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CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1296

Introduced by Assembly Member Bonilla

February 18, 2011

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

LEGISLATIVE COUNSEL'S DIGEST

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

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

Benefit Exchange (Exchange), specifies the powers and duties of the board governing the Exchange relative to determining eligibility for enrollment in the Exchange and arranging for coverage under qualified health plans, and requires the board to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and qualified small employers by January 1, 2014.

This bill would enact the Health Care Eligibility, Enrollment, and Retention Act, which would require the California Health and Human Services Agency, in consultation with specified entities, to establish standardized single, accessible application forms and related renewal procedures for Medi-Cal, the Healthy Families Program, and the Exchange, 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 April 1, 2012, regarding policy changes needed to implement the bill. The bill would otherwise be operative January 1, 2014, except as specified.

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

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

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

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

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

(b) (1) By January 1, 2012, the California Health and Human Services Agency, in consultation with the State Department of Health Care Services (department), Managed Risk Medical Insurance Board (MRMIB), the California Health Benefit Exchange (Exchange), counties, health care service plans, consumer advocates, and other stakeholders shall have undertaken a planning process to develop plans and procedures to implement this part and the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law

111-152), related to eligibility for, and enrollment and retention in, public health coverage programs.

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

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

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

(1) "Accessible" means in compliance with the requirements of state and federal accessibility laws, including Sections 504 and 508 of the federal Rehabilitation Act of 1973, as amended (29 U.S.C. Secs. 794 and 794d), the federal Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), Title VI of the Civil Rights Act of 1964, Section 1557 of the PPACA (42 U.S.C. Sec. 18116), and Section 11135 of the Government Code.

~~(2) "Limited-English-proficient" means unable to speak English fluently.~~

(2) "Limited-English-proficient" means speaking English less than very well.

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

(4) "Public health coverage programs" means Medi-Cal, the Healthy Families Program, the Exchange program of premium tax credits, or reduced-cost sharing, or both, the Access for Infants and Mothers Program (AIM), and, if enacted, the Basic Health Program, as set forth in SB 703 of the 2011–12 Regular Session.

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

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

(c) A single, accessible, standardized paper, electronic, and telephone application for public health coverage programs shall be developed by the department in consultation with MRMIB and

the board governing the Exchange and shall be used by all entities authorized to make an eligibility determination for any of the public health coverage programs and by their agents. The department shall consult with counties and stakeholders, including consumer advocates, regarding 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. If developing a state form, the department shall consult with stakeholders in development of the application. The application shall be tested and operational by July 1, 2013. The application forms shall satisfy all of the following criteria:

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

(2) Be readily available in alternative formats and translations including, but not limited to, braille, large font print, compact disc, audio recording, and threshold languages. For purposes of this part, "threshold languages" means languages spoken by at least 20,000 or more limited-English-proficient health care consumers in California.

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

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

(5) Include questions that are voluntary for applicants to answer, regarding demographic data categories, including race, ethnicity, sex, primary language, disability status, and other categories recognized by the federal Secretary of Health and Human Services under Section 4302 of the PPACA. For race, ethnicity, and primary language, the state shall incorporate data collection standards recommended by the Institute of Medicine. For disability, data collection shall include information relating to functional limitations and impairments, such as those incorporated into the federal American Community Survey, to collect data on disability status.

(d) All locations of any kind where applications for any of the public health coverage programs are received or accepted, including physical and telephone locations and Internet Web portals or other

electronic systems, shall treat the applications described in subdivision (c) as an application for all of the public health coverage programs. The entity making the eligibility determination shall enroll the applicant in the public health coverage program for which the applicant is eligible. If an application is forwarded or transferred between or among entities for processing, this process shall not require the applicant to submit any new information that is not necessary to determine her or his eligibility. The applicant shall be informed at the time of application how to obtain information about the status of his or her application at any time and the information shall be promptly provided when requested.

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

(f) Nothing in this section shall preclude the use of a provider-based application form or enrollment procedures for public health coverage programs or other health programs that differs from the application form described in subdivision (c), and related enrollment procedures, to comply with, at a minimum, any of the following:

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

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

(B) Provide for a program of accelerated enrollment through which children and pregnant women screened eligible are immediately enrolled from the medical point of service into

coverage with benefits continuing until a final eligibility determination is made.

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

(3) The department shall adopt a process for hospitals to enroll infants deemed eligible for Medi-Cal under Section 1396a(e)(4) of Title 42 of the United States Code or the Healthy Families Program under Section 12693.70 of the Insurance Code immediately online, without an application.

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

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

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

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

apply to the fullest extent permitted by federal law with federal financial participation:

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

(B) Presumptive eligibility shall continue until the applicant is enrolled in ongoing coverage through a public health coverage program, or found to be ineligible for all of these programs and informed of the denial of coverage in accordance with all applicable due process requirements.

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

(A) The applicant shall be clearly informed of the overpayment penalties under the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (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.

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

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

(3) An applicant who is not eligible for a public health coverage program for a reason other than income eligibility, or for any reason if the individual resides in a county that offers a health program for individuals with income above the maximum allowed for the Exchange subsidies or tax credits, shall be referred to the county health coverage program in his or her county of residence.

(i) The eligibility, enrollment, and retention system shall ensure that applicants and recipients have available assistance with their application or renewal for public health coverage programs. Applicants and recipients shall also be given a meaningful opportunity to provide information on their applications and renewal forms. Applicants and recipients shall be provided with reasonable accommodations and policy modifications as necessary to ensure meaningful access to benefits by persons with disabilities and limited-English-proficient individuals, including, but not

limited to, the reading aloud of information over the telephone, assistance with filling out forms, and the ready availability of information concerning all benefit programs in alternative formats and translations, including interpretation in any language and translation in threshold languages. The department shall effectively communicate notice of the availability of the assistance described in this section to all applicants and recipients.

(j) At application, renewal, or a transition due to a change in circumstances, entities making eligibility determinations for public health coverage programs shall ensure that eligible applicants and recipients of public health coverage programs meeting all program eligibility requirements move seamlessly between programs without any breaks in coverage and without being required to provide duplicative or otherwise unnecessary verification, forms, or other information.

(k) The department shall, in coordination with MRMIB and the Exchange board, streamline and coordinate all eligibility rules and requirements among public health coverage programs using the least restrictive rules and requirements to ensure that all applicants whose income is less than 400 percent of the federal poverty level shall be determined eligible for Medi-Cal, the Healthy Families Program, or the Exchange when they meet the eligibility requirements and that all entities processing applications use the same least restrictive methodologies. This process shall include coordination of rules for determining income levels, assets, household size, citizenship and immigration status, and documentation and verification requirements.

(*l*) Renewal procedures shall be coordinated across all public health coverage programs and among entities that accept and make eligibility determinations so as to use all relevant information already included in the individual's Medi-Cal, other public benefits, the Healthy Families Program, or Exchange case file, or that of the individual's parent or child, or electronic databases authorized for data sharing by the PPACA to renew benefits or transfer eligible recipients seamlessly between programs without a break in coverage and without requiring a recipient to provide redundant information. Renewal procedures shall be as simple and user-friendly as possible, accessible, and shall require recipients to provide only information that has changed, if any, and shall use all available methods for reporting renewal information, including,

but not limited to, face-to-face, telephone, and online renewal. Families shall be able to renew coverage at the same time for all family members enrolled in any public health coverage program, including when family members are enrolled in more than one public health coverage program. A recipient shall be permitted to update his or her eligibility information at any point.

(1) A recipient providing an update to his or her eligibility information in between renewal dates shall be given the option to renew eligibility at the time of the update.

(2) Eligibility for public health coverage programs shall be automatically renewed whenever any public benefits program renewal is conducted *if the recipient is otherwise eligible for a public health coverage program*.

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

(1) The department, the California Health and Human Services Agency, MRMIB, and the Exchange board shall provide a forum in which the public, including consumers and their advocates, may on a regular basis, and no less than once a month, give feedback in person on the implementation of the eligibility, enrollment, and retention system for public health coverage programs, including, but not limited to, activities of any public or private entity or individual providing eligibility screening or application or retention assistance, for timely corrective action by the department, MRMIB, and the Exchange board.

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

(A) Provide for evaluation of information technology (IT) programming by an independent expert before implementation, by testing functionality, compliance with eligibility rules, and accuracy of enrollment decisions. This evaluation shall be made available to the public sufficiently in advance of implementation to allow for an opportunity for review and comment.

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

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

(n) In designing and implementing the eligibility, enrollment, and retention system, the department, MRMIB, and the Exchange board shall ensure that all privacy and confidentiality rights under the PPACA, other federal and California laws and regulations, the Medi-Cal Program, and the Healthy Families' Program are strictly incorporated and followed. This includes, but is not limited to, adopting and implementing policies and procedures to ensure all of the following:

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

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

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

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

to decline online screening, application, renewal, and electronic verification and instead may apply or renew in person, by mail, or by telephone.

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

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

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

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

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

15927. Except as otherwise specified, this part shall become operative on January 1, 2014.

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