NLSLA

Neighborhood Legal Services
of Los Angeles County

Health Benefits Overview

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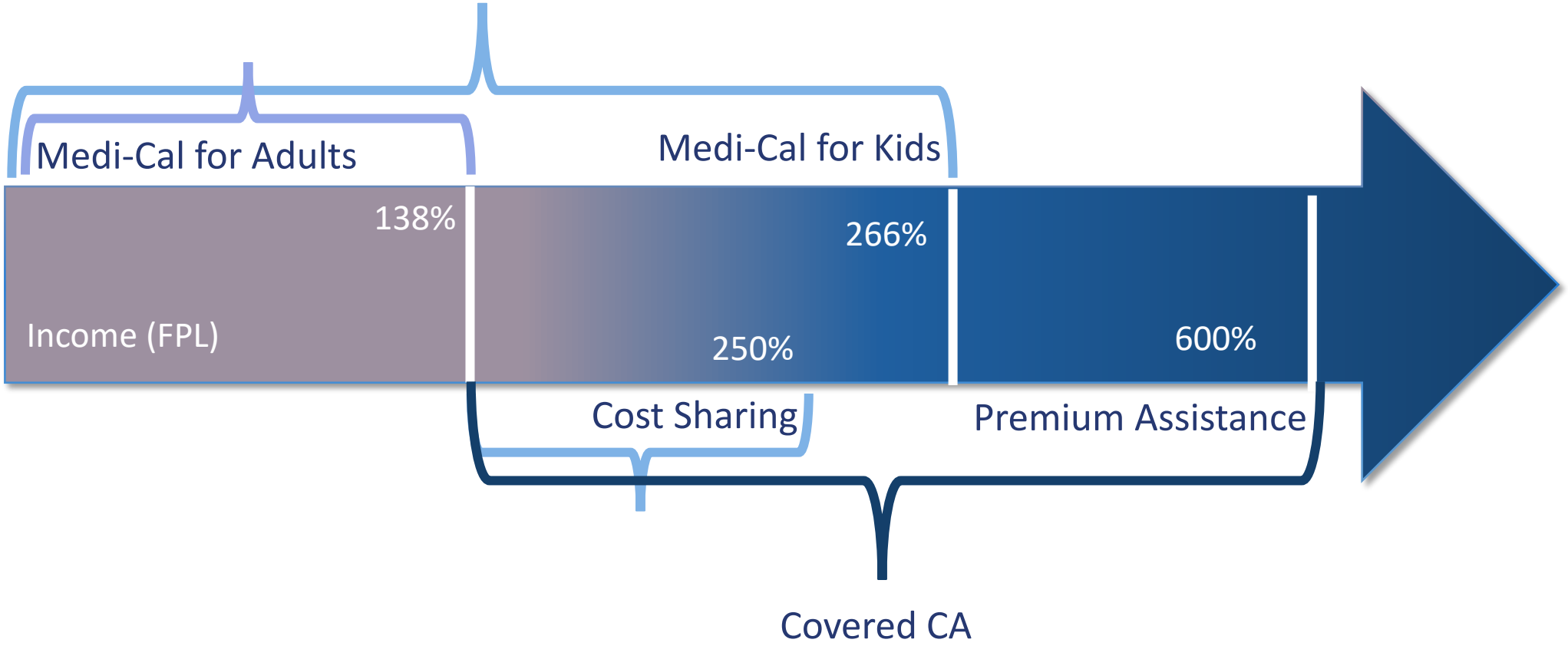
Medical Legal Community Partnerships (MLCP)
February 7, 2024

Overview

- Introduction: Affordable Care Act (ACA) Coverage Continuum Model
- Medi-Cal
- Medicare
- Covered CA
- COBRA
- Fertility Preservation

The Affordable Care Act (ACA) Coverage Continuum



HCA
Health Consumer Alliance

California Insurance Affordability Programs Income Levels

(Effective January 1, 2024 to December 31, 2024 for MAGI programs, unless otherwise noted; effective April 1, 2024 to March 31, 2025 for non-MAGI programs, unless otherwise noted)

# Persons	Maintenance Need Level (MNL)		100% FPL*		109% FPL (MAGI Medi-Cal Parents and Caretaker Relatives)		138% FPL (MAGI Medi-Cal Expansion Adults & Non-MAGI Aged, Blind & Disabled***)		160% FPL (MAGI Medi-Cal Kids/Targeted Low Income Children's Program - no premium, children up to age 19)		213% FPL (MAGI Medi-Cal Pregnancy-Related Medi-Cal)		250% FPL (Non-MAGI Medi-Cal Working Disabled Program)		250% FPL (MAGI Covered California Cost Sharing Reductions (CSRs)) Through 10/31/24*		266% FPL (MAGI Medi-Cal Kids/Targeted Low Income Children's Program - premiums / cost sharing, children up to age 19)		322% FPL (MAGI Medi-Cal Access Program (MCAP) for Infants and Mothers (formerly AIM) 214% - 322%FPL)		400% FPL (MAGI Covered California Premium Tax Credits (PTCs)) Through 10/31/24*^	
	Monthly	Annual	Monthly	Annually	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual
1	$600	$7,200	$1,255	$15,060	$1,368	$16,416	$1,732	$20,783	$2,008	$24,096	$2,674	$32,078	$3,138	$37,650	$3,038	$36,450	$3,339	$40,060	$4,042	$48,494	$4,860	$58,320
2	$ 750 **	$9,000	$1,704	$20,440	$1,858	$22,280	$2,351	$28,208	$2,727	$32,704	$3,630	$43,538	$4,259	$51,100	$4,109	$49,300	$4,533	$54,371	$5,487	$65,817	$6,574	$78,880
3	$934	$11,208	$2,152	$25,820	$2,346	$28,144	$2,970	$35,632	$3,444	$41,312	$4,584	$54,997	$5,380	$64,550	$5,180	$62,150	$5,725	$68,682	$6,930	$83,141	$8,287	$99,440
4	$1,100	$13,200	$2,600	$31,200	$2,834	$34,008	$3,588	$43,056	$4,160	$49,920	$5,538	$66,456	$6,500	$78,000	$6,250	$75,000	$6,916	$82,992	$8,372	$100,464	$10,000	$120,000
5	$1,259	$15,108	$3,049	$36,580	$3,324	$39,873	$4,207	$50,481	$4,879	$58,528	$6,495	$77,916	$7,621	$91,450	$7,321	$87,850	$8,111	$97,303	$9,818	$117,788	$11,714	$140,560
6	$1,417	$17,004	$3,497	$41,960	$3,812	$45,737	$4,826	$57,905	$5,596	$67,136	$7,449	$89,375	$8,742	$104,900	$8,392	$100,700	$9,303	$111,614	$11,261	$135,112	$13,427	$161,120

* The federal government sets the poverty levels every year. The 2024 FPL limits are effective January 1 for the MAGI Medi-Cal programs and April 1 for the non-MAGI Medi-Cal Aged, Blind & Disabled and the Working Disabled Program. For Covered California, the 2022 FPLs are effective at the beginning of the upcoming open enrollment period; therefore, the FPL limits in effect through October 31, 2022 for Covered California programs and credits are the 2021 income limits used during the most recent open enrollment period that began November 1, 2021. *See* 10 C.C.R. § 6410. Before open enrollment begins in November 2022, Covered California will release new limits here: https://www.coveredca.com/support/financial-help/federal-poverty-

** Pregnant people or adult & child: $750/mo. If 2 adults, Maintenance Need Level is $934/mo or $11,208/year.

^ Consumers at 400% FPL or higher may receive a federal premium tax credit to lower their premium to a maximum of 8.5% of their income based on the second-lowest-cost Silver plan in their area.

Notes:

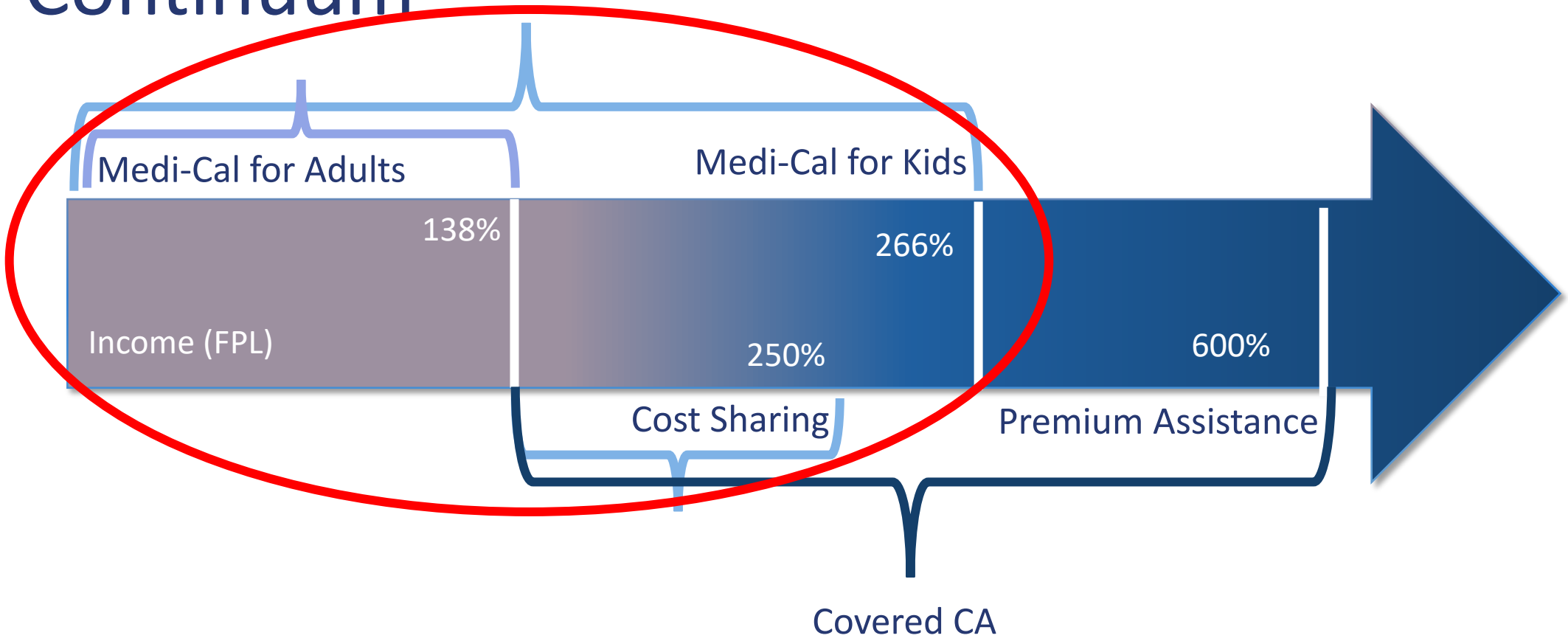
- **Monthly and Annual FPL Levels are rounded up to the next highest dollar**. For example, 1.2 rounds up to 2.
- **Monthly income** is 4.33 times weekly income.
- For **MSP applicants or recipients** who receive Title II RSDI income, the effective date for the new FPLs is March 1, 2024.
- The **5% income disregard** has been applied to MAGI income levels where it applies.
- **For families with more than 6 members:** add $448.33/month or $5,380/year to the 100% FPL amount for each additional person and then round up.

Medi-Cal


STATE OF CALIFORNIA
BENEFITS IDENTIFICATION CARD
ID No. 01234567A96144
JOHN Q RECIPIENT
M 05 20 1991 Issue Date 05 24 16
MEDI-CAL
SAMPLE


THE GREAT SEAL OF THE STATE OF CALIFORNIA
EUREKA
State of California
Benefits Identification Card
ID No. 90000000A95001
SUE G RECIPIENT
F 05 20 1993 Issue Date 01 0 1 05
SAMPLE

The Affordable Care Act (ACA) Coverage Continuum



Progression of Medi-Cal Coverage

- Pre-ACA, Medi-Cal was limited to certain populations
  - Children
  - Parents of dependent minor children
  - Disabled individuals
- Following ACA implementation in 2014, Medi-Cal was expanded
  - All individuals 19-64 with citizenship/qualifying immigration status at or below 138% FPL
- California has incrementally opted to expand full-scope Medi-Cal to several immigrant populations
  - Jan. 2020: Young Adult Expansion to adults 19-26 regardless of immigration status
  - May 2022: Health4AllSeniors expansion to adults 50+ regardless of immigration status
  - January 1, 2024: SB 184 Expansion allows adults ages 26 through 49 to qualify for full-scope Medi-Cal, regardless of immigration status

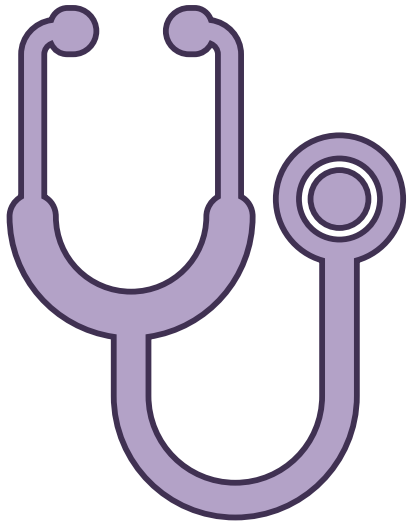
Full Scope Medi-Cal Expansion

SB 184

- Removed immigration status for 26-49 y/o Californians if income eligible

- Existing Restricted Medi-Cal beneficiaries (referred as “transitional population” by DHCS)
  - Automatically enrolled in Full Scope
  - Notices were mailed out in November 2023
  - Need to choose Managed Care plan

- People who don’t have Medi-Cal
  - Will need to enroll in Medi-Cal



Full Scope Medi-Cal Expansion

Who is Eligible for Medi-Cal?

- California Resident

- Income
  - 138% of FPL for 19 – 64 y/o (MAGI Medi-Cal Adults)
  - 213% of FPL for MAGI Pregnancy Medi-Cal
  - 250% of FPL for Non-MAGI Medi-Cal Working Disabled
  - 322% of FPL for Medi-Cal Access Program (MCAP)

- Asset (65 y/o+ or disabled)
  - Asset test lifted in 2024 !!!

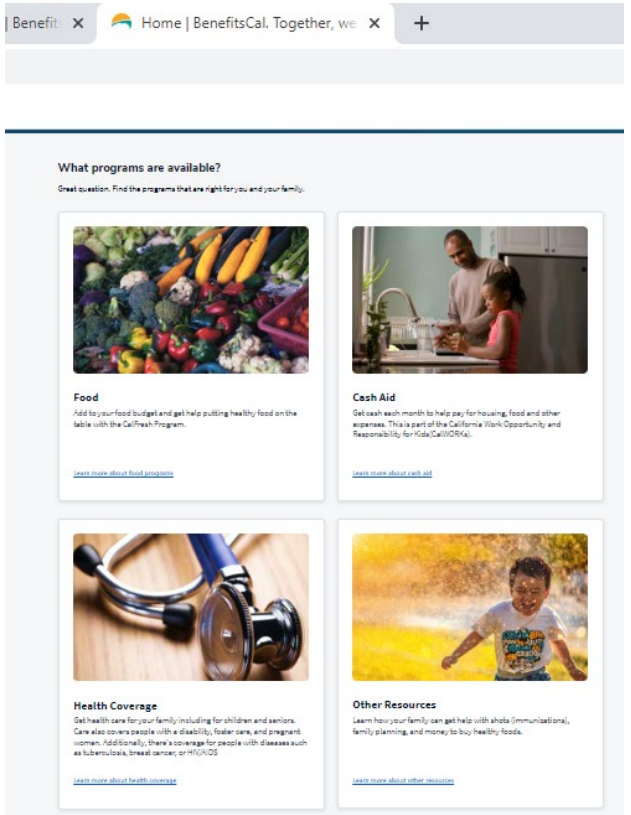
Full Scope Medi-Cal Expansion

Where can they apply for Medi-Cal?

- BenefitsCal
- Local DPSS field office
- Covered California website or call 800-300-1506

What if existing beneficiary does not select a managed care plan?

- DHCS will choose one for them after 90 days from notice



Medi-Cal is Comprehensive

- Medical
- Dental
- Vision
- Long Term Care
- Special Programs (which you can't get from any other insurance!):
    - EPSDT-Early Periodic Screening Diagnosis and Treatment
    - IHSS-In-Home Supportive Services
    - NEMT-Non-Emergency Medical Transportation, NMT-Non-Medical Transportation

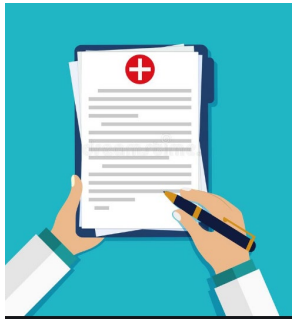
Medi-Cal Special Programs: In Home Supportive Services (IHSS)

- Provides full Medi-Cal beneficiaries with disabilities or over 65 with personal care in home services to let them safely live at home.
  - Domestic services, self-care, paramedical services, transportation, and more
- Services are free with full, no-SOC Medi-Cal

Non-Emergency Medical Transportation, Non-Medical Transportation (NEMT, NMT)

- NEMT is reserved for beneficiaries who cannot be transported by ordinary means due to mental or physical disabilities and illness
- Doctors prescribe rides months in advance detailing time of day, number of weekly treatments, and vehicle type necessary to transport patient
- Users must be provided safe, reliable transport with **door-to-door** service
- NMT can be utilized for beneficiaries who can use ordinary means of transport (e.g., rideshare, taxis) and need rides to appointments

Medical Exemption Request (MER)



- MER is a form filled out by provider to allow consumer to continue being treated/ stay on Fee-For Service Medi-Cal
  - https://www.healthcareoptions.dhcs.ca.gov/content/dam/digital/united-states/california/ca-hco/documents/english/download-forms/request-for-medical-exemption-from-plan-enrollment/MU_0003383_ENG_TempMedExemptionWEB.pdf
  - **Must be filled out every year**
- Common cases: consumers in middle of specialized treatment, consumers with complex varying disabilities that require access to a group of experts for treatment

- NLSLA Impact Litigation improved the MER hearing process, including:
  - Requiring DHCS medical consultants to review evidence to justify the MER,
  - Reviewing evidence, transcripts, and recordings before deciding against a MER,
  - Using medical consultants to consider all medical records and submissions if DHCS alters MER decision,
  - Only using evidence from the MER fair hearing record to alternate the proposed decision,
  - Stating which evidence was relied on and specify reasons for altering the MER decisions, and
  - Maintaining identifying information on the medical consultants for 5 years after the hearing.

Medi-Cal Estate Recovery

see https://canhr.org/californias-medi-cal-recovery-program-frequently-asked-questions/ for more detail

- After the Medi-Cal beneficiary's death, the State can make a claim under the following circumstances:
  - Beneficiary was 55+ years old and received Medi-Cal benefits for:
    - Nursing facility services,
    - Certain home and community-based services (intermediate care for developmentally disabled, waiver programs such as Assisted Living Waiver, Multipurpose Senior Services Program, In Home Operations and Nursing Facility/Acute Hospital Waiver programs)
    - Hospital and prescription drug services provided to an individual while receiving nursing facility services and home or community-based services mentioned above
  - Beneficiaries of any age who were "permanently institutionalized" in a nursing facility, intermediate care facility or other medical institution and for whom, after notice and opportunity for hearing, it was determined that they could not reasonably be expected to be discharged and return home
  - Beneficiary's estate includes real and personal property or other assets **subject to California probate law**

Any Questions on Medi-Cal?

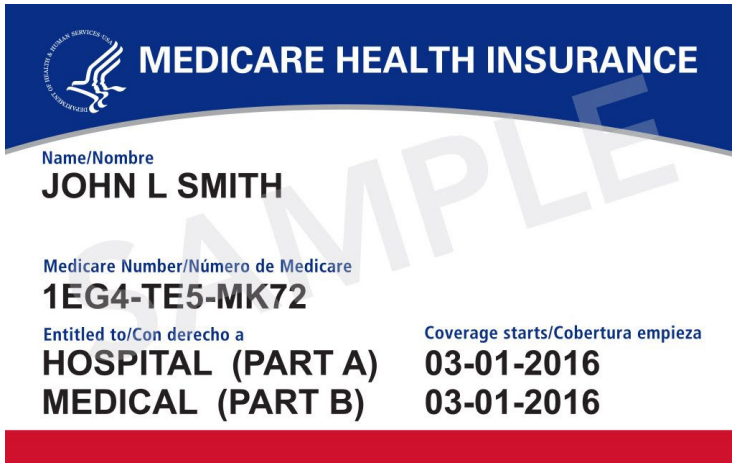
Medicare Basics

- Medicare coverage is generally available to people 65 or older or those with certain disabilities.
  - *Disabled patients generally need to have been enrolled onto SSDI benefits for a period of 24 months before qualifying for Medicare.*
- Medicare helps with the cost of health care, but it does not cover all medical expenses or the cost of most long-term care.
  - Patients who are dual eligible for Medicare and Medi-Cal without a share of cost often qualify for additional cost-sharing benefits

Dual-Eligible Enrollees (“Medi-Medi”)

- May receive coverage under both Medicare and Medi-Cal
- Must have limited income in order to qualify for Medi-Cal (asset test eliminated as of 1/1/24)
- Medi-Cal is the payor of last resort and can cover certain services not paid for by Medicare
  - Premiums, cost-sharing, NEMT, some durable medical equipment/supplies
  - Seniors are now required to enroll in Pt. D (as opposed to prior drug benefits under Medi-Cal)
- Private insurance and Medi-Cal?
  - Potential issues with Medicare/Medi-Cal provider disconnects

Medicare Parts



- Part A (Hospital Insurance) helps cover:
  - Inpatient care in hospitals
  - Skilled nursing facility care
  - Hospice care
  - Home health care
- Part B (Medical Insurance) helps cover:
  - Services from doctors and other health care providers
  - Outpatient care
  - Home health care
  - Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
  - Many preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits)
- Part D (Drug coverage) helps cover the cost of prescription drugs (including many recommended shots or vaccines)

Medicare Work Requirements

- Free Part A if age 65 or older and you or your spouse worked and paid Medicare taxes for at least 10 years
- If you did not pay Medicare taxes while you worked, and you are age 65 or older and a citizen or permanent resident of the United States, you may be able to buy Part A
- Everyone must pay for Part B if they want it. This monthly premium is deducted from their retirement checks or billed directly to them
  - Dual-eligible enrollees may be able to get Part B covered by Medi-Cal

Medicare Options

- Original Medicare
  - Includes Part A (Hospital Insurance) and Part B (Medical Insurance)
  - Patients can join a separate Medicare drug plan (Part D)
  - To help pay out-of-pocket (e.g., 20% coinsurance), patients can also shop for and buy supplemental coverage
  - Can use any doctor or hospital that takes Medicare, anywhere in the U.S.
- Medicare Advantage (also known as Part C)
  - Medicare Advantage is an “all in one” alternative to Original Medicare. These “bundled” plans include Part A, Part B, and usually Part D
  - Plans may have lower out-of-pocket costs than Original Medicare
  - In many cases, patients will need to use doctors who are in the plan’s network
  - Most plans offer extra benefits that Original Medicare doesn’t cover—like vision, hearing, dental, and more

Questions on Medicare?

Covered California Basics

WHAT IS IT?

- Full health insurance coverage with help (based on income) for paying for medical appointments (CSRs) and monthly insurance premiums (APTCs).

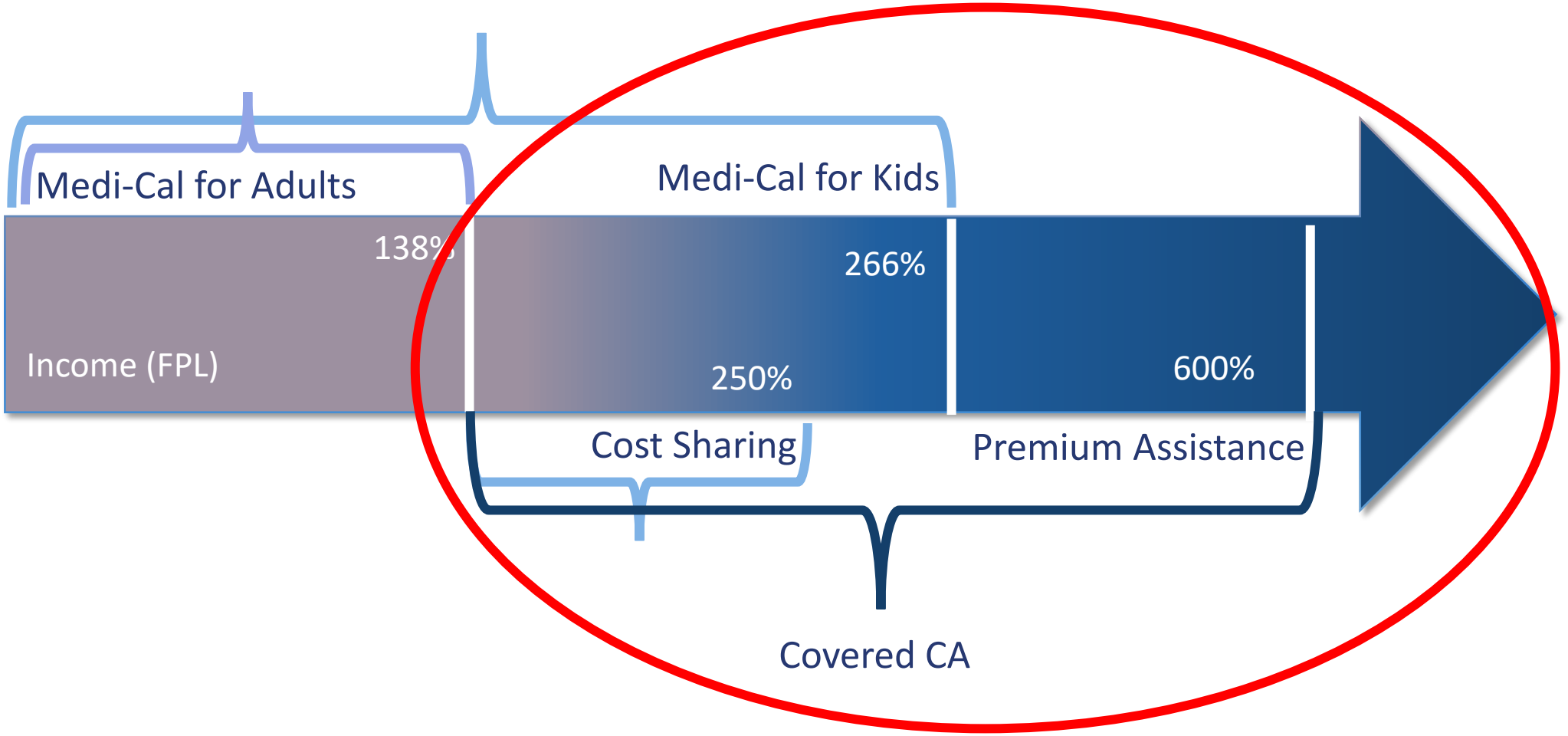
WHO QUALIFIES?

- Individuals/families living in California with incomes too high for Medi-Cal
- Don't have affordable insurance through your work and meet *immigration*, and *income* requirements – only excludes undocumented/DACA. You can be on CovCA with visas (tourist visa, student/work visas) but may not qualify for premium assistance.

WHEN TO SIGN UP?

- Open enrollment **Nov. 1 – January 31** & during "Special Enrollment Periods"

The ACA Coverage Continuum



Covered California: Types of Plans

Metal Tier Levels

- Bronze – 60%
  - low monthly premiums, high deductible.
- Silver – 70%
  - Enhanced Silver – up to 94% (with income based subsidies)
- Gold – 80%
- Platinum – 90%
  - highest monthly premiums but no deductible.

Types of Plans

- HMO
- PPO
- EPO

Covered California: What Will My Premium Cost?

- Everyone will pay something! There are no free policies on Covered California.
- You are only responsible to pay your "fair share."
- Depending on your income in relation to the cost of the plan you may qualify for Advance Premium Tax Credits or Cost-Sharing Reductions.
  - Must meet immigration requirement
  - Must agree to file tax return

Advanced Premium Tax Credits & Cost Sharing Reductions

Advanced Premium Tax Credits / APTC

- 139% to 600% of the FPL = potential subsidies
- APTC as a Monthly reduction of premium OR Lump Sum at Tax filing
- No other offer of Minimum Essential Coverage that's affordable/minimum value

Cost Sharing Reductions / CSR

- Cost Sharing 139% to 250% of the Federal Poverty level
- Reductions = reduction in cost of doctor's visit
- Only available with Silver plans: "Enhanced Silver"

Requirements for APTCs and CSRs

- Purchased plan from Covered CA
- Meet immigration requirement
- MAGI falls within income requirements
- No other offer of Minimum Essential Coverage that's affordable/minimum value
- Agree to file tax return

Questions on Covered CA?

COBRA Basics

WHAT IS IT?

- The Consolidated Omnibus Budget Reconciliation Act ("COBRA") is a federal law that continues health insurance coverage for covered employees, their spouses (and former spouses), and dependent children where coverage would otherwise be lost due to specific events.

WHO QUALIFIES?

- Your group health plan was covered by COBRA;
- A qualifying event occurred; and
- You were a qualified beneficiary for that qualifying event.

WHEN DO I ENROLL?

- Within 60 days of receiving notice of eligibility from employer.

COBRA Basics

Summary of Qualifying Events, Qualified Beneficiaries, and Maximum Periods of Continuation Coverage

The following chart shows the specific qualifying events, the qualified beneficiaries who are entitled to elect continuation coverage, and the maximum period of continuation coverage that must be offered, based on the type of qualifying event. **Note that an event is a qualifying event only if it would cause the qualified beneficiary to lose coverage under the plan.**

QUALIFYING EVENT	QUALIFIED BENEFICIARIES	MAXIMUM PERIOD OF CONTINUATION COVERAGE
Termination (for reasons other than gross misconduct) or reduction in hours of employment	Employee Spouse Dependent Child	18 months[2]
Employee enrollment in Medicare	Spouse Dependent Child	36 months[3]
Divorce or legal separation	Spouse Dependent Child	36 months
Death of employee	Spouse Dependent Child	36 months
Loss of “dependent child” status under the plan	Dependent Child	36 months

COBRA Basics

- Cal-COBRA is a California law that provides COBRA-equivalent protections in California for small employers with 2 to 19 workers. Cal-COBRA may also be available to eligible persons who exhausted their continued coverage under COBRA.

WHERE CAN I FIND MORE INFORMATION ON COBRA AND CAL-COBRA?

- https://www.dmhc.ca.gov/healthcareincalifornia/typesofplans/keepyourhealthcoverage(cobra).aspx
- https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/cobra-continuation-health-coverage-consumer.pdf
- https://www.dol.gov/sites/dolgov/files/legacy-files/ebsa/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf

Questions on COBRA?

Insurance Options after Losing Employment

- COBRA
- Covered California Special Enrollment Period
- Medi-Cal

Insurance Options after Losing Employment- COBRA

- Beneficiary must enroll within 60 days of receiving the notice of eligibility from the employer
- Beneficiary must pay first premium 45 days after sending in enrollment form
- When Federal COBRA ends, eligible employees can buy 18 months additional health coverage under Cal-COBRA

Insurance Options after Losing Employment- Covered California Special Enrollment Period (SEP)

- Individuals who have experienced a "qualifying life event" (e.g., involuntary loss of health insurance due to job loss) may qualify for SEP enrollment outside of general open enrollment periods
- The qualifying life event must have occurred within the last 60 days
- Individual must enroll by the 15th of the month to receive an effective date of the 1st of the next month.
- However, often can apply by the end of the month and still start coverage on the 1st of the next month

COVERED CALIFORNIA

Insurance Options after Losing Employment- Medi-Cal

- Individuals who have experienced job loss may potentially qualify for Medi-Cal if their monthly income is below the allowable income limit
- Must provide verification of income to the County (LA County Department of Public Social Services, or DPSS)
- DPSS typically processes applications within 30-45 days

Questions on Insurance Options after Losing Employment?

Authorization Requests for Medical Services

- Health plans (e.g., managed care plans/HMOs under Medi-Cal, Covered California, etc.) will require treatment authorization requests for certain services
- The treatment authorization request must be completed by the patient's treating provider and must outline the medical justification/medical necessity for the requested service
- Confusion over authorization request requirements and delays in processing could lead to lengthy wait times for coverage of requested services

Options for Authorization Request Issues

- Informal Resolution
  - Care coordination through the managed care plan
- Grievances & Appeals
  - Internal Health Plan grievances & appeals
- Department of Managed Health Complaint & Independent Medical Reviews (generally requires plan grievance exhaustion)
- State Fair Hearings (90 days from Notice of Action)
  - Service delays or denials

Questions on Authorization Requests?

Fertility Preservation Basics

- Iatrogenic infertility – infertility caused by other medical treatment like radiation and chemotherapy – is a common and often overlooked barrier faced by patients of child-rearing age
- Along with the stress of a new cancer diagnosis, young patients could find themselves having to quickly decide whether they should undergo the collection and storage of their reproductive material to preserve the ability to have kids one day in the future
- Patients often may have just a few days to make this difficult decision

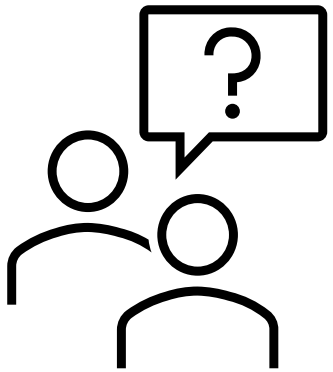
Fertility Preservation Coverage Issues

- Even after grants and foundation support, the cost of fertility preservation services is unaffordable for many
- In 2020, California Senate Bill 600 came into law and confirmed that fertility preservation services should be covered by most health insurance carriers governed by DMHC and CDI, including Covered CA plans and other managed care plans
  - Unfortunately, the benefit is excluded from Medi-Cal coverage currently
  - There are advocates statewide looking at how Medi-Cal patients can also be included moving forward
  - Self-insured plans are excluded

Questions on Fertility Preservation?

How can patients with health access issues get assistance?

- Patients residing in LA County can contact NLSLA's Health Consumer Center (HCC)
  - Can call HCC hotline at 800-896-3202
    - Callers can leave a message Monday - Friday between 9am - 5pm; someone will return your call as soon as possible
    - For non-health cases, patients can call NLSLA's general hotline at 800-433-6251
  - Can also complete an intake on our website: www.NLSLA.org
- Patients residing outside LA County, can contact the Health Consumer Alliance (https://healthconsumer.org/)
  - Can call 1-888-804-3536



Any Questions?