NHeLP
NATIONAL HEALTH LAW PROGRAM

1444 I Street, NW
Suite 1105
Washington, DC 20005
Ph. (202) 289-7661
Fax (202) 289-7724
nhelpdc@healthlaw.org

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VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services

Attention: **incomeconversion@cms.hhs.gov**
Conversion of Net Income Standards to Equivalent Modified Adjusted Gross Income Standards and Solicitation of Public Input

Dear Sir/Madam:

The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state levels. We appreciate the opportunity to provide CMS with comments on the proposed guidance for the conversion of net income standards to modified adjusted gross income ("MAGI") standards.

NHeLP commends CMS' thoughtful effort to identify the best method to convert current income limits to MAGI equivalents. We particularly appreciate CMS' solicitation of public input to include stakeholder feedback. NHeLP believes stakeholder input will be critical to designing a good policy because of the incredible variation in state Medicaid categories, income limit levels, population demographics, and deduction, income counting and disregard methodologies. Our comments below emphasize the importance of minimizing breaks in enrollment and continuity of care for enrolled individuals. We believe this represents the most efficient approach to setting conversion standards and matches the legal requirements and intent of the ACA.

A. General Framework

While we would welcome a policy that requires maintaining the eligibility of every *individual* through the conversion to MAGI and we believe the law would support such an interpretation, we realize the statute does not require and CMS is not currently considering such a policy. CMS could easily set such a methodology (simply calculating the equivalent MAGI threshold for the individual with highest current deductions or one at the 95th percentile if CMS wanted to avoid the outliers) to maximize eligibility and continuity. We recognize it might increase enrollment levels and potentially lessen state enhanced matching funds.

Assuming CMS does not pursue a method to maintain *individual* eligibility, we support CMS' intent to ensure *aggregate* equivalence. We believe this approach meets the minimum requirements of the ACA. To comply with statutory language, we make two broad recommendations for the conversion methodology.

First, if the conversion methodology resulted in fewer individuals enrolled, it would violate the language, intent and structure of the ACA. We therefore recommend that CMS require that conversions never have the effect of reducing the aggregate eligible population, regardless of the validity of the method. Another way of saying this is that the "Same Number Net and Gross Method" (discussed below) should form a minimum threshold for every state.

Second, we recommend that CMS build some additional enrollment into the conversion methodology. The conversion methodology should result in an increased number of *potentially* eligible individuals. This is critical because, while we can be sure that states will identify and disenroll all individuals who become *ineligible* based on the conversion (losers), it is equally clear that states will not successfully identify and enroll all individuals who are *potentially eligible* (winners). Some individuals may never come into the system, others may fail in the enrollment process, and others may be misidentified and enrolled into the wrong program (for example, if their categorical eligibility is not identified). In short, while all the conversion losers will lose, only a fraction of the winners will win. Assuming that no state will successfully enroll all the potential winners, any mathematically accurate MAGI-conversion method will necessarily result in an aggregate reduction in enrollment—an as-applied violation of the statutory language and intent. We note this problem will be especially grave for individuals in states that do not implement a Medicaid Expansion. Potential winners may already think they are not categorically eligible without the expansion and never bother to apply. Worse, many individuals who lose Medicaid eligibility would not qualify for subsidies on the exchange and so end up completely uninsured.

Therefore, we recommend that the selected methodology build in an enrollment cushion (and CMS might consider the need to make that additional enrollment even higher in states that don't adopt a Medicaid Expansion). This recommendation is entirely consistent with the intent and letter of the ACA. The language of the statute does not command CMS to peg the conversion to the *exact same* level. Instead, it commands CMS to set conversion standards "that are *not less* than the effective income eligibility levels" currently in place. ACA § 2002(a) adding new Social Security Act § 1902(e)(14) (emphasis added). This statutory language clearly supports setting the standards *above* the current standards – and we believe the statute was written this way in recognizing that converting current standards faithfully and fairly might require raising eligibility levels.

We recognize that, from the point of view of individuals, there will be winners and losers under every methodology except one that protects all *individuals*. (We note that this

methodology, too, would be consistent with the requirement for converted MAGI income levels "that are *not less* than the effective income eligibility levels.") However, there is nothing in the statute requiring CMS to create equal numbers of winners and losers. Continuity of care, the needs of this low-income population, administrative simplicity, and basic fairness all mitigate in favor of minimizing losers. These considerations support our suggestion to guarantee at least equal eligibility numbers and provide for additional eligibility. This is entirely consistent with the legal intent and language of the statute.

Finally, we note that The Supreme Court's decision regarding the Medicaid Expansion decision has potential to significantly change the impact of the conversion standard in states that forego the expansion. In such states, many individuals made ineligible by the conversion would lose *all* eligibility for coverage. We believe CMS should consider implementing a two-tiered system whereby non-expansion states would use a conversion methodology that more heavily favors maintaining current eligibility. Otherwise, the outcome of the conversion could prove catastrophic in non-expansion states.

B. Specific Recommendations

1. *Same Number Method With 10% Additional Potential Eligibility.*

NHeLP recommends that CMS use the "Same Number Net and Gross Method" ("Same Number"). This seems the more reliable approach and we have concerns with the Average Disregard Method ("Average Disregard"). As indicated above, we recommend further that CMS build additional eligibility into the Same Number method to account for the failure of potentially eligible individuals to enroll. NHeLP believes that the Same Number method, with additional protections we have recommended, meets the legal requirements of the ACA and effectuates the intent of the ACA to reasonably preserve coverage for individuals. If CMS does not adopt our recommendations, we urge that CMS set the Same Number method result as a *minimum* for other conversion systems.

The Same Number method is the better option because it is the most reliable way to achieve the required result, that the conversion lead to at least an equivalent aggregate result. The Average Disregard method, by contrast, would lead to divergent results depending on how the population is distributed around the mean. In addition, the Same Number methodology allows states to account fairly for both income counting and household composition differences between current Medicaid rules and MAGI rules, which we find important to ensure the accuracy of the model. For example, the income of stepparents and siblings who must file tax returns counts under MAGI rules, substantially increasing gross income for some children. The Same Number method would build in this difference, while the Average Disregard method may not. There is no basis for only considering "disregards" in the methodology and not considering these other significant income counting and household composition changes.

NHeLP makes two additional recommendations with respect to implementing the Same Number method (or any other method). First, because state data and enrollment fluctuate over the year, CMS should require states to use baseline data from the quarter in the past year with the highest enrollment. If CMS does not adopt our recommended approach, it should at least require states to use an annual data average to correct for potential seasonal dips in enrollment. Second, CMS should require the Same Number method, or any other conversion method, to *at least* maintain enrollment for a specified threshold percentage of enrollees. For example, CMS might require that at least 90% of the enrolled population might maintain enrollment after conversion. Under such a policy, if only 87% of the population remained enrolled after a Same Number (or other) conversion, the state would then adjust upwards the converted figure until it reached the 90% minimum. Using such a method, CMS could ensure that the conversion reasonably minimized disruption for the covered population. (We reiterate that the percentage threshold would be a minimum; a Same Number conversion that enrolled 92% would *not* be adjusted downwards). We believe it is particularly important for CMS to implement such a protection in all non-expansion states.

We recommend against the Average Disregard method because it could result in fewer individuals being potentially eligible after a conversion. In states where more than half of the individuals are receiving a deduction that is greater than the average (i.e., where the median is greater than the mean), there would be a net loss in eligibility due to the conversion. Since the language of the ACA requires a conversion not less than the effective eligibility standard and the purpose of the ACA was to maintain or expand Medicaid coverage, the Average Disregard method is not sustainable under the letter or intent of the law.

In addition, the Average Disregard method presents serious calculation challenges. In many states, deductions are applied by caseworkers informally and there is almost no way to ensure that the disregard data reported by a state actually reflects state practice. It is likely that official state data understates disregards significantly, because there is no need to identify all additional available disregards for individuals already below the income limits. The model as described would include such individuals and so artificially reduce the average disregard across the population. This difficulty is exacerbated by the fact that states have a financial incentive to understate disregards for conversion purposes. Disregards are, in most states, very complex and not well suited to mass tabulation. If CMS selects a disregard-based method, it would need to develop a system to carefully review state disregard aggregation. We also believe that, to meet the statutory requirement for a conversion standard that is not less than the effective income eligibility levels currently in place, CMS would need to additionally require the state to confirm that at least as many people as would be found eligible by the Same Number method. It would unnecessarily burden states to do both calculations, and thus CMS should simply rely on the Same Number method. In addition, if CMS used the Average Disregard method it would also need to:

- Develop an additional calculation to compensate for differing income counting rules and household composition rules (described above).
- Develop an additional adjustment to account for the potentially eligible individuals who don't enroll, particularly in a state that does not implement a Medicaid Expansion.
- Calculate average disregard based only on individuals actually receiving disregards. Using data that includes all individuals, including those receiving no disregards, would hide the real effect of the disregard. As noted above, for individuals who are already below the income limits, many states do not apply any deductions, even if the individual might be eligible for a deduction. Counting these "zero" deductions would be inaccurate and artificially bring down the average. We note that disregards are specifically tied to important policy considerations impacting low income people, such as child care deductions, and simply bumping general eligibility levels a few points will not account for these policy considerations.

The Major Average Disregard method is problematic for all of the reasons described above in the Average Disregard method and additionally because we are concerned about how states might manipulate the calculation, the quality of the data sources, and the administrative difficulty in establishing what is a "major" disregard in each state (for example, is a disregard minor if it is rarely used but large when claimed, or, if it is very small but claimed very frequently?). CMS notes that this would only be possible in states that document disregards individually and may not permit adjustments for changes in household composition and income counting. We are concerned with the reliability of state data and the administrative burden required to identify "major disregards." Finally, if CMS used such a method, CMS would also need to find a way to approximate and add the total value of the "minor" disregards which may be independently minor but significant when aggregated. Failure to do this would surely result in a lower effective eligibility standard, which is prohibited by the statute.

RECOMMENDATION: CMS should adopt the Same Number Net and Gross Method, with an additional 10% of the "same number" added to the conversion. For example, if 100,000 people are eligible in a state under the current Medicaid income limit, the MAGI conversion should be pegged to the number which makes 110,000 people eligible.

2. *Minimums Should Be Converted.*

When commenting on the August 17, 2011 Proposed Rule on Medicaid Eligibility Changes Under the Affordable Care Act, NHeLP, along with many other commenters, urged CMS to reconsider its proposal to *not* require the conversion of *minimum* income standards for eligibility into a MAGI-equivalent standard so as to preserve categorical eligibility for persons currently eligible for Medicaid. NHeLP was very disappointed that CMS rejected the commenters' position and, in the Final Rules published on March 23,

2012, stayed with its proposal to use a MAGI-equivalent standard only to establish the *maximum* allowable income standard for states. In light of the Supreme Court's decision in *NFIB*, which has eliminated HHS's ability to eliminate all Medicaid funding if a state refuses to implement the Medicaid expansion, we urge CMS to reconsider its decision about how to apply the MAGI conversion.

CMS justified the decision to not convert minimums on the basis that affected populations were either protected (by MOE) or eligible for other satisfactory coverage. While we still disagree that the other coverage is satisfactory, in a state that doesn't implement the Medicaid Expansion there would now be individuals at risk for losing coverage altogether. Individuals who are below the threshold for exchange assistance (100% FPL) would have *no coverage alternative* if they were in the group that was eligible before conversion, but ineligible afterwards. Thus, for example, there may be no alternative Medicaid eligibility category available for parents and caretaker relatives who lose eligibility because a state, faced with budget difficulties, decides to lower its minimum standard, which under the Final Rule may be as low as the State's AFDC income standard in effect as of May 1, 1988 for the applicable family size.

We note that given the significant size of disregards in many states, failure to convert minimums could lead to large numbers of disenrollments in a state that decides to lower a limit to the minimum. CMS should require conversion of minimums in all non-Expansion states. Even in states that do implement the Medicaid Expansion, the failure to convert minimums could result in worse Medicaid (benchmark) coverage for many individuals, and it could result in even worse Exchange coverage for others, such as pregnant women and children (in 2019).

We recommend that CMS must also require that in states where the current limit is in fact the minimum limit, the state must still do a conversion (i.e., CMS should clarify that states must convert all of their current limits, even if their current limit happens to be set at the minimum).

<u>RECOMMENDATION</u>: In light of changes brought about by the Supreme Court's decision, NHeLP recommends that CMS must reverse its decision and require that minimum income standards be converted to MAGI-equivalents.

3. *Use of National Data Must Account For Variations In State Demographics and Medicaid Rules.*

To the extent that CMS or states rely on national level data, regardless of the methodology, it is critical that CMS adjust the data to account for significant variations in state demographic profiles and Medicaid eligibility rules. For example, national demographic data used for population sampling should be adjusted to reflect more accurately a state's population; national data applied to a state with above-average proportions of individuals below 50% of FPL should be adjusted to reflect that

characteristic. Similarly, national data about income counting or household composition should be adjusted to account for significant state differences in these areas. Furthermore, CMS and states should be required to make publicly available any demographic adjustment methodologies, including which demographic parameters are included in the adjustment and a description of potential inaccuracies due to data limitations in the adjustment model.

RECOMMENDATION: Regardless of the conversion method, CMS must ensure that national data does not disfavor individuals in states based on their state's demographics, income counting rules, household composition definition, or other similar factors.

4. *Uniform MAGI-conversion Method.*

NHeLP urges CMS to adopt one uniform MAGI-conversion methodology to be implemented in all states (our recommendation is the Same Number method with an eligibility cushion). We understand that there are strong reasons to allow for flexibility in methodologies; states and federal data may differ greatly among states and the calculation may simply turn out very differently in different states. Nonetheless, we believe there are stronger reasons to use a uniform standard.

To begin with, some states afforded flexibility to choose their own standards may exploit the opportunity to strategically select the standard that yields the lowest enrollment. We believe this is of particular concern with the Average Disregard method, and even more so for the Major Average Disregard method. There are too many uncertainties around how faithfully states will identify the deductions they use, how they'll calculate the average, and how they'll define "Major" in the case of the Major Average method. This problem is compounded by the fact that multiple methods being used in 51 different states will complicate CMS' review, monitoring, and enforcement of state conversion methods.

RECOMMENDATION: CMS should adopt one national MAGI-conversion method.

5. *CMS Should Clarify the FMAP Conversion Method.*

It is our understanding that the conversion identified by this guidance will set the limit for purposes of categorical eligibility (impacting benefits package) *and* the newly eligible FMAP rate. Further, it is our understanding that while the categorical limit may be subject to change (pursuant to Medicaid flexibility permitted by the Act) the FMAP limit is a permanently fixed threshold. We note that in aligning these limits and/or setting the FMAP conversion, CMS should not create any flexibility or incentive for states to lower the FMAP limit if it will also reduce categorical eligibility.

6. *CMS Should Require Transparency.*

Regardless of the method(s) used for conversion, each state will still have to implement the methodology considering its existing income disregards, income counting rules, household definitions, and/or enrollment numbers. This process should be transparent. Stakeholders should be given the opportunity to comment on the state's proposed methodology, statistical assumptions, and calculations before CMS approves them. CMS should also make all data from the RAND study of ten pilot states publicly available, as consumer stakeholders cannot provide fully informed comments with only partial information. If CMS adopts an averaging methodology (which we have recommended against) we believe that transparency will be particularly important in the state's identification of deductions, their values, and their frequency of use.

RECOMMENDATION: CMS must require state transparency in setting and using conversion methods.

7. *CMS Should Conduct Surveying and Factor in the Woodwork Effect.*

The statutory language requires that effective income limits after conversion *at least* equal pre-conversion standards. CMS should conduct a post-implementation evaluation that evaluates the impact of conversion on eligibility, and which ultimately ensures that the conversion did not reduce aggregate enrollment. This is especially critical in non-expansion states because in many cases beneficiaries who lose eligibility due to MAGI-conversion will have no access to Premium Tax credits on the exchange if their income is below 100%FPL.

More specifically, NHeLP strongly recommends that the CMS post-implementation evaluation should compensate for the "woodwork effect", whereby publicity around health reform implementation increases enrollment of already eligible individuals. For example, if before conversion there were 50,000 eligible, and after conversion in mid-2014 there were also 50,000 enrolled, that would in fact likely represent a *decrease* in enrollment with respect to the originally enrolled population, because some of the latter 50,000 people would include individuals who were already eligible but weren't enrolled until the fanfare around Medicaid and Exchange implementation in 2014 caught their attention.

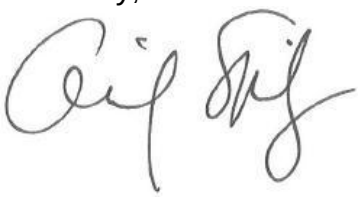
To account for this, we suggest that CMS should conduct post-implementation surveys that compare a representative sample of the state's low-income population (i.e., demographic data independent of Medicaid enrollment status) using pre-conversion and MAGI-converted eligibility rules to determine the accuracy of the conversion. Such a design would avoid the confounding factor of the "woodwork effect." Any evaluation based only on a "before and after" comparison of eligibility rolls would have difficulty distinguishing the impact of MAGI-conversion from the impact of already expected enrollment increases. Without adjustment, an appropriate MAGI-conversion would

produce an evaluation that appears too generous to beneficiaries (because the woodwork effect would inflate the numbers).

Conclusion

In summary, we believe CMS' guidance suggests a methodology (Same Number) which sets a useful minimum for converted MAGI enrollment, but that CMS must supplement that minimum with additional enrollment to protect individuals and properly implement the requirements of the ACA. If you have questions about these comments, please contact Leonardo Cuello at (202) 289-7661 or cuello@healthlaw.org. Thank you for consideration of our comments.

Sincerely,



Emily Spitzer,
Executive Director