to provide all medically necessary medical services to pregnant women to help prevent premature delivery and low birth weight and to promote women's overall health, well-being, and financial security. In addition, data show that women with family income under 200% of FPL are significantly more likely to be in poor health coming into care than women with higher incomes and to have psychosocial and/or medical complications that a general community obstetrician/gynecologist may be less prepared to manage. Examples of medical complications that are more likely to be present in low-income populations of pregnant women include seizure disorder, poorly controlled diabetes, hypertension, heart disease, and chronic renal failure due to poor control of hypertension or diabetes. Furthermore, almost half of all births in California are financed by the Medi-Cal program and the child is likely to be eligible at birth. Preventing complications in the baby is therefore ideal.

The intersection of the current public programs for pregnant women and new requirements under the ACA has opened up new opportunities that present policy choices, as well as technical challenges. For instance a state can use premium assistance for cost-sharing assistance and benefit wrap-around coverage requirements to the extent that the current programs don't meet Medicaid standards to purchase a QHP in the Exchange. These solutions appear to meet the requirements for comprehensive coverage and cost effectiveness. Ensuring a coordinated comprehensive benefit package that meets federal standards, that is not administratively burdensome and is easy to access will require additional design details.

- b) Legal Immigrants. Federal law subjects lawfully present immigrants to the individual mandate and related tax penalty, unless exempt due to very low-income. This category of immigrants is eligible to enroll in a QHP and is eligible for premium tax credits. However, the current federal immigration eligibility restrictions apply so that there is a five-year waiting period for most lawfully residing, low-income immigrant adults before federal matching funds are available in the Medicaid program. This bill attempts to maximize funding by taking advantage of premium assistance opportunities for newly eligible immigrants, obtaining premium tax credits and limiting the out-of-pocket costs for low-income immigrants. This bill also attempts to provide Medi-Cal scope of benefits and resolve timing challenges posed by the limited open enrollment periods of the Exchange.
- c) Eligibility verification and reasonable compatibility. If eligibility information obtained through the state's verification process is reasonably compatible with the information provided by the individual, it must be used to determine eligibility without requesting further information. The definition of reasonably compatible is left to the states. This bill provides for self-attestation where allowed under federal law, but does not yet include the specifications of a verification plan. This bill also does not provide guidance on what will be considered reasonably compatible and how discrepancies are to be resolved. These details will have to be added.

- d) Early adoption of MAGI-based rules. During the 2013 open enrollment period for coverage in the Exchange or an insurance affordability program (October 1, 2013 to December 31, 2013), eligibility for certain applicants will be determined using MAGI-based methodologies for coverage scheduled to start on January 1, 2014. In addition, during this period, people applying for or renewing Medicaid for coverage in 2013 will also need to have their eligibility assessed based on existing Medicaid rules. As a result, states will need to be able to determine Medicaid eligibility under both MAGI-based rules and current rules during this limited period of time. To avoid having to operate two sets of rules for children, parents and caretaker relatives, pregnant women, and other non-disabled, non-elderly adults that may be eligible for Medicaid or CHIP enrollment during this period, CMS is offering states the opportunity to begin using the new MAGI-based methodology for these populations effective October 1, 2013, to coincide with the start of the open enrollment period. CMS is also offering the states the option of extending the Medicaid renewal period so that renewals that would otherwise occur during the first quarter of calendar year 2014 (January 1, 2014 through March 31, 2014), occur later. This is to ensure, as required by the ACA, a person enrolled in Medicaid on or before December 31, 2013, is not found ineligible solely because of the application of MAGI and new household composition rules before March 31, 2014, or the individual's next regular renewal date, whichever is later. The author may wish to consider adding these options.
- e) Options to enroll based on other eligibility. Recent studies by both the Center on Budget and Policy Priorities and the Urban Institute find that, despite the differences in household composition and income-counting rules, the vast majority of non-elderly, non-disabled individuals who receive SNAP benefits are very likely also to be financially eligible for Medicaid. Based on these analyses, CMS is offering states the opportunity to streamline the enrollment into Medicaid of these non-elderly, non-disabled SNAP participants. To assist states in the initial phases of implementing new eligibility and enrollment systems, CMS is also offering states the opportunity to facilitate the Medicaid enrollment of parents whose children are currently enrolled in Medicaid and who are likely to be Medicaid-eligible. This opportunity is available for a temporary period and could remain in effect until such time as the initial influx of applications is addressed or the state is able to handle the demands associated with the new system most efficiently. The author may also wish to consider these options.
- f) Medi-Cal plan choice. CalHEERS is developing online tools to assist consumers with choosing a QHP based on extensive research and testing by organizations with experience in consumer behavior and preferences. However, the design specifications have delayed equivalent tools for individuals eligible for Medi-Cal to be able to choose a plan. Medi-Cal currently uses a Health Care Options (HCO) process, through which the individual receives a paper choice form. If the individual does not choose a plan and is in a mandatory enrollment county, they are default enrolled. Additional amendments are needed to reconcile the existing HCO process with the new simplified and streamlined enrollment process and to allow a Medi-Cal or CHIP eligible individual to be able to choose a plan at the point of application, either through the Exchange or the county social services agency.
- g) Regulatory authority. The Administrative Procedures Act (APA) requires every department, division, office, officer, bureau, board, or commission in the executive

branch of the California state government to follow the rulemaking procedures in the APA and regulations adopted by the Office of Administrative Law (OAL), unless expressly exempted by statute from some or all of these requirements. The APA requirements are designed to provide the public with a meaningful opportunity to participate in the adoption of regulations or rules that have the force of law by California state agencies and to ensure the creation of an adequate record for the public, OAL, and judicial review. Regulations are required to be adopted with opportunities for public comment, including public hearings. There are provisions for adoption of emergency regulations with an abbreviated process. DHCS has regularly requested to be exempt from these requirements and has sought legislative authority to adopt policy changes by means of all-county letters, provider bulletins, all-plan letters, or other similar instructions. In the process of identifying the changes that must be made to current law to conform to the ACA, it became apparent that this lack of a coherent statutory and regulatory framework makes it very difficult to determine what the law is. This bill attempts to codify, as much as possible, provisions required to implement the ACA. This includes codifying or revising existing regulations or superseding policy adopted without regulation. This bill also limits the grants of further authority to DHCS to make or adopt policy without new legislation or the adoption of regulations.

REGISTERED SUPPORT / OPPOSITION:

Support

100% Campaign

AARP

Alliance for Boys and Men of Color Health Policy Work Group

American Cancer Society Cancer Action Network

American Congress of Obstetricians and Gynecologists

American Federation of State, County, and Municipal Employees

American Heart Association

Arc and United Cerebral Palsy California Collaboration

Asian Pacific American Legal Center

Autism Speaks

Binational Center for the Development of Oaxacan Indigenous Communities

California Academy of Family Physicians

California Association of Addiction Recovery Resources

California Association of Alcoholism and Drug Abuse Counselors

California Association of Public Hospitals and Health Systems

California Black Health Network

California Chapter of the National Organization for Women

California Chiropractic Association

California Coverage and Health Initiatives

California Family Resource Association

California Health Advocates

California Hospital Association

California Immigrant Policy Center

California Labor Federation

California Latinas for Reproductive Justice

California Mental Health Directors Association

California National Organization for Women
California Nurses Association
California Opioid Maintenance Providers
California Pan-Ethnic Health Network
California Primary Care Association
California School Employees Association, AFL-CIO
California School Health Centers Association
California State Association of Counties
California State Parent Teacher Association
California Teachers Association
Californians for Patient Care
Californians for Safety and Justice
Children Now
Children's Defense Fund California
Children's Partnership
Chinese Progressive Association of San Francisco
Congress of California Seniors
Counsel of Mexican Federations
Consumers Union
County Welfare Directors Association of California
Epilepsy California
Friends of the Family
Greenlining Institute
Health Access California
Health Officers Association of California
Korean Community Center of the East Bay
Latino Coalition for a Healthy California
Latino Health Alliance
Los Angeles Area Chamber of Commerce
Los Angeles County Board of Supervisors
Mexican American Legal Defense and Educational Fund
March of Dimes Foundation – California Chapter
Maternal and Child Health Access
National Association of Social Workers – California Chapter
National Council of La Raza
National Health Law Program
Partners in Advocacy
PICO California
Planned Parenthood Advocacy Project Los Angeles County
Planned Parenthood Affiliates of California
Planned Parenthood Mar Monte
Planned Parenthood of Orange and San Bernardino Counties
Planned Parenthood of the Pacific Southwest
PolicyLink
San Joaquin County Board of Supervisors
San Mateo County Central Labor Council
Santa Clara County Board of Supervisors
Service Employees International Union – California State Council
Six Rivers Planned Parenthood

Transgender Law Center
United Nurses Association of California/Union of Health Care Professionals
United Ways of California
Western Center on Law and Poverty

Opposition

None on file.

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