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B-326715

March 13, 2015

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

The Honorable Fred Upton
Chairman
The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
House of Representatives

Subject: *Department of Health and Human Services, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016*

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; HHS Notice of Benefit and Payment Parameters for 2016" (RIN: 0938-AS19). We received the rule on February 25, 2015. It was published in the *Federal Register* as a final rule on February 27, 2015, with stated effective dates of April 28, 2015, and January 1, 2016. 80 Fed. Reg. 10,750.

This final rule sets forth payment parameters and provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost sharing parameters and cost-sharing reductions; and user fees for federally-facilitated exchanges. It also finalizes additional standards for the individual market annual open enrollment period for the 2016 benefit year, essential health benefits, qualified health plans, network adequacy, quality improvement strategies, the Small Business Health Options Program, guaranteed availability, guaranteed renewability, minimum essential coverage, the rate review program, the medical loss ratio program, and other related topics.

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
Deputy Director, ODRM
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;
HHS NOTICE OF BENEFIT AND PAYMENT PARAMETERS FOR 2016"
(RIN: 0938-AS19)

(i) Cost-benefit analysis

The Centers for Medicare & Medicaid Services (CMS) analyzed the costs and benefits of this final rule. Among the benefits of this rule identified by CMS are (1) increasing enrollment in the individual market leading to improved access to health care for the previously uninsured, especially individuals with medical conditions, which will result in improved health and protection from the risk of catastrophic medical expenditures; (2) encouraging continuous quality improvement among qualified health plan (QHP) issuers to improve health outcomes at lower costs; (3) allowing exchanges to make informed QHP certification decisions; (4) increasing coverage options for small businesses and their employees while mitigating the effect of adverse selection; and (5) ensuring that consumers in group health plans not subject to the Employee Retirement Income Security Act of 1974 receive the benefit of medical loss ratio (MLR) rebates in a timely manner.

CMS estimated that the annualized monetized cost per year for 2015 to 2018 will be \$6.77 million in 2015 dollars. Quantitative costs include costs incurred by issuers and contributing entities to comply with provisions in the rule and costs incurred by states for complying with audits of state-operated reinsurance programs. CMS also estimated that this rule will result in annualized monetized transfers of \$418.61 million (at a 7 percent discount rate) or \$418.52 (at a 3 percent discount rate) from contributing entities and health insurance issuers to the federal government for the years 2015 to 2018.

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

In its submission to us, CMS indicated that it prepared a regulatory flexibility analysis for this final rule. CMS estimated that approximately 141 out of 500 issuers of health insurance coverage nationwide had total premium revenue of \$38.5 million or less and therefore would be considered small entities. However, the provisions of this final rule only establish a deadline for the use of MLR rebates by certain policyholders similar to the deadline that is already followed by most group policyholders and do not otherwise alter the requirements for rebate use by such policyholders. In addition, the clarification regarding how health insurance issuers must treat cost-sharing reductions in their MLR calculations simply aligns the MLR regulatory language with the risk corridors program.

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

Although CMS did not quantify all costs, it stated that the combined administrative cost and user fee impact on state, local, or tribal governments and the private sector may be above the Act's

threshold of \$100 million (\$141 million adjusted for inflation). In its statement to us, CMS indicated that it prepared a statement under the Act.

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

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

On November 26, 2014, CMS published a proposed rule. 79 Fed. Reg. 70,674. CMS received 313 comments from various stakeholders, including states, health insurance issuers, consumer groups, labor entities, industry groups, provider groups, patient safety groups, national interest groups, and other stakeholders. CMS responded to the public comments in the final rule.

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

CMS determined that this final rule contains information collection requirements under the Act. CMS identified 12 such requirements with a total of 2,400 respondents, a total annual burden of 149,504.9 hours or \$7,441,865, and a total annual cost, including capital and maintenance costs, of \$7,529,240.

Statutory authorization for the rule

CMS promulgated this final rule under the authority of sections 2701 through 2763, 2791, and 2792 of the Public Health Services Act. 42 U.S.C. §§ 300gg through 300gg-63, 300gg-91, 300gg-92.

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

The Office of Management and Budget determined that this final rule is economically significant under the Order because it is likely to have an annual effect of \$100 million in any one year.

Executive Order No. 13,132 (Federalism)

In CMS's view, while this final rule will not impose substantial direct requirement costs on state and local governments, the 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 relating to health insurance that is offered in the individual and small group markets. However, CMS anticipates that the federalism implications of this rule are substantially mitigated because states have choices regarding the structure and governance of their exchanges and risk adjustment and reinsurance programs.