NASTAD™
NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

HEALTH REFORM ISSUE BRIEF

OUTREACH, ELIGIBILITY AND ENROLLMENT

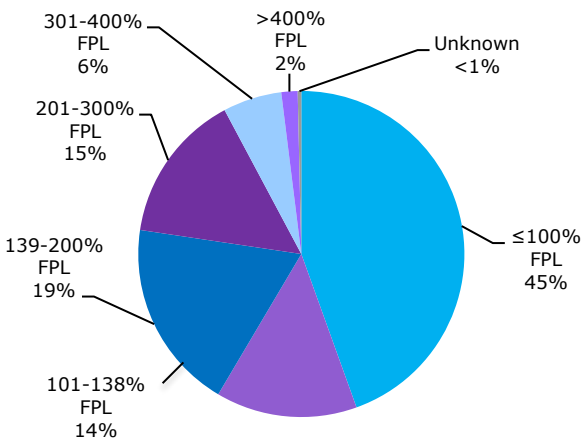
Overview

This issue brief will focus on the Affordable Care Act's (ACA) outreach, eligibility, and enrollment provisions and programs and how these provisions may interact with HIV/AIDS and viral hepatitis programs. The ACA creates streamlined, consumer-friendly processes that allow applicants to apply for multiple coverage options (e.g., Medicaid and federal subsidies to purchase private insurance) at the same time. It will be essential for AIDS Drug Assistance Programs (ADAPs) and other HIV/AIDS and viral hepatitis programs to coordinate with ACA outreach, eligibility, and enrollment processes to ensure that clients experience a smooth transition to new public and private insurance coverage options. For questions about how these systems will impact your state's HIV/AIDS and viral hepatitis programs, please contact Amy Killelea.

ACA Eligibility and Application

In 2014, tens of thousands of people living with HIV and viral hepatitis – including a significant proportion of current ADAP clients – will become eligible for public and private insurance coverage available through the ACA.

ADAP Clients Served by Income Level (June 2012)



NASTAD Annual ADAP Monitoring Report, January 2013

ACTION STEPS

As state HIV/AIDS and viral hepatitis programs prepare for health reform, there are four things to keep in mind when planning for outreach and enrollment:

1. **Align AIDS Drug Assistance Program (ADAP) and Ryan White Program income eligibility with the modified adjusted gross income (MAGI)**
2. **Require clients to accept the premium tax credit in advance**
3. **Ensure that case managers and other HIV/AIDS outreach and enrollment staff are accessing available ACA grant funding and training opportunities**
4. **Prepare a staggered client transition plan that aligns with Marketplace open enrollment and coverage effective dates**

ACA Coverage Options and Income Eligibility

2014 ACA Coverage Option	Income Eligibility Threshold
Medicaid Expansion	Income up to 138% FPL
Advance Premium Tax Credit for purchase of private insurance through Marketplaces	Income between 100 and 400% FPL (ineligible for Medicaid or affordable employer-based coverage)
Cost-sharing subsidies to offset out-of-pocket costs of private insurance through Marketplaces	Income between 100 and 250% FPL (ineligible for Medicaid or affordable employer-based coverage)
Unsubsidized private insurance coverage through Marketplaces	Income below 100% FPL (ineligible for Medicaid)

Last Updated: July 2013

As clients transition to new coverage, ADAPs and other HIV/AIDS and viral hepatitis programs are preparing their own outreach, application, and enrollment processes to align with ACA processes. The application process and eligibility criteria are discussed in detail below.

Single Streamlined Application

The ACA embraces a consumer-friendly "no wrong door" approach to application and eligibility determination. Applicants are able to apply for Medicaid and federal subsidies to purchase Marketplace coverage through a single streamlined application. Applicants will be able to apply directly through the Marketplace or through their Medicaid program. The application will be able to identify eligibility for Medicaid, Qualified Health Plan coverage, and premium tax credits and cost-sharing reductions.[1]

- **Medicaid** is available to:
  - U.S. citizens and legal permanent residents (after a five-year waiting period in most states)
  - Those eligible for the expansion population in states that are expanding (legal permanent residents with income up to 138% FPL)
  - Those who meet traditional Medicaid eligibility categories (e.g., individuals with disabilities and pregnant women)

- **Qualified Health Plan (QHP)** coverage purchased through the Marketplace is available to:
  - U.S. citizens and legal permanent residents (five-year Medicaid waiting period does NOT apply)
  - Those who reside within the state the Marketplace serves
  - Those who are not incarcerated

- **Premium tax credits and cost-sharing reductions** are available to:
  - U.S. citizens and legal permanent residents (five-year Medicaid waiting period does NOT apply)
  - Those who reside within the state the Marketplace serves
  - Those who are not incarcerated
  - Those with income between 100 and 400 percent FPL (for premium tax credit eligibility)[2] and income between 100 and 250 percent FPL (for cost-sharing reductions) who are not eligible for Medicaid or other government-sponsored coverage[3] and who do not have access to affordable employer-sponsored health coverage.[4]

    - NOTE: the tax credit may be paid in advance by the federal government directly to plans on a monthly basis, meaning that people do not have to wait until their taxes are filed to receive the subsidy, nor do they have to pay any upfront costs for premiums. However, applicants must *choose* to have the full tax credit paid in advance. Applicants have the option of foregoing the full amount of the advance tax credit, paying the full cost of their premiums, and receiving the tax credit when they file their federal taxes.[5]

Modified Adjusted Gross Income (MAGI)

MAGI is the formula that will be used to determine income eligibility for most Medicaid applicants as well as income eligibility for subsidies to purchase private insurance.[6] The purpose of moving to MAGI is to standardize income determinations across Medicaid and the Marketplaces. MAGI is based on Internal Revenue Service (IRS) definition of adjusted gross income with a few modifications:

- MAGI = Adjusted Gross Income minus certain income (e.g., alimony and business expenses)
- No asset tests or income disregards
- Non-taxable portion of social security benefits (e.g., Social Security Disability Income benefits) are counted as income
- Household = tax filing unit (individual and anyone the individual can claim as tax dependent)[7]

In preparation for open enrollment, states are developing income screening tools – like the one developed by the Duke AIDS Legal Project to help assess ADAP client eligibility for Marketplace coverage. To learn more about MAGI please see NASTAD's MAGI Definition Chart.[8]

STEP 2 Current job & income information

☐ Employed – If you're currently employed, tell us about your income. Start with question 1.
☐ Not Employed – Skip to question 11. ☐ Self Employed – Skip to question 10.

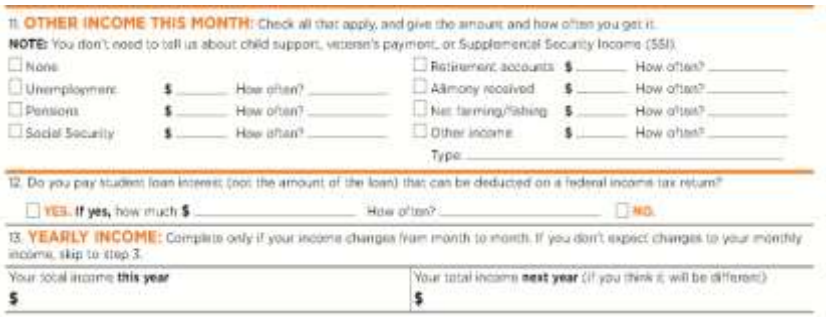
CURRENT JOB 1:

1. Employer name and address | 2. Employer phone number ( ) – | 3. Average hours worked each week

4. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

Applicant should have employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements).



11. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Retirement accounts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing $ _____ How often? _____
☐ Other income $ _____ How often? _____
Type: _____

12. Do you pay student loan interest (not the amount of the loan) that can be deducted on a federal income tax return?

☐ YES. If yes, how much $ _____ How often? _____ ☐ NO.

13. YEARLY INCOME: Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to step 3.

Your total income this year: $ | Your total income next year (if you think it will be different): $

Premium tax credits and cost-sharing reductions are based on annual income. If an applicant's income fluctuates, he/she should estimate annual income, but should report any changes in income to the Marketplace throughout the year.

Enrolling in the Right Plan

After applicants are found eligible for coverage, they will have to enroll in Medicaid (which may include a Medicaid managed care plan[9]) or a QHP. The Marketplace will include a "plan finder" function to help consumers determine the benefits covered, the providers included in the plan network, and the costs associated with coverage. In addition, ADAP insurance purchasing programs may limit the plans for which ADAP will provide premium and cost-sharing obligations of clients (based on the plans' scope of coverage and cost), and ADAP clients and AIDS Services Organizations, case managers and others assisting clients into insurance will need to take this information into account when choosing a plan. Consumer assistance programs and resources (discussed in more detail below) will be available to help consumers find the plan that meets their care, treatment, and affordability needs. For more information on the benefits available through ACA coverage options see NASTAD's Health Reform Issue Brief on Essential Health Benefits.

Coverage Effective Dates

After an individual is found eligible for Medicaid or QHP coverage through the Marketplace, the actual date that coverage begins may vary. ADAPs and other HIV/AIDS and viral hepatitis programs should familiarize themselves with coverage effective dates to ensure clients do not experience harmful disruptions in care and treatment.

COVERAGE EFFECTIVE DATES	
Medicaid	QHP Through Marketplace
Up to 90-day eligibility determination	Eligibility determination "promptly and without undue delay"
Continuous enrollment	Open enrollment periods: • Individuals must enroll in Marketplace coverage during open enrollment (extended open enrollment for first year runs from October 1, 2013 through March 31, 2014; subsequent open enrollment periods will be from October 15 through December 7 annually). Special enrollment periods: Individuals may enroll in coverage outside of the open enrollment period if a specific triggering event occurs.[10]
Retroactive coverage up to 3 months prior to the date of application	Coverage begins: • If the plan selection is received by the Marketplace on or before December 15, 2013, coverage begins January 1, 2014. • If the plan selection is between the 1st and 15th day of any subsequent month during the open enrollment period, coverage begins the first day of the following month. If the plan selection is received between the 16th and last day of the month, coverage begins the first day of the second following month.

ACA Outreach and Enrollment Opportunities

Starting October 1, 2013, consumers will be able to apply for and enroll in health insurance coverage through Marketplaces. To help consumers understand their new options and to apply for and enroll in appropriate coverage, the ACA includes a number of consumer assistance programs and opportunities discussed in detail below.

- **Patient Navigators** are funded entities (through grants run by state-based Marketplaces or the federal government in federally facilitated and partnership run Marketplaces) that will assist consumers in applying for ACA coverage as well as provide outreach and education about the Marketplace. Navigators must observe conflict-of-interest standards and must complete comprehensive training.

- **In-person assisters** are funded entities (through grants run by state-based Marketplaces) and will perform generally the same functions as Navigators. They will only be available in state-based Marketplaces. In-person assisters must also abide by conflict-of-interest standards and complete comprehensive training.

- **Certified application counselors** will perform many of the same functions as Navigators and in-person assisters, including consumer education and application and enrollment assistance. They will not receive new Marketplace grant funding for these activities. Certified application counselors must also abide by conflict-of-interest standards and will be required to complete comprehensive training.

- **Community health centers** will receive separate federal funding to provide in-person enrollment assistance to help people enroll in ACA coverage. This funding will allow community health centers to ramp up their application assistance staff to prepare for the influx of people who will be newly eligible for Medicaid and Marketplace coverage.

Opportunities for HIV/AIDS Program Coordination with ACA Outreach, Eligibility, and Application Programs and Processes

To coordinate with ACA eligibility processes, ADAPs and other HIV/AIDS programs are considering the following:

- *Aligning ADAP and Ryan White Program income eligibility with MAGI*

  As ADAPs prepare systems for ACA implementation, many are considering aligning ADAP income criteria with ACA income criteria (MAGI). To assess the impact of using MAGI instead of current income criteria, ADAPs are taking a sample of clients and using the new MAGI methodology to determine impact (if any) on ADAP income eligibility. Several states that have conducted this analysis are transitioning to MAGI for ADAP income eligibility for the sake of administrative simplicity. In addition, because recipients of the ACA's premium tax credits *must* file federal taxes in the year in which they receive the tax credit, ADAPs are considering requiring applicants to provide federal tax return information to demonstrate income eligibility. Educating clients about tax filing and directing them to tax preparation resources will be particularly important given the fact that many clients do not currently file federal taxes.

- *Requiring clients to accept the premium tax credit in advance*

  Applicants will have the choice to receive the premium tax credit in advance (meaning that the credit is paid directly to the plans on a monthly basis at the point a person enrolls in coverage) or to forego the full amount of the advance payments, pay the full cost of premiums, and receive the tax credit when federal taxes are filed (meaning that the credit would be paid directly to the taxpayer). For administrative purposes, if ADAPs are assisting clients by paying premiums, they should consider requiring clients to take the premium tax credit in advance. Clients indicate this decision when applying for insurance and the premium tax credit during open enrollment. This will allow ADAPs to better track the amount of premium tax credit clients are receiving and to coordinate monthly payment of any remaining premium obligation. It will also prevent the ADAP from having to attempt collection of any overpayments returned to the client at the end of the year. Clients should also be made aware that they must promptly report changes in income that would affect their premium tax credit amount to the Marketplace. If the federal government overpays the client's advance premium tax credits, the overpayment will be recouped when the client files federal taxes for the year in which he/she received the credit.[11] See NASTAD's Issue Brief on Premium Tax Credits and Cost-Sharing Reductions for more information.

- *Ensuring that case managers and other HIV/AIDS outreach and enrollment staff are accessing available ACA grant funding and training opportunities*

  Many state HIV/AIDS and viral hepatitis programs and community-based organizations applied for Patient Navigator funding (either as a lead entity or as part of a consortium of applicants). HIV/AIDS and viral hepatitis programs are also investigating training and certification opportunities – for instance through the certified application counselor program – to ensure that health department staff (including case managers) are aware of ACA coverage options and application procedures so that they can help clients navigate application and enrollment starting in October 2013. Training and certification for participation in ACA outreach and enrollment activities will begin in late summer 2013. HIV/AIDS and viral hepatitis programs are also working with Marketplaces and other safety net providers (e.g., community health centers) to ensure that information about available HIV/AIDS and viral hepatitis services and programs – including ADAP – is available through broader ACA outreach and enrollment activities. Effective client education, outreach and enrollment efforts are particularly important to reach vulnerable populations and populations most impacted by the HIV/AIDS epidemic (e.g., gay men and men who have sex with men (MSM) and communities of color). HIV/AIDS and viral hepatitis programs as well as

community-based organizations should think innovatively about how to use ACA funding and training opportunities to develop targeted outreach and enrollment programs.

- *Preparing a staggered client transition plan that aligns with Marketplace open enrollment and coverage effective dates*

  HIV/AIDS and viral hepatitis programs are creating detailed transition plans for current Ryan White and ADAP clients who will be moving to new ACA coverage options. Following assessment of clients' current sources of coverage and potential eligibility for ACA coverage options, states are developing a staggered transition plan for clients. Planning will take into account the limited open enrollment period for Marketplace coverage (October 1, 2013 through March 31, 2014), the closure of the federal Pre-existing Condition Insurance Plans (PCIPs) and many state high risk pools on December 31, 2013, and the coverage effective dates of Medicaid and QHP coverage. Colorado offers a useful model for ACA transition planning.

Resources on ACA Eligibility, Outreach, and Enrollment Provisions

- Enroll America is a non-profit organization whose mission is to ensure that all Americans are enrolled in and retain health coverage. Enroll America will be developing a number of resources to assist consumers as they transition to ACA insurance coverage in 2014.

- Consumers Union is a non-profit organization that advocates for consumer protections in the health insurance world and is developing resources to help inform health reform implementation in ways that ensure smooth enrollment processes.

- Families USA has developed a number of issue briefs and other documents geared toward consumers on a range of ACA topics, including affordability provisions.

NASTAD Resources on Health Reform

- NASTAD Health Reform Website houses NASTAD's presentations, issue briefs, fact sheets, and other resources on health reform.

- NASTAD Blog provides timely updates and breaking news with regard to federal and state health reform implementation.

[1] States had the option to allow the Marketplace to conduct eligibility determinations for Medicaid or allow the Marketplace to screen for Medicaid eligibility and electronically send the application to the state Medicaid program for a final eligibility determination. Under either approach, the consumer experience should be the same. See State Health Reform Assistance Network, Policy Brief: Overview of Final Medicaid Eligibility Regulation, April 2013, available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf72572.

[2] Tax credits are also available for legal immigrants with incomes *below* 100 percent of the FPL and not eligible for

[3] Government-sponsored coverage includes Medicare, Medicaid, the Children's Health Insurance Program, TRICARE, or veterans' health care.

[4] "Minimum essential coverage" is defined as having access to an employer-sponsored plan that costs less than 9.5 percent of the individual's household income and has an actuarial value of at least 60 percent.

[5] 45 CFR §155.310(d)(2).

[6] ACA, § 2002; Centers for Medicare and Medicaid Services, Final Rule: Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010, 42 CFR Parts 431, 435, and 457, available at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/html/2012-6560.htm.

[7] See National Health Law Program, Modified Adjusted Gross Income (MAGI): A Primer (April 2013), available at http://www.healthlaw.org/images/stories/2013_04_Vol_12_Health_Advocate.pdf.

[8] The U.S. Supreme Court's decision striking down a key portion of the federal Defense of Marriage Act (DOMA) will affect the federal definition of household for purposes of MAGI. This means that same-sex married couples must report their combined household income for the purposes of determining eligibility for federal programs.

[9] In addition, some states are considering using federal Medicaid funding to pay for private insurance coverage through the Marketplace for Medicaid-eligible individuals rather than through the traditional Medicaid program. CMS has released guidance on the premium assistance plan, requiring that states implementing a premium payment plan for Medicaid ensure that Medicaid protections and requirements are followed, including Medicaid cost-sharing limits and access to Medicaid required benefits.

[10] The following circumstances constitute triggering events that would allow someone to apply for Marketplace coverage outside of the open enrollment period:

- A qualified individual or dependent loses minimum essential coverage;
- A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;
- An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
- A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Marketplace or HHS, or its instrumentalities as evaluated and determined by the Marketplace. In such cases, the Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
- An enrollee adequately demonstrates to the Marketplace that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An 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, regardless of whether such individual is already enrolled in a QHP. The Marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A qualified individual or enrollee gains access to new QHPs as a result of a permanent move;
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and
- A qualified individual or enrollee demonstrates to the Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Marketplace may provide. 45 CFR § 155.420.

[11] The overpayment amount is capped at $300 for an individual with income of 200 percent FPL or lower and gradually increasing to a cap of $1,750 for an individual with income of 500 percent FPL.