Eligibility & Enrollment

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California Health Benefit Exchange Board Meeting
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Eligibility and Enrollment Guiding Principles

- Through a “No Wrong Door” approach, promote maximum enrollment into coverage.
- Facilitate a smooth enrollment process beginning with the use of a single streamline application and seamless renewal process.
- Present information in a manner that is accurate, accessible, understandable and transparent to consumers to inform and educate them.
- Continue to learn and adjust strategies and tactics based on input from our national partners, California stakeholders, ongoing research, evaluation and measurement of the programs’ impact on awareness and enrollment.

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Policy Update

Key Policy Issues:

- Staff are identifying and making initial recommendations on key policy issues to the Board and the Stakeholders for consideration and discussion.
- A Stakeholder webinar was conducted on March 14, 2013.
- Stakeholder and public comments on the key policy issues and proposed draft Eligibility & Enrollment State Regulations were due on March 28, 2013.

- **Staff recommendations guided by the:**
  - ✓ Affordable Care Act
  - ✓ Covered California's Eligibility and Enrollment Guiding Principles
  - ✓ Interim final Federal Regulations (published on March 27, 2012)
  - ✓ Recently proposed Federal Regulations (published on January 22, 2013)

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Stakeholders Providing Comments

1. Asian Law Alliance
2. Asian Pacific American Legal Center
3. California Food Policy Advocates
4. California Lesbian, Gay, Bisexual, Transgender Health and Human Service Network
5. California Pan Ethnic Health Network
6. California Rural Indian Health Board
7. Center for Democracy & Technology
8. Children Now
9. Children's Defense Fund - California
10. Coalition for California Welfare Rights Organizations
11. Community Health Councils, Inc.
12. Consumers Union
13. Disability Rights, Education, and Defense Fund
14. Greenlining Institute
15. Health Access
16. Health Legal Services
17. Maternal and Child Health Access
18. National Health Law Program
19. National Immigration Law Center
20. Neighborhood Legal Services of Los Angeles County
21. Project Inform
22. Social Interest Solutions
23. The Children's Partnership
24. Transgender Law Center
25. Western Center on Law and Poverty

Policy Update

Key Policy Issues
Processing time frames to conduct eligibility determinations
Special exceptions to maintain enrollment after 90-day reasonable opportunity period
Periodic data matching process
Requirements for consumers to self-report changes
Authorized Representative process
Appeals process

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Covered California's Key Policy Issue

Timeframes to Conduct Eligibility Determinations
Special Exceptions to Maintain Enrollment After 90-Day Reasonable Opportunity Period

Key Policy Issue:	Staff Preliminary Recommendation:
Processing Time Frames to Conduct Eligibility Determinations: Affordable Care Act (ACA) and Federal Regulations do not explicitly identify the processing timeframe (e.g., how many days) to conduct an eligibility determination once an application is received. Federal statutes and Regulations state that the eligibility determination must be conducted in "real time" and without "undue delay."	• **Complete on-line applications** (e.g., self-service or in-person assistance) and **telephone applications** will occur "real time" and within minutes. • **Complete paper** (e.g., self-service or in-person assistance) or **faxed applications** that do not require resolution of any inconsistency will be processed within 10 calendar days of receipt*. • **Incomplete paper** (e.g., self-service or in-person assistance) **or faxed applications** that require follow-up as a result of missing information will be processed within 10 calendar days of receipt*. ✓ It is recommended that the administrative service level standards to process applications and eligibility determinations occur within 5 business days. • All applications resulting in conditionally eligibility for Covered California will allow the consumer at least 90 days to resolve the inconsistency.
Special Exceptions to Maintain Enrollment After 90-Day Reasonable Opportunity Period: Federal Regulations require Covered California to extend the 90-day reasonable opportunity period on a "case by case" basis.	• Consumers may submit a request to extend the 90-day reasonable opportunity period: ✓ Must provide the reason why the consumer is unable to furnish documents or why documents do not exist to resolve the inconsistency. Examples below model policies adopted by Department of Health Care Services for the Medi-Cal Programs: ▪ Applicant provides a copy of a request to obtain documentation such as a photocopy of letter or e-mail to the agency who will issue documentation. ▪ Provide a copy of a check, receipt, order form, or other documentation notating that the documentation has been ordered. ▪ Provide a written or verbal statement describing the applicant's efforts to obtain documentation needed. ✓ Consumer's justification will be reviewed and must be approved by Covered California in order for the 90-day reasonable opportunity period be extended. Recommend a 15 business day processing timeframe. • If approved, Covered California will follow-up with the consumer, reminding them that they need to resolve the inconsistency during this exception period. • Written notification will be sent to the consumer with the outcome of the decision.

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Covered California's Key Policy Issue

Periodic Data Matching Process

Key Policy Issue:	Staff Preliminary Recommendation:
Periodic Data Matching Process: Federal Regulations require that, once a consumer is determined eligible and enrolled in Covered California, periodic data matching must occur. During the periodic data matching process, Federal Regulations require Covered California to at a minimum verify: 1) Whether the consumer is deceased; and 2) Whether the consumer had a recent eligibility determination which resulted in enrollment into Medicare or no-cost Medi-Cal. Federal Regulations permit Covered California to consider periodically verifying other eligibility requirements (e.g., income), so long as it would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delays.	• Periodic data matching process occurs semi-annually. ✓ Staff will later review and re-assess its effectiveness to determine whether more frequent matching needs to be considered. • Periodic data matching also occurs for household income. This approach has the following benefits to the consumer: ✓ Help inform and educate the consumer about any potential impact to his/her eligibility for tax credit or cost sharing reductions due to changes in income. ✓ Enable the consumer to adjust his/her tax credit accordingly based on their needs, which will help minimize repayment of excess advance tax credit taken during the benefit year. ✓ Increase the ability to obtain more affordable coverage when income decreases. • In the event the periodic data matching indicates that the consumer's income is different compared to what was originally used to determine his/her initial eligibility: ✓ A notice will be sent to the consumer which identifies the new income information, as well as, the enrollee's projected eligibility. ✓ The consumer will have 30 calendar days to respond to the notice. ✓ If the consumer does not respond to the notice, the consumer will be able to maintain their Covered California eligibility and tax credit, based on their original eligibility information. ▪ The consumer will have to confirm their eligibility during the annual eligibility redetermination process and will be required to reconcile the tax credit at the end of the year through his/her annual tax filing.

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Covered California's Key Policy Issue

Requirements for Consumers to Self-Report Changes

Key Policy Issue:	Staff Preliminary Recommendation:
Requirements for Consumers to Self-Report Changes: Federal Regulations require that consumers self-report changes to Covered California within 30 calendar days from the date of a change. Specifically for: 1) Change in U.S. Citizenship, National or lawfully present status, 2) Change in state residency status, or 3) Incarceration status. Federal Regulations allow Covered California to establish a reasonable threshold which an individual is not required to report a change of income.	• Consumers be required to report any change of income that may impact the amount of their tax credit or cost sharing reduction. • This approach has the following benefits to the consumer: ✓ Help inform and educate consumers about any potential impact to their eligibility for tax credit or cost sharing reductions due to changes in income. ✓ Enable consumers to adjust their tax credit accordingly based on their needs, which will help minimize repayment of excess advance tax credit taken during the benefit year. ✓ Increase the ability to obtain more affordable coverage when income decreases.

Stakeholder Feedback:

- Do not require consumers to report change of income, in the event the change does not impact the consumer's tax credit or cost sharing reduction eligibility.
- Or, require the consumers to report a change of income if their income changes by 10%.
- Require that notices to enrollees include a clear explanation that requires an enrollee to report changes within 30 days.

Staff Recommendation:

- Consider stakeholder's feedback **not** to require consumers to report **any** change of income, but rather identify a threshold in which consumers will be required to report income changes. A specific threshold will be recommended at the May 2013 Board Meeting.
- Concur with stakeholder feedback regarding the need to ensure clear messaging and explanations are provided to consumers regarding when (and under what circumstances) they must report changes in their status.

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Covered California's Key Policy Issue
Authorized Representative Process

Key Policy Issue:	Staff Preliminary Recommendation*:
Authorized Representative Process: Current Proposed Regulations indicate that consumers may designate an Authorized Representative to act on their behalf in **all** matters: • Authorized Representative is valid until the consumer modifies the authorization; • Consumer must notify the Authorized Representative and Covered California that the representative is no longer authorized to act on the consumer's behalf; or • Authorized Representative notifies the consumer and Covered California that they no longer are acting in such capacity.	Allow consumers the flexibility to designate a more limited role for an Authorized Representative. Rather than giving full authority to the representative to act on behalf of the consumer in all matters, the consumer would have the choice to **limit** the role of the Authorized Representative. For example, the consumer may decide to only allow the Authorized Representative to act on their behalf during any of the following circumstances (or combination thereof): • Initial application process • Initial enrollment or effective date of coverage • Disenrollment process • Appeals process • Annual eligibility re-determination process • Change of circumstances • Periodic eligibility determinations

Note: *The initial implementation of the Authorized Representative process will be consistent with the requirements identified in the proposed Federal Regulations. The recommended approach to permit consumers to limit the role of the Authorized Representative will not be available at the initial implementation launch; however, will be made available at a later date. In addition, the recommended approach will be incorporated into our proposed State Regulations.*

Stakeholder Feedback:

- Broaden the requirements within the definition of Authorized Representative to allow an online signature to be sufficient to designate an Authorized Representative.
- The application should include language notifying consumers that they have the right to change their Authorized Representative along with information about how they can remove or change an Authorized Representative from their case.

Staff Comments:

- Consumers will have the functionality to designate an Authorized Representative during the online and paper application process.
- Information about the consumers right to change or remove their Authorized Representative will be presented to them at the time in which they are designating an Authorized Representative.

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Covered California's Key Policy Issue
Appeal Process

Key Policy Issue:	Staff Preliminary Recommendation:
Appeals Process: Proposed Regulations identify the appeals process for Covered California and require the coordination of appeals between Covered California and Department of Health Care Services. Consumers may submit their Covered California appeals with any of the following: 1) Eligibility determination; 2) Determination of the amount of advance payments of the premium tax credit and level of cost sharing reductions; 3) Annual redetermination of eligibility; and 4) Eligibility determination for an exemption from the individual mandate.	Staff recommends that the proposed Federal Regulations consider extending the 90-day timeframe to adjudicate appeals to be 120 calendar days. This allows adequate time for Covered California to work closely with the consumer to conduct a thorough and comprehensive informal resolution process. An effective informal process will provide consumers with a quicker resolution of their problem.

Stakeholder Feedback:

- Maintain the 90-day timeframe for the adjudication of appeals consistent with proposed Federal Regulations in order to ensure timely resolution of appeals.

Staff Comments:

- Recommend that Covered California has 120 calendar days to adjudicate an appeal as noted above.

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Eligibility & Enrollment

Draft Proposed State Regulations

(Covered California Individual Subsidized and Non-Subsidized Programs)

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Eligibility and Enrollment Regulations

(Covered California Individual Subsidized and Non-Subsidized Programs)

Articles and Sections of the draft Eligibility and Enrollment proposed State Regulations related to subsidized and non-subsidized programs are as follows:

Articles	Sections (Table of Contents)
Article 2: Abbreviations and Definition	• Abbreviations and definition of terms throughout the proposed State Regulations
Article 4: General Provisions	• Accessibility and Readability Standards • Exemption from Individual Responsibility
Article 5: Application, Eligibility and Enrollment Process for the Individual Exchange	• Application • Eligibility Requirements for Advanced Premium Tax Credits and Cost Sharing Reductions • Eligibility Determination Processes • Verification Processes & Inconsistencies • Special Eligibility Standards for Federally Recognized Native American Indians • Annual Eligibility and Redetermination • Initial and Annual Open Enrollment • Special Enrollment Period • Termination of Coverage • Appeals of Eligibility Determinations (Reserved/Placeholder)

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Key Issue #1: Requiring Initial Premium Payment to Effectuate Coverage

Stakeholder Feedback:

- Federal Regulations do not specify that consumers must make a full initial premium payment during the open enrollment and special enrollment period, in order to effectuate coverage.

Federal Regulation/Guidance:

- While Federal Regulations do not explicitly indicate that consumers are required to make a full initial premium payment in order to effectuate coverage, the Center for Consumer Information and Insurance Oversight (CCIIO) provided direction and guidance to Covered California and other states, informing Exchanges that a full initial premium payment is required in order to effectuate coverage.

Draft State Regulation:

- **§ 6502(b):** "For purposes of this section, enrollment shall be deemed complete when the applicant's coverage is effectuated, which shall occur when the QHP issuer receives the applicant's initial premium payment in full."

Staff Preliminary Recommendation:

- Preserve the language as specified in the draft State Regulations for the following reasons:
  - Requiring an initial full premium payment to effectuate coverage is standard industry practice and is also consistent with the guidance provided by CCIIO.
  - Covered California Qualified Health Plan Model Contract includes provisions which require the plans to collect the full initial premium payment before coverage will be effectuated.

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Key Issue #2: Allowing Covered California Qualified Health Plans to Assist Applicants to Apply for Coverage

Stakeholder Feedback:

- Allowing issuers to assist consumers to apply for coverage may allow insurers access to private information about income and health status, which should only be available once the consumer is enrolled in the Covered California qualified health plan (QHP).

Federal Regulation/Guidance:

- **§ 156.265(b)(2)(ii):** "If an applicant initiates enrollment directly with the QHP issuer for enrollment through the Exchange, the QHP issuer must either:
  (i) Direct the individual to file an application with the Exchange in accordance with §155.310, or
  (ii) Ensure the applicant received an eligibility determination for coverage through the Exchange through the Exchange Internet website."

Draft State Regulation:

- **§6500(g)(2):** "If an applicant initiates enrollment directly with a QHP issuer for enrollment through the Exchange, the QHP issuer shall either:
  (1) Direct the individual to file an application with the Exchange, or
  (2) Assist the applicant, upon the applicant's request, to apply for and receive an eligibility determination for coverage through the Exchange through the Exchange Internet website."

Staff Preliminary Recommendation:

- Preserve the language as specified in the draft State Regulations for the following reasons:
  - Federal Regulations permit Covered California QHP to assist consumers apply for coverage, which is an important policy in order to reach high enrollment goals.
  - The Board Recommendations Brief, titled "Partnering with Health Plan Issuers to Promote Enrollment," was previously approved by the Board during the August 2012 Board Meeting.
  - Health plan issuers are important partners to Covered California and their expertise and resources will be important to maximize enrollment. Individuals who are currently covered through the QHP outside of the Exchange in the individual market will be eligible for subsidized coverage available through Covered California. Therefore, QHPs already have established relationships with consumers and have an important role in conducting outreach, education and enrollment activities to populations that already have coverage through the existing individual commercial market.
  - Partnering with health plan issuers is consistent with the approach taken by other state Exchanges.
  - Covered California Qualified Health Plan Model Contract will include provisions which will identify the rules of engagement for plans who assist consumers apply for coverage.

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Key Issue #3: Collection of Social Security Numbers

Stakeholder Feedback:

- Social Security Number(s) (SSN) should only be required and verified for applicants applying for coverage and not for other individuals. Draft State Regulations require that the SSN be provided for non-applicant tax filer, in the event the filer has a SSN and files for the relevant tax year. If draft State Regulations continue to request the non-applicant's SSN, there should be a requirement that the application filer be notified that their SSN will be used **only** for purposes of income verification and cannot be shared for any other purposes and will only be used for eligibility determination.

Federal Regulation/Guidance:

- **§ 155.310 (3)(ii):** "The Exchange may not require an individual who is not seeking coverage for himself or herself to provide a Social Security number, except as specified in §155.305(f)(6)."
- **§155.305(f)(6):** "The Exchange must require an application filer to provide the Social Security Number of a tax filer who is not an applicant, only if an applicant attests that the tax filer has a Social Security Number and filed a tax return for the year for which tax data would be utilized for verification of household income and family size."

Draft State Regulation:

- **§ 6474(c)(5):** "An application filer shall provide the SSN of a tax filer who is not an applicant only if an applicant attests that the tax filer has a SSN and filed a tax return for the year for which tax data would be used to verify household income and family size."

Staff Preliminary Recommendation:

- Preserve the language as specified in the draft State Regulations for the following reasons:
  - State Regulations are consistent with Federal Regulations.
  - Covered California will message the use of the individual's SSN will be confidential and will be used for only the purposes of eligibility determination and administration of enrollment in Covered California. Messaging to the consumer will be critical to ensure that they are aware of the confidentiality standards and safeguards of personnel and financial information.

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Key Issue #4: Electronic Verification of Immigration Status

Stakeholder Feedback:

- Federal requirements permit electronic verification of immigration status using an individual's Alien Registration Number ("A#") . Paper documentation should be required only if the Alien Registration Number verification process is not successful against the federal data services hub (e.g., Department of Homeland Security [DHS]).

Federal Regulation/Guidance:

- **§ 155.315(c)(2):** "Verification with records from the records of the DHS. For an applicant who has documentation that can be verified through the DHS and who attest to lawful presence, or who attests to lawful presence, or attests to citizenship and for whom the Exchange cannot substantiate a claim of citizenship through the Social Security Administration, the Exchange must transmit information from the applicant's documentation and other identifying information to the U.S. Department of Health and Human Services (HHS), which will submit necessary information to the DHS for verification."

Draft State Regulation:

- **§ 6478 (c)(2):** "For an applicant who has documentation that can be verified through the DHS and who attests to lawful presence, or who attests to citizenship and for whom the Exchange cannot substantiate a claim of citizenship through the SSA, the Exchange shall transmit information from the applicant's documentation and other identifying information to HHS, which will submit necessary information to the DHS for verification of an applicant."

Staff Preliminary Recommendation:

- Preserve the language as specified in the draft State Regulations for the following reasons:
  - Perform verification based on attested information.
  - Whenever the federal data services hub verifies that an individual is lawfully present in the U.S., the individual will not be required to provide paper documentation.
  - In the event the federal services data hub cannot verify that an individual is lawfully present in the U.S., then, the consumer will be required to provide paper verification, in which they will have a 90-day reasonable opportunity period to provide the document.

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Key Issue #5: Readability Standards

Stakeholder Feedback:

- The readability standards identified in the draft State Regulations should be no higher than a 6th grade level (not at a 9th grade level as proposed by Covered California). A 6th grade is the level used by Medi-Cal and there will be many individuals with low literacy levels applying for coverage and receiving written notices.

Federal Regulation/Guidance:

- **§ 155.205 (c)(1):** "*Accessibility:* Information must be provided to applicants and enrollees in plain language and in a manner that is accessible and timely.."

Draft State Regulation:

- **§ 6452 (b):** "Information shall be provided to applicants and enrollees in plain language, as defined in Section 6410 of Article 2 of this chapter, and all written correspondence shall also:

  (1) Be formatted in such a way that it can be understood at the ninth-grade level."

Staff Preliminary Recommendation:

- Preserve the language as specified in the draft State Regulations for the following reasons:
  - Whenever feasible, the goal will be to produce written materials at a 6th grade reading level.
  - In circumstances in which complex information is being presented to the consumer (e.g., advance premium tax credits, cost sharing reductions, or reconciliation of the tax credit at the end of the year through annual tax filing), then written materials will not exceed a 9th grade reading level.

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Next Steps

Activity:	Proposed Timeline:
First draft of proposed Eligibility & Enrollment State Regulations presented at Board Meeting (discussion item)	April 23, 2013
Stakeholder webinar to solicit public feedback and input	Early-May 2013
Final proposed Eligibility & Enrollment State Regulations presented at Board Meeting (for Board action)	May 23, 2013
Submission of Final Eligibility & Enrollment Regulations to the Office of Administrative Law	Early-June 2013

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California-Based
Single Streamline Application Update

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California-Based Single Streamline Application Update

- **Application data elements currently being developed and identified. And, were guided by:**
  - Center for Medicare & Medicaid Services federal single streamline application data elements and draft paper application prototype.
  - Questions currently identified on the Medi-Cal and the Healthy Families applications (MC 210 and MC 321).
  - Covered California's Eligibility & Enrollment Guiding Principles
  - Consumer focused specific questions needed to make eligibility determinations for full array of insurance affordability programs.
  - Not asking questions that make it more burdensome for the consumer to apply for coverage.

- **Data elements identified currently being used as the basis to design the on-line website portal (e.g., California Healthcare Eligibility, Enrollment, & Retention System [CalHEERS]).**

- **Paper application will be developed modeling the data elements that are currently identified and the prototype of the federal paper application.**

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California-Based Single Streamline Application Update

Summary of Application Sections
Getting Started • Terms and conditions (e.g., how the consumer's information will be used) • Authorized Representative or Assister Information • How did the consumer hear about Covered California • Open Enrollment or Special Enrollment Period
Primary Contact Information (including written/spoken language and preferred method of communication)
Additional Household Members • Contact Information • Demographic Data • Personal Tax information • Blind/disabled for non-Modified Adjusted Gross Income (non-MAGI) Medi-Cal Program eligibility determination • Retro-Active Medi-Cal Coverage
Applying Members: • Long term care needs (for non-MAGI Medi-Cal Program) • Other Healthcare Information (e.g., employer sponsored insurance) • Referral to Non-Health Services (e.g., CalWORKS and/or CalFRESH)
Income: • Household Information • Summary
• **Signatures**

* Please refer to Board handout material for list of proposed California-based application data elements.

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Key Issue #1: Pre-Populated Application Data with Federal Data Services Hub Information

Stakeholder Feedback:

- Covered California will not be fully leveraging the real-time capabilities of the federal data services hub during the application, in order to simplify the process, avoid unnecessary data entry, and maximize data accuracy. Covered California is not considering to pre-populate data on the application based on information received from the federal data services hub.

Current State Function:

- Applicants will be required to provide their information on the application. The applicant's attested information will then be verified again the federal data services hub. This will occur once the application is submitted to Covered California.

Staff Comments:

- Currently, the California Healthcare Eligibility, Enrollment & Retention System (CalHEERS) application functionality does not support the capability of pre-populating application information using data obtained through the federal data services hub.
- In collaboration with the Department of Health Care Services during the CalHEERS joint application design, a collective decision was made to not pre-populate application data during the initial application process using information stored by the federal services hub, due to security and confidentiality concerns.
- Annual Eligibility Redetermination forms will identify pre-populated information stored by the federal services hub, since the consumer is already known by the CalHEERS system.

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Key Issue #2: Domestic Partner Relationship

Stakeholder Feedback:

- The single streamline application and any other forms used for the purposes of eligibility or enrollment should include response options that permit same-sex couples to accurately report their relationship status. The "Type of Relationship" application data element should allow respondents to indicate that they are in a domestic partnership or civil union, in addition to the option indicating marriage.

Current State Function:

- The current application will provide Domestic Partner as a "Type of Relationship."

Staff Comments:

- Covered California's application is consistent with the stakeholder feedback. Registered Domestic Partner is provided as an option for "Marital Status" as well.

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Key Issue #3: Same-Sex Married Couples and Registered Domestic Partners

Stakeholder Feedback:

- Although Federal Regulations prohibit same-sex married couples and registered domestic partners from applying jointly for advance premium tax credits to purchase coverage through Covered California due to Internal Revenue Services (IRS) rules, families headed by same-sex couples should be able to apply any individually-calculated credits to purchase family coverage offered by Covered California Qualified Health Plans (QHP). Policies developed by Covered California related to the application of tax credits toward the purchase of QHP coverage must account for the reconciliation between the individually-calculated credits and their joint application for the purchase of QHP-based family coverage.

Current State Function:

- Current application functionality does not allow for individually-calculated tax credits being reconciled between any accounts and/or QHP plans. Rather, tax credits are applied towards the tax filer's household claimed on their annual tax filings.

Staff Comments:

- When same sex married couples and registered domestic partners file their taxes separately, their eligibility for advanced premium tax credits (APTC) and cost sharing reductions (CSR) will be based on their tax filing household, in accordance to federal requirements.
- Covered California is exploring the functionality to allow couples, whether registered domestic partners or same-sex married couples (who live in the same household yet separately file taxes), to apply for coverage by completing a single application to determine eligibility for each individual within their household. This functionality may not be available at the initial implementation launch and requires further legal analysis regarding confidentiality and security standards.
- Individuals will be able to select the same health plan as their partner so long as they both live in the same service area. However, this is not considered to be a "family plan."

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Key Issue #4: Privacy Policy Statements

Stakeholder Feedback:

- The application does not provide important reassurances about non-discrimination, privacy and confidentiality, and general explanations regarding the type of information collected from applicants.

Current State Function:

- Covered California will have a privacy policy that will be presented to consumers. The information will identify non-discrimination, privacy, and confidentiality standards and requirements to the consumers.

Staff Comments:

- A high level draft overview of the application data elements was provided for comment, which did not include specific privacy policy language. Covered California and the Department of Health Care Services is in the process of developing its policy language which will be presented in the single streamline application.

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Key Issue #5: Preferred Written and Spoken Languages

Stakeholder Feedback:

- Model and use the Healthy Families Application (MC 321) to ask questions about preferred written and spoken language and include a third question measuring language proficiency, which will result in a more accurate measurement of primary language. Covered California must ensure that applicants who are limited-English proficient or have other challenges receive free help that meets their needs with information about how to access the help.

Current State Function:

- The current application will request preferred written and spoken languages. No additional proficiency questions will be asked at this time.

Staff Comments:

- The development of the single streamline application is currently being guided by questions identified on the Medi-Cal and Healthy Families Applications (MC 210 and MC 321).
- Staff will consider asking more detailed questions about the level of the consumer's limited-English proficiency.

Key Issue #6: Other Program Referrals

Stakeholder Feedback:

- In addition to facilitating a referral for CalWORKS and CalFresh, the single streamline application should provide a mechanism to refer applicants (and electronically transfer their data when possible) to help them apply for other support programs, such as Earned Income Tax Credit, other food and nutrition support, and indigent health programs (in the event that they do not qualify for health coverage via the California Healthcare Eligibility, Enrollment & Retention System [CalHEERS]).

Current State Function:

- Current application functionality does not provide for electronic interfacing between additional programs other than CalWORKS and CalFresh.

Staff Comments:

- Although interfacing between other programs besides CalWORKS and CalFresh is not currently available, the CalHEERS website, will provide links to other program websites, in order to refer consumers to other programs. Website links will be provided for the following programs:
  - Women, Infants, and Children
  - Child Health and Disability Prevention programs
  - California Family Planning, Access, Care, and Treatment
  - Early Periodic Screening, Diagnostic, and Treatment
  - Voter Registration

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Key Issue #7: Sexual Orientation and Gender

Stakeholder Feedback:

- Where appropriate, the application should collect a comprehensive range of demographic information, including sexual orientation and gender identity. This information is an important component in order to identify lesbian, gay, bisexual, and transgender (LGBT) populations for outreach planning, compliance with non-discrimination requirements, and customer satisfaction evaluations.

Current State Function:

- The current application only identifies a male or female gender as data elements.

Staff Comments:

- Covered California will conduct surveys to gather additional demographic information that may not be collected on the application.
- Covered California is consulting with Department of Health Care Services regarding optional questions to collect comprehensive sexual orientation and gender identify data elements. If additional optional data elements are considered, it would likely be implemented in 2015.

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Next Steps

Activity:	Proposed Timeline:
Readability & Usability Evaluation Began for CalHEERS	January 2013
AB 1296 Stakeholder Process	March 8, 2013
First Stakeholder webinar to solicit public feedback and input	March 14, 2013
Readability & Usability Evaluation Begins for Paper Application	April 2013
Second Stakeholder webinar to solicit public feedback and input	Late-April/Early-May 2013
Focus Group Testing/Field Testing Begins (English, Spanish and Asian languages in northern central and southern California)	Summer 2013
Draft Prototype for Paper Single Streamline Application	Summer 2013
Written Translations Begins (to produce application in culturally and linguistically appropriate manners)	Summer 2013
Federal Review and Approval of Paper Application Prototype	TBD

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QUESTIONS and SUGGESTIONS?

Submit written comments/suggestions to:

Eligibility@covered.ca.gov

Due Date:

May 6, 2013

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