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:

As organizations committed to the health and well-being of the nation's children and pregnant women, we appreciate the opportunity to comment on the HHS document, "*Conversion of Net Income Standards to Equivalent Modified Adjusted Gross Income Standards*." The conversion to MAGI-equivalent standards is of particular importance to the nation's children because it will determine the maximum income cutoff for children's eligibility for Medicaid and CHIP through 2019 and potentially beyond. It also has important implications for the minimum income threshold in Medicaid for pregnant women.

Many of the disregards and deductions now in place are extremely valuable to families, particularly working families. They have the effect of allowing them to secure Medicaid coverage for their children at income levels that are well in excess of net income standards. For example, a working parent in Utah with two young children in childcare now can qualify for work expense and childcare disregards worth $490, an amount that effectively moves her income level 30 percentage points up the federal poverty line. If done properly, the conversion will allow states to use a more simplified measure of family income (i.e., MAGI) when evaluating eligibility without causing children to miss out on coverage as a result of the loss of such disregards and deductions. However, if the conversion methodology is not sound, children's eligibility levels will, in effect, be lower than they were prior to passage of the Affordable Care Act (ACA). We believe that such an outcome would be a violation of the clear intent of the ACA to protect children's coverage, and our comments below are aimed at avoiding such a result.

SPECIFIC COMMENTS

- **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. As a result, we recommend that any conversion methodology should have to meet a hard and fast standard of not resulting in fewer children, pregnant women and others qualifying for Medicaid. Specifically, 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 (as is required in the survey methodology put forth by HHS). Moreover, HHS should establish through analysis and data that none of its options will result in fewer people securing coverage, and make such data available to the public for review and analysis.

- **Evaluate the use of conversion methods over time and allow for modification if there is evidence they are causing children to miss out on coverage**. The task of identifying appropriate conversion methodologies is clearly new and complex that carries great risk for

problems. Given the high stakes, we strongly recommend that HHS establish a system for tracking and evaluating how well the conversion methodologies are working, and that it reserve the right to require states to make modifications if families, researchers, stakeholders, or others are able to identify that children 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.

- **Eliminate or significantly revise the "average disregard" method, which appears almost certain to result in far fewer children qualifying for Medicaid and CHIP.** It appears very likely that the proposed "average disregard" method as currently designed would understate existing eligibility thresholds for children, pregnant women and other groups, potentially dramatically. We encourage you to drop this as an option or to significantly revise it to ensure that roughly the same number of children, pregnant women and others would remain eligible after conversion. The basic issue is that adding the value of average disregards to a net income threshold is not the same thing as determining the effective income threshold at which families can now qualify for coverage, as called for in the ACA. Under the average disregard method, many families with little or no income – and for whom disregards are irrelevant to their eligibility for Medicaid – are included in the "average" calculation, pulling down the value of disregards dramatically. A more appropriate methodology would be to consider the average value of disregards among those families for whom they are relevant. Specifically, if HHS continues to offer the average disregard method as an option to states, it should require them to consider the average value of disregards among families with gross income above the net income threshold (i.e., the universe of families for whom disregards are relevant). If it cannot make this adjustment, we recommend that HHS drop this option for states.

- **Explicitly reaffirm its position that all pregnant women in Medicaid—including those eligible for "pregnancy-related coverage" – are entitled to receive comprehensive medical services and coverage.** We are concerned that the solicitation for input on conversion options suggests that pregnant women might receive something less than comprehensive medical care, leaving open the possibility that pregnant women will lose access to important medical services they are eligible to receive today. Extensive evidence on the biological processes undergirding pregnancy confirms the inextricable link between maternal health during pregnancy and the health of the developing fetus and infant. Indeed, factors seemingly unrelated to a woman's pregnancy, such as asthma,[1] dental care,[2] and depression[3] can all substantially impact her child's health. Without comprehensive coverage, there is a plausible danger that the health of both pregnant women and their expected children could be compromised.

  As you know, under current law, states must only provide comprehensive coverage for women with incomes below the Aid to Families with Dependent Children (AFDC) income standard in effect as of May 1, 1988. For low-income pregnant women above that threshold (but still below the 133% FPL), states have the option to provide limited benefit packages that cover only "pregnancy related services" and "conditions likely to complicate

[1] V. Murphy, P. Gibson, et al, "Maternal Asthma Is Associated with Reduced Female Fetal Growth," Am. J. Respir. Crit. Care Med., 2003(168) 11: 1317-1323.
[2] Kumar J, Samelson R, eds. 2006, Oral Health Care During Pregnancy and Early Childhood: Practice Guidelines. Albany, NY: New York State Department of Health. Available at: www.health.state.ny.us/publications/0824.pdf.
[3] H. Nasreen, Z. Kabir, Y. Forsell, and M. Edhborg, "Low birth weight in offspring of women with depressive and anxiety symptoms during pregnancy: results from a population based study in Bangladesh," BMC Public Health, 2010, 10:515.

pregnancy" (§435.116). Though this distinction technically still applies under the Affordable Care Act, CMS, in the Preamble to the Final Rule regarding Eligibility Changes to Medicaid (HHS File Code: CMS-2349-F), nevertheless conveyed its expectation that all pregnant women receive full Medicaid benefits. It also indicated it will require states planning to exclude certain services for pregnant women to justify in a State plan amendment for the Secretary's approval its rationale for determining that these services are *not* pregnancy-related (pg. 17149).

Unfortunately, the Solicitation of Public Input regarding the MAGI standards may not adequately convey this interpretation. CMS, in describing how MAGI-equivalent income standards will be used to identify which individuals are eligible for specific benefits when benefits are tied to income limits, cites, as an example, "full Medicaid benefits for pregnant women instead of pregnancy-related benefits" (pg. 6). By juxtaposing full Medicaid coverage with pregnancy-related coverage, the text seemingly implies that the scope of benefits for pregnant women eligible for "pregnancy-related coverage" would necessarily be limited. This reading, if correct, seemingly contradicts CMS's prior interpretation that pregnancy-related services are necessarily comprehensive. In any final conversion guidance, as well as in any other related HHS materials, we respectfully urge CMS to clarify and explicitly reaffirm its position that all pregnant women in Medicaid—including those eligible for "pregnancy-related coverage" -- are entitled to receive comprehensive medical services and coverage.

- **Eliminate the potential cutback in coverage for parents.** Given the strong connection between the health and well-being of parents and children, we are concerned that the conversion requirement would not apply to the minimum income threshold for low-income parents. Instead, HHS's final Medicaid eligibility rule allows states to move to MAGI-based methods for evaluating income without any commensurate adjustment to reflect the loss of disregards and deductions. Prior to the Supreme Court's ruling, this decision had only modest consequences because any parents who lost coverage as a result of a state's failure to convert would have been picked up by the Medicaid expansion. Now, however, if HHS does not revisit its policy, we will see more uninsured low-income parents in states that fail to cover adults up to 133 percent of the federal poverty line than if the ACA had not passed. Since children are more likely to enroll in coverage and use services when their parents also are covered, this is an issue with important implications for children as well as the adults in their lives.

Again, thank you for the opportunity to comment on the proposed conversion methodologies. As you continue your work on this important topic, we encourage you to keep in mind the high stakes for our nation's children and pregnant women.

Sincerely,

American Academy of Pediatrics
Children's Defense Fund
Family Voices
First Focus
Georgetown University Center for Children and Families
March of Dimes
National Association of Children's Hospitals
Voices for America's Children