

Introduction to Part II: Getting and Keeping Health Coverage

In addition to the rules for eligibility for Medi-Cal, the Medi-Cal Access Program (MCAP), or a Covered California health plan, there are rules governing the process for enrollment into and retaining coverage for these programs. While advocates have engaged in successful legislative and policy advocacy to remove many barriers and have pursued litigation to fix procedures that were too burdensome, there are still hoops to jump through to obtain and maintain coverage in public health programs in California.

A. Application Channels

The Affordable Care Act attempted to simplify applying for the “insurance affordability programs” (Medi-Cal, MCAP¹, and Covered California) through the development of an online and paper single streamlined application for all programs and the creation of a “no wrong door” policy allowing applicants to go to a variety of places to apply. Individuals can apply online, by phone, in person or by mail. Many Medi-Cal programs also have expedited coverage channels for certain populations (such as Presumptive Eligibility for Pregnant Women or Accelerated Enrollment for Children) or for certain conditions (such as Accelerated Enrollment for the Federal Breast and Cervical Cancer Treatment Program) or in certain locations (such as Hospital Presumptive Eligibility for individuals receiving hospital services). Additionally, some people receive Medi-Cal due to their enrollment in another public benefits program and do not need to submit an application (such as CalWORKS and SSI). Nonetheless, some channels have proven easier for some populations. For example, for someone over age 65, in most cases applying through the county will be faster than using the Single Streamlined Application as they can submit a property supplement at the same time they submit their application; this information is required to make an eligibility determination, but is not on the Single Streamlined Application because many programs do not have a property limit.

For information about application channels, see Chapter 5, Section A.

1. The Medi-Cal Access Program is included as a CHIP program. The former Healthy Families program is now a part of Medi-Cal. C-CHIP programs (local children’s insurance programs in three counties) are also being added to the online application but are not covered in this guide due to the limited, local scope of the programs.

B. Verification Requirements

When reviewing an application for eligibility, the Covered California and Medi-Cal programs must verify the contents of the application. Depending on the element, verification may be handled through self-attestation (accepting what the application states unless there is information to the contrary), electronic verification by checking other federal, state, or county databases, or require documentation. In general, for the elements that cannot be verified through self-attestation, the program will try electronic verification first, and, if that does not work, will request documentation. However, applicants may also submit documentation with their application online, via mail, or in person.

For information about verification requirements, see Chapter 5, Section B.

C. Starting Coverage

For Medi-Cal, coverage generally begins the first day of the month when the application is submitted. If an applicant would have been eligible in the months preceding the application, the applicant may also request retroactive Medi-Cal coverage for medical bills in the three months preceding the month of application. Medi-Cal also has presumptive eligibility programs designed to grant instant eligibility for a limited time from the date requested, but the applicant must submit a full application to receive ongoing and retroactive coverage. Coverage starts after the application is processed for the Medi-Cal Access Program² and Covered California health plans. In addition, applicants can only enroll during open enrollment or a special enrollment period for Covered California health plans and must pay their first premium to effectuate coverage.

For information on starting coverage, see Chapter 5, Section C.

-
2. MCAP has very limited reimbursement for up to \$125 in services received prior to enrollment.

D. Plan Selection

In general, a Medi-Cal applicant is first enrolled in fee-for-service Medi-Cal and later sent a health plan choice packet, provided that the applicant is required to or chooses to enroll in a managed care plan and the county of residence has more than one managed care plan. Prior to enrolling in a managed care plan, the individual accesses services through Medi-Cal's fee-for-service network. Medi-Cal members who are required to be in a managed care plan and do not choose one are "defaulted" into a plan by Medi-Cal.

For the Medi-Cal Access Program and Covered California, applicants pick a health plan when they apply.

For information on plan selection, see Chapter 5, Section D.

E. Reporting Changes

Medi-Cal beneficiaries must report changes that affect their eligibility, such as income or household size, within 10 days. Medi-Cal Access Program beneficiaries must report within 30 days when they give birth so that the duration of the coverage may be determined. Covered California enrollees must report changes that affect their eligibility for enrollment or financial assistance within 30 days.

For information on reporting changes, see Chapter 6, Section A.1.

F. Annual Renewal³

Medi-Cal beneficiaries must have their eligibility redetermined every 12 months from the last time their eligibility was reviewed. Thus, individuals have annual redetermination dates throughout the year. For MAGI Medi-Cal if the county has access to information showing a beneficiary is eligible they receive a form laying out the information upon which their continued eligibility is based and told to inform Medi-Cal if the information is wrong. Otherwise, they do not need to return any

-
3. There is no annual redetermination for the Medi-Cal Access Program because it does not last for more than one year.

information. If the counties do not have sufficient information to automatically renew a beneficiary they receive a pre-populated form with information that the county has. The beneficiary sends any additional or changed information needed. For non-MAGI Medi-Cal, while the program is also moving towards pre-populated forms, because assets must always be verified, there is no automatic verification.

Covered California enrollees can update their income and other eligibility elements, as well as pick a different health plan, during the rolling renewal period that starts just before open enrollment for the next calendar year. Thus, everyone in Covered California renews at more or less the same time. Enrollees who do not participate in the renewal process will be kept in their same health plan, provided it is still on the market and Covered California has permission to verify their income with the IRS.

For information on annual renewals, see Chapter 6, Section A.3.

G. Appeals

For either Medi-Cal or Covered California, individuals may appeal when they disagree with an eligibility determination or when they are terminated from the program. Each program outlines specific requirements of the notices, has specific timelines for requesting appeals, and allows for appeals to be resolved prior to the hearing or on an expedited nature where necessary.

For information on appeals, see Chapter 6, Section B.

Program Comparisons

	MAGI Medi-Cal	Non-MAGI Medi-Cal	MCAP	Covered California
Best Ways to Apply Directly	Single Streamlined Application: Online (CalHEERS) or mailed; County Office; or with the help of Certified Enrollment Counselor.	County Office in person or by mail – can use the Single Streamlined Application but should submit with property supplement if possible. Many also get Medi-Cal automatically via another public program.	Online via CalHEERS; or with the help of Certified Enrollment Counselor.	Single Streamlined Application: Online (CalHEERS), Covered California Service Center (phone), or with help of Certified Enrollment Counselor.
Required Verification Prior to Starting Coverage	Income (Residency is not currently verified but may be) Conditional enrollment pending immigration/citizenship status.	Income, assets, and possibly residency. Conditional enrollment pending immigration/citizenship status.	Income	None. Conditional enrollment pending immigration/citizenship status and income. If income verification is not resolved, can move to unsubsidized coverage.
Coverage Start	The 1 st of the month of application + 3 months prior if eligible	The 1 st of the month of application + 3 months prior if eligible	Up to 20 days after complete application is received. ⁴	Not earlier than the month <i>after</i> enrollment, but depends on date enrolled and payment of premium. If applying during Open Enrollment in November, no coverage until January 1 at earliest.

Enrollment Period	Can apply any time.	Can apply any time.	Can apply any time	Enroll during open enrollment or if a qualifying life event gives a special enrollment period.
Plan Selection	After enrollment.	After enrollment.	With application	With application and must pay first premium to enroll.
Change Reporting	Within 10 days of change.	Within 10 days of change	Within 30 days of the end of pregnancy (to reduce contribution) or birth of child (to determine last day of benefits.	Within 30 days of change.
Annual Renewal Process	County renews “ex-parte” if possible. Otherwise, sends pre-populated form and requests needed information.	County renews “ex parte” if possible. Beneficiary must also send in renewal forms with income and assets information.	N/A for mother. Special rules for baby which require income verification.	Covered California redetermines APTC/CSR eligibility if tax information is available and passively renews enrollee into same plan if the enrollee does not choose another plan.
Appeals	Appeal through DSS State Fair Hearing Division.	Appeal through DSS State Fair Hearing Division.	Two levels of informal appeal followed by appeal through DSS State Hearing Division.	Appeal through DSS State Fair Hearing Division.

4. 10 CCR §§ 2699.203(a)(up to 10 days to determine eligibility); 2699.209(a)(up to 10 calendar days until coverage goes into effect).