BUILDING A CONSUMER-DRIVEN ELIGIBILITY, ENROLLMENT, AND RENEWAL SYSTEM

Essential Design Features for Effective Health Reform in California

The Children's Partnership

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About The Children's Partnership

The Children's Partnership (TCP) is a national, nonprofit organization working to ensure that all children—especially those at risk of being left behind—have the resources and opportunities they need to grow up healthy and lead productive lives. The Children's Partnership focuses particular attention on the goals of securing health coverage for every child and their families and on ensuring that the opportunities and benefits of digital technology reach all children. Consistent with that mission, we have educated the public and policy-makers about how technology can measurably improve children's health, education, safety, and opportunities for success. We work at the state and national levels to provide research, build programs, and enact policies that extend opportunity to all children and their families.

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Executive Summary

Under the Patient Protection and Affordable Care Act (ACA), California has the unprecedented opportunity to construct a smart, efficient, consumer-centered system that connects people with appropriate health care coverage. As the first state in the nation to approve a Health Benefit Exchange (in addition to passing legislation to construct an integrated eligibility and enrollment system), the stage is set to provide up to 97 percent of Californians with affordable health insurance coverage.

The ACA and proposed federal guidance set a high bar, calling on states to build a first-class consumer experience with a "high level of service, support, and ease of use, similar to that experienced by customers of leading service and retail companies and organizations." In order to meet that standard, California policy-makers will need to measure all policy decisions by their impact on the State's ability to develop a system that consistently helps Californians find and maintain coverage without needless hassle or delay. At the same time, these policy decisions must be made quickly to support the development of a fully functional system by October 2013, when the first Exchange open enrollment period begins (with coverage effective January 1, 2014), and to maximize federal funding.

Getting this right, out of the gate, will be critical to setting expectations for an efficient and workable system, which will, in turn, promote enrollment among the almost 4 million Californians who are the intended beneficiaries of this effort. This report offers a roadmap for some of the more critical eligibility and enrollment policies and design features that are required to fulfill the consumer-friendly expectations laid out in The Children's Partnership's prior report *Easy, Efficient, and Real-Time: A Framework for a First-Class Health Insurance Enrollment Experience in California*. Grounded in known federal and state requirements, on-the-ground knowledge of enrollment policy, and stakeholder input, it provides the strategies and technological infrastructure required to achieve the following essential design features of an eligibility, enrollment, and renewal system, as viewed through the lens of the consumer:

1. Smart connections through multiple doorways and accessible consumer assistance.
2. Integrated eligibility criteria and processes across programs.
3. Real-time, immediate, and ongoing enrollment.
4. Easy navigation of coverage.

Federal Requirements

The ACA's statutory language and proposed federal rules released by U.S. Department of Health and Human Services and the Internal Revenue Service provide fairly detailed state and program policy directives. Under the law, states will:

- Create "no wrong door" where applicants will enroll in whichever program they are eligible for wherever they apply (whether through a new Web portal, in person, by mail, or over the phone), using a single application.
- Align income eligibility rules and household income definitions, with some exceptions, through application of a Modified Adjusted Gross Income (MAGI) standard that eliminates assets tests and replaces income disregards with a 5% across-the-board increase in income eligibility. Retain pre-ACA rules for certain Medi-Cal populations (i.e., aged, blind, or disabled).
- Establish real-time enrollment through modernized information technology systems that allow for electronic transfer of information and electronic data-matching for verifying eligibility (requiring documentation only when a match is not "reasonably compatible").
- Set up easy, user-friendly renewal procedures in the insurance affordability programs, and establish one-year enrollment periods.
- Provide new modeling options for determining FMAP without requiring multiple eligibility determinations, and provide enhanced federal funding for building required IT systems.

Roadmap to Essential Design Features

The decisions being made today to implement the ACA will have a greater impact on consumers' access to health coverage than any made in a generation. As these critical choices are made, this set of recommendations will help ensure that the consumer enrollment experience is user-friendly, integrated, simplified, and modernized across Medi-Cal, Healthy Families, and subsidized Exchange coverage (the insurance affordability programs).

To plan for and design these policy elements, California should draw upon all available resources, including federal funding for planning and development of technological systems, the Enroll UX 2014 project, and the stakeholder workgroup established by AB 1296 to develop policy recommendations pertaining to eligibility, enrollment, and renewal process. Additionally, because of the short timeline required for this process, decision-makers will need to keep a strategic eye on the legislative calendar for any policies requiring statutory changes beyond what is already provided in the Exchange enabling legislation.

1. Smart Connections Through Multiple Doorways and Accessible Consumer Assistance

Implement outreach and enrollment strategies that are targeted to harder-to-reach populations who will more likely require hands-on or live connections and assistance. Page 10

- Leverage trusted community resources and networks to provide outreach and assistance.
- Target consumers seeking unemployment and emergency room services.
- Deploy outreach beyond Exchange open enrollment periods and innovate to reach younger, underserved populations.

Ensure that the Exchange consumer assistance function and toll-free call center provide consumers with real-time (either automated and live human) assistance. Page 11

- Establish accuracy and timeliness standards and other relevant measures to guarantee quality of service.
- Provide assistance in a manner that is accessible to individuals with disabilities and limited English proficiency.

Build the Web portal to support the full coverage experience. Page 11

- Engage consumers by designing the online service to allow them to research their options, start and manage an account, and complete eligibility, enrollment, insurance plan selection and ongoing management functions.
- Establish strong privacy protections, allow users to provide access to Navigators and third party facilitators, and make the portal accessible via a range of Web browsers, mobile platforms, and applications.

Use express lane strategies and technology to prepare for large-scale pre-enrollment. Page 12

- Use information on file to prepopulate an application form for parents of children currently enrolled in Medi-Cal or Healthy Families who want coverage.
- Automatically transfer children from 101% to 138% FPL from Healthy Families to Medi-Cal and provide support to maintain continuity of care.
- Target and streamline enrollment of adults in other limited health benefit programs, including those receiving coverage through the Section 1115 waiver, FamilyPACT, and Breast and Cervical Cancer Treatment Program (BCCTP).

3. Real-Time, Immediate, and Ongoing Enrollment

Develop a modernized enrollment system and state verification hub (with connections to the federal hub) that can provide adequate information to support the application, mid-year updates, and renewal. Page 20

- Prepopulate online and paper forms, to the greatest degree possible, pulling information already in state and federal databases. Prioritize state and private data sources that are more up-to-date than the federal hub.
- Utilize attestation of eligibility criteria to the greatest extent allowed by federal law, supported by verification where required, including for citizenship, nationality, and immigration status.
- Automate renewal using available data for both MAGI and non-MAGI-based cases.

Develop a data hierarchy that helps resolve inconsistencies in eligibility data and reduces the need for follow-up with applicants. Page 21

- Establish a policy that finds incompatibility within an application only where the data at issue would have a "material" impact on eligibility (i.e., would change the outcome).
- When material data discrepancies exist, provide the consumer with an opportunity to independently resolve the discrepancy and, if documentation is required, allow for submission by e-mail, sending a picture via mobile device, fax, or mail.

Whenever real-time eligibility and enrollment are not possible, provide immediate coverage to otherwise eligible consumers prior to a final determination. Page 22

- Provide seamless transition for consumers who undergo a non-MAGI Medi-Cal review, from their initial MAGI-based enrollment into non-MAGI Medi-Cal, where found eligible, and provide continuity of plan/provider choices as much as possible.
- Pending resolution of a data issue, provide immediate coverage for consumers who appear eligible for Medi-Cal, Healthy Families, and Exchange.

Establish consumer-protection policies to govern the use of data. Page 23

- Obtain informed authorization prior to retrieving and/or sharing data.
- Guarantee that any information provided will be kept confidential and will be accessed, used, and disclosed only for eligibility and enrollment purposes (and retained only for so long as is reasonably needed for such purposes).

4. Easy Navigation of Coverage

Ensure that health plan enrollment is integrated into the eligibility process and occurs as part of the application and, if possible, in real time. Page 25

- Build plan selection, governed by corresponding consumer protections, into CalHEERs such that the whole process from application to plan selection could be accomplished in one sitting.
- Ensure that families in different programs can view and compare across programs about available benefits, carriers, providers, costs, and other important issues.
- Provide consumers with nonelectronic means for completing the plan selection process at their option.

Coordinate premium payment across programs. Page 26

- Design the premium payment function in CalHEERS so that consumers receive one monthly bill for the whole family.
- Allow payment through multiple venues, including online, EFT, mail, in person, and mobile devices.
- Discount the Healthy Families premium for mixed-coverage families paying other premiums and conform the premium grace period to match the Exchange grace period (three months).

Establish consumer-friendly procedures for those facing changing circumstances. Page 26

- Provide clear, easy-to understand instructions as to required change reporting, providing each consumer with a personalized reporting threshold.
- Allow change reporting online, over the phone, via mail, in person, or when paying monthly premiums.
- Identify consumers who may be experiencing loss of income (such as those applying for unemployment, new benefits, and those failing to pay premiums) and proactively help them adjust subsidies and/or enrollment, as appropriate.
- Eliminate unnecessary paperwork and ensure that consumers transferring between programs experience no gaps in coverage.

Establish policies for mixed-coverage families that will assist them in navigating through the different programs. Page 27

- Coordinate and consolidate how mixed-coverage families choose health plans, make premium payments, and receive correspondence.
- For families applying outside Exchange open enrollment, enroll eligible children in Healthy Families but reset their renewal date to coincide with parents' eventual Exchange enrollment.
- Promote availability of Medi-Cal, Healthy Families, and child-only plans for children even among parents who are not eligible for insurance affordability programs.

Assist Small Business Options Program (SHOP) participants in navigating their health coverage and connecting them to the insurance affordability programs, when appropriate. Page 29

- Provide SHOP participants with the same consumer-friendly features envisioned for the insurance affordability programs, such as hands-on assistance, access to online accounts, and easy-to-understand information on health plan options.
- Allow employees to designate on the SHOP application when they have dependents in need of health coverage and promote SHOP employees' ability to access applicable insurance affordability programs for their dependents, where dependent coverage is unavailable or unaffordable, through education and linkages.

Introduction

The road to health reform has been a long one, with a tremendous amount of work still left to accomplish by 2014 to reach the vision laid out by the Patient Protection and Affordable Care Act (ACA).[1] As the administrative and operational pieces are developed and discussions occur over specific policies, it will be very easy to lose sight of the very fundamental goal that is at stake—to provide up to 97 percent of Californians with affordable health insurance coverage.[2]

There is no doubt that the ACA sets California up for success. It puts into place smart and modernized changes to Medicaid and the Children's Health Insurance Program (Medi-Cal and Healthy Families in California), whose eligibility rules are fairly antiquated and rigid in design but have nonetheless sustained the health of millions of individuals across the state. In addition to strengthening the current coverage field, the new law gives many more consumers the ability to purchase and maintain affordable and comprehensive health insurance.

Meeting health reform's objectives will entail a sustained effort that will both challenge stakeholders and, in many ways, push California to change the way it does business. At the forefront of this process, and ultimately the driving force behind any decision-making, should be the answer to the question: When the doors open for business, what do we want the consumer experience to be?

In the July 2011 publication *Easy, Efficient, and Real-Time: A Framework for a First-Class Health Insurance Enrollment Experience in California*, The Children's Partnership began to answer this question by providing a framework of expectations for building a first-class consumer-driven eligibility, enrollment, and retention system. It recommended that consumers have the ability to:

- **Access the enrollment system through many doorways,** being able to choose the location and method that best suits their needs (whether online, by mail or phone, in person, or through existing gateways) in addition to obtaining consumer assistance at any juncture.
- **Apply for coverage using a clear, logical, and user-friendly application** requesting the minimal amount of information required, being screened for all available coverage programs, and being referred to other health and human services programs, if applicable.
- **Receive real-time enrollment and automatic renewal** using data available from electronic databases in a way that is transparent and eliminates the need for paper documentation.
- **Manage health care enrollment** across programs in a single online location that allows for comparing and choosing a plan, paying premiums, and reporting a change of circumstances, with seamless transfer between programs, if applicable.

How to Use this Report

This report is written for policy-makers, health care and consumer advocates, community leaders, and other stakeholders working in California to implement health care reform. It is written with a specific focus on California. However, most of the information and recommendations will be relevant to decision-makers in any state.

The nucleus of the report is the chapter "Essential Design Features" and its four sections:

1. Smart connections through multiple doorways and accessible consumer assistance.
2. Integrated eligibility criteria and processes across programs;
3. Real-time, immediate, and ongoing enrollment; and
4. Easy navigation of coverage.

For each of these sections you will find:

- Key policy questions (with answers) facing decision-makers;
- A roadmap of final recommendations for achieving the policies described; and
- Federal and state legal requirements (listed in Appendix A) corresponding to each of the four design features.

At the end of the report are two additional resources: technology features required for a shared eligibility system (Appendix B) and a chart of program verification rules (Appendix C).

An interactive graphic complemented the findings by walking through what an individual consumer's health insurance enrollment experience should look like. (See *A Step-by-Step Guide to Health Insurance Enrollment in California*.)

This report picks up where those resources left off. It offers a roadmap on some of the more critical eligibility and enrollment policies and design features that are required to fulfill the consumer-friendly expectations the previous paper laid out. We took the report's findings, applied analysis of current federal and state rules relating to the ACA and our knowledge of real, on-the-ground processes, and, with input from stakeholders, developed recommendations on the strategies and technological infrastructure required to achieve the following core components of an eligibility, enrollment, and renewal system:

1. Smart connections through multiple doorways and accessible consumer assistance;
2. Integrated eligibility criteria and processes across programs;
3. Real-time, immediate, and ongoing enrollment; and
4. Easy navigation of coverage.

We are cognizant that other topics (e.g., benefit design, market reforms, or premium structure) are also critical pieces to the final product and require further exploration. Additionally, since this report looks at eligibility and enrollment policies through the lens of the consumer, it may not address every operational procedure and function envisioned. It also focuses primarily on public programs—including subsidized Exchange coverage—and not on coverage that will be available to consumers at full cost through the Exchange or employer coverage through the Small Business Options Program (SHOP). These will be important considerations moving forward, and we hope that this report provides a starting point for real discussion and decision-making.

The Legal Underpinnings

While federal officials have not issued final regulations pertaining to most provisions of the ACA, the law's statutory language provides fairly detailed state and program policy directives. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, and the Internal Revenue Service have also released proposed regulations related to eligibility and enrollment portions of the ACA.[3] (See Appendix A for provisions of the proposed federal rules.) These regulations may change, and others still need to be written, but the law and the proposed rules provide a solid framework from which to examine key policy questions facing California.

With a 2014 implementation date, time is of the essence. In fact, with a January 1, 2014 effective coverage date, a working eligibility, enrollment, and retention system must be in place much earlier. Another important milestone for California is receiving federal approval for its Exchange and system changes, which has a deadline of January 1, 2013 and requires the State to undergo certain federal evaluative and testing processes. (See Box 1 of key dates.)

California officials have fully embraced the charge put before them. The Governor and Legislature created the California Health Benefit Exchange[4] (HBEX) and have applied for and already received available federal funding.[5] The State has also taken steps to choose the vendor who will be charged with designing and building the eligibility, enrollment, and renewal system required to implement the ACA (referred to as the California Healthcare Eligibility, Enrollment, and Retention System or CalHEERS).

Legislation (AB 1296)[6] signed into law by Governor Brown also provides the building blocks for implementing the ACA's requisite streamlined and integrated eligibility and enrollment system. Besides establishing a formalized process through which state agencies, consumer advocates, and other stakeholders can consider policies to effectuate this change and monitor progress on an ongoing basis, AB 1296 puts into place main pieces of the ACA, which California needs to create a consumer-driven eligibility, enrollment, and renewal system. Additionally, California is well positioned for putting the consumer first as one of eleven states participating in the Enroll UX 2014 project, a public-private partnership that is developing and offering first-class user enrollment design standards to states implementing health reform.[7]

Essential Design Features

The ACA expands coverage to new consumers, primarily through an expansion of Medicaid to adults, the maintenance of children's coverage through Medicaid and the Children's Health Insurance Program (CHIP), and the creation of premium tax credits and cost-sharing reductions for those not eligible for the public programs (referred to in this report as subsidized Exchange coverage). It also establishes new marketplaces where individuals (through an Exchange) and employers (through SHOP) can easily purchase coverage and it implements private health insurance reforms that will make it easier for consumers to obtain and keep their coverage. States can effectuate these changes through a state-based (with the option to employ certain federally managed functions, such as premium tax credit determinations) or a federally facilitated Exchange.

California has moved forward to establish a state-based and operated Exchange and, as a result, must be ready to provide coverage to 3.84 million consumers newly eligible for Medi-Cal and subsidized Exchange coverage[8] by January 1, 2014. (See Figure 1 for eligibility in 2014.) This is in addition to the over 8 million Californians who already receive Medi-Cal and Healthy Families and who will renew or transition among the coverage options in 2014 and beyond.[9] Other consumers will enroll in nonsubsidized Exchange coverage.

The following four sections explore some of the design features necessary to not only make these enrollment numbers a reality but, even more importantly, create a post-2014 world in which the consumer enrollment experience is user-friendly, integrated, simplified, and modernized across Medi-Cal, Healthy Families, and subsidized Exchange coverage (referred to as the insurance affordability programs).[10]

Box 1. The Clock is Ticking: Federal and State Deadlines to Health Reform

2012	
April 17	• California Health Benefit Exchange awards California's Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) vendor contract.
June 29	• Last day to apply for ongoing federal Exchange funding. (California's current grant expires.)
July 1	• California Health and Human Service Agency reports to Legislature on policy and statutory changes needed to implement AB 1296 recommendations.
September – November	• California submits application to federal authorities for Exchange approval; CalHEERs undergoes operational readiness assessments (vendor design reviews already completed).
2013	
January 1	• Federal authorities certify Exchanges for approval (or conditional approval). • California Office of Patient Advocate begins to provide assistance to consumers. Other outreach strategies and Navigator training/certification should begin.
July1 (October 1 at the latest)	• Open enrollment starts. • CalHEERS in place. Applicants use new eligibility and enrollment process to submit applications, receive consumer support, and navigate coverage.
2014	
January 1	• Coverage effective; enrollment in Medi-Cal/Healthy Families continues beyond open enrollment. • Ongoing testing and monitoring is in place. • Integration of eligibility and enrollment for human service programs into CalHEERs begins. (Availability of 90 percent federal Medi-Cal match for IT start-up costs ends December 31, 2015.)

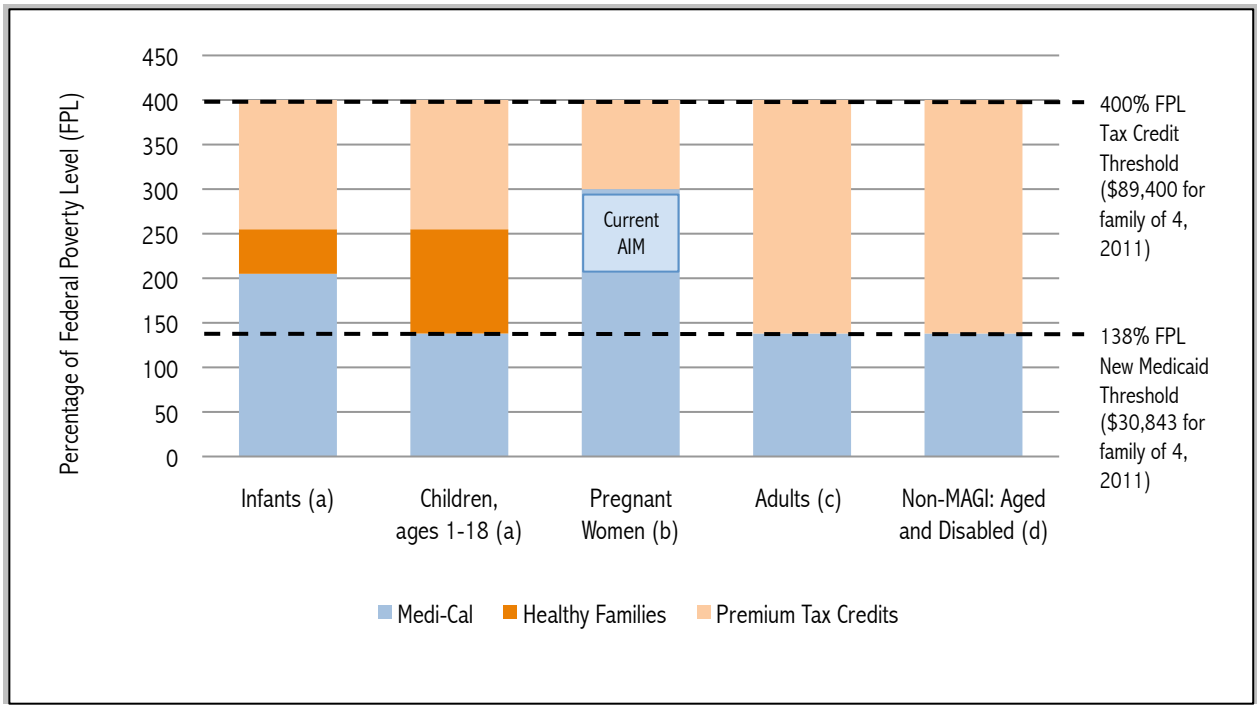
Design Feature 1: Smart Connections Through Multiple Doorways and Accessible Consumer Assistance

The ACA changes the playing field for uninsured individuals seeking health insurance outside of their employer. Instead of trying to navigate the individual health insurance marketplace or figure out what public programs exist and how to apply, consumers applying for coverage will be able to easily access information, apply using a single application, and enroll into a program and/or health plan for which they are eligible, no matter what doorway they enter. As federal guidance explains, the process should be "similar to that experienced by customers of leading service and retail companies and organizations."[11]

Recommendations concerning the single application (e.g., whether California will use a federal template or develop its own) will be discussed within the stakeholder and state agency workgroup established by AB 1296 to address this and similar eligibility and enrollment policies. The following are additional policy questions that should be considered to ensure that consumers find their way into this new and modernized enrollment system.

Unless otherwise noted, references to federal and state law can be found in Appendix A.

Figure 1. Eligibility for California's Insurance Affordability Programs, 2014



Notes:

a. States must maintain Medicaid and CHIP for children in effect on March 23, 2010 until October 1, 2019. As a result, infants will maintain Medi-Cal eligibility up to 205% FPL and infants/children not eligible for Medi-Cal will be covered under Healthy Families up to 255% FPL. Children currently in Healthy Families ages 6-18 from 100 to 138% FPL will be shifted to Medi-Cal. To ensure continued coverage for children at pre-ACA levels, a "MAGI- equivalent" standard will be applied, which could raise the eligibility levels further. Further federal guidance is expected on this standard.

b. Pregnancy-related Medi-Cal will be maintained up to 205% FPL. Pregnancy-related and postpartum services are also provided to women in California through AIM up to 300% FPL. This report recommends providing full Medi-Cal coverage to pregnant women up to 300% FPL.

c. Childless adults up to 138% FPL and parents with incomes from 107 to 138% will become eligible for Medi-Cal. California received federal approval in 2010 to provide health coverage services, on a county-by-county basis, for non-elderly adults with incomes up to 200% FPL (who in 2014 will be shifted to Medi-Cal and Exchange coverage, as applicable).

d. The Aged & Disabled FPL program currently provides coverage to children and adults up to 100% FPL (plus a disregard). Working disabled adults are also eligible for Medi-Cal coverage with a premium up to 250% FPL. Individuals above these eligibility levels could also receive Medi-Cal through the Medically Needy Program with or without a share of cost.

How Should Consumers Learn About and Access Coverage Options and Receive Ongoing Assistance?

Over the last dozen years, California (like most states) undertook a rigorous effort to enroll "eligible but uninsured" children into Medi-Cal and Healthy Families. Outreach tactics and enrollment strategies were deployed in communities and statewide. At the end of the day, over 4.5 million children (ages 0-18) in California can see a doctor when they are sick because they have Medi-Cal or Healthy Families coverage.[12] Unfortunately, 695,000 children remain uninsured but eligible for the programs.[13] Health reform directly addresses some of the more entrenched barriers that have contributed to this failure by fundamentally transforming the complicated—and sometimes bewildering—application, eligibility, and enrollment processes that families face. What history has taught us, however, is that there remains a critical outreach and assistance role for the State to play in ensuring that consumers come through the door in the first place and, once there, receive the help they need to complete the process.

Outreach and Enrollment Strategies

Under health reform, there will be a mix of consumers newly eligible for coverage. Some will be lower income and new to health insurance, while others will have more moderate incomes with or without experience purchasing employer coverage. While broad-based media campaigns, social media, and online enrollment will be important avenues for a number of these consumers (especially those more savvy to the health insurance marketplace), most challenging will be connecting with harder-to-reach populations who have limited to no knowledge of health insurance and who may rely more heavily on word-of-mouth, in-person assistance, and a paper application. Strategies should include the following.

- Navigator Program. The Navigator program required under the ACA will help by providing hands-on consumer assistance, including education about the different programs, help completing an application, and information on navigating care once enrolled. A variety of entities will be eligible to receive Navigator grants, but California should ensure broad representation from those with established relationships and trust in underserved communities, experience conducting successful outreach strategies, and demonstrated expertise in providing culturally and linguistically appropriate assistance. To be relevant, the Navigator program should be operational prior to open enrollment in 2013.
- Community-Based Support. While health reform rightly places emphasis on the value that technology can play in creating a more consumer-friendly experience, it may take awhile for everyone to get there. California officials cannot lose sight of the fact that not all consumers will respond to Web site and e-mail addresses, but instead will want to know how they can obtain real help from a live person (in person or by phone). Experience also shows that using existing networks that are in regular touch with families can have a tremendous impact on reaching consumers where they live and work.[14] This includes utilizing schools, religious institutions, libraries, employers, etc. to educate consumers about their choices and connect them to enrollment entities.

  Strategies should also ensure that connections to potentially uninsured consumers seeking services—such as through other public programs (like unemployment insurance or COBRA) and at a doctor's office, community clinic, or hospital—are created. The Office of Patient Advocate (created by AB 922), which will be established in January 2013 to provide outreach and education about coverage options, will be a critical avenue through which to provide these community-based outreach and enrollment strategies.[15]
- Enrollment Messages. Since over half of those newly eligible for health coverage in 2014 will enroll in Medi-Cal,[16] it will be important to broaden message strategies beyond the Exchange open enrollment periods. While consumers eligible for Exchange coverage can only be enrolled in coverage during open enrollment periods (with exceptions, for example, if a person loses coverage during the year), those eligible for Medi-Cal or Healthy Families can apply and enroll at any time during the year. Medi-Cal- and Healthy Families-eligible consumers should not be discouraged from applying when they most need coverage in addition to those needing coverage due to a changing life event (and potentially eligible for subsidized Exchange coverage via a special enrollment period).

Special consideration should also be given to the first year of open enrollment, which is proposed under federal rules to begin October 1, 2013. Although Exchange and new Medi-Cal coverage are effective January 1, 2014, applicants applying in 2013 could be eligible for Medi-Cal and Healthy Families under the old rules (especially children). These consumers should be able to immediately access coverage but have their cases aligned with other family members, if applicable, once eligibility for all of the programs occurs at the start of the year.

Exchange Consumer Assistance Function

The consumer assistance function (including a toll-free call center) housed within the Exchange should also translate into providing all consumers (those eligible for Medi-Cal, Healthy Families, or Exchange coverage) with real-time assistance with all aspects of health care enrollment that is available in person, by phone or mail, and online. This includes in-person support offered at convenient locations where applicants can get questions answered or obtain assistance in completing the application in addition to phone or online support that is available beyond normal business hours.

To ensure the effectiveness of this assistance, the State should establish testing mechanisms, and accuracy and timeliness standards for how promptly a person can get through on a phone line, schedule an appointment with a helper, and other relevant measures. As required under AB 1296, this assistance should also be provided "in a manner that is accessible to individuals with disabilities and those who are limited English proficient."[17] Finally, the assistance function should be coordinated with the Navigator program and the Office of Patient Advocate.

Exchange Web Portal

For consumers comfortable using the Internet, a newly required Exchange eligibility and enrollment Web portal will become a primary source of contact and information. As such, it should be built to ensure that the applicant and enrollee (whether in Medi-Cal, Healthy Families, or Exchange coverage) have full control over the process, but can request assistance at any time. This includes allowing consumers to visit the site to obtain clear and concise eligibility information prior to starting the application process (a few simple questions could easily screen out those who may not be eligible, without requiring them to complete an application first) in addition to allowing consumers to save an application in progress and come back to it later.

Consumers should also be able to maintain a personal account, manage how their personal information could be accessed and used, ask for further assistance through a robust "help" function (ranging from online Q&A to real-time online assistance via e-chat), and be provided with the calculations used in making an eligibility decision (and information on appeal procedures, as appropriate). The account should automatically generate notices as to all critical points in the enrollment experience (such as open enrollment opportunities, renewal inquiry, etc.), which should be provided in the format chosen by the consumer.

Additionally, the Web site should be designed to provide Navigators and other appropriate third-party facilitators with direct access and functionality that allows them to assist applicants and enrollees in applying for and managing their benefits at the applicant or enrollee's option. Consumer privacy protections should be a central component of the portal (see Design Feature 3 for further discussion of privacy standards), and it should be accessible via a range of Web browsers, mobile platforms, and smartphone applications.

Can Large-Scale Automated Enrollment Be Facilitated Prior to the Launch of Health Reform?

Once the Exchange is accepting applications in 2013 (for coverage effective January 1, 2014), California will have almost 4 million people to enroll in the insurance affordability programs (not to mention the additional applicants who will be seeking unsubsidized Exchange coverage).[18] Fortunately, Medi-Cal already has a presence in millions of lives and can be utilized to target large groups of newly eligible individuals prior to launch. California should utilize express lane strategies and technology (for which an enhanced federal matching rate is available)[19] to automate enrollment for the following populations.

Parents of Medi-Cal and Healthy Families Children

Some of the adults who will gain eligibility for Medi-Cal or subsidized Exchange coverage are parents of children who are enrolled in Medi-Cal or Healthy Families. For most of them, eligibility information already held by the programs will be adequate to determine eligibility. A prepopulated application should be sent to parents requesting their consent for an eligibility determination (if they require coverage). The form would seek confirmation of data on file along with any changes or additions including whether other family members need coverage. The materials should also provide information on how to finalize the process (either online, by phone, by fax, or by mail) and how to obtain assistance, if needed.

While multiple contacts may be required to reach these families, the number of consumers that could be potentially enrolled will make it an efficient use of resources. The determination for parents should also reset the enrollment period for the child so that the family has the same renewal dates. If new information would detrimentally change the child's eligibility, he or she would stay enrolled in their current program through the established renewal date.[20]

Healthy Families Children (Ages 6-18) from 101 to 138 Percent of the Federal Poverty Level (FPL)

Under the ACA, Medi-Cal will provide coverage to children and nonelderly adults up to at least 138 percent FPL.[21] Since Healthy Families currently covers some children within this income range, California Department of Healthcare Services estimates that about 162,000 children in Healthy Families must be shifted into Medi-Cal.[22] California should rely on Healthy Families income and other eligibility findings to automatically transfer these kids. Given its joint Medi-Cal/Healthy Families application, it is likely that most parents or caretakers have already provided affirmative consent to enroll their children in Medi-Cal. This allows for a one-time automatic rollover of affected Healthy Families children into Medi-Cal. To limit disruptions, California should help ensure, unless they wish to make a change, that children remain with the same health insurer when possible (or at the very least maintain their provider network), educate families on how to obtain care, and monitor any shifts in access to care.

Adults Eligible Under California's Waiver Program and Other Health Programs

California has a head start in identifying the adults who will be newly eligible in 2014 for Medi-Cal or subsidized Exchange coverage. On November 2, 2010, the State received federal approval under a Section 1115 waiver to phase in health coverage services, on a county-by-county basis, to up to 500,000 adults with incomes up to 200 percent FPL. As a condition of the waiver, the State must develop a plan for seamlessly transitioning this population to the new coverage options available under the ACA. The plan must include enrolling eligible consumers into Medi-Cal, without requiring a new application prior to December 31, 2013.[23] The plan ultimately decided upon should also be utilized, altered as necessary, for those adults above 138 percent FPL not eligible for Medi-Cal but potentially eligible for subsidized Exchange coverage. Similarly, California should target other likely eligible adult populations enrolled in health programs with limited-scope benefits, such as Family PACT and the Breast and Cervical Cancer Treatment Program (BCCTP), for streamlined enrollment into the insurance affordability programs.[24]

Can Enrollment Gateways Be Utilized to Reach More Uninsured Consumers?

The requirement that most individuals have health insurance—and the financial penalties that come with noncompliance—is a huge incentive for consumers to enter the Exchange.[25] However, some consumers with incomes below the tax-filing threshold (which for a family of three equates to roughly 100 percent FPL)[26] will not be obligated under the mandate. Many others, especially at lower incomes, may be hard to reach because of access barriers or inexperience with health insurance. The good news is that California has experience reaching out to these populations.

Express Lane Eligibility (ELE) Through Other Public Programs

California has already implemented an early form of ELE in participating schools' school lunch program. But new provisions in the Children's Health Insurance Program Act (CHIPRA) allow states to go even further.[27] California can base Medi-Cal and Healthy Families eligibility for children on the findings of other need-based programs, even if the program uses different methodologies from those used by Medi-Cal and Healthy Families. This can

greatly simplify the eligibility process for large numbers of uninsured consumers enrolled in other public programs. Additionally, the modernized and integrated electronic eligibility system and data-sharing envisioned by the ACA should provide the infrastructure for connecting the other public programs with Medi-Cal and Healthy Families for simpler processing.

The ACA and proposed rules contemplate the use of ELE by exempting ELE applicants from the new Modified Adjusted Gross Income standard (discussed further in the Design Feature 2). Even so, to be truly beneficial, California should seek, through a federal waiver if necessary, the ability to apply ELE to adults as well as children. Since applying ELE to a wider population is consistent with the intent of the ACA, federal officials should want to encourage its greater application.

California should begin by using the data already gathered for other public programs to implement large-scale, one-time enrollment when the ACA first takes effect. CalFresh is a good place to start, where 370,000 enrolled individuals have no insurance coverage.[28] These individuals have already provided demographic information, a social security number (SSN), and proof of legal immigration status or citizenship in addition to having an eligibility finding that places them under 130 percent FPL. The State should access the information in the CalFresh case files to automatically complete a Medi-Cal eligibility determination. Individuals would be contacted to provide affirmative consent to enroll, along with selecting a plan, to complete the enrollment process. Between now and 2014, the CalFresh application should also be modified to allow families to consent or opt out of such information-sharing. This same process should be applied at renewal.

Newborn Hospital Gateway

Babies whose mothers have Medi-Cal at the time of delivery are deemed eligible for Medi-Cal for the first year of life. There is no application or eligibility determination required. Instead a mother completes a one-page Newborn Referral Form or calls their eligibility worker. This policy holds great promise for health reform by ensuring that no baby leaves a hospital without health coverage. Unfortunately, efforts to make the process more systemic (e.g., allowing hospitals to electronically enroll the eligible infants) have not come to fruition, although, as described in the next section, a component of the program has been successfully implemented through the CHDP Gateway.[29]

Now is the time for California to implement an electronic newborn hospital gateway by requiring hospitals to automatically enroll infants born to Medi-Cal moms into Medi-Cal through the Web portal. No application would be required (although an application could be submitted on behalf of other family members requiring coverage). This same process should be applied to someone who has Exchange coverage. Prior to leaving the hospital, the family should be able to log into their online account (or the hospital could be required to submit information on the child's birth to the Exchange through the Web portal) to add the child to Exchange coverage or Healthy Families, as applicable. Guaranteeing that families leave the hospital with insurance for their newborns ensures that there will be no delay in bringing them in for well-baby care, which begins in the first weeks of life.

A Roadmap to Smart Connections Through Multiple Doorways and Accessible Consumer Assistance

Implement Outreach and Enrollment Strategies that Are Targeted to Harder-to-Reach Populations Who Will More Likely Require Hands-On or Live Connections and Assistance.

- Ensure that the Navigator program has broad representation from those entities with established relationships and trust in underserved communities, experience conducting successful outreach strategies, and demonstrated expertise in providing cultural and linguistically appropriate assistance.
- Use existing networks that are in regular touch with families, such as schools, religious institutions, libraries, employers, etc., to reach consumers where they live and work. Implement strategies that make connections to potentially uninsured consumers seeking services through other public programs (like unemployment insurance or COBRA) and at a doctor's office, community clinic, or emergency room. Utilize authority provided to the Office of Patient Advocate to implement community-based outreach and enrollment strategies.
- Broaden outreach strategies beyond the Exchange open enrollment periods to reach Medi-Cal- and Healthy Families-eligible consumers in addition to those needing coverage due to a changing life event (and potentially eligible for subsidized Exchange coverage via a special enrollment period). Immediately enroll Medi-Cal- and Healthy Families-eligible consumers applying during 2013 Exchange open enrollment and, if applicable, align effective coverage dates with other family members.

Ensure that the Exchange Consumer Assistance Function and Toll-Free Call Center Provide All Consumers with Assistance with all aspects of health care enrollment and delivery that is available in person at convenient locations as well as remotely (i.e., online or by phone or mail) beyond normal business hours.

- Establish testing mechanisms, and accuracy and timeliness standards for how promptly a person can get through on a phone line, schedule an appointment with a helper, and other relevant measures.
- Coordinate with the Navigator program and the Office of Patient Advocate, and provide assistance in a manner that is accessible to individuals with disabilities and limited English proficiency.

Ensure that the Exchange Eligibility and Enrollment Web Portal Is Consumer-Friendly and Easy to Navigate.

- Allow applicants to screen their eligibility prior to starting an application, save an application in process and come back to it, establish and maintain a personal account and manage their information, receive live help and notices in their chosen format, and view how their eligibility was determined.
- Establish strong privacy protections, allow users to provide access to Navigators and third-party facilitators, and make the portal accessible via a range of Web browsers, mobile platforms, and smartphone applications.

Use Express Lane Strategies and Technology to Implement Large-Scale Enrollment Prior to the Launch of Health Reform.

- Streamline enrollment for uninsured parents of children already receiving Medi-Cal and Healthy Families who want health coverage using information on file and a prepopulated application. Unless the information would detrimentally change the child's eligibility, reset renewal dates to coincide with other family members.
- Automatically transfer children in Healthy Families who are have incomes from 101 to 138 percent FPL into Medi-Cal, relying on the income and other eligibility findings already on file (and the family's consent provided as part of the application process). Unless they want to make a change, ensure that children remain with the same health insurer when possible (or at the very least maintain their provider network), educate families on how to obtain care, and monitor any shifts in access.
- Target and automate Medi-Cal or subsidized Exchange coverage enrollment of adults in other health programs with more limited benefits, including California's Section 1115 waiver, FamilyPACT, and BCCTP.

Leverage Enrollment Gateways to Reach More Uninsured Consumers.

- Allow for the use of Express Lane Eligibility for adults and children enrolled in CalFresh (seeking a federal waiver, if necessary). With consent, use information and eligibility findings in the CalFresh files to automatically complete a Medi-Cal eligibility determination. Between now and 2014, modify the CalFresh application to allow families to opt out of such information-sharing.
- Implement a newborn hospital gateway by requiring hospitals to automatically enroll infants born to Medi-Cal moms into Medi-Cal through the Web portal and to assist those with Exchange coverage in adding a child.

Design Feature 2: Integrated Eligibility Criteria and Processes Across Programs

Persons eligible for public health programs in California face a myriad of eligibility rules that oftentimes make it difficult for them to understand available health care options. While the State over the years has taken important steps to make this process more efficient, parents enrolling their children in coverage can still find themselves, for example, in limbo between a county Medi-Cal office and Healthy Families. Subsidized Exchange coverage will add another layer to this backdrop, making it critical to successfully integrate eligibility processes across California's health programs. This "no wrong door" approach also ensures that California avoids duplication of costs, processes, and effort. While these policies offer a new and simple eligibility model in California, they also raise important operational questions for the State.

Unless otherwise noted, references to federal and state law can be found in Appendix A.

How Will "No Wrong Door" Be Applied?

The ACA sets into motion an unprecedented opportunity for California to construct a single, coordinated, consumer-centered health enrollment system. Federal and state law (AB 1296, specifically) provide the key components required to execute such a system, including one application, the Exchange Web portal, coordinated eligibility and verification rules, and emphasis on real-time enrollment (discussed further in the next section).

The ACA and proposed federal rules also require that state-based Exchanges evaluate all consumers applying for coverage for Medi-Cal and Healthy Families and, conversely, that Medi-Cal and Healthy Families screen a consumer for "potential eligibility" for subsidized Exchange coverage (with the state option that they conduct a full determination). State-based Exchanges also have the option to use federally managed services, such as eligibility determinations for the premium tax credit. (See "MAGI Eligibility Determinations" in Appendix A for a detailed description of federal rules as they relate to agency responsibility.) Finally, the proposed rules lay out an expectation that states will adopt a shared eligibility service that will "coordinate determination and renewal requirements for eligibility in each of the insurance affordability programs."[30]

It is California's job to take all of these pieces and fit them together in a way that ensures uniformity across the programs and from various entry points within the enrollment system. This can, and should, be accomplished through the adoption of a single state-operated eligibility rules engine that is used, through CalHEERS, by all programs and through which all applicants begin the process (even if applying at a county Medi-Cal office or with a paper application). The alternative is unworkable—having each program process the applications it receives and, if it finds applicants ineligible, send their case files to another program for an additional eligibility determination. While legal responsibility for the cases and any further action required (see non-MAGI discussion below, in particular) will ultimately reside with the agency and staff administering the program, a single shared system ensures that consumers will experience a seamless and consistent eligibility process, no matter which entry point they access. Such a system also offers a far greater chance of achieving real-time eligibility determinations since the alternative system-to-system interface would be reliant on receiving results from another system's rules engine. And, maybe most relevant to state officials, duplicative or redundant systems will likely not be approved for receipt of federal enhanced Medicaid funding available for the development and ongoing operation of health reform's information technology systems.[31]

Building the technological infrastructure required for a single shared eligibility system through CalHEERS should be a priority of California. Appendix B describes the key components of a single shared eligibility system.

How Will Income and Household Eligibility Requirements Be Aligned Among the Insurance Affordability Programs?

The ACA and proposed federal rules go a long way in coordinating the income eligibility rules between the programs. The application of a Modified Adjusted Gross Income (MAGI) standard and replacement of all disregards with a five percent across-the-board income standard will help to streamline the application and eligibility processes significantly for many people.

Additionally, the State can utilize sampling or other methodologies to claim enhanced federal matching funds for "newly eligible" Medi-Cal adults instead of applying old and new income eligibility rules on a case-by-case basis (essentially to set up two eligibility processes).[32] Nonetheless, the programs retain certain distinct income eligibility criteria that the State must address. The ACA and proposed rules retain Medicaid's income standard (current monthly income versus annual income) in addition to its definition of household composition and type of income counted under certain scenarios. The MAGI standard also will not apply for all Medi-Cal populations, including those who are aged, blind, or disabled.[33]

There are some important functional policies that could help simplify this process. Applicants, no matter where they apply, will be first evaluated for MAGI-based Medi-Cal. This means that the State will not necessarily have to review whether an individual who meets the MAGI Medi-Cal standard (e.g., adults with income up to 138 percent FPL) is also eligible as a disabled individual, which entails a more involved eligibility determination. (See discussion below regarding application of this policy if "newly eligible" MAGI Medi-Cal applicants receive a less comprehensive benefit package.) Additionally, the Exchange Web portal will enable the use of technology to streamline the eligibility process by only seeking answers to questions when necessary and relevant to the specific individual. Accomplishing this will be more difficult with a paper application.

There are also two policies that California should implement that will mitigate possible problems with the application of both current monthly income (Medi-Cal and Healthy Families) and projected annual income (subsidized Exchange coverage). There could be instances in which a person would find themselves ineligible for both Medi-Cal or Healthy Families and subsidized Exchange coverage. For example, a seasonal worker could apply with current income at a monthly level that is too high to qualify for Medi-Cal, but with an annual income that makes him or her ineligible for Exchange premium subsidies. California should limit these situations by requiring that the application ask about "reasonably predictable decreases in future income" during the application process. The State should also implement a state option to maintain Medi-Cal or Healthy Families eligibility for enrollees with fluctuating monthly incomes so long as their annual income for the current calendar year remains at or below the Medi-Cal income standard.

Ultimately, the distinct remaining differences between the programs with regard to income and household calculations illustrate how critical it is that the process be conducted using a single eligibility rules engine. Without it, applicants applying to the different programs could find themselves being bounced back and forth between the programs and systems.

Are There Other Eligibility Rules that Need Addressing?

In addition to income, the ACA and proposed regulations coordinate other eligibility rules between the insurance affordability programs. Specifically, a new state residency standard will be established across programs and the Exchange will apply Medicaid's definition of lawfully present immigrants for its purpose.[34] The proposed rules also require that applicants provide a SSN (currently not required by Healthy Families).[35] (See Appendix C for a chart listing the eligibility criteria for each of the programs.)

There remains a very critical difference, however, between subsidized Exchange coverage and Healthy Families that must be addressed. According to the proposed federal rules, consumers are not eligible for subsidized Exchange coverage if they are enrolled in any employer-sponsored plan (no matter the cost) or if they are eligible for an employer-sponsored plan that meets affordability standards (if the employee contribution for self-only coverage does not exceed 9.5 percent of household income or the employer plan pays at least 60 percent of the allowable cost of covered services).[36] (See Design Feature 4 for a further description of how this affordability test could be applied.) There are no such requirements for Medicaid but under CHIP an applicant cannot be enrolled in an employer-sponsored plan at the time of application.[37] Some states, like California, have also established waiting periods for employer coverage.[38] In California, a Healthy Families applicant cannot be enrolled in employer coverage for three months prior, with some exceptions.[39] This conflict could cause complications for mixed-coverage families in which the child is eligible for

Healthy Families and the parents are eligible for subsidized Exchange coverage. (See Design Feature 4 for a further discussion of mixed-coverage families.) For this reason, California should eliminate the three-month waiting period in Healthy Families, which is not required under federal law. Without such protections, Healthy Families-eligible children will experience gaps in coverage when employer coverage becomes unaffordable and the family can no longer maintain it.

What Structures Should Be in Place to Process Applications for Non-MAGI Populations?

As mentioned, certain populations (specifically, aged, blind, and disabled) will require special processing under CalHEERS. Once a consumer is found ineligible for MAGI-based Medi-Cal, they will undergo an eligibility determination for non-MAGI Medi-Cal (in addition to Healthy Families and subsidized Exchange coverage). These cases may require additional processing, which may not be possible in real time as envisioned for other applicants and may require specialized assistance. As such, under the proposed federal rules, applicants not eligible for MAGI Medi-Cal, but potentially eligible for MAGI Medi-Cal, should receive Healthy Families or subsidized Exchange coverage, if otherwise eligible, pending a final non-MAGI determination.[40]

The applicant's eligibility information and other necessary data (collected through a separate or supplemental application, per federal law) should then be forwarded to the county Medi-Cal office for any more involved follow-up or case management required. To ensure that the final disposition of cases will be conducted seamlessly, the applicant and enrollee will remain in CalHEERS and will have full access to the consumer functions of the Web portal for accessing information on their application and managing their ongoing coverage.

The process envisioned for reviewing consumers first for MAGI Medi-Cal could streamline eligibility for a large number of consumers. California would not need to review whether an individual who meets the applicable MAGI Medi-Cal standard (for adults, up to 138 percent FPL) is also eligible as a disabled or medically needy individual. However this contemplated policy would be significantly undermined if the State utilizes the federal option to provide newly eligible Medi-Cal beneficiaries with a benchmark or benchmark-equivalent benefits package, which typically provides a more limited scope of health benefits.[41] Since a state cannot require individuals who are eligible for Medicaid on the basis of being pregnant, blind, disabled, or "medically frail" (among other things) to enroll in benchmark benefit plans, applicants below the MAGI Medi-Cal standard would still have to be screened for eligibility based on these other factors, thereby eliminating the benefit of a first-level Medi-Cal MAGI screen.[42] To guarantee a more streamlined and integrated process, California should maintain full-scope benefits for all Medi-Cal enrollees.

How Will Eligibility for Other Health and Human Service Programs Be Handled?

California provides a number of essential health services to its residents beyond full-scope Medi-Cal and Healthy Families (though they are oftentimes interconnected). These services and/or programs include pregnancy-related care (through Medi-Cal and AIM), periodic health assessments for children (CHDP), services for children with special health care needs (CCS), family planning (Family PACT), and breast and cervical cancer treatment (BCCTP). Elimination of these critical services could leave many without access to specialized care, even if eligible and enrolled in Medi-Cal or subsidized Exchange coverage. In addition, undocumented immigrants (who are not eligible for full-scope Medi-Cal, Healthy Families, subsidized Exchange coverage and cannot purchase coverage through the Exchange) are eligible for pregnancy-related and restricted Medi-Cal for emergency situations and some county-level programs.

California should ensure that there are complementary coverage pathways between these programs and the insurance affordability programs to ensure those eligible for coverage get the care for which they are eligible and to retain the important gateways (often community-based) and specialized services these programs provide to California's residents. AB 1296 lays the groundwork for this policy by requiring that applicants not eligible for the insurance affordability programs be referred to

county health coverage programs.[43] Specific consideration should be provided for the following programs.

- **California Children's Services (CCS)** ensures that children with special health care needs get seen and cared for by providers, currently through a separate reimbursement process, who have expertise with their condition.[44] It is available for children with a family annual income of less than $40,000 or high-cost medical bills. This program has worked as a complement to Medi-Cal and Healthy Families for children enrolled in those programs and can work in the same manner for those enrolled in subsidized coverage. To effectively identify these children, the single application for the insurance affordability programs should ask whether an applicant child has any specific medical condition requiring special treatment, services, medical equipment, etc.
- **Pregnancy-Related Services in Medi-Cal and Access for Infants and Mothers (AIM)** provide free and low-cost medical coverage for women during pregnancy and postpartum. Medi-Cal provides care up to 200 percent FPL and AIM up to 300 percent FPL, regardless of the woman's immigration status. After 2014, pregnant women will be eligible for full-scope Medi-Cal up to 138 percent FPL, which includes comprehensive pregnancy-related care. This leaves a complicated picture of eligibility for many women above 138 percent FPL who will be eligible for Medi-Cal pregnancy-related services only when pregnant, but for subsidized Exchange coverage when not pregnant.[45]

  To streamline the availability of these programs and services, California should take advantage of federal law to provide pregnant women with full Medi-Cal coverage up to 300 percent FPL.[46] Women already enrolled in Exchange coverage at the time of their pregnancy would receive these services as wraparound or supplemental coverage to mitigate the need to switch plans or providers during pregnancy. Providing these services to women in Exchange coverage will also ensure that they receive the important benefits that Medi-Cal provides, which might be missing from commercial coverage, including health education, psychosocial services, nutrition counseling, and breast pumps. Presumptive eligibility currently available to pregnant women would be maintained to expedite coverage. Additionally, the linkage that provides Healthy Families to babies born to women enrolled in AIM would be retained through Medi-Cal's newborn coverage requirement.
- **Child Health and Disability Prevention Program (CHDP)** provides periodic health assessments and services to low-income children. At the time of CHDP program assessment, a child is electronically pre-enrolled in temporary Medi-Cal or Healthy Families (up to 60 days). This process is conducted electronically through a point of service (POS) system or the Internet. The family then completes a full Medi-Cal/Healthy Families application to continue receiving coverage. Families greatly benefit from being able to apply for and access immediate coverage when sitting in the doctor's office.

  Additionally, the CHDP Gateway has become a pathway for automatically enrolling infants into Medi-Cal (at the time of their first pediatrician visit) who are eligible due to their mother's receipt of coverage at the time of delivery. California should continue CHDP, and modify its linkage to Medi-Cal and Healthy Families so that it provides a coverage pathway for the entire family. Since it already has an electronic interface in place, the State could continue the practice of temporarily enrolling children into Medi-Cal or Healthy Families so that they can receive services at the doctor visit, but at the same time allow families to apply through the new Web portal for ongoing coverage for the child and other family members.

  Alternatively, with the family's consent, the CHDP Gateway could mail families a prepopulated application or e-mail a link to an online application. Those families who chose to complete the application but are ineligible for ongoing coverage would be directed to other programs for which they may be eligible, including restricted Medi-Cal or county programs.

What Processes Will Be in Place for Connecting to Other Human Service Programs?

California should look beyond health coverage to connect consumers with other human service programs (specifically, CalFresh and CalWORKS) for which many consumers are likely eligible. Most immediately, when the enrollment doors open in 2013 this can occur by sending, with the enrollee's consent, relevant information from the application to other programs for processing or follow-up.

Eventually, these other human service programs should be integrated into CalHEERS to allow for automatic connections and enrollment using the information already supplied by the applicant through the health insurance application. Federal guidance paved the way for this integration by allowing states, through 2015, to claim enhanced match funding to include human service programs in the new eligibility systems for the affordability insurance programs without apportioning out development costs to the other public programs.[47]

A Roadmap to Integrated Eligibility Criteria and Processes Across Programs

Adopt a Single Shared Eligibility System through CalHEERS that Is Used by All Insurance Affordability Programs and Through Which All Applicants Begin the Eligibility Determination Process, No Matter What Program Door They Entered.

- Evaluate every applicant first for MAGI-based Medi-Cal, followed by non-MAGI Medi-Cal, Healthy Families (as relevant), and subsidized Exchange coverage, asking only the minimum amount of information that is required to make an eligibility determination and process the application.
- Provide full-scope Medi-Cal benefits to the "newly eligible" adult group to streamline the eligibility process, eliminating the need to identify those below the MAGI standard with disabilities or other health conditions who require full coverage.
- Forward non-MAGI Medi-Cal eligibility information to the county Medi-Cal office for any necessary follow-up and case management (after providing otherwise eligible applicants with Healthy Families or subsidized Exchange coverage).

Conform Income and Other Eligibility Criteria to the Greatest Extent Possible.

- Require Medi-Cal applicants to provide information on any predictable drops in income and adopt the state option to maintain eligibility for those with fluctuating incomes so long as their annual income for the current calendar year remains below the Medi-Cal income standard.
- Eliminate the three-month waiting period in Healthy Families for children who have employer coverage.

Continue Essential Health Services and Create Complementary Coverage Pathways with the Insurance Affordability Programs.

- Maintain CCS and identify children eligible for the program by including a question on the single application about medical conditions requiring special treatment, services, medical equipment, etc.
- Enhance and streamline services under pregnancy-related Medi-Cal and AIM by providing full Medicaid coverage to pregnant women up to 300 percent FPL. Coordinate coverage for women eligible for subsidized Exchange coverage.
- Continue the use of the CHDP Gateway to reach uninsured children and their family members eligible for Medi-Cal, Healthy Families, or other available health care options. Allow all family members to apply for coverage through the Web portal or by consenting to receipt of a prepopulated application.

Integrate Eligibility and Enrollment for Human Service Programs (CalFresh and CalWORKS, in particular) into CalHEERS to take advantage of enhanced federal funding available through 2015. Most immediately, with consent, electronically forward the eligibility information for enrollees potentially eligible for the human service programs.

Design Feature 3: Real-Time, Immediate, and Ongoing Enrollment

A central component of the ACA is its expectation of real-time, immediate, and ongoing enrollment. This is primarily achieved through a data-driven verification system in which an applicant or enrollee can declare and/or affirm the eligibility requirements so that enrollment in coverage occurs at the time of application or renewal. By its very nature, applicants applying online or by phone/in person with an assistor (who will enter the information into CalHEERS) will receive the greatest benefit of this policy, although paper filers will also gain from faster processing without documentation burdens and streamlined renewal. Additionally, the goal of providing consumers with immediate coverage carries over to cases in which a more extensive and longer review is needed.

To achieve this real-time enrollment capability, California will need to dramatically modernize its enrollment process, which currently requires families to provide various paper documents—a key cause for why families fail to enroll or stay enrolled.[48] (Box 2 describes the burden of documentation.) The following section reviews some of the questions that California stakeholders must contemplate as this new modernized eligibility and enrollment system is put into place.

Unless otherwise noted, references to federal and state law can be found in Appendix A.

How Will Attestation Be Applied?

The ACA and proposed federal rules expressly permit states to accept attestation of information to confirm eligibility criteria (except possibly as it relates to immigration status for Medicaid and CHIP, see next question). Attestation can be established through two primary methods:

- **Attestation with No Verification**—a declaration made by an applicant of an eligibility element, which will not be verified prior to a determination (except to ensure it matches up with other available information).
- **Attestation with Verification**—a declaration of an eligibility element that is then checked against accepted electronic data sources in real time prior to a determination.

The proposed federal rules are pretty clear about which attested data require verification and which are intended to stand on their own without verification except where it conflicts with other information provided by the applicant. (See Appendix C providing proposed federal rules on data retrieval and attestation as it relates to each eligibility requirement.) In implementing AB 1296, California should take full advantage of the authority afforded it to develop an enrollment process that primarily relies on attestation, with verification only for the required elements. When verification is necessary, it must be conducted via electronic data sources accessible through both state and federal verification hubs. Documentation can only be requested from applicants in cases where data conflicts cannot be resolved (with the possible exception being immigration status, see question below). To ensure California has the most up-to-date information available, state officials should prioritize the development of a single state verification hub (in coordination with creating connections to the federal hub) that includes databases with the most recent data.[49]

How Should the State Address Citizenship/Immigration Status?

Exchange coverage (subsidized and nonsubsidized), Medi-Cal, and Healthy Families are available to U.S. citizens, nationals, and legal immigrants. To establish citizenship and nationality for the programs, California can accept an attestation along with a SSN to conduct a data check with the Social Security Administration (SSA). Subsidized Exchange coverage can also accept attestation as to immigration status (other than citizen/national), accompanied by submission of an Alien Registration Number (A#) and date of entry, to confirm eligibility against the Department of Homeland Services (DHS) databases.

However, it is less clear what is allowed regarding immigration status for Medi-Cal and Healthy Families. It would seem that the same procedure for Exchange coverage should be available to Medi-Cal and Healthy Families, but current federal law speaks to the requirement of "documentation" for these programs.[50] In fact, the DHS data match may be adequate to establish documentation for Medi-Cal and Healthy Families as well.

California should seek the greatest streamlining of this process that is allowed by federal law and use fully electronic procedures for as many applicants as possible. The State should also provide due process protections (90 days to provide any needed documentation, during which coverage is provided if all other criteria are met) to Medi-Cal and Healthy Families applicants when resolving any discrepancy. This is consistent with the Exchange coverage proposed regulations and current Medi-Cal and CHIP law (as provided under CHIPRA).[51]

Box 2. Eliminating the Burden of Documentation in an Electronic Age

Health reform transports Medi-Cal and Healthy Families into the electronic age by structuring eligibility and enrollment to optimize the use of available state and federal data. California's ability to implement policies and modernize computer systems that successfully support these changes could determine whether health reform successfully increases participation in, and retention of, health insurance for its residents.

Families have identified burdensome application requirements as a key reason that they fail to enroll or stay enrolled in public health programs.[52] In contrast, when families experience less burdensome application and enrollment processes, including prepopulation of forms and no documentation requirements, they are more likely to participate and to retain health coverage continuously.[53] It also has positive operational results:[54]

- Attestation policies, like other administrative simplifications, improve caseworker productivity and speed up the enrollment and renewal process while also reducing state costs to the taxpayer.
- States are confident about the accuracy of the databases that they use to verify the attested information (even when the data is not as recent).
- Post-eligibility audits confirm that the use of attestation and third-party database verification results in accurate eligibility determinations.

The move away from paper documents and toward use of attestation and electronic verification, when necessary, requires a dramatic change for California, but one that will have lasting effects on the health of its population and efficiency of its program agencies.

Where There Is a Conflict in Data, How Should it Be Resolved?

As provided for in the federal proposed rules, where the information submitted by the applicant is not "reasonably compatible" with other available information, states can then request additional information, including documentation, from the applicant. From the consumer's perspective, he or she will provide and attest to eligibility information and the system will do its work. The consumer will only be asked to take further steps where:

- He or she presents inconsistent information while completing the forms;
- The data he or she provides during the application/renewal process differs from data retrieved from available databases; and
- Data retrieved from one database conflicts with data from another database.

If the individual provided the conflicting data, he or she should be able to independently resolve the error or problem in almost every case. The system should flag any inconsistencies and ask the applicant to review and correct the data. If databases are the source of a discrepancy, California should develop a hierarchy to reflect which source provides the most reliable, up-to-date data, and such data hierarchy would be programmed into the rules engine, drilling down on and resolving the inconsistency in most cases.

The most challenging situation would arise where the individual provides information they believe to be true, but which conflicts with available data. If the discrepancy would not make a difference in terms of eligibility, then the State should not take any further action. If the discrepancy would require an eligibility change, it should be assumed that the individual has the most current information and, thus, may be the preferred and most accurate source. However, in this situation, the State should query the individual as to the reason for the discrepancy (with check off boxes for standard reasons), but only request documentation as to the eligibility element when such an element is material to the eligibility decision. Situations in which a person reports a change in circumstances (i.e., database shows certain income but the applicant knows his or her income is dropping) should be similarly handled, with

verification of the change obtained through other databases followed by documentation only when necessary (with the exception that subsidized Exchange coverage must accept attestation without verification of expected increases in income).

In all instances involving data discrepancies, the individual should have clear information about how to get assistance, since help may be required to resolve their situation. In addition, where data was retrieved from a database, the individual should be clearly informed as to the source of the data, since this information may help the individual evaluate the accuracy of the data. Additionally, when documentation is required, the applicant should be able to utilize a number of means for submission, including e-mail or mobile device (through taking a picture of the document), fax, or mail.

What Will the Eligibility Determination Process Look Like in Practice?

In line with federal law and expectations set out in proposed rules, attestation and data retrieval should be used in at initial the eligibility determination at application and during the benefit year.

Application
The consumer applying online, by phone, or in person will provide a few basic, authenticating details and the system will query available databases to prepopulate the form at their request.[55] The consumer will then review, correct as relevant, and attest to the accuracy of that data. Where information is not obtainable from other databases or where such data is conflicting, the consumer will provide information, help reconcile differences, and attest to those criteria. A consumer applying through a paper application will need to provide and attest to all of the requested information on their paper form.

Mid-Year Updates
Where the system identifies information that could indicate a change in circumstances that might affect the enrollee's eligibility during the enrollment year (such as an application for unemployment benefits or failure to make premium payments), the system will contact the enrollee, ask him/her about this information, and obtain his/her attestation as to new information. (See Design Feature 4 for information on consumers facing a change in circumstances.)

What Will the Renewal Process Look Like in Practice?

In line with the federal proposed rules, annual renewal for the MAGI-based insurance affordability programs (non-MAGI Medi-Cal, at state option) will be accomplished largely as an automated process. As an enrollee's renewal period approaches, he or she will be sent a notice of eligibility or a prepopulated form (depending on the program) and asked to attest to the continued relevance of eligibility data and to any changes. Those enrolled in coverage with no changes will not have to do anything (except that those enrolled in subsidized Exchange coverage will be asked to sign and return the notice). Those with changes will simply have to report such to finalize the process. California should ensure that this process is completed through a method most accessible to the consumer, whether online, via e-mail, over the phone, or through the mail.

How Will the State Ensure Real-Time Enrollment?

While real-time and immediate enrollment is made possible through data retrieval and attestation, questions still remain on what timeliness standards states will be held to in determining eligibility, i.e., how the requirement that consumers have their eligibility determined "promptly and without undue delay" will be defined and what it means when someone submits a paper application. The proposed federal rules confirm that "performance standards and metrics" will be developed in this regard.

Ultimately, the ability of California to ensure consumers receive a real-time eligibility determination will be predicated on the strength of its enrollment system. To meet the expectation of real-time procedures, California should prioritize the development of a system that can provide adequate information to not only verify but also prepopulate the application and renewal processes and support this data-driven process with operational rules and a "smart" user interface that make a data-driven system work effectively, with as much automation as possible. Such operational rules would utilize prepopulation wherever possible and establish that incompatibility in data is only of concern when it is material to eligibility. Additionally, for more complicated cases, California can ensure that consumers do not go without

coverage. Per the proposed regulations, otherwise eligible applicants waiting for a typically more time-intensive non-MAGI Medi-Cal eligibility determination will receive immediate subsidized Exchange coverage or Healthy Families. This receipt of coverage and requests for any additional information should be relatively seamless for consumers. In addition, the State should coordinate the health plan choices so that consumers, as much as possible, can remain with the same plan once a final decision is made (in which case, if non-MAGI eligible, the applicant will be shifted to that program for ongoing coverage).

Consistent with this policy, whenever there is a need to conduct follow-up that does not allow for a real-time determination, California should temporarily enroll any applicant who appears Medi-Cal- or Healthy Families-eligible, pending resolution of the data issue. This procedure will be in place for subsidized Exchange coverage (otherwise eligible applicants have 90 days to resolve discrepancy, during which time they will receive coverage) and is compatible with current California law that provides immediate coverage to children screened at the Single Point of Entry as eligible for Medi-Cal, pending a final eligibility determination.

How Will the State Handle its Obligations Under Quality Control/Audit Provisions?

States will be required to meet program integrity guidelines, which are currently in the form of the Payment Error Rate Measurement Program (PERM) [56] and Medicaid Eligibility Quality Control (MEQC) program.[57] Federal guidance has clarified that if a state is following federally approved procedures (which under the ACA would include attestation, data retrieval, and electronic verification), PERM classifies the case as an accurate determination. The guidance specifically states that "…where States rely on self-attestation to establish certain facts regarding eligibility, PERM audits also rely on those self-attestations to establish those facts."[58] This same principle should be employed in regard to eligibility determinations involving advance payments of the premium tax credit.

How Can Consumers Trust that Their Information Is Being Used Appropriately?

In order for consumers to feel comfortable using a shared eligibility system and related insurance affordability programs, they must be able to trust that any information they provide will be kept confidential and that it will be accessed, used, and disclosed only for eligibility and enrollment purposes (and retained only for so long as is reasonably needed for such purposes). These same concerns are present in a paper environment but become more urgent in an electronic environment, where consumers can worry that their information will be shared far and wide in an instant.[59]

To achieve appropriate protection in a manner that promotes consumer trust, measures must be taken to:

- Enable the consumer to authorize the use of relevant personal information for this purpose, in a manner that is clear and understandable, including on forms/applications being submitted to other programs that could facilitate a simplified enrollment process;
- Allow the consumer to authorize and set up access by a third party to their consumer account to facilitate assistance;
- Ensure that the consumer understands exactly what information is required and what is optional and that explanations for any optional information are provided (such as explaining why the consumer might benefit from providing an e-mail address);
- Educate consumers about privacy practices and their rights in plain language through appropriate notices in accordance with fair information practice principles;
- Do not require unnecessary information from family members who are not applying for coverage;

- Allow consumers the opportunity to explore the options anonymously without starting an application or having any of their private information cached until they indicate a desire to begin the process of applying;
- Hold agencies and any third parties involved in data-sharing accountable for implementing reasonable security measures to protect the information they are collecting from individuals, extend these same protections to any information provided to or accessed from third parties, and provide penalties for knowing and willful uses or disclosures of information that violate the privacy policies; and
- Ensure that information technology projects undertaken in support of the ACA comply with all relevant HIPAA standards, including those for protection of protected health information.

Roadmap to Real-Time, Immediate, and Ongoing Enrollment

Prioritize the Development of a Modernized Enrollment System and State Verification Hub (with Connections to the Federal Hub) that Can Provide Adequate Information to Support the Application, Mid-Year Updates, and Renewal Processes.

- Primarily rely on attestation of eligibility criteria, with verification as to only those elements required under federal law. Utilize attestation and electronic verification procedures to establish citizenship, nationality, and immigration status to the greatest degree possible. In doing so, provide current due process protections (90 days to provide any needed documentation, during which coverage is provided if all other criteria were met).
- To the greatest degree possible, for applicants applying online, prepopulate and ask for the applicant's attestation and/or correction of data rather than asking an applicant to provide information already in state and federal databases.
- Ensure that MAGI-based Medi-Cal and Healthy Families have the capacity to conduct, in the majority of cases, renewals utilizing data obtained electronically in which the enrollee is notified of eligibility (and only has to take action if changes). Implement the same renewal simplifications in non-MAGI cases.
- Prioritize inclusion of state and private data sources that reflect income that is more up-to-date than that in the federal hub.
- Implement smart and efficient verification rules that ensure program integrity guidelines are met, but do not hinder the overarching objectives of the new system.

Develop a Data Hierarchy that Helps Resolve Inconsistencies in Eligibility Data and Reduces the Need for Follow-Up with Applicants.

- Establish that where there is incompatibility within an application, only those conflicts that are "material" will generate the need for follow-up and potential documentation. A difference should not be deemed "material" if both pieces of information would identify the individual as eligible.
- When data discrepancies exist, provide consumers with specific information on what is in question, an opportunity to independently resolve the error or problem, and clear instructions on how to obtain assistance. Allow applicant to submit documentation by e-mail, mobile device (sending a picture of the document), fax, or mail.

Whenever Real-Time Eligibility and Enrollment Are Not Possible, Provide Immediate Coverage to Consumers Prior to a Final Determination.

- Develop seamless steps for providing otherwise eligible consumers undergoing a non-MAGI Medi-Cal review with subsidized Exchange coverage or Healthy Families. Coordinate the health plan choices so that consumers, as much as possible, can remain with the same plan once a final decision is made.
- As required for subsidized Exchange coverage, provide applicants with 90 days to resolve a discrepancy and immediate coverage during the interim to those who appear Medi-Cal- or Healthy Families-eligible.

Establish Consumer-Protection Policies that Educate Applicants on How Their Data Will Be Used, seek authorization when data are being used, and guarantee that any information provided will be kept confidential and that it will be accessed, used, and disclosed only for eligibility and enrollment purposes (and retained only for so long as is reasonably needed for such purposes).

Design Feature 4: Easy Navigation of Coverage

The enrollment process does not end with the eligibility determination. Instead, eligible applicants must be able to choose their health plan, pay premiums, review their coverage and plan details, and generally maintain their case or account. For a number of consumers, ongoing contact with the programs will be fairly minimal. For those facing changing circumstances during the year, management will be more complicated.

Even more challenging will be the environment for families whose members qualify for and enroll in different programs inside and outside of the insurance affordability programs. (See Figure 2 for a look at the different coverage options families can face as life circumstances change.) Such families need to be able to enroll, renew, and manage coverage easily across programs without gaps in coverage and in a manner that helps them secure the most beneficial coverage for each individual within the family. The following questions explore some of the key issues and policies that must be addressed to ensure an easy navigation system for families.

Unless otherwise noted, references to federal and state law can be found in Appendix A.

How Will Consumers Be Able to Choose a Health Plan and Obtain Coverage?

For a first-class user experience, it is important that plan comparison and selection be seamless and coordinated among all of the insurance affordability programs. This is consistent with federal law, which proposes that the single application include the ability to enroll in an Exchange health plan. Federal regulations also contemplate that applicants applying online will complete eligibility and plan selection into the Exchange in a single session and, optimally, in real time.[61] When real time is not possible, the consumer should receive the tools needed to complete the process in-person or remotely.

California must take a number of steps to integrate health plan enrollment into the eligibility process, particularly as it relates to Medi-Cal managed care and Healthy Families. As noted, plans participating in the Exchange are required to have plan comparison and selection functions built into the application and Web portal. However, there is currently no requirement for this same role in Medi-Cal managed care and Healthy Families. As such, California should automate the Medi-Cal Health Care Options and Healthy Families plan functions for integration with CalHEERS. Medi-Cal's corresponding consumer protections (i.e., the ability to change plans for any reason or the right to have

Figure 2. Changing Family Circumstances and Coverage at 180% FPL

	Husband	Wife	Child #1	Child #2
At Initial Application: • Father has no insurance through job. • Nonworking mom is pregnant. • They have one child (age 5).	Exchange, with subsidy	Medi-Cal[60]	Healthy Families	N/A
During Enrollment Year: • Mom gives birth.	No change	Exchange, with subsidy	No change	Medi-Cal
Two Years Later: • Husband obtains new job with slight salary bump and insurance (7% of income). • Since adding dependents is costly, family keeps children in public coverage.	Employer coverage, not eligible for subsidy	Employer coverage, not eligible for subsidy	No change	Healthy Families

60 days to make a health plan selection with fee-for-service coverage in the interim) must also be coordinated with the enrollment process.

Additionally, since some consumers will be enrolling family members across different programs, this function should be built in a manner that helps them understand their varying options and any differences in benefits, providers, cost-sharing, or other considerations that may apply.

How Will Premium Payments Be Structured?

California has the option to build premium payment collection into the Exchange in addition to allowing consumers to pay their chosen health plan directly. The most sensible solution is to provide consumers with one monthly bill and one place (CalHEERS) through which to pay premiums, no matter which health plan and/or program different family members are enrolled in. This will help to eliminate confusion on behalf of families on what, when, and how to pay, especially for families who are paying premiums for both the Exchange and Healthy Families. Families should be able to make payments with no added charges through multiple venues, including online, Electronic Fund Transfer (EFT), mail, or in person. California should also explore how to support consumers in making payments utilizing mobile media devices, such as cell phones.

In addition, policies should be established and rules aligned to assist those families enrolled in multiple programs. Under proposed federal rules, the computation of a family's premium obligation under the Exchange does not take into account Healthy Families premium amounts. California should discount the Healthy Families premium for these families so that no family pays above its expected contribution (defined as a percent of family income) to the Exchange. The State should also conform its premium grace period in Healthy Families (currently 60 days) to that required under the Exchange (three months). Besides premium payments, California will need to track the cost-sharing charges faced by enrollees in the insurance affordability programs and make the information readily accessible. States are already required to ensure that cost-sharing charges (including premiums) faced by Medi-Cal and Healthy Families enrollees do not consume more than that allowed under federal law (generally five percent of income).[62] This same rule should be applied to individuals enrolled in Exchange coverage, which has limits on out-of-pocket costs (beyond premiums) that can be incurred. This will be especially important for lower income enrollees (those with incomes up to 250 percent FPL) who are eligible for further limits and will need to easily understand what those limits are.[63]

What Procedures Will Exist to Assist Enrollees with Changing Circumstances in the Benefit Year?

There are an endless number of scenarios by which individuals will find themselves with life changes that could affect their eligibility for the insurance affordability programs. The effect of such changes is particularly important for consumers receiving the Exchange tax subsidies, since the ACA requires repayment (up to a capped amount for low- and moderate-income taxpayers) when a beneficiary's annual income exceeds projected levels. Further federal guidance establishing "safe harbors" for consumers experiencing changes (e.g., loss of a job or divorce) would greatly assist these families. Additionally, as required by AB 1296, education about the tax penalties that will be assessed for overpayments (in addition to those for failure to obtain coverage) will help consumers to better understand their options prior to enrollment.

Ultimately, however, the fear of losing tax refunds or even owing money to the IRS could lead consumers to remain uninsured rather than claim tax credits needed to make coverage affordable. The federal proposed rules generally place the responsibility for reporting changes on the consumer, but the State can take some steps to help guide consumers through the process to ensure that such fears do not undermine the effectiveness of the ACA.

Easy and Clear Reporting Mechanisms
Since it may be difficult for consumers to appreciate under what circumstances to report changes (especially in cases that are not major life transformations), the State should establish clear and easy-to-understand descriptions of when a change should be reported. For example, the enrollment system rules engine could calculate and notify the subsidized Exchange enrollee as to the specific income change that would alter their subsidy level

and, thus, necessitate reporting. Enrollees should be able to report these changes through the same avenues available to them at enrollment (online, phone, mail, or in person) and when making a premium payment.

Identifying Significant Changes
The State should also be proactive in assisting consumers who will experience negative financial consequences if new data were not considered (e.g., they have experienced loss of income and should be placed in Medi-Cal, or they have experienced a material increase in income and need to adjust their premium tax subsidy). Strategies should include mid-year data checks such as with unemployment insurance (in addition to those minimally required of the Exchange by proposed federal rules for such things as death) and following up with families who stop making Exchange premium payments. However, the State should be strategic in the application of these data checks to target only instances of *significant* changes in order to eliminate unnecessary and burdensome administrative processes for the consumer and state. The State should also actively identify newly pregnant women in subsidized Exchange coverage under 300 percent FPL (and, as proposed in this report, eligible for full Medi-Cal coverage) to ensure they receive appropriate care and are efficiently transferred between programs, as applicable.

No Disruptions in Coverage
Consistent with proposed federal rules and AB 1296, the State should ensure that anyone requiring transfer to a new program (whether during the year or at renewal) would experience a smooth and seamless transition. This includes eliminating any requirement to complete another application or submit documentation and ensuring that there are no gaps in coverage between the time coverage under the prior program is terminated and coverage under the new program becomes effective. To facilitate this process, Medi-Cal and Healthy Families should maintain coverage through the end of the month after an affirmation that the receiving program enrollment has occurred, consistent with the Exchange's first of the month coverage effective date.

What Role Should the Eligibility, Enrollment, and Renewal System Play in Facilitating Coverage for "Mixed-Coverage" Families?

Children have generally fared better than their parents and other adults in obtaining health coverage, primarily due to the availability of Medicaid and CHIP. The ACA maintains these critical benefits for children while, at the same time, ushering in new opportunities for covering the whole family. Because of the way eligibility is structured, however, roughly 20 million children nationwide will find themselves with different health coverage than that of their parents or caregivers.[64] This includes instances where parents have employer-sponsored insurance without affordable dependent coverage or children who are eligible for Medicaid or CHIP have parents who are not, either because of different income eligibility thresholds or differences related to immigration status. California should establish policies to help these families effectively manage their health insurance. Technology advances will be a critical component for integrating coverage between family members.

Families Eligible for Different Coverage Options Within the Exchange
The seamless eligibility, enrollment, and retention system provided for in the ACA and AB 1296 (and described in this report) is especially important for "mixed-coverage" families inside the Exchange. In addition to the policies already discussed to integrate coverage across the programs, the State should present families with a unified user experience that handles machinations of the different programs behind the scenes. For example, when parents are enrolled in subsidized Exchange coverage and the children in Healthy Families, the family should be able to view carriers that offer coverage in both the Exchange and Healthy Families and understand any differences in plan benefits, provider networks, and cost-sharing that may exist for each family member. Communication with the families should also be streamlined so that they receive consolidated notices, bills, and other correspondence.

Additionally, there will be instances in which mixed-coverage families will face different renewal periods among the family members. This will not be applicable if the family applies for coverage during

Exchange open enrollment or if they qualify for a special enrollment period. However, if they apply outside of these situations, the children could be enrolled in Healthy Families (which has no enrollment timing restrictions) while the parents must wait until open enrollment to obtain subsidized Exchange coverage. In these cases, the child's case file should be flagged so that when open enrollment occurs, the family can be sent a prepopulated application (or a notice linking them to their online account) to finalize the parent's enrollment process. At this point, if there are no changes to eligibility, the child's renewal period should be reset to coincide with the parent's enrollment date. If new information would detrimentally change the child's eligibility, however, he or she should stay enrolled in their current program consistent with California's continuous eligibility for children rule.

Families with Children Eligible for Insurance Affordability Programs And the Parents Are Not

Other situations will occur where the children will be eligible for the public programs, but the parents or caretakers will not (due to available employer coverage, undocumented status of a parent, or the availability of other coverage, e.g., a grandparent caretaker receiving Medicare). California should promote the availability of Medi-Cal and Healthy Families for these children, emphasizing that the availability of employer dependent coverage does not impact eligibility for Medi-Cal or Healthy Families, although it can for subsidized Exchange coverage. (See Box 3 for a description of affordability issues in regard to employer coverage and eligibility for the Exchange.)

Additionally, those children who on their own are eligible for subsidized Exchange coverage (e.g., where an employer offers the parent affordable coverage that does not include dependent coverage) will need to enroll in child-only plans, which insurers in the Exchange must offer.[65] Further federal guidance will help to understand how the premium subsidies will be calculated when only the child is receiving coverage. However, the State can ensure that these parents and caretakers receive targeted outreach and education regarding the availability of coverage for the child, even if they themselves are not eligible. Parents and caretakers should also be informed of their ability to receive a tax subsidy on their child's behalf (or their own) even where they did not file taxes in the prior year (though they will be required to file taxes for the year in which they receive a tax credit).

Box 3. The Affordability Test: A Particular Challenge for Families

The ACA excludes consumers who are enrolled in an employer-sponsored plan or offered a plan that meets affordability and minimum coverage standards from subsidized Exchange coverage. How this "affordability" test is applied has important implications for families. Current interpretation under the IRS proposed rules defines "affordable" employer-based coverage, including for a family, in relation to whether the cost of self-only coverage is less than 9.5 percent of household income.[66] As such, an employee and his/her dependents with an offer of family coverage that exceeds 9.5 percent of income could be ineligible for subsidized Exchange coverage because the cost of self-only coverage meets the affordability standard.

If the proposed rule is applied in this manner, it discriminates against families and children by denying them access to Exchange subsidies even though they may not be able to afford to purchase family coverage offered by the employer. In fact, UC Berkeley Center for Labor Research and Education and UCLA Center for Health Policy Research report that in California this narrow interpretation of the ACA will result in 144,000 consumers (nearly half of whom will be children) not receiving subsidized Exchange coverage.[67]

California should ask federal authorities to ensure that the affordability test considers the cost of coverage for the full family where there is coverage being offered. If this common-sense standard is not used, the State can help mitigate the impact on families by promoting the availability of Medi-Cal and Healthy Families and subsidized child-only Exchange coverage and prohibiting waiting periods in Healthy Families (so that Healthy Families-eligible children do not experience gaps in coverage when employer coverage becomes unaffordable and the family can no longer maintain it).

How Should the Intersection Between SHOP and Other Insurance Affordability Programs Be Addressed?

SHOP will play an important role in achieving the overarching goal of the ACA to expand health coverage. To this end, SHOP participants, whether the employer or the employee, should have access to the same consumer-friendly functions envisioned for the insurance affordability programs. This includes receiving hands-on assistance and access to online accounts and Web portals providing easy-to-understand information on their health care options.

Additionally, for the reasons already touched upon in regard to employer coverage, it is important that connections be made between SHOP and the insurance affordability programs. This will be particularly relevant in situations in which families are offered employer coverage through SHOP that does not include an affordable dependent option. These families will need to be connected to other available programs in a manner that promotes their successfully obtaining appropriate coverage for their dependents. California should define rules around dependent coverage to ensure that families are made aware of, and have access to, the most suitable and affordable coverage for their children. For some families, Medicaid, CHIP, or subsidized "child-only" coverage through the Exchange may be the optimal way to obtain dependent coverage.

Roadmap to Easy Navigation of Coverage

Ensure that Health Plan Enrollment Is Integrated into the Eligibility Process and Occurs as Part of the Application and, If Possible, in Real Time.

- Build the Medi-Cal Health Care Options and Healthy Families plan function, and corresponding consumer protections (i.e., the ability to change plans for any reason), into CalHEERS, allowing the whole process from application through to plan selection in one sitting, if the consumer wishes.
- Ensure that families in different programs can view and compare across programs about available benefits, carriers, providers, costs, and other important issues.
- When real time is not possible, provide the consumer with the tools needed to complete the process in person or remotely.

Build the Premium Payment Function into CalHEERS so that Consumers Receive One Monthly Bill No Matter What Health Plan and/or Program Family Members Belong To.

- Allow payment through multiple venues, including online, EFT, mail, in person, and mobile devices, such as cell phones.
- Discount the Healthy Families premium for mixed-coverage families who must pay premiums in both Healthy Families and the Exchange and conform the premium grace period in Healthy Families (currently 60 days) to that required under the Exchange (three months).
- Track cost-sharing and out-of-pocket costs incurred by enrollees in the insurance affordability programs to identify when defined limits are reached and make the information readily accessible to the consumer.

Establish Consumer-Friendly Procedures for Those Facing Changing Circumstances That Could Affect Eligibility in the Middle of a Benefit Year.

- Provide clear and easy-to-understand descriptions on when a change should be reported, including providing enrollees with a specified dollar amount that would necessitate reporting. Allow for reporting online, over the phone, via mail, in person, or when paying premiums.
- Proactively identify instances in which consumers could experience negative financial consequences if a re-determination is not made through the use of strategic mid-year data checks (such as for those applying for unemployment benefits or other public programs) and by following up with families who stop making Exchange premium payments.
- Eliminate unnecessary paperwork requirements for consumers transferring between programs and ensure that there will be no gaps in coverage (with Medi-Cal and Healthy Families maintaining coverage through end of month to coincide with the first of month Exchange effective coverage date).

Establish Policies for Mixed-Coverage Families that Will Assist Them in Navigating Through the Different Programs.

- Coordinate and consolidate how mixed-coverage families choose health plans, make premium payments, and receive correspondence. For families applying outside Exchange open enrollment, enroll the eligible children in Healthy Families but reset their renewal date (if no eligibility change) to coincide with the parents' enrollment, via a prepopulated application, at the next open enrollment.
- Promote the availability of Medi-Cal, Healthy Families, and child-only plans for children, even when parents are not eligible for insurance affordability programs, and the process for applying (particularly the requirement of filing a tax form for receipt of tax subsidies that benefit year).

Assist SHOP Participants in Navigating Their Health Coverage and Connecting Them to the Insurance Affordability Programs, When Appropriate.

- Provide SHOP participants with the same consumer-friendly functions envisioned for the insurance affordability programs, including hands-on assistance and access to online accounts and Web portals providing easy-to-understand information on their health care options.
- Promote the ability of SHOP employees to obtain affordable dependent coverage when that coverage option is not provided in SHOP. Allow employees to designate on the application whether they have dependents who need health coverage, and direct them to resources for determining eligibility for, and enrollment in, other available health coverage options.

Conclusion

The task ahead for California to develop a consumer-driven eligibility, enrollment, and renewal system is monumental, and, with deadlines looming, it is imperative for everyone to roll up their sleeves to obtain the best outcomes possible. This report, coupled with The Children's Partnership's July 2011 document *Easy, Efficient, and Real-Time: A Framework for a First-Class Health Insurance Enrollment Experience in California*, provides relevant expectations and rules and a detailed guide for action. Most of the recommendations included in the report can be accomplished administratively through the existing legislative authority (AB 1602/SB 900 and AB 1296) provided to the California Health Benefit Exchange and Health and Human Services Agency to implement the ACA and its subsequent regulations. AB 1296 also already requires that the California Health and Human Services Agency report to the Legislature on policy and statutory changes needed to implement the workgroup's recommendations.

Because of the short timeline required for this process, we encourage decision-makers to exercise this authority to the greatest extent possible, only utilizing new legislation when absolutely necessary (e.g., the recommendation to eliminate the three-month waiting period in Healthy Families is one of the policies that may require a statutory change).

California also has some important resources to draw upon, not the least of which is new federal funding available for the development of supporting information technology through both Medicaid administrative funding and Exchange planning and establishment grants. State officials should leverage this enhanced funding and other supports, including the Enroll UX 2014 project, which will provide the framework for building a high-quality user experience.

Additionally, AB 1296's workgroup requirement allows the state agencies to draw upon the expertise of a range of stakeholders and interested parties to plan for and design many of the policy elements discussed in this report. The State should make the most of this opportunity by fully engaging in the process.

The job will not end in January 2014. Like any new system, there will be "fits and starts" and a tremendous amount of "on-the-job" experience to inform how the system functions once it is operational and guide needed improvements. AB 1296 requires ongoing monitoring of the eligibility systems post-2014 that, coupled with federal reporting requirements, is a critical component that should not be shortchanged in the rush to get the system up and running. Strong mechanisms should be established for obtaining stakeholder input, identifying potential corrections or enhancements, utilizing consumer feedback (as required through federal law), and implementing timely changes.

When all is said and done, the answer to the question posed in the introduction to this report is fairly simple. When the doors open for business in 2014, the consumer must find a system that is **easy to access, easy to use, informative, dependable, secure, and empowering.** Meeting these consumer expectations, however, will require the implementation of a number of policies and design features that may not be so easy to put in place. We hope this report helps to provide a clear and concise roadmap to meeting the challenges ahead. The Children's Partnership looks forward to working with the state's leaders and stakeholders who will make these all-important decisions.

APPENDIX A: FEDERAL AND STATE LEGAL REQUIREMENTS

The provisions below (which are organized according to each section of *Essential Design Features*) reference proposed Medicaid, CHIP, and Exchange regulations outlined in 76 *FR* 41866 (July 15, 2011) and 76 *FR* 50931, 76 *FR* 51148, and 76 *FR* 51201 (August 17, 2011). Unless otherwise noted, the citations denote where each regulation will be codified in 26 CFR Part 1 (IRS-premium tax subsidies); 45 CFR Parts 155 and 157 (HHS; Exchange); and 42 CFR Parts 435 and 457 (HHS; Medicaid and CHIP).

Smart Connections Through Multiple Doorways and Accessible Consumer Assistance

Medicaid/CHIP Eligibility (§ 435.110; § 435.116; § 435.118; § 435.119; § 435.218)
Current eligibility categories will be collapsed into three eligibility groups (children under 19, parents/caretakers, and pregnant women) and a new mandatory Medicaid category for nondisabled individuals under age 65 will be created. All of these individuals will be eligible for Medicaid up to 138 percent FPL (133 percent FPL plus a new 5 percent income disregard). States are also required to maintain Medicaid and CHIP for children in effect on March 23, 2010 until October 1, 2019 (§ 1902(a)(74), § 1902(gg) and § 2105(d)(3) of the Social Security Act). Other mandatory Medicaid populations (i.e., aged, blind, or disabled) will continue to receive coverage based on pre-ACA eligibility criteria, and states will continue to have the option to provide Medicaid coverage to individuals at higher income levels (with exceptions).

Exchange Web Portal (§ 155.205(b); § 435.1200(d); § 457.335) and **Application** (§ 155.405; § 435.907; § 457.330)
The ACA envisions that consumers will primarily sign up for (and renew) coverage for any of the insurance affordability programs through a new Web site. However, consumers will also be able to enroll using a single streamlined application in person, through the mail, over the phone, or via facsimile. (Note that the Exchange proposed rules do not offer facsimile as a requirement.) California has the option of using a federal application template or adopting its own (which must be approved by federal authorities). The State can also use a federally approved separate or supplemental application for applicants eligible for non-MAGI Medicaid (§ 155.405; § 435.907; § 457.330). The application, in addition to all forms and notices, must meet accessibility and readability requirements for persons with disabilities and/or limited English proficiency (§ 155.230; § 435.905; § 457.335). AB 1296 establishes a process for the State to develop the application, including making a recommendation on whether it will use the federal template or not (§ 15925(b) and (c)). AB 1296 also requires that, at a minimum, forms and notices be provided in the same threshold languages as Medi-Cal managed care (i.e., a language identified in a geographic area as the primary language of the lower of 3,000 beneficiaries or five percent of the beneficiary population, per Title 9, California Code of Regulations § 1810.410(f)(3)) (§ 15926(k)).

Consumer Assistance (§ 155.205; § 435.908; § 457.340(a))
States must provide consumer assistance through a number of venues, although the proposed rules offer little specificity. Exchanges must set up a toll-free call center, conduct "outreach and education activities," and establish a Navigator program (§ 155.210) that awards grant funds to public or private entities to conduct outreach and enrollment assistance. Additionally, an Exchange must establish a "consumer assistance function" that, at a minimum, makes referrals to state consumer assistance programs. In California this includes the Department of Managed Health Care's Help Center, which received a $4.1 million consumer assistance program grant under federal health care reform. Medicaid and CHIP must provide application assistance in person, over the telephone, and online. (See http://www.dmhc.ca.gov.)

Enrollment Periods (§ 155.410 and § 420)
Persons will apply for Exchange coverage during annual open enrollment periods, much like they would if they had employer-sponsored insurance. In addition, special enrollment periods will be established to address life events (such as the birth of a child), instances when individuals lose coverage during the year for various reasons, and other unique situations. This allows individuals to transfer between programs when they become

newly eligible for subsidies (including when an employer-sponsored plan is no longer affordable or provides minimum value, per the federal definition). In contrast, Medicaid and CHIP are required to allow enrollment at any time.

Integrated Eligibility Criteria and Processes Across Programs

MAGI Standard (§ 1.36B-2; § 435.603; § 457.315)
A MAGI standard currently utilized by the IRS will apply to Medicaid, CHIP, and subsidized Exchange coverage. The MAGI standard defines a family as the "tax-filing unit," or the number of personal exemptions that an individual claims. This is in contrast to current Medicaid and CHIP law that generally counts only parents and the children with whom they are living. The proposed Medicaid and CHIP rules also carve out exceptions to MAGI and define household size for those that do not file taxes (specifically counting spouses/parents and children who are living together). Medicaid and CHIP will continue to:

- Use current monthly income in contrast to projected annual income. Medicaid and CHIP can ask about "reasonable predictable decreases in future income" during the application process and maintain eligibility for enrollees with fluctuating monthly incomes so long as their annual income for the current calendar year remains at or below the program income standard.
- Count lump sum payments in the month received (to correspond with the "current monthly income" standard), exclude scholarship and grant monies, and not count certain income of American Indians and Alaska Natives from consideration (to avoid these populations having to forgo Medicaid and CHIP).
- Apply its household composition rules as they relate to determining the eligibility of qualifying relatives claimed as tax dependents by another taxpayer (such as a grandparent caring for a grandchild), a child claimed as a tax dependent by a noncustodial parent, a pregnant women (defined as a two-person household), and married couples who do not file jointly (who are ineligible for subsidy purposes).

Additionally, income deductions will no longer be allowed, and, instead, a five percent across-the-board income standard will be applied to Medicaid and CHIP. MAGI-based Medicaid can also no longer utilize an assets test for adults (§ 435.603(d)(1) and (g); § 457.315) To ensure continued coverage for children at pre-ACA levels, current income standards will also be converted to a "MAGI-equivalent" standard, which could raise the eligibility levels for children eligible for Medi-Cal and Healthy Families. Further federal guidance is expected on how this standard will be determined and applied (§ 435.118(c)).

Non-MAGI Medicaid (§ 155.345(b); § 435.603(i); § 435.911(c)(2); § 435.1200(g)(2); § 457.350(b)(2) and § 457.350(j))
The MAGI standard will not apply for all Medicaid populations including aged, blind, or disabled, those eligible for Medicare cost-sharing or the Medicaid Medically Needy program, and those eligible due to a need for long-term care. For these groups, the pre-ACA eligibility rules and, in most cases, an assets test will continue to apply. Individuals automatically eligible for Medicaid due to their participation in other public programs are also not subject to MAGI methodologies. This applies to those receiving SSI, TANF, or Foster Care and Adoption Assistance and to children eligible via Express Lane Eligibility.

Medicaid must determine an applicant's eligibility for non-MAGI Medicaid following a determination of ineligibility for MAGI Medicaid. It must also screen applicants awaiting a non-MAGI determination on the basis of being blind and disabled for potential eligibility for subsidized Exchange coverage and CHIP and transfer accordingly. The Exchange and CHIP must screen applicants for potential non-MAGI Medicaid eligibility and transfer the cases to Medicaid for a full determination. Those applicants who are also otherwise eligible for subsidized Exchange coverage or CHIP must be enrolled in coverage pending the final non-MAGI Medicaid determination. Those ultimately found eligible for non-MAGI Medicaid will not be liable for any tax subsidies received (§ 1.36B-2)(c)(2)).

MAGI Eligibility Determinations (§ 155.305; § 155.310; § 155.345(d); § 435.911(c); § 435.1200(e), (f), and (g)(1); § 457.348; and § 457.350)
All agencies will have certain responsibilities in undertaking eligibility determinations for the insurance affordability programs.

- Exchange: State-based Exchanges will be responsible for making binding determinations for MAGI-based Medicaid and CHIP and transmitting relevant information to the agencies so that the applicant receives coverage "promptly and without undue delay." (Note: consumers are not eligible for subsidized Exchange coverage if they are eligible for "minimum essential coverage," which includes Medicaid and CHIP.) States can have the Exchange facilitate health plan enrollment, including providing consumers with available health plan options and transmitting information to the health plans. States with a federally facilitated Exchange will have the option to retain responsibility for Medicaid and CHIP eligibility and enrollment. State-based Exchanges will also be able to use "federally managed services" to make determinations for the subsidized Exchange coverage. (See Centers for Medicare and Medicaid Services, "State Exchange Implementation Questions and Answers," November 29, 2011.)
- Medicaid/CHIP: Medicaid must first determine eligibility for MAGI-based Medicaid (and non-MAGI Medicaid, discussed above) and, at a minimum, screen applicants for potential eligibility for CHIP and subsidized Exchange coverage and forward the cases to the respective agencies. CHIP agencies must also screen applicants for potential eligibility for MAGI-based Medicaid and subsidized Exchange coverage (in addition to a full CHIP determination) and forward the cases to the respective agencies. Medicaid and CHIP can accept as binding an eligibility determination conducted by the other agency. Additionally, states can have Medicaid and CHIP conduct binding subsidized Exchange determinations (§ 1413(d)(2) of the ACA).

Generally, for cases transferred between programs following eligibility screens, each agency must finalize a determination for its respective program without requesting information already on file or conducting duplicative verifications.

See Appendix C for a chart describing eligibility rules for the MAGI-based insurance affordability programs, per the ACA and proposed federal regulations.

Real-Time, Immediate, and Ongoing Enrollment

Verification (§ 155.315; § 155.320; § 435.945; § 435.948; § 435.952; § 457.380)
States can accept attestation with or without verification, depending on the criteria, to confirm eligibility for each of the insurance affordability programs. States must also continue to comply with provisions of § 1137 of the Social Security Act to request information from trusted data sources when useful to verifying financial eligibility. Verification will be achieved through a new "federal hub" (consisting of the Social Security Administration, the Department of Treasury, the Department of Homeland Security, and any other appropriate agency) and a state-required verification system using state and federal agency data. Additional information (including documentation) can only be requested when information cannot be obtained electronically or the information obtained is not "reasonably compatible" with that provided on the application. Applicants must be given sufficient time to provide this information (in Exchange, applicants have a minimum of 90 days and, in Medicaid and CHIP, applicants will be provided with a "reasonable period.") With their consent, applicants otherwise eligible for subsidized Exchange coverage will be enrolled pending a resolution.

AB 1296 gives applicants the ability to consent to the prepopulation of their application from available databases, if the enrollment system has the ability to do so. Where information is prepopulated for initial applications or renewal, consumers will be given an opportunity to review and correct such data. In addition, AB 1296 provides that all insurance affordability programs may accept self-attestation, to the extent

permitted by state and federal law, and that electronic verification will be conducted as laid out in federal regulation and guidance (§ 15926(f)).

Citizenship/Immigration Rules (§ 155.305(a)(1) and (f)(2); § 155.315(b))
Federally funded Medicaid and CHIP is available to otherwise eligible citizens, naturalized citizens, and "qualified" immigrants who have been in the U.S. for five years or longer (with exceptions). States can also receive federal funding to provide Medicaid and CHIP to "lawfully residing" pregnant women and children (which includes "qualified" immigrants in addition to other categories) without the five-year waiting period (§ 1903(v)(4) of the Social Security Act, as added by section 214 of the Children's Health Insurance Program Reauthorization Act). California utilizes this option and covers other adults during the five-year waiting period with state funding. Exchange coverage is available to citizens, nationals, and "lawfully present" immigrants (who are reasonably expected to have that status for the entire enrollment period). Since the "lawfully present" standard differs from the "satisfactory immigration" standard used by Medicaid and CHIP (except for pregnant women and children in states that have adopted the coverage option described above), the Exchange must verify whether an applicant who is not a citizen or national meets the immigration status definition and five-year waiting period, if applicable in the state, for Medicaid and CHIP.

Renewal (§ 155.335; § 435.916; § 457.343)
Coverage in the insurance affordability programs will be renewed annually. MAGI-based Medicaid and CHIP will conduct an eligibility determination using available information where applicants need only take action if the data is incorrect. If unable to obtain data required for an "administrative renewal," enrollees will be sent a prepopulated recertification form to complete and return within 30 days. Subsidized Exchange coverage will require enrollees to verify their information and report any changes through a prepopulated form. The enrollee must sign and return the notice within 30 days. If there is no response (and the enrollee has filed taxes), the Exchange will determine eligibility using the information provided in the prepopulated form and notify the enrollee.

See Appendix C for a chart describing verification rules for the MAGI-based insurance affordability programs, per the ACA and proposed federal regulations.

Easy Navigation of Coverage

Premium Payments (§ 155.240)
Premium tax credits available to those in the Exchange will be paid directly to the health plan. For any remaining amount owed, states must allow enrollees to make payment directly to the health plan, but can also facilitate collection and payment of premiums through the Exchange. Consumers enrolled in Exchange plans will receive a grace period of three months nonpayment as long as they have a history of making payments (§ 156.270(d)). Federal Medicaid and CHIP premium rules have not changed (generally premiums are allowed for CHIP and certain adults in Medicaid but within limitations based on family income) (§ 1916 and § 1916A of the Social Security Act; § 457.500). CHIP requires a 30-day premium grace period before cancelling a child's coverage; California allows 60 days (§ 2103(e)(3) of the Social Security Act). In California, Healthy Families bills and collects premium payments monthly (with a discount provided when three months have been paid in advance). Consumers can pay in person (through Western Union), over the phone or online, through the mail, or set up automatic payments with a credit card or a bank checking/savings account (and receive a discount).

Change of Circumstances (§ 155.330; § 435.916(c) and (d); § 457.343)
Those receiving subsidized Exchange coverage are required to report within 30 days any changes that would affect eligibility, while Medicaid and CHIP must have procedures that allow enrollees to make "timely and accurate reports" of changes. Proposed federal rules contemplate limiting when enrollees in subsidized Exchange must report changes. The Exchange must also periodically examine data sources to identify, at a minimum, death and enrollment in Medicare or other insurance affordability programs (which makes them

ineligible for Exchange coverage). Any changes from an Exchange redetermination will be effective on the first day of the first or second month (depending on the timing) following notice to the enrollee. In instances of disenrollment, Exchange must maintain the enrollee's health plan enrollment (without subsidies) for a month following notice. Medicaid and CHIP must conduct redeterminations if new information is received. AB 1296 also requires the workgroup to consider whether to allow recipients to update their eligibility information in between renewal dates and, at that time, renew eligibility in order to reset their renewal date (§ 15925(b)).

Transfer Between Programs (§ 155.430; § 435.915(b); § 457.340(f))
In general, individuals transferring between coverage options will retain coverage until enrolled in the new program. For example, enrollees who are found ineligible for Exchange coverage but newly eligible for Medicaid or CHIP will retain Exchange coverage through the last day before the effective date of the new coverage. To further facilitate this process, the proposed regulations seek comment on whether to comport Medicaid and CHIP law with the Exchange's coverage month, which for subsidized coverage begins on the first day of the month (except in the case of birth or adoption when coverage begins on that related date). This would mean that Medicaid and CHIP would extend coverage through the end of the month when terminating coverage. The proposed federal regulations also revise the effective date of eligibility for CHIP by requiring states to determine an effective date that will ensure no gaps in coverage for children moving between programs due to changing circumstances.

APPENDIX B. KEY COMPONENTS OF A SINGLE SHARED ELIGIBILITY SYSTEM

Consumers applying for health coverage under health reform should be able to apply through a multiple of venues connected to a single shared eligibility system. This system will be particularly beneficial to those applying online, but will also be utilized by eligibility workers and assistors helping consumers applying in person or over the phone. Those using a mailed paper application will also benefit from the utilization of the shared eligibility system to determine eligibility faster, manage the applicant's case and plan specifics, and streamline the renewal process. The following describe the key components of a single shared eligibility system (as they particularly would be applied to online procedures) that should be implemented through California's Healthcare Eligibility, Enrollment, and Retention System (CalHEERS),

1. **Consistency, Accuracy, Efficiency, and Seamlessness**
    - All online applications will flow into a single shared eligibility system, which will house the business rules engine that calculates MAGI and makes eligibility determinations for the insurance affordability programs (MAGI and non-MAGI Medi-Cal, Healthy Families, subsidized Exchange coverage, and the Basic Health Program, if applicable) as well as unsubsidized Exchange coverage.
    - Once the electronic application has been received, the system will connect via middleware with the federal verification hub and state verification system (consisting of state and private wage and other databases such as the Income and Eligibility Verification System) to retrieve and verify eligibility information, as appropriate.
    - In real time, the consumer will review, attest to or correct, and add required eligibility information.
    - The rules engine will apply a data hierarchy and other rules to resolve any inconsistencies and will determine eligibility wherever possible.
    - Once the review is completed consumers will receive an eligibility decision, with an explanation as to the calculations used in making the final assessment and information on any appeal procedures, as appropriate.
    - Upon conclusion, the case will flow to the next appropriate steps in the enrollment process (which includes health plan enrollment, see #3, and transfer of legal responsibility for the case to the appropriate agency). In addition, non-MAGI Medi-Cal applicant case files and other relevant information will be forwarded to the appropriate county Medi-Cal agency for further follow-up and case management; those otherwise eligible for subsidized Exchange coverage or Healthy Families will be enrolled in coverage pending the non-MAGI determination.
2. **Adequate Support and Consumer Engagement**
    - The online application will link consumers to resources that can help them complete their tasks—including an online Q&A, real-time online assistance (including e-chat features), and a toll-free call center as well as convenient locations that can offer in-person assistance.
    - Consumers will create an online health coverage account that allows them to review current program enrollment status (across programs, for all family members), report changes in circumstances, access payment history, and make premium payments (online or through other channels), among other functions. The account will automatically generate notices for all critical points in the enrollment experience (such as open enrollment opportunities, renewal inquiry, etc.), which will be provided in the format chosen by the consumer.
    - Consumers will be able to authorize trusted persons such as family members and assisters to view and modify their account.

3. Informed Plan Selection

- Medi-Cal's Health Care Options function and Healthy Families and Exchange plan selection will be built as part of the single eligibility system. The system will allow users to view and compare available carriers and providers/hospitals as well as costs and other parameters for all family members, across programs. It will identify different options or protections (and run different rules) that apply for different programs, as relevant.
- As much as possible, consumers will be able to enroll in their selected carrier in real time. This will involve the consumer communicating with the carrier directly from within their account.
- Those consumers not processed in real time (or requiring additional time to choose a health plan) will be given a case number and will be able to access their account to complete this process. As with all of the online processes, the consumer will be able to complete this step with in-person or other assistance and will be able to access their account from anywhere.

4. Linkage with SHOP

- Qualified SHOP employees that do not have access to affordable employer dependent coverage will be asked whether they need coverage for any dependents. If answered affirmatively, the employee will be provided a direct link to the shared eligibility system.

5. Optimized Linkages to Other Human Service Programs

- At the end of a health enrollment experience, consumers will be presented with a list of other health coverage and human service programs that they are likely eligible for and asked to select any for which they would like to apply. When this option is selected, the relevant eligibility information will be pulled and forwarded to the relevant agency for processing.
- For the foreseeable future, counties will perform eligibility and case management for multiple human service programs, all of which will need to communicate bidirectionally with the shared eligibility system in order to facilitate initial eligibility and renewal through the use of current information.
- Eventually, the shared eligibility system could be expanded to house the rules engine for these other health and human service programs.

6. Accountability and Flexibility

- The shared eligibility system will be developed with a modular, scalable design that separates the business rules from core programming in accordance with federal requirements.
- The system will track all cases and report out on all measures required by federal law as well as other performance measures set out by the AB 1296 stakeholder group.
- The consumer account will maintain a log of case activity, including payments, data exchange, and correspondence with programs and official notices.

APPENDIX C. ELIGIBILITY & VERIFICATION RULES FOR INSURANCE AFFORDABILITY PROGRAMS[a]

Eligibility Element	Subsidized Exchange Coverage	Medicaid and CHIP
Basic Demographic and Identifying Information (Name, Address, SSN, Date of Birth, etc.)	• No requirement for age and date of birth. • SSN of the primary taxpayer required (45 CFR 155.305(f)(6)). SSN of other applicants requesting benefits used (but not required) to verify income and, if applicable, citizenship (§ 155.315(b); § 155.320(c)).	• Can accept attestation of age and date of birth with or without verification through state/federal agencies and/or databases (42 CFR 435.956(f); 42 CFR 457.380(e)). • SSN of applicants requesting benefits required (§ 435. 910; § 457.340(b)).
State Residency *Also required for unsubsidized Exchange coverage.*	• Must accept attestation with no verification, unless Medicaid/CHIP agency requires such verification (§ 155.315(c)).	• Can accept attestation with or without verification through state/federal agencies and/or databases (§ 435.956(c); § 457.380(c)).
Incarceration Status *Also required for unsubsidized Exchange coverage.*	• Must verify attestation with approved electronic data sources. Where none exist, must rely on attestation (§ 155.315(d)). .	• Can accept attestation ((§ 435.945(b); § 457.380(e)). • Incarceration status is not an element of Medicaid eligibility; however, payment of services cannot be made while someone is incarcerated (§ 435.1099). Under CHIP, an applicant cannot be an inmate of a public institution (§ 457.310(c)(2)(i)).
Household Composition	• Must accept attestation with no verification (§ 155.320(c)(3)(i)).	• Must accept attestation with no verification (§ 435.956(e); § 457.380(e)).
Income (for Household) • Exchange: Projected Annual Income • Medicaid/CHIP: Current Monthly Income	• Must obtain tax data from the IRS and have applicant attest that it is an accurate projection of the family's income for the benefit year (§ 155.320(c)(3)(ii)). • Must accept attestation of expected increase in income (§ 155.320(c)(3)(iii)). • Must verify attestation of expected decrease in income, change in family size, application for unemployment benefits, or if tax data is unavailable (§ 155.320(c)(3)(iv) and (v)). • For advance payments, primary taxpayer must attest that he/she will file a tax return (a joint return, if married) and claim a personal deduction for applicants identified as family members (§ 155.301(d)(2)).	• Must "corroborate or verify" attestation through federal verification system and other state/federal agencies and/or databases (§ 435.948; § 457.380(d)). • Can take into account reasonably anticipated changes in income (which must be attested to and verified). Uncertain changes in future income cannot be considered (§ 435.603(h)(3); § 435.948; § 457.315; § 457.380(d)).
No Employer or Public Coverage	• Applicant not eligible if enrolled in any employer-sponsored plan or eligible for an employer-sponsored plan that meets affordability standards (26 CFR 1.36B(c)(2)(C)).[b] Must accept attestation with no verification if enrolled in employer plan (§ 155.320(d)). Must verify attestation if eligible for employer plan (§ 155.320(e)). • Must verify whether applicant is eligible for minimum essential coverage through data match with U.S. Department of Health and Human Services (§ 155.320(b)).	• Medicaid: No requirements. • CHIP: Applicant cannot be enrolled in an employer plan at time of application. Can accept attestation (§ 457.380(e)). Some states have established waiting periods for employer coverage.[c] In California an applicant cannot be enrolled in employer coverage for three months prior, with exceptions (10 CCR 2699.6607(d)).
Pregnancy Status	• No requirement.	• Must accept attestation with no verification (§ 435.956(e); § 457.380(e)).

Eligibility Element	Subsidized Exchange Coverage	Medicaid and CHIP
Citizenship/National/ Lawfully Present Status *Also required for unsubsidized Exchange coverage*.	• Where applicant has SSN and attests to being citizen/national, Social Security Administration (SSA) data match suffices. (§ 155.315). • Where applicant attests to lawful status[d], must verify name, date of birth, and identifying information with Department of Homeland Security (DHS) (§ 155.315).	• Where applicant has SSN and attests to being citizen/national, SSA data match suffices (SSA § 1902(ee)). • Where applicant attests to lawful status, applicant must present DHS documentation or "such other documents as the State determines constitutes reasonable evidence." State must verify documentation (SSA § 1137(d)(2)). Interpretation of this rule could allow electronic verification to suffice as "documentation," as with Exchange coverage.
Mid-Year Redetermination	• Relies on enrollee to provide updated information within 30 days. Must periodically examine data sources to identify death and other program determinations[e] (§ 155.330).	• Must redetermine eligibility when receives information about changes that may affect eligibility. Must allow enrollees to make "timely and accurate reports" of changes (§ 435.916(c); § 457.343).
Renewal	• Annually • Must provide prepopulated renewal notice with updated information using data-matching. Enrollee will verify and report any changes. If no reply, must complete determination with available information (§ 155.335).	• Every 12 months • Must verify continuing eligibility on electronic data-matching. No action required from enrollee if information is correct. Cannot require return of signed renewal form. • If unable to redetermine eligibility using available data, must send prepopulated form. Applicant has 30 days to respond. Can allow attestation; can require return of signed form. (§ 435.916; § 457.343)
Compatibility Standard	• Generally, when information provided by applicant is not "reasonably compatible" with available data, can examine other data sources. • Where information is still incompatible or cannot be verified, must "make a reasonable effort to identify and address the causes of such inconsistency" electronically or otherwise. Where inconsistency remains, must provide applicant a minimum of 90 days to resolve, such as with documentation, and provide coverage in the interim. (§ 155.315(e))	• When information provided by applicant is not "reasonably compatible" with available data, can contact applicant for information explaining the discrepancy or other documentation. • Applicant must be provided with a "reasonable period" to provide additional information. (§ 435.952; § 435.952(c); § 457.380(f))

Notes:

a. Information for this chart is based upon the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148) and corresponding proposed regulations: 76 *FR* 41866 (July 15, 2011) and 76 *FR* 50931, 76 *FR* 51148, and 76 *FR* 51201 (August 17, 2011). The requirements for subsidized Exchange coverage are based on section 1411 of the ACA. The requirements for Medicaid and CHIP are based on Sections 1137, 1902(a)(4), 1902(a)(19), 1903(r)(3) and 1943(b)(3) of the Social Security Act and section 1413 of the ACA.

b. Proposed federal rules define employer-sponsored coverage as unaffordable for an employee and his/her spouse or dependents if the employee contribution for self-only coverage exceeds 9.5 percent of household income or the employer plan pays on average less than 60 percent of the allowable cost of covered services. 76 *FR* 50931 (August 17, 2011).

c. States must describe in their state plans the procedures that they will use to ensure that CHIP coverage does not substitute for group-based coverage but are not required to implement specific procedures, including waiting periods. § 2102(b)(3)(C) of the Social Security Act.

d. The "lawfully present" standard differs from the "satisfactory immigration" standard used by Medicaid and CHIP except for pregnant women and children in states that have adopted the option to provide Medicaid and CHIP without a five-year waiting period (§ 1903(v)(4) of the Social Security Act, as added by section 214 of the Children's Health Insurance Program Reauthorization Act). The Exchange must verify whether an applicant who is not a citizen or national meets the satisfactory immigration status definition (and five-year waiting period, if applicable in that state) for Medicaid and CHIP. California has eliminated the five-year waiting period for all populations. 76 *FR* 51201 (August 17, 2011); § 155.315(f).

e. The proposed regulations solicit comments on whether there should be an additional role for Exchange-initiated data-matching, limits on when an enrollee reports a change (i.e., only when income changes a certain percentage), and whether enrollees should be able to receive reminders to report changes. 76 *FR* 51201 (August 17, 2011), pp. 51218-9.

End Notes

[1] Patient Protection and Affordable Care Act of 2010, Pub. L. 111–148, 124 Stat. 119 (2010).
[2] S.A. Lavarreda and L. Cabezas, "Two-Thirds of California's Seven Million Uninsured May Obtain Coverage Under Health Care Reform," UCLA Center for Health Policy Research (2011). Represents uninsured adults and children in 2009 who would be eligible in 2014 for Medi-Cal or Exchange coverage with or without subsidies.
[3] "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Proposed Rule," *Federal Register* 76:41866-41927 (July 15, 2011); "Health Insurance Premium Tax Credit Proposed Rule," *Federal Register* 76:50931-50949 (August 17, 2011): "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010; Proposed Rule," *Federal Register* 76:51148-51199 (August 17, 2011); "Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers; Proposed Rule," *Federal Register* 76:51201-51237 (August 17, 2011); and Centers for Medicare and Medicaid Services, "State Exchange Implementation Questions and Answers," (November 29, 2011).
[4] A.B. 1602, 2009-2010 Legislative Session (California, 2010) and S.B. 900, 2009-2010 Legislative Session (California, 2010).
[5] For further information, see http://www.healthexchange.ca.gov/Grants/Pages/GrantInformation.aspx.
[6] A.B. 1296, 2010-2011 Legislative Session (California, 2011).
[7] For further information, see http://www.ux2014.org.
[8] N. Pourat, *et al*., "Californians Newly Eligible for Medi-Cal Under Health Reform," UCLA Center for Health Policy Research (May 2011) and N. Pourat, *et al*., "Who Can Participate in the California Health Benefit Exchange?," UCLA Center for Health Policy Research (May 2011).
[9] State of California, Department of Health Care Services, "Medi-Cal Program Enrollment Totals for FY 2009-10," (June 2011) and State of California, California Managed Risk Medical Insurance Board, "Healthy Families Program: August 2011 Summary," (September 14, 2011).
[10] The term "insurance affordability programs" refers to Medicaid, CHIP, premium tax subsidies and cost-sharing reductions through the Exchange and a state-established Basic Health Program (BHP). California has not determined whether it will implement a BHP, which would provide subsidized coverage outside of the Exchange to low-income individuals up to 200 percent FPL.
[11] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Guidance for Exchange and Medicaid Information Technology (IT) Systems Version 2.0," (May 2011), p. 4.
[12] State of California, Department of Health Care Services, "Population Distribution by Age/Gender, July 2010," (July 2011) and State of California, California Managed Risk Medical Insurance Board, "Healthy Families Program: August 2011 Summary," (September 14, 2011).
[13] G. Kenney, *et al*., "Who And Where Are the Children Yet to Enroll in Medicaid and The Children's Health Insurance Program?," *Health Affairs*, 29 (October 2010).
[14] V. Wachino and A. Weiss, "Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children," National Academy for State Health Policy (February 2009) and Covering Kids and Families National Program Office and the Southern Institute on Children and Families, "Promising Practices from the Nation's Single Largest Effort to Insure Eligible Children and Adults Through Public Health," (April 2007).
[15] A.B. 922, 2010-2011 Legislative Session (California, 2011).
[16] *op. cit.* (8). An estimated 2.13 million Californians will be newly eligible for Medi-Cal in 2014 and 1.71 million will be newly eligible for premium tax credits through the Exchange.
[17] *op. cit.* (6); § 15926(g).
[18] *op. cit.* (8).
[19] "Medicaid Program; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities," *Federal Register* 76:68583-68595 (April 19, 2011). Federal reimbursement for the design, development, and installation of state eligibility and enrollment systems is available at a federal match rate of 90 percent (increased from the current 50 percent federal match), effective until December 31, 2015. The maintenance and operation of such systems is also eligible for an increased reimbursement rate of 75 percent.
[20] Children enrolled in Medi-Cal and Healthy Families have 12-month continuous eligibility, meaning that a child remains eligible for the programs during that 12-month period regardless of changes in income or family status. See § 14005.25 of the California Welfare and Institutions Code and § 12693.74 of the California Insurance Code.
[21] To ensure continued coverage at pre-ACA levels, current income standards in Medicaid for children and CHIP will be converted to a "MAGI-equivalent" standard. Further federal guidance is expected on how this standard will be determined and applied. See 76 *FR* 51148 (August 17, 2011); § 435.118(c).
[22] Internal analysis conducted in May 2010 by California Department of Healthcare Services, cited in W. Bernstein, *et al.,* "Implementing National Health Reform in California: Changes to Public and Private Insurance," Manatt Health Solutions for California HealthCare Foundation (June 2010).
[23] Centers for Medicare and Medicaid Services, "California Bridge to Reform Demonstration, Special Terms and Conditions," (November 2, 2011).
[24] See A.B. 714, 2011-12 Legislative Session (California, 2011), which requires a pre-enrollment process for these and other programs.
[25] Georgetown Center for Children and Families and Community Catalyst, "The New Responsibility to Secure Coverage: Frequently Asked Questions," (July 13, 2010).
[26] For 2010, the tax-filing threshold was $9,350 for an individual (86 percent of FPL) and $18,700 for a family (101 percent FPL for a family of three and 84 percent FPL for a family of four).
[27] Section 203 of the Children's Health Insurance Program Reauthorization Act of 2009 permits state Medicaid and CHIP agencies to rely on findings from an Express Lane agency, designated by the state, to conduct simplified eligibility determinations and facilitate enrollment of children in Medicaid and CHIP. See 42 U.S.C. 1396(a)(e)(13).
[28] 2009 California Health Interview Survey, "Currently Receiving Food Stamps and Insured*,"* accessed on November 15, 2011.
[29] Maternal and Child Health Access, "Improving Enrollment Policies While Moving Toward Long-Range Enrollment Modernization," (April 10, 2009). SB 24 was passed into law in October 2003. The bill required the California Department of Health Care Services to establish a Newborn Hospital Gateway, which would enable hospitals to electronically submit enrollment data for infants automatically eligible for Medi-Cal due to the mother's receipt of Medi-Cal. Subsequently the Newborn Gateway was implemented as a component of the CHDP Gateway.
[30] 76 *FR* 51148 (August 17, 2011); p. 51167.
[31] *op. cit.* (19). According to the guidance, state eligibility systems are eligible for the enhanced federal matching rate if they determine eligibility for Medicaid, CHIP, and premium tax credits and cost-sharing benefits through the Exchange in a streamlined and integrated fashion.

[32] 76 *FR* 51148 (August 17, 2011); § 433.10(c)(6) and § 433.206(a) and (b).
[33] Those not subject to MAGI methodologies include those who do not require a financial determination (those receiving SSI, CalWORKs, and Foster Care and Adoption Assistance), aged, blind or disabled populations, those eligible for Medicare cost sharing, the Medicaid Medically Needy program or Express Lane Eligibility, and those eligible due to a need for long term care. See 76 *FR* 51148 (August 17, 2011); § 435.603(i).
[34] Medicaid and CHIP use the "lawfully present" standard for pregnant women and children in states that have adopted the option to provide coverage without the five-year waiting period (under section 1903(v)(4) of the Social Security Act, as added by section 214 of the Children's Health Insurance Program Reauthorization Act). This standard differs from the "satisfactory immigration" definition used for other Medicaid populations. As such, the Exchange will be required to verify whether an applicant who is not a citizen or national meets the satisfactory immigration status definition and, if applicable in that state, five-year waiting period. (Note: California has eliminated the five-year waiting period for all populations.) See 76 *FR* 51201 (August 17, 2011); § 155.315(f).
[35] Note that, there may be some program elements particular to Medicaid that will need to be addressed at application and coordinated with the other programs. For example, Medicaid provides three months of retroactive coverage for eligible applicants who have unpaid medical bills.
[36] 76 *FR* 50931 (August 17, 2011), p. 50935; § 1.36B-2(c)(3)(v).
[37] § 2110 (b)(1)(C) of the Social Security Act.
[38] CHIP requires states to describe in their state plans the procedures that they will use to ensure that CHIP coverage does not substitute for group-based coverage. It, however, does not specify exactly which procedures a state must use and does not require the implementation of waiting periods. See § 2102(b)(3)(C) of the Social Security Act.
[39] 10 CCR 2699.6607(d).
[40] Note that while the federal proposed rules specify that CHIP and subsidized Exchange coverage would enroll all otherwise eligible potential non-MAGI applicants into coverage, Medicaid would forward only those non-MAGI applicants potentially eligible on the basis of being blind or disabled to these programs for such coverage. 76 *FR* 51148 (August 17, 2011); § 435.1200(g)(2).
[41] Note that benchmark packages can also be designed to be equal to or more comprehensive than traditional Medicaid. In addition, the ACA requires that benchmark coverage benefits meet minimum essential health benefits available in the Exchange in addition to other specific services (i.e., mental health services, family planning services and supplies, and prescription drug coverage). See Centers for Medicare and Medicaid Services, "Family Planning Services Option and New Benefit Rules for Benchmark Plans," (July 2, 2010) and "Medicaid Program; State Flexibility for Medicaid Benefit Packages; Final Rule," *Federal Register* 75:23068-23104 (April 30, 2010).
[42] 75 *FR* 23068 (April 30, 2010), pp. 23069-23070.
[43] *op. cit.* (6); § 15926(h).
[44] Note that under California's Section 1115 waiver the State has awarded grants to five county pilots to evaluate the effectiveness of managed care delivery models in improving delivery of health care services for children eligible for CCS.
[45] Under proposed federal rules, California must maintain Medi-Cal coverage for pregnant women with incomes up to at least 185 percent FPL after 2014. 76 *FR* 51148 (August 17, 2011); § 435.116.
[46] 76 *FR* 51148 (August 17, 2011); § 435.116(d).
[47] U.S. Department of Agriculture and U.S. Department of Health and Human Services, Letter to State Exchange Grantees, Medicaid and CHIP Directors (August 10, 2011).
[48] K. Kronebusch and B. Elbel, "Simplifying Children's Medicaid and SCHIP: What Helps? What Hurts? What's Next for States?" *Health Affairs* 23, no. 3 (May/June 2004): 239, Exhibit 1 and M. Perry, E. Stark, and R. Burciaga Valdez, "Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment: Findings from Eight Focus Groups in California with Parents of Potentially Eligible Children," Kaiser Family Foundation (1998).
[49] Possible databases worth exploring include Work Number and TALX both by Equifax, the California Child Support Automation System, Income and Eligibility Verification System, California Employment Development Department (quarterly wage reporting, unemployment insurance, disability insurance), and those of other public programs.
[50] § 1137(d)(2) of the Social Security Act states that where an applicant attests to lawful status, he/she must present DHS documentation or "such other documents as the State determines constitutes reasonable evidence."
[51] Section 211; § 1902(ee) of the Social Security Act.
[52] *op. cit*. (48).
[53] *Ibid* (Kronebusch).
[54] D. Holahan and E. Hubert, "Lessons from States with Self-Declaration of Income Policies," United Hospital Fund (2004); L. Cox, "Allowing Families to Self-Report Income: A Promising Strategy for Simplifying Enrollment in Children's Health Coverage Programs," Center on Budget and Policy Priorities (December 2001); J. Wooldridge, "Making Health Care a Reality for Low-Income Children and Families," Robert Wood Johnson Foundation and Mathematica Policy Research, Inc (2007); D.C. Ross and I. Hill, "Enrolling Eligible Children and Keeping Them Enrolled," *Future of Children* 13, no. 1 (2003): 86; and A.W. Dick *et al*., "Consequences of States' Policies for SCHIP Disenrollment," *Health Care Financing Review* 23, no. 3 (2002): 65-88.
[55] Proposed federal rules specify that before a request for information from a third-party data source is initiated, an individual must receive notice of the information being requested and its use. 76 *FR* 51148 (August 17, 2011); § 435.945(f).
[56] Centers for Medicare and Medicaid Services, "Payment Error Rate Measurement Manual, v. 1.2," (September 19, 2011), p. 59.
[57] 42 CFR 431.810-822.
[58] Centers for Medicare and Medicaid Services, "State Exchange Implementation Questions and Answers," (November 29, 2011).
[59] For instance, see The Practice Fusion, "EHR vs Paper Charts," (October 21-23, 2011).
[60] Pregnancy-related Medi-Cal will be provided up to 205% FPL. This report recommends providing full Medi-Cal coverage to pregnant women. If pregnant at application, she would enroll in Medi-Cal (and transfer to Exchange coverage at birth) but if she becomes pregnant while receiving Exchange coverage, she would receive those additional services as a wraparound or supplemental coverage.
[61] 76 *FR* 51201 (August 17, 2011); § 155.405(a).
[62] "Medicaid Program; Premiums and Cost Sharing; Final Rule," *Federal Register* 75:30243-30265 (May 28, 2010).
[63] Sections 1302 and 1402 of the Patient Protection and Affordable Care Act.
[64] Stacey McMorrow, *et al*., "Addressing Coverage Challenges for Children Under the Affordable Care Act," The Urban Institute (May 2011).
[65] 76 *FR* 51201 (August 17, 2011); § 156.200(c)(2).
[66] *op. cit.* (36).
[67] K. Jacobs, *et al*., "Proposed Regulations Could Limit Access to Affordable Health Coverage for Workers' Children and Family Members," UC Berkeley Center for Labor Research and Education and the UCLA Center for Health Policy Research (December 2011).

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