FactSHEET

Understanding the New Health Reform Law
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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 Premium 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 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 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 premium 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 premium credits. ■ States have the option to allow Medicaid agencies to determine eligibility for premium credits, as well as for Medicaid and CHIP. Or state exchanges can determine eligibility for Medicaid, CHIP, and premium credits for coverage in the exchanges. ■ 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, developed recommendations for enrollment in health and human services programs (including but not limited to health coverage programs). These recommendations were issued in September 2010. ■ The recommendations that were issued in September are consumer-oriented and call for enrollment processes that meet the following criteria:

- Are online, transparent, and easy to use;
- Accommodate people with different online user capabilities and language preferences;
- Seamlessly integrate public and private insurance options;
- Connect consumers with a range of human services programs, including health coverage programs and other programs (such as the Supplemental Nutrition Assistance Program—SNAP, and Temporary Assistance for Needy Families—TANF); and
- Provide strong privacy and security protections.

- These recommendations will apply to federally and state-operated exchanges, and they will likely be tied to future federal funding opportunities with respect to designing and updating eligibility and enrollment systems.

Medicaid and CHIP

Enrollment Processes

- The law requires states to establish procedures that will allow individuals to apply for Medicaid or CHIP though 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 sources of income.
- 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

- States that use presumptive eligibility for children or pregnant women can now also use presumptive eligibility for groups that were made newly eligible for Medicaid under health reform, as well as for Section 1931 parents.[1]
- Beginning on January 1, 2014, hospitals that participate in Medicaid may conduct presumptive eligibility determinations for Medicaid, regardless of whether the state is using presumptive eligibility in any other settings or for any other Medicaid eligibility groups.

Other Provisions

- The Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that will allow states to draw a 90 percent federal match when they invest in improvements to their Medicaid eligibility and enrollment systems. Once the rule is finalized, this 90 percent match will be available to qualifying states until December 31, 2015. States that qualify for this enhanced funding will also receive a 75 percent federal match for maintaining these systems in 2016 and beyond.
- 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 web 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 credit).
- To prevent undocumented immigrants from receiving premium 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 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 assistance for which they are eligible.

Income Methodology (for premium credit eligibility)

- 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 Premium 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 premium 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 credits as part of filing federal income taxes. For consumers with incomes up to 500 percent of the federal poverty level, the repayment amount is limited, varies according to income, and ranges from $600 for people with incomes up to 200 percent of poverty ($36,620 for a family of three in 2010) to $3,500 for people with incomes between 450 and 500 percent of poverty (between $82,395 and $91,550 for a family of three in 2010).
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 premium credit amounts directly to the insurance plans in which consumers enroll. ■ Individuals who receive premium 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 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