



## California's Safety Net Law and Low Income Health Programs (Early Medicaid Expansion Waiver Program)

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### I. Introduction

For more than 100 years, California's counties have been charged with providing basic medical care to their low-income residents. Over time, Federal and state health programs, like Medicaid (called Medi-Cal in California), Medicare, and the Children's Health Insurance Program (called Healthy Families in California) have stepped in to provide care for many low-income and vulnerable people in our state. But one population has been left out of those programs—low income adults without disabilities and without minor children living at home. This group, often referred to as the “childless adults,” have continued to rely on county safety net programs to obtain basic health care services.

Then, in 2010, the Federal Department of Health & Human Services approved a Medicaid Waiver for California pursuant to § 1115 of the Social Security Act. That waiver allows California counties to receive federal reimbursement for health services they provide to certain low-income people, starting in 2011. The waiver services are provided through the Low Income Health Programs (LIHPs). The LIHPs have begun to serve many of the same “childless adults” who have historically been served by California's safety net health care providers under state law that requires counties to provide basic subsistence health services to indigent individuals.

This brief compares the obligations created by California's safety net statute and the LIHP waiver, including the remaining obligations of counties that implement a LIHP to comply with the state safety net law. It also describes some of the possible lessons that are being learned from the LIHPs to prepare for California's implementation of the Affordable Care Act in 2014.

## **II. California counties have a legal obligation to provide medical care to certain low-income residents.**

Counties' obligation to provide health care for low-income residents is set out in California Welfare and Institutions Code § 17000 (§ 17000).<sup>1</sup> The statute states:

Every *county* and every city and county *shall relieve and support all* incompetent, poor, *indigent persons*, and those incapacitated by age, disease, or accident, *lawfully resident therein, when such persons are not supported and relieved* by their relatives and friends, by their own means, or by state hospitals or other state or private institutions.<sup>2</sup>

Section 17000 ensures that low-income childless adults who are not eligible for Medi-Cal or other public programs have access to a minimum safety net to meet their health care needs.

### **A. Section 17000 imposes a mandatory duty upon counties.**

Over the years, the courts have interpreted various components of § 17000 to determine the extent of the obligation to indigent residents. Because the statute clearly addresses itself to counties using the word “shall,” their duty is mandatory, and they must offer basic medical services (as described below) to low-income residents.<sup>3</sup>

### **B. Financial eligibility for § 17000 programs**

The income eligibility rules for § 17000 programs are derived from the phrase “indigent persons” in the statute. There is no bright-line eligibility level for § 17000 programs across the state; rather, case law has interpreted “indigent persons” to mean those unable to afford the basic necessities of life in the county. Thus, this provision requires each county to determine the cost of “minimum subsistence” in that county, and set income eligibility limits for their county health programs accordingly. To determine the cost of minimum subsistence in a county, the county must account for the cost of “at the very least . . . housing, food, utilities, clothing, transportation and medical care.”<sup>4</sup> As described in greater detail below, a county must extend eligibility not only to those whom it determines will not be able to pay for “minimum subsistence” if required to pay health care costs, but also to those who can only afford to pay part of the cost of their care. In most counties, this requirement translates into a set income eligibility threshold under which program participants receive free care, and another, higher income threshold under which program participants must pay some part of the cost (“cost-sharing”) for services. In addition to these income limits, counties are permitted by statute to impose a limit on the amount of resources a person may retain to be eligible for their programs.<sup>5</sup>

### **C. Residency limits in § 17000 programs**

The statutory language limits eligibility for health care services under § 17000 to individuals who are residents in the county where they are applying for aid. Residence is defined in the law as “the place where one remains.”<sup>6</sup> In general, the residence provisions that apply to eligibility for health care services under § 17000 seem to require both physical location and intent to stay in a place.<sup>7</sup> These provisions are very similar to those that generally govern residency in California, which are encoded at Government Code § 244.

The statute limits the county’s obligation to support those who *lawfully* reside. The term “lawfully” has been interpreted to allow counties to limit services to individuals with a satisfactory immigration status.<sup>8</sup> Counties have the discretion to aid undocumented immigrants and/or non-residents but are not required to do so.<sup>9</sup> No case has precisely defined which immigration statuses should be considered “lawfully resident” and which do not, but one at least one court suggests that counties may follow CalWORKS welfare rules, which are generally more restrictive than Medi-Cal rules, which interpret satisfactory immigration status broadly.<sup>10</sup>

### **D. Programmatic limits in § 17000 programs**

Finally, the statute limits a county’s obligation to provide care to only those individuals who do not have another source of care for the services they request from a county. Practically speaking, this provision is usually used as a legal basis to require applicants for county programs to apply for Medi-Cal or other potential sources of health coverage, including other public programs (like the Preexisting Condition Insurance Plan, COBRA, or employer coverage) before the county will cover their health care costs. A county doesn’t have to provide health care to those persons who are enrolled in, or who are eligible for, Medi-Cal—even if Medi-Cal doesn’t cover all of the health services they need.<sup>11</sup> But a county does have to provide health care to those who have a Medi-Cal application pending; it may recoup the cost of those services provided from the state Medi-Cal program if the Medi-Cal application is ultimately approved. While a county most likely would not be required to provide health care services to individuals who are privately insured or whose family and friends are willing to pay the cost of care—those particular parts of the section 17000 law remain legally untested to date. However, a county may be obligated to cover medically necessary services that are not covered by a person’s private insurance.<sup>12</sup>

### **E. Other eligibility rules in § 17000 programs**

Generally, counties may not place any other limits on eligibility for § 17000 programs. The statute requires counties to serve “all” county residents who meet the program criteria and counties are not given discretion to condition eligibility on factors that are not found within the statute.<sup>13</sup> For example, a county cannot deny aid to someone because she does not have an address.<sup>14</sup> Nor may a county refuse aid to someone because she has been convicted of a drug-related felony.<sup>15</sup>

### **F. Scope of services in § 17000 programs**

The kind of care counties must provide to their low-income residents is derived from the statutory obligation to “relieve and support.” That phrase has not been interpreted to obligate counties to provide their low-income residents with a set benefits package; instead, the cases have required counties to provide “subsistence medical care.”<sup>16</sup> This standard requires counties to provide “at least...medical services necessary for the treatment of acute life-and-limb threatening conditions and emergency medical services.”<sup>17</sup> But the mandate does not merely require the provision of emergency services; rather, counties must provide “medically necessary care”<sup>18</sup> that is “sufficient to remedy substantial pain and infection.”<sup>19</sup> And in the case of emergency care, counties must pay for that care even if it is provided out-of-network or out-of-county.<sup>20</sup>

### **G. Cost-sharing in § 17000 programs**

The phrase “relieve and support” also defines how counties are to determine the amount of cost-sharing that those low-income residents may be required to pay for services rendered. The phrase means that the cost-sharing imposed on subsistence medical care must still allow people to meet their “actual subsistence needs.”<sup>21</sup> In other words, counties may not charge cost-sharing that is prohibitively expensive such that a low-income person is effectively left without access to subsistence medical care.<sup>22</sup> And counties must still provide assistance to those individuals who are able to pay a portion of the cost of their care, but cannot afford the full cost.<sup>23</sup>

### **H. Due Process in § 17000 Programs**

The mandatory language of the statute creates a property interest in the health care services required by § 17000; that property interest endows those entitled to services with constitutional due process rights.<sup>24</sup> The precise scope of the due process entitlement has not been fully fleshed out by case law. At a minimum, the basic protections of *Goldberg v. Kelly*, 397 U.S. 254 (1970) and *Matthews v. Eldridge*, 424 U.S. 319 (1976) apply in § 17000 programs.<sup>25</sup> Those cases generally require a pre-termination hearing before the government can cut off services or benefits in which a person has a property interest, rendered by an impartial decision-maker who gives the reasons for the decision, and in which the person may be represented by an attorney if he or she wishes.<sup>26</sup>

But counties have broad discretion with respect to the content of their notices, the timeframes within which residents may request review of adverse decisions, and the procedural rules for their hearings. County notice and appeal policies that appear extremely unfair are generally found to violate due process. For example, a Merced County policy that required those whose benefits were terminated to request a hearing within two days of receiving a notice was struck down as violating due process; though the court declined to specify what minimum timeframe would suffice.<sup>27</sup> But courts have been reluctant to require that § 17000 programs afford due process rights beyond the basic right to a pre-termination notice and hearing. For example, while a Santa Clara

County policy that did not provide any mechanism to confront or cross-examine adverse witnesses was also found to violate due process, the policy's lack of subpoenas, testimony under oath, or verbatim transcripts was upheld, as was the fact that a law student employed by County Counsel served as the hearing officer.<sup>28</sup>

**III. Through CA's 1115 Medicaid Waiver, California counties now have the ability to obtain federal funding to help pay for many medical services provided to low-income residents through the Low Income Health Program (LIHP).**

The ACA contains a provision that will expand Medicaid coverage to most adults with income under 133% of the Federal Poverty Line starting in 2014, and will provide subsidies for most adults with income under 400% of the Federal Poverty Line to purchase private health insurance coverage.<sup>29</sup> In 2014, the federal government will pay the full cost of providing Medicaid to “new enrollees”—mainly those childless adults who have historically been excluded from categorical Medicaid programs.<sup>30</sup> But states have had the option to begin expanding Medicaid to childless adults before 2014, albeit at a reduced reimbursement rate.<sup>31</sup>

The LIHPs are California's early Medicaid expansion (at county option) through the § 1115 waiver. The waiver built upon an earlier program, called the Coverage Initiative, that was available in ten counties from 2007 to 2011 pursuant to an earlier iteration of the § 1115 waiver. But while those programs were quite limited in scope, the passage of the Affordable Care Act (ACA) in the time since the earlier § 1115 waiver was approved paved the way to make the LIHPs more expansive.

***A. LIHPs are optional programs***

While § 17000 imposes a mandatory obligation on California counties, the LIHPs are an optional program. No county is required to participate in the LIHPs, but each county may choose to participate. In fact, counties must apply to and receive approval from the state and federal government to participate in the LIHPs; approval will only be granted if a county demonstrates that its proposed LIHP will comply with the terms and conditions of California's § 1115 waiver.<sup>32</sup> In addition, once a county's LIHP is approved, it will then be able to claim 50% reimbursement for certain health care expenditures made on behalf of low-income residents.<sup>33</sup>

***B. Financial eligibility for the LIHPs***

Because the LIHPs are optional programs, the counties have some discretion over whom they serve in the LIHPs. Most importantly, each county may establish its income eligibility limit for its LIHP anywhere between 1 and 200% FPL, as long as it serves lower income people before higher income people.<sup>34</sup> And if a county determines that its LIHP is nearing capacity, it may lower the income eligibility limit and even establish a waiting list for its program.<sup>35</sup> The reimbursement mechanisms, and some program requirements are different for enrollees whose income is 133% FPL or below, compared

to those whose income is between 134 and 200% FPL.<sup>36</sup> LIHPs may not establish an asset or resource test for their eligibility.<sup>37</sup>

### ***C. Residency limits in LIHPs***

LIHPs may only enroll county residents in their LIHPs (an LIHP that serves multiple counties may enroll residents in any of those counties), and counties have discretion to define residency for the purposes of their LIHPs.<sup>38</sup> This discretion has led some counties to adopt restrictive residency policies; for example, Santa Cruz County has defined county residency as presence in the county for at least six months.<sup>39</sup>

In addition, LIHPs will only be reimbursed for services provided to “citizens, nationals, or [individuals who] otherwise have satisfactory immigration status.”<sup>40</sup> By application of federal immigration law, this provision limits federal financial participation in the LIHPs to persons who have qualifying immigration status (such as a legal permanent resident) for a minimum of five years, although certain immigrants (including refugees and asylees) need not wait the five years.<sup>41</sup>

### ***D. Programmatic eligibility limits in the LIHPs***

LIHP eligibility is limited to persons who are ineligible for Medi-Cal and Healthy Families.<sup>42</sup> A person who has applied for Medi-Cal and is awaiting a Medi-Cal eligibility determination may be made eligible for a LIHP at the county’s option.<sup>43</sup> This provision may allow certain people with disabilities to be enrolled in the LIHPs while their Medi-Cal applications are pending, since disability-based eligibility determinations can take several months in California. Further, while the LIHPs may restrict eligibility for persons with income over 133% FPL who have another source of insurance (e.g., employer-sponsored insurance), those with income at or below 133% FPL must be allowed to enroll in the LIHP even if they have other coverage, although the LIHP will become a secondary payer.<sup>44</sup>

### ***E. Other eligibility rules in the LIHPs***

Like § 17000 programs, LIHPs must accept all persons who are eligible under the terms and conditions of the § 1115 waiver and may not target eligibility to certain groups. For example, a county may not limit eligibility to individuals who are homeless, or deny eligibility to those who receive General Assistance, since those eligibility criteria do not appear in the terms and conditions of the § 1115 waiver. By the terms of the waiver, however, LIHPs are only open to individuals who are between the ages of 19 and 64.<sup>45</sup>

### ***F. Scope of services in the LIHPs***

LIHPs must adhere to much more specific standards for the provision of benefits than § 17000 programs. The terms and conditions of the § 1115 waiver set forth a detailed list of the minimum benefits that must be provided to LIHP enrollees.<sup>46</sup> Counties may provide additional benefits beyond the minimum if those benefits are provided in

California's Medi-Cal program, and the federal government approves.<sup>47</sup> So far, several counties have opted to provide more generous benefits in the areas of dental care, optometry, and behavioral health care. The LIHPs are responsible for network adequacy and timely access standards. Specifically, the LIHPs must ensure that the number of providers in their networks are sufficient to meet patient needs by demonstrating that primary care providers are available within 60 minutes or 30 miles of enrollees' homes.<sup>48</sup> The LIHPs also must ensure that enrollees can access services within set timeframes—20 business days for primary care, 30 days for specialty care, 48 hours for urgent care (or 96 hours if prior approval is required), and immediately for emergency care.<sup>49</sup> Financial penalties may be assessed against LIHPs that fail to meet these requirements.<sup>50</sup>

### ***G. Cost-sharing in the LIHPs***

The terms and conditions of the § 1115 waiver also limit how much the LIHPs can charge enrollees in cost-sharing, which includes premiums and copayments. For enrollees with income below 133% FPL, the LIHPs may only charge “nominal copayments” as defined by Federal Medicaid law—usually a dollar or two per service.<sup>51</sup> LIHPs have discretion to charge premiums and copayments to enrollees with income between 134 and 200% FPL, but the sum of all cost sharing may not exceed 5% of the enrollees' household income.<sup>52</sup>

### ***H. Due Process in the LIHPs***

Because the LIHPs are not a mandatory, statewide program, due process rights only accrue once a county has opted to implement a LIHP. Once a county establishes an LIHP, it must ensure that the LIHP provides notice and appeal rights that at least meet minimum standards, based on the terms and conditions of the § 1115 waiver, and set out in more detail in additional guidance from the state.<sup>53</sup> In general, LIHP due process requirements follow federal Medicaid rules, and require enrollees to complete an internal county or plan complaint process before they may request a hearing from the state.<sup>54</sup>

## **IV. When a county implements a LIHP, it is subject to both § 17000 and the terms and conditions of the Medicaid Waiver.**

When a county chooses to implement a LIHP, its residual obligations under state law do not go away. While a LIHP may partly fulfill a county's obligations under § 17000, it likely will not fulfill them entirely. Further, a county that chooses not to implement a LIHP (as Fresno and San Luis Obispo counties have done) is clearly still fully subject to § 17000 obligations.

For example, some counties have implemented LIHPs only for persons whose incomes are extremely low. Those counties still have a residual obligation under § 17000, however, to provide services to county residents whose income is over the LIHP eligibility level, but who are unable to afford the basic necessities of life in the county.

Similarly, the residual § 17000 program must provide services to residents who are lawfully present, but who have not yet passed the five-year immigration waiting period required by the LIHPs. The county need not provide the LIHP scope of services to individuals served by a residual § 17000 program, however, as long as it provides “subsistence medical care.”<sup>55</sup>

#### **V. What we can learn from the LIHPs about counties’ continuing residual legal obligation when Medi-Cal Expansion and the Exchange are implemented in 2014.**

In 2014, California will undertake an enormous expansion of coverage for low-income people as it implements the Affordable Care Act. Most low-income people with income below 133% FPL will become eligible for Medi-Cal expansion, and many other low-income people will be able to buy subsidized insurance through the Health Benefits Exchange. Like the LIHPs, these new programs will significantly reduce the burden of § 17000 obligations placed on counties, but they will not repeal it. The counties will have a continuing obligation to provide needed health care services to low-income residents who cannot access care through these new programs.

One lesson the LIHPs have taught us is that the coverage expansion programs under federal health reform will not fulfill all existing needs. For example, many lawfully present recent immigrants are not eligible for the LIHPs. To ensure that all individuals who need health coverage are able to get it, advocates in counties that implement LIHPs have had to closely monitor their counties’ plans to ensure that lawfully present recent immigrants continue to have access to safety net health care services. Once the ACA is fully implemented, there will likely remain some county residents who are left out of the new coverage programs due to immigration status, temporary coverage gaps, or other factors. Advocates should work with their counties to make sure that those residents continue to have access to basic health care services.

Another lesson we’ve learned from the LIHPs is that new funding streams under the ACA can strengthen the safety net that has long served as the source of health care services for low-income people. Advocates should encourage the Exchange and Medi-Cal expansion program to invest in the safety net. Not only are many of those individuals newly eligible for these coverage sources already accustomed to receiving their care through safety net providers, but the investment will keep the safety net viable for others who will continue to need to access services through § 17000.

A final lesson learned from the LIHPs is that affordability is a key to coverage. LIHP enrollment has been successful in large part because the financial barriers to enrollment are so low—no program so far charges any premium, and the copayments are also very low or non-existent. The cost-sharing structure in most LIHPs is very similar to what we expect cost-sharing to look like in the Medi-Cal expansion program in 2014. Projections suggest that the cost of coverage in the Exchange, however, will be much higher—with premiums as high as \$67 per month for a single adult with income at 150% FPL.<sup>56</sup> If Exchange-subsidized insurance is not accessible to low-income Californians due to

cost, counties could be required to offer them services under § 17000.<sup>57</sup> Alternately, counties might consider subsidizing people's cost to obtain coverage in the Exchange, which might be more cost-effective than providing the services directly at full county cost.

## VI. Conclusion

California has a rich history of providing basic health care to its lowest-income residents through a county safety net system. In 2014, fewer Californians will rely on their counties to provide them with subsistence health care services as they become eligible instead for federally funded health programs—the Medi-Cal expansion program or subsidized insurance in the Exchange. Nevertheless, § 17000 will remain as an important backstop to ensure that the most vulnerable individuals who cannot obtain full coverage through health reform do not fall through the cracks and continue to get the care they need. In order to achieve that, new programs must invest in the safety net infrastructure on which low-income Californians have come to rely.

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<sup>1</sup> This provision is also interpreted to require counties to pay cash aid, which takes the form of General Assistance or General Relief, to very poor residents. *Mooney v. Pickett*, 4 Cal.3d 669, 671 (1971). The cash aid requirement has been significantly curtailed by statute. See *Welfare Rights v. Frank*, 25 Cal. App. 4th 415, 420-21 (1994).

<sup>2</sup> *Id.* (emphasis added) (describing the legislative history of these provisions).

<sup>3</sup> *County of San Diego v. State of California*, 15 Cal. 4th 68, 104-05 (1997).

<sup>4</sup> *Boehm v. Superior Court*, 178 Cal. App. 3d 494, 502 (1986).

<sup>5</sup> Welf. & Inst. Code § 17107.

<sup>6</sup> *Id.* § 17101.

<sup>7</sup> See *Nelson v. San Diego County Bd. Of Supervisors*, 190 Cal. App. 3d 25 (1987).

<sup>8</sup> *Khasminskaya v. Lum*, 47 Cal. App. 4th 537, 543 (1996).

<sup>9</sup> Welf. & Inst. Code § 17003.

<sup>10</sup> See *Khasminskaya*, 47 Cal. App. 4th at 543.

<sup>11</sup> Welf. & Inst. Code § 17030.

<sup>12</sup> Cf. *McCormick v. County of Alameda*, 193 Cal. App. 4th 201 (2011) (General Assistance, the cash aid counterpart to § 17000 health programs, must pay for services when CalWORKS provides no cash assistance).

<sup>13</sup> See *County of San Diego*, 15 Cal. 4th at 101 (“[C]ounties have no discretion to refuse to provide medical care to ‘indigent persons’ within the meaning of section 17000 who do not receive it from other sources.”).

<sup>14</sup> *Nelson v. San Diego County Bd. Of Supervisors*, 190 Cal. App. 3d 25 (1987).

<sup>15</sup> *Arenas v. San Diego County Bd. Of Supervisors*, 93 Cal. App. 4th 210 (2001).

<sup>16</sup> *Hunt v. Superior Court*, 21 Cal. 4th 984, 1012 (Cal. S. Ct. 1999).

<sup>17</sup> *Id.* at 1014.

<sup>18</sup> *County of Alameda v. State Bd. of Control*, 14 Cal. App. 4th 1096, 1108 (1993)

<sup>19</sup> *Cooke v. Superior Court*, 213 Cal. App. 3d 401, 404 (1989).

<sup>20</sup> *Fuchino v. Edwards-Buckley*, 196 Cal. App. 4th 1128 (2011).

<sup>21</sup> *Hunt*, 21 Cal. 4th at 1012.

<sup>22</sup> See *Id.* at 1014.

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- <sup>23</sup> *Alford v. County of San Diego*, 151 Cal. App. 4th 16, 33 (2007).
- <sup>24</sup> See *Griffeth v. Detrich*, 603 F. 2d 118, 122 (9th Cir. 1979). *But cf. Zobriscky v. Los Angeles County*, 28 Cal. App. 3d 930, 933 (Cal. Ct. App. 1972) (finding that applicants for § 17000 benefits are only entitled to judicial relief, not to administrative notices or hearings).
- <sup>25</sup> See *Griffeth*, 603 F. 2d.
- <sup>26</sup> See *Goldberg*, 397 U.S. at 270-71; *Mathews*, 424 U.S. at 333.
- <sup>27</sup> *Boehm v. County of Merced*, 163 Cal. App. 3d 447, 456 (1985); see also *Brown v. Crandall*, 198 Cal. App. 4th 1, 16 (2011) (suggesting that Humboldt County's refusal to determine an applicant's eligibility, to issue her any notice, to allow her to appeal, or to hold any hearing on the matter was improper).
- <sup>28</sup> *Jennings v. Jones*, 165 Cal. App. 3d 1083, 1089 (1985).
- <sup>29</sup> 42 U.S.C. § 1396a(10)(A)(i)(VIII); 26 U.S.C. § 36B.
- <sup>30</sup> 42 U.S.C. § 1396d(y).
- <sup>31</sup> *Id.* § 1396a(k)(2).
- <sup>32</sup> CENTER FOR MEDICARE & MEDICAID SERVICES, SPECIAL TERMS AND CONDITIONS, AMENDED APRIL 1, 2012, CALIFORNIA BRIDGE TO REFORM DEMONSTRATION ¶¶ 42-47 [hereinafter STC], available at [http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Publications/California%20STCs%20\(3-30-12\).pdf](http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Publications/California%20STCs%20(3-30-12).pdf); see also CAL. DEP'T OF HEALTH CARE SERV. LOW INCOME HEALTH PROGRAM BRANCH, REVISED PROGRAM REQUIREMENTS AND APPLICATION PROCESS LOW INCOME HEALTH PROGRAM (LIHP) (2011), available at <http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Applications/ProgramRequirementsandApplicationProcessREV01-25-11.pdf>.
- <sup>33</sup> *Id.* ¶ 45.
- <sup>34</sup> *Id.* ¶ 58.
- <sup>35</sup> *Id.* ¶ 58(b)(ii), (c).
- <sup>36</sup> *Id.* ¶ 58(a).
- <sup>37</sup> *Id.* ¶ 58.
- <sup>38</sup> *Id.* ¶ 48(a).
- <sup>39</sup> SANTA CRUZ COUNTY HEALTH SERV. AGENCY, MEDICRUZ ADVANTAGE POLICIES AND PROCEDURES MANUAL 7 (2011), available at <http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Deliv/SantaCruz/Deliv18.pdf>.
- <sup>40</sup> STC ¶ 48(a).
- <sup>41</sup> 8 U.S.C. § 1613.
- <sup>42</sup> STC ¶¶ 48, 58.
- <sup>43</sup> *Id.*
- <sup>44</sup> *Id.* ¶ 58.
- <sup>45</sup> *Id.* ¶ 58.
- <sup>46</sup> *Id.* ¶ 63.
- <sup>47</sup> *Id.*
- <sup>48</sup> *Id.* ¶ 72(a).
- <sup>49</sup> *Id.* ¶ 72.
- <sup>50</sup> *Id.* ¶ 72(g)-(h).
- <sup>51</sup> *Id.* ¶ 70(a); 42 U.S.C. § 1396o.
- <sup>52</sup> STC ¶ 70(b).
- <sup>53</sup> *Id.* ¶ 76; Cal. DEP'T OF HEALTH CARE SERV., CALIFORNIA BRIDGE TO REFORM DEMONSTRATION HEARINGS AND APPEALS PROCESS FOR LOW INCOME HEALTH PROGRAMS (LIHP) (2011), available at [http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Hearings-Appeals/Hearing-Appeals\\_Process\\_062911.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Hearings-Appeals/Hearing-Appeals_Process_062911.pdf).
- <sup>54</sup> See sources cited *supra* note 53.

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<sup>55</sup> *Hunt*, 21 Cal. 4th at 1012.

<sup>56</sup> UC BERKELEY CTR. FOR LABOR RESEARCH & EDUC. & UCLA CTR. FOR HEALTH POLICY RESEARCH, ESTIMATING THE CHANGE IN COVERAGE IN CALIFORNIA WITH A BASIC HEALTH PROGRAM 3 (2012), available at <http://www.healthexchange.ca.gov/StakeHolders/Documents/UCB-UCLA%20BHP%20Memo%20Final%2008-9-12.pdf>; see also MERCER, STATE OF CALIFORNIA FINANCIAL FEASIBILITY OF A BASIC HEALTH PROGRAM 14 (2011), available at <http://www.mercer-government.mercer.com/basic-health-program/feasibility> (estimating the premium for an individual with income at 150% FPL at \$61 per month).

<sup>57</sup> *Cf McCormick. v. County of Alameda*, 193 Cal. App. 4th 201 (2011) (General Assistance, the cash aid counterpart to § 17000 health programs, must pay for services when CalWORKS provides no cash assistance).