HCA
Health Consumer Alliance

1764 San Diego Avenue, Suite 200 San Diego, CA 92110
Phone 619-471-2637 Statewide Toll Free 888-804-3536 HealthConsumer.org

November 16, 2015

Jennifer Kent
Department of Health Care Services
Via email to Jennifer.Kent@dhcs.ca.gov

Diana Dooley, Chair
Paul Fearer,
Genoveva Islas,
Marty Morganstern,
Art Torres,
Covered California Board
Via email to boardcomments@covered.ca.gov

Dear Ms. Kent and Covered California Board,

We write to you as members of the Health Consumer Alliance to elevate the issue of the inability of consumers who lose their Medi-Cal to enroll in Covered California without a gap in coverage. The Health Consumer Alliance (HCA) is a partnership of community-based legal services organizations serving low-income health consumers in all 58 counties. We help consumers navigate barriers to enrollment and access to services and meet regularly with DHCS and Covered California staff to ensure that consumers are able to access and maintain health coverage.

The failure of the Department of Health Care Services (DHCS), Covered California, and county social services offices to work together to assist consumers during this vulnerable transition time is contrary to law and the spirit of health care reform.

In 2011, AB1296 was signed into law implementing the key framework for coordination between Covered California and Medi-Cal to ensure that consumers faced no wrong door in accessing health coverage. Essential to this framework is the means to move between programs as life circumstances change without losing coverage or access to healthcare. As such, the law specified,

> "***During the processing of*** an application, renewal, or ***a transition due to a change in circumstances, an entity making eligibility determinations*** for an insurance affordability program ***shall ensure that an eligible applicant and recipient*** of insurance affordability programs that meets all program eligibility requirements and complies with all necessary requests for information ***moves between programs without any breaks in coverage*** and without being required to provide any forms, documents, or other information or undergo verification that is duplicative or otherwise unnecessary. . . ."
>
> Welfare & Institutions Code § 15926(h) (Emphasis added).

There has been no process for ensuring continued coverage for Medi-Cal recipients who become eligible for Covered California since the implementation of health reform in 2014. Advocates have had several meetings with DHCS and Covered California staff to try to work together to create such a process since late 2014 including "deep dive" meetings in March and April of this year, an ongoing workgroup on notices, and a newly started transitions workgroup this month. Advocates also forwarded consumer case examples and faulty notices to both agencies early this past spring and made recommendations on several occasions to current DHCS policy guidance ACWDL 15-33 that were not incorporated. Several consumer advocates continue to participate, in good faith, in AB 1296 transitions and notices workgroups to try to again resolve these issues. Despite these efforts, we feel it imperative to call to your attention the serious, ongoing problems with these transitions. We alerted the current workgroups that we would be outlining our concerns in a letter.

In the meantime, Medi-Cal recipients continue to lose access to health care services with no assistance in enrolling in a Covered California plan. Even worse, the only information such recipients are sent indicates they have 60 days to choose a Covered California plan without informing them that failure to pick a plan before their Medi-Cal coverage ends will result in a gap in coverage. DHCS staff and county eligibility workers continue to wrongly state that it is not possible for a person losing Medi-Cal to enroll in a Covered California health plan without a gap in coverage due to a misunderstanding of the Covered California special enrollment rules and consequently do not even attempt to help consumers bridge the gap.[1] Some Covered California call center representatives fail to understand that individuals losing Medi-Cal coverage are entitled to enroll in a Covered California health plan without a gap in coverage and fail to advise consumers that if they pick a plan by the end of the month it will be effective the first of the next month.

One of our Los Angeles consumers started working in September and reported his new income. As a result, his Medi-Cal was terminated October 1. Because he was not informed about the possibility of having immediate coverage if he selected a Covered California plan before his Medi-Cal ended, he did not call Covered California until October to enroll in a plan and was told his new plan would not be effective until December 1. It was not until he was nearly out of his medication to control his diabetes that he found Neighborhood Legal Services of Los Angeles County to assist in his case. This consumer never received information from either Medi-Cal or Covered California on how to enroll without a gap in coverage.

Similarly, we've seen other cases where consumers are wrongly referred to Medi-Cal, and when found to be income ineligible, are simply denied, rather than referred back to Covered California and assisted with plan enrollment. Finally, when there is a gap in coverage and consumers do not find legal

[1] The Covered California special enrollment regulations allow coverage "on the first day of the month following the loss of coverage if the plan selection is made on or before the date of the loss of coverage." 10 CCR 6504(h)(3), referencing 10 CCR 6504(a)(1)(A), referencing 10 CCR 6504(b)(1)(B). Thus, a Medi-Cal beneficiary need only choose a Covered California plan prior to the loss of Medi-Cal to avoid a gap in coverage. The governing federal regulations provides "In a case where a consumer loses coverage . . . if the plan selection is made before or on the day of the loss of coverage, *the Exchange must ensure that the coverage effective date is on the first day of the month following the loss of coverage*." 45 CFR 155.420(b)(2)(iv).

assistance to help them rectify the situation or are unable to pay many months premiums in arrears, consumers can face tax penalties. For example, a young mother enrolled in a limited Medi-Cal program rather than Covered California in January 2014. After over a year of attempting to resolve her health coverage situation on her own, she found an advocate who assisted her with enrolling into a Covered California plan in July 2015 but now faces potential tax penalties for the period of time she did not have minimum essential coverage.

Such loss of coverage violates the letter and intent of AB1296 and California's longstanding due process principles that require that consumers be sufficiently informed so that they can take appropriate actions when fundamental interests are at stake. Perpetuating the coverage gap further violates the requirement that DHCS and the county social services agencies must "endeavor at all times to perform [their] duties in such manner as to secure for every person the amount of aid to which he is entitled." Welfare & Institutions Code § 10500. The statute delineating additional duties of the Covered California Board requires that it coordinate with other state and local agencies administering health care programs "to ensure consistent eligibility and enrollment processes and *seamless transitions* between coverage." Government Code § 100503(a).

Swift action is required by both DHCS and Covered California to ensure that no more Medi-Cal recipients wrongly lose coverage or receive incorrect, incomplete or confusing information; and are able to move from Medi-Cal to Covered California without assistance. Specifically, we ask that the following steps be taken:

1. DHCS must issue guidance to the counties instructing counties on how to process renewals and changes in circumstances so that when a Medi-Cal recipient reports a change in income or household size that makes the recipient ineligible for Medi-Cal and thus eligible for Covered California, the recipient is seamlessly transferred to Covered California without a break in coverage.
2. The recipient must be given sufficient time and information to choose a Covered California health plan – a termination notice with only 10 days warning is not adequate. Such guidance must clearly delineate the responsibilities of county eligibility workers in assisting consumers in choosing Covered California health plans and include clear instructions on how to resolve technical issues like removing cases from the pending status known as "soft pause."
3. DHCS must revise the Medi-Cal notice of discontinuance attached to its guidance ACDWL 15-33 so that it meets due process standards. Specifically, it must be revised to include a specific finding of facts for the determination, as required by law. The position that DHCS has taken on this matter, that they are unable to effectuate a legally adequate notice until February 2016 at the earliest, is wholly unacceptable. The notice must also inform recipients of the actions they must take to effectuate coverage in a Covered California health plan and the fact that both county and Covered CA staff are available to assist them in making a transition without a break in coverage by choosing a plan before the end of the month.
4. Covered California must revise the notice that a consumer gets when moving from Medi-Cal to Covered California so that it does not tell a Medi-Cal recipient who reported a change in income to Medi-Cal "thank you applying for health insurance through Covered California." As Medi-Cal

recipients have generally not even contacted Covered California when they receive this notice, this is very confusing information. Further, the notice should be changed so as not to wrongly imply that consumers can wait 60 days to get into a Covered California health plan; on the contrary, consumers must be warned about the consequences of waiting to enroll.

5. Covered California must issue guidance to call center workers regarding the policy and internal procedures for effectuating seamless transitions between Medi-Cal and Covered California. Covered California must also assign individuals responsible for assisting consumers who are losing their Medi-Cal who need assistance to ensure that their Covered California health plan is in place as soon as their Medi-Cal coverage ends.
6. DHCS and Covered California must ensure that there are sufficient methods of flagging recipients losing Medi-Cal for increases in income or decreases in household size so that they can be identified by Covered California staff as consumers who need special assistance. While these consumers have already been determined eligible for Covered California many of them have had no contact with Covered California and are not familiar with plan selection and payment procedures or the Covered California online system.

We have already met with your staff on numerous occasions on these issues with little tangible progress. While we believe the response of DHCS and Covered CA has been well-intentioned, it has thus far been inadequate to address the reality of how the process is currently failing consumers who are struggling to maintain health insurance coverage in a post-ACA environment. At this point we would like to see the guidance, procedures, and notices described above and stand ready as always to advise and assist in this effort.

Please contact Jen Flory at (916) 282-5141 or jflory@wclp.org or Cori Racela at (310) 736-1646 or racela@healthlaw.org to discuss these comments.

Sincerely,

The Health Consumer Alliance