

Enrollment Policy Provisions in the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (Affordable Care Act) will result in an estimated 32 million uninsured Americans gaining comprehensive, affordable coverage through new state health insurance exchanges, Medicaid, and the Children's Health Insurance Program (CHIP). Coordinating enrollment between existing state Medicaid and CHIP programs and the yet-to-be created state exchanges will be an enormous challenge. Fortunately, the health reform law includes several provisions that are designed to guide states in coordinating the eligibility and enrollment processes for all three programs. This fact sheet provides an overview of these provisions.

The first section outlines provisions of the Affordable Care Act that apply to Medicaid, CHIP, and the exchanges and that help to coordinate enrollment among the three programs. The second section focuses on enrollment provisions that pertain only to Medicaid and CHIP, and the final section highlights the enrollment policy provisions that apply only to state exchanges.

Coordinating Enrollment:

Medicaid, CHIP, and the New Tax Credits for Coverage in the State Exchanges

No Wrong Door

- The Secretary of Health and Human Services (HHS) will establish a system that will allow individuals and families to apply for whichever forms of assistance they are eligible: premium tax credits (for coverage through state exchanges), Medicaid, or CHIP. Applicants will be screened for eligibility for all three programs and will be referred to the appropriate program for enrollment.
- The Secretary of HHS will provide states with a single, streamlined application form for all three programs. States may also use their own forms, subject to HHS approval.
- Individuals must be able to submit their application online, in person, by mail, or by phone. They will be able to file applications with either the agency that administers the state exchange, or with the state Medicaid or CHIP agency.

Data Sharing

- The law requires each state to establish a secure, electronic interface that will facilitate data exchanges that will allow for the determination of applicants' eligibility for the premium tax credits, Medicaid, or CHIP based on one application. This interface will also allow enrollees to renew their coverage online.
- The exchanges, Medicaid, and CHIP must participate in data matching, and, whenever possible, must use data that are available in existing federal databases to establish, verify, and update eligibility.
- Individuals may seek a determination of eligibility for Medicaid, CHIP, or the tax credits without completing application forms by authorizing the disclosure of personal information in existing government databases (for example, tax information in the IRS database).

The Role of State Agencies

- States must screen individuals who are found to be ineligible for Medicaid or CHIP to see if they are eligible for the premium tax credits.
- States have the option to allow Medicaid agencies to determine eligibility for premium tax credits, as well as for Medicaid and CHIP. State exchanges can also determine eligibility for premium tax credits for coverage in the exchanges. However, the exchanges will not have the authority to determine Medicaid or CHIP eligibility.
- By no later than January 1, 2014, each state is required to establish and maintain a website that is linked to the state's exchange website(s) that enrollees and prospective enrollees can use to compare benefits, premiums, and cost-sharing among Medicaid, CHIP, and plans in the exchange.
- No provision changes current law that requires Medicaid eligibility to be determined by public agencies.

Health Information Technology (HIT) Standards

- The Secretary of HHS, in consultation with the HIT Policy Committee and the HIT Standards Committee, will develop standards for enrollment in health and human services programs (these programs are yet to be determined by the Secretary, but they may be broader than just health coverage programs). These standards must be issued by September 2010.
- The standards and protocols for electronic enrollment in health and human services programs should allow for the following:
 - electronic matching with existing federal and state data;

- the simplification and submission of electronic documents;
- the ability to reuse stored eligibility information;
- the capability for individuals to apply, recertify, and manage their eligibility online and at other community-based locations and receive notifications via email and cell phones; and
- other measures that are necessary to streamline enrollment.
- The Secretary of HHS will award grants (amounts are yet to be determined) to eligible entities to develop new, and adapt existing, technology systems to implement the HIT enrollment standards and protocols. Qualified entities will be determined by the Secretary of HHS along with the recommendations of the HIT Policy Committee and the HIT Standards Committee.
- The Secretary of HHS may require states to incorporate the standards from the HIT Policy and HIT Standards Committees as a condition of receiving these grants.

Medicaid and CHIP

Enrollment Processes

- The law requires states to establish procedures that will allow individuals to apply for Medicaid or CHIP through a website to be established by no later than January 1, 2014.
- States must establish online enrollment, renewal, and consent through an electronic signature for Medicaid and CHIP.
- People that a state exchange identifies as eligible for Medicaid or CHIP must be referred to and enrolled in the appropriate program without any further determination.

Income Methodology

- Starting in 2014, all states will be required to use modified adjusted gross income (MAGI) to determine income eligibility for Medicaid and CHIP.
- Exceptions will be made for those who are eligible for Medicare, people in the Medicaid medically needy category, people with disabilities, and those who are eligible for Medicaid because of their eligibility for another program. Existing income methodologies will continue to be used for people in these eligibility categories.
- States must apply an across-the-board 5 percent income disregard in Medicaid and CHIP, but other disregards will no longer be permitted.

- Other Medicaid and CHIP rules about how income is counted continue to apply, including prospective budgeting and household definition.
- There is a hold-harmless provision that is designed to ensure that no one who was eligible for Medicaid when health reform was enacted will lose coverage because of the transition to using MAGI to determine eligibility. States will have some flexibility in determining income during the transition period.

Assets Tests

- States cannot use assets tests in determining applicants' eligibility for early Medicaid expansions (Medicaid expansions to the new eligibility category, adults without dependent children, that are implemented between 2010 and 2014).
- The law removes assets tests beginning on January 1, 2014, for most populations (excluding those who are eligible for Medicare, people in the Medicaid medically needy category, people with disabilities, and those who are eligible for Medicaid because of their eligibility for another program).

Presumptive Eligibility

- Beginning on January 1, 2014, states that use presumptive eligibility for children or pregnant women can also use presumptive eligibility for groups that were made newly eligible for Medicaid under health reform, as well as section 1931 parents.¹
- Hospitals that participate in Medicaid may conduct presumptive eligibility determinations for Medicaid, even if the state currently does not conduct presumptive eligibility or has not authorized the hospital as a "qualified entity."

Other Provisions

- The law requires states to conduct Medicaid and CHIP outreach to vulnerable and underserved populations.
- Health reform includes an additional \$40 million for outreach and enrollment grants under the CHIP Reauthorization Act (CHIPRA) that are to be used during fiscal years 2009-2015.

The Exchanges

Enrollment Processes

- The Secretary of HHS must develop a model template for the Internet portals that are used for state exchanges and assist states in developing and maintaining their portals.
- An initial open enrollment period will be established, as determined by the Secretary of HHS (the determination must be made by no later than July 1, 2012). The Secretary of HHS will determine annual open enrollment periods for calendar years after this initial enrollment period.
- Individuals must provide their name, address, date of birth, and Social Security number in order to enroll in exchange coverage (whether or not the individual is eligible for a premium tax credit).
- To prevent undocumented immigrants from receiving premium tax credits or enrolling in exchange coverage, legally residing immigrants must also provide other information that the Secretary of HHS, in cooperation with the Secretary of Homeland Security, specifies in order to verify immigration status. Citizens' status will be verified by the Social Security Administration. The immigration and/or citizenship status of non-citizens and those who attest to be citizens but whose status cannot be confirmed by the Social Security Administration will be verified by the Secretary of Homeland Security.
- Applicants for premium tax credits must not be required to provide information beyond the minimum amount that is needed to authenticate their identity, determine their eligibility, or determine the level of subsidy for which they are eligible.

Income Methodology

- As with Medicaid and CHIP, income will be based on modified adjusted gross income (MAGI). States must use MAGI for the taxable year ending in the second calendar year that precedes the calendar year during which the plan year begins. For example, they would use the 2012 tax year for coverage that starts on January 1, 2014.

Determining Eligibility for Subsidies

- Individuals must report their income (MAGI) from their prior year's tax return to their state exchange to apply for premium tax credits and cost-sharing subsidies.
- The Secretary of HHS can make eligibility determinations based on information other than household income in the most recent taxable year for individuals whose incomes or other household circumstances change substantially, who file for unemployment benefits, or who experience other significant changes that might affect their eligibility (e.g., a decrease in income of more than 20 percent or the receipt of unemployment benefits).
- After the initial application, consumers may not be able to change the amount of the tax credit they receive even if their household circumstances change over the course of the year. Guidance from HHS is needed to clarify this.
- Consumers must repay any excess premium tax credits as part of filing federal income taxes. For consumers whose household incomes are less than 400 percent of the federal poverty level (\$73,240 for a family of three in 2010, federal poverty guidelines are updated annually), this is limited to a maximum of \$250 per individual or \$400 per family.

Paying for Coverage

- Enrollees will pay premiums directly to the health plans in which they are enrolled, not to state exchanges.
- The Secretary of Treasury will pay tax credit amounts directly to the insurance plans in which consumers enroll.
- Individuals who receive tax credits but who fail to pay their share of premiums will have a three-month grace period before being disenrolled from their health plan.

Other Provisions

- The exchanges will also be required to establish and make available electronically a calculator that applicants can use to determine the actual cost of coverage after any premium tax credits are applied.

Source: The Patient Protection and Affordable Care Act of 2010 (Public Law No. 111-148), Sections 1401, 1411, 1412, 1413, 1414, 1561, 2001, 2002, and 2201.

¹ Section 1931 provides Medicaid eligibility for families that, in the past, had been eligible for Medicaid as a result of their eligibility for the Aid to Families with Dependent Children (AFDC) program, as well as for other families that meet income and resource limits established by states. Section 1931 also allows states to define income and resources in ways that raise Medicaid eligibility levels for families.