



The Obamacare Opportunity: Implementing the Affordable Care Act to Improve Health, Reduce Hardship, and Grow the Economy for All Californians

August 2013



Next Generation



EAST BAY
COMMUNITY
LAW CENTER

Acknowledgments

The Policy Advocacy Clinic of the East Bay Community Law Center (EBCLC) prepared this report for the Next Generation. U.C. Berkeley School of Law student Theresa Cheng conceived and initiated this project as an intern at Next Generation. Ms. Cheng and fellow Berkeley Law students Katherine Adamides and Stephanie Campos were the primary authors of the report under the supervision of Clinic Director Jeffrey Selbin and in collaboration with Next Generation's Vice President Ann O'Leary and Research Associate Rey Fuentes.

The authors consulted with and are grateful to the following individuals for their time and input (institutional affiliations are for identification purposes only):

- Kevin Aslanian (Coalition of California Welfare Rights Organizations)
- Ed Barnes (East Bay Community Law Center)
- Jessica Bartholow (Western Center on Law and Poverty)
- Claire Conlon (Office of California State Senator Kevin de León)
- Adam Dondro (California Department of Social Services)
- Richard Figueroa (The California Endowment)
- Scott Graves (California Budget Project)
- Maureen Hensley-Quinn (National Academy for State Health Policy)
- Ken Jacobs (University of California Berkeley Labor Center)
- Chauncy Lennon (Ford Foundation)
- Kim McCoy Wade (Alliance to Transform CalFresh)
- Cathy Senderling-McDonald (County Welfare Directors Association of California)
- Alice Weiss (National Academy for State Health Policy)

The Next Generation works to build a sustainable energy future and improve opportunities for children and families. As a nonpartisan organization, the Next Generation generates strategies that advance these goals through research, policy development, and strategic communications. In its home state of California, the Next Generation works to create ground-tested solutions that demonstrate success to the rest of the nation.

The East Bay Community Law Center is a community-based legal services clinic affiliated with the University of California, Berkeley, School of Law. EBCLC's mission is to make the community more healthy, secure, productive, hopeful, and just. EBCLC's Policy Advocacy Clinic pursues projects serving the systemic needs of underrepresented individuals and groups on problems identified in the Center's direct service practices.

Table of Contents

Acknowledgments	2
Table of Contents	3
Introduction	4
Summary of Recommendations	5
I. The Participation Problem: California’s Low “Take up” Rates in Public Benefit Programs	6
A. California’s Underutilized Public Benefit Programs	6
B. Benefits of Increased Take up	7
C. Barriers to Increased Take up	8
II. The ACA Opportunity: Horizontal Integration of Public Benefit Programs	10
A. The ACA Vertical Integration Mandate	10
B. The ACA Horizontal Integration Option	11
C. Federal Incentives to Integrate	11
III. Policy Options: Horizontal Integration in California and Elsewhere	13
A. California’s Horizontal Integration Infrastructure	13
B. Horizontal Integration Best Practices from Other States	13
C. Pennsylvania: A Model State for Horizontal Integration	15
IV. Recommendations	16
A. EDUCATE: Provide Information about Public Benefit Programs	16
B. ASSIST: Screen and Connect to Public Benefit Programs	16
C. STREAMLINE: Integrate Health and Public Benefit Programs	17
D. ENROLL: Move toward Auto-Enrollment in Key Public Benefit Programs	17
E. YEAR 2015: Integrate while the Federal Government Pays for It	18
Conclusion	19
Glossary	20
Notes	22

Introduction

Federal healthcare reform is here. States are implementing the Patient Protection and Affordable Care Act (ACA), which will expand health coverage to tens of millions of Americans. To accomplish this expansion, the ACA mandates the creation of health insurance Marketplaces, which must be operational by January 1, 2014.¹ Marketplaces will offer premium tax credits and subsidies to increase the availability of health insurance for individuals and small businesses. The ACA also permits states to expand Medicaid eligibility to people with incomes at or below 138 percent of the federal poverty level.

California was the first state in the nation to enact implementing legislation in response to the ACA. California has opted to expand Medicaid coverage, and the state has established its own Marketplace, known as Covered California, where individuals and small businesses can shop for health insurance beginning next year. Within Marketplaces, the ACA requires the *vertical* integration of public and private health insurance options. That is, applicants to Covered California must be screened for eligibility for all health insurance programs – a process that promises higher participation rates and better health outcomes for Californians.

The ACA encourages, but does not require, the *horizontal* integration – or “interoperability” – of Marketplaces with safety net programs such as the Supplemental Nutritional Assistance Program (SNAP, formerly known as food stamps and known as CalFresh in California) and Temporary Assistance to Needy Families (TANF, known as CalWORKs in California). The ACA is silent on integration of Marketplaces with work support programs, such as Unemployment Insurance. California lags behind other states in “take up” of some public benefit programs to the detriment of low-income individuals, families, and communities.

This report describes how California can take advantage of ACA implementation to increase access both to health coverage and to vital safety net and work support programs.

In Section I, we describe California’s public benefit take up problem. We identify the take up rates of the key safety net and work support programs, barriers to greater participation, and the benefits of increasing participation in such programs.

In Section II, we describe how ACA implementation can increase take up rates for health insurance *and* public benefit programs. States can expand integration infrastructure and operations across a broad range of programs and the federal government will pay most of the costs.

In Section III, we set forth various policy options for integrating California’s Marketplace with public benefit programs. We describe California’s existing integration efforts and present ACA and non-ACA best practices from other states regarding take up strategies.

In Section IV, we make recommendations focused on a single goal – increasing the take up rate of safety net and work support programs to improve health, reduce hardship, and grow the economy for all Californians.

Summary of Recommendations

California should lead the nation in the integration of healthcare and public benefit programs. California has the most to gain by going *broad* (integrating as many safety net and work support programs as possible), *deep* (moving as close to auto-enrollment as possible), and *fast* (leveraging the multiple benefits of one-time federal infrastructure dollars as soon as possible). While practical obstacles prevent implementation of seamless auto-enrollment across all public benefit programs in the near term, we recommend that the state take the following “EASE-Y” steps in that direction:

Educate: Provide Information about Public Benefit Programs

To overcome knowledge and stigma gaps and to increase participation, Covered California should provide information to all health coverage applicants – in person, online, by mail or by phone – about the availability of public benefit programs for which they are eligible. The details of such an educational effort can be determined and implemented over time, but the baseline principle must be established from the beginning.

Assist: Screen and Connect to Public Benefit Programs

To minimize transaction costs and reduce institutional barriers, Covered California should facilitate the screening of customers for eligibility for major public benefit programs beyond health care. This should be accomplished online, through the new ACA Assisters and Navigators, and over the phone at the new Covered California call center. Screen and connect is especially important to begin integrating the state’s three major work support programs, which are administered by the Employment Development Department.

Streamline: Integrate Healthcare and Safety Net Programs

To streamline eligibility for safety net programs and reduce administrative burdens for consumers, Covered California’s automated eligibility and enrollment system, call center, and paper application should integrate as smoothly as possible with the existing State Automated Welfare System (SAWS) and county call centers. Additionally, SAWS and county call centers should continue to simplify their application and enrollment processes to ensure a seamless interface with Covered California.

Enroll: Move toward Auto-Enrollment in Key Programs

The most comprehensive way to increase participation rates in healthcare and public benefit programs is to auto-enroll applicants in all programs for which they qualify. States have demonstrated that auto-enrollment is possible with effective leadership and commitment. While not feasible in the short run, investing in infrastructure now will pave the way for greater integration, including the gold standard of auto-enrollment.

Year 2015: Integrate while the Federal Government Pays for It

California must act quickly on horizontal integration to take advantage of federal funding that expires soon. The federal government will pay for 90 percent of state investments in horizontal integration infrastructure, but only through 2015. Thereafter, the federal government will pay for 75 percent of the on-going costs of integration maintenance and operations.

We urge the Governor, Legislature, and other stakeholders to integrate public benefit programs with ACA programs as broadly, deeply, and quickly as possible.

I. The Participation Problem: California’s Low “Take up” Rates in Public Benefit Programs

Like other states, California manages public benefit programs that serve both as a safety net for low-income individuals and families and as work support for people across the income spectrum. California, however, lags behind many states in program take up rates. For a number of interrelated reasons, many eligible individuals do not participate in existing programs, resulting in poor health outcomes, unnecessary hardship, and missed economic opportunity.

In this Section, we describe California’s major public benefit programs and their respective participation rates. We identify the substantial benefits of increased take up to individuals, families, and the state. We then address take up barriers for select programs, and conclude by underscoring the possibilities for improvement through implementation of the ACA.²

A. California’s Underutilized Public Benefit Programs

The state of California administers several major safety net and work support programs. California counties also operate a safety net program of last resort, and the federal government administers an

important safety net program and generous work support programs through the tax code.³ All of these programs are under-utilized by eligible Californians.

1. State Safety Net Programs

California’s three major safety net programs include CalFresh (the state’s version of SNAP, formerly known as food stamps), CalWORKs (TANF), and Medi-Cal (Medicaid). CalFresh issues monthly electronic benefits to low-income households to purchase food. The Women, Infants and Children (WIC) program also offers nutrition security to new mothers and their children. CalWORKs provides cash assistance – and in some cases, childcare subsidies – to low-income families for basic needs. Medi-Cal currently provides health insurance to low-income people, including families with children, individuals 65 years or older, those who are pregnant, and those with disabilities or with specific diseases. All of these programs are jointly administered by state and county agencies, and consumers access services at the county level. These programs, which have distinct eligibility criteria based on income and other factors, help California’s families most in need.

Figure 1

Safety Net		Work Support	
County	State	State	Federal
<ul style="list-style-type: none"> • General Assistance / General Relief (GA / GR) 	<ul style="list-style-type: none"> • Cal Fresh • CalWORKs (& Childcare Subsidies) • Medi-Cal • WIC 	<ul style="list-style-type: none"> • Unemployment Insurance (UI) • State Disability Insurance (SDI) • Paid Family Leave (PFL) 	<ul style="list-style-type: none"> • Earned Income Tax Credit • Child & Dependent Care Credit

2. State Work Support Programs

California also administers three work support programs through the Employment Development Department, including Unemployment Insurance (UI), State Disability Insurance (SDI), and Paid Family Leave (PFL). UI is supported by employer contributions, while SDI and PFL are supported by employee contributions. Benefits for all three programs are based on worker earnings for a specified period of time. UI and SDI provide partial and short-term wage replacement for unemployed or temporarily disabled workers. PFL provides up to six weeks of benefits for covered employees to care for a seriously ill child, spouse, parent, or registered domestic partner, or to bond with a new child. These programs help California's working families stay connected to the labor force and make ends meet between jobs or while temporarily away from employment.

3. Other Public Benefit Programs

In addition to the safety net and work support programs noted above, the state administers a variety of smaller public benefit programs for targeted individuals and families.⁴ Outside of the spectrum of state-administered safety net and work support programs are: (1) the county-administered General Assistance or General Relief (GA/GR) programs, which are a safety net of last resort primarily for single, childless adults;⁵ and (2) the federally-administered Earned Income Tax Credit (EITC) and Child and Dependent Care Credit (CDCC), which provide direct tax subsidies to working families.⁶

Eligibility criteria for GA/GR differ considerably by county in California, but in most counties the benefits are only available for nine months or less and only for adults who are participating in work activities or deemed unemployable. Eligibility criteria for the EITC and CDCC are set forth in the Internal Revenue Code. These programs are also very different in scale, as cash safety net programs such as GA and CalWORKs have shrunk in enrollment while healthcare and work support programs have generally grown.

Regardless of their size and scope, and while take up rates and barriers to take up vary across programs, all public benefit programs fail to enroll a substantial number of eligible individuals. For example, California's Medi-Cal take up rate is currently 61 percent, meaning almost two out of every five

individuals eligible for Medi-Cal are not receiving benefits.⁷ California has the lowest CalFresh (SNAP) take up rate in the United States with only 55 percent of eligible individuals enrolled.⁸ Among the working poor, the participation rate is even worse – currently at 42 percent.⁹ That is, almost half of all individuals eligible for CalFresh do not receive food assistance, and almost 6 in 10 eligible working poor Californians do not receive CalFresh.¹⁰ Work support programs themselves also fail to enroll eligible individuals. For example, between 2002 and 2006, only two-thirds of women who received SDI for pregnancy also filed for PFL's family bonding benefits.¹¹

B. Benefits of Increased Take Up

Increasing take up rates for both safety net and work support programs is beneficial to individuals, families, and the state.¹² Public benefit programs can improve health outcomes and reduce hardship associated with poverty. Increased take up of such programs, in turn, has a positive multiplier effect on the economy.

1. Improved Health and Well-Being

The ACA mandates the vertical integration of health coverage within Marketplaces. That is, consumers shopping in Covered California must be screened for all possible healthcare benefits, including Medi-Cal and healthcare tax credits. Not only will vertical integration save money, it will ensure greater coverage and improved health outcomes.¹³ Evidence also suggests that increased take up of other public benefit programs can improve health outcomes as much as or even more than increased access to some types of health care.¹⁴

In fact, introduction of CalFresh appears to have improved birth outcomes in California, an indicator of the overall health of the population.¹⁵ And although children in low-income families often have lower academic achievement,¹⁶ they show improved math and reading scores when their families receive the EITC.¹⁷ These benefits extend well beyond the period of time during which families typically claim the credit.¹⁸

2. Reduced Hardship and Increased Social Mobility

Increased take up rates of public benefit programs can help reduce poverty and its associated

hardships. Current safety net programs keep one in every seven Americans – or more than 40 million people – above the federal poverty line.¹⁹ The take up of public benefits can have an immediate effect on a family’s income and well-being. As the Census Bureau’s Supplemental Poverty Measure shows, applying the SNAP benefit to the calculation reduced the childhood poverty rate in the United States from 21 to 18 percent in 2011, lifting over two million children out of poverty.²⁰ TANF, UI, and the EITC had similar effects on the childhood poverty rate.²¹

Early childhood opportunities have important effects as children grow into adulthood. More than two-thirds of children who are born in poverty remain in poverty as adults, thus facing limited social mobility and reduced economic productivity for their entire lives.²² Lifting families out of poverty can help to break intergenerational cycles of hardship. Research demonstrates that children in families that receive the EITC are more likely to attend college and earn more than those who do not receive the tax credit.²³ The same study found that “a \$3,000 increase in family income ... between a child’s prenatal year and fifth birthday is associated with an average 17 percent increase in annual earnings and an additional 135 hours of work” when a child reaches adulthood.²⁴

3. Economic Growth

Increasing take up of public benefit programs – especially CalFresh – will also yield important economic benefits to California.²⁵ Though modest administrative costs are shared by federal, state, and local governments, CalFresh benefits are 100 percent federally funded. With 45 percent of individuals eligible for CalFresh falling through the cracks, California leaves nearly \$5 billion of federal nutrition money unclaimed.²⁶ Further, the multiplier effect of each federal dollar boosts California’s economy for everyone: each CalFresh dollar generates \$1.79 in economic activity.²⁷ These unclaimed dollars translate into \$8.7 billion in lost economic activity, \$86 million in lost state tax revenue, and \$51 million in lost county tax revenue.²⁸ While joint state-federal funded programs like Medi-Cal and CalWORKs impose upfront costs on the state, they keep low-income individuals participating in the local economy.

While safety net programs promise measurable gains, increasing take up of work support programs is also important, because these programs help keep recently working individuals and their families from falling into poverty. Whether an individual is not working due to an illness in the family, pregnancy, or a downturn in the economy, UI, SDI, and PFL help people who have unexpectedly stopped working stay afloat. In addition, the EITC helps cushion low-income working families by letting them keep more of what they earn. By increasing take up of these programs, California can prevent poverty among low-wage workers and those who temporarily need to stop working.

C. Barriers to Increased Take Up

Research shows that barriers to program take up include lack of knowledge, stigma, transaction costs, and institutional barriers.

1. Knowledge and Stigma

Some people who are eligible do not apply for benefits because they do not know about the program or do not realize they qualify for it. These knowledge gaps plague many programs, and studies have documented the problem with respect to take up rates for SNAP,²⁹ childcare subsidies,³⁰ and PFL.³¹ This barrier may also impede taxpayers from taking up EITC, since EITC participation improved with promotion of the program.³² Even if a person is aware of a program and knows she is eligible, she may not apply because of associated stigma.³³ While difficult to quantify,³⁴ stigma may be at work in lowering take up of all benefits programs when people are ashamed of asking for help to meet their basic needs.

2. Transaction Costs

Even after overcoming knowledge gaps and stigma, people may still fail to enroll because of high transaction costs. Transaction costs include travel time to public benefit offices, long wait times, and the general complexity of existing programs. Studies show that transaction costs act as a barrier to take up of SNAP,³⁵ TANF,³⁶ Medicaid,³⁷ and UI.³⁸ Such costs often disproportionately affect those with daytime jobs, poor health, or small children because they may not have time or energy necessary to pursue a successful application for these programs.

3. Administrative Burdens

Administrative burdens, or “bureaucratic disentanglement,” also limit the take up of public benefits.³⁹ These barriers include, but are not limited to, front-end interviews and screening, onerous documentation requirements, and frequent renewal or recertification processes. For example, until 2011, CalFresh required fingerprinting during the application process.⁴⁰ Barriers like these inhibit individuals’ desire to pursue benefits and reduce their likelihood of receiving and retaining assistance.

While it can be difficult to isolate the barriers to take up for particular programs, successful initiatives in other states suggest these challenges are surmountable. With the implementation of the ACA, California can lower these barriers by integrating its Marketplace with a broad array of public benefit and work support programs while taking the opportunity to integrate and modernize the entire delivery system.

II. The ACA Opportunity: Horizontal Integration of Public Benefit Programs

ACA implementation presents a unique opportunity to improve long and short-term outcomes for individuals, families, and the larger economy. States can maximize the impact of the ACA by increasing take up rates in public benefit programs ranging from county-administered General Assistance/Relief, through state-administered safety net and work support programs, to the federally administered Earned Income Tax Credit. By integrating public benefit programs with healthcare benefits, states can directly address barriers to take up by increasing knowledge about eligibility, lessening stigma, and reducing administrative burdens.

In this Section, we describe the ACA mandate to integrate vertically healthcare programs within Marketplaces like Covered California. Next, we discuss the ACA's encouragement for Marketplaces to integrate *horizontally* with other public benefit programs. Finally, we note important, time-sensitive ACA incentives to foster horizontal integration by the states. The federal government will cover 90 percent of the initial infrastructure costs associated with such integration through 2015.

A. The ACA Vertical Integration Mandate

While the ACA offers states the option to create their own Marketplaces and expand Medicaid, the law requires Marketplaces to streamline and simplify application processes for available state and federal healthcare programs. This so-called "vertical integration" (see Figure 2) will be accomplished by standardizing eligibility rules for Medicaid, the Children's Health Insurance Program (CHIP), and the new federal health insurance subsidies.⁴¹ If states choose to expand Medicaid, all individuals with incomes at or below 138 percent of the Federal Poverty Level (FPL) will be eligible for enrollment in the states' Medicaid programs.⁴² Consumers with incomes between 138 and 400 percent of the FPL will be eligible for federal health insurance subsidies and may directly compare and purchase health insurance plans in the Marketplace.

Within Marketplaces, "Assisters" and "Navigators" will help screen consumers for healthcare benefits. Assisters and Navigators are required to educate, enroll, and help individuals maintain health insurance coverage.⁴³ Marketplaces must also streamline eligibility and enrollment by offering a seamless "no wrong door" customer experience so that individuals can interact with the Marketplace online, by mail, by phone, or in person.

California has already established its own Marketplace, Covered California, and the state has committed to expanding its Medi-Cal program. In addition to the estimated 880,000 Californians currently eligible for, but not receiving Medi-Cal, policymakers estimate that one million residents will be newly eligible due to the Medi-Cal expansion.⁴⁴ An additional 1.2 million people will be eligible for federally subsidized coverage.⁴⁵ As a result of these expansions, experts predict that between 1.8 and 2.7 million Californians will gain healthcare coverage by 2019.⁴⁶

Applicants for Medi-Cal, CHIP, or new health insurance coverage within Covered California will complete one streamlined application. Staff members at Covered California call centers will identify applicants eligible for Medi-Cal by asking seven threshold questions and will then refer these cases to the appropriate county welfare office via a "warm hand-off" on the phone.⁴⁷ Applicants are not

ACA Vertical Integration Mandate

Medicaid

CHIP

Federal Subsidies

Private Insurance

Figure 2

supposed to wait more for more than 30 seconds while their cases are transferred to the county worker for processing.

B. The ACA Horizontal Integration Option

In contrast to *mandated* vertical integration of healthcare programs, the ACA *encourages* the integration of Marketplaces with “human services” (public benefit) programs, such as SNAP and TANF.⁴⁸ This so-called “horizontal integration” (see Figure 3) refers to a spectrum of interconnectedness between and among program eligibility and enrollment systems. At the simplest level of integration, caseworkers or Assisters inform applicants of the existence of other programs for which they might be eligible. At the more integrated level, people applying for one program will be enrolled automatically in all programs for which they are eligible.



Figure 3

While not mandating horizontal integration, the ACA does require “interoperability” between the Marketplaces and states’ public benefit programs.⁴⁹ The Health Information Technology for Economic and Clinical Health Committee, a federal agency dedicated to improving health information infrastructure, recommends a level of interoperability where “Federal agencies ... use a set of standardized Web services that could also support the eligibility determination processes in other health and human services programs such as SNAP and TANF.”⁵⁰

The ACA also includes certain features that will foster horizontal integration of the Marketplace and public benefits programs, for example, by developing common terminology in standardized formats between IT systems. Under federal law, enrollment into health coverage will be facilitated by: (1) *data*

sharing, or the exchange of information about client circumstances across service programs; and (2) *data matching*, or the use of federal and state databases to verify consumer background.⁵¹ The federal government has not provided any guidance on more comprehensive integration between Marketplaces and public benefit programs beyond SNAP and TANF.

California’s Marketplace, Covered California, hired the consulting firm Accenture to develop an information technology system to manage and connect the federal subsidies program and Medi-Cal/CHIP.⁵² The new system is called the California Healthcare Eligibility, Enrollment & Retention System (CalHEERS). Covered California will screen each application it receives for subsidized health insurance, enroll people eligible for subsidies, and refer people eligible for Medi-Cal to the counties, which will continue to make final eligibility determinations. This two-tiered model will require efficient data exchange between CalHEERS and counties, which use one of the three consortia that comprise the Statewide Automated Welfare System (SAWS).⁵³

Such data exchange will also be important to the implementation of horizontal integration. The interface between CalHEERS and SAWS will include consumer information necessary for eligibility determination of several programs. It will also track whether a consumer is applying for non-health services programs, such as CalWORKs and CalFresh.⁵⁴ For now, horizontal integration with public benefit programs has been secondary to the task of launching the Marketplace by October 1, 2013.⁵⁵

C. Federal Incentives to Integrate

To incentivize horizontal integration, the federal government will pay 90 percent of the costs of design, development, and implementation of health coverage eligibility systems, even when these changes improve other public benefit programs beyond healthcare.⁵⁶ For systems developed before the 2015 expiration date, the federal government will pay for 75 percent of ongoing maintenance and operations costs. The federal government recently further simplified the approval process to encourage states to take advantage of federal funding.⁵⁷

The federal government has encouraged states to seize this financial incentive to create the

integration model outlined in Figure 4. The Obama administration issued an executive order calling on “greater coordination across agencies [to] reduce [the significant number of regulatory] requirements, thus reducing costs and simplifying and harmonizing rules.”⁵⁸ The Administration for Children and Families and Health and Human Services released *Your Essential Interoperability Toolkit*, a comprehensive set of background interoperability documents to help state human services agencies connect with health programs and maximize ACA benefits.⁵⁹

California is not alone in implementing the ACA and making decisions about horizontal integration. Many states have already instituted some form of horizontal integration of existing public benefit programs with Medicaid or other state health insurance programs. Private organizations like the Ford Foundation and the Annie E. Casey Foundation have offered grant money to states looking to improve their methods of streamlining and integrating public benefit enrollment with health insurance and other programs.⁶⁰

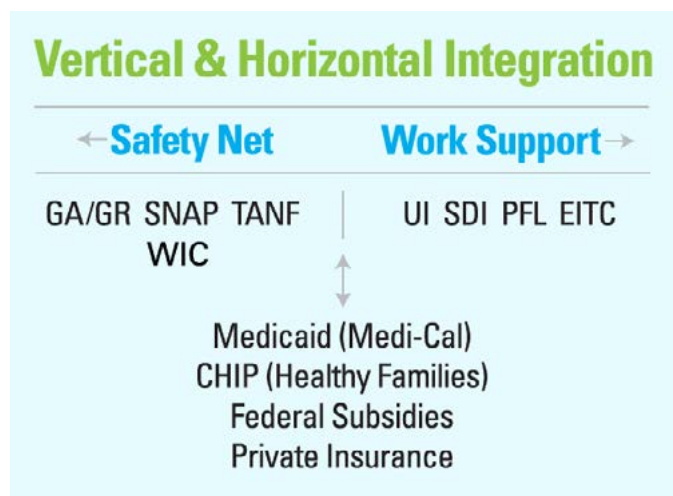


Figure 4

III. Policy Options: Horizontal Integration in California and Elsewhere

In this Section, we describe California's existing infrastructure for public benefit integration, including the state's online portals for Medi-Cal, CalWORKs, and CalFresh. We then turn to horizontal integration best practices from other states, including ACA and non-ACA related initiatives. Finally, we highlight Pennsylvania as a model state from which California can draw lessons.

A. California's Horizontal Integration Infrastructure

California's current public benefits system is partially integrated, but not seamless. The state offers a single application for its three main safety net programs: CalFresh, CalWORKs, and Medi-Cal. When applying for CalFresh, CalWORKs, and Medi-Cal, the applicant receives and fills out the SAWS 1, the official application form for these three programs. Though the process continues to vary some by county, applicants generally can apply online, by phone, by mail, or in person. Via a single website (www.benefitscal.org), online applicants can access one of three portals depending on their county of residence. In addition to application sites, these portals provide some education on the eligibility and enrollment processes for other public benefit programs.

With the development of SAWS and the online portals, California has made some progress toward the horizontal integration of certain public benefit programs. Unfortunately, the system is far from optimal. As required by federal law, people who apply online can do so without including complete information, like household size, a phone number or a social security number. This results in significant delays and requires further outreach by caseworkers or in-person visits to welfare offices by applicants.⁶¹

Greater horizontal integration of public benefit application and enrollment in California will be challenging, but is not insurmountable. Horizontal integration must build on the three consortia that comprise California's existing Statewide Automated Welfare System (SAWS): Benefits CalWIN (CalWIN), C4Yourself (C-IV), and LEADER. Each integrates the

application process for CalWORKs, CalFresh, and Medi-Cal through its own distinct online portals. California plans to update the LEADER system to a LEADER Replacement System, (LRS) with the goal to migrate C-IV participating counties to this new system.⁶² Although the state spent \$6 million over the last six years on LRS, the replacement system is not yet operational.⁶³ Variations in program eligibility requirements also limit the potential to improve California's application, data sharing, and data matching.

In September 2012, Governor Jerry Brown vetoed Senate Bill (SB) 970, which would have required horizontal integration in California.⁶⁴ Under SB 970, Marketplace customers would have been given the option of forwarding their application information to county human services departments to initiate simultaneous eligibility determinations for CalWORKs and CalFresh.⁶⁵ The bill would have leveraged the opportunity to fund 90 percent of the integrated IT system with federal dollars. The Governor's veto message described the bill as unnecessary and stated his intentions to pursue horizontal integration without legislation.⁶⁷

Following this commitment, horizontal integration moved one step forward with the June 2013 passage of California's 2013-2014 budget, which includes a provision requiring the state to seek federal waivers to use CalFresh enrollment data to determine Medi-Cal eligibility for people younger than 65 years of age.⁶⁷ Though the State Department of Social Services filled a new position for an Assistant Director for Horizontal Integration in April 2013, it remains unclear to what extent the state plans to implement horizontal integration over the medium to long term.⁶⁸

B. Horizontal Integration Best Practices from Other States

Many states have begun to integrate their public benefit programs in recent years. Some states have consolidated public benefit programs into single applications with online portals. Some have also instituted data sharing across agencies with the goal

of pre-populating applications for certain programs based on data from others. States have even used data matching, in combination with data sharing, to auto-enroll eligible individuals into certain programs. While California differs from most states due to the county-based nature of its enrollment systems for safety net programs like SNAP and Medicaid, other states' efforts are nevertheless instructive.

1. Integrated Applications and Online Portals

Most states already incorporate multiple public benefit programs into a single application. As mentioned, California combines applications for its SNAP, TANF, and Medicaid programs into a single form known as the SAWS 1. In the absence of integrated applications, many states have created online portals, like California's C4Yourself or Benefits CalWIN, which provide information about other public benefit programs. Many of these online portals include eligibility screeners, which allow consumers to see if they qualify for certain programs. Some portals go further by offering applications for these other programs. For example, Colorado's Program Eligibility and Application Kit allows potential enrollees to screen and apply for nine programs.⁶⁹

2. Data Sharing

Some states have moved beyond the consolidation of programs into a single application or online portal toward the sharing of data across state agencies and departments. Wisconsin's Department of Health co-administers SNAP and Medicaid using an online benefit portal that allows users to directly apply for SNAP and health coverage and offers supplemental information about how to apply for other programs like TANF, school meal programs, and energy assistance programs.⁷⁰ Other states use information gathered by an agency for one program to determine eligibility for another. For example, fifteen states and the District of Columbia coordinate SNAP benefits with the federal Low Income Home Energy Assistance Program to maximize so-called "heat and eat" benefits for low-income households.⁷¹ Similarly, Vermont effectively employs a single application to auto-enroll recipients of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) in health coverage, and vice versa. As a result, 97 percent of Vermont's young children receiving WIC also have

health insurance, compared to only 61 percent of children nationwide.⁷²

3. Data Matching

Some states have streamlined enrollment processes for social services programs by allowing for data matching, eliminating the need to verify already reported enrollee information. Congress has promoted the move toward data sharing as well as matching with its Express Lane Eligibility (ELE) initiative.⁷³ The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) gives states the choice to base child Medicaid and CHIP eligibility or renewal determinations on findings of other need-based programs like SNAP and WIC, eliminating reassessment of common eligibility factors.⁷⁴ States have also linked agencies that administer school lunch programs, taxes, and home energy assistance programs. For example, New Jersey links Medicaid and CHIP to the Department of Revenue as well as to its free and reduced lunch programs.⁷⁵

Louisiana was the first state to participate in the ELE initiative.⁷⁶ The state uses eligibility findings from SNAP to identify and automatically enroll eligible-but-unenrolled children into Medicaid, requiring no additional eligibility determination. The program has been very successful with over 20,500 children identified as eligible and more than half of them enrolled and provided service.⁷⁷ Some of the other ELE states do not auto-enroll applicants into other public benefit programs, and instead perform outreach to eligible individuals. For example, South Carolina performs mail and telephone outreach to potential SNAP and TANF enrollees.⁷⁸ While most states have limited ELE to children, some states have applied for Section 1115 waivers to expand the program to adults.⁷⁹

4. Integrating Work Support Programs

Currently, most states do not integrate work support programs with safety net programs. Massachusetts, however, has linked health coverage to Unemployment Insurance. The Unemployment Health Insurance program, also known as the Medical Security Program, is offered to recipients of unemployment assistance and eligibility is based upon one's income, generally less than 400 percent of the federal poverty level. One can either receive premium assistance or direct coverage, which ends when unemployment benefits cease.⁸⁰

C. Pennsylvania: A Model State for Horizontal Integration

The Commonwealth of Pennsylvania Access to Social Services (COMPASS) allows users to apply for up to thirteen benefits programs in a single application.⁸¹ A pioneer of horizontal integration, Pennsylvania has been a model for other states. The system allows for cross-program data sharing and has the ability to access information from employment databases, childcare databases, and the national school lunch program database. The system also checks for eligibility for CHIP and forwards eligible cases to the Department of Insurance.

Philadelphia improves upon ELE, which only uses SNAP or other public benefit application responses to enroll people in health insurance, but does not enroll in the opposite direction, from health insurance to SNAP. Philadelphia, however, has piloted its own program for health insurance-to-SNAP enrollment. Launched in June 2012 and funded by a demonstration grant from the U.S. Department of Agriculture, BenePhilly sought to increase the use of SNAP among eligible seniors in Philadelphia.⁸² In a single year, the program successfully used existing Medicaid enrollment data to increase SNAP enrollment among seniors by 23 percent.⁸³

In order to accomplish horizontal integration, Pennsylvania had to simplify many of the eligibility requirements for its programs and apply for federal waivers of face-to-face interviews.⁸⁴ The state has also forged alliances across agencies like creating alignment agreements between the Departments of Public Welfare and Insurance. Unlike California, Pennsylvania manages these programs at a state level as opposed to the county level, which clearly facilitated some aspects of integration. Nevertheless, the Pennsylvania experience suggests that populous states like California can integrate public benefit programs with the new Marketplace and across agencies.

In fact, several states anticipate providing some level of horizontal integration with their respective ACA Marketplaces and existing public benefit programs.⁸⁵ Colorado,⁸⁶ Maryland,⁸⁷ Wisconsin,⁸⁸ and the District of Columbia⁸⁹ all proposed plans for integration. These states intend to incorporate horizontal integration by 2015 to take advantage of available federal funding for integrated Marketplace

development and design. California can learn from the experience of Pennsylvania and states that are integrating their Marketplaces with public benefit programs.

IV. Recommendations

California should lead the nation in the integration of healthcare and public benefit programs. California has the most to gain – for its people and economy – by going *broad* (integrating as many safety net and work support programs as possible), *deep* (moving as close to auto-enrollment as possible) and *fast* (taking advantage of federal infrastructure dollars and reaping benefits as soon as possible) to align and integrate public benefits within Covered California. While practical obstacles prevent implementation of seamless auto-enrollment across all public benefit programs in the near term, we recommend that the state take the following “EASE-Y” steps in that direction:

A. EDUCATE: Provide Information about Public Benefit Programs

To help overcome knowledge and stigma gaps and to increase participation in public benefit programs, Covered California should provide information to all applicants – online, by phone, by mail, or in person – about the availability of public benefit programs for which they are eligible. The details of such an educational effort can be determined and implemented over time, but the baseline principle must be established from the beginning. Public benefit programs should also incorporate into their existing delivery models information about Covered California and the newly available healthcare options.

The California Department of Social Services is currently overseeing a statewide CalFresh outreach program.⁹⁰ The program is supported by matching funds from the United States Department of Agriculture (USDA) and grants from the California Endowment, MAZON: A Jewish Response to Hunger, local county boards of supervisors, and other private donors. The effort involves seven partner organizations, fourteen sub-partners, and 100 subcontractors who in turn promote CalFresh enrollment through more than 3,000 community-based organizations in 51 of the state’s 58 counties.⁹¹

Since Covered California is launching its own outreach and education campaign, the state should coordinate efforts to take advantage of existing networks, materials, and experience to ensure maximum reach and impact.

B. ASSIST: Screen and Connect to Public Benefit Programs

To reduce transaction costs and lower institutional barriers, Covered California should screen low-income applicants for eligibility for public benefit programs. Screen and connect has been used effectively with safety net programs in other states.⁹² For example, California could emulate states like New Mexico and develop an informative benefits calculator, which would provide applicants with an estimate of benefit amounts that they would receive.⁹³ Covered California already has a cost-benefits calculator on its website for health coverage and subsidy determinations, and it could add a similar calculator, or eligibility screener, for safety net programs.⁹⁴ As noted above, states that have a robust screen and connect system, like Pennsylvania’s BenePhilly, have increased take up rates.

California should also prioritize screen and connect strategies for work support programs. **While some of this can be accomplished online, the new Assisters and Navigators should be funded and trained to assume a central role in the screen and connect strategy.** The Employment Development Department (EDD) administers the three most important work support programs – UI, SDI, and PFL – which will make it easier for Assisters and Navigators to screen and connect customers. They can screen with simple questions like, “Are you working?” and “If not, is it because you are sick? Are you caring for a sick family member? Did you lose your job?”

C. STREAMLINE: Integrate Health and Public Benefit Programs

To further reduce transaction costs and institutional barriers, the new online health portal should integrate as seamlessly as possible with the existing State Automated Welfare System (SAWS) to streamline eligibility determinations for safety net programs. In particular, we recommend that CalHEERS prioritize the integration of health plan data with the SAWS so that applicants can easily apply for CalFresh and CalWORKs. After an applicant provides personal information to purchase health insurance, the system should pre-populate application forms for these two important benefit programs. If the state has the ability to align CalFresh, CalWORKs, and Medi-Cal in SAWS, the system should be able to share applicants' data with CalHEERS (and vice versa) to help eligible individuals enroll in all programs for which they qualify.⁹⁵ **The interface that will connect CalHEERS to the SAWS has been delayed, and will not be operational during the pre-enrollment period that begins in October 2013. Covered California and Accenture should ensure that its development is a high priority going forward.**

With the enactment of AB 174 (Monning) in 2012, California now authorizes increased data sharing between Covered California and work support programs administered by the EDD.⁹⁶ The new law permits the use of EDD data to determine or verify the eligibility of applicants for healthcare and other benefits.⁹⁷ Linking different enrollment systems is the first step toward true integration. The state should strengthen this data link and further align EDD eligibility with healthcare eligibility determinations by pre-populating applications for multiple programs with consumer information. At a minimum, Covered California Assistants and Navigators can use this already-collected information to educate and connect eligible applicants to EDD programs, such as Unemployment Insurance, State Disability Insurance, and Paid Family Leave.

While this report does not recommend specific eligibility reforms, existing rules place limits on pre-populating applications for some programs. Nevertheless, California will undertake data matching with federal systems like the IRS to determine eligibility for subsidized health insurance and Medi-Cal.⁹⁸ In addition, with the approval of necessary federal waivers, California will be able to

use CalFresh data to enroll individuals under 65 into the Medi-Cal program.⁹⁹

D. ENROLL: Move toward Auto-Enrollment in Key Public Benefit Programs

The most comprehensive way to increase participation rates in healthcare and public benefit programs is to auto-enroll applicants in all programs for which they qualify. Auto-enrollment addresses most take up barriers and maximizes program participation for eligible individuals and families. Although auto-enrollment will not be feasible for all programs immediately, California should simplify as many application processes as possible. At the very least, California should ensure that Accenture incorporates into CalHEERS the technological flexibility to allow for auto-enrollment of key safety net programs such as CalFresh and CalWORKs as soon as possible.

In guidance released May 17, 2013, the federal Department of Health & Human Services Centers for Medicare & Medicaid Services (CMS) encouraged states to adopt auto-enrollment strategies to increase participation in Medicaid.¹⁰⁰ Specifically, states should consider enrolling individuals into Medicaid based on SNAP eligibility to ease the administrative burdens of conducting multiple, independent eligibility determinations. Studies conducted by the Urban Institute and the Center on Budget and Policy Priorities reveal that, despite differences in eligibility business rules, 90 to 97 percent of SNAP recipients will qualify for ACA-expanded Medicaid programs.¹⁰¹ Such federally-funded auto-enrollment strategies will provide a much-needed interim safeguard to ensure no applicants fall through the gaps between Covered California and social services offices.

California's Assembly Bill 191 (2013) would help to operationalize the CMS guidance by improving the alignment between CalFresh and Medi-Cal. The bill would make households with a Medi-Cal recipient categorically eligible for CalFresh, thus bringing food assistance and millions of dollars in federal aid to more than 200,000 medically-needy Californians.¹⁰² **Passage of AB 191 would be a critical step in the direction of complete auto-enrollment between public benefits programs and healthcare programs.**¹⁰³

E. YEAR 2015: Integrate while the Federal Government Pays for It

Auto-enrollment will entail upfront implementation costs. Coordinating technology and personnel to integrate Marketplaces with safety net and work support programs will be challenging. Nevertheless, we urge the Governor, Legislature, Covered California, and other stakeholders to integrate public benefit programs with healthcare programs as broadly, deeply, and quickly as possible.

In particular, California should capitalize on the ACA's financial incentive for horizontal integration. **The federal government will pay for 90 percent of state investments in horizontal integration infrastructure, but only through 2015.** Thereafter, the federal government will pay for 75 percent of the on-going costs of integration maintenance and operations.

Conclusion

With implementation of the federal Affordable Care Act, California has a once-in-a-generation opportunity to increase access both to health coverage and to critical safety net and work support programs. At the most basic level, the state can educate and assist consumers who apply for health benefits through Covered California. Such information and help should flow bi-directionally between Covered California and key public benefit programs. At the same time, California should integrate the new healthcare infrastructure more directly with safety net and work support programs by streamlining the application process and auto-enrolling eligible participants.

Time is of the essence. California must act quickly to take full advantage of federal funding for horizontal integration infrastructure through 2015. Increasing participation in ACA, safety net and work support programs will improve health, reduce hardship, and grow the economy for all Californians.

Glossary

ACA: The federal Patient Protection and Affordable Care Act, which is designed to expand healthcare coverage to tens of millions of Americans and reduce healthcare costs through state-implemented mandates, tax credits and subsidies to individuals and small businesses.

MyBenefits CalWIN: CalWIN's online portal for individuals to determine eligibility and apply for Medi-Cal, CalWORKs, and CalFresh.

C4yourself: C-IV's online application system for individuals to apply and monitor their benefits for Medi-Cal, CalWORKs, and CalFresh.

C-IV: The largest of California's three automated welfare systems (SAWS) consortia, which was designed to manage the data in 35 counties for CalWORKs, CalFresh, Medi-Cal and other public benefit programs.

CalFresh: California's version of the federally funded Supplemental Nutrition Assistance Program (formerly known as Food Stamps) providing low-income recipients with electronic cash benefits to purchase food.

CalHEERS: The California Healthcare Eligibility, Enrollment and Retention System, Covered California's new eligibility and enrollment system designed to simplify and streamline access to health coverage for individuals and small businesses beginning January 1, 2014.

CalWIN: One of California's three SAWS consortia that administers safety net programs in 18 counties, including eligibility and benefits determination, client correspondence, management reports, and interfaces and case management for safety programs, including CalWORKs, CalFresh, Medi-Cal, and other public benefit programs.

CalWORKs: California's version of TANF (formerly known as AFDC), which provides cash aid and services to needy families with dependent children.

CHIP: The joint state-federal Children's Health Insurance Program, which provides health insurance

coverage to children in families with incomes above Medi-Cal eligibility but insufficient to purchase private coverage.

Covered California: California's ACA Marketplace, which is scheduled to begin offering individuals and businesses affordable health insurance coverage in January 2014.

EDD: California's Employment Development Department, the state agency that administers Unemployment Insurance, State Disability Insurance, and Paid Family Leave.

EITC: The federal Earned Income Tax Credit, which is a refundable tax credit for low- and moderate-income working people, primarily for those who have qualifying children.

ELE: Express Lane Eligibility, which was authorized by the Children's Health Insurance Program Reauthorization Act of 2009 and incentivizes states to use information from existing government databases and other safety net programs to simplify eligibility determinations for Medicaid and CHIP.

FPL: The Federal Poverty Line generally refers to poverty thresholds issued by the U.S. Census Bureau to estimate the number of people living in poverty each year. The Department of Health and Human Services issues poverty guidelines, which are used to determine eligibility for a variety of public benefit programs.

Healthy Families: California's version of CHIP, which provides low cost health, dental, and vision coverage to children who do not have insurance and do not qualify for free Medi-Cal.

LEADER: One of California's three SAWS consortia, the Los Angeles Eligibility, Automated Determination, Evaluation and Reporting System manages data for social service programs in Los Angeles County, including CalWORKs, CalFresh, Medi-Cal, and other public benefit programs.

LRS: The LEADER Replacement System, which is designed to update the LEADER system and

integrate more public benefits programs.

Marketplaces: Venues where states will offer ACA-related health coverage. Marketplaces have also been called health benefits exchanges and health insurance exchanges.

Medi-Cal: California's version of Medicaid, which offers free and low-cost health care and services to qualifying low-income residents.

PFL: California's Paid Family Leave, which is administered by the Employment Development Department and provides partial wage replacement to eligible workers on leave for caregiving and bonding.

Public benefit programs: Programs administered by the federal, state or local government, which provide a safety net or work support to eligible individuals and families.

Safety net programs: Means-tested public benefit programs such as CalFresh, CalWORKs and Medi-Cal, which provide basic assistance to prevent hardship for individuals and families.

SAWS: The Statewide Automated Welfare System, made up of three consortia (CalWIN, C-IV, LEADER) that support county-level eligibility and benefit determination, enrollment, and case management for some of the state's public benefit programs.

SDI: California's State Disability Insurance, which is administered by the Employment Development Department and provides partial wage replacement to eligible workers who are unable to work due to temporary disability.

SNAP: The Supplemental Nutrition Assistance Program (formerly known as Food Stamps), which offers federal nutrition assistance to eligible, low income individuals and families.

TANF: Temporary Assistance for Needy Families, the joint state-federal program which provides cash assistance and services to indigent families with dependent children.

UI: Unemployment Insurance, a state-federal program administered by the Employment Development Department that provides partial wage replacement to unemployed workers.

WIC: The Special Supplemental Nutrition Program for Women, Infants, and Children, a joint state-federal

program which provides for the health and nutrition of low-income pregnant women, breastfeeding women, and infants and children under the age of five.

Work support programs: Social insurance and tax credit programs such as Unemployment Insurance, State Disability Insurance, Paid Family Leave, and the Earned Income Tax Credits.

Your Benefits Now: The LEADER-run online portal for Los Angeles County residents to apply and check their benefits for CalWORKs, CalFresh, and Medi-Cal.

Notes

- 1** Policymakers have used a variety of terms to describe the state agencies charged with offering comprehensive, integrated and streamlined healthcare options under the ACA, including health benefit exchanges and health insurance exchanges. Covered California has chosen to use the term Marketplace, which we will use here. Residents of states which opted not to create their own Marketplaces will access healthcare benefits through a federal exchange.
- 2** This report does not discuss the Small Business Health Option Program (SHOP) Marketplace, simplification possibilities for public benefit program eligibility and enrollment requirements, or other physical sites of horizontal integration. For information on a proposal to integrate public benefit programs at other sites, such as the Department of Motor Vehicles, see Ken Jacobs, "Remaining Uninsured in California under the Affordable Care Act: Regional and County Estimates" (UC Berkeley Labor Center, 2012), available at http://laborcenter.berkeley.edu/healthcare/aca_fs_uninsured.pdf.
- 3** Please see the glossary for definitions of safety net and work support programs. Though there is overlap between the purposes of these programs – for example, some safety net programs include work support and incentives – we use these general terms to categorize programs based on their primary role in social welfare policy.
- 4** Other public benefit programs with varying degrees of connection to CalWORKs, Medi-Cal and CalFresh include, but are not limited to: Adoption Assistance Program (AAP), Cash Assistance Program for Immigrants (CAPI), Child Care Programs, Emergency Assistance (EA), Employment Services (WtW, FSET), Foster Care, In Home Support Services (IHSS), Kinship Guardianship Assistance Program (KinGAP), Refugee Assistance Program, and federally funded nutrition programs such as National School Lunch Program and Women, Infants and Children (WIC).
- 5** California Department of Social Services, "General Assistance or General Relief," available at <http://www.dss.cahwnet.gov/cdssweb/PG132.htm> (last accessed April 27, 2013).
- 6** Internal Revenue Service, "EITC Home Page," available at <http://www.irs.gov/Individuals/EITC-Home-Page--It%E2%80%99s-easier-than-ever-to-find-out-if-you-qualify-for-EITC> (last accessed April 27, 2013); Internal Revenue Service, "Child and Dependent Care Information," available at <http://www.irs.gov/Individuals/Child-and-Dependent-Care-Information> (last accessed May 31, 2013). The Child Tax Credit is a more general subsidy to families with children, unrelated to employment status. Internal Revenue Service, "Child Tax Credit," available at <http://www.irs.gov/Individuals/Child-Tax-Credit> (last accessed May 31, 2013). The federal government also manages the means-tested Supplemental Security Income program and the insurance-based Social Security program, which provide vital income support and wage replacement for the blind, disabled, and elderly.
- 7** Laurel Lucia and others, "Medi-Cal Expansion under the Affordable Care Act: Significant Increase in Coverage with Minimal Cost to the State" (UCLA Center for Health Policy Research & UC Berkeley Labor Center, 2013), p. 6. California's Medicaid take up rate ranks fifteenth in the country. Jim Jones, Jennifer Jordan and Lisa Chan-Sawin, "Apply & Connect: Opportunities and Challenges for Horizontal Integration of Health and Human Service Programs with the Implementation of California's Health Benefit Exchange and the Affordable Care Act" (Philadelphia: Sellers Dorsey, 2012), p. 22.
- 8** Karen Cunyngnam, Laura Castner & Amang Sukasih, "Empirical Bayes Shrinkage Estimates of State Supplemental Nutrition Assistance Program Participation Rates in 2008-2010 for All Eligible People and the Working Poor" (Mathematica Policy Research, 2013), p. 29.
- 9** *Id.*
- 10** We were unable to obtain data on CalWORKs take up rates, but enrollment recently dropped by 4.2 percent following program cuts. Scott Graves, "Deep Cuts Contribute to Steep Drop in CalWORKs Enrollment" (California Budget Project, 2012), p. 1.
- 11** Sarah Fass, "Paid Leave in the States: A Critical Support for Low-Wage Workers and their Families" (National Center for Children in Poverty, 2009), available at http://www.nccp.org/publications/pub_864.html; Rona Sheriff, "Balancing Work and Family" (California Senate Office of Research, 2007), p. 5.
- 12** As described in this report, increased uptake of public benefit programs will help Californians in numerous ways. However, critics of healthcare, safety net and work support programs have historically opposed social welfare spending on moral and economic grounds. This larger debate is beyond the scope of this report.
- 13** The White House, "Affordable Care Act: The New Health Care Law at Two Years" available at <http://www.whitehouse.gov/sites/default/files/uploads/careact.pdf>.
- 14** United States Department of Agriculture, "Building a Healthy America: A Profile of the Supplemental Nutrition Assistance Program" (Food and Nutrition Service Office of Research and Analysis, 2012); Hilary W. Hoynes, Douglas L. Miller and David Simon, "Income, the Earned Income Tax Credit, and Infant Health" (University of California Davis Center for Poverty Research, 2011); Douglas Almond, Hilary W. Hoynes and Diane Whitmore Schanzenbach, "Inside the War on Poverty: The Impact of Food Stamps on Birth Outcomes" (Review of Economics and Statistics, 2011); James S. House and others, "The Health Effects of Social and Economic Policy: The Promise and Challenge for Research and Policy" (Ann Arbor: National Poverty Center, 2009); Robert F. Schoeni and others, "Social and Economic Policies as Health Policy" (Ann Arbor: National Poverty Center, 2009); Janet Currie and Enrico Moretti, "Did the Introduction of Food Stamps Affect Birth Outcomes in California?" (Ann Arbor: National Poverty Center, 2006).
- 15** Currie and Moretti, "Did the Introduction of Food Stamps Affect Birth Outcomes in California?"
- 16** Kristin Anderson Moore and others, "Children in Poverty: Trends, Consequences, and Policy Options" (Washington D.C.: Child Trends, 2009), available at http://www.childtrends.org/files/child_trends-2009_04_07_rb_children-inpoverty.pdf.
- 17** Gordon B. Dahl and Lance Lochner, "The Impact of Family Income on Child Achievement: Evidence from the Income Tax Credit," *American Economic Review* 102 (5) (2012): 1927-1956, available at <http://dss.ucsd.edu/~gdahl/papers/children-and-EITC.pdf>.
- 18** Chuck Marr, Jimmy Charite and Chye-Ching Huang, "Earned Income Tax Promotes Work, Encourages Children's Success in School, Research Finds" (Washington D.C.: Center on Budget and Policy Priorities, 2013), p. 1.
- 19** Sharon Parrott, "Ryan Budget Would Undermine Safety Net's Work Supports" (Washington D.C.: Center on Budget and Policy Priorities 2013), pp. 2-3.

- 20** Kathleen Short, “Supplemental Poverty Measure, 2011” (United States Census Bureau, 2012), available at https://www.census.gov/hhes/povmeas/methodology/supplemental/research/Short_ResearchSPM2011.pdf.
- 21** TANF reduced child poverty from 18.7 percent to 18 percent, Unemployment Insurance reduced child poverty from 19.7 percent to 18 percent, and refundable tax credits reduced child poverty from 24.3 percent to 18 percent. Kathleen Short, “Supplemental Poverty Measure, 2011.”
- 22** Liz Voyles, “Income and Wealth in America Across Generations” (Washington D.C.: Economic Mobility Project, 2013), available at <http://www.pewstates.org/research/data-visualizations/income-and-wealth-in-america-across-generations-85899453568> (estimating increased risk of poverty for 2.3 million low-income workers due to new employer penalties that will likely result in reduced work hours for this group).
- 23** Marr, Charite, and Huang, “Earned Income Tax Credit Promotes Work, Encourages Children’s Success at School, Research Finds” (Washington D.C.: Center for Budget and Policy Priorities, 2013).
- 24** *Id.*
- 25** Tia Shimada, “Lost Dollars, Empty Plates: The Impact of CalFresh Participation on State and Local Economies” (California Food Advocates, 2012).
- 26** Nanette Miranda, “California food stamps: 3.5M eligible don’t enroll; \$5B federal funds unclaimed,” ABC News, February 21, 2013, available at <http://abclocal.go.com/kabc/story?section=news/state&id=9001890>.
- 27** *Id.*
- 28** Shimada, “Lost Dollars, Empty Plates.” p. 3.
- 29** Perri Smith and Christopher Wimer, “The SNAP Program in California: A C-WELL Research Update” (California Welfare Laboratory, 2012), pp. 2-3; United States Department of Agriculture, “Building a Healthy America: A Profile of the Supplemental Nutrition Assistance Program” (2012).
- 30** Anne B. Shlay and others, “Barriers to subsidies: why low-income families do not use child care subsidies” (Social Science Research, 2004).
- 31** Eileen Appelbaum and Ruth Milkman, “Paid Family Leave in California: New Research Findings” (The State of California Labor, 2004); Robert F. Schoeni and others, “Social and Economic Policies as Health Policy.”
- 32** Janet Currie, “The Take up of Social Benefits” (IZA Discussion Paper Series, 2004), p. 20.
- 33** For an example, see United States Department of Agriculture, “Building a Healthy America.”
- 34** For an example, see Currie, “The Take up of Social Benefits” (explaining the difficulty in assessing stigma in relation to other barriers to SNAP take up).
- 35** United States Department of Agriculture, “Building a Healthy America.” p. 16.
- 36** Pamela J. Loprest, “How Has the TANF Caseload Changed over Time?” (Temporary Assistance for Needy Families – Research Synthesis Brief Series, 2012), p. 5.
- 37** Currie, “The Take up of Social Benefits.” Low-income families also often fail to receive childcare subsidies for which they are eligible. Shlay and others, “Barriers to subsidies;” Gina Adams, Kathleen Snyder and Jodi R. Sandfort, “Navigating the Child Care Subsidy System: Policies and Practices that Affect Access and Retention” (Washington D.C.: The Urban Institute, 2002).
- 38** Currie, “The Take up of Social Benefits.” p. 24.
- 39** Michael Lipsky, *Street Level Bureaucracy: Dilemmas of the Individual in Public Services* (New York: The Russell Sage Foundation, 2010).
- 40** Pursuant to Assembly Bill 6 (2011) California eliminated the finger-imaging requirement for CalFresh eligibility, established less frequent reporting requirements for CalFresh and CalWORKs recipients, and created a “Heat and Eat” initiative linking eligibility for CalFresh and the Low-Income Home Energy Assistance Program.
- 41** Pursuant to Assembly Bill 1494 (2012), all participants in California’s version of CHIP, Healthy Families, are being transitioned to Medi-Cal over the course of one year beginning January 1, 2013.
- 42** Laurel Lucia and others, “Medi-Cal Expansion under the Affordable Care Act.”
- 43** The Assisters will be compensated for each non-Medicaid enrollee they navigate through the Marketplace to purchase a qualified health plan and have the ability to facilitate the kind of vertical integration anticipated under the ACA. States will decide how to provide grants to eligible Navigators. California, under Proposition 26 (2010), must spend “fees” to provide a directly proportional benefit to the paying entity. Thus, funds from Covered California may not be used to compensate Medi-Cal enrollees. See Richard Heath and Associates, Inc., “Phase I and II Statewide Assisters Program Design Options, Recommendations and Final Work Plan for the California Health Benefits Marketplace” (2012), available at http://www.healthexchange.ca.gov/Stakeholders/Documents/CHBE_DHCS_MRMIB_StatewideAssistersProgramDesignOptionsRecommendationsandWorkPlan_6-26-12.pdf.
- 44** “Health Care Reform Stakeholder Group: Meeting Notes, February 1, 2013,” available at <http://www.dhcs.ca.gov/Documents/2-1-13HealthCare-ReformStakeholderGroupSummaryFINAL.pdf>.
- 45** *Id.*
- 46** Laurel Lucia and others, “After Millions of Californians Gain Health Coverage under the Affordable Care Act, Who Will Remain Uninsured?” (UCLA Center for Health Policy Research & UC Berkeley Labor Center, 2012).
- 47** National Health Law Program, “Health Reform in CA: Lessons Learned from a Leader State,” Health Advocate Volume 14 (June 2013).
- 48** Department of Health and Human Services, “Patient Protection and Affordable Care Act Section 1561 Recommendations,” available at <http://www.healthit.gov/sites/default/files/rules-regulation/aca-1561-recommendations-final2.pdf>.
- 49** Administration for Children and Families, “Your Essential Interoperability Toolkit” (2012) p. 29, available at http://www.acf.hhs.gov/sites/default/files/assets/acf_toolkit_july_2012_final.pdf
- 50** “Patient Protection and Affordable Care Act Section 1561 Recommendations: Appendix A, D” §1561(b)(5) states that Marketplaces must have the “ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply streamlined verification and eligibility processes to other Federal and State programs, as appropriate.” The provision alone fails to define interoperability but the HITECH committee has provided some clarification through its recommendations. Other recommendations emphasized the importance of “support[ing] integration across systems and across programs to support a seamless user experience by addressing program hierarchy and providing capacity for addition of other programs.”
- 51** Federal databases include those maintained by the Internal Revenue Service, the Social Security Administration, and the Department of Homeland Security. Patient Protection and Affordable Care Act §1411, Center for Medicare and Medicaid Services, “Medicaid Programs: Eligibility Changes under the Affordable Care Act of 2010,” Federal Register Volume 76, Number 159 (Aug. 17, 2011), pp. 51148-99, available at <http://www.regulations.gov#!documentDetail;D=CMS-2011-0139-0002>.
- 52** While Accenture has been awarded the contract to develop the technology underlying Covered California, the exact plans for the system as well as the timeline on which it will release certain aspects of the system remain unknown. After speaking with some advocates, it has become clear that certain portions of the system that were initially anticipated to be ready by October 2014 will not be functional until much later.

53 “BSD2-CalHEERS-SAWS-MEDS Interface: Business Services Definitions,” available at <http://www.healthexchange.ca.gov/Stakeholders/Documents/BSD%20%20-%20CalHEERS%20SAWS%20MEDS%20Interface%20-%20Business%20Services%20Definition.pdf> (last accessed Jan. 04, 2013).

54 *Id.*

55 “What’s Changing and When,” available at <http://www.healthcare.gov/law/timeline/> (last accessed April 16, 2013).

56 Letter from Administration for Children and Families, Centers for Medicare & Medicaid Services, and US Department of Agriculture’s Food and Nutrition Service, August 10, 2011 (making the integration exception to the cost allocation requirements established by Section C.3 of the OMB Circular A-87).

57 42 C.F.R. §433.112 (2011). Advocates in California and elsewhere are seeking to extend the deadline for federal funding.

58 Exec. Order No. 13563, 76 Fed. Reg. 14 (January 18, 2011).

59 Administration for Children and Families, “Your Essential Interoperability Toolkit” (2012).

60 The Ford Foundation developed the Work Initiatives Program, in cooperation with the Urban Institute and Center for Budget and Policy Priorities, to design, and test public benefit systems. It has provided over \$21 million for testing purposes over a five-year period to Colorado, Idaho, Illinois, North Carolina, Rhode Island, and South Carolina. Results of these tests from the first year of implementation were released in April 2013 and can be found at <http://www.urban.org/publications/412789.html>. More information about the program is available at <http://www.fordfoundation.org/issues/economic-fairness/ensuring-good-jobs-and-access-to-services>. The Annie E. Casey Foundation is developing model integrated one-stop enrollment centers across the nation. The project is currently in 24 cities across the nation and began in 2005. More information available at <http://www.aecf.org/MajorInitiatives/CenterforFamilyEconomicSuccess.aspx>.

61 After applications are processed, state regulations require the agency to approve benefits as soon as possible but no later than 30 days after the application date. Department of Social Services, Manual-FS §63-301 (1990). In practice, however, advocates report that applicants can experience much longer delays, raising questions about the effectiveness of the existing integration of the SAWS 1 form and online portals.

62 Legislative Analyst Office, Consolidating California’s Statewide Automated Welfare System (Feb. 13, 2012). More information available at <http://www.lao.ca.gov/reports/2012/ssrv/saws/saws-021312.pdf>.

63 Letter from Kelly Brooks, Legis. Rep., Cal. State Ass’n of Counties, and Frank J. Mecca, Exec. Dir., Cnty. Welfare Dirs. Ass’n of Cal., to S. Budget Subcomm. No. 3 (May 19, 2011), available at <http://www.cwda.org/uploads/Budget%20Memo%20-%20LRS%20Suspension%20-%20Senate.pdf>. The state and federal government are in on-going discussions about the wisdom and benefits of California’s multiple public benefit data systems. The federal government is seeking to force California to consolidate existing systems into a single system no later than 2020. See Letter from Cindy Mann, Dir., Ctr. for Medicaid and CHIP Servs., to Will Lightbourne, Dir., U.S. Dep’t of Soc. Servs. (Apr. 5, 2012); Letter from Will Lightbourne, Dir., U.S. Dep’t of Soc. Servs. and Toby Douglas, Dir. Dept of Health Care Servs. to Cindy Mann, Dir., Ctr. for Medicaid and CHIP Servs. (Apr. 16, 2012); Allen Ng, Reg. Admin., U.S. Dep’t of Agric. to Melody Hayes, Dir., Cal. Health and Human Servs. Agency (Jan. 22, 2013).

64 Jerry Brown, “SB 970 Veto Message” (Sept. 30 2012).

65 Senator Kevin De León authored and the Western Center on Law and Poverty sponsored SB 970, “Streamlining Enrollment into Health and Human Services Programs.” 54 organizations supported the bill.

66 Jerry Brown, “SB 970 Veto Message.”

67 The full text of the SEC. 13, Section 14005.66 reads, “The department shall seek any federal waivers necessary to use the eligibility information of individuals who have been determined eligible for the CalFresh program under Chapter 10 (commencing with section 18900) of Part 6, and who are under 65 years of age and are not disabled, to determine their Medi-Cal eligibility.” Full bill text is available at http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320141SB1&search_keywords.

68 The position description emphasizes that the duties will primarily be “implementing the horizontal integration of social services programs with health care programs in California.” California Department of Social Services, “Assistant Director for Horizontal Integration,” available at http://jobs.spb.ca.gov/bull2/exemptpdfs/10222012_1.pdf (last accessed April 29, 2013).

69 Colorado Department of Human Services, “Colorado PEAK,” available at <http://peak.state.co.us/selfservice/selfserviceLogout?LANGUAGE=EN> (last accessed Jan. 27, 2013). Colorado integrates the enrollment of the following programs: Aid to the Needy Disabled, Adult Protective Services, Child Health Plan Plus, Colorado Indigent Care Program, Colorado Works, Food Assistance, Medicaid, and Old Age Pension.

70 Dorothy Rosenbaum and Stacy Dean, “Improving the Delivery of Key Work Supports: Policy and Practice Opportunities at a Critical Moment” (Washington, D.C.: Center on Budget and Policy Priorities, 2011).

71 Food Research and Action Center, “SNAP Cuts = Cuts in Meals for Americans Struggling to Heat and Eat” (2013), available at http://frac.org/pdf/snap_cuts_and_heat_and_eat.pdf. See also Stan Dorn and Elizabeth Lower-Basch, “Moving to 21st Century Public Benefit: Emerging Options, Great Promise, and Key Challenges” (Coalition for Access and Opportunity, 2012), p. 29.

72 Stan Dorn, “Automatic Enrollment Strategies” (The Urban Institute, 2007).

73 If states choose to continue or adopt ELE, Medicaid eligibility would not be determined according to the Modified Adjusted Gross Income or “MAGI” criteria but would use existing criteria. The Patient Protection and Affordable Care Act, Public Law 111-148, U.S. Statutes at Large: (2010) 186, available at <http://housedocs.house.gov/energycommerce/ppacacon.pdf>.

74 42 U.S.C. §1396a(e)(13) (2010). Alabama, Georgia, Iowa, Louisiana, Massachusetts, Maryland, New Jersey, New York, South Carolina, and Oregon all have some form of ELE process.

75 Maureen Hensley-Quinn, “State Experiences with Express Lane Eligibility: Policy Considerations and Possibilities for the Future” (State Health Reform Assistance Network, 2012).

76 The Kaiser Commission on Medicaid and the Uninsured. “Louisiana’s Express Lane Eligibility” (Optimizing Medicaid Enrollment: Spotlight on Technology, 2010).

77 Letter from Katherine Iritani, United States Government Accountability Office, to the Honorable Max Baucus, Chairman of the Committee on Finance, December 5, 2012.

78 Hensley-Quinn. “State Experiences with Express Lane Eligibility.”

79 To date, only Massachusetts and Alabama have applied for Section 1115 waivers to expand ELE to adult populations.

80 Executive Office of Labor and Workforce Development, “Medical Security Program (MSP),” available at <http://www.mass.gov/lwd/unemployment-insur/programs-and-services-for-claimants/medical-security-program-msp/> (last accessed Aug. 27, 2013).

- 81** Pennsylvania Department of Public Welfare. "Commonwealth of Pennsylvania Access to Social Services (COMPASS)," available at <https://www.humanservices.state.pa.us/Compass.Web/CMHOM.aspx> (last accessed April 17, 2013). COMPASS integrates the applications of the following programs: Medicaid, Medicare, CHIP, case assistance (TANF, diversion program, state blind program, refugee cash assistance program), LIHEAP, SNAP, home and community-based services, long term care, and school meals.
- 82** Benefits Data Trust, "BenePhilly Final Report" (Philadelphia: The Center for Hunger Free Communities, 2012).
- 83** *Id.*
- 84** Food and Nutrition Service, "Food Stamp Program: State Options Report 6th ed." (United States Department of Agriculture, 2006), available at http://www.fns.usda.gov/snap/rules/Memo/Support/State_Options/6-State_Options.pdf.
- 85** These states include those listed as well as Utah and most of the participating states in the Ford Foundation Work Supports Initiative Program.
- 86** Colorado intends to integrate with its existing public benefit system known as PEAK. In its blueprint, the Board mentions five levels of possible integration. Colorado will phase integration by December 2015, though by June 2013 Colorado plans to have interoperable Marketplaces. See "Colorado Health Insurance Exchange: Eligibility, Verification and Enrollment" (2011), available at <http://www.getcoveredco.org/COHBE/media/COHBE/PDFs/Board/COHIX-Board-EVE-Presentation-post.pdf>.
- 87** Maryland will also phase in levels of horizontal integration. At Phase 2 of Marketplace implementation, it will offer integration with TANF and SNAP. At Phase 3, Marketplaces will function as single points of entry for applicants with a goal of full integration with other state IT systems. Maryland did not provide specific dates. See Maryland State Archives. Maryland Health Benefit Exchange. Nov. 16, 2012. <http://msa.maryland.gov/msa/mdmanual/25ind/html/42healben.html>.
- 88** Wisconsin currently operates a one-stop shop with its existing ACCESS system. Wisconsin plans to implement a single, intuitive Marketplace portal through which users can access health care and other state programs. National Association of State Chief Information Officers, "On the Fence: IT Implications of the Health Benefits Exchanges." (Lexington, 2011).
- 89** The District of Columbia will phase in integration, but because it does not currently have an existing online benefits system, it will plan an entirely new system, DCAS, which will allow for functional integration of SNAP and TANF by October 2014. By 2015, D.C. will integrate other public programs like teen protective services and homeless services. District of Columbia. 2012. "IT Sub-Committee Meeting," available at <http://healthreform.dc.gov/DC/Health+Reform/About+Health+Reform/Implementation/HRIC+Subcommittees/IT+Subcommittee/IT+Sub-Committee+Meeting+Presentation++March+8,+2012> (last accessed April 16, 2013).
- 90** "CalFresh Outreach," available at <http://www.cdph.ca.gov/programs/cpns/pages/foodstampoutreach.aspx> (last accessed May 29, 2013). With support from the USDA, the Network is also providing nutrition education to low-income Californians. "About the Network for a Healthy California," available at <http://www.cdph.ca.gov/programs/cpns/Pages/AboutUs.aspx> (last accessed May 29, 2013).
- 91** "Partners educate the community, prescreen individuals and families for potential eligibility and assist candidates with the CalFresh application, and follow up with those eligible to retain their benefits. CalFresh partners developed the statewide, toll-free CalFresh Information Line (1-877-847-FOOD (3663)) and in Spanish (1-888-9-COMIDA (26-6432)). Callers are assisted in English or Spanish. In many cases, a live operator takes the call. Callers can receive information about CalFresh and how to apply in the county where they live." "CalFresh Outreach," available at <http://www.cdph.ca.gov/programs/cpns/pages/foodstampoutreach.aspx> (last accessed May 29, 2013).
- 92** Dorothy Rosenbaum and Stacy Dean, "Improving the Delivery of Key Work Supports: Policy & Practice Opportunities at a Critical Moment" (Washington D.C.: Center for Budget and Policy Priorities, 2011).
- 93** Center on Budget and Policy and Priorities. "Online Services for Key Low Income Benefit Programs: What States Provide Online with Respect to SNAP, TANF, Child Care Assistance, Medicaid, CHIP, and General Assistance," (2013).
- 94** "Covered California," available at <http://www.coveredca.com> (last accessed April 27, 2013).
- 95** CalHEERS on-line application will include the following question:
 "Would anyone in the household like a referral to the local Health and Human Services Agency for any of the following programs?
 –CalWORKS
 –CalFresh"
 California Department of Health Care Services & Covered California, "CalHEERS Project and Usability Update," April 8, 2013, p. 27. The SAWS portal will add relevant questions to link to Covered California for insurance-only applications. *Id.* at 28.
- 96** California Assembly Bill 174, Office of Systems Integration: California Health and Human Services Automation, available at http://leginfo.ca.gov/pub/11-12/bill/asm/ab_0151-0200/ab_174_bill_20120930_chaptered.pdf (last accessed May 29, 2013).
- 97** *Id.*
- 98** Patient Protection and Affordable Care Act Public Law 111-148, § 1413.
- 99** California Assembly Bill 191 (Bocanegra), Cal-Fresh: Categorical Eligibility, available at http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB191 (last accessed July 8, 2013).
- 100** Centers for Medicare & Medicaid Services, "Facilitating Medicaid and CHIP enrollment and Renewal in 2014," (May 17, 2013), available at <http://medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-13-003.pdf>.
- 101** Urban Institute, "Using SNAP Receipt to Establish, Verify and Renew Medicaid Eligibility" (May 2013), available at <http://www.urban.org/UploadedPDF/412808-Using-SNAP-Receipt-to-Establish-Verify-and-Renew-Medicaid-Eligibility.pdf>; Center on Budget & Policy Priorities, "A Technical Assessment of SNAP and Medicaid Financial Eligibility under the Affordable Care Act," (April 25, 2013), available at <http://www.cbpp.org/cms/index.cfm?fa=view&id=3939>.
- 102** California Assembly Bill 191.
- 103** The bill passed the full Assembly on May 29, 2013. On June 25, 2013, the Senate Human Services Committee passed AB 191, which is currently pending in the Senate Appropriations Committee.