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Testimony at the New York City Public Forum on the Establishment of a Health Insurance Exchange in New York State

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The Importance of Improving Eligibility and Enrollment Systems for Dually-Eligible New Yorkers

The Medicare Rights Center (Medicare Rights) stands with Health Care for All New York (HCFANY) in stressing the importance of passing legislation in this legislative session that establishes a New York Health Insurance Exchange. Failing to establish an Exchange jeopardizes New York's ability to acquire five years' worth of federal funding that would essentially finance the establishment of our State's Exchange. Additionally, a number of complex health policy, insurance and financial issues must be resolved before the Exchange becomes operational in the summer of 2013.

As New York State implements health care reform, including the establishment of Health Insurance Exchange, it is critical to develop a thoughtful and comprehensive roadmap that considers all consumers—including those with Medicare. If designed well, the Exchanges will create a modern, streamlined access and enrollment interface for consumers interested in whether they qualify for Medicaid or an insurance subsidy. These Exchanges have the potential to be a significant technological and administrative improvement on the current Medicaid enrollment process.

The Affordable Care Act (ACA) authorizes the creation of state health insurance Exchanges that will determine eligibility for, and enroll individuals in, health insurance, including Medicaid and subsidized insurance products for those above the Medicaid eligibility threshold.[1] The Exchange will serve as central resource for consumers while creating multiple application submission pathways including online, by mail, by telephone or in person. In addition, the ACA leverages federal and state databases and agency information to verify application information, taking the burden off of consumers to produce proof of income and other documentation requirements. Additional paperwork

[1] H.R. 3590--111th Congress: Patient Protection and Affordable Care Act. §§ 2001, 2002 (2009), *hereinafter ACA*.

and documentation is only required if the information is inconsistent with the data match.[2]

Beginning in 2014, all state Medicaid programs, including New York's, will be required to provide Medicaid to those with incomes up to 138% of the federal poverty level (FPL), eliminate any asset or resource test and use a modified adjusted gross income (MAGI) calculation to determine eligibility.[3] The same MAGI calculation will be used to determine subsidy eligibility in the Exchange for those from 138% FPL to 400% FPL. The use of MAGI across these income categories aligns Medicaid programs with the other subsidized insurance products offered in the Exchange, facilitating the use of the Exchange by all subsidy-eligible consumers and seamlessness of coverage as income changes.

The ACA also requires that Medicaid programs simplify enrollment processes for the MAGI population.[4] These measures include the use of data matching between governmental agencies to determine eligibility and enhanced customer service through the exchange, which would include telephone enrollment assistance and establishment of procedures for enabling individuals, through a secure Internet website, to enroll in Medicaid.[5]

The more generous 138% FPL threshold, elimination of the asset test and the MAGI income calculation required by the ACA do not apply to individuals who are eligible for Medicaid due to age or disability—i.e., those dually eligible for Medicare and Medicaid (the non-MAGI population).[6]

This exclusion, however, does not bar states from liberalizing eligibility standards for the non-MAGI populations. New York for example, has already eliminated the asset test for the Medicare Savings Program (MSP), a state administered program that helps pay for Medicare costs. New York also has the ability to apply simplified and streamlined application and enrollment processes to all Medicaid populations, including the dually eligible.

Although consumers who are dually eligible for Medicare and Medicaid will not shop for their Medicare health coverage through the Exchange, it is important for states to consider extending the technological and enrollment benefits to them. A bifurcated Medicaid system, in which non-Medicare-eligible consumers are able to use a streamlined online eligibility and enrollment tool and Medicare eligible consumers rely on outdated technology and a paper and telephone-based system, will create inequity and inefficiencies.

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[2] ACA, § 1413(b)(2).
[3] *Id at* § 2002.
[4] H.R. 3590--111th Congress: Patient Protection and Affordable Care Act. § 2201 (2009). In GovTrack.us (database of federal legislation). Retrieved March 14, 2011, from http://www.govtrack.us/congress/bill.xpd?bill=h111-3590&tab=reports.
[5] Ibid.
[6] *Id.*

It is critical that this issue not be left behind until the Exchange is already built for non-Medicare eligible consumers. Beginning in 2014, people who have Medicaid under the new eligibility rules established by the ACA and coverage through an exchange plan will need to transition to Medicare. This transition should occur as seamlessly as possible to prevent penalties, high out of pocket costs that will make access to care difficult, and gaps in coverage.