Congressional Research Service
Informing the legislative debate since 1914

The Use of Modified Adjusted Gross Income (MAGI) in Federal Health Programs

Evelyne P. Baumrucker, Coordinator
Analyst in Health Care Financing

Patricia A. Davis
Specialist in Health Care Financing

Bernadette Fernandez
Specialist in Health Care Financing

Annie L. Mach
Analyst in Health Care Financing

Carol A. Pettit
Legislative Attorney

April 22, 2015

Congressional Research Service
7-5700
www.crs.gov
R43861

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) created Section 36(B) of the Internal Revenue Code (IRC) to define household income, based on modified adjusted gross income (MAGI). MAGI is used to determine (1) penalty amounts owed if a person does not comply with the individual mandate or whether an individual is exempt from the individual mandate; (2) eligibility for and the amount of a premium credit to purchase coverage through a health insurance exchange; and (3) Medicaid income eligibility for certain populations. MAGI is also used to determine which Medicare beneficiaries pay high-income premiums. However, MAGI has many different definitions, depending on the purpose for which it is being calculated.

For these government health programs, MAGI begins with Adjusted Gross Income (AGI) as calculated for tax purposes. From there, various types of income are included (or in the case of Medicaid subtracted) to calculate MAGI for each particular program. Although the different health programs use the word "household," they do not necessarily refer to the same groupings of people. For example, married couples living together are counted as the same Medicaid household regardless of whether they file a joint tax return. By contrast, married couples must file a joint tax return to be eligible for premium credits.

This report explores the different MAGI definitions across health programs, including Medicare, the health insurance exchanges under the ACA, and Medicaid. It also addresses why MAGI is used, and how it is applied, specific to each program.

Contents

Tables

Appendixes

Contacts

Introduction

Certain portions of our government health programs rely on means-testing. Medicare premiums, the individual mandate exemptions and penalties and eligibility for premium credits available under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), and Medicaid eligibility are determined, in part, by the modified adjusted gross income (MAGI) income counting rule. MAGI, however, has many different definitions, depending on the purpose for which it is being calculated.

To determine which Medicare beneficiaries pay high-income premiums, the Social Security Administration uses the most recent federal tax return provided by the Internal Revenue Service (IRS). These determinations are based on the MAGI income definition, which is defined differently under Medicare than under other health programs.

ACA created Section 36(B) of the Internal Revenue Code (IRC, Title 26 of the *U.S. Code*) to define household income, based on MAGI, which is used to determine (1) penalty amounts owed if a person does not comply with the individual mandate or whether an individual is exempt from the individual mandate; (2) eligibility for and the amount of a premium credit to purchase coverage through a health insurance exchange; and (3) Medicaid income eligibility for certain populations. The initial intent of using MAGI across the ACA low-income subsidy programs was to standardize the definition of income for Medicaid eligibility purposes and to provide consistency between Medicaid and the health insurance exchanges.[1] Although these programs use similar terms, they do not necessarily refer to the same thing.

For all of these government health programs, the MAGI calculation begins with Adjusted Gross Income (AGI).[2] However, from there various types of income are included (or in the case of Medicaid subtracted) to calculate MAGI for each particular program. Also, while the different health programs use the word "household," they do not necessarily refer to the same groupings of people. For example, married couples living together are counted as the same Medicaid household regardless of whether they file a joint tax return. By contrast, married couples must file a joint tax return to be eligible for premium credits. This report explores how MAGI is defined differently across health programs, including Medicare, the health insurance exchanges under the ACA, and Medicaid. It also discusses why MAGI is used, and how it is applied, specific to each program.

Definition of MAGI in Health Programs[3]

The starting point for calculating MAGI for these health programs is, in all cases AGI, which generally originates on a federal income tax return. AGI is determined by subtracting allowable adjustments from gross income.

Gross income is defined as "all income from whatever source derived" unless otherwise statutorily excepted.[4] Exceptions to gross income include gifts (cash, property, or in-kind),

[1] See *Federal Register*, vol. 76, no. 159, August 17, 2011, Proposed Rule.

[2] 26 U.S.C. §62.

[3] This section was written by Carol A. Pettit, Legislative Attorney, x7-9496.

inheritances, interest on state and local bonds, a portion of Social Security benefits received, some income earned in foreign countries or in U.S. possessions and territories, and the costs paid by an individual toward some retirement plans.

Adjustments to gross income include alimony paid, penalties on early withdrawal of savings (e.g., from Certificates of Deposit [CDs]), moving expenses, student loan interest paid, and health savings account deductions. When these adjustments are subtracted from gross income, the result is AGI. This is the amount found on the bottom line of the first page of IRS Form 1040 (Individual Income Tax Return).

MAGI is used in a number of contexts within the IRC. For example, it is used to determine the extent to which Social Security benefits are included in gross income. It is also used to determine eligibility for an adjustment to income for tuition and fees paid.

However, for health programs, MAGI begins with AGI as calculated for tax purposes. From there, various types of income not included in AGI are added to calculate MAGI for each particular program. For Medicaid programs, these types of income are added in calculating MAGI, but under Medicaid regulations, particular types of income included in AGI may be subtracted to calculate MAGI for determining Medicaid eligibility.[5] **Table 1** summarizes the additions and subtractions to AGI that are used to calculate MAGI for various health programs. These adjustments are discussed in detail in the Medicare, Individual Mandate, Exchanges and Premium Tax Credits, and Medicaid subsections of this report.

Table 1. Additions and Subtractions to Federal Adjusted Gross Income (AGI) to Calculate Modified Adjusted Gross Income (MAGI) for Health Programs

	Modified Adjusted Gross Income			
Description of Income	**Medicare Premiums**	**ACA Individual Mandate**	**ACA Premium Credit**	**Initial Medicaid Eligibility[a]**
Tax-exempt interest income received or accrued (e.g., interest from state and local bonds)[b]	Added to AGI	Added to AGI	Added to AGI	Added to AGI
Interest from U.S. savings bonds used to pay higher education tuition and fees[c]	Added to AGI	Added to AGI	Added to AGI	Added to AGI
Earned income of U.S. citizens living abroad that was excluded from gross income[d]	Added to AGI	Added to AGI	Added to AGI	Added to AGI
Non-taxable portion of Social Security benefits[e]			Added to AGI	Added to AGI
Income from sources within Guam, American Samoa, the Northern Mariana Islands,[f] or Puerto Rico,[g] not otherwise included in AGI	Added to AGI			

(...continued)

[4] 26 U.S.C. §61.

[5] Per State Children's Health Insurance Program (CHIP) regulations at 42 C.F.R. §457.315, the MAGI rules at 42 C.F.R. 435.603 (b) through (i) also apply to CHIP.

Description of Income	Modified Adjusted Gross Income			
	Medicare Premiums	ACA Individual Mandate	ACA Premium Credit	Initial Medicaid Eligibility[a]
Irregular income received as a lump sum and included in AGI (e.g., state income tax refund, lottery or gambling winnings)[h]				Included in monthly AGI only in month received[i]
Certain payments to American Indians and Alaska Natives if included in AGI[j]				Subtracted from AGI
Certain scholarships, awards, and fellowship grants if included in AGI[k]				Subtracted from AGI

Source: Congressional Research Service, compilation from sources within the U.S. Code and Regulations. Current as of the date of this report.

a. "Initial" Medicaid Eligibility refers to eligibility rules that apply to applicants and new enrollees (i.e., not current enrollees seeking an eligibility redetermination).

b. 26 U.S.C. §103.

c. 26 U.S.C. §135.

d. 26 U.S.C. §911.

e. While the Internal Revenue Service's definition of MAGI excludes non-taxable social security benefits, the Three Percent Withholding Repeal and Job Creation Act (P.L. 112-56) changed the definition of income for the purposes of determining eligibility for ACA premium credits and Medicaid to include such non-taxable social security benefits.

f. 26 U.S.C. §931.

g. 26 U.S.C. §933.

h. 42 C.F.R. §435.603(h)(1).

i. Under Medicaid, income eligibility for applicants and new enrollees is based on current monthly household income (see 42 C.F.R. §435.603(h)(1)). By contrast, when redetermining eligibility for current Medicaid enrollees, states are permitted to use current monthly income and family size, or projected annual income and family size for the remaining months of the calendar year (see 42 C.F.R. §435.603(h)(2)).

j. 42 C.F.R. §435.603(e)(3).

k. 42 C.F.R. §435.603(e)(2). See also 45 C.F.R. §233.20.

Medicare Income-Related Premiums[6]

Medicare is the nation's federal insurance program; it pays for covered health services for most persons aged 65 and older, and for most permanently disabled individuals under the age of 65. The program consists of four distinct parts: (1) Part A, which covers inpatient services; (2) Part B, which covers physician and outpatient services; (3) Part C (Medicare Advantage), a private health plan option that covers most Part A and B services; and (4) Part D, which covers outpatient prescription drugs. *Eligibility for Medicare is not based on income.* Most individuals are eligible for premium-free Part A if they or their spouse paid Medicare payroll taxes for at least 40

[6] This section was written by Patricia A. Davis, Specialist in Health Care Financing, x7-7362.

quarters. Parts B and D are optional and require the payment of premiums. Those premiums are means-tested, and the income levels used to determine the premiums are based on a unique Medicare definition of MAGI.

For the first 41 years of the Medicare program, all Part B enrollees paid the same Part B premium amounts regardless of their income. However, the Medicare Modernization Act of 2003 (MMA; P.L. 108-173)[7] required that, beginning in 2007, higher-income enrollees pay higher premiums. The ACA imposed similar high-income premiums for Medicare Part D prescription drug benefit enrollees beginning in 2011. The Centers for Medicare & Medicaid Services (CMS) estimates that fewer than 5% of Medicare beneficiaries pay these higher premiums.[8]

For Medicare Part B, standard premiums are set at 25% of average annual per capita Part B program expenditures.[9] Under Part D, base premiums are set at 25.5% of expected per capita costs for basic Part D coverage.[10] Adjustments are made to the Parts B and D premiums for higher-income beneficiaries, with the percentage of per capita expenditures paid by these beneficiaries increasing with income. This percentage ranges from 35% to 80% of average per capita expenditures for both Parts B and D.[11] In 2015, individuals whose income exceeds $85,000, and couples whose income exceeds $170,000, are subject to higher premium amounts. Income thresholds used to determine high-income premiums for 2011 through 2017 are frozen at the 2010 levels.[12]

Determination of Income

To determine which Medicare beneficiaries pay high-income premiums, the Social Security Administration uses the most recent federal tax return provided by the IRS. The income determinations are based on an individual's tax filing status (i.e., individual filing, joint filing, or married filing separately).[13] The income definition on which these determinations are based is

[7] The MMA would have phased in the increase over five years; however, the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) shortened the phase-in period to three years.

[8] See U.S. Department of Health and Human Services, "2015 Medicare Part B Premiums and Deductibles to Remain the Same as Last Two Years," press release, October 9, 2014, at http://www.hhs.gov/news/press/2014pres/10/20141009a.html.

[9] In 2015, the standard monthly Part B premium is $104.90. For additional information on Part B premiums, see CRS Report R40082, *Medicare: Part B Premiums*.

[10] In 2015, the base monthly Part D premium is $33.13; however, actual premiums paid by beneficiaries may vary depending on the prescription drug plan that they select. See CRS Report R40611, *Medicare Part D Prescription Drug Benefit*.

[11] There are four high-income premium tiers; depending on income, beneficiaries can pay 35%, 50%, 65%, or 80% of per capita Parts B or D expenditures. For additional information, see Social Security Publication *Medicare Premiums: Rules for Higher-Income Beneficiaries*, 2015 at http://www.ssa.gov/pubs/EN-05-10536.pdf.

[12] Section 3402 of the ACA froze the thresholds used to determine high-income premiums at the 2010 level. These levels will be maintained through 2017. In 2018 and 2019, Section 402 of the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10) maintains the freeze on the income thresholds for the lower two high-income premium tiers but reduces the threshold levels for the two highest income tiers so that more beneficiaries will fall into the higher percentage categories. Beginning in 2020, the thresholds will be adjusted annually for inflation. See CRS Report R43962, *H.R. 2: The Medicare Access and CHIP Reauthorization Act of 2015*, coordinated by Jim Hahn and Kirstin B. Blom.

[13] Centers for Medicare & Medicaid Services, "Medicare Program: Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2015," 79 *Federal Register* 61314, October 10, 2014, http://www.gpo.gov/fdsys/pkg/FR-2014-10-10/pdf/2014-24248.pdf.

MAGI,[14] which is defined differently under Medicare than under other programs. Section 1839(i)(4) of the Social Security Act (SSA) defines MAGI for this purpose as adjusted gross income increased by the amount of certain other income that is exempt from tax under the IRC.[15]

For the purpose of identifying who is required to pay high-income Medicare premiums, MAGI is defined as the sum of (as defined in **Table 1**):

- the beneficiary's AGI, plus
- certain income exempt from tax under the IRC,[16] including
  - tax-exempt interest income received or accrued (e.g., interest from state and local bonds);
  - interest from U.S. savings bonds used to pay higher education tuition and fees;
  - earned income of U.S. citizens living abroad that was excluded from gross income;
  - income from sources within Guam, American Samoa, the Northern Mariana Islands, or Puerto Rico, not otherwise included in AGI.

If a Medicare beneficiary had a one-time increase in taxable income in a particular year (e.g., from the sale of income-producing property), that increase would be considered in determining the individual's total income for that year, and thus would be a liability for the income-related premium two years ahead. It would not be considered in the calculations for future years. In the case of certain major life-changing events that result in a significant reduction in MAGI,[17] an individual may request to have the determination made for a more recent year than the second preceding year.[18]

Individual Mandate[19]

Beginning in 2014, ACA requires most individuals to maintain health insurance coverage or otherwise pay a penalty.[20] Certain individuals are exempt from the individual mandate. For example, individuals with qualifying religious exemptions and those for whom health insurance

[14] See also Social Security Program Operations Manual, HI 01101.010, "Modified Adjusted Gross Income (MAGI)," at https://secure.ssa.gov/poms.nsf/lnx/0601101010.

[15] The Parts B and D high-income premium determinations are based on the same definition of MAGI. Specifically, the Social Security Act §1860D-13(a)(7)(C) states that MAGI has the same meaning for Part D as it does for Part B as defined in §1839(i)(4).

[16] 20 C.F.R. §418.1010(b)(6).

[17] Major life-changing events include (1) death of a spouse; (2) marriage; (3) divorce or annulment; (4) partial or full work stoppage for the individual or spouse; (5) loss by individual or spouse of income from income-producing property when the loss is not at the individual's direction (e.g., a natural disaster); or (6) reduction or loss for individual or spouse of pension income due to termination or reorganization of the plan or scheduled cessation of the pension. (C.F.R. §418.1205.)

[18] Social Security Form SSA-44, http://www.ssa.gov/online/ssa-44.pdf.

[19] This section was written by Annie L. Mach, Analyst in Health Care Financing, x7-7825.

[20] For more information about the individual mandate, see CRS Report R41331, *Individual Mandate Under ACA*.

coverage is "unaffordable" will not be subject to the mandate or its associated penalty. Individuals who do not maintain health insurance coverage and are not exempt from the mandate will have to pay a penalty for each month of noncompliance. The penalty is assessed through the federal tax filing process; any penalty that taxpayers are required to pay for themselves or their dependents must be included in their return for that taxable year.

Determination of Income

An individual's household income is used to determine any penalty amounts owed, and it is used to determine whether an individual is eligible for certain exemptions from the individual mandate. With respect to the individual mandate, household income is defined as the MAGI of the taxpayer, plus the aggregate MAGI of all other individuals for whom the taxpayer is allowed a deduction for personal exemptions for the taxable year.[21] As shown in **Table 1**, MAGI for the purposes of the individual mandate is AGI increased by tax-exempt interest income received or accrued, interest from U.S. savings bonds used to pay higher education tuition and fees, and earned income of U.S. citizens living abroad that was excluded from gross income.[22]

For individuals who do not maintain health insurance coverage and are not exempt from the individual mandate, the penalty is based either on a formula or on a flat-dollar amount, whichever is greater. The formula is a specific percentage multiplied by a person's "applicable income." The percentage is 2% in 2015 and 2.5% thereafter. An individual's "applicable income" is defined as the amount by which an individual's household income exceeds the applicable filing threshold for federal income taxes for the tax year.[23] In other words, "applicable income" is the aggregate MAGI above the tax filing threshold for the taxpayer and all dependents required to file a tax return. The flat-dollar amounts are $325 in 2015 and $695 in 2016 and beyond (adjusted for inflation), assessed for each taxpayer and any dependents.

Certain individuals are exempt from the individual mandate and its associated penalty. Household income based on MAGI is used to determine eligibility for some exemptions. Individuals for whom coverage is "unaffordable" are exempt; in 2015, coverage is considered unaffordable if an individual's required contribution for self-only coverage exceeds 8.05% of his or her household income.[24] Individuals are also exempt if their household income is less than the filing threshold for federal income taxes for the applicable tax year.

[21] 26 U.S.C. §5000A(c)(4)(B). The individuals for whom a taxpayer is allowed a deduction for personal exemptions are identified in 26 U.S.C. §151.

[22] P.L. 112-56, which changed the definition of income for the purposes of determining eligibility for ACA premium credits and Medicaid to include non-taxable social security benefits, did not apply the change to the individual mandate provision.

[23] In 2015, the filing thresholds for individuals under the age of 65 are $10,300 for a single filing status and $20,600 for a married couple filing jointly. The filing threshold is linked to an inflation adjustment based on the CPI-U, and therefore it may be higher in future years.

[24] In statute, the affordability threshold was set at 8% for 2014. The 8.05% threshold for 2015 is a result of the statutory requirement that the threshold percentage be adjusted in subsequent years to reflect the excess rate of premium growth above the rate of income growth for the period.

Exchanges and Premium Tax Credits[25]

Health insurance exchanges operate in every state and the District of Columbia (DC), per the ACA statute.[26] Exchanges are not insurance companies; rather, they are "marketplaces" that offer private health plans to qualified individuals[27] and small businesses.[28] Given that ACA specifically requires exchanges to offer insurance options to individuals and small businesses, exchanges are structured to assist these two different types of "customers." Consequently, there is an exchange to serve individuals and families, and another to serve small businesses ("SHOP exchanges"), within each state.[29]

Certain enrollees in the *individual* exchanges are eligible for premium assistance in the form of federal tax credits.[30] Such credits are not provided through the SHOP exchanges. The premium credit is an advanceable, refundable tax credit, meaning tax filers need not wait until the end of the tax year to benefit from the credit, and they may claim the full credit amount even if they have little or no federal income tax liability.

To be eligible for a premium credit through an individual exchange, a person (or family) must

- have a household income (based on MAGI) between 100% and 400% of the federal poverty level (FPL), with an exception,[31]
- *not* be eligible for "minimum essential coverage"[32] (such as Medicaid, Medicare, or an employer-sponsored plan that meets certain requirements),[33] other than through the individual health insurance market;

[25] This section was written by Bernadette Fernandez, Specialist in Health Care Financing, x7-0322.

[26] See Kaiser Family Foundation, "State Health Insurance Marketplace Decisions," January 27, 2014, at http://kff.org/health-reform/slide/state-decisions-for-creating-health-insurance-exchanges/. ACA §1323 allowed U.S. territories to choose to either establish an exchange or not; as of the date of this report, no territory opted to establish an exchange.

[27] Enrollment in an exchange plan is voluntary; see ACA §1312(d)(3). The voluntary nature of exchange enrollment also applies to Members of Congress and their personal staff, who may be offered by the federal government only coverage created under the ACA or offered through an exchange, per ACA §1312(d)(3)(D). In other words, although the federal government may make only certain health coverage available to applicable Members and staff, such individuals retain their right to enroll in any coverage that may be available to them (e.g., a private employer's health plan offered to the Member's spouse). For a comprehensive discussion about these issues, see CRS Report R43194, *Health Benefits for Members of Congress and Certain Congressional Staff*.

[28] Before 2016, states will have the option to define "small employers" either as those with 100 or fewer employees or 50 or fewer employees. Beginning in 2016, small employers will be defined as those with 100 or fewer employees. Beginning in 2017, large groups may participate in exchanges, at state option.

[29] ACA gives states the option to merge both exchanges and operate them under one structure.

[30] For additional information about ACA's premium tax credits, see CRS Report R43945, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) in 2015*.

[31] An exception is made for lawfully present aliens with income below 100% FPL who are ineligible for Medicaid for the first five years that they are lawfully present. These taxpayers will be treated as though their income is exactly 100% FPL for purposes of the premium credit.

[32] The definition of minimum essential coverage is broad. It generally includes Medicare Part A; Medicaid; the State Children's Health Insurance Program (CHIP); TRICARE; the TRICARE for Life program, a health care program administered by the Department of Veteran's Affairs; the Peace Corps program; a government plan (local, state, federal), including the Federal Employees Health Benefits Program (FEHBP); any plan established by an Indian tribal government; any plan offered in the individual, small-group, or large-group market; a grandfathered health plan; and any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS Secretary in coordination with the Treasury Secretary.

- be enrolled in an exchange plan; and
- be part of a tax-filing unit.[34]

Once eligibility is determined, income will be used in some (but not necessarily all) instances to determine the amount of the tax credit. The calculation of the credit amount is based on a comparison of two amounts that result from two different scenarios. The first scenario (and amount) is straightforward: the monthly premium for the exchange plan in which the person/family enrolls. The second scenario is more complicated, involving a formula that considers the premium for a standard plan[35] in the local area in which the person/family resides, and an amount that the person/family may be required to contribute toward the premium. This required contribution amount is based on income, with contributions capped between 2% and 9.5% of income. Based on a comparison of the two amounts (resulting from the two scenarios), the premium credit will be the lesser amount.

Determination of Income

Household income is measured according to MAGI.[36] As shown in **Table 1**, MAGI for the purposes of the premium credit is AGI as calculated for tax purposes increased by tax-exempt interest income received or accrued during the taxable year, as well as interest from U.S. savings bonds used to pay higher education tuition and fees, earned income of U.S. citizens living abroad that was excluded from gross income, and non-taxable portion of Social Security benefits. Household income, for purposes of determining premium credit eligibility, refers to the MAGI of a given taxpayer and the aggregate MAGI of all persons for whom the taxpayer claims a deduction for a personal exemption.[37] Given this definition, the household may include the taxpayer, the taxpayer's spouse, and other tax dependents.[38]

Note that the use of "household" to determine eligibility for and amount of the premium credit, based on income, is not necessarily equivalent to a family seeking coverage in an exchange ("coverage family"). For example, a hypothetical taxpayer may have three children, two of whom are tax dependents and one of whom is 25 years old (and therefore, because of age, may not be claimed as a dependent). However, the parent and children wish to enroll in the same exchange

(...continued)

[33] Individuals who are offered health coverage through an employer may be eligible for the premium tax credit if the employer coverage does not meet affordability and adequacy standards. For a discussion of those standards, see CRS Report R43945, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) in 2015*.

[34] Since the premium tax credits are administered through the individual income tax filing process, credit recipients are required to file federal tax returns, even if they do not have federal tax liability.

[35] The standard plan that will be used in the premium credit formula is the second lowest cost "silver" plan in the local area. Silver refers to a type of health plan that meets an actuarial value of 70%. For a summary discussion about actuarial value, see the "Essential Health Benefits Package" section of CRS Report R43854, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*.

[36] 26 U.S.C. §36B(d)(2).

[37] These individuals are identified in 26 U.S.C. §151.

[38] The IRS final regulations on premium tax credits (77 *Federal Register* 30377) clarified that the household could include individuals who are exempt from the ACA individual mandate. Moreover, although an individual who is incarcerated or not lawfully present may not enroll in an exchange health plan (and is consequently ineligible for premium credits), he or she may be an applicable taxpayer for a family member who *is* eligible to enroll in an exchange (and potentially eligible for premium credits).

plan. The coverage family is a total of four individuals, because the 25-year-old may be included as a dependent for health insurance purposes. Given that the young adult is not a tax dependent, the young adult's income is not included with the parent's income for premium credit purposes. The parent would claim the credit based on his or her income, using a household size of three (parent and two tax-dependent children). The young adult may claim his or her own credit, using the income amount calculated on his or her own tax return, separate from the parent. In other words, the tax definition of "dependent" results in a separate premium calculation for the young adult, even though the health insurance definition allows the young adult to enroll with the family in the same health plan.[39]

Medicaid[40]

Medicaid is a joint federal-state program that finances the delivery of primary and acute medical services, as well as long-term services and supports (LTSS), to certain low-income individuals.[41] Eligibility for Medicaid is determined by both federal and state law, whereby states set individual eligibility criteria within federal minimum standards. Individuals must meet both categorical (e.g., elderly, individuals with disabilities, children, pregnant women, parents, certain nonelderly childless adults) and financial (i.e., income and sometimes assets limits) criteria, and must otherwise be eligible for coverage.[42] Some eligibility groups are mandatory, meaning that all states with a Medicaid program must cover them; others are optional.

Determination of Income

Under the ACA, states are required to transition to a new income-counting rule based on MAGI to establish uniform standards for what income to include or disregard in determining Medicaid eligibility for most nonelderly and nondisabled individuals, children under the age of 18, and adults and pregnant women under the age of 65.[43] Medicaid's MAGI income-counting rule is set forth in law and regulation.[44] In addition to specifying the types of household income that must be considered during eligibility determinations, the policies also define "household." The income of any person defined as a part of an individual's "household" must be counted when determining that individual's income level for purposes of a Medicaid eligibility determination.[45] These rules are discussed in further detail below.

[39] This hypothetical example is a summary of an example included in the IRS final regulations. For the full example and explanation, see 26 C.F.R.1.36B-3(h).

[40] This section was written by Evelyne P. Baumrucker, Analyst in Health Care Financing, x7-8913.

[41] For more information about Medicaid, see CRS Report R43357, *Medicaid: An Overview*, and CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*.

[42] Individuals also need to meet federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship.

[43] The transition to MAGI represents a major change in terms of the types of information collected (e.g., what counts as income) and the definition of "household" (e.g., the inclusion of step-parent income) compared with former Medicaid income-eligibility rules. Under the former Medicaid income-eligibility rules, those regarding income exclusions and disregards varied greatly across states and Medicaid eligibility categories.

[44] 42 C.F.R. §435.603(e) and §1902(e)(14)(E)) of the Social Security Act. Per State Children's Health Insurance Program (CHIP) regulations at 42 C.F.R. §457.315, the MAGI rules at 42 C.F.R. 435.603 (b) through (i) also apply to CHIP.

[45] See 42 C.F.R. §435.603.

Transition to MAGI

The ACA requires states to transition to the MAGI income-counting rule no later than January 1, 2014. In transitioning to the new rule, states were required to establish income eligibility thresholds that were no less than the standards applicable on the date of ACA's enactment (i.e., March 23, 2010).[46] The ACA also included maintenance of effort (MOE) provisions, under which states were required to maintain their Medicaid programs for adults with no more restrictive eligibility standards, methodologies, and procedures through December 31, 2013 (i.e., until the exchanges were operational), and for Medicaid-eligible children up to the age of 19 until September 30, 2019.[47] (States that fail to comply with the ACA MOE requirements lose all of their federal Medicaid matching funds.) The purpose of these policies was to ensure that individuals who were eligible for Medicaid prior to 2014 could maintain coverage in 2014 under the MAGI-equivalent income standards. In addition, through December 31, 2013, states were permitted to establish more expansive income eligibility policies (within federal parameters). As of January 1, 2014, states were no longer permitted to expand eligibility standards to higher income levels through the adoption of income disregards.[48]

How MAGI Is Applied in Medicaid

Under the Medicaid MAGI income-counting rules, a state will look at an individual's MAGI, deduct an amount equal to 5% of FPL (which the law provides as a standard disregard),[49] and compare that income to the new income standards set by each state in coordination with CMS to determine whether the individual meets the program's eligibility requirements.[50] (For a complete list of Medicaid eligibility categories that are subject to the MAGI income-counting rules, see **Table A-1** in the **Appendix** of this report.)

MAGI-Exempted Groups

Under the ACA, certain groups are exempt from the MAGI income-counting rule. (For a complete list of Medicaid eligibility categories that are exempt from the MAGI income-counting rules, see **Table A-2**.) Pre-ACA income determination rules under Medicaid will continue to apply to the following MAGI-exempted groups:

- Individuals who are eligible for Medicaid through another federal or state assistance program (e.g., foster care children and individuals receiving Supplemental Security Income [SSI]).
- The elderly (defined as aged 65 and older).

[46] §1902(e)(14)(E)) of the Social Security Act.

[47] §1902(gg) of the Social Security Act

[48] §1902(e)(14)(B) of the Social Security Act.

[49] The 5% FPL income disregard is applicable only if an individual is at the highest income limit for coverage. See 42 C.F.R. §435.603(d)(4).

[50] For state Medicaid income eligibility standards for Medicaid eligibility groups subject to the MAGI income counting-rules, based on state decisions as of July 1, 2014, see http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf.

- Certain disabled individuals who qualify for Medicaid on the basis of being blind or disabled, without regard to the individual's eligibility for SSI.
- The medically needy (defined as individuals who are members of one of the broad categories of Medicaid-covered groups, but who do not meet the applicable income requirements).
- Enrollees in a Medicare Savings Program (e.g., qualified Medicare beneficiaries for whom Medicaid pays the Medicare premiums or coinsurance and deductibles).

In addition, MAGI does not affect eligibility determinations through Express Lane enrollment (to determine whether a child has met Medicaid or State Children's Health Insurance Program [CHIP] eligibility requirements). Nor does MAGI affect eligibility determinations for low-income subsidies for Medicare prescription drugs, or for Medicaid long-term services and supports.[51] For these MAGI-exempted groups, pre-ACA income-determination rules under Medicaid will continue to be used.

Countable Income

Income eligibility for Medicaid applicants and new enrollees is based on *current monthly* household income.[52] As indicated in **Table 1**, MAGI-based income under Medicaid refers to income calculated using the same methodology used to determine MAGI in Section 36B(d)(2)(B) of the IRC (i.e., it includes tax-exempt interest income earned or accrued, interest from U.S. savings bonds used to pay higher education tuition and fees, earned income of U.S. citizens living abroad that was excluded from gross income, and non-taxable portion of Social Security benefits), with some exceptions. Specifically, under Medicaid regulations, particular payments included in AGI may be subtracted to determine MAGI. These include certain payments to American Indians and Alaska Natives, and certain scholarships, awards, and fellowship grants (i.e., work study income) if used for educational costs and not for living expenses. Under Medicaid regulations, irregular income received as a lump sum (e.g., state income tax refund, lottery or gambling winnings, one-time gifts or inheritances) is counted as income only in the month received.[53]

[51] Long-term services and supports include institutional services, such as nursing facility care, and home- and community-based services, such as home care, personal care, transportation, and care management, furnished under the Medicaid state plan or the state's Medicaid waiver program.

[52] When redetermining eligibility for current Medicaid enrollees states are permitted to use current monthly income and family size, or projected annual income and family size for the remaining months of the calendar year. For states that choose the latter measure, the rules for projected household income and family size under Medicaid differ as compared to the rules under the exchanges. Specifically, Medicaid requires the applicant to predict income and household size for the remaining months of the calendar year, whereas applicants seeking eligibility for premium tax credits must predict income and household size based on the tax year. See 42 C.F. R. §435.603(h)(2). States are required to use "reasonable methods" to account for changes in income such as, increases or decreases in income due to seasonal work. See 42 C.F. R. §435.603(h)(3).

[53] 42 C.F. R. §435.603(e).

Family Size and Total Household Income

The MAGI income-counting rule for Medicaid has two components: (1) family size (or the number of persons counted as members of an individual's household), and (2) total household income.[54]

Family size is determined on a person-by-person basis and is affected by criteria such as living arrangements, legal status, age, how the individuals are related to each other (e.g., multi-generational families), whether the individual is pregnant, who is seeking the Medicaid eligibility determination (i.e., the tax filer or the dependent), and whether the individual is a student. For example, Medicaid rules include unborn children when determining family size, and married couples living together are counted as the same Medicaid household regardless of whether they file a joint tax return.[55]

Once an applicant's family size has been established, a second step is required to determine whether to include the income of each household member in the calculation of total household income. In general, Medicaid defines total household income as the sum of the MAGI-based income of every individual included in the household. However, certain exceptions apply when counting Medicaid household income.[56] These exceptions include

- the income of a child who is included in the household of his or her natural parent, adopted parent, or step-parent and is not expected to file a tax return is *not* included in the Medicaid household income;
- the income of a tax dependent who is not expected to file a tax return is *not* included in the Medicaid household income of the taxpayer, regardless of whether the tax dependent files a tax return;
- Medicaid household income may, at state option, include cash support above nominal amounts provided by another tax payer expected to claim a member of the household (other than a spouse, a natural child, adopted child, or step-child) as a tax dependent; and
- beginning January 1, 2014, in determining Medicaid eligibility using MAGI-based income, a state must subtract an amount equal to 5 percentage points of the FPL for the applicable family size.[57]

In a final step, family size and total household income are then compared to the Medicaid eligibility thresholds (which are expressed as a percentage of the FPL) to determine whether the applicant qualifies for the program.[58]

---

[54] 42 C.F. R. §435.603.

[55] 42 C.F. R. §435.603(f)(4).

[56] 42 C.F. R. §435.603(d)(2) through (d)(4).

[57] 42 C.F.R. §435.603(d)(4) makes it clear that the MAGI 5% income disregard applies only if an individual is on the verge of not being Medicaid-eligible because his or her income is too high.

[58] For a specific example of how these rules play out, see Rules and Regulations, 77 *Federal Register* 17152, Friday, March 23, 2012. For more information on Medicaid's new MAGI-based eligibility levels adjusted for the 5% disregard, effective January 1, 2014, see Table A-1 of CRS Report R43347, *Budgetary and Distributional Effects of Adopting the Chained CPI* .

Appendix. MAGI and Medicaid's Eligibility Categories

Table A-1 shows the Medicaid eligibility categories where MAGI applies, beginning January 1, 2014. **Table A-2** shows Medicaid eligibility categories that are exempt from MAGI. Exempted groups include (1) those expressly listed in statute; (2) those where the state does not conduct an income determination (e.g., Supplemental Security Income [SSI] recipients); and (3) those for whom an income test is not required as a part of the statutory requirements for the eligibility pathway (e.g., former foster care children up to the age of 26, and women needing treatment for breast or cervical cancer).

Table A-1. Medicaid MAGI-Based Eligibility Categories, Beginning January 1, 2014

Eligibility Category	Social Security Act Citation	Regulatory Citation (42 C.F.R.)
Mandatory Eligibility Categories		
Parents/caretaker relatives		
Low-income families	1902(a)(10)(A)(i)(I) and 1931	§435.110
Consolidated group for pregnant women[a]		§435.116
Low-income families	1902(a)(10)(A)(i)(I) and 1931	
Qualified pregnant women	1902(a)(10)(A)(i)(III)	
Poverty-level related pregnant women (mandatory)	1902(a)(10)(A)(i)(IV)	
Pregnant women financially eligible for Aid to Families for Dependent Children (AFDC)	1902(a)(10)(A)(ii)(I)	
Pregnant women who would be eligible for AFDC if not institutionalized	1902(a)(10)(A)(ii)(IV)	
Poverty-level related pregnant women (optional)	1902(a)(10)(A)(ii)(IX)	
Consolidated group for children under the age of 19[a]		§435.118
Low-income families	1902(a)(10)(A)(i)(I) and 1931	
Qualified children under the age of 19	1902(a)(10)(A)(i)(III)	
Poverty-level related infants (mandatory)	1902(a)(10)(A)(i)(IV)	
Poverty-level related children between the ages of 1 and 5	1902(a)(10)(A)(i)(VI)	
Poverty-level children between the ages of 6 and 18	1902(a)(10)(A)(i)(VII)	
Children who would be eligible for AFDC if not institutionalized	1902(a)(10)(A)(ii)(IV)	
Poverty-level related infants (optional)	1902(a)(10)(A)(ii)(IX)	

Eligibility Category	Social Security Act Citation	Regulatory Citation (42 C.F.R.)
ACA Medicaid expansion group[b]	1902(a)(10)(A)(i)(VIII)	§435.119
Optional Eligibility Categories		
Parents and other caretaker relatives financially eligible for AFDC	1902(a)(10)(A)(ii)(I)	NA[c]
Reasonable classifications of children under the age of 21 financially eligible for AFDC or who would be financially eligible if not institutionalized	1902(a)(10)(A)(ii)(I) and (IV)	§435.222
Individuals under the age of 21 who are under state adoption assistance agreements	1902(a)(10)(A)(ii)(VIII)	§435.227
Optional targeted low-income children under the age of 19	1902(a)(10)(A)(ii)(XIV)	§435.229
Optional group for individuals needing treatment for tuberculosis	1902(a)(10)(A)(ii)(XII)	NA
Optional Chafee independent foster care adolescents under the age of 21	1902(a)(10)(A)(ii)(XVII)	NA
Individuals under the age of 65 with income more than 133% of the federal poverty level (FPL) and at or below standard established by state	1902(a)(10)(A)(ii)(XX)	§435.218
Family Planning Option	1902(a)(10)(A)(ii)(XXI)	NA

Source: Centers for Medicare and Medicaid Services (CMS), Medicaid and Children's Health Insurance Program (CHIP) Eligibility Groups in 2014, September 2012. Available at http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Groups-in-2014.pdf.

a. Represents existing groups that were consolidated beginning January 1, 2014.

b. On June 28, 2012, the U.S. Supreme Court issued a decision in *National Federation of Independent Business v. Sebelius.* The Court held that the federal government cannot terminate current Medicaid program federal matching funds if a state does not expand its Medicaid program, effectively making the ACA Medicaid expansion for this new adult group optional.

c. NA means not applicable.

Table A-2. MAGI-Excepted Eligibility Categories, Beginning January 2014

Eligibility Category	Social Security Act Citation	Regulatory Citation (42 C.F.R.)
Mandatory Eligibility Categories		
Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E of the Social Security Act (SSA)	1902(a)(10)(A)(i)(I)	§435.115(e) and §435.145
Former foster care children up to the age of 26	1902(a)(10)(A)(i)(IX)	NA[a]
Medicare Savings Program		
Qualified Medicare Beneficiary (QMB)	1902(a)(10)(E)(i) and 1905(p)	NA

Eligibility Category	Social Security Act Citation	Regulatory Citation (42 C.F.R.)
Specified Low Income Medicare Beneficiary (SLMB)	1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii)	NA
Qualifying Individuals (QI)	1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii)	NA
Qualified Disabled and Working Individuals (QDWI)	1902(a)(10)(E)(ii), 1905(p)(3)(A)(i), and 1905(s)	NA
Aged, blind, or disabled individuals		
Supplemental Security Income (SSI) recipients in §1634 of SSA and SSI criteria states	1902(a)(10)(A)(i)(II)	§435.120
Individuals meeting more restrictive criteria than SSI in 209(b) states[b]	1902(f)	§435.121
Working disabled individuals	1902(a)(10)(A)(i)(II), 1619(a), 1619(b), and 1905(q)	NA
Disabled widows and widowers ineligible for SSI due to increase in Old-Age, Survivors, and Disability Insurance (OASDI)	1634(b)	§435.137
Disabled adult children	1634(c)	NA
Early widows/widowers	1634(d)	§435.138
Individuals ineligible for SSI/State Supplemental Program (SSP) because of requirements prohibited by Medicaid	NA	§435.122
Individuals receiving mandatory state supplements under Section 212 of P.L. 93-66	Section 13(c) of P.L. 93-233	§435.130, §435.1011
Individuals who would be eligible for SSI/SSP but for Old-Age, Survivors, and Disability Insurance (OASDI) Cost of Living Adjustments (COLA) increases since April 1977[c]	Section 503 of P.L. 94-566	§435.135
Individuals who would be eligible for SSI/SSP but for OASDI COLAs in 1972[c]	Public Law 92-36	§435.134
Institutionalized individuals continuously eligible since 1973	NA	§435.132
Blind or disabled individuals eligible in 1973[c]	NA	§435.133
Individuals eligible as essential spouses in 1973[c]	NA	§435.131
Optional Eligibility Categories		
Women needing treatment for breast or cervical cancer[d]	1902(a)(10)(A)(ii)(XVIII)	NA

Eligibility Category	Social Security Act Citation	Regulatory Citation (42 C.F.R.)
Aged, blind, or disabled individuals financially eligible for SSI cash assistance	1902(a)(10)(A)(ii)(I)	§435.210 or §435.230
Aged, blind, or disabled individuals who would be financially eligible for SSI cash assistance if they were not institutionalized	1902(a)(10)(A)(ii)(IV)	§435.211
Individuals in institutions who are eligible under a special income level	1902(a)(10)(A)(ii)(V)	§435.236
Individuals eligible for home and community-based waiver services under institutional rules	1902(a)(10)(A)(ii)(VI)	§435.217
Individuals receiving hospice care	1902(a)(10)(A)(ii)(VII) and 1905(o)	NA
Poverty level (100% federal poverty level) aged or disabled individuals	1902(a)(10)(A)(ii)(X) and 1902(m)(1)	NA
Aged, blind, or disabled individuals receiving only optional state supplements	1902(a)(10)(A)(ii)(IV) and (XI)	§435.232 or §435.234
Work Incentives Eligibility Group (BBA) with income less than 250% FPL	1902(a)(10)(A)(ii)(XIII)	NA
Ticket to Work Basic Group (TWWIIA) of working disabled individuals	1902(a)(10)(A)(ii)(XV)	NA
Ticket to Work Medical Improvements Group (TWWIIA MI) of working disabled individuals	1902(a)(10)(A)(ii)(XVI)	NA
Family Opportunity Act for Children with Disabilities (FOA)	1902(a)(10)(A)(ii)(XIX)	NA
Individuals eligible for home and community-based state plan services (150% FPL)	1902(a)(10)(A)(ii)(XXII) and 1915(i)	§435.219
Individuals eligible for home and community-based state plan services (special income level)	1902(a)(10)(A)(ii)(XXII) and 1915(i)	§435.219
Qualified disabled children under the age of 19 who would be eligible for Medicaid if they were in a medical institution (Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA] children)	1902(e)(3)	§435.225
Individuals participating in a Program of All-inclusive Care for the Elderly (PACE) program under institutional rules	1934	NA
Medically Needy		
Pregnant women	1902(a)(10)(C)	§435.301
Children under the age of 18	1902(a)(10)(C)	§435.301

Eligibility Category	Social Security Act Citation	Regulatory Citation (42 C.F.R.)
Individuals under the age of 21 (or under the ages of 20 or 19) or reasonable classifications of such individuals	1902(a)(10)(C)	§435.308
Parents and other caretaker relatives	1902(a)(10)(C)	§435.310
Aged	1902(a)(10)(C)	§435.320, §435.330
Blind	1902(a)(10)(C)	§435.322, §435.330, §435.340
Disabled	1902(a)(10)(C)	§435.324, §435.330, §435.340

Source: Centers for Medicare and Medicaid Services (CMS), *Medicaid and Children's Health Insurance Program (CHIP) Eligibility Groups in 2014,* September 2012. Available at http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Groups-in-2014.pdf.

a. NA means not applicable.

b. Federal law gives states the option to use financial eligibility criteria for their aged, blind, and disabled populations that are more restrictive than SSI. States that use this alternative to SSI program rules are typically referred to as "209(b) states."

c. Closed to new enrollment.

d. Individuals are determined eligible for this pathway based on screening by Centers for Disease Control and Prevention (CDC) program without an income test performed by Medicaid.

Author Contact Information

Evelyne P. Baumrucker, Coordinator
Analyst in Health Care Financing
ebaumrucker@crs.loc.gov, 7-8913

Patricia A. Davis
Specialist in Health Care Financing
pdavis@crs.loc.gov, 7-7362

Bernadette Fernandez
Specialist in Health Care Financing
bfernandez@crs.loc.gov, 7-0322

Annie L. Mach
Analyst in Health Care Financing
amach@crs.loc.gov, 7-7825

Carol A. Pettit
Legislative Attorney
cpettit@crs.loc.gov, 7-9496