

# OVERVIEW OF THE AFFORDABLE CARE ACT



**Through a Medicaid and CHIP Lens**

Medicaid and CHIP  
**MAC**  
*Learning Collaboratives*

## Outline

- **The New Continuum of Coverage**
- **Medicaid and CHIP Are Changing**
- **The New Marketplaces and Premium Tax Credit & Cost Sharing Reductions**
- **Private Insurance Market Reforms & Shared Responsibility Payment**

New  
Continuum of  
Coverage

Medicaid and CHIP Are  
Changing

Marketplaces and  
Premium Tax Credit &  
Cost Sharing Reductions

Market Reforms and  
Shared Responsibility  
Payment

# The New Continuum of Coverage

## Key Elements of the New Coverage Continuum

The Affordable Care Act (“ACA”) was signed into law on March 23, 2010. It makes major changes to how uninsured people secure health coverage in the United States.

- Expansion of Medicaid and improvements to Medicaid and the Children’s Health Insurance Program (CHIP)
- Establishment of new “Marketplaces” for individuals and small businesses
- New insurance affordability programs
- Private insurance market reforms
- New requirement for individuals to obtain health coverage, obtain an exemption, or pay a fee
- New ways to apply for coverage and receive help from assisters.

Although not covered in this manual, the ACA also mandates changes to the health care delivery system, establishes new public health initiatives, and includes a range of provisions aimed at financing the ACA.



# Major Coverage Changes



## Medicaid & CHIP Expansion and Improvements

- Expands eligibility to 133% FPL for low-income adults
- As a result of the Supreme Court decision, some states may elect not to expand Medicaid
- In all states, makes major changes to simplify enrollment and allow for coordination with the Marketplaces.



## Health Insurance Marketplaces for Individuals and Small Businesses

- Launched in fall of 2013 with coverage effective as early as 1/1/14
- Offer Qualified Health Plans (QHPs) with comprehensive benefits
- In general, individuals with incomes 100%-400% FPL are eligible for a premium tax credit and with incomes 100-250% FPL are eligible for cost sharing reductions to help subsidize the cost of coverage.



## Private Insurance Market Reforms

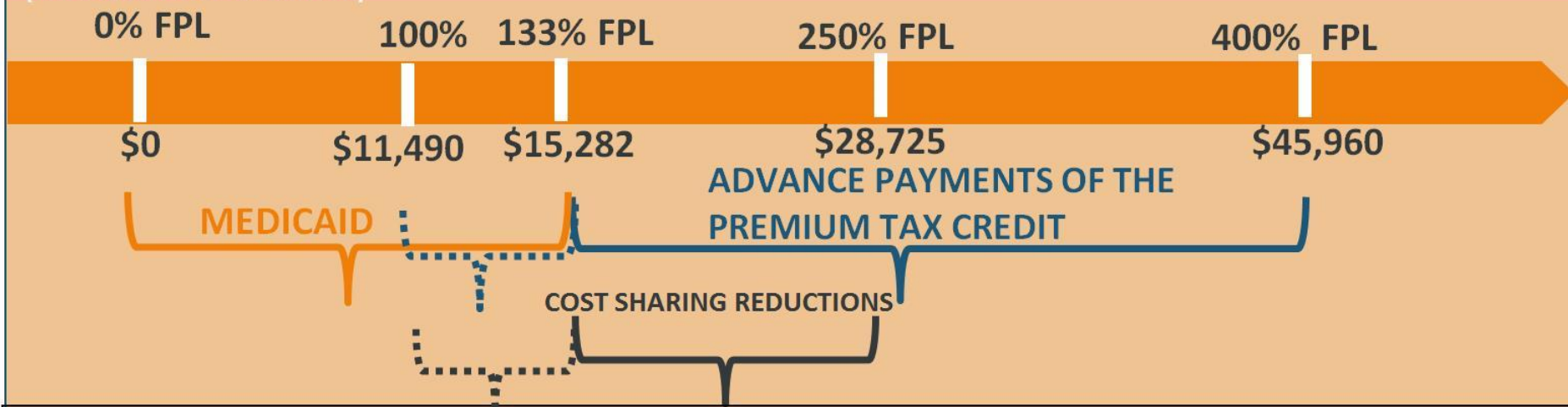
- Guaranteed issue & renewability
- No annual or lifetime limits
- Health status may not be considered in setting premiums
- Must cover preventive health services at no cost
- Young adults may remain on parent's plan until age 26.

# Continuum of Coverage

- Eligibility for insurance affordability programs falls along a continuum based on income, age, and other eligibility factors.
- On this continuum, income is measured as a percent of the federal poverty level, or FPL, based on household size.
- Most children qualify for Medicaid and CHIP at higher income levels than their parents. As a result, families may have members in more than one insurance affordability program.

## Continuum of Insurance Affordability Programs for Adults

(thresholds differ for children)



A premium tax credit and cost sharing reductions are available for eligible individuals beginning at 100% FPL in states that do not expand Medicaid and to lawfully residing immigrants below 100% FPL who are ineligible for Medicaid.



# Insurance Affordability Programs

- The Affordable Care Act creates new coverage options by expanding Medicaid and creating Health Insurance Marketplaces that offer Qualified Health Plans (QHPs).
- The law includes several programs that help low- and moderate-income people purchase health insurance coverage. Together, they are known as “insurance affordability programs”.

## Advance Payments of the Premium Tax Credit (APTC)

- NEW federal program that uses tax credits to reduce premium costs for QHP enrollees.
- For people who meet financial criteria and don't have access to other coverage that meets certain standards.
- Can be paid in “advance” to provide immediate help in paying premiums.
- IRS reconciles over/under payments of advance payments of the premium tax credit when people file taxes.

## Cost Sharing Reductions (CSR)

- NEW federal program for people who are eligible for a premium tax credit.
- Helps reduce out-of-pocket costs for enrollees in QHPs.
- Payments are made directly to issuers to reduce deductibles, co-insurance and/or copayments (out of pocket) costs.

## Medicaid

- Existing federal-state health insurance program for people with low incomes.
- Expanded to more low-income adults by the ACA. States can opt out of expansion.
- Provides comprehensive health care benefits
- Minimal out-of-pocket costs.

## Children's Health Insurance Program (CHIP)

- Existing federal-state health insurance program for low- and moderate-income children and pregnant women in some states.
- Provides comprehensive health care benefits
- Modest out-of-pocket costs.

New  
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**Medicaid and CHIP Are  
Changing**

Marketplaces and  
Premium Tax Credit &  
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# **Medicaid and CHIP Are Changing**

## The New Vision for Medicaid and CHIP

- **Coverage Expansion:** Expands eligibility for low-income adults.
- **Single, Streamlined Application:** Provides new, simple way to apply for coverage. Help from assisters is available and people can apply for coverage online, over the phone, by mail, and in-person.
- **Simplified Eligibility and Enrollment Rules:** Changes the way eligibility is determined (“MAGI-based rules”), simplifies Medicaid eligibility groups, increases reliance on electronic data sources to verify information, requires coordination across Medicaid, CHIP and other insurance affordability programs.
- **Modernized Eligibility Systems:** Increased use of automated rules engines to enable real-time eligibility determinations. Eligibility workers no longer will have to touch every case.
- **Children’s Coverage Improvements:** Holds children’s coverage steady through 2019 and applies Medicaid changes to CHIP.



# Medicaid Expansion for Adults

- Covers adults 19 - 64 with incomes up to 133% FPL who are not eligible for and enrolled in a mandatory group
- Provides “benchmark” benefits to the new adult coverage group
- Enhanced federal funding
- All other Medicaid rules apply to new adult group

## Enhanced FMAP for Newly Eligible Adults ≤ 133% FPL

Year	State Share	Federal Share
2014	0 %	100%
2015	0 %	100%
2016	0 %	100%
2017	5 %	95%
2018	6 %	94%
2019	7 %	93%
2020	10 %	90%

## New Adult Group

To be eligible for the new adult group, individuals must meet non-financial requirements and the following eligibility criteria:



Age 19 – 64

Income below 133% FPL

Not pregnant

Not entitled to or enrolled in Medicare Part A

Not otherwise eligible and enrolled in a mandatory  
Medicaid group

# New Former Foster Care Eligibility Group



**Basic Rule:** The ACA creates a new Medicaid eligibility group for children up to age 26 who were in foster care in the state and covered under Medicaid when they were 18 (or, at state option, a higher age). There is no income test for this new eligibility group, ensuring continuity of coverage for former foster youth up to age 26.

**State option:** Former foster care children that were in another state on their 18<sup>th</sup> birthday can be made eligible for this category.



## Supreme Court Decision – June 28, 2012

- Upheld the constitutionality of the ACA, including the individual shared responsibility provision, which provides that each individual must have basic health coverage for each month, qualify for an exemption, or make a payment when filing his or her federal income tax return.
- Ruled that a state may not lose federal funding for its existing Medicaid program if it chooses not to expand Medicaid for low-income adults to 133% FPL

### MEDICAID IMPACT

As a result of the Supreme Court decision, states have the choice to expand Medicaid to low-income adults.



## Supreme Court Decision – Other Medicaid and CHIP Provisions Still Apply

All other Medicaid and CHIP provisions remain in place:

- Use of a single streamlined application that can be submitted multiple ways including online, over the phone, by mail and in person.
- Coordination with other insurance affordability programs
- Major changes in the way Medicaid eligibility is determined (use of “MAGI-based” rules and “converted” eligibility thresholds)
- Electronic verification of information and minimization of paper documentation
- Continuation of coverage for children through 2019 and other child-specific improvements in Medicaid and CHIP



# Implications of Not Expanding Medicaid

## State Implications

- 1 Still must implement all other ACA Medicaid and CHIP changes.
- 2 The Marketplace will make available certificates of exemption from the shared responsibility payment to adults found ineligible for Medicaid due to decision not to expand.

## Consumer Implications

- 1 Most low-income adults below 100% FPL will face a coverage gap because premium tax credits, in general, are available only to adults 100% - 400% FPL.
- 2 Low-income parents in the coverage gap still have children who qualify for coverage, and may need help understanding this and applying.
- 3 May require assistance securing an exemption from the shared responsibility payment.
- 4 Consumers may be confused by ACA media stories and not understand they are ineligible for Medicaid.

# The Single Streamlined Application

**Individuals and families can use a new application to apply for Medicaid, CHIP and other insurance affordability programs.**

- A new application that may be used to apply for Marketplace coverage and all insurance affordability programs (Medicaid, CHIP, premium tax credit and cost sharing reductions) on one application.
- People do not need to know in advance the program for which they are likely to qualify. If they submit the single, streamlined application, they will be evaluated for all insurance affordability programs.
- The application may only include questions that are necessary to determine an individual's eligibility for coverage.
- In general, individuals who are not applying for coverage may still apply for other eligible family members without providing Social Security Numbers or citizenship/immigration status.
  - Caveat: To obtain a premium tax credit for other family members, consumers must provide a Social Security Number if they have one.
- No in-person interviews may be required.



## New Ways to Apply

**Individuals will have new ways to submit an application for coverage. They can apply online, in-person, by mail, or by phone.**

**These channels must be available in every state.**



In-person



Online



Mail



Phone

# Help From Assisters is Available

Various kinds of entities will help people apply for coverage.



**State Agency**  
(e.g., Depts. Of  
Health / Social  
Services)

**State eligibility workers will continue to help people apply for coverage. They may see an increase in volume as people hear about new coverage options.**



**Certified  
Application  
Counselors**

**Your state may already have groups, such as hospitals, clinics, and non-profit organizations, that help individuals apply for Medicaid and CHIP. They may continue to do so as “certified application counselor” if they undergo training and meet other requirements.**



**Navigators**

**Marketplaces will establish new “Navigator” programs to help people applying for coverage. They will assist with QHP enrollment, but also be knowledgeable about Medicaid and CHIP.**



**Non-  
Navigator  
Assisters**

**Sometimes also known as “in-person assisters,” they will provide services similar to Navigators.**



**Agents/  
Brokers/  
Producers**

**Will help people and small businesses apply for Marketplace coverage.**



## Eligibility & Enrollment Simplifications: Consolidated Eligibility Groups & New Adult Group

Old eligibility groups for people without a disability are consolidated into three primary “MAGI-based” eligibility groups and a new group for adults is added:



**Children**



**Pregnant Women**



**Parents and  
caretaker relatives**



**Adults age 19-64**

- Modified Adjusted Gross Income (MAGI) is the new income methodology used to determine Medicaid and CHIP eligibility for these groups (basically everyone except aged, blind and disabled).
- The new process and rules apply for individuals who apply beginning on October 1, 2013 for coverage effective January 1, 2014 (there will be some state variation here for states that begin making eligibility determinations based on MAGI beginning in October 2013).



## Non-MAGI Populations

States continue to use *existing* income and household composition rules for other eligibility groups, including:



Aged, Blind, Disabled

Medically needy individuals

Populations for whom income is not an eligibility factor, such as foster care children

## New “MAGI-Based” Household and Income Rules

- MAGI rules are based on IRS-defined concepts of income and household.
- Allow for coordination with premium tax credits and cost sharing reductions, which also rely on a version of MAGI rules.
- In a small number of instances, there are modest differences in the MAGI-based rules used for Medicaid and CHIP versus for other insurance affordability programs.
- Asset/resource test eliminated for MAGI groups.
- Current income disregards, like the \$90 earned income disregard, are eliminated and replaced by a converted income threshold. In addition, a 5 percentage point disregard is added if it affects eligibility.
- These rules are covered in detail in other manual sections.

## Examples of How MAGI Rules Differ from Old Methods



### Household:

- Households largely defined by who files taxes together, with exceptions
- Step-parents and step-siblings are now included as part of a child's household



### Income:

- Child support income no longer counts in calculating household income



## Types of Income and Deductions Included in MAGI

### Income Counted

- Taxable wages/salary (before taxes are taken out)
- Self-employment (profit once business expenses are paid);
- Social Security benefits;
- Unemployment benefits;
- Alimony received;
- Most retirement benefits;
- Interest (including tax-exempt interest);
- Post investment income, such as interest and dividends;

- Rental or royalty income (profit after subtracting costs);
- Other taxable income, such as canceled debts, court awards, jury duty pay not given to an employer, cash support, and gambling, prizes, or awards; net capital gains (profit after subtracting capital losses); and foreign earned income.

### Deductions

- Allowed:
  - Tax deductions allowed on page 1 of the 1040 Form. For example: student loan interest paid; higher education expenses (tuition and fees); self-employment tax; alimony payments
- Not Allowed:
  - States' current Medicaid deductions
  - Itemized deductions (like charitable contributions)

## Types of Income Not Included in MAGI

### Income NOT Counted

- TANF and other government cash assistance
- Child support received
- Supplemental Security Income (SSI)
- Workers' compensation payments
- Veteran's benefits
- Proceeds from life insurance, accident insurance, or health insurance
- Federal tax credits and Federal income tax refunds
- Gifts and loans
- Inheritances



## Converting Existing Eligibility Levels to a MAGI-Equivalent Level

- Income disregards and deductions will be eliminated when states begin using MAGI-based eligibility rules, such as:
  - No disregard for child care expenses
  - No work expense disregard
- ACA requires states to establish new, “converted” MAGI eligibility levels to reflect loss of disregards and deductions.
- The converted eligibility thresholds will be slightly higher than the old levels because they account for disregards people received under the old rules.
- A general disregard of income equal to 5 percentage points of the FPL is applied when it would affect a consumer’s eligibility for coverage.

## Coordinating Eligibility with the Marketplace

Your state chose to use the  
Model

People are not eligible for a premium tax credit or cost sharing reductions if they qualify for Medicaid or CHIP. As a result, the Marketplaces must assess/determine eligibility for Medicaid and CHIP before evaluating eligibility for the Marketplace.

States have two basic choices—

- 1 **Determination model** – The Marketplace operating in the state determines eligibility for Medicaid/CHIP. In general, Medicaid and CHIP take no further action.
- 2 **Assessment model** – The Marketplace operating in the state assesses potential eligibility for Medicaid/CHIP. When applicants appear eligible, it will transfer their account to the state Medicaid/CHIP agency for a final determination.

States working with the Federally-Facilitated Marketplace had to declare their choice. The details of how Medicaid/CHIP eligibility will be handled depends on a state's decision whether to use the “determination” or “assessment” model.

## Your State's New Eligibility Levels

Medicaid/CHIP Eligibility Group	% of the Federal Poverty Level
Infants age 0-1	
Children age 1-5	
Children age 6-18	
Pregnant Women	
Parents/Caretaker Relatives	
Adults	



## Medicaid/CHIP Verification Procedures

New verification rules rely primarily on electronic data sources. Each state has its own verification policies that are explained in a verification plan provided to CMS.

- States must use electronic data sources to the **maximum extent possible** to verify and renew eligibility; people cannot be asked to provide paper documentation when information can be verified electronically.
- States use the new federal data services hub that provides a portal for federal data sources (i.e. IRS, Social Security Administration, Department of Homeland Security). States also use existing state data sources.

## Medicaid/CHIP Verification Procedures continued..

### Reasonable Compatibility Rules

- States must use a “reasonable compatibility standard” to determine if the information an individual provided on the application can be considered verified against the data sources. When the data sources are considered “reasonably compatible” with the information the applicant provides, individuals are not required to submit additional documentation.
- Data sources are considered “reasonably compatible” with income information provided by an individual if the data sources and information provided by the individual are both at, above, or below Medicaid/CHIP eligibility levels.
- If information provided on an application is not reasonably compatible with data, applicants are provided an opportunity to provide a “reasonable explanation” to address the discrepancy.
- States have discretion to define reasonable compatibility more broadly than what is required under federal minimum standards.

## Modernizing Eligibility and Enrollment Systems

As part of implementing the ACA, federal funding was provided to states to support the modernization of their eligibility and enrollment systems.

- Individuals must be able to apply for health coverage online for all insurance affordability programs, including Medicaid and CHIP.
- Increased use of automated rules engines to enable real-time eligibility determinations. Eligibility workers no longer will have to touch every case.
- HHS established a federal data services hub that provides a portal to federal data sources for states to electronically verify application information.



# Medicaid/CHIP Renewals



As of January 1, 2014, Medicaid beneficiaries whose eligibility is determined using MAGI-based methodologies must have their eligibility renewed once every 12 months



*Unless the agency receives information about a change that may affect eligibility*



Renewal must be made with information available to the agency, either contained in the person's account (case record) or more current information in accessible databases.

## ABLE TO RENEW

If agency is **able to renew** based on available information, the consumer must be notified of the determination and its basis.

If all of the **information** used to make the determination **is accurate**, the beneficiary does nothing and renewal takes place .

If any of the **information** used to make the determination **is inaccurate**, the beneficiary must inform the agency.

## UNABLE TO RENEW

If agency is **unable to renew** with current information, a pre-populated renewal form must be sent to beneficiary.

**Beneficiary has 30 days** from the date of the renewal form **to submit any necessary information, sign and return the form**. Agency must verify information provided & notify the beneficiary of their decision.

If the beneficiary **fails to submit the renewal form** or necessary information by the deadline, the agency will reconsider the eligibility of the beneficiary in a timely manner without requiring a new application if they submit the form **within 90 days (or a later date set by the state)** after the date of termination.

# Children's Coverage Improvements

## Creating Equity in Medicaid Coverage for Children Across Age Groups

- Historically, federal law has required states to provide Medicaid to children under age 6 up to 133% FPL and to children ages 6 to 19 up to 100% FPL.
- As of January 1, 2014, all children up to age 19 with family incomes < 133% FPL (or a converted MAGI-equivalent level) must be made eligible for Medicaid.
  - Children ages 6 to 19, 100% - 133% FPL in separate CHIP programs will move to Medicaid.
  - States will continue to receive enhanced CHIP match for uninsured children moved to Medicaid as a result of the change.



## Maintenance of Effort

States must maintain Medicaid and CHIP coverage for children at no less than the level in place on March 23, 2010 (date ACA signed) through 2019.

Applies to:


- Eligibility thresholds
- Eligibility & enrollment processes.

Additional simplifications and expansions are permitted, but states cannot roll back coverage for children.



# Hospital-Based Presumptive Eligibility

In all states, hospitals can now determine individuals to be presumptively eligible (PE) for Medicaid. This is not a state option.\*

State Options & Oversight Tools	Check if Yes 
May require PE training	
May limit PE to MAGI-based eligibility groups	
May choose to require attestation of residency/ citizenship/immigration status	
May require helping individuals complete and submit a full application	
May establish hospital performance measures	
May limit the annual number of PE periods	

- Children, Parents/Caretaker Relatives, Adults, Foster Care Children, BCCT
- State option to allow determinations on additional bases

### Requirements for Hospitals:

- Participate as a Medicaid provider
- Notify the state they will make PE determinations
- At state option, assist individuals in completing and submitting the full application
- At state option, meet performance standards



## Certain Existing Eligibility Rules Remain in Place

### Retroactive Coverage

The ACA did not make any changes to retroactive Medicaid. Medicaid coverage is available up to 3 months prior to the month the individual applies if the individual would have been eligible and received Medicaid services during that time period.\*

### Emergency Medicaid

The ACA did not make any changes to emergency Medicaid. Individuals who qualify for Medicaid but for their immigration status continue to qualify for coverage of emergency medical conditions.

Both of these provisions apply to the new adult group.

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# **The New Marketplaces and Premium Tax Credit & Cost Sharing Reductions**

# The Marketplace

**Think: A way to shop for “Qualified Health Plans,” health insurance plans offered by private issuers, that cover core benefits known as “essential health benefits.”**

**Opened for enrollment on October 1, 2013  
Coverage is effective as early as January 1, 2014\***

**Marketplaces  
are a major  
new entryway  
to Medicaid.**

- ➔ Find out your eligibility for Medicaid, CHIP, and APTC/CSRs
- ➔ Find out your eligibility for QHPs
- ➔ Compare your plan options
- ➔ Choose a plan and enroll



## Individual Marketplace

Consumers shopping for themselves will use the Individual Marketplace



## SHOP Marketplace

Small businesses shopping for their employees will use the Small Business Health Options Program (SHOP) Marketplace



# Residents of All States Have Access to Marketplaces

## Three Marketplace Options for States

Your state chose to have a  
Marketplace

### State-Based Marketplace



State operates all Marketplace functions; state may use federal government services for certain activities.

### State Partnership Marketplace



State takes on some responsibility for running Marketplace, such as providing consumer assistance or managing which QHPs are offered. However, the Federal government performs the remaining functions.

### Federally- Facilitated Marketplace



HHS operates all functions.

## Who is Eligible for a Qualified Health Plan in the Marketplace?

- Resident of the state
- U.S. citizen or lawfully present
- Not incarcerated

# Enrollment Period & Coverage Effective Date

- Initial open enrollment: October 1, 2013-March 31, 2014
- In 2014 and beyond, annual open enrollment: October 15 - December 7

Plan Selection Date	Coverage Effective Date
Oct. 1-Dec. 15, 2013	Jan. 1, 2014
Between 1 <sup>st</sup> and 15 <sup>th</sup> during Jan. 1-Mar. 15, 2014	First day of following month
Between 16 <sup>th</sup> and last day during Dec. 16, 2013-Mar. 31, 2014	First day of second following month
Oct. 15-Dec. 7, 2014 and subsequent years	Jan 1. of following year

- Individuals may qualify for a Special Enrollment Period at any time during the year.

### **MEDICAID IMPACT**

Individuals can still apply for and enroll in Medicaid or CHIP at any time during the year. Individuals accustomed to Medicaid/CHIP may need help understanding that Marketplace enrollment is generally limited to the open enrollment period.



# Special Enrollment Periods



**Individuals can enroll in a QHP in the Marketplace outside of the open enrollment period if they qualify for a Special Enrollment Period.**

**Triggering events for a special enrollment period include:**

- Individual or dependent loses minimum essential coverage
- Individual gains dependent or becomes a dependent through marriage, birth, adoption or placement for adoption, or placement in foster care
- Individual, not previously a citizen, national, or lawfully present individual, gains such status
- Individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost sharing reductions
- Individual's employer-sponsored coverage is no longer affordable or does not provide minimum value for the upcoming year
- Individual gains access to new QHPs as result of a permanent move.
- Members of federally-recognized tribes may enroll in QHP or change from one QHP to another one time per month.
- Individual demonstrates they meet other exceptional circumstances as Marketplace may provide.
- Errors or contract violations on the part of the Marketplace, issuer, or other agents of the Marketplace

# Types of Qualified Health Plans Offered in the Marketplace

Premium Costs Lower	<b>Catastrophic</b> High Deductible Health Plan for individuals up to age 30 or individuals with a hardship exemption from the shared responsibility payment
	<b>Bronze</b> 60% actuarial value
Benchmark	<b>Silver</b> 70% actuarial value
	<b>Gold</b> 80% actuarial value
Premium Costs Higher	<b>Platinum</b> 90% actuarial value

**What is actuarial value?**  
The percentage of an enrollee's medical costs that a plan will cover on average. The balance will be covered by the enrollee though co-pays and deductibles.

# QHPs Cover 10 Essential Health Benefits



**Ambulatory Patient Services**



**Prescription Drugs**



**Emergency Services**



**Rehabilitative & Habilitative  
Services & Devices**



**Hospitalization**



**Laboratory Services**



**Maternity and Newborn Care**



**Preventive & Wellness  
Services & Chronic  
Disease  
Management**



**Mental Health and Substance Use  
Disorder Services, including  
Behavioral Health Treatment**



**Pediatric Services, including  
Oral & Vision Care**



## Two Types of Financial Assistance for QHPs



### **Premium Tax Credit: 100% - 400% FPL**

New federal financial assistance will help subsidize the cost of purchasing a QHP on the Marketplace for individuals without access to other coverage that meets certain standards.

### **Cost Sharing Reductions: 100% - 250% FPL**

New federal financial assistance that will help reduce out-of-pocket costs after payment of premiums for people who are eligible for an APTC. There are special cost sharing protections for members of federally-recognized Indian tribes (which are covered later).

Individuals can receive both a premium tax credit and cost sharing reductions.

## What is a Premium Tax Credit?

- A new federal tax credit that will help subsidize the cost of purchasing a QHP through the Marketplace.
- It reduces the cost of a plan's premium.
- It is available in advance or at tax filing time. If paid in advance, known as an "Advance Payment of the Premium Tax Credit" or "APTC."
- It can be used to help purchase any metal level plan (though silver-level plans allow for the opportunity to also obtain cost sharing reductions).

# Who's Eligible For a Premium Tax Credit?

Individuals are eligible for a premium tax credit if they:

- 1 Enroll in a QHP
- 2 Have projected annual income between 100% - 400% FPL (with exception for legal immigrants).
- 3 Lack access to other coverage that meets some basic standards ("minimum essential coverage"), **including Medicaid/CHIP**. People with limited Medicaid coverage may still be eligible for an APTC.
- 4 Meet various tax-based requirements
  - Plan to file a federal tax return
  - If married, plan to file a joint tax return
  - Not eligible to be claimed as a dependent on someone else's tax return

## MEDICAID IMPACT

Low-income adults below 100% FPL are ineligible for an APTC even if they reside in a state that fails to expand Medicaid. As a result, there is a coverage "gap" for most low-income adults in non-expansion states.

## **Special Rule for Lawfully Present Individuals Below 100% FPL:**

- Immigrants with incomes below 100% FPL who are lawfully present and ineligible for Medicaid because of their immigration status may be eligible for an APTC.
- They must also meet all of the other APTC eligibility criteria that apply to individuals with incomes >100% FPL.



# Minimum Essential Coverage

Access disqualifies someone from receiving APTC/CSR.

- Basic health coverage that meets minimum standards.
- Major examples include:
  - Job-based coverage that meets “**affordability**” and “**minimum value standards**”
  - Medicaid, CHIP, TRICARE and certain other coverage.
- With a few exceptions, people are ineligible for APTC if they have access to MEC even if they are not enrolled in it

**MEDICAID IMPACT**  
If individuals are eligible for Medicaid or CHIP, they are not eligible for APTC/CSRs. This is true even if they choose not to enroll in Medicaid or CHIP.

However, limited Medicaid coverage (e.g. pregnancy-related and family planning services) does not count as MEC.

## Affordability:

- A plan is considered affordable if the person is required to contribute 9.5% of their income or less toward the lowest-cost self-only plan (the cost of family plans is not considered).

## Minimum Value:

- Job-based coverage provides minimum value if it pays for 60% of the benefits covered by the plan.

# Three Ways to Take the Premium Tax Credit

- 1 In Advance:** Families can receive the tax credit on an “advance” basis when they buy their QHP. Known as an “advance payment of the premium tax credit,” the credit makes sure that families can receive help without having to wait to file taxes at the end of the year.
- 2 At Tax Filing Time:** Families can also “front” the money to pay their premiums and receive the credit when they file their tax returns. When taken at tax filing, known as a “premium tax credit”.
- 3 Combination Approach:** People can use a combination of these approaches and take some of the premium tax credit in advance and some at tax filing time.



## End of Year Reconciliation

An individual who receives an APTC is obligated to file taxes; when they do, the IRS conducts a “reconciliation” to ensure they received the right amount of tax credit. If an individual experiences a change in circumstances during the year, they must report it to the Marketplace to ensure they receive the right amount of tax credit for the rest of the year.

### Step-by-Step Process for Reconciliation:

STEP

1

APTC recipients file their annual taxes.

STEP

2

IRS uses their tax return income to determine the appropriate size of their premium tax credit for the prior year.

STEP

3

IRS compares the size of the amount they already received in APTC to their actual premium tax credit.

- If they received more APTC than their income tax data indicates they qualify for, they must re-pay the excess. This might happen if someone gets a salary increase in the middle of a year and forgets to report it.
- If they receive less APTC than their income tax data indicates they qualify for, they receive a tax refund (or offset to any tax liability). This might happen if someone loses a job in the middle of a year and forgets to report it.

If the IRS finds that the individual has to repay credits, there is a cap on the amount they have to pay back. The cap is a sliding scale based on income. Note: There is no cap for individuals with income above 400% FPL at tax filing time.



## Cost Sharing Reductions (CSRs)

- In general, families are eligible to receive cost-sharing reductions (CSR) to help with out-of-pocket costs (not premiums) if they qualify for an APTC and their income is below 250% FPL.
- The amount of help provided by a CSR depends on a person's income – more substantial help is available to people at lower income levels.
- People who apply for insurance affordability programs are automatically assessed for CSR.
- There are special cost sharing protections for members of federally-recognized Indian tribes (this will be covered later).

## Who's Eligible for Cost Sharing Reductions ?

**Individuals are eligible for a cost sharing reduction (CSR) if they:**

- 1 Meet the eligibility criteria for APTC
- 2 In general, have annual household income below 250% FPL for the coverage year

Individuals can only get cost sharing reductions applied to their plan if they enroll in a **silver level plan**. This does not apply to members of federally-recognized Indian tribes.

## Special CSR Rules for Members of Federally-Recognized Indian Tribes

### No Cost Sharing Obligation Below 300% FPL

- Members of federally-recognized Indian tribes with income below 300% FPL are exempt from out-of-pocket costs, regardless of which plan they select. They are not required to enroll in a silver plan to qualify for this “no cost-sharing” protection.

### Limited Cost Sharing Obligation Above 300% FPL

- Members of federally-recognized Indian tribes with income above 300% FPL are exempt from cost-sharing for services provided by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services. They will have a limited cost sharing obligation regardless of which plan they select. They are not required to enroll in a silver plan to qualify for this “limited cost-sharing” protection.



New  
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# Private Insurance Market Reforms & Shared Responsibility Payment

# Major Private Market Reforms



- Young adults may remain on parent's plan until age 26 (effective 9/2010)
- Eliminates pre-existing condition exclusions – insurers no longer may refuse to cover individuals because of a pre-existing condition; to exclude coverage of the condition; or to charge individuals more because of a condition.
- Guaranteed renewal – People must be allowed to renew their coverage unless they've failed to pay premiums, engaged in fraud or meet a limited number of other conditions
- Premium pricing reforms – Plans must establish fair premiums that vary only based on:
  - Geography
  - Age (oldest beneficiaries may be charged up to 3 times as much as the youngest)
  - Smoking status (smokers may be charged up to 1.5 times as much as non-smokers)
  - Family size
  - Insurers cannot charge more because of gender or health status.

## MEDICAID IMPACT

Some individuals who might have lost coverage and ended up on Medicaid as a result of developing a serious health condition may now be able to retain their private insurance.

## Individual Shared Responsibility Payment

Beginning in 2014, each individual must have basic health coverage (minimum essential coverage) for each month, qualify for an exemption, or pay a fee (the shared responsibility payment) when filing his or her federal income tax return.

### **Reason for Shared Responsibility Provision**

The new requirement is designed to support the private market insurance reforms included in the ACA, such as the ban on denying coverage to people with a pre-existing health condition.

In the absence of this requirement, individuals might wait until they got sick to purchase insurance, making it impossible to sustain the private insurance market reforms.



## Minimum Essential Coverage

**Certain types of health coverage count as minimum essential coverage. People who have minimum essential coverage will not be assessed a shared responsibility payment.**

- Basic health coverage that meets certain standards.
- Major examples include:
  - Individual market policies
  - Job-based coverage
  - Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

**Medicaid Impact  
Medicaid and CHIP  
count as minimum  
essential coverage.  
However, limited  
Medicaid coverage  
(e.g. pregnancy-  
related and family  
planning services)  
does not count as  
MEC.**



# Individual Shared Responsibility Payment Grows Over Time

	 <i>per adult</i>	 <i>per child</i>	 <i>per family</i>	<i>% of family income above tax filing threshold</i>
<b>2014</b>	\$95	\$47.50	\$285 <i>max</i>	1% <i>family income</i>
<b>2015</b>	\$325	\$162.50	\$975 <i>max</i>	2% <i>family income</i>
<b>2016 and beyond</b>	\$695	\$347.50	\$2085 <i>max</i>	2.5% <i>family income</i>

*or*

*whichever is greater*

## Exemptions from the Shared Responsibility Payment

1. Individuals who cannot afford coverage
2. Individuals with household income below the federal tax filing threshold
3. Members of federally-recognized Indian tribes and other individuals eligible for services through an Indian health care provider
4. Individuals who experience a hardship. If people apply for Medicaid and are denied solely because their state did not expand Medicaid, they may apply for a hardship exemption
5. Individuals who experience a short coverage gap of < 3 months
6. Members of certain religious sects
7. Members of a health care sharing ministry
8. Incarcerated individuals
9. Individuals who are not lawfully present

**Individuals who decide to make the payment are uninsured and thus responsible for all healthcare costs.**



## Conclusion

- Medicaid and CHIP are a key part of the continuum of health coverage under the ACA
- The outreach and education accompanying ACA will foster greater awareness and interest in Medicaid and CHIP
- The new Marketplaces may become a major new gateway to Medicaid and CHIP coverage
- As a result of the Supreme Court decision, some states may elect not to expand Medicaid, creating a coverage gap for consumers and communications challenges for those states
- In all states, however, sweeping improvements are coming in the way that people sign up for and renew their Medicaid and CHIP coverage.

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# Appendix

## 2013 Federal Poverty Level (FPL)

The Federal Poverty Level is used to identify who qualifies for insurance affordability programs. The Federal Poverty Level is updated annually.

### 2013 Monthly Federal Poverty Level Guidelines

(all states and DC except Alaska and Hawaii)

Household Size	100%	133%	150%	200%	300%	400%
1	\$957	\$1,273.48	\$1,426.25	\$1,915	\$2,872.50	\$3,830
2	\$1,292.50	\$1,719.03	\$1,938.75	\$2,585	\$3,877.50	\$5,170
3	\$1,627.50	\$2,164.58	\$2,441.25	\$3,255	\$4,882.50	\$6,510
4	\$1,962.50	\$2,610.13	\$2,943.75	\$3,925	\$5,887.50	\$7,850
5	\$2,297.50	\$3,055.69	\$3,446.25	\$4,595	\$6,892.50	\$9,190
6	\$2,632.50	\$3,501.23	\$3,948.75	\$5,265	\$7,897.50	\$10,530



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**Thank you for participating in this training.**