



July 23, 2012

Stephanie Kaminsky
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

RE: Comments on the *Conversion of Net Income Standards to Equivalent Modified Adjusted Gross Income Standards*

Dear Ms. Kaminsky:

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families. Central to our work is providing research and policy assistance to state administrators and state-based organizations on strategies for covering children and their families through public insurance affordability programs, especially Medicaid and CHIP. We conduct research and analysis to inform federal and state policymakers about issues impacting children and families in health care reform and to improve Medicaid and CHIP, particularly around streamlining enrollment and renewal systems.

Thank you for the opportunity to comment on the *Conversion of Net Income Standards to Equivalent Modified Adjusted Gross Income Standards* solicitation. To account for the elimination of income disregards and ensure continued coverage at pre-ACA levels, states must convert their current income standards to a "MAGI-equivalent" standard for all groups for which eligibility will be determined using MAGI. As this conversion will determine eligibility going forward, the stakes are incredibly high and may be the greatest for children, as the new MAGI-equivalent standards will set the bar for children's public coverage. If the conversion is done poorly or inconsistently across states, children's eligibility levels could, in effect, be lower than they were prior to passage of the Affordable Care Act (ACA). This would be in direct conflict with the intent of the law and all effort should be taken to avoid such an outcome.

Other populations are also at risk, especially if, as stipulated in the final Medicaid regulations, states are not required to convert their minimum eligibility thresholds. In fact, §1931 coverage for parents is most likely to be impacted by such an exclusion, especially in states that do not go forward with the Medicaid expansion to new adults. When HHS issued the final rule, this "option" was not available to states. As such, the administration considered the potential loss of benefits and coverage counterbalanced against increased simplification in determining that, on net, converting the minimum values was unnecessary. However, in light of the Supreme Court ruling, HHS should reconsider this decision, as the quest for administrative simplification should not result in the loss of coverage; a much more likely scenario following the ruling.

§2002(a) of the Affordable Care Act (ACA) requires states to develop eligibility thresholds that are not less than the effective income levels in place at the time of enactment. Additionally, it is important that when states convert their existing thresholds to MAGI-equivalent standards, they ensure that, on balance, individuals who were eligible for Medicaid under the existing standards do

not lose coverage. In the comments below, we offer concrete suggestions on the methodologies put forth in the solicitation.

- 1. Minimum eligibility thresholds should be converted to MAGI-equivalent standards.** In proposing a simplified approach to eligibility based on the new MAGI methodology, the intent is that current eligibility will not change for any of the populations. However, the conversion to MAGI is only required for the maximum effective income levels, not the minimum standards. The final rule describes that HHS considered requiring states to convert the minimums to protect eligibility for those who would lose coverage if a state reduced eligibility to the minimum standards, but chose not to as it would result in different minimum eligibility standards across states and reduce simplification. Given the recent Supreme Court ruling effectively making the Medicaid expansion for adults “optional,” CMS should reconsider this decision as the consequences are far more troubling now, especially in states that choose not to expand coverage.

Under the final Medicaid rule (§435.110), it was envisioned that parents and other caretaker relatives who might lose eligibility under §1931 if a state reduced coverage to the minimum permitted under the statute would retain eligibility under the new adult group. While there were concerns that important benefits would be lost for these individuals in states that choose to provide more restrictive benchmark plans to the new adult group, eligibility for coverage was assured. However, in states that chose not to expand coverage to the new adult group, eligibility for coverage for these parents could be further restricted if the minimum eligibility thresholds are not converted.

For example, in Florida, earned income disregards alone increase the effective eligibility level 38 percentage points. If states chose to “opt out” of the expansion and subsequently rolled back coverage to the minimum eligibility levels, the accompanying failure to convert these standards would essentially result in a notable reduction in eligibility. Such a result would fly in the face of the law, which requires states to establish an effective income threshold that is not lower than what was in place on the date of enactment.

There are additional reasons to require all states, not just those that do not expand coverage to the new adult group, to convert their minimum eligibility standards to MAGI equivalents. For example, failing to convert minimum standards to MAGI would also adversely impact pregnant women. If a state were to decrease its income standard to the statutory minimum level (after the maintenance-of-effort requirements end in 2014), there is no other coverage group to which affected pregnant women can be transferred. As a result, a woman in this situation would likely become eligible for advanced payments of the premium tax credit for enrollment through the Exchange. This will most likely mean a less generous benefit package for pregnant women and a violation of the intent of the statute.

Additionally, HHS stated in the proposed Medicaid regulation that the impact on children from failing to convert minimum eligibility standards will not be significant because eligibility for children must be maintained through September 2019, in accordance with the maintenance-of-effort provisions. HHS added that when these provisions expire, eligibility for “only a small number of children would be affected if a State were to drop coverage to the minimum level permitted.” It is unclear what data HHS relied on to make this assumption and we are concerned that a large number of children could be impacted if states roll back eligibility after 2019. As such, it is important that the minimum thresholds also be converted to protect the benefits and cost-sharing protections children are currently afforded in Medicaid and CHIP. If

these levels are not converted, more children will likely move to coverage in the Exchange, where the safeguards are far more limited.

People who are eligible for Medicaid now should not be made worse off upon the implementation of health reform. To ensure this is the case, for all MAGI-based Medicaid categories, we recommend that HHS require states to convert their minimum eligibility standard to a MAGI-equivalent standard to account for disregards and exclusions currently used by the state. This conversion should not be burdensome for the states, and some states may already plan on undergoing a MAGI conversion for the purpose of determining the federal matching rate. At a minimum, states that choose not to expand coverage to the new adult group should be required to convert the minimum thresholds for their §1931 coverage to protect parents in the event that a state should reduce eligibility to the lowest possible values.

2. **Clarify that separate eligibility standards should be established for mandatory and optional groups.** Under the final Medicaid eligibility rule, states will need to convert current income standards for mandatory and, depending on their current eligibility rules, optional categories. The final MAGI conversion procedures should make it clear that each group will have to be converted individually. For example, in the draft guidance under 3, it is clear that if a state has child eligibility standards that differ by age (also known as stair-step eligibility), different MAGI-equivalent standards need to be developed for each age group. However, it is not as clear under 4, that separate income thresholds need to be established for each optional group covered within the state.

The solicitation also asks about whether any adjustments need to be made for demographic or other characteristics. While we understand and support the need for simplicity as states convert their eligibility thresholds, where there are meaningful differences states should be required to develop multiple conversion values. For example, family size and structure have a considerable impact on the effective eligibility level. Take a family of three with one working parent and two young children – in a typical state, they would receive a \$90 earnings disregard, as well as disregards for child care expenses and child support received, totaling \$540. Another three-person family with two working parents and an older child could find the state disregarding \$355 when determining eligibility. These examples highlight that current effective income thresholds (taking into account disregards and deductions) vary significantly by family type. As a result, states should be expected to take into account different family sizes and compositions when setting MAGI conversion levels.

However, in circumstances where the distinction within a group is no longer meaningful, states should be required to have a single conversion standard for the group (set at the highest threshold within that group) as laid out in the introduction to the solicitation. For example, as TANF benefits are no longer linked to Medicaid, using different disregards for applicants and beneficiaries that are tied to work incentives no longer makes sense. As such, states should not differentiate between the two in developing MAGI-converted thresholds. When setting a single converted threshold for applicants and beneficiaries, we strongly agree with the approach described in the solicitation that would require states to select the higher effective level of the two standards.

3. **Any methodology available to states to convert their current eligibility to MAGI-equivalents must ensure that, on balance, current beneficiaries do not lose eligibility as a result.** The high stakes of the shift to MAGI makes the approach behind it all that much more

important. Both of the proposed methods pose concerns, as well as methodological challenges for states. We provide more specific comments on the proposed approaches below.

- **Require that any methodology result in at least the same number of children qualifying for coverage.** We strongly believe that the intent of the ACA was to protect children’s coverage. The move to MAGI-based income was designed to simplify administration of affordability programs, not to reduce the number of children who qualify for coverage. In fact, due to the “welcome mat” effect resulting from outreach and enrollment efforts, as well as the individual responsibility requirement, more children are expected to secure Medicaid and CHIP after ACA implementation.¹

Therefore, we recommend that any conversion methodology not result in fewer children, pregnant women, and others qualifying for Medicaid. Specifically, as is required in the survey methodology put forth by the agency, HHS should not make any conversion options available to states that have not met a test of resulting in roughly the same number of people securing coverage, adjusted to reflect the expected increased participation rate following implementation. To adjust the target enrollment figure, HHS, for example, could look at the change in participation rate for those at the lower end of the income scale (where the conversion to MAGI should not impact eligibility). Additionally, HHS should produce and share publicly an analysis that shows that the options being proposed will not lead to fewer people securing coverage.

- **Using the “average disregard” method as currently designed would understate existing eligibility thresholds and adjustments should be made.** The income distribution of Medicaid enrollees is concentrated towards the lower end of the income scale. As such, disregards are either not applied, for example because the beneficiaries do not work and therefore do not use income disregards, or, if they are even recorded, they do not impact eligibility. Taking the average disregard and including those who do not benefit from the use of any disregards, would vastly understate the effective income threshold at which people can now secure coverage.

Current beneficiaries can be divided into three groups – one that does not qualify for any disregards (e.g., not working and no childcare expenses); one where the family may qualify for disregards, but they do not impact eligibility (in these situations, disregards may not be recorded or applied as the person is already viewed as eligible); and one where disregards are applied and impact the beneficiary’s eligibility. When trying to convert the existing effective eligibility levels to a MAGI-equivalent by averaging the disregards, including individuals in the first two groups would be akin to including missing data in the calculation, skewing the result.

An alternative approach would be to include only those for whom disregards are relevant in the sample when calculating the average. A similar method is proposed on page 12 in the solicitation with regards to justifying the use of only “major” disregards. In justifying the use of this subset of disregards, CMS suggests that it may be appropriate to ignore disregards that are either time-limited, minor, or seldom used, as they would not impact the vast majority of enrollees. Extending such logic, it would also seem appropriate to ignore situations in which disregards are not a factor in eligibility. By taking such an approach, the

¹ G. Kenney, *et al.*, “Improving Coverage For Children Under Health Reform Will Require Maintaining Current Eligibility Standards For Medicaid And CHIP,” *Health Affairs*, 30(12): 2371-2381 (December 2011).

disregards would still be weighted as the average is taken; however, the average would be a more accurate measure of the effective income level at which people can currently qualify for coverage given the impact of disregards.

If you cannot make the changes recommended here or other, comparable changes that would ensure that roughly the same number of children and others qualify for coverage under the new effective income thresholds as under old net income standards, we strongly recommend that you drop the average disregards method.

- **The “same number method” would help states to ensure that the conversion to MAGI, on balance, does not result in some beneficiaries losing eligibility.** While state administrative data on enrollment and disregards would not be utilized, as mentioned below, the use of this data may not be feasible regardless of which method is implemented. However, this method would be state-specific by taking into account a state’s disregards to determine the number of people who would be eligible under each category, allowing for state-specific and categorical variation similar to the average method discussed above. The end goal here would be to result in the same number of beneficiaries remaining eligible for coverage, a possibility that, the average method, if not done with the suggested alterations above, would likely not achieve.

However, there are some serious concerns with this method, as states could end up with the same number of people eligible for coverage before and after the conversion, but the people themselves could be entirely different. While it may be unlikely that all prior beneficiaries would be considered no longer eligible, it is quite conceivable that a large number would shift out of coverage. No matter the method, states and beneficiaries should be confident that a considerable share of those who are currently eligible remain eligible after the conversion is implemented. As the “same number” method could result in this accurate conversion ratio being very low, CMS should develop some minimum threshold in evaluating this measure to ensure that a majority of beneficiaries retain eligibility.

An additional complication with the “same number” method is where states set the adjusted gross threshold. While the adjusted sample is representative of the population, it is certainly not complete and leaves room for error. As such, setting the threshold at the exact level where the same number of people is eligible (14.2 percent in the solicitation example) seems arbitrary. Accounting for some of this error by setting the value between the lowest and highest values (14.2 percent and 15.3 percent respectively from the example), as suggested in the solicitation, would help account for the error. One way to adjust the result would be to look at the distribution of the sample and adjust the new threshold based on the standard deviation. In addition, as mentioned above, this threshold should be adjusted to reflect the anticipated increased enrollment following implementation of the ACA.

- **If the option is extended to include only major disregards when converting eligibility thresholds for children, pregnant women, and parents, states should be required to include a basic subset of disregards.** According to a survey examining the use of disregards, states tend to use those associated with their welfare rules, either the old standards under Aid to Families with Dependent Children (AFDC) or their newer standards under Temporary Assistance for Needy Families (TANF).² More recent data show that these

² L. Ku, F. Ullman, & R. Almeida, “What Counts? Determining Medicaid and CHIP Eligibility for Children,” Urban Institute (May 2005).

disregards have not changed over time and typically include earnings disregards, child care expenses, and child support paid and received.³ In some states, additional disregards may be taken, such as for other types of income, which should also be considered for inclusion. At a minimum, states should be required to include existing earnings-related deductions, as well as child care expenses and child support paid and received, regardless of which methodology is utilized. Additionally, any en bloc disregards should be factored into the conversion, as these are also likely to have a dramatic impact on eligibility.

While we understand and support the use of only major disregards for simplicity sake, we do not feel that this option should be immediately available to states. As our data and understanding of states' use of disregards, especially those that may be considered "minor," are limited, a complete assessment of whether ignoring certain disregards may impact eligibility is not possible. As such, CMS should conduct a study to examine the use of disregards more closely. Until a more thorough evaluation is available, the option to consider major disregards only in the conversion should be placed on hold.

- **Allowing states a choice of methodology should be pursued with caution, as concerns exist with both approaches.** As outlined above, both methodologies have limitations that could leave many current beneficiaries ineligible following the conversion. To ensure consistency for beneficiaries across states, it would be preferable to have a single methodological approach. We would support the use of the "average disregard" method, if the above suggestions are incorporated and HHS could establish that roughly the same number of people secure coverage; if these changes are not made, however, the "same number" approach based on sampling may be more viable. While we do not support giving states a choice of methodologies, if that option is retained, there should be a default option should a state not make a choice (similar to how the essential benefit package will be determined). The default option should be the option that best protects coverage for low-income children, parents and others.

Where we believe an option should be offered to states is in regards to which data they use in determining their converted thresholds. As discussed more below, states may or may not be able to access the data they need from their existing administrative files. If the data are available, they may prefer to use existing enrollees in their sample to more accurately convert their thresholds. While the survey data may be the only viable option for some states, others, especially smaller states, may not feel that the data are a true representation of their caseload. As such, giving states an option as to which data source they rely upon will help assuage these concerns and allow states to pick the source that makes the most sense for their particular data circumstances.

4. **Data limitations make the conversion to a MAGI-equivalent standard difficult.** Given that most states continue to operate antiquated legacy eligibility and enrollment systems, it may be difficult for some of them, if not many of them, to accurately identify the disregards used for current beneficiaries, especially on a case-by-case basis. Survey data are also limited in what they provide in terms of the level of detail. While all three suggested data sources (SIPP, CPS, and ACS) include earnings and some information on child support, none include information on child care payments, a routine and highly valuable disregard. Many other less common disregards are also likely to be missing from survey data. On the other hand, survey data would

³ Preliminary data from a survey conducted by the Georgetown Center for Children and Families and the Kaiser Commission on Medicaid and the Uninsured (2011).

allow states to take into account how family structure and income-counting rules affecting eligibility, additional adjustments in the MAGI conversion that would be unavailable if a state utilizes administrative data. In addition, while it has a much smaller sample size, the SIPP would allow for examining income on a monthly basis, which is consistent with how Medicaid eligibility is actually determined.

Depending upon the data source utilized, the number of observations for a particular state may not be large enough to create a representative sample. As such, it will be important, as mentioned in the solicitation, to adjust the survey data to more accurately reflect the demographic characteristics of the state's Medicaid population. However, given this additional complication, states may not have the expertise to adequately adjust the data to produce a representative sample of their state and intensive technical assistance will be needed.

5. **States should examine a year's worth of data to ensure that seasonal fluctuations are taken into account.** Regardless of whether states use administrative data or survey data, states should look back over an entire year. By doing so, they can more accurately take into account seasonal fluctuations that often occur among lower-wage workers, such as those who work in retail or agriculture. The data should not be annualized, which would likely minimize any seasonal fluctuations, but should be examined on a monthly basis over the course of a year to better align with true Medicaid determinations. Again, as this is methodologically complicated, states will continue to need ongoing assistance to implement the MAGI conversion.
6. **The conversion to MAGI should be transparent and evaluated over time.** While HHS has released and requested comments on the possible approaches to conversion, the contract work being done by the RAND, in conjunction with SHADAC and NCSL, has not been shared publicly. This makes it very difficult to evaluate the proposed conversion methodologies, except in the abstract. Prior to issuing final guidance or regulations on conversion options, HHS should share data on the impact of the different options. At a minimum, it is vital that children's advocates and other stakeholders be able to see accurate estimates of how many children will be eligible for coverage under the various efforts. In addition to enhancing the transparency of the HHS process, it is important that as states determine which option (if they are given one) they will implement, the process should also be made public, as the stakes are incredibly high for current and future Medicaid beneficiaries.

Additionally, conversion should be evaluated and revisited over time to ensure that the change to MAGI has not adversely affected the number of people securing coverage, nor had a disproportionately negative impact on lower-income individuals who might have qualified under old rules. Specifically, we strongly recommend that HHS establish a system for tracking and evaluating how well the conversion methodologies are working. Moreover, it should reserve the right to require states to make modifications if families, researchers, stakeholders, or others are able to identify that children or others are missing out on coverage as a result. HHS already has adopted a similar "phased approach" to dealing with other complex implementation issues raised by the ACA, and we encourage it to do so again here.

One options for evaluating the effectiveness of the conversion methodologies would be to compare enrollees' eligibility under both approaches. While such an evaluation would require states to take a sample of enrollees and ask more detailed questions about income, there may not be another readily available data source. However, to minimize the burden on beneficiaries, it could be done post-enrollment and for a small number of people, perhaps tied in with routine PERM evaluations. As long as it was made clear that supplying such information would not

impact eligibility, hopefully the burden on beneficiaries of answering these follow-up questions would not be too great.

The sample could be evaluated under the old method to determine the accurate conversion ratio, with this ratio being compared to the national average. If the state's ratio does not fall within a certain number of percentage points of the national level, the state would need to adjust its conversion method to more accurately reflect the pre-existing eligibility level. The accuracy of the conversion method should also improve over time, with the allowable difference between the national and state levels becoming smaller.

Finally, it is important to note that we do not support a sampling method to determine the matching rate, as other viable and less cumbersome options exist for determining the correct matching rate for enrollees post-2014. However, we believe that the importance of a successful conversion to MAGI necessitates a robust analysis and an approach other than sampling a subset of enrollees may not serve that purpose.

Thank you for your consideration of our comments. If we may provide further information, please contact Martha Heberlein at 202-687-4929.