



United States Government Accountability Office
Washington, DC 20548

B-323296

April 5, 2012

The Honorable Max Baucus
Chairman
The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate

The Honorable Fred Upton
Chairman
The Honorable Henry Waxman
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Dave Camp
Chairman
The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
House of Representatives

Subject: *Department of Health and Human Services, Centers for Medicare & Medicaid Services: Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010*

Pursuant to section 801(a)(2)(A) of title 5, United States Code, this is our report on a major rule promulgated by the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), entitled “Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010” (RIN: 0938-AQ62). We received the rule on March 20, 2012. It was published in the *Federal Register* as a final rule; interim final rule on March 23, 2012, with an effective date of January 1, 2014. 77 Fed. Reg. 17,144.

The final rule implements several provisions of the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act). The Affordable Care Act expands access to health insurance coverage through improvements to the

Medicaid and Children's Health Insurance (CHIP) programs, the establishment of Affordable Insurance Exchanges ("Exchanges"), and the assurance of coordination between Medicaid, CHIP, and Exchanges. This final rule codifies policy and procedural changes to the Medicaid and CHIP programs related to eligibility, enrollment, renewals, public availability of program information and coordination across insurance affordability programs.

Enclosed is our assessment of CMS's compliance with the procedural steps required by section 801(a)(1)(B)(i) through (iv) of title 5 with respect to the rule. Our review of the procedural steps taken indicates that CMS complied with the applicable requirements.

If you have any questions about this report or wish to contact GAO officials responsible for the evaluation work relating to the subject matter of the rule, please contact Shirley A. Jones, Assistant General Counsel, at (202) 512-8156.

signed

Robert J. Cramer
Managing Associate General Counsel

Enclosure

cc: Agnes Thomas
Correspondence and Regulations Assistant
Department of Health and Human Services

REPORT UNDER 5 U.S.C. § 801(a)(2)(A) ON A MAJOR RULE
ISSUED BY THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
CENTERS FOR MEDICARE & MEDICAID SERVICES
ENTITLED
"MEDICAID PROGRAM; ELIGIBILITY CHANGES
UNDER THE AFFORDABLE CARE ACT OF 2010"
(RIN: 0938-AQ62)

(i) Cost-benefit analysis

CMS states that the Regulatory Impact Analysis (RIA) uses the estimates of Office of the Actuary (OACT) and the estimates prepared by the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation. CMS notes that it provides both estimates to illustrate the uncertainty inherent in projections of future Medicaid financial operations. According to CMS, analysis by OACT indicates that the final rule will result in an estimated additional 24 million newly eligible and currently eligible individuals enrolling in Medicaid by 2016, including approximately 2–3 million individuals with primary health insurance coverage through employer sponsored plans who would enroll in Medicaid for supplemental coverage. CMS notes that this is the same estimate as was in the regulatory impact analysis of the Medicaid Eligibility proposed rule (August 2011). OACT notes that such estimates are uncertain, since they depend on future economic, demographic, and other factors that cannot be precisely determined in advance. Similarly, CMS believes that the actual behavior of individuals and the actual operation of the new enrollment processes and Exchanges will affect enrollment and costs. According to CMS, the CBO has estimated a net increase of 16 million newly and previously eligible people enrolled in Medicaid and CHIP in 2016 as a result of the new law, less 500,000 to 1 million due to the change in the definition of modified adjusted gross income (MAGI) to include Social Security income.

CMS states that for new enrollees, eligibility for Medicaid will improve access to medical care, resulting in improved health outcomes and greater financial security. CMS notes that research demonstrates that when uninsured individuals obtain coverage (including Medicaid), the rate at which they obtain needed care increases substantially. CMS believes individuals with insurance coverage are more likely to have regular checkups, recommended health screenings, and a usual source of care to help manage their health. In addition, CMS explains that people with health insurance coverage have less out of pocket costs and are less likely to have unpaid medical bills.

OACT estimates that federal spending on Medicaid for newly and currently eligible individuals who enroll as a result of the changes made by the Affordable Care Act would increase by a total of \$164 billion from FY 2012 through 2016. Reflecting different data, assumptions, and methodology, CBO estimates an increase in federal spending of \$162 billion over the same period of time, less \$7.9 billion resulting from the November 2011 legislative changes to the definition of MAGI. OACT estimates that state expenditures for individuals, who choose to enroll as a result of changes implemented by the Affordable Care Act, will total approximately \$14 billion for FYs 2012 through 2016. (According to CMS, while the increased federal medical assistance percentage for expansion states is not included in this final rule, it is estimated that \$9.1 billion will be transferred from the federal government to the relevant states between FY 2012 and 2016, reducing the net impact of the Medicaid coverage provisions on those states.) CMS notes that these estimates do not consider offsetting savings to states that will result, to a varying degree depending on the state, from this final rule.

CMS states that this final rule will benefit states and providers by improving the health of their residents and patients, reducing uncompensated care costs, and allowing states to receive federal financial participation (FFP) on spending for health coverage that currently is paid for with state and local funds. In addition, the simplified Medicaid eligibility policies will, over time, reduce administrative burdens on state Medicaid agencies. According to CMS, an Urban Institute analysis estimates that the costs to states from Medicaid expansion will be more than fully offset by other effects of the legislation, for net savings to states of \$92 to \$129 billion from 2014 to 2019.

(ii) Agency actions relevant to the Regulatory Flexibility Act (RFA), 5 U.S.C. §§ 603-605, 607, and 609

Because this final rule is focused on eligibility and enrollment in public programs, CMS states that it does not contain provisions that would have a significant direct impact on hospitals, and other health care providers that are designated as small entities under the RFA. However, CMS believes the provisions in this final rule may have a substantial, positive indirect effect on hospitals and other health care providers due to the substantial increase in the prevalence of health coverage among populations who are currently unable to pay for needed health care, leading to lower rates of uncompensated care at hospitals. CMS notes that section 1102(b) of the Act requires it to prepare a regulatory impact analysis if a final rule may have a significant economic impact on the operations of a substantial number of small rural hospitals. According to CMS, this analysis must conform to the provisions of section 604. For purposes of section 1102(b) of the Act, CMS defines a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. CMS did not prepare an analysis for section 1102(b) of the Act because the Secretary determined that this final rule will not have a direct economic impact on the operations of a substantial number of small rural hospitals.

(iii) Agency actions relevant to sections 202-205 of the Unfunded Mandates Reform Act of 1995, 2 U.S.C. §§ 1532-1535

CMS states that section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2011, that threshold is approximately \$136 million. However, it is important to understand that UMRA does not address the total cost of a rule. Rather, CMS states that it focuses on certain categories of cost, mainly costs resulting from (a) imposing enforceable duties on state, local, or tribal governments, or on the private sector, or (b) increasing the stringency of conditions in, or decreasing the funding of, state, local, or tribal governments under entitlement programs. CMS believes that states can take actions that will largely offset the increased medical assistance spending for newly enrolled persons. Because the net effects are uncertain and the overall costs significant, CMS drafted the RIA to meet the requirements for analysis imposed by UMRA, together with the rest of the preamble. According to CMS, the extensive consultation with states it describes later in this analysis was aimed at the requirements of both UMRA and Executive Order 13,132 on Federalism.

(iv) Other relevant information or requirements under acts and executive orders

Administrative Procedure Act, 5 U.S.C. §§ 551 et seq.

CMS states that in light of the magnitude and scope of the Medicaid expansion and the changes in the eligibility determination system required by the Affordable Care Act, and the statutory implementation date of January 1, 2014, it is critical to provide final rules to guide states in making necessary program changes to prepare for implementation. CMS believes states will need to make changes to their electronic and manual systems, will need to amend their Medicaid state plans, and may need to enact authorizing legislation on the state level. Because of the short time needed to make necessary changes, CMS finds that it would be contrary to the public interest to delay issuance of comprehensive final rules. CMS also determined to provide an additional opportunity for public comment by issuing the affected provisions (§ 431.300(c)(1) and (d), § 431.305(b)(6), § 435.912, § 435.1200, § 457.340(d), § 457.348 and § 457.350(a), (b), (c), (f), (i), (j), and (k)) as an interim final rule with opportunity for comment within the context of the overall comprehensive rule. CMS is adopting this approach because it found that it would be contrary to the public interest to delay issuance of comprehensive final rules in order to issue a new proposed rule to address issues that it may not have specifically addressed in the proposed rule. CMS believes that the public interest is served by issuing a single consolidated rule instead of issuing a separate proposed rule, to enable readers to see the context and interrelationships in the overall regulatory framework. As this approach will provide an equivalent opportunity for

public comment, CMS also believes that issuance of a separate proposed rule is unnecessary. Additionally, CMS notes that there will be no adverse effect from this approach because the new requirements will not be effective until January 1, 2014, and there will be a full and fair opportunity prior to the effective date for public comment and any necessary revisions to the interim final provisions. Therefore, for the reasons stated above, CMS finds good cause to waive the notice of proposed rulemaking and to issue a portion of this final rule as an interim final rule. CMS notes that certain provisions of this final rule are being issued as interim final, and will consider comments received by May 7, 2012.

Paperwork Reduction Act, 44 U.S.C. §§ 3501-3520

CMS states that under the Paperwork Reduction Act (PRA) of 1995, it is required to provide 60-day notice in the *Federal Register* and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval to fairly evaluate whether an information collection should be approved by OMB.

In the Medicaid Eligibility proposed rule, CMS states that it solicited public comments for 60 days on the information collection requirements (ICRs) and no PRA-related comments were received. CMS notes that the following provisions of this final rule will have their PRA implications reviewed under CMS–10398, OMB 0938–1148: *Medicaid and CHIP State Plans*: §§ 431.10(c) and (d); 431.11(d); 435.110(b); 435.116(b); 435.118(b); 435.119(b); 435.218(b); 435.403(h) and (i); 435.603(a); 435.908, 435.916, 457.305(a) and (b); 457.310(b); 457.315, 457.320(d); 457.340(f); 457.343; and 457.350. CMS notes that it will also be addressing items related to the development and adoption of the single streamlined application as well as alternate applications and supplemental forms for the Exchanges, Medicaid, and CHIP under a separate PRA package. CMS states that provisions of this final rule that will be addressed in that package include, § 435.907, § 435.910, § 457.330; § 457.340. According to CMS, information collection requests for these sections are under development, and there will be a separate opportunity for public notice and comment on these materials once they have been developed.

Statutory authorization for the rule

CMS states that the legal authority for this final rule comes from the Patient Protection and Affordable Care Act (Pub. L. No. 111–148, enacted on March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111–152, enacted on March 30, 2010), and together referred to as the Affordable Care Act of 2010 (Affordable Care Act).

Executive Order No. 12,866 (Regulatory Planning and Review)

CMS states that the OMB has determined that this rule is “economically significant” for the purposes of Executive Order 12,866. Therefore, CMS prepared a RIA that presents the costs and benefits of this rulemaking.

Executive Order No. 13,132 (Federalism)

CMS notes that the Affordable Care Act and this final rule have significant direct effects on states. The Affordable Care Act requires major changes in the Medicaid and CHIP programs, which will require changes in the way states operate their individual programs. While these changes are intended to benefit beneficiaries and enrollees by improving coordination between programs, they are also designed to reduce the administrative burden on states by simplifying and streamlining systems. CMS states that it received input from states on how the various Affordable Care Act provisions codified in this final rule will affect them. CMS notes that it participated in a number of conference calls and in-person meetings with state officials in the months before and since the law was enacted, and these discussions have enabled the states to share their thinking and questions about how the Medicaid changes in the legislation would be implemented. Additionally, CMS notes that the conference calls and meetings also furnished opportunities for state Medicaid directors to comment informally on implementation issues and plans (although to be considered comments on the Medicaid Eligibility proposed rule, written comments using the process described in the Medicaid Eligibility proposed rule were required). CMS also continued to engage in ongoing consultations with Medicaid and CHIP Technical Advisory Groups (TAGs), and through meetings with these TAGs, CMS has been able to get input from states specific to issues surrounding the changes in eligibility groups and rules that will become effective in 2014.