DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010

(CMS-2349-F)

Final Regulatory Impact Analysis

Centers for Medicare & Medicaid Services

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SUMMARY

This document announces the impact statement for the final rule entitled "Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010," which is published in the Federal Register. We received no comments on the anticipated effects of the proposed rule, which was published in the Federal Register on August 17, 2011. The only significant change in this impact statement reflects the enactment of legislation on November 21, 2011 (Pub. L. 112-56), changing the modified adjusted gross income (MAGI) definition of income to include all Social Security benefits.

IMPACT ANALYSIS

I. Executive Orders 13563 and 12866

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993) and Executive Order 13563 on Improving Regulation and Regulatory Review (February 2, 2011). Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects ($100 million or more in any 1 year). The Office of Management and Budget has determined that this rulemaking is "economically significant" within the meaning of section 3(f)(1) of Executive Order 12866, because it is likely to have an annual effect of $100 million or more in any one year. Accordingly, we have prepared an RIA that presents the costs and benefits of this rulemaking.

This final rule updates the regulations to include the new Medicaid coverage groups created by the Affordable Care Act, simplifies eligibility policy for Medicaid and the Children's Health Insurance Program (CHIP), streamlines the eligibility and enrollment processes, and coordinates eligibility procedures with those of the Affordable Insurance Exchanges (Exchanges). This analysis will serve as the base for estimating Medicaid impacts of these interrelated provisions. The proposed rule also set out the methodologies for determining the increased Federal Medical Assistance Percentage (FMAP) rates related to "newly eligible" individuals and "expansion States." We will finalize the methodologies for the FMAP policy in future rulemaking.

II. Need for Regulatory Action

A central aim of the Affordable Care Act is to expand access to health insurance coverage through Exchanges, Medicaid, CHIP, and other sources of private insurance. The number of uninsured Americans is rising due to lack of affordable insurance, a reduction in employer-sponsored coverage, barriers to insurance for people with pre-existing conditions, limited competition, small risk pools, and market failures.[1] Millions of people without health insurance use health care services for which they do not pay, shifting the uncompensated cost of their care to health care providers, people who do have insurance (in the form of higher premiums), and State and local governments.[2] The Affordable Care Act includes a number of policies to address these financial challenges, including changes to Medicaid eligibility and enrollment.

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[1] U.S. Census Bureau, Income Poverty and Health Insurance Coverage in the United States: 2010, 2011.; J. Holahan, "The 2007–09 Recession And Health Insurance Coverage." Health Affairs January 2011 vol. 30 no. 1 145-152; K. Schwartz, "Health Coverage in a Period of Rising Unemployment," Kaiser Family Foundation. 2008. Government Accountability Office, "2008 Survey Results on Number and Market Share of Carriers in the Small Group Health Insurance Market," 2009. E. Simantov, et al., "Market Failure? Individual Insurance Markets For Older Americans." Health Affairs July 2001 vol. 20 no. 4 139-149.

[2] Families USA, Hidden Health Tax: Americans Pay a Premium (Washington, DC: Families USA, 2009) (http://familiesusa2.org/assets/pdfs/hidden-health-tax.pdf).

Starting in 2014, individuals and small businesses will be able to purchase health insurance through State-based competitive marketplaces called Affordable Insurance Exchanges (Exchanges). Exchanges will offer competition, choice, and purchasing power to Americans in need of health insurance. Insurance companies will compete for business on a level playing field, driving down costs. Consumers will have a choice of health plans to fit their needs. Exchanges will give individuals and small businesses the same purchasing clout as big businesses. The Departments of Health & Human Services, Labor, and the Treasury (the Departments) are working in close coordination to release guidance related to Exchanges in several phases. For example, Initial Guidance to States on Exchanges was issued in November 2010. Three proposed regulations were published in July 2011 to implement components of the Exchange and health insurance premium stabilization policies in the Affordable Care Act and to establish the Consumer Operated and Oriented Plan (CO-OP) Program. Finally, two proposed regulations were published with the Medicaid Eligibility proposed rule in the August 17, 2011 Federal Register (76 FR 50931) and (76 FR 51202) to implement the health insurance premium tax credit and eligibility for advance payments of premium tax credits and cost-sharing reductions and enrollment in a qualified health plan through the Exchanges. The Exchanges final rule was published in March 2012.

The provisions that are included in this final rule implement certain requirements of sections 1413, 1414, 2001, 2002, 2101, and 2201 of the Affordable Care Act. In combination with other provisions, these proposals aim to accomplish the major goals of the law – expanding coverage, improving care, and lowering costs. The first goal is to improve access to care by filling in coverage gaps, with the Federal government providing significant financial assistance to the States in doing so. Medicaid and CHIP have long been central to meeting the health care

needs of low-income children, pregnant women, seniors, and people with disabilities. However, Medicaid has historically been limited to certain "categories" of individuals, and for many of these groups, coverage has been available only to those with incomes significantly below the poverty line. The median income threshold for working parents' eligibility for Medicaid is 63 percent of the Federal poverty level,[3] and before the Affordable Care Act, no category existed for non-elderly, non-disabled adults without children, no matter how low their income. This has led to a large fraction of the uninsured – 41 percent in 2010 – having income below the poverty threshold.[4]

A second challenge addressed in this rule is the complexity of and barriers to Medicaid and CHIP enrollment and retention. Research has demonstrated that confusion over Medicaid's current eligibility requirements has deterred some eligible people from enrolling in coverage.[5] Research has also indicated that eligibility requirements, such as asset tests and the documentation associated with verifying such requirements, can serve as a barrier to otherwise eligible people enrolling in Medicaid coverage.[6] There is also evidence that a major factor contributing to lapses in coverage is the difficulty low-income families have with negotiating through the administrative complexities at renewal.[7] Gaps in coverage in turn make it more difficult to assure access to high quality care and positive health outcomes. Studies have shown

[3] M. Heberlein, et al., "Performing Under Pressure: Annual findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost Sharing Policies in Medicaid and CHIP, 2011-2012" Kaiser Commission on Medicaid and the Uninsured, 2012.

[4] Henry J. Kaiser Family Foundation, "The Uninsured: A Primer: Key facts about Americans without health insurance," 2011. KCMU/Urban Institute analysis of the 2011 ASEC supplement to the CPS.

[5] J. Stuber, et al., "Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid?" Washington, D.C.: The George Washington University Center for Health Services Research and Policy, 2000.

[6] V. Smith, et al, "Eliminating the Medicaid Asset Test for Families: A Review of State Experiences". Kaiser Commission on Medicaid and the Uninsured (2001); B. Sommers and A. Epstein (2010). "Medicaid Expansion – the Soft Underbelly of Health Reform?" New England Journal of Medicine. Vol 363(22), 2085-2087.

[7] L. Ku and D. Cohen Ross, Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families (New York: The Commonwealth Fund, Dec. 2002); K. Lipson, et al. Rethinking Recertification: Keeping Eligible Individuals Enrolled in New York's Public Health Insurance Programs.(New York: The Commonwealth Fund, August 2003).

that individuals with health coverage gaps are more likely to experience harmful health consequences and higher rates of hospitalizations for illnesses that can be effectively managed through ongoing primary care, such as asthma, diabetes, and cardiovascular disease.[8]

Finally, in addition to the effect on coverage and care, Medicaid's complex eligibility rules and procedures can result in substantial administrative costs for States. A 2005 study of churning in California's Medicaid program, Medi-Cal, found that over a 3-year period, 600,000 children who were disenrolled, reapplied in a very short timeframe, 4 months for most. The cost of reenrollment in Medi-Cal and then into their managed care plan was $120 million over the 3 years.[9] The Affordable Care Act and this final rule to implement it aim to simplify and streamline eligibility determinations and renewals, increasing coverage and access to care, and reducing administrative costs.

III. Summary of Provisions in this Final Rule

This final rule implements sections of the Affordable Care Act related to Medicaid and CHIP eligibility and enrollment. The final rule also provides for coordination of Medicaid and CHIP eligibility procedures with the procedures that will apply to eligibility determinations for the premium tax credits and other insurance affordability programs. This final rule, together with the rule establishing the eligibility parameters for advance payments of premium tax credits and cost-sharing reductions and enrollment in a qualified health plan through the Exchanges, as well as the rule developed by the Department of the Treasury regarding the health insurance premium assistance tax credit, establishes a framework for States to implement the changes to the Medicaid program that will take place in 2014 as a result of the Affordable Care Act.

[8] L. Ku, et al., "Improving Medicaid's Continuity of Coverage and Quality of Care." Association for Community Affiliated Plans (ACAP) (2009); A. Bindman, et al., "Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care–Sensitive Conditions." Annals of Int Medicine 2008;149:854-860.
[9] G. Fairbrother, "How Much Does Churning in Medi-Cal Cost?" California Endowment, April 2005.

This final rule has three key elements:

(1) Expanding Medicaid eligibility to individuals with household incomes at or below 133 percent of the Federal poverty level (FPL) and eliminating categorical exclusions for all States participating in the program.

Implementing the Affordable Care Act, this final rule codifies a new eligibility group effective in all States participating in Medicaid, referred to as the "adult group." Effective January 1, 2014, this group consists of individuals with household incomes at or below 133 percent of the FPL, who are age 19 through 64, not pregnant and not otherwise covered under Medicaid or Medicare.[10]

(2) Simplified eligibility rules for most Medicaid and CHIP beneficiaries.

As required by the Affordable Care Act, this final rule establishes the use of a simplified income methodology for determining Medicaid eligibility known as modified adjusted gross income (MAGI). MAGI-based methodologies will be applied to most populations the Medicaid program will serve (including children and adults under age 65) and to CHIP. MAGI will also be used to determine eligibility for advanced payment of premium tax credits and cost-sharing reductions for Exchange coverage, promoting the seamless eligibility system envisioned by the Affordable Care Act. Financial eligibility under the applicable MAGI standard is based on a set of financial methodologies to determine income which are applied consistently across insurance affordability programs (for example, Medicaid, CHIP, and the Exchange).

The final rule describes the process for applying the new simplified MAGI test. In addition, it establishes policies for ensuring that individuals who do not meet the simplified

[10] We note that eligibility for the adult group also includes a 5 percent income disregard, leading to an effective FPL of 138 percent.

income test are evaluated for Medicaid eligibility on other bases (for example, disability) and for potential eligibility for other insurance affordability programs.

This final rule also amends existing regulations to establish a Federal regulatory framework that promotes a simplified approach to eligibility. This includes consolidation of multiple Medicaid eligibility groups into four broad categories – children, pregnant women, parents and caretaker relatives, and the new adult group.

(3) Streamlined processes designed to create a seamless enrollment experience across Medicaid, CHIP and the Exchange.

As required by the Affordable Care Act, the final rule codifies procedures for enabling individuals to apply, enroll, and renew coverage in Medicaid and CHIP through an Internet web site using a single, streamlined application. The final rule allows States considerable flexibility to determine how they will set up their programs and integrate systems at the State level. This may be accomplished through complete integration of all insurance affordability programs into one administrative entity or through the use of shared services and agreements to promptly and efficiently adjudicate placement for most individuals.

This final rule also makes Medicaid renewal policies consistent with other insurance affordability programs by establishing a standard 12-month period of eligibility, absent information indicating a change in circumstances, consistent with policies most States have already adopted for children and parents. States will redetermine Medicaid eligibility using reliable information contained in the case account, or other more current information available to the Medicaid agency. Additional documentation is permitted as necessary and more frequent redeterminations of eligibility will occur whenever a State has information suggesting a relevant

change in circumstances, either from the individual or family, data sources, or other program information.

Overall, the major provisions included in the proposed rule are maintained in the final rule with modest modifications. In addition to the change in the definition of MAGI as required per Pub. L. 112-56, this rule includes two substantive changes as follows. First, we revised the proposed rule to permit disabled individuals and those needing long-term care services to enroll under an optional eligibility group, instead of the new adult group, if they meet the eligibility requirements. Second, consistent with the final rule for Exchanges, we revised the policy regarding the relationship between Exchanges and Medicaid, by establishing an option for State Medicaid agencies to determine individuals' Medicaid eligibility based on MAGI when the single, streamlined application is submitted to either a State-based or Federally-facilitated Exchange. Specifically, State Medicaid and CHIP agencies may either make the final Medicaid and CHIP eligibility determination based on the Exchange's initial review; or the State Medicaid and CHIP agencies may accept a final eligibility determination made by an Exchange that uses State MAGI eligibility rules and standards. Because the system will be well coordinated regardless of approach, we expect that these two changes will have little impact on costs or enrollment.

IV. Estimates of the Impact of the Final Rule

The expansion of Medicaid eligibility under the Affordable Care Act will provide health insurance coverage for millions of Americans who would otherwise be uninsured, allowing them to live longer, healthier lives and avoid personal financial strain due to the high costs of unpredictable health emergencies. Individuals, as well as States, will benefit from streamlining the eligibility rules and the application process and coordinating with the Exchanges and other

assistance programs. Moreover, some States may experience net fiscal gains from the Medicaid eligibility changes along with other provisions of the Affordable Care Act due to the reduction in uncompensated care and the greatly diminished need for State-funded programs to serve populations such as childless adults that are currently ineligible for Medicaid, but will gain eligibility under the expansion.[11]

This impact analysis uses the estimates of the CMS Office of the Actuary (OACT)[12] and the estimates prepared by the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation.[13] It provides both estimates to illustrate the uncertainty inherent in projections of future Medicaid financial operations. These modeling efforts generally account for all of the interactions among the Medicaid, CHIP, and Exchange pieces of the Affordable Care Act. The difference in estimates included in this impact analysis, compared to those in the proposed rule, can be attributed primarily to the change in the MAGI definition of income to include non-taxable Social Security benefits, as required under Pub. L. 112-56. In addition, the OACT estimates have been updated with the most recent economic and health care expenditure and enrollment data and projected trends and with further refinements to the methodology used to develop these estimates.

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[11] M. Buettgens et al., "Consider savings as well as costs: State governments would spend at least $90 billion less with the ACA than without it from 2014 to 2019," The Urban Institute (July 2011). Available online at: http://www.urban.org/uploadedpdf/412361-consider-savings.pdf; The Lewin Group, Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers (June 2010), available at http://www.lewin.com/~/media/lewin/site_sections/publications/lewingroupanalysis-patientprotectionandaffordablecareact2010.pdf; Stan Dorn and Matthew Buettgens, Net Effects of the Affordable Care Act on State Budgets (Urban Institute, December 2010), available at http://www.urban.org/UploadedPDF/1001480-Affordable-Care-Act.pdf.

[12] OACT's original estimates are documented in an April 22, 2010 memorandum "Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended," available at https://www.cms.gov/ActuarialStudies/downloads/PPACA_2010-04-22.pdf. These estimates have been updated for the President's FY 2013 budget to include later data from the Medical Expenditure Panel Survey (MEPS) and the Current Population Survey (CPS), together with updated participation assumptions and later information on policy decisions. Additional information on the updated estimates is available from OACT.

[13] CBO. Analysis of the Major Health Care Legislation Enacted in March 2010. Statement of Douglas W. Elmendorf. March 30, 2011, available at http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12119/03-30-healthcarelegislation.pdf.

A. Anticipated Effects on Eligible and Potentially Eligible Medicaid Enrollees

In FY 2011, an estimated 56 million Americans were enrolled in Medicaid coverage, on average.[14] Eligibility rules vary by State, but all States cover individuals who meet the Federal minimum eligibility standards. By extending Medicaid eligibility to adults with incomes at or below 133 percent of the FPL, moving to a new, simplified income standard based on MAGI, streamlining and coordinating eligibility processes and policies with the processes for advance payment of premium tax credits and cost-sharing reductions for Exchange coverage, the law as codified in the final rule allows millions of uninsured low-income persons who did not have access to or could not afford health insurance to obtain coverage. These provisions also help ensure that eligible people remain enrolled in coverage, whether the appropriate coverage source is Medicaid, CHIP or the Exchange, even when their circumstances change.

OACT estimates that by 2016, an additional 24 million people will be enrolled in Medicaid, including approximately 2-3 million individuals with primary health insurance coverage through employer-sponsored plans who would enroll in Medicaid for supplemental coverage (see Table 1). This is the same estimate as was in the regulatory impact analysis of the Medicaid Eligibility proposed rule (August 2011). While this coverage increase includes mostly newly eligible individuals, it also includes some currently eligible but not enrolled individuals who will choose to enroll as a result of the simplified application processes, greater outreach efforts, and other changes implemented by the Affordable Care Act.

[14] HHS FY 2013 Budget in Brief, available online at http://www.hhs.gov/budget/budget-brief-fy2013.pdf.

TABLE 1: OACT Estimated Effects of this Rule on Medicaid Enrollment, FY 2012-2016 (in millions)

	2012	2013	2014	2015	2016
Enrollment	0	0	15	22	24

Source: CMS Office of the Actuary.

OACT notes such estimates of enrollment are inherently uncertain, since they depend on future economic, demographic, and other factors that cannot be precisely determined in advance. Moreover, the actual behavior of individuals and the actual operation of the new enrollment processes and Exchanges could differ from OACT's assumptions. The sensitivity of estimated future Medicaid enrollment to different assumptions and projection factors can be illustrated by a comparison of OACT's estimates with those prepared by the Congressional Budget Office. CBO estimated a net increase of 16 million newly and previously eligible people enrolling in Medicaid and CHIP in 2016 as a result of the Affordable Care Act (Table 2).[15] [16]

TABLE 2: CBO Estimated Effects of this Rule on Medicaid & CHIP Enrollment, CY 2012-2016 (in millions)

	2012	2013	2014	2015	2016
Enrollment	0	0	9	12	16

Source: Congressional Budget Office.
NOTE: Because this estimate was developed prior to passage of Pub. L. 112-56, it still includes the 500,000 to 1 million individuals, depending on the year, who are no longer eligible for Medicaid due to the change in the definition of MAGI and who will likely move to coverage through the Exchange, employer sponsored insurance, or become uninsured.

[15] CBO. Analysis of the Major Health Care Legislation Enacted in March 2010. Statement of Douglas W. Elmendorf. March 30, 2011 -- http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12119/03-30-healthcarelegislation.pdf. The CBO estimates exclude individuals with primary coverage through employer-sponsored plans who enroll in Medicaid for supplemental coverage.
[16] CBO Cost Estimate. H.R. 2576: A bill to amend the Internal Revenue Code of 1986 to modify the calculation of modified adjusted gross income for purposes of determining eligibility for certain healthcare-related programs. October 14, 2011. http://www.cbo.gov/sites/default/files/cbofiles/attachments/hr2576.pdf.

The CBO and OACT data, assumptions, and methodology are notably different. While CBO's actual assumptions have not been published, researchers have approximated the participation rate assumed by CBO at a much lower level than that assumed by OACT, which may explain a portion of the difference in estimates.[17] Given the numerous sources of data and assumptions and potential differences in methodologies, there are a number of reasons why the OACT and CBO estimates differ, which may include, but are not limited to: projections of future Medicaid enrollment, enrollment in other types of insurance, and the number of uninsured excluding the impact of this legislation; projections of wage growth, economic growth, and changes in the unemployment rate that may affect how many people are eligible for Medicaid in the future; estimates of the number of persons that would be eligible under current Medicaid criteria and future Medicaid criteria; estimates and assumptions about the participation rate in Medicaid and other forms of insurance among eligible persons; estimates and assumptions about States' decisions regarding optional eligibility levels beyond Federal requirements; projections of the growth in the utilization of health care services; projections of the growth in the price and reimbursement rates for health care services; estimates of the health care costs of new Medicaid enrollees and their response to gaining Medicaid coverage; and different data sources for health care expenditures and population characteristics that may be used to develop such projections.

OACT prepared its estimates using data on individuals and families, together with their income levels and insured status, from the Current Population Survey and the Medical

[17] CBO's specific take-up assumptions are not available. Researchers at the Urban Institute have approximated the participation rate assumed by CBO. The Kaiser Family Foundation has characterized this assumption as follows: "These results assume moderate levels of participation similar to current experience among those made newly eligible for coverage and little additional participation among those currently eligible. This scenario assumes 57 percent participation among the newly eligible uninsured and lower participation across other coverage groups." J. Holahan and I. Headen, "Medicaid coverage and spending in health reform: National and State-by-State results for adults at or below 133 percent FPL," Kaiser Commission on Medicaid and the Uninsured, May 2010, available online at http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.

Expenditure Panel Survey. In addition, OACT made assumptions as to the actions of individuals in response to the new coverage options under the Affordable Care Act and the operations of the new enrollment processes and the Exchanges. The estimated Medicaid coverage and financial effects are particularly sensitive to these latter assumptions. Among those eligible for Medicaid under the expanded eligibility criteria established by the Affordable Care Act, and who would not otherwise have health insurance, OACT assumed that 95 percent would enroll. This assumption, which is significantly higher than current enrollment percentages, reflects OACT's consideration of the experience with health insurance reform in Massachusetts and its expectation that the streamlined enrollment process and enrollment assistance available to people through the Exchanges will be very effective in helping eligible individuals and families become enrolled.[18] As noted, CBO appears to have assumed a considerably lower participation rate.

Overall, we do not expect that the conversion to MAGI rules will result in many currently eligible individuals losing coverage. However, there may be a relatively small number of currently eligible individuals who would no longer be eligible based on the MAGI methodology. For these individuals, there will be a cost of obtaining coverage through the Exchange, but this cost could be mitigated by premium tax credits and cost-sharing reductions. At the same time, the use of the MAGI definition of income may have the effect of increasing Medicaid eligibility for a small number of individuals and families who would not have been previously eligible. We anticipate no substantial net gain or loss in enrollment due to conversion to MAGI rules.

The overall net increase in enrollment in the Medicaid program and reduction in the number of uninsured individuals will produce several benefits. For new enrollees, eligibility for

[18] A recent analysis of Massachusetts participation rates shows an 80 percent rate among adults and a nearly 100 percent rate among children. Turnbull N. "Why are So Many Low-Income People in Massachusetts Still Uninsured?" Boston, MA: WBUR. 2011 Dec 11 [cited 2012 Jan 5]. Available from: http://commonhealth.wbur.org/2011/12/low-income-uninsured-massachusetts/.

Medicaid will improve access to medical care. Evidence suggests that improved access to medical care will result in improved health outcomes and greater financial security for these individuals and families.

Evidence on how Medicaid coverage affects medical care utilization, health, and financial security comes from a recent evaluation of an expansion of Oregon's Medicaid program.[19] In 2008, Oregon conducted a lottery to expand access to uninsured adults with incomes below 100 percent of the FPL. Approximately 10,000 randomly selected low-income adults were newly enrolled in Medicaid. The evaluation is particularly strong because it was able to compare outcomes for those who won the lottery with outcomes for those who applied but did not win, and contains an estimate of the benefits of Medicaid coverage. The evaluation concluded that for low-income uninsured adults, Medicaid coverage has the following benefits:

- Significantly higher utilization of preventive care (mammograms, cholesterol monitoring, blood tests for high blood sugar related to diabetes, etc.);
- A significant increase in the probability of having a regular office or clinic for primary care; and
- Significantly better self-reported health.

While there are limitations on the ability to extrapolate from these results to the likely impacts of the Affordable Care Act's expansion of Medicaid coverage – in particular, the Oregon expansion targeted a population that is slightly lower income, on average, than those likely to gain Medicaid coverage in 2014 – these results provide solid evidence of quantifiable health and financial benefits associated with coverage expansions for a population of non-elderly adults.

[19] Amy Finkelstein, et al, "The Oregon Health Insurance Experiment: Evidence from the First Year," National Bureau of Economic Research Working Paper No. 17190, July 2011.

The results of the Oregon study are consistent with prior research, which has found that health insurance coverage improves health outcomes, while lack of insurance coverage has been associated with additional mortality and lost workplace productivity.[20] The Institute of Medicine (IOM) concluded that having insurance leads to better clinical outcomes for diabetes, cardiovascular disease, end-stage renal disease, HIV infection and mental illness, and that uninsured adults were less likely to have regular checkups, recommended health screening services and a usual source of care to help manage their disease than a person with coverage.[21]

In addition to being able to seek treatment for illnesses when they arise, Medicaid beneficiaries will be able to more easily obtain preventive care, which will help maintain and improve their health. Research demonstrates that when uninsured individuals obtain coverage (including Medicaid), the rate at which they obtain needed care increases substantially.[22] [23] [24]

Having health insurance also provides significant financial security. Comprehensive health insurance coverage provides a safety net against the potentially high cost of medical care, and the presence of health insurance can mitigate financial risk. The Oregon study found that people who gained coverage were less likely to have unpaid medical bills referred to a collection agency. Again, this study is consistent with prior research showing the high level of financial

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[20] Institute of Medicine, Care without coverage: too little, too late (National Academies Press, 2002).); Ayanian J, et al., 2000. "Unmet Health Needs of Uninsured Adults in the United States." JAMA 284(16):2061-9. 27 ; Roetzheim R, et al., 2000. "Effects of Health Insurance and Race on Colorectal Cancer Treatments and Outcomes." American Journal of Public Health 90(11): 1746-54; Wilper, et al., 2009, "Health Insurance and Mortality in US Adults." American Journal of Public Health, 99(12) 2289-2295; S. Dorn, "Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality," Urban Institute (2008); Richard Kronick, "Health Insurance Coverage and Mortality Revisited," Health Services Research 44:4 (August 2009), 1211-31.

[21] Institute of Medicine, Care without coverage: too little, too late (National Academies Press, 2002); see also Jack Hadley, "Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition," JAMA. 2007;297(10):1073-1084. doi: 10.1001/jama.297.10.1073.

[22] S.K. Long, et al., "How well does Medicaid work in improving access to care?" HSR: Health Services Research 40:1 (February 2005).

[23] Henry J. Kaiser Family Foundation, "Children's Health—Why Health Insurance Matters." Washington, DC: KFF, 2002.

[24] C. Keane, et al., "The impact of Children's Health Insurance Program by age," Pediatrics 104:5 (1999).

insecurity associated with lack of insurance coverage. Some recent research indicates that illness and medical bills contribute to a large and increasing share of bankruptcies in the United States.[25] Another recent analysis found that more than 30 percent of the uninsured report having zero (or negative) financial assets and uninsured families at the 90th percentile of the asset distribution report having total financial assets below $13,000 – an amount that can be quickly depleted with a single hospitalization.[26] Other research indicates that uninsured individuals who experience illness suffer on average a loss of 30 to 50 percent of assets relative to households with insured individuals.[27]

Finally, the proposed revision to the process by which Medicaid beneficiaries renew their coverage should greatly reduce the likelihood that eligible individuals will lose coverage and be uninsured for some period of time. Research has demonstrated the importance of continuous coverage in promoting access to care and in ensuring more efficient delivery of care. For example, children with unstable coverage are similar to children with no coverage at all in the benefits they receive from health care.[28] Uninterrupted coverage is associated with improvements in care and a 25 percent reduction in avoidable hospitalizations.[29]

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[25] D.U. Himmelstein, et al., "Medical bankruptcy in the United States, 2007: Results of a National Study," The American Journal of Medicine 122 no. 8, (2009).

[26] ASPE. The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills. (2011).

[27] Cook, K. et al., "Does major illness cause financial catastrophe?," Health Services Research 45, no. 2 (2010).

[28] G. Fairbrother and J. Schuchter, "Stability and Churning in Medi-Cal and Healthy Families," The California Endowment, March 2008.

[29] L. Ku, "New Research Shows Simplifying Medicaid Can Reduce Children's Hospitalizations," Center on Budget and Policy Priorities, June 2007; L. Simpson and G. Fairbrother, "Health Policy Influences Quality of Care in Pediatrics," Pediatric Clinics of North America - August 2009 (Vol. 56, Issue 4, Pages 1009-1021, DOI: 10.1016/j.pcl.2009.05.014); G. Fairbrother, et. al., "Policy Brief: Monitoring Enrollment and Retention of Children in Ohio Medicaid Programs"; Volume 2, Issue 3: The Child Policy Research Center at Cincinnati Children's Hospital Medical Center/University of Cincinnati; 2010; A. Bindman, A. Chattopadhyay, and G. Auerback, "Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care–Sensitive Conditions," *Annals of Int Medicine* 2008;149:854-860.

B. Anticipated Effects on States

State participation in Medicaid is voluntary, and currently all 50 States and the District of Columbia operate Medicaid programs. The Federal government matches State spending for covered services based on the FMAP. The Affordable Care Act provides for a significant increase in the FMAP for medical assistance expenditures for individuals who are considered to be "newly eligible." In addition, States that had already covered low-income adults up to a specified income level before enactment of the Affordable Care Act (known as "expansion States"), will have some of their costs matched at rates established by a formula in the statute which are initially higher than their regular Federal match rate but lower than the rate for newly eligible populations. These rates will increase annually until 2019, when they will be equal to the rates for the newly eligible population.

OACT estimates that State expenditures on behalf of individuals gaining Medicaid coverage as a result of the Affordable Care Act will total $3.2 billion in FY 2014, $4.9 billion in FY 2015, and $5.9 billion in FY 2016. The total increase in State coverage costs for FY 2012 through 2016, after the Federal contribution, is estimated to be $14 billion.[30] (While the increased FMAP 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 expansion on those States.[31] When the FMAP for expansion States is considered, the Federal government is estimated to pay 97 percent of the new costs in 2012-2016 and the States are estimated to pay the other 3 percent, representing a 0.8 percent increase of total projected State baseline spending on Medicaid absent the Affordable Care Act.) This reflects the estimated net financial effects for States from all of

[30] CBO did not publish the impact on States by year so CBO estimates for a comparable period are not available.
[31] These estimates are dependent upon which States are ultimately determined to be expansion States under the Affordable Care Act.

the changes that would be implemented by this regulation, including: (1) the expanded eligibility criteria; (2) conversion to the MAGI definition of income (including the change to the MAGI definition of income to include all Social Security benefits); and (3) costs for people who were previously eligible for Medicaid but who now become enrolled as a result of the streamlined enrollment process and application assistance through the Exchanges. We note that these estimates also take into account matters not addressed in this regulation, such as benefits changes. However, these estimates do not consider offsetting savings that will result, to a varying degree depending on the State, from less uncompensated care, reduced need for State-financed health services and coverage programs, and greater efficiencies in the delivery of care.

In estimating the costs of this rule (both State and Federal costs), OACT reviewed data on current health care costs of persons expected to enroll in Medicaid under the eligibility expansion and analysis of the impact that gaining health insurance has on health care spending. Beyond current health care costs, OACT considered other factors based on recent research regarding the relative increase in health spending expected when an uninsured person receives full health care coverage.[32] These estimates do not account for any potential impact on the supply and availability of health care with the significant increase in the number of people with health insurance beginning in 2014.[33]

For comparison, a study by the Urban Institute and Kaiser Family Foundation looked at coverage, costs, and offsetting savings. This study, which was conducted prior to the enactment of Pub. L. 112-56, estimated that from 2014 to 2019 the Federal government will bear between 92 and 95 percent of the overall costs of the new coverage provided as a result of the Affordable

[32] Based on Hadley, et al., "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," Health Affairs, August 25, 2008.
[33] "Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended," available at https://www.cms.gov/ActuarialStudies/downloads/PPACA_2010-04-22.pdf

Care Act (including both the currently eligible but not enrolled individuals and the newly eligible individuals), with the States shouldering the remaining five to eight percent of the coverage costs. According to the analysis, relative to what would have been spent by States in the absence of the Affordable Care Act, State costs may increase by 1.4 to 2.9 percent from 2014 to 2019. States are expected to benefit from the large influx of Federal dollars; and higher levels of coverage will allow States to reduce payments they make to support uncompensated care costs and other services that have historically been financed solely by the States.[34] A subsequent Urban Institute analysis estimates that the costs to States from the 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. [35]

The Urban Institute study is consistent with other analyses of potential offsetting savings and benefits to States. The transfer of Federal funding to State Medicaid programs for newly eligible individuals will substantially decrease the number of uninsured individuals across the States and will help provide a significantly stronger safety net, enabling low-income individuals to access affordable health coverage. As a result, the burden of uncompensated care could be substantially reduced. It has been estimated that the cost of uncompensated care will fall significantly by 2019 as a result of the policies contained in the Affordable Care Act, including the Medicaid expansion.[36] For example, estimates from the RAND COMPARE model, which predicts the effects of health policy changes at national and State levels, suggest that the

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[34] J. Holahan and I. Headen, "Medicaid coverage and spending in health reform: National and State-by-State results for adults at or below 133% FPL," Kaiser Commission on Medicaid and the Uninsured, May 2010, available online at: http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.

[35] M. Buettgens et al., "Consider savings as well as costs: State governments would spend at least $90 billion less with the ACA than without it from 2014 to 2019," The Urban Institute (July 2011). Available online at: http://www.urban.org/uploadedpdf/412361-consider-savings.pdf.

[36] J. Holahan and S. Dorn. "What Is the Impact of the Patient Protection and Affordable Care Act (PPACA) on the States?" The Urban Institute (June 2010).

Affordable Care Act will reduce Connecticut's health care spending by 10 percent (roughly $2.7 billion) over 10 years due to the reduction in uncompensated care costs and the reduced need for services that are currently 100 percent State-funded.[37] Studies indicate that Medicaid spending also boosts State economies by supporting jobs and generating health care sector income. In turn, this generates higher income in other sectors of the economy due to the multiplier effect.[38]

Evidence from Massachusetts suggests that the reduction in uncompensated care costs due to Affordable Care Act coverage expansions may generate substantial savings for States. Subsequent to the enactment of health reform in Massachusetts in 2006,[39] the Massachusetts government realized annual savings of about $250 million from lower payments to hospitals for uncompensated care for the uninsured and underinsured.[40] Payments and utilization of the uncompensated care pool/health safety net trust fund have decreased and the rate of non-urgent emergency department visits declined by 2.6 percent among patients with premium assistance for coverage and uninsured patients in 2008 compared to 2006.[41] Note that Medicare and Medicaid Disproportionate Share Hospital (DSH) payments will be reduced under the Affordable Care Act by an estimated $19 billion from 2012-2016, according to OACT. Of the $19 billion reduction, the States' share would be about $1 billion.

States could experience other financial benefits beyond the reduction in uncompensated care and the reduced need for programs that are wholly State-funded. Simplifying Medicaid eligibility policies will also reduce administrative burdens for States and for individuals.

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[37] David Auerbach, Sarah Nowak, Jeanne S. Ringel, Federico Girosi, Christine Eibner, Elizabeth A. McGlynn, and Jeffrey Wasserman, The Impact of the Coverage-Related Provisions of the Patient Protection and Affordable Care Act on Insurance Coverage and State Health Care Expenditures in Connecticut (RAND Corporation: Santa Monica, CA, 2011) (http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR973.1.pdf).

[38] Kaiser Commission on Medicaid and the Uninsured, The Role of Medicaid in State Economies: A Look at the Research (Washington, DC: Kaiser Commission, 2008), http://www.kff.org/medicaid/upload/7075_02.pdf.

[39] Chapter 58 of the Acts of 2006 of the Massachusetts General Court.

[40] Massachusetts Division of Health Care Finance and Policy, "2009 Annual Report Health Safety Net."

[41] Smulowitz, Peter B. et al., "Emergency Department Utilization After the Implementation of Massachusetts Health Reform," Annals of Emergency Medicine In Press, Corrected Proof.

Medicaid's current patchwork structure of eligibility rules is complex for States to administer, requiring significant State resources and staff attention. The coordination of Medicaid eligibility policy and processes with those of the new Exchanges; the movement to a simplified income standard for most populations; the removal of asset tests; implementing an online, data-driven rather than paper-reliant application, verification and renewal process; employing a single, streamlined application for coverage across Medicaid, CHIP, the Exchange and other insurance affordability programs; and streamlining Medicaid eligibility categories should all result in a Medicaid eligibility system that is far easier for States to administer than Medicaid's current, more complex system. These changes could generate administrative savings and increase efficiency. For example, Florida's online application system reportedly saves the State nearly $83 million each year.[42] The new Federal data services hub through which States will verify certain information with other Federal agencies, such as income data from the IRS, will also relieve State Medicaid agencies of some current responsibilities, creating further efficiencies for the States.

While administrative simplification is expected to lower State administrative costs, we expect that States may incur short-term increases in administrative costs (depending on their current systems and practices) as they implement these changes. The extent of these initial costs will depend on current State policy and practices. As noted in the proposed rule, many States have already adopted the administrative simplifications addressed in the rule. Moreover, Federal support is available to help States finance these system modifications. Notably, in previous rulemaking, CMS increased Federal funding to States to better support State efforts to develop significantly upgraded eligibility and enrollment systems. To anticipate and support these

[42] UnitedHealth Center for Health Reform and Modernization, "Coverage for Consumers, Savings for States: Options for Modernizing Medicaid" (April 2010).

efforts, CMS published the "Federal Funding for Medicaid Eligibility Determination and Enrollment Activities" final rule (75 FR 21950) in the April 19, 2011 Federal Register. That rule amended the definition of Mechanized Claims Processing and Information Retrieval Systems to include systems used for eligibility determination, enrollment, and eligibility reporting activities by Medicaid, and made this work eligible for enhanced funding with a Federal matching rate of 90 percent for development through 2015 and 75 percent for ongoing maintenance and operations costs. Systems must meet certain standards and conditions in order to qualify for the enhanced match.

C. Anticipated Effects on Providers

We expect that the expansion and simplification of Medicaid eligibility could also benefit providers, including those that serve low-income and vulnerable populations. As more individuals obtain health insurance coverage, health centers, hospitals, clinics, physicians, and other providers are likely to experience a significant increase in their insured patient volume. We expect providers that serve a substantial share of the low-income population to realize the most substantial increase in insured patients. Providers, such as hospitals and federally-qualified health centers that serve a low-income population, may financially benefit from having a higher insured patient population and providing less uncompensated care. In addition, we expect continuity of coverage to improve providers' ability to maintain their relationship with patients and to reduce provider administrative burdens such as time spent helping patients to access information on coverage options and to apply for Medicaid or CHIP.

The improved financial security provided by health insurance also helps ensure that patients can pay their medical bills. The Oregon study found that coverage significantly reduces

the level of unpaid medical bills sent to a collection agency.[43] Most of these bills are never paid, so this reduction in unpaid bills means that one of the important benefits of expanded health insurance coverage, such as the coverage that will be provided through Medicaid, is a reduction in the level of uncompensated care provided.

Because the majority of those gaining coverage under this provision are likely to be previously uninsured individuals, for whom providers did not receive regular reimbursement, we do not anticipate that the provisions of this rule will impose new costs on providers. Medicaid generally reimburses providers at a lower rate than employer-sponsored health insurance or other forms of private health insurance. For the minority of individuals who become eligible for Medicaid under this provision who are currently covered by employer-sponsored health insurance, there is a possibility that their providers may experience lower payment rates. Conversely, Medicaid reimburses federally-qualified health centers at a higher rate than employer-sponsored insurance and many new Medicaid enrollees may seek treatment in this setting, which would increase payment to these providers. At the same time, the increased Federal financial support for Medicaid, the growth in Medicaid enrollment, and the potential that many plans will operate in both the Exchange and in Medicaid may result in States electing to increase Medicaid payment rates to providers.[44] Moreover, section 1202 of the Affordable Care Act increases Medicaid payments to physicians providing primary care to the higher Medicare rates in 2013 and 2014, with the differential in payments assumed fully by the Federal government.

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[43] A. Finkelstein, et al., "The Oregon Health Insurance Experiment: Evidence from the First Year," National Bureau of Economic Research Working Paper Series No. 17190(2011).

[44] D. Bachrach, et al., "Medicaid's role in the Health Benefits Exchange: A road map for States," A Maximizing Enrollment Report, National Academy for State Health Policy and Robert Wood Johnson Foundation (March 2011). Available online at http://www.nashp.org/sites/default/files/maxenroll%20Bachrach%20033011.pdf.

D. Anticipated Effects on Federal Budget

Table 3 presents estimates of the effect of the Affordable Care Act on net Federal spending for Medicaid benefits. OACT estimates that Federal expenditures on behalf of the additional individuals and families gaining Medicaid coverage as a result of the Affordable Care Act will total about $37.2 billion in FY 2014 and $164.3 billion over the 3-year period from FY 2014 through 2016.[45] The impact of these changes is already assumed in the Medicaid baseline for the FY 2013 President's Budget, adding no new costs to Medicaid relative to projections of current law.

TABLE 3: OACT Estimated Federal Budgetary Effects
FY 2012-2016 (in billions of dollars)

	2012	2013	2014	2015	2016	2012-2016
Impact on Medicaid Benefit Spending of the Eligibility Expansion under the Affordable Care Act	0	0	37.1	57.2	70.0	164.3

Source: CMS Office of the Actuary.

These estimates have changed since the proposed rule for three reasons. Most notably, these estimates include the impact of Pub. L. 112-56, which changed the MAGI income standard to include all Social Security benefits; previously, the income definition excluded most Social Security benefits. The effect of this law was to lower projected Medicaid enrollment and expenditures starting in 2014. OACT estimated that projected Federal Medicaid expenditures would decrease by $4.9 billion in 2014 and by $21.5 billion between 2014 and 2016, and that projected Medicaid enrollment would decrease by 1.1 million persons in 2014 and by 1.7 million persons in 2016, compared to the estimates included in the proposed rule.

[45] The FMAP for expansion States, though not included in this rule, is estimated to increase Federal expenditures by an additional $9.1 billion from FY 2014-2016. These costs will be included in the FMAP final rule.

OACT also refined its current model in the time since the estimates were developed for the proposed rule. The most significant change was that the definition of a health insurance unit was further refined in OACT's model. This change more consistently aligned the definition of a health insurance unit used in the model with the definition being used in policy. (The refinement to the model was technical and did not reflect any change in proposed policy in either the proposed or final rule.) In addition, the underlying data used in the models developed by OACT have been updated since the estimates were made for the proposed rule. This includes the most recent data and projections of health care spending and enrollment in the U.S., as well as other underlying economic data and projections. The result of these changes was an increase in projected enrollment of 1.3 million in 2014 and 2.3 million in 2016, but a small decrease in projected Federal Medicaid expenditures of $1.6 billion in 2014 and $7.6 billion between 2014 and 2016, as most of the increase in projected enrollment was amongst relatively younger persons with low health care costs and because health care costs generally are projected to grow slightly slower in the most recent projections of total health spending growth.

Reflecting CBO's different assumptions, CBO estimated a smaller increase in Federal spending over the same 3-year time period. CBO estimated an increase in Federal spending of $162 billion over the 2012-2016 time period.[46] Less the $7.9 billion reduction in spending that CBO anticipated due to the change in the definition of MAGI,[47] the cost to the Federal government would be $154 billion from 2012 through 2016 as shown in Table 4.

[46] CBO. Analysis of the Major Health Care Legislation Enacted in March 2010. Statement of Douglas W. Elmendorf. March 30, 2011 -- http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12119/03-30-healthcarelegislation.pdf.

[47] CBO Cost Estimate. H.R. 2576: A bill to amend the Internal Revenue Code of 1986 to modify the calculation of modified adjusted gross income for purposes of determining eligibility for certain healthcare-related programs. October 14, 2011. http://www.cbo.gov/sites/default/files/cbofiles/attachments/hr2576.pdf.

TABLE 4: CBO Estimated Net Federal Budgetary Effects
FY 2012-2016 (in billions of dollars)[48]

	2012	2013	2014	2015	2016	2012-2016
Net Impact on Medicaid and CHIP Benefit Spending due to Changes made by the Affordable Care Act Section 2001	0	0	29	52	73	154

Source: Congressional Budget Office.
NOTE: These estimates include CHIP benefit spending and the FMAP for expansion States, which are not covered in this final rule.

V. Alternatives Considered

The majority of the proposals in this final rule, including the Medicaid coverage expansion and the move to the simplified MAGI income standard, codify the Affordable Care Act. In finalizing this rule, we considered alternatives to some of the simplified eligibility policies included here, as well as to the streamlined, coordinated process and eligibility policies this rule established between Medicaid, the Exchanges, and other insurance affordability programs. Because the majority of provisions in this rule are statutorily required, we did not have significant flexibility to choose alternative policies.

One alternative considered was complete alignment of the application of MAGI-based methods for determining Medicaid financial eligibility with the definitions of "modified adjusted gross income" and "household income" in section 36B of the Internal Revenue Code of 1986. The 36B definitions are used by the Exchanges to determine financial eligibility for advanced payment of premium tax credits. We also considered retaining existing Medicaid rules to a

[48] These estimates include CBO's March 2011 estimate of the effects of the Affordable Care Act on Federal Medicaid spending less CBO's estimated impact of the change in the definition of MAGI per Pub. L. 112-56.

greater extent in the application of such methods for determining financial eligibility for Medicaid as of January 1, 2014.

The rules adopted are for the most part fully consistent with the 36B definitions. While there are some modest differences between the 36B definitions and the MAGI-based household and income counting rules adopted for Medicaid, largely due to statutory requirements at section 1902(e)(14)(H) of the Act for continued application of Medicaid rules regarding point-in-time income, we believe that alignment with 36B definitions to the extent reflected in these rules best accomplishes the goals of maximizing affordable coverage and achieving overall simplicity relative to current Medicaid household and income counting rules.

Other alternatives considered would have set more uniform, national standards for eligibility determinations. However, we have maintained a great deal of State flexibility in making eligibility determinations and have adopted rules that continue to allow States to develop policies and procedures that are most appropriate to their circumstances and populations, while also ensuring a national streamlined approach to eligibility as envisioned by the Affordable Care Act. Also, as described in section II.J. of the final rule, the final rule gives States additional flexibility with respect to eligibility determinations based on MAGI. Specifically, State Medicaid and CHIP agencies may make the final Medicaid and CHIP eligibility determination based on the Exchange's initial review of information submitted in the single streamlined application; or the State Medicaid and CHIP agencies may accept a final eligibility determination made by an Exchange that uses State eligibility rules and standards.

VI. Limitations of the Analysis

A number of challenges face estimators in projecting Medicaid benefits and costs under the Affordable Care Act and the final rule. Health care cost growth is difficult to project,

especially for people who are currently not in the health care system – the population targeted for the Medicaid eligibility changes. Such individuals could have pent-up demand and thus have costs that may be initially higher than other Medicaid enrollees, while they might also have better health status than those who have found a way (for example, "spent down") to enroll in Medicaid.

There is also considerable uncertainty about behavioral responses to the Medicaid changes. Individuals' participation rates are particularly uncertain. Medicaid participation rates for adults already eligible tend to be relatively low. An analysis based on the Current Population Survey (CPS) from 2007-2009 estimated that among eligible adults (ages 19-64) without private health insurance, 62 percent currently participate in Medicaid, including SSI recipients who participate at significantly higher rates relative to adults without SSI.[49] Among children, a recent analysis by the Urban Institute looked at data from the American Community Survey for 2008 and 2009 and found that among eligible children without private coverage, 84.8 percent participated in Medicaid or CHIP in 2009.[50] It is not clear how the changes will affect those already eligible, or those who will be newly eligible, as previously described.

These estimates are inherently difficult and depend on many factors, including State behavior, employer behavior, and the pace of development of new modernized systems. As reflected in participation rates for individuals, the States' actions on simplification and outreach affect whether or not individuals sign up and stay enrolled in Medicaid. It may also affect the types of enrollees: a broad-based outreach campaign may attract individuals already eligible but

[49] Sommers BD, Epstein AM. (2010). "Medicaid expansion--the soft underbelly of health care reform?" N Engl J Med; 363:2085-7.
[50] Kenney GM, Lynch V, Haley J, Huntress M, Resnick D, Coyer C. Gains for Children: Increased Participation in Medicaid and CHIP in 2009: Urban Institute / Robert Wood Johnson Foundation; 2011.

not enrolled in Medicaid, whereas a campaign targeted at the newly eligible uninsured may yield different cost and coverage results.

While considering the implementation of Medicaid expansion in 2014, it is important to evaluate and monitor if the changes reflected in this rule achieve the goal of providing coverage to uninsured individuals. We will evaluate over time, and encourage others to evaluate, the effects of this rule on Medicaid enrollment, on Federal, State, and enrollee costs, and on health outcomes.

VII. Accounting Statement

As required by OMB Circular A-4 (available at http://www.whitehouse.gov/omb/circulars_a004_a-4/), in Table 5 we have prepared an accounting statement table showing the classification of the impacts associated with implementation of this final rule. Consistent with standard practice, we show all direct effects as transfer payments. The first row of the table describes the transfer of funds from the Federal government to States to cover the Federal share of spending on newly eligible Medicaid beneficiaries, while the second row describes the State share of such spending.

TABLE 5: Accounting Statement: Classification of Estimated Net Costs, from FY 2012 to FY 2016 (in millions)[51]

Category: TRANSFERS	Year Dollar: 2012	Units Discount Rate: 7%	Units Discount Rate: 3%	Period Covered
Annualized Monetized Transfers from Federal Government to States on Behalf of Beneficiaries	Primary Estimate[52]	$30,211	$31,705	FYs 2012-2016
Annualized Monetized Transfers from States on Behalf of Beneficiaries	Primary Estimate	$2,568	$2,694	FYs 2012-2016

Source: CMS Office of the Actuary

[51] This table no longer includes transfers from the Federal government to States related to the FMAP for expansion States. Those transfers will be included in the rule finalizing changes to the FMAP methodologies.
[52] The primary estimates are the annualized value of the net Federal budgetary effects reported in Table 3.