The New Health Law: California Issue Briefs

issue brief #6

Eligibility and Enrollment Changes and Simplification

Health Consumer Alliance

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On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law.[1] The new health care law aims to increase access to health insurance through more accessible private insurance and an expansion of Medicaid (Medi-Cal in California). This issue brief discusses the many new changes the ACA makes to eligibility and enrollment systems and the eligibility rules for the following public health coverage programs in California: Medi-Cal, Healthy Families and the Exchange premium subsidies. ***The changes and requirements described in this issue brief are effective January 1, 2014***.

Streamlined eligibility & enrollment

Starting January 1, 2014, the ACA expands Medi-Cal to people – including "childless adults" – with family incomes up to 133% of the federal poverty guidelines, also referred to as the federal poverty level (FPL).

In order to facilitate the selection of health insurance plans for people who do not qualify for Medi-Cal and Healthy Families, the ACA creates the Exchange, a new mechanism for individuals and small businesses to purchase health insurance. Many people with incomes between 133% and 400% FPL will be eligible for premium subsidies through the Exchange. Read the *Subsidies under the Health Insurance Exchanges* issue brief in this series for more information.

In addition to expanding subsidized health coverage programs, the ACA requires fundamental changes in the way people apply for, are enrolled in, and renew for public health coverage. By January 1, 2014, California must implement simplified enrollment procedures for Medi-Cal, Healthy Families, and Exchange subsidies. To do this, California must establish a "no wrong door" eligibility and enrollment system, allow multiple application venues, and be able to electronically verify some information.

Determining eligibility: "No Wrong Door"

The ACA requires that no matter where people apply for coverage, California must determine their eligibility for Medi-Cal, Healthy Families, and subsidies through the Exchange and enroll them into the program for which they are eligible.

If someone applies for Medi-Cal or Healthy Families but is eligible for Exchange subsidies, that person must be enrolled into the Exchange without having to file an additional application.[2] Similarly, if someone applies to the Exchange but is eligible for Medi-Cal or Healthy Families that person must be enrolled accordingly without additional steps.[3]

A single application, multiple application venues

People must be able to apply for public health coverage using any of four methods: online, in person, by mail, and by telephone.[4] The Secretary of the U.S. Department of Health and Human Services (HHS) will develop a single application form for all of the public health coverage programs.[5] California can choose to use that form or develop its own single application consistent with the federal standards.[6] California may seek federal approval to use a supplemental eligibility form for those whose income is not determined under the Modified Adjusted Gross Income (MAGI) standard discussed below.[7]

California must develop a website that allows people to apply for, enroll in, and renew Medi-Cal, Healthy Families, and Exchange premium subsidies, and that accepts an electronic signature.[8] The state must establish a secure, electronic interface for determining applicants' eligibility for Medi-Cal, Healthy Families and the Exchange subsidies.[9] The website must provide information about the various plans offered within the Exchange, including information that compares coverage through an Exchange plan against Medi-Cal or Healthy Families.[10]

Pursuant to the ACA, hospitals may elect to make presumptive eligibility determinations for all populations eligible for Medi-Cal and Healthy Families – an expansion beyond the current populations of just children, pregnant women, and breast and cervical cancer patients.[11]

Verification systems

Under the ACA, people can authorize the disclosure of personal information found in existing government databases to state agencies for assessment of their health coverage eligibility.[12] California's public health coverage programs must participate in data matching arrangements that will allow them to determine eligibility by matching applicants' information with reliable, third-party data. The data must be collected consistent with standards developed by the Secretary of Health and Human Services, which will include privacy and data security safeguards. An applicant who wants to use data matching to verify eligibility for public health coverage programs must authorize disclosure of information for determining eligibility for health coverage.[13] The state cannot require applicants to submit information and documentation after applying unless the information they provided conflicts with electronic data or "is otherwise insufficient to determine eligibility."[14]

Outreach and data collection

States must establish programs to outreach to and enroll "vulnerable, underserved populations [eligible for Medi-Cal or Healthy Families], including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance abuse disorders, and individuals with HIV/AIDS."[15]

Beginning in 2015, the State must collect data on its enrollment and retention efforts, and report it to HHS.[16]

Changing eligibility rules: income, household size and assets

In addition to changing the ways people apply for and are enrolled into coverage, the ACA changes the rules that apply in determining eligibility for public health coverage programs.

Income Rules

- **Modified Adjusted Gross Income (MAGI)**

  The ACA moves away from the welfare-program income rules in Medi-Cal to a tax-based system for counting individual or household income, called Modified Adjusted Gross Income (MAGI).[17] MAGI is defined in the newly added Internal Revenue Code section 36B(d)(2)(B). The MAGI rules also apply to premium tax credits in the Exchange.[18] MAGI is defined as adjusted gross income increased by certain income that is usually exempt from taxes.[19] "Household income" is the MAGI of the tax-payer plus the aggregate MAGI of all other persons who were taken as a tax deduction and were required to file a tax return in the taxable year.[20]

  The ACA replaces current income disregard rules with a standard 5 percent income disregard.[21]

- **Income Eligibility Thresholds**

  States must establish income eligibility thresholds for Medi-Cal that are not less than the effective income eligibility levels under the state plan on the enactment of the ACA – March 23, 2010.[22] During the transition to MAGI methodology, the state must establish an equivalent income test to ensure that people do not lose Medi-Cal coverage.[23]

Household size

The ACA defines family size for a taxpayer as the number of individuals for whom the taxpayer can claim a deduction under section 151 of the Internal Revenue Code.[24] This is different than the current Medi-Cal rules for determining family budget unit. For example, a stepmother who files taxes with her stepson currently would not count in determining the stepson's family size or household income. But under the MAGI rules, this same stepmother will be included in her stepson's family unit and her income will be counted.

Assets test

Under the ACA, states may not use an assets test to determine eligibility for Medi-Cal for most populations.[25] The exceptions are listed below.

The elimination of the assets test and conversion to MAGI rules do not apply to the following populations. The existing income and assets rules will still be used for:

- Individuals who are eligible for Medi-Cal through another program including SSI, Adoption Assistance, and foster youth;
- Individuals who are 65 years of age or older;
- Those who are eligible for Social Security Disability Income;
- Medically Needy individuals;
- Those in a Medicare Savings program; and
- People with a disability.[26]

The MAGI rules and the elimination of the assets test will also not apply to income eligibility determinations for Express Lane, Medicare Part D prescription drug low-income subsidies, or Medi-Cal long term care services.[27]

Immigration rules

The ACA does not change the citizenship documentation and immigration status requirements for Medi-Cal or Healthy Families. Most lawfully present immigrants are eligible for full-scope Medi-Cal or Healthy Families.

Lawfully present immigrants are eligible for premium subsidies and cost-sharing reductions in the Exchange.

Undocumented immigrants are neither eligible for premium tax credits in the Exchange nor allowed to buy coverage through the Exchange at full cost. They are exempt from the individual mandate to have health coverage. Undocumented immigrants remain eligible for emergency and restricted-scope Medi-Cal.

The Exchange must verify citizenship or lawful presence to enroll applicants in coverage. For citizens, proof of citizenship will be verified by the Social Security Administration.[28] For legal immigrants, proof of status will be verified by the Department of Homeland Security.[29] If information cannot be electronically verified or is incorrect, the applicant or enrollee will have an opportunity to provide documentation or correct the record.[30]

[1] Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (2010).
[2] ACA § 2201; 42 U.S.C.A § 1396w-3(b)(1)(C) (West 2011).
[3] ACA § 2201; 42 U.S.C.A. § 1396w-3(b)(1)(B) (West 2011).
[4] ACA § 1413(b)(1)(A)(ii); 42 U.S.C.A. § 18083(b)(1)(A)(ii) (West 2011).
[5] ACA § 1413(b)(1)(A); 42 U.S.C.A. § 18083(b)(1)(A) (West 2011).
[6] ACA § 1413(b)(1)(B); 42 U.S.C.A. § 18083(b)(1)(B) (West 2011).
[7] ACA § 1413(b)(1)(C); 42 U.S.C. § 18083(b)(1)(C) (West 2011).
[8] ACA § 2201; 42 U.S.C.A. § 1396w-3(b)(1)(A) (West 2011).
[9] ACA § 2201; 42 U.S.C.A. § 1396w-3(b)(1)(D) (West 2011).
[10] ACA § 2201; 42 U.S.C.A. § 1396w-3(b)(4) (West 2011).
[11] ACA §§ 2202(a)(3) and 2202(b)(2); 42 U.S.C.A. §§ 1396a(a)(47) and 1396b(u)(1)(D)(v) (West 2011).
[12] ACA § 1413(c)(2)(B)(ii)(II); 42 U.S.C.A. § 18083(c)(2)(B)(ii)(II) (West 2011).
[13] ACA § 1413(c)(2)(B) and (C); 42 U.S.C.A. § 18083(c)(2)(B) and (C) (West 2011).
[14] ACA § 1413(b)(2); 42 U.S.C.A. § 18083(b)(2) (West 2011).
[15] ACA § 2201; 42 U.S.C.A. § 1396w-3(b)(1)(F) (West 2011).
[16] ACA § 2001(d)(1)(C); 42 U.S.C.A. § 1396a(a)(75) (West 2011).
[17] ACA § 2002(a), as amended by HCERA §§ 1004(b)(1)(A) and 1004(e); 42 U.S.C.A. § 1396a(e)(14)(A) (West 2011).
[18] ACA § 1401(a); 26 U.S.C.A. § 36B(a) (West 2011).
[19] ACA § 1401(a), as amended by HCERA § 1004(a)(2)(B); 26 U.S.C.A. § 36B(d)(2)(B) (West 2011).
[20] ACA § 1401(a), as amended by HCERA § 1004(a)(1)(A); 26 U.S.C.A. § 36B(d)(2)(A)(i) and (ii) (West 2011).
[21] ACA § 2002(a), as amended by HCERA §§ 1004(b)(1)(A) and 1004(e); 42 U.S.C.A. § 1396a(e)(14)(B) and (I)(i) (West 2011).
[22] ACA § 2002(a), as amended by HCERA §§ 1004(b)(1)(A) and 1004(e); 42 U.S.C.A. § 1396a(e)(14)(A) (West 2011).
[23] Id.
[24] ACA § 1401(a); 26 U.S.C.A. § 36B(d)(1) (West 2011).
[25] ACA § 2002(a); 42 U.S.C.A. § 1396a(e)(14)(C) (West 2011).
[26] ACA § 2002(a); 42 U.S.C.A. § 1396a(e)(14)(D)(i) (West 2011).
[27] ACA § 2002(a); 42 U.S.C.A. § 1396a(e)(14)(D)(ii – iv) (West 2011).
[28] ACA §§ 1411(b)(2)(A) and (c)(2)(A); 42 U.S.C.A. §§ 18081(b)(2)(A) and (c)(2)(A) (West 2011).
[29] ACA §§ 1411(b)(2)(B) and (c)(2)(B); 42 U.S.C.A. §§ 18081(b)(2)(B) and (c)(2)(B) (West 2011).
[30] ACA § 1411(e)(3); 42 U.S.C.A. § 18081(e)(2) (West 2011).

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