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March 27, 2014

The Honorable Ron Wyden
Chairman
The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
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: Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity*

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 “Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity” (RIN: 0938-AR93). We received the rule on March 11, 2014. It was published in the *Federal Register* as a final rule on March 12, 2014. 79 Fed. Reg. 14,112.

The final rule establishes the Basic Health Program (BHP), as required by section 1331 of the Affordable Care Act. The BHP provides states the flexibility to establish a health benefits coverage program for low-income individuals who would otherwise be eligible to purchase coverage through the Affordable Insurance Exchange (Exchange). The BHP complements and coordinates with enrollment in a qualified health plan (QHP) through the Exchange, as well as with enrollment in Medicaid and the Children’s Health Insurance Program. The final rule also sets forth a framework for BHP eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, and federal oversight. Additionally, this final rule amends another rule issued by the Secretary of the Department of Health and Human Services in order to clarify the applicability of that rule to the BHP.

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

REPORT UNDER 5 U.S.C. § 801(a)(2)(A) ON A MAJOR RULE
ISSUED BY THEDEPARTMENT OF HEALTH AND HUMAN SERVICES,
CENTERS FOR MEDICARE & MEDICAID SERVICES

ENTITLED

"BASIC HEALTH PROGRAM: STATE ADMINISTRATION OF BASIC HEALTH PROGRAMS;
ELIGIBILITY AND ENROLLMENT IN STANDARD HEALTH PLANS;
ESSENTIAL HEALTH BENEFITS IN STANDARD HEALTH PLANS;
PERFORMANCE STANDARDS FOR BASIC HEALTH PROGRAMS;
PREMIUM AND COST SHARING FOR BASIC HEALTH PROGRAMS;
FEDERAL FUNDING PROCESS; TRUST FUND AND FINANCIAL INTEGRITY"
(RIN: 0938-AR93)

(i) Cost-benefit analysis

CMS states that the BHP established by the final rule will provide benefits to both consumers and states. The benefits to consumers, explained by CMS, is that the BHP targets low-income individuals who would be eligible for premium and cost-sharing reductions, if they purchased health insurance through an Exchange. These individuals may have variable income that causes them to move between insurance programs. For example, if their income drops, they may be eligible for Medicaid, and when their income rises, they would be eligible to purchase insurance (with premium and cost-sharing reductions) on an Exchange. This phenomenon is known as "churning." Because Medicaid health plans and health plans offered on Exchanges vary in terms of benefits, provider networks, cost-sharing, and administration, churn can be disruptive. According to CMS, researchers it has cited have estimated that the BHP will significantly reduce the number of individuals that churn between Medicaid and Exchanges. CMS has modified the rule to include the option of 12 months continuous eligibility. This option will further reduce churn in states that adopt it, by enabling those enrolled to remain eligible for a full 12 months regardless of income fluctuation. However, CMS explained that it is not adjusting the payment methodology and clarified in the response to comment that states will bear the associated financial burden to the extent there is one.

The benefits to states, according to CMS are that several states currently operate health insurance programs for low-income adults with incomes above Medicaid eligibility levels. These states believe that the programs confer benefit to their residents beyond what those individuals could obtain by purchasing health insurance on an Exchange. The BHP established by this rule will give states the option to maintain these programs rather than having those individuals purchase insurance through the Exchange.

According to CMS, the provisions of the final rule were designed to minimize regulatory costs. It minimizes new administrative structures, because the BHP does not include administrative funding and because of the need for states to coordinate with other insurance affordability programs. To the extent possible, CMS says that it borrowed structures from existing programs. In finalizing the rule, CMS says that it further extended the use of existing administrative infrastructure by permitting the use of the Exchange appeals process for BHP. Additionally, CMS says that it created an interim certification level to mitigate the risk associated with state expenditure of start-up funding prior to receiving any conceptual approval for the program.

As part of the cost-benefit analysis, CMS also discussed transfers. CMS states that the provisions of the rule are designed to transfer funds that will be available to individuals for premium and cost-sharing reductions for coverage purchased on an Exchange to states to offer coverage through a BHP. In states that choose to implement a BHP, eligible individuals will not be able to purchase health insurance through the Exchange. As a result, fewer individuals will use the Exchange to purchase health insurance. Depending on the profile of the people in BHP, this may result in adjustments to the risk profile of the Exchange.

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

CMS states that it clarified in the final rule that it does not have statutory authority to mandate the inclusion or exclusion of particular providers. According to CMS, the final rule is focused on eligibility and enrollment in public programs, and it sets out broad contracting standards but 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 RFA. However, the provisions in the 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 determined that the final rule will not have a significant economic impact on a substantial number of small entities.

Section 1102(b) of RFA requires the preparation a regulatory impact analysis if a proposed rule may have a significant economic impact on the operations of a substantial number of small rural hospitals. For purposes of section 1102(b) of the Act, CMS defined a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. CMS stated that while there may be indirect positive effects from reductions in uncompensated care, it has concluded that there is not a direct economic impact on these facilities.

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

According to CMS, states have the option, but are not required, to establish a BHP. Thus, the final rule does not mandate expenditures by state governments, local governments, or tribal governments.

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

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

On September 25, 2013, CMS published a proposed rule in the *Federal Register*. 78 Fed. Reg. 59,122. CMS states that it received a total of 132 timely comments from state agencies, groups advocating on behalf of consumers, health care providers, employers, health insurers, health care associations, tribes, tribal organizations, and the general public. In addition, CMS held an all-state/advocate consultation session on November 6, 2013, as well as a tribal consultation session on November 7, 2013, to provide an overview of the BHP proposed rule where interested parties were afforded an opportunity to ask questions and make comments. CMS says that it continued to meet during this time with interested states through the “learning collaborative” that was established prior to the publication of the proposed rule to solicit input related to program operations and coordination between all insurance affordability programs. CMS explained that at the consultation and learning collaborative sessions, participating parties

were reminded to submit written comments before the close of the public comment period that was specified in the BHP proposed rule. The final rule includes a summary of the public comments that CMS received and its responses.

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

CMS states that the information collection requirements/burden that were set out in the September 25, 2013, proposed rule estimated one respondent per year. 78 Fed. Reg. 59,122. Based on comments it received, CMS continues to estimate one respondent in this final rule. According to CMS, it estimates fewer than PRA's threshold of 10 respondents per year, so the information collection requirements/burden that are associated with this final rule are not subject to the requirements of PRA.

Statutory authorization for the rule

CMS states that the final rule implements section 1331 of the Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted on March 23, 2010) (codified at 42 U.S.C. 18051) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111.152, enacted on March 30, 2010), which are collectively referred to as the Affordable Care Act.

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

CMS determined that the final rule is economically significant as measured by the \$100 million threshold under Executive Order 12,866 and states that the rule was reviewed by the Office of Management and Budget. The aggregate economic impact of the final rule is estimated to be -\$900 million from CY 2015 to 2019 (measured in real 2015 dollars). The federal government is expected to reduce its overall expenditures, as the payments to the states for BHP are anticipated to be less than the payments that would have been made to QHPs for premium tax credits (PTCs) and cost-sharing reductions (CSR), if persons had been enrolled in those plans instead of in BHP. In general, we expect that federal payments to states for BHP would be 5 percent less than the federal payments for PTCs and CSR to QHPs if persons had been enrolled in those plans through the exchange. CMS included a table and an explanation with estimated federal impacts for the BHP.

Executive Order No. 13,132 (Federalism)

CMS states that the BHP is entirely optional for states, and if implemented in a state, provides access to a pool of funding that would not otherwise be available to the state. CMS concluded that there is not an impact on federalism by this voluntary state program.