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



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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 would be eligible for 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)) 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, and who has 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 advanced premium tax credits and cost-sharing reductions 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.



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(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).

(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 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.

(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, July 1, 2019,~~ 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.~~



## LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, \_\_\_\_\_.

General Subject: Medi-Cal: eligibility.

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 and funded by federal Medicaid Program provisions. Under existing federal law, a person who enters the United States as a qualified alien is not eligible for any federal means-tested public benefit for a period of 5 years from the date of entry. Existing law makes an individual meeting specified criteria who would otherwise be eligible for Medi-Cal benefits but for this 5-year eligibility limitation, and who is enrolled in coverage through the California Health Benefit Exchange with an advanced premium tax credit, eligible for specified Medi-Cal benefits and insurance premium costs and cost-sharing charges paid by the department, as specified. Under existing law, beneficiaries who are eligible for benefits under these provisions are eligible for the premium and cost-sharing



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payments up to the amount necessary to pay for the 2nd lowest silver level plan in his or her qualified health plan pricing region. Under existing law, a beneficiary may select or remain in a more expensive metal level plan only if he or she agrees to be responsible for paying all the applicable premium and cost-sharing charges that are in excess of what is covered by the department.

This bill would require the individual to be enrolled in a one of the 2 lowest priced silver level health plans available in his or her pricing region through the Exchange and would require the individual to have an annual income of less than or equal to 150% of the federal poverty level in order to qualify for the above-specified benefits. The bill would make related changes.

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

