Medicaid Expansion in Federal Health Care Reform: The Gift of the MAGI

This article was co-authored by Trilby de Jung of Empire Justice and Lisa Sbrana of the Legal Aid Society and published in the Summer 2010 issue of the Legal Services Journal.

"The Gift of the MAGI" is a famous O. Henry short story about a poverty-stricken husband and wife who make personal sacrifices to give each other gifts. The functional value of the gifts turn out to be hugely diminished by the sacrifice each made for the other. She cuts and sells her long, beautiful hair so that she can buy him a band for his watch. He sells his watch to buy her a comb for her hair. (Here is a link if you would like to read the whole story: http://www.auburn.edu/~vestmon/Gift_of_the_Magi.html)

MAGI is also the name of the new form of Medicaid budgeting that will be required of all states starting in 2014 under the Patient Protection and Affordable Care Act (PPACA). It stands for Modified Adjusted Gross Income. MAGI comes with gifts - higher income levels, streamlined budgeting, and enhanced federal reimbursement. However, MAGI also introduces challenges for New York. The transition will be complex as the changes will not apply to all Medicaid applicants and benefit packages may require adjustment.

This article will explain the Medicaid expansion in federal health care reform and explore some of the repercussions for New York State. At the conclusion, you can be the judge of the value of MAGI for our clients.

Fundamental Change to Categorical Eligibility Rules

Section 2001(a)(1) of PPACA establishes a new Medicaid eligibility group and mandates coverage for the new group up to 133 % of the federal poverty level (FLP) by 2014. In essence the law defines the new group by filling in the gaps in existing Medicaid. Thus, the law describes the individuals eligible under the new group as those who are not:

- Age 65 or older;
- Pregnant;
- Entitled to or enrolled in benefits under Medicare Part A;
- Enrolled under Medicare Part B; or
- A member of any of the other mandatory groups in the statute [Subsections (I)-(VII) of section 1902(a)(10)(A)(i) of the Social Security Act] - i.e. not children, certain parents, or persons eligible under the SSI program.

PPACA describes the new group in a new Subsection VIII of Â§1902(a)(10)(A)(i) of the Social Security Act. Thus the new group is referred to as the Subsection VIII group, or the

VIII group. In essence, the VIII group is comprised of those historically considered the "undeserving poor" -- childless adults under age 65.

States are required to extend eligibility to those with income up to 133% of the FPL in the VIII group beginning January 1, 2014. However, states have the option of taking several other steps. States can expand coverage to the new VIII group sooner, and if they do, they can expand the VIII group to include other low-income adults, such as parents and SSI-related groups. In addition, states like New York that have utilized presumptive eligibility for pregnant women and children could extend presumptive eligibility to the new VIII group, as well as to parents and caretakers. Finally, beginning in 2014, states can elect to cover the new VIII group beyond 133% of the Federal Poverty Level (FPL).

The new VIII group is subject to all existing rules in Medicaid, such as rules regarding immigration status and residency.

For many states, mandated coverage of the new VIII group up to 133% of FPL will significantly expand access to public health insurance coverage because childless adults are not covered by most state Medicaid programs. In New York, while there will certainly be some newly eligible adults, the increase in coverage will be less dramatic. New York's Family Health Plus (FHP) program currently covers childless adults with income up to 100% of the FPL. This means that the mandated newly eligible in New York will be limited to childless adults with income between 100% and 133% of the FPL.

Fundamental Changes to Budgeting Rules

MAGI Budgeting - Section 2002 of PPACA provides that, starting in 2014, states must eliminate resources tests and transition to a new form of Medicaid budgeting for most, but not all, Medicaid applicants. The new budgeting uses adjusted gross income as defined in the Internal Revenue Code, Â§36B(d)(2). PPACA requires states to modify the adjusted gross income by applying the 5% disregard- thus the term Modified Adjusted Gross Income, or MAGI.

States must use the new MAGI form of budgeting for most Medicaid applicants (including those in the new VIII group) beginning in 2014. The combined effect of mandating coverage up to 133% of FPL, and then requiring use of MAGI budgeting, effectively raises the income level for most Medicaid applicants to 138% of the FPL.

The shift to MAGI budgeting rules will have several significant consequences. First, MAGI, as defined in the tax code, does not include the types of disregards we are used to in Medicaid, such as earned income and child care disregards. While the new five percent income disregard will be helpful, it is not likely to fully offset the elimination of earned income and child care disregards. However, MAGI allows for deductions of other income not currently deducted under Medicaid, including alimony and educational expenses such as student loans. Deductions that are allowed under adjusted gross income include trade and business deductions of the taxpayer, losses from the sale or exchange of property,

alimony, retirement savings, moving expenses, interest on educational loans, higher education expenses, and health savings accounts. For a full list of adjusted gross income deductions, see 26 U.S.C. Â§62. Also, under the IRS/tax model, certain income is not countable as gross income. This includes SSI and Social Security Survivor benefits in certain circumstances, as well as child support.

Second, MAGI defines family size as those who file taxes together. In MAGI, if a step-parent is in the family and the parent and the step-parent file taxes together, the step-parent's income will be included and counted in a child's budget. Likewise, a grandparent or kinship caregiver who might be excluded from a child's budget under current Medicaid rules, may be included in the family unit and have his or her income counted, assuming the caregiver files taxes and counts the grandchild or kinship child as a dependent for tax purposes.

PPACA does instruct states to develop eligibility standards that will not cause individuals who would be eligible on March 23, 2010 to lose coverage. However, achieving that goal for all may be challenging. Further guidance from Centers for Medicare and Medicaid Services (CMS) is needed to clarify how MAGI should be implemented. Eligibility workers and advocates will need to become familiar with tax rules and may need to consult clients' tax returns to screen for Medicaid eligibility.

Once the dust has settled, MAGI budgeting will likely be beneficial for many of our clients, as will the expansion of income eligibility to 133% for the new VIII group. However, not all applicants will be able to use the new MAGI budgeting. Moreover, not all will escape the asset test.

Exclusions from MAGI Budgeting - The following individuals are excluded from MAGI budgeting. PPACA allows states to continue to use asset tests for those who are excluded from MAGI budgeting.

- SSI recipients and children in foster care;
- Those over 65;
- SSI-related applicants;
- Those utilizing spend down to access Medicaid (the medically needy);
- Medicare Savings Plans (MSP) enrollees;
- Those utilizing long-term care services, either community-based or institutional.

Federal health care reform has thus created a new division between Medicaid applicants. Those who will use MAGI; and those who remain subject to the more complicated form of disregard budgeting. Those who cannot be subject to an asset test, and those who can still be required to prove assets below a level set by the state.

New York is already running a two tiered system with regard to asset tests. New York eliminated the asset test for all adults budgeted under the single/childless couple category and for all adults with minor children budgeted under the Aid for Dependent Children category in January of 2010. The asset test was eliminated earlier for pregnant women and

children. Individuals who remain subject to an asset test in NY - those in need of long term care services, or certified disabled or blind, or over the age of 65 - are also excluded from MAGI budgeting under federal law.

New York's two-tiered system may become even more pronounced under PPACA, however, because the federal law aligns eligibility for those who use MAGI with eligibility for tax credit subsidies in the Exchanges (see below for more information on Medicaid alignment with the Exchanges). This means that outreach and enrollment processes for those who use MAGI to qualify for Medicaid, and those who apply for subsidies in the exchange are likely to be parallel if not completely alike. The process for Medicaid recipients and applicants who cannot use MAGI and are still subject to an asset test, will be governed by different rules and may end up looking very different.

Recognizing the risks associated with utilizing different eligibility standards for low-income elderly and disabled applicants, Congress did include a provision in PPACA that allows the Secretary to waive the provisions excluding dual eligibles from MAGI, "to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals." PPACA Â§ 2002(a). However, it is not clear that pushing for MAGI budgeting would be beneficial for all dual eligible New Yorkers. While alignment with the mainstream insured population is almost always beneficial, some individuals eligible for Medicaid using the generous earned income disregards in SSI-related budgeting might actually lose coverage using MAGI.

Streamlining Eligibility and Enrollment - Aligning Medicaid with the Exchange

PPACA requires states to create Health Benefit Exchanges (Exchanges), or market places in which people can buy private insurance. Section 1413 of PPACA requires the federal government to establish a system that allows state residents to apply for "state health subsidy programs", which are broadly defined to include not just tax subsidies for private insurance, but coverage under Medicaid and Child Health Plus (CHP) programs as well. Thus, enrollment in all three programs is to be coordinated.

By 2014, individuals must be able to apply online for all three options using the same application. State systems must be capable of cross-screening for eligibility. Individuals who qualify for both public health coverage (Medicaid or CHP or in New York, FHP) and tax subsidies for private coverage are to receive information sufficient to allow for an informed choice between the options.

States are also required to establish, verify and update eligibility for participation in all three programs using data matching arrangements and must determine eligibility based upon reliable third party data. The only exception is when the costs of using a data matching arrangement outweigh expected gains in accuracy, efficiency and program participation.

These provisions offer incredible promise for our clients, who are often overwhelmed and defeated by New York's complex application and enrollment process. The screening provisions in particular have the potential for creating a "no wrong door approach", which has tremendous potential for enrolling the significant number of children who fall through the cracks between Medicaid and Child Health Plus during the renewal process. The requirement that there be a single application available online for both applications and renewals also offers a tremendous opportunity to enroll and retain the estimated 900,000 New Yorkers who are currently uninsured, but eligible for public health insurance.

The no wrong door approach should also significantly reduce barriers currently imposed by the variation in eligibility processes in different counties across New York, and help make the application and renewal processes more uniform across the state. In addition to these changes on the federal level, the State Legislature passed legislation in June authorizing the Commissioner of the Department of Health to "create and implement a plan for the state to assume the administrative responsibilities of the medical assistance program performed by social services districts." This legislation promises to bring about significant changes in how New York runs the Medicaid program, providing an opportunity for uniformity in the application and renewal processes and in how benefits are administered (S. 6608/A. 9708, Part B. Sec. 47-b).

Nothing in PPACA prohibits states from contracting with private entities to determine eligibility for all applicable state health subsidy programs. However, PPACA has not disturbed the Title XIX requirement that Medicaid eligibility be determined by a public agency. Â§1413(d). This means that the state Medicaid agency will continue to be responsible for Medicaid determinations and cannot delegate this authority because of private contracting related to coordinated enrollment processes.

Advocates will need to think carefully about processes and forms as they are being created to assess whether they meet the needs of our clients. It will be important to track the regulations regarding data matching carefully to protect client confidentiality and minimize discrepancies that could trigger unnecessary inquiries, even fraud investigations for our clients. Literacy level and language access will also need to be addressed, as will the never-ending challenge of minimizing the amount of information that is required of our clients, in order to reduce barriers to enrollment.

New Financial Funding - but Only for Benchmark Coverage?

Section 2001 of PPACA temporarily increases the federal medical assistance percentage (FMAP) for newly eligible Subsection VIII populations. Enhanced Federal Funding for newly eligible Subsection VIII individuals is 100% for the first three years of the mandatory program (2014-2017). Enhanced matching funds will ramp down gradually to the level of 90% in the year 2020 and thereafter. States like New York that already cover some of the newly eligible with state funds or through a waiver will receive the increase in federal funding at a lower rate (75%) initially, ramping up to the same level (90%) as other states by 2020.

The gift of enhanced federal funding does not come without strings. PPACA Â§ 2001(b) prohibits states from imposing any eligibility standards, methodologies or procedures that would be more restrictive than what existed in their Medicaid or SCHP programs on the date the new federal law was enacted. This Maintenance of Effort (MOE) requirement continues for adults until 2014, although coverage can be modified for certain adults (e.g. parents) starting in 2011 based on the State's certification of a budget deficit. MOE continues for children, under CHP and Medicaid, until 2019.

While the MOE provisions generally benefit our clients here in New York, another string in the federal funding provisions may work in the opposite direction. Under Â§2001(a)(2), the new federal matching funds will not be available for the VIII group unless they are receiving what federal law refers to as "benchmark" or "benchmark-equivalent" coverage (42 U.S.C. Â§1396u-7(b)(1)(d)). Some groups are exempted from enrollment in benchmark coverage, including those who qualify for Medicaid as disabled. In addition, benchmark coverage includes an option for "Secretary approved coverage." States that elect the early coverage option prior to 2014 may be permitted to provide full Medicaid coverage for Section VIII individuals.

New York's Medicaid coverage is currently more comprehensive than the benchmark coverage defined in federal law. It will be very important for New York State to opt for Secretary-approved coverage in order that we not lose precious ground in ensuring that Medicaid covers all medically-necessary services.

PPACA Â§1331 allows states to offer a "Basic Health Program" for individuals between 134% and 200% of the FPL through the exchange. Given that prior to the adoption of the PPACA, New York requested a federal waiver to raise the Family Health Plus (FHP) income levels for childless adults and those living with minor children to 200% of the FPL, whether FHP can become New York's Basic Health Program should be explored.

In Conclusion

MAGI and other provisions in the PPACA have the potential to not only bring in new federal funds, but also hopefully qualify more people for public health insurance coverage, and streamline the eligibility and enrollment process. MAGI's reach from public programs into subsidies for private coverage will help break down the separate nature of Medicaid. MAGI is precious gift indeed if it can move the Medicaid program closer to an identity as a health insurance program rather than a welfare benefit. Nevertheless, we need to take time and care in designing the transition process, to ensure that we have not left those excluded from MAGI behind. In the end, the value of the gift of MAGI is likely to depend on who your client is, just as the O. Henry's story teaches.

This article was authored by the Empire Justice Center and the Health Law Unit of the Legal Aid Society.

Article ID: 141
Last updated: 22 Oct, 2010
Revision: 1
Federal Health Reform -> Medicaid Expansion in Federal Health Care Reform: The Gift of the MAGI
http://health.wnylc.com/health/entry/141/