The Health and Human Service Integration Opportunity Toolkit

What's in the Affordable Care Act

The health insurance reform law, the Patient Protection and Affordable Care Act (ACA), became law in March 2010. This brief provides the basics of the law with a focus on what is most relevant to human services integration.

ACA Overview

- **ACA expands coverage.** Medicaid will cover adults and children up to 138 percent of the federal poverty level.[1] This represents a substantial eligibility expansion for adults, especially those without minor children. Income will be counted using a new methodology (Modified Adjusted Gross Income) based on federal tax rules that is substantially simpler than current methods and is consistent across all subsidized health programs (Medicaid, CHIP, exchange subsidies). In many cases, states will be able to use income tax data to determine eligibility for health programs.[2] In addition, the law eliminates the Medicaid asset limit for nonelderly adults and children. These changes must take effect by Jan. 1, 2014, but states have the option of implementing them earlier. Individuals with incomes too high to qualify for Medicaid but under 400 percent of the federal poverty level will qualify for tax-based subsidies to allow them to purchase insurance through the health insurance exchanges.
- **ACA requires the creation of health insurance Exchanges.** A health insurance exchange is a regulated marketplace where eligible consumers can purchase health insurance with federal subsidies. Most exchanges will be run by states, although if a state chooses not to run an exchange or if they do not meet federal requirements, the federal government will do so. Exchanges will have a range of obligations, including: helping individuals determine their eligibility for Medicaid, CHIP, or other state or local health programs; enrolling eligible consumers; helping individuals calculate available health tax credits, and establishing a website to fulfill these obligations.
- **ACA calls for a no wrong door approach.** Consumers can apply for coverage with the exchange, with the social services agencies that determine Medicaid eligibility, or with a CHIP program. Consumers must be allowed to apply in-person, on-line, by mail, by fax, or by phone. However and with whatever office the application is filed, government agencies must work together behind the scenes to determine eligibility and route each applicant and family member to the right program.
- **ACA requires most individuals to obtain health coverage.**[3] Beginning in 2014, individuals who can afford to do so are required to maintain a basic level of health care coverage or else pay a tax penalty.[4]

ACA and Human Services Integration

To meet the requirements of the ACA, states are making major upgrades to their eligibility determination systems, with significant federal financial support. This presents an unprecedented opportunity to bring the ACA vision of a modernized, seamless customer-friendly eligibility system to human

services as well.

Section 1561 of ACA, which discusses information technology requirements for eligibility systems, requires the Department of Health and Human Services (HHS) to "develop interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs" (emphasis added). The standards and protocols must allow for:

- **Electronic data matching** against existing data in federal and state systems, such as the Internal Revenue Service and the Social Security Administration, in lieu of paper-based documentation requirements (e.g. having to bring in paystubs and birth certificates);
- **Simplification and submission** of electronic documentation, digitization of documents, and systems verification of eligibility; and
- **Online access** for managing application and recertification, i.e. applicants should be able to access and track information about their eligibility and recertification at points of health care service and other community-based locations.

HHS developed guidelines to help states implement Section 1561. The underlying philosophy of the recommendations is that the consumer will be best served by a health and human service enrollment system that is transparent, makes decisions in real time when possible, accommodates a range of consumers, provides confidentiality and privacy, and connects consumers not only with health coverage but also with the range of other human service programs.[5]

Some of the guidelines developed by the Office of the National Coordinator for Health Information Technology recommend[6]:

- **Standardization of core data:** Federal and state agencies administering health and human service programs should use the National Information Exchange Model (NIEM) guidelines to develop and support translation standards for consistent use of data among programs and states. This does not require states to change how they currently store data, but requires a consistent methodology for allowing databases to talk with each other.
- **Verification interfaces:** Federal agencies are required to share data with states to inform eligibility decisions. The federal government is building a central data hub so that states can match with a single data source that will include information from multiple federal agencies.
- **Business rules:** The policies and practices that states use to determine eligibility should be built into a computerized "rules engine" to make the eligibility process more transparent and make it easier to reuse the logic underpinning eligibility determinations across programs and states. The federal government will keep a repository of all of the rules for public health insurance coverage. Business rules covering human service programs should be added to the repository over time.
- **Privacy and security:** Consumers should have access to timely and accurate information about their eligibility and enrollment as well as knowledge of how their enrollment information will be used and should be able to request updates to their information. Consumers should be able to designate third parties to assist with enrollment, and should be able to designate specific levels of access a third party has to consumer information. States are responsible for implementing strong security safeguards.

Endnotes

1. Individuals and children with income below 133% of the federal poverty level (FPL) will be eligible for Medicaid, and there is a 5% income disregard, so effectively those with income below 138% FPL will be covered.
2. Individuals whose income is too low to file taxes, and individuals whose income has fluctuated from the previous tax year are examples of circumstances when federal tax data will be insufficient.
3. People with very low incomes are exempt.
4. http://www.familiesusa.org/assets/pdfs/health-reform/summary-of-the-health-reform-law.pdf
5. http://healthit.hhs.gov/pdf/electronic-eligibility/aca-1561-recommendations-final2.pdf
6. http://healthit.hhs.gov/pdf/electronic-eligibility/aca-1561-recommendations-final2.pdf