

Appendix A

The EZ Method: Getting to a Simplified Application Process Through “No Wrong Door”

The Challenge: To fulfill Section 1413’s vision of a single, streamlined application process which enables individuals, regardless of where they apply, to obtain a determination of their eligibility for any applicable state health subsidy.

Premise: The type of burdensome eligibility processes now employed by Medicaid programs will greatly suppress participation and defeat the purposes of the Affordable Care Act. The millions of uninsured Americans who are currently eligible for but not enrolled in Medicaid attest to that reality. It is therefore better to simplify the application process, even if that means that some applicants receive less favorable coverage or subsidy than they might obtain through a more exhaustive assessment of eligibility.

Objectives:

- Minimize the number of applicants who have to submit the full application, including resource and disability information, required to determine eligibility for many categories of traditional Medicaid eligibility. That application is burdensome, invites a political backlash from middle class applicants seeking the premium tax credit, and will needlessly deter applications from MAGI eligible individuals.
- Ensure that, to the maximum extent possible, every person who completes the streamlined application receives **some kind of state health subsidy** on the strength of that application alone, even if the completion of the traditional Medicaid application would qualify the person for better coverage. Make sure the person is at least enrolled in the program for which she can most easily apply, before asking her to complete the more onerous application for traditional Medicaid, so that she doesn’t leave the application process empty-handed.
- Avoid asking people up front whether they are willing to submit the burdensome information required for a full assessment of traditional Medicaid eligibility. Many will make the wrong choice. Many who do request a comprehensive Medicaid eligibility assessment would be eligible under MAGI but will fail to complete the full application, resulting in their getting no health subsidy at all.
- Ensure that everyone who is enrolled in a category that provides less than the standard full Medicaid coverage package is offered an opportunity to be fully screened for traditional Medicaid.

The process:

- Divert applicants who are over 65 or receiving Medicare, and who cannot qualify for any subsidy program other than traditional Medicaid; require them to complete the full Medicaid application. Everyone else (except undocumented individuals or, in 1634 states, SSI recipients) completes the streamlined application.
- The streamlined application only collects MAGI information, and perhaps a few additional pieces of information (e.g., pregnancy status) whose value, in terms of making applicants eligible, outweighs the additional increment of burdensomeness to answer.
- Determine those categories of traditional eligibility for which there is no resource requirement (e.g., pregnancy and children’s coverage).
- Assess everyone else for eligibility with MAGI under 133% FPL, including some who, for purposes of FMAP calculations, cannot be considered newly eligible under Subsection VIII, § 2001(a)(1). The Secretary’s authorization of a sampling methodology would make it unnecessary for purposes of FMAP calculations to determine on an individual basis which Medicaid enrollees are newly eligible. Sampling can reliably ensure that Medicaid costs are allocated between the federal government and the states in accordance with the law. Quality assurance rules provide a precedent. See 42 C.F.R. §§ 431.814 and 431.978.
- States that choose to provide the *standard full Medicaid coverage package to all Medicaid beneficiaries*, as authorized by 42 C.F.R. § 440.330, need not test anyone for traditional Medicaid

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eligibility who qualifies through the streamlined process. That choice also relieves the state of any need to identify those who are exempt from benchmark benefits under 42 C.F.R. § 440.315.

- States that choose to provide *less generous coverage to the newly eligible* must:
 - notify everyone who is enrolled through the streamlined process that they can seek better coverage by completing the full Medicaid application or submitting proof that they are benchmark exempt 42 C.F.R. § 440.315; the notice should inform them of their right to appeal a denial of the more favorable coverage.
 - also use reasonably available data matches to identify everyone who is exempt from benchmark benefits under 42 C.F.R. § 440.315, without requiring them to apply for exempt status. For example, the state should check foster care payment data to identify children exempt under § 440.315(h). Claims data should be used to identify those receiving long term care, or whose utilization reflects medical frailty or special needs. In the case of determinations of exempt status that are made on the basis of claims data, the benchmark exemption should relate back to the person’s date of initial enrollment or for some fixed period (e.g., six months) prior to the determination of exempt status.
- Absent a request by an applicant, the state will only demand information on resources and other traditional Medicaid eligibility criteria from those who: (1) cannot qualify for Medicaid through the streamlined process AND (2) whose incomes are below a specified income ceiling. For purposes of illustration, the chart sets that ceiling at 200% [see purple box]. The actual income ceiling should be set based on an empirical analysis of the characteristics of relevant eligibility categories. The income level is not a literal limit or cap on eligibility but merely serves as a trigger, below which a person is asked for further Medicaid eligibility information. The level should be set at a level below which there is a reasonable possibility of qualifying under a category (e.g., Medically Needy, Pickle Amendment, disabled adult child, etc.) of traditional Medicaid that covers individuals above 135% FPL. The use of this income level avoids the burden, cost and political backlash of asking for Medicaid information from individuals whose MAGI is too high for them to have any realistic prospect of qualifying for Medicaid under a traditional category of eligibility.

NOTE: The income ceiling that triggers a demand for resource and other traditional Medicaid eligibility information should be set as low as is defensible. Since the law bars those who are eligible for Medicaid from receiving a premium tax credit, the income ceiling needs to be set at a level which the Secretary can defend as effectively capturing all, or close to all, of those who would be Medicaid eligible. That is so that those who are not Medicaid eligible via the streamlined process can immediately qualify for a premium tax credit, a result that is in keeping with the goal of ensuring that all eligible applicants get *some* coverage at the end of the streamlined process. Those above 135% FPL but below the ceiling will get *no* subsidy at all without submitting a traditional Medicaid application, a requirement that will leave many people without coverage; hence the need to set that ceiling as close to 135% FPL as possible.

Notes to the asterisked sections of the chart:

- * Notice will advise applicant that she is eligible for limited Medicaid benefits and can seek additional benefits by submitting further info. [to qualify for traditional Medicaid or benchmark-exempt status].
- ** Notice will explain why applicant is ineligible for Medicaid benefits [based on MAGI determination], advise that she can appeal and/or submit further information [for traditional Medicaid eligibility].
- *** Notice will explain why applicant has been found ineligible for Medicaid under either new or traditional categories, will advise of appeal rights.
- **** 200% FPL is used here for purposes of illustration. Actual income ceiling percentage should be based on analysis of empirical data to determine income ceiling that can reasonably be expected to catch those individuals with incomes above 133% FPL who would qualify for Medicaid under traditional eligibility rules that require the testing of resources or determination of disability.

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