U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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July 23, 2013

The Honorable Tom Harkin
Chairman
The Honorable Lamar Alexander
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate

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

Subject: *Department of Health and Human Services, Centers for Medicare & Medicaid Services: Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment*

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 and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment" (RIN: 0938-AR04). We received the rule on July 10, 2013. It was published in the *Federal Register* as a final rule on July 15, 2013. 78 Fed. Reg. 42,160.

The final rule implements provisions of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act). This final rule finalizes new Medicaid eligibility provisions; finalizes changes related to electronic Medicaid and the Children's Health Insurance Program (CHIP) eligibility notices and delegation of appeals; modernizes and streamlines existing Medicaid eligibility rules; revises CHIP rules relating to the substitution of coverage to improve the coordination of CHIP coverage with other coverage; and amends requirements for benchmark and benchmark-equivalent benefit packages consistent with sections 1937 of the Social Security Act (which CMS refers to as ''alternative benefit plans'') to ensure that these benefit packages include essential health benefits and meet certain other minimum standards. This rule also implements specific provisions including those related to authorized representatives, notices, and verification of eligibility for qualifying coverage in an eligible employer-sponsored plan for Affordable Insurance Exchanges. The final rule also updates and simplifies the complex Medicaid premium and cost sharing requirements, to promote the most effective use of

services, and to assist states in identifying cost sharing flexibilities. It includes transition policies for 2014 as applicable.

The effective date for the additions of 42 C.F.R. §§ 435.118, 435.603, 435.911, 435.949, 435.956, 435.1200, 457.315, 457.330 and 457.348; amendments to 42 C.F.R. §§ 431.10, 431.11, 435.110, 435.116, 435.119, 435.907, 435.916, 435.940, 435.945, 435.948, 435.952, 457.340, and 457.350; the removal of 42 C.F.R. §§ 435.953 and 435.955; and the redesignation of 42 C.F.R. §§ 435.911 through 435.914 as 42 C.F.R. §§ 435.912 through 435.915 in CMS–2349 (FR Doc. 2012–6560) published on March 23, 2012, which were to become effective in January 1, 2014, are now effective October 1, 2013.

Other provisions of this final rule that are codified in title 42 of the Code of Federal Regulations are effective January 1, 2014, with the exception of amendments to the following which are effective on October 1, 2013: 42 C.F.R. §§ 431.10, 431.11, 431.201, 431.205, 431.206, 431.211, 431.213, 431.230, 431.231, 431.240, 435.119, 435.603, 435.907, 435.918, 435.1200, 457.110, 457.348, and 457.350; and the addition of 42 C.F.R. §§ 435.1205 and 457.370, which are effective on October 1, 2013. Regulations in the final rule that are codified in title 45 of Code of Federal Regulations are effective on September 13, 2013.

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: Ann Stallion
Program Manager
Department of Health and Human Services

ENCLOSURE

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 AND CHILDREN'S HEALTH INSURANCE PROGRAMS:
ESSENTIAL HEALTH BENEFITS IN ALTERNATIVE BENEFIT PLANS,
ELIGIBILITY NOTICES, FAIR HEARING AND APPEAL PROCESSES, AND
PREMIUMS AND COST SHARING; EXCHANGES: ELIGIBILITY AND ENROLLMENT"
(RIN: 0938-AR04)

(i) Cost-benefit analysis

CMS examined costs and benefits as part of its regulatory impact analysis (RIA). CMS summarized alternatives considered and estimated the impact of the Medicaid premium and of cost sharing provisions and for exchange provisions. CMS also prepared an accounting statement showing the classification of the impacts associated with implementation of the final rule.

Additionally, CMS states that the provisions included in this final rule amend provisions of the Exchange Establishment final rule. CMS does not believe the modifications made significantly alter the benefits associated with these provisions. Therefore, CMS refers to the benefits discussion included in the regulatory impact analysis associated with the Exchange Establishment final rule for a full analysis. The Exchange Establishment final rule regulatory impact analysis can be found at www.cms.gov/CCIIO/Resources/Files/Downloads/hie3r-ria-032012.pdf.

CMS also outlined the costs of the proposed regulation. CMS states that the Affordable Care Act and the implementing regulations found in subpart D of the final rule and the Exchange Establishment final rule provide for a streamlined system based on simplified eligibility rules, and an expedited process that will facilitate enrollment of eligible individuals and minimize costs to states, Exchanges, and to the federal government. To support this new eligibility structure, CMS notes that states seeking to operate Exchanges are expected to build new or modify existing information technology (IT) systems. CMS believes that how each state builds and assembles the components necessary to support its Exchange and Medicaid infrastructure will vary and depend on the level of maturity of current systems, current governance and business models, size, and other factors. According to CMS, it is important to note that, although states have the option to establish and operate an Exchange, there is no federal requirement that each state establish an Exchange. CMS believes the proposed provisions provide options and flexibility to states that minimize costs and burden on Exchanges, consumers, employers, and other entities. CMS also believes that overall administrative costs may increase in the short term as states build IT systems; however, in the long term, states may see savings through the use of more efficient systems.

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

CMS states that the Secretary has determined that this final rule will not have a significant economic impact on a substantial number of small entities, and has not prepared an RIA.

Additionally, CMS explains that it is not preparing an analysis for section 1102(b) of the Act because the Secretary has 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 the final rule does not mandate expenditures by state governments, local governments, tribal governments, in the aggregate, or the private sector, of $140 million. According to CMS, the majority of state, local, and private sector costs related to implementation of the Affordable Care Act were described in the RIA accompanying the March 2012 Medicaid eligibility rule (77 Fed. Reg. 17,144). Furthermore, CMS notes that the final rule does not set any mandate on states to set up an Exchange.

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

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

On January 22, 2013, CMS published a proposed rule entitled "Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing." 78 Fed. Reg. 4594. CMS received a total of 741 timely comments from individuals, state Medicaid and CHIP agencies, advocacy groups, tribes and tribal organizations, policy and research organizations, health care providers, employers, insurers, and health care associations.

CMS notes that it received many comments about the complexity of the proposed rules and the significance of the changes that need to be made to fully implement the provisions of the Affordable Care Act. According to CMS, many commenters were concerned about the short timeframes for implementation and about states' ability to make needed changes to policy, operations, and information technology systems. CMS recognizes that the timing of the final rule may result in implementation challenges, especially from a systems perspective. Therefore, CMS has evaluated the provisions of the January proposed rule that are necessary to meet the deadlines and are finalizing in this rule only those provisions that CMS believes states will be reasonably able to (or have already been planning to) implement by January 1, 2014. CMS notes that remaining provisions will be finalized in future rulemaking.

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

CMS submitted a copy of the final rule to the Office of Management and Budget (OMB) for its review of the rule's information collection and recordkeeping requirements. CMS notes that these requirements are not effective until they have been approved by OMB and invites public comments on these potential information collection requirements.

Statutory authorization for the rule

CMS states that the final rule is authorized by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act). Pub. L. 111-148, as amended.

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

OMB has determined that this rulemaking is "economically significant." Accordingly, CMS has prepared a Regulatory Impact Analysis that presents the costs and benefits of the final rule.

Executive Order No. 13,132 (Federalism)

Executive Order 13,132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct effects on states, preempts state law, or otherwise has federalism implications. CMS notes that the impact of changes related to implementation of the Affordable Care Act were described in the RIA of the March 2012 Medicaid eligibility rule. 77 Fed. Reg. 17,144. As discussed in the March 2012 RIA, CMS consulted with states to receive input on how the various Affordable Care Act provisions codified in this final rule will affect states. And, CMS continues to engage in ongoing consultations with Medicaid and CHIP Technical Advisory Groups (TAGs), which have been in place for many years and serve as a staff level policy and technical exchange of information between CMS and the states. Through consultations 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.

CMS notes that because states have flexibility in deciding whether to implement an Exchange and, if a state opts to, the state's decisions will ultimately influence both administrative expenses and overall premiums in the design of its Exchange. However, because states are not required to create an Exchange, CMS explains that these costs are not mandatory. According to CMS, for states electing to create an Exchange, the initial costs of the creation of the Exchange will be funded by Exchange Planning and Establishment Grants. After this time, Exchanges will be financially self-sustaining with revenue sources left to the discretion of the state.

In the CMS's view, while the final rule does not impose substantial direct effects on state and local governments, it has federalism implications due to direct effects on the distribution of power and responsibilities among the state and federal governments relating to determining standards relating to health insurance coverage (that is, for Qualified Health Plans) that is offered in the individual and small group markets. According to CMS, each state electing to establish a State-Based Exchange must adopt federal standards contained in the Affordable Care Act and in the final rule, or have in effect a state law or regulation that implements these federal standards. However, CMS anticipates that the federalism implications (if any) are substantially mitigated because states have choices regarding the structure and governance of their Exchanges.