

# May 28, 2013 ACA PLANNING GROUP MEETING

## Welcome & Introductions

Joel Diringer

## Policy/Program Updates

Joel Diringer

- Covered California (Health Exchange)
- Outreach & Education Grants
- Medi-Cal expansion

## Care Coordination & Capacity Update

CenCal Health

## Outreach & Education Update

- Provider Activities CHC
- Non-Profit & Public Sector Activities Penny Borenstein
- Private Sector Activities Michael Framberger

## Open Discussion

**Proposed Next Meeting: Tuesday, June 25, 2013, 3:30 to 5:00, Location TBD**

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# Affordable Care Act Implementation Updates



Joel Diringer, JD, MPH  
May 28, 2013

# Covered California

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## Rating Region 12

San Luis Obispo, Ventura,  
Santa Barbara

**Number of subsidy eligible individuals:** 95,000



# Covered California

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- Example rates: 40 yr old single individual, Silver Plan
  - ▣ Federal subsidies in green

Plan	150 FPL	200 FPL	250 FPL	400 FPL
<b>Blue Shield</b> PPO	\$46 \$268	\$109 \$205	\$181 \$133	\$314 \$0
<b>Anthem</b> PPO	\$57 \$268	\$121 \$205	\$193 \$133	\$326 \$0
<b>Kaiser Permanente</b> HMO	\$64 \$268	\$127 \$205	\$200 \$133	\$332 \$0
<b>Ventura County Health Care Plan</b> HMO	\$68 \$268	\$131 \$205	\$204 \$133	\$336 \$0

# Covered California

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□ Without subsidies

25 YEAR OLD		
Plan	Catastrophic	Bronze
Blue Shield PPO	\$196	\$206
Anthem PPO	\$165	\$193
Kaiser Permanente HMO	\$195	\$197
Ventura County Health Plan HMO	\$173	\$199

40 YEAR OLD				
Plan	Bronze	Silver	Gold	Platinum
Blue Shield PPO	\$262	\$314	\$374	\$429
Anthem PPO	\$246	\$326	\$395	\$458
Kaiser Permanente HMO	\$250	\$332	\$408	\$439
Ventura County Health Plan HMO	\$253	\$336	\$376	\$430

# Outreach & Education Grants

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- Covered California outreach and education grantees funded to do work in San Luis Obispo County:
  - ▣ California School Health Centers Association
  - ▣ Regents of UC – UC Berkeley School of Public Health – Health Initiative of Americas (??)
  
- HRSA allocation:
  - ▣ Community Health Centers: \$290,499

# Medi-Cal Expansion and County Re-alignment

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- May Revise Budget proposal
  - ▣ Statewide approach
  - ▣ Same benefits as current Medi-Cal
  - ▣ No asset test, except possibly for long term care benefit
  - ▣ Gradual take-back of State Realignment funds provided to counties based on actual spending of indigent care

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# Covered California Draft Applications

## Application for Health Coverage & Help Paying Costs (Short Form)

THINGS TO KNOW



### Use this application to see what coverage you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)



### Who can use this application?

- Single adults who:
- Aren't offered health coverage from their employer
  - Don't have any dependents and can't be claimed as a dependent on someone else's tax return

**NOTE:** If any of the following apply, you need to fill out a different form to make sure you get the most benefits possible:

- You're married or have dependent children.
- You were in the foster care system, and you're under age 26.
- You have items that can be deducted from your income. If your only deduction is student loan interest, you **can** use this form.
- You're American Indian or Alaska Native.



### Apply faster online

Apply faster online at [HealthCare.gov](https://www.healthcare.gov).



### What you may need to apply

- Your Social Security number (or document number if you're a legal immigrant)
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)



### Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private, as required by law.**



### What happens next?

Send your complete, signed application to the address on page 3. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow up with you within 1-2 weeks. Filling out this application doesn't mean you have to buy health coverage.



### Get help with this application

- **Online:** [HealthCare.gov](https://www.healthcare.gov).
- **Phone:** Call our Help Center at 1-800-XXX-XXXX.
- **In person:** There may be counselors in your area who can help. Visit [HealthCare.gov](https://www.healthcare.gov), or call 1-800-XXX-XXXX for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al 1-800-XXX-XXXX.

# STEP 1

## Tell us about yourself.

1. First name, Middle name, Last name, & Suffix \_\_\_\_\_

2. Home address (Leave blank if you don't have one.) \_\_\_\_\_

3. Apartment or suite number \_\_\_\_\_

4. City \_\_\_\_\_

5. State \_\_\_\_\_

6. Zip code \_\_\_\_\_

7. County \_\_\_\_\_

8. Mailing address (if different from home address) \_\_\_\_\_

9. Apartment or suite number \_\_\_\_\_

10. City \_\_\_\_\_

11. State \_\_\_\_\_

12. ZIP code \_\_\_\_\_

13. County \_\_\_\_\_

14. Phone number

( ) -

15. Other phone number

( ) -

16. Do you want to get information about this application by email?  Yes  No

Email address: \_\_\_\_\_

17. Preferred spoken or written language (if not English) \_\_\_\_\_

18. Date of birth (mm/dd/yyyy) \_\_\_\_\_

19. Sex

Male  Female

20. Social Security number (SSN) \_\_\_\_\_

**We need this if you want health coverage and have an SSN.** We use SSNs to check income and other information to see if you're eligible for help with health coverage costs. If you need help getting an SSN, call 1-800-772-1213 or visit [socialsecurity.gov](https://www.socialsecurity.gov). TTY users should call 1-800-325-0778.

21. Are you a U.S. citizen or U.S. national?  Yes  No

22. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?

Yes. Fill in your document type and ID number below.

a. Immigration document type \_\_\_\_\_

b. Document ID number \_\_\_\_\_

c. Have you lived in the U.S. since 1996?  Yes  No

d. Are you a veteran or an active-duty member of the U.S. military?  Yes  No

23. Are you pregnant?  Yes  No

**If yes,** how many babies are expected during this pregnancy? \_\_\_\_\_

24. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?  Yes  No

25. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

Mexican  Mexican American  Chicano/a  Puerto Rican  Cuban  Other \_\_\_\_\_

26. **Race (OPTIONAL—check all that apply.)**

White

American Indian or

Filipino

Vietnamese

Guamanian or Chamorro

Black or African  
American

Alaska Native

Japanese

Other Asian

Samoan

Asian Indian

Korean

Native Hawaiian

Other Pacific Islander

Chinese

Other \_\_\_\_\_

## STEP 2 Current job & income information

- Employed – If you're currently employed, tell us about your income. Start with question 1.  
 Not Employed – Skip to question 11.  Self Employed – Skip to question 10.

### CURRENT JOB 1:

1. Employer name and address	2. Employer phone number ( ) -	3. Average hours worked each week
4. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly		
\$ _____		

### CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

5. Employer name and address	6. Employer phone number ( ) -	7. Average hours worked each week
8. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly		
\$ _____		

9. In the past year, did you:  Change jobs  Stop working  Start working fewer hours  None of these

### 10. If self-employed, answer the following questions:

a. Type of work

\_\_\_\_\_

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

\$ \_\_\_\_\_

### 11. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

<input type="checkbox"/> None		<input type="checkbox"/> Retirement accounts	\$ _____	How often? _____	
<input type="checkbox"/> Unemployment	\$ _____	How often? _____	<input type="checkbox"/> Alimony received	\$ _____	How often? _____
<input type="checkbox"/> Pensions	\$ _____	How often? _____	<input type="checkbox"/> Net farming/fishing	\$ _____	How often? _____
<input type="checkbox"/> Social Security	\$ _____	How often? _____	<input type="checkbox"/> Other income	\$ _____	How often? _____
Type: _____					

### 12. Do you pay student loan interest (not the amount of the loan) that can be deducted on a federal income tax return?

- YES. If yes, how much \$ \_\_\_\_\_ How often? \_\_\_\_\_  NO.

### 13. YEARLY INCOME: Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to step 3.

Your total income this year \$ _____	Your total income next year (if you think it will be different) \$ _____
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## STEP 3 Your health coverage

### 1. Are you enrolled in health coverage now from any of the following?

- YES. If yes, check which coverage you have.  NO.

- Medicaid  
 CHIP  
 Medicare  
 TRICARE (don't check if you have Direct Care or Line of Duty)  
 Peace Corps

- VA health care programs  
 Other

Name of health insurance

\_\_\_\_\_

Policy number

\_\_\_\_\_

## STEP 4 Read & sign this application.

- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I know that I must tell the Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit [HealthCare.gov](http://HealthCare.gov) or call 1-800-XXX-XXXX to report any changes. I understand that a change in my information could affect my eligibility.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting [www.hhs.gov/ocr/office/file](http://www.hhs.gov/ocr/office/file).
- I confirm that I'm not incarcerated (detained or jailed).
- I confirm that next year I expect to file a federal income tax return, won't claim dependents on that return, and can't be claimed as a dependent on anyone else's federal income tax return.
- I confirm that I'm not offered health coverage from an employer.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

### Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

5 years (the maximum number of years allowed), or for a shorter number of years:

4 years  3 years  2 years  1 year  Don't use information from tax returns to renew my coverage.

### If I'm eligible for Medicaid

If I enroll in Medicaid, I'm giving the Medicaid agency my rights to pursue and get any money from other health insurance, legal settlements, or other third parties.

### My right to appeal

If I think the Marketplace or Medicaid/Children's Health Insurance Program (CHIP) has made a mistake, I can appeal its decision. To appeal means to tell someone at the Marketplace or Medicaid/CHIP that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at 1-800-XXX-XXXX. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative, you may sign here as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)
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## STEP 5 Mail completed application.

Mail your signed application to:

**Health Insurance Marketplace**  
1005 XYZ Drive  
Washington, DC 20005



### What happens next?

We'll follow up with you within 1-2 weeks. You'll get instructions on how to take the next steps to get your health coverage. If you don't hear from us within 2 weeks, visit [HealthCare.gov](http://HealthCare.gov) or call 1-800-XXX-XXXX.

If you want to register to vote, you can complete a voter registration form at [XXXXX.gov](http://XXXXX.gov).



# Update on O&E Grant Applications

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- ❑ Covered California (California's Health Exchange) Outreach & Education Grant
- ❑ Blue Shield of California Foundation (BSCF) County Enrollment Assistance Grant
- ❑ Covered California Assisters Programs: In-Person Assisters Program and Navigator Grant Program

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# Care Coordination & Capacity Update

CenCal Health

# Outreach & Education Update

- ❑ Provider Activities: CHC
- ❑ Non-Profit & Public Sector Activities: Penny Borenstein
- ❑ Private Sector Activities: Michael Framberger

# Community Forum?

Santa Barbara County



*You're Invited...*



*Janet Wolf, 2nd District Supervisor; the Santa Barbara County Public Health Department; and CenCal Health invite you to a **free community forum** on:*

## Understanding Health Care Reform



**Free Forum!**  
Refreshments provided courtesy of CenCal Health

**Who Should Attend:**  
Local residents, school district and community-based organization staff, health care workers



**Date and Time:** Thursday, May 23, 2013 from 5:30 to 7:30 pm

**Location:** Goleta Union School District Office, 401 N. Fairview, Goleta

### Content:

- Why was the Affordable Care Act (ACA) enacted?
- Who does it affect? Who is not affected?
  - Who is eligible under the Medi-Cal expansion?
  - What is "Covered California"?
  - Who is eligible for subsidies under the Covered California Health Benefit Exchange?
- What does it do?
  - New protections and benefits
    - What's in place now
    - What will go into effect in 2014?
- What is being done locally to be ready and to help people enroll?
- What is still being worked out at the State level?



### Agenda:

- 5:30 Gather, Refreshments, Welcome  
*Supervisor Janet Wolf, Board of Supervisors, 2nd District*
- 5:45 **Presentation: Understanding Health Care Reform**  
*Takashi Wada, MD, MPH, Public Health Department Director/Health Officer; and Bob Freeman, Chief Executive Officer, CenCal Health*
- 7:00 Question & Answer
- 7:20 Wrap Up

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# Open Discussion



Proposed next meeting date:

Tuesday, June 25, 2013

3:30 to 5:00

Location TBD