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B-324510

March 12, 2013

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 A. Waxman  
Ranking Member  
Committee on Energy and Commerce  
House of Representatives

Subject: *Department of Health and Human Services: Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation*

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 (HHS), entitled "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation" (RIN: 0938-AR03). We received the rule on February 25, 2013. It was published in the *Federal Register* as a final rule on February 25, 2013, with an effective date of April 26, 2013. 78 Fed. Reg. 12,834.

This final rule sets forth exchange and issuer standards related to coverage of essential health benefits (EHB) and actuarial value (AV). Beginning in 2014, all non-grandfathered health insurance coverage in the individual and small group markets, Medicaid benchmark and benchmark-equivalent plans, and Basic Health Programs (if applicable) will cover EHB, which include items and services in 10 statutory benefit categories, such as hospitalization, prescription drugs, and maternity and newborn care, and are equal in scope to a typical employer health plan. In addition to offering EHB, non-grandfathered health insurance plans will meet specific AVs: 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. These AVs, called "metal levels," are meant to

assist consumers in comparing and selecting health plans by allowing a potential enrollee to compare the relative payment generosity of available plans. Taken together, EHB and AV are designed to significantly increase a consumer's ability to compare and make an informed choice about health plans. This rule also finalizes a timeline for qualified health plans to be accredited in federally-facilitated exchanges and amends regulations providing an application process for the recognition of additional accrediting entities for purposes of certification of qualified health plans.

Enclosed is our assessment of HHS'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 HHS 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 THE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
ENTITLED  
"PATIENT PROTECTION AND AFFORDABLE CARE ACT;  
STANDARDS RELATED TO ESSENTIAL HEALTH BENEFITS,  
ACTUARIAL VALUE, AND ACCREDITATION"  
(RIN: 0938-AR03)

(i) Cost-benefit analysis

The Department of Health and Human Services (HHS) analyzed the benefits and costs of this final rule. According to HHS, this rule will improve coverage in benefit categories typically less available and expand access to coverage, including maternity and prescription drug coverage, particularly in the individual market. Other benefits identified by HHS are alignment with current consumer and employer choices, flexibility for states, limited market disruption, allowance for health plan innovation, efficiency due to greater transparency, and a consumer's ability to compare coverage. HHS did not estimate the quantitative value of these benefits.

HHS estimated the annualized costs of this final rule for the period 2013 to 2016 at 7 percent and 3 percent discount rates. HHS estimated that the costs will be 3.4 million per year at a 7 percent discount rate and 3.1 million per year at a 3 percent discount rate. HHS also determined that insurers will incur administrative costs associated with altering benefit packages to ensure compliance with the definition of essential health benefits established in this rule. Issuers may also incur minor administrative costs related to computing actuarial value. Additionally, as consumers gain additional coverage for benefits that previously did not meet the standards outlined in this proposed rule (for example, pediatric dental or vision coverage), utilization, and thus costs, may increase and a portion of this increased utilization and costs may be economically inefficient.

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

HHS determined that this final rule will not have a significant effect on a substantial number of small entities.

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

HHS anticipates that this final rule will not impose costs above \$100 million (\$139 million adjusted for inflation) on state, local, or tribal governments because states are not required to set up an exchange and because grants are available for funding of the establishment of an exchange by a state. In addition, because states largely already collect information on plan rates and benefits to license them, HHS believes that the burden on states is limited. HHS also does not anticipate that the final rule will impose costs greater than \$139 million on the private sector.

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

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

On November 26, 2012, HHS published a proposed rule. 77 Fed. Reg. 70,644. HHS received approximately 5,798 public comments including roughly 600 total unique letters on the essential health benefit proposals, including comments from states, health plans, industry experts, health care providers, Members of Congress, consumer groups, and members of the public. HHS responded to these comments in the final rule.

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

HHS determined that this final rule contains four information collection requirements under the Act. The first requirement is for qualified health plan issuers to quantify and report the cost attributable to essential health benefits. HHS estimates that the cost for this information collection requirement will be \$1,721,250. The second requirement concerns state selections of base-benchmark plans and HHS believes that this requirement is already captured in the information collection approved under Office of Management and Budget (OMB) Control Number 0938-1174. The third requirement is for issuers seeking to take advantage of an exception to the actuarial value calculator to submit an annual actuarial certification. HHS estimates that this requirement will cost \$1,620,000 per year for qualified health plans and \$1,691 per state choosing this option. The fourth requirement is for stand-alone dental plans to demonstrate they have a reasonable annual limitation on cost sharing. HHS estimates that the total annual cost for this requirement will be \$3,080.

Statutory authorization for the rule

HHS promulgated this final rule under the authority of sections 2701 to 2763, 2791, and 2792 of the Public Health Service Act, as amended, and sections 1301 to 1304, 1311 to 1313, 1321, 1322, 1324, 1331, 1334, 1342, 1343, 1401, 1402, and 1411 to 1413 of title I of the Affordable Care Act. 26 U.S.C. § 36B; 42 U.S.C. §§ 300gg to

300gg–63, 300gg–91, 300gg–92, 18021 to 18024, 18031 to 18033, 18041, 18042, 18044, 18051, 18054, 18061, 18063, 18071, and 18081 to 18083.

Executive Order Nos. 12,866 and 13,563 (Regulatory Planning and Review)

HHS determined that this final rule is economically significant under the Order. It was reviewed by OMB.

Executive Order No. 13,132 (Federalism)

HHS determined that this final rule does not impose substantial direct costs on state and local governments. However, HHS also believes that this final rule has federalism implications due to direct effects on the distribution of power and responsibilities among the state and federal governments relating to determining standards for health insurance coverage that is offered in the individual and small group markets. HHS expects that the federalism implications, if any, are substantially mitigated because of the flexibility and options this rule reserves for the states. To comply with the Order, HHS made efforts to consult with and work cooperatively with states as evidenced by continued communication through weekly calls and listening sessions.