An act to amend and repeal Sections 14102 and 14148.67 of, and to repeal Section 14148.65 of, the Welfare and Institutions Code, relating to Medi-Cal.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14102 of the Welfare and Institutions Code is amended to read:

14102. (a) Notwithstanding any other law and except as otherwise provided in this section, any individual who is 21 years of age or older, who ~~does not have minor children eligible for Medi-Cal benefits and~~ is not pregnant, would be eligible for full scope Medi-Cal benefits ~~pursuant to Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII))~~ without a share of cost under this chapter but for the five-year eligibility limitation under Section 1613 of Title 8 of the United States Code, ~~and~~ who is enrolled in ~~coverage~~ one of the two lowest-priced silver level health plans available in his or her pricing region through the Exchange with an ~~advanced premium tax credit~~ advance premium tax credit, and who has annual income less than or equal to 150 percent of the federal poverty level as determined by the Exchange for the purpose of determining advance premium tax credits and cost-sharing charges, shall be eligible for the following:

(1) Those Medi-Cal benefits for which he or she would have been eligible but for the five-year eligibility limitation only to the extent that they are not available through his or her individual health plan.

(2) The department shall pay on behalf of the beneficiary:

(A) The beneficiary's insurance premium costs for an individual health plan, minus the beneficiary's premium tax credit authorized by Section 36B of Title 26 of the United States Code and its implementing regulations.

(B) The beneficiary's cost-sharing charges so that the individual has the same cost-sharing charges as he or she would have in the Medi-Cal program.

(b) (1) If an individual is eligible for benefits under subdivision (a) and he or she is otherwise eligible for state-only funded full-scope benefits, but (A) he or she is barred from enrolling in an Exchange qualified health plan because he or she is outside of an available enrollment period for coverage or (B) the Exchange and the department do not have the operational capability to implement the benefits under subdivision (a), he or she shall remain eligible for those state-only funded benefits subject to paragraph (2).

(2) On the first date that an individual referenced in paragraph (1) is eligible for and can enroll in coverage under a qualified health plan offered through the Exchange, he or she shall be ineligible for the state-only funded full-scope benefits referenced in paragraph (1) unless the Exchange and the department do not have the operational capability to implement the benefits under subdivision (a).

(3) If a woman who is eligible for and receiving benefits under subdivision (a) becomes pregnant, remains eligible for Medi-Cal without a share of cost, continues to have an annual income less than or equal to 150 percent of the federal poverty level as determined by the Exchange for the purpose of determining advance premium tax credits, and remains eligible for advance premium tax credits, she shall have the option to remain enrolled in her Covered California health plan and continue to receive benefits under this section or to enroll in Medi-Cal based on that pregnancy.

(c) The department shall inform and assist individuals eligible under this section on enrolling in coverage through the Exchange with the premium assistance, cost

sharing, and benefits described in subdivision (a), including, but not limited to, developing processes to coordinate with the county entities that administer eligibility for coverage in Medi-Cal and the Exchange.

(d) For purposes of this section, the following definitions shall apply:

(1) "Cost-sharing charges" means any expenditure required ~~by~~ of or on behalf of an enrollee by his or her individual health plan with respect to essential health benefits and includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, and spending for noncovered services.

(2) "Exchange" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(3) "CalHEERS" means the California Healthcare Eligibility, Enrollment, and Retention System developed under Section 15926.

(e) Benefits for services under this section shall be provided with state-only funds only if federal financial participation is not available for those services. The department shall maximize federal financial participation in implementing this section to the extent allowable.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. The department shall adopt regulations by July 1, ~~2017,~~ 2020, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning

six months after the effective date of this section, and notwithstanding Section 10321.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

~~(g) This section shall become operative on January 1, 2014.~~

(g) When implementing this section, the department shall maximize federal financial participation to the extent allowable and this section shall be implemented only if and to the extent that any necessary federal approvals have been obtained.

(h) This section shall not be implemented until the director certifies in writing to the Department of Finance that the Exchange and the department have the administrative processes in place necessary to implement this section and CalHEERS has been programmed to implement this section, or January 1, 2018, whichever is later.

(i) If the Exchange ceases to operate or if advance premium tax credits are not available to help lower the beneficiary's premium payment for enrollment in coverage through the Exchange, this section shall immediately become inoperative and shall be repealed on January 1 of the year following the date upon which this section becomes inoperative.

SEC. 2. Section 14148.65 of the Welfare and Institutions Code is repealed.

~~14148.65. (a) (1) It is the intent of the Legislature, in adding this section and Sections 14005.22 and 14148.67, to help prevent premature delivery and low-birth weights, the leading cause of infant morbidity and mortality, and to promote women's overall health, well-being, and financial security, while maximizing federal funds.~~

~~(2) It is, therefore, the intent of the Legislature to maintain and not to alter, reduce, suspend, restrict, or otherwise limit any Medi-Cal benefits or services currently available to eligible pregnant women receiving only pregnancy-related and postpartum services through the Medi-Cal program to the extent those services and benefits are not available through the beneficiary's qualified health plan through the Exchange.~~

~~(3) It is further the intent of the Legislature to maximize federal funding while making no-cost health care coverage available to pregnant women receiving only pregnancy-related and postpartum services who opt to enroll or remain enrolled in a qualified health plan through the Exchange. To this end, it is the intent of the Legislature to enact an affordability and benefit program for pregnant women within the applicable income range within the Exchange. The intent of the Legislature is to enact a program within the Exchange that would provide pregnant women with no-share of cost health benefits so that pregnant women may receive a benefit package equal to full-scope, comprehensive benefits that are provided for Medi-Cal beneficiaries who are pregnant. It is also the intent of the Legislature that no-cost health coverage for pregnant women receiving only pregnancy-related and postpartum services means Exchange qualified health plans and providers serving beneficiaries pursuant to those plans are prohibited from charging, billing, requesting, or requiring the women to pay any of the costs or charges for any services covered by the Exchange qualified health plan, or any premiums or cost sharing during their pregnancy and postpartum coverage as provided in paragraph (1) of subdivision (b) of Section 14148.67. The Legislature reaffirms that Medi-Cal providers are prohibited from charging, billing, requesting, or requiring beneficiaries~~

~~to pay for or refusing to provide Medi-Cal covered services that are not available through an eligible woman's Exchange qualified health plan.~~

~~(b) After the director determines in writing that CalHEERS has been programmed for implementation of this section, but no sooner than January 1, 2015, the department, in coordination with the Exchange, shall implement this section for women eligible for Medi-Cal pregnancy-related and postpartum services who are or will be enrolled in individual health care coverage through the Exchange. At the applicant's or beneficiary's option, the department shall allow the individual to enroll or remain enrolled in an Exchange qualified health plan while at the same time enrolling or remaining enrolled in the Medi-Cal program, and shall ensure that the beneficiary receives the services and benefits to which she is entitled as a result of her eligibility for and enrollment in the Medi-Cal program as follows:~~

~~(1) If a beneficiary is only eligible for pregnancy-related and postpartum services under this chapter and the beneficiary has opted to enroll or remain enrolled in both Medi-Cal and coverage under a qualified health plan offered under the Exchange, the department shall pay both of the following on behalf of the beneficiary in accordance with Section 14148.67:~~

~~(A) The beneficiary's premium costs for Exchange coverage, minus the beneficiary's premium tax credit authorized by Section 36B of Title 26 of the United States Code and its implementing regulations during the beneficiary's period of eligibility for pregnancy-related and postpartum services under this chapter.~~

~~(B) The beneficiary's cost sharing for benefits and services under the Exchange qualified health plan during the beneficiary's period of eligibility for pregnancy-related and postpartum services under this chapter.~~

~~(2) The department shall provide beneficiaries who are receiving benefits under this section with only those Medi-Cal benefits for pregnancy-related and postpartum services that are covered under the Medi-Cal program and, except when otherwise required by state or federal law, that are not available through the beneficiary's qualified health plan. These beneficiaries shall retain all rights and responsibilities to which they are legally entitled under the Medi-Cal program. The beneficiaries shall have the right to access Medi-Cal providers' services through the Medi-Cal program that are not contracting with the Exchange qualified health plan as required under state or federal law, including, but not limited to, the right to access family planning services, services provided by Comprehensive Perinatal Services Program (CPSP) Medi-Cal providers, perinatal specialists, certified nurse-midwife services, and alternative and freestanding birth center services, to the extent those services are not available through the beneficiary's Exchange qualified health plan, except when state or federal law requires the right to access the service without regard to its availability through the beneficiary's Exchange qualified health plan. The department shall implement its policies and procedures on other health care coverage in a manner consistent with this subdivision.~~

~~(3) Nothing in this section shall preclude a beneficiary from opting to enroll or remain enrolled in Medi-Cal for pregnancy-related and postpartum services without enrolling or remaining enrolled in an Exchange qualified health plan or from enrolling~~

~~or remaining enrolled in an Exchange qualified health plan without enrolling or remaining enrolled in Medi-Cal for pregnancy-related and postpartum services.~~

~~(c) The department shall consult with the Exchange, Exchange contracting health care service plans and health insurers, and stakeholders, including consumer advocates, Medi-Cal providers, counties, the State Department of Public Health, county maternal, child, and adolescent health directors, and county CPSP coordinators, in the development and implementation of all of the following:~~

~~(1) Processes and procedures to inform affected applicants and beneficiaries in a clear, consumer-friendly manner of all of their enrollment options under the Medi-Cal program and the Exchange, of the manner in which they may receive the benefits and services covered through the Exchange coverage, and of the manner in which they may receive benefits and services under this section. This information shall be provided at the time of application and renewal and when a beneficiary who is enrolled in the Medi-Cal program or in an Exchange qualified health plan informs Medi-Cal or the Exchange qualified health plan that she is pregnant.~~

~~(2) A process and procedure for applicants and beneficiaries who are eligible for the Medi-Cal program based on pregnancy to exercise the option to remain in or enroll in Exchange coverage and receive Medi-Cal coverage for pregnancy-related and postpartum services not covered by the beneficiary's Exchange qualified health plan and related assistance for premiums and cost sharing as outlined in subdivision (b) or to remain in or enroll in Medi-Cal and not enroll in Exchange coverage. The process and all options shall be made available to women at the time of applying to the Medi-Cal~~

~~program or the Exchange and during their enrollment in Medi-Cal or Exchange coverage, as applicable.~~

~~(3) The process for implementing other health coverage policy and the right to access Medi-Cal providers' services through the Medi-Cal program that are not contracting with the Exchange qualified health plan, including, but not limited to, family planning services, services provided by CPSP Medi-Cal providers, perinatal specialists, certified nurse-midwife services, and alternative and freestanding birth center services, to the extent those services are not available through the beneficiary's Exchange qualified health plan, except when state or federal law requires the right to access the service without regard to its availability through the beneficiary's Exchange qualified health plan.~~

~~(4) Standardized notices and procedures to inform affected Medi-Cal applicants and beneficiaries and affected individuals applying for or enrolled in the Exchange of the option and the process for eligible women to enroll or remain enrolled in Exchange coverage and receive Medi-Cal pregnancy-related and postpartum coverage under this section or to remain in or enroll in Medi-Cal and not enroll in Exchange coverage.~~

~~(5) Standardized notices and procedures to inform Medi-Cal beneficiaries receiving benefits under this section that infants born to pregnant women receiving Medi-Cal benefits at the time of birth are automatically eligible for the Medi-Cal program throughout the infant's first year of life and of the processes for enrolling their newborns in the Medi-Cal program without an application.~~

~~(6) Provider notices to ensure that Medi-Cal providers are aware of the Medi-Cal pregnancy program under this section for women enrolled in the Exchange and that~~

~~providers comply with state and federal laws applicable to Medi-Cal pregnancy coverage for women who exercise the option to remain in Exchange coverage.~~

~~(7) Monitoring and data reporting required by subdivision (c).~~

~~(d) All notices developed under subdivision (c) shall be accessible to persons who have limited English language proficiency and persons with disabilities consistent with all federal and state requirements.~~

~~(e) (1) In addition, the department shall consult with the Exchange and Exchange contracting qualified health plans in the development of a process for the department to make the payment of premiums and cost sharing under this section and in the development of a process for the department to evaluate the birth outcomes of women who are receiving benefits under this section.~~

~~(2) (A) The department shall consult with the Exchange regarding the inclusion of certified CPSP Medi-Cal providers in qualified health plan provider networks. Additionally, the department shall encourage certified CPSP Medi-Cal providers to contract with Exchange qualified health plans in order to serve the beneficiaries who are receiving services under this section.~~

~~(B) The department shall monitor the birth outcomes of women who are receiving benefits under this section and the birth outcomes of women receiving full scope and limited scope pregnancy services under the Medi-Cal program, shall monitor access to and the utilization of CPSP services from Medi-Cal providers by beneficiaries receiving benefits under this section, and shall assess if there are any differences in birth outcomes between pregnant women receiving full scope and limited scope services under the Medi-Cal program and women receiving benefits under this section.~~

~~(C) To the extent possible, the department shall assess CPSP Medi-Cal provider participation as contracted providers with Exchange qualified health plans.~~

~~(f) (1) The department may contract with public or private entities, or both, including the Exchange, to implement this section and Section 14148.67. Contracts entered into under these sections may be on a noncompetitive bid basis and are exempt from the following:~~

~~(A) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.~~

~~(B) Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code.~~

~~(C) Review or approval of contracts by the Department of General Services.~~

~~(2) For contracts entered into under this subdivision, the department shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on the projected or actual beneficiary enrollments to a total amount not to exceed the amount appropriated for the program.~~

~~(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. The department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Notwithstanding Section 10231.5 of the Government Code, beginning six months after the effective~~

~~date of this section, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.~~

~~(h) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.~~

~~(i) For purposes of this section, the following definitions shall apply:~~

~~(1) "Beneficiary" means a woman eligible for Medi-Cal pregnancy-related and postpartum services.~~

~~(2) "CalHEERS" means the California Healthcare Eligibility, Enrollment, and Retention System developed under Section 15926.~~

~~(3) "Cost sharing" means the expenditures, required by or on behalf of the beneficiary by her qualified health plan with respect to essential health benefits, and includes deductibles, coinsurance, copayments, and similar charges, but excludes premiums, and spending by an eligible beneficiary for benefits or services not covered by the qualified health plan.~~

~~(4) "Exchange" means the California Health Benefit Exchange established in Title 22 (commencing with Section 100500) of the Government Code.~~

~~(5) "Postpartum services" means those services and benefits provided during a postpartum period under Section 14005.18.~~

SEC. 3. Section 14148.67 of the Welfare and Institutions Code is amended to read:

14148.67. (a) When implementing the premium and cost-sharing payments required under ~~Sections 14102 and 14148.65,~~ Section 14102, the department shall make the premium and cost-sharing payments required under ~~those sections~~ that section to the beneficiary's qualified health plan in conformity with the requirements of this section.

(b) (1) The beneficiary shall not be charged, billed, asked, or required to make any premium or cost-sharing payments to his or her qualified health plan or service provider for any services that are subject to premium or cost-sharing payments by the department under Section ~~14102 or 14148.65.~~ 14102.

(2) If the beneficiary makes any premium or cost-sharing payments to his or her plan or provider for services that are subject to premium or cost-sharing payments by the department under Section ~~14102 or 14148.65,~~ 14102, the department shall reimburse the beneficiary for those payments. The department shall make every reasonable effort to do both of the following:

(A) Make the reimbursement process simple and easy for beneficiaries to use.

(B) Promptly reimburse beneficiaries under this paragraph.

(3) If, as a result of reconciliation in a tax year in which the beneficiary was eligible for covered premium payments under Section ~~14102 or 14148.65,~~ 14102, the beneficiary owes and makes a tax payment to the federal government to return a portion of the ~~advanced~~ advance premium tax credit to which the beneficiary was not entitled and the beneficiary notifies the department, the department shall reimburse the beneficiary for the amount of the tax payment related to the tax credits for covered premium payments under Section ~~14102 or 14148.65.~~ 14102.

(4) If, as a result of reconciliation in a tax year in which the beneficiary was eligible for covered premium payments under Section ~~14102 or 14148.65,~~ 14102, the federal government owes and makes a tax refund to the beneficiary based upon the beneficiary's ~~advanced~~ advance premium tax credit, the beneficiary shall reimburse the department for the portion of the refund that is related to the tax credits that were applied to the premium payments made by the department.

(c) (1) ~~Except as provided in paragraph (2), beneficiaries~~ Beneficiaries who are eligible for benefits under Section 14102 ~~or 14148.65~~ shall be eligible for the premium ~~and cost-sharing~~ payments required under ~~those sections~~ that section only up to the amount necessary to pay for the first or second lowest silver level plan in his or her qualified health plan pricing region, as modified by ~~cost-sharing reductions.~~ advance premium tax credits, and for the cost-sharing payments required for services provided by one of his or her health plan's network providers, as modified by cost-sharing reductions. The department shall not pay any cost-sharing payments for services from a provider that is not one of the beneficiary's individual health plan's network providers that is in excess of cost-sharing payments for network provider services.

(2) If a beneficiary selects ~~or remains in a metal level~~ a health plan that ~~is more expensive than the metal level plan amount limit required under paragraph (1),~~ covers services provided by a provider that is not one of his or her individual health plan's network providers, the beneficiary may select or remain in that plan only if he or she agrees to be responsible for paying all ~~applicable premium and~~ cost-sharing charges that are in excess of what is covered by the department. The department is not

responsible for paying for any premium or cost sharing that is in excess of the ~~metal level~~ health plan amount limit required under paragraph (1).

(d) The department shall consult with the Exchange, Exchange contracting health care service plans and health insurers, and stakeholders, including consumer advocates, Medi-Cal providers, and the counties, in the development and implementation of the following:

(1) Processes and procedures to inform affected applicants and beneficiaries in a clear, consumer-friendly manner of all of their enrollment options under the Medi-Cal program and the Exchange, of the manner in which they may receive the benefits and services covered through the Exchange coverage, and of the manner in which they may receive benefits and services under Section 14102.

(2) Provider notices to ensure that Medi-Cal providers are aware of the Medi-Cal program under Section 14102 and that providers comply with state laws applicable to Medi-Cal coverage for individuals eligible under Section 14102.

(e) All notices developed under subdivision (d) shall be accessible to persons with limited English language proficiency and persons with disabilities consistent with all federal and state requirements.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. The department shall adopt regulations by July 1, ~~2017,~~ 2020, in accordance with the requirements of Chapter 3.5 (commencing with

Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Notwithstanding Section 10231.5 of the Government Code, beginning six months after the effective date of this section, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(g) ~~This section shall be implemented only if and to the extent that federal financial participation is available and~~ When implementing this section, the department shall maximize federal financial participation to the extent allowable. This section shall be implemented only if, and to the extent that, any necessary federal approvals have been obtained.

(h) For purposes of this section, the following definitions shall apply:

(1) "Cost sharing" means any expenditure required of or on behalf of an enrollee by his or her individual health plan with respect to essential health benefits and includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums and spending for noncovered services.

(2) "Exchange" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(3) "Network provider" means a provider that is an in-network, preferred, or participating provider in a health plan's network of providers.

(i) If the Exchange ceases to operate or if advance premium tax credits are not available to help lower the beneficiary's premium payment for enrollment in coverage through the Exchange, this section shall immediately become inoperative and shall be

repealed on January 1 of the year following the date upon which this section becomes inoperative.

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LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Medi-Cal: benefits.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid Program provisions. Existing law provides that an individual who is 21 years of age or older, does not have minor children eligible for Medi-Cal benefits, would be eligible for Medi-Cal benefits but for a specified 5-year eligibility limitation, and who is enrolled in and covered through the California Health Benefit Exchange ("Exchange") with an advance premium tax credit, shall be eligible for specified Medi-Cal benefits and insurance premium costs and cost-sharing charges paid by the department, instead of full-scope state funded Medi-Cal benefits, as specified.

This bill would revise those eligibility criteria to grant those benefits to an individual who is 21 years of age or older, is not pregnant, would be eligible for full-scope Medi-Cal benefits without a share of cost but for that 5-year eligibility limitation, is enrolled in a specified level of health plan with an advance premium tax credit, and who does not exceed a specified income limit. The bill would give a woman who is eligible for and receiving benefits under these revised eligibility criteria, and who becomes pregnant, the option to remain enrolled in her health plan and to continue to receive those benefits or to enroll in Medi-Cal based on that pregnancy. The bill would provide that these benefits shall not be implemented until the later of January 1, 2018, or the date that the Director of Health Care Services certifies that the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) has been programmed for implementation of these provisions. The bill would limit the amount of premium payments to be paid by the department pursuant to these provisions to that required for specified health plan levels, and would limit the amount of cost-sharing payments to that required for services provided by the health plan's network providers, as specified. The bill would provide that these benefits and premium and cost-sharing assistance provisions would cease to operate if the Exchange ceases to operate or if advance premium tax credits are not available to lower the beneficiary's payments for enrollment through the Exchange.

Existing law requires the department to implement a specified option for women eligible for Medi-Cal pregnancy-related and postpartum services who are enrolled or will be enrolled in individual health care coverage through the Exchange and also opt to enroll in Medi-Cal. Existing law, except as provided, requires the department to

provide specified benefits and pay the beneficiary's insurance premium costs and the beneficiary's cost sharing for benefits and services during the beneficiary's period of eligibility for pregnancy-related and postpartum services under the Medi-Cal program.

This bill would repeal those provisions.

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