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March 13, 2013

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

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

Subject: *Department of Health and Human Services: Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review*

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; Health Insurance Market Rules; Rate Review" (RIN: 0938-AR40). We received the rule on February 27, 2013. It was published in the *Federal Register* as a final rule on February 27, 2013. 78 Fed. Reg. 13,406.

The final rule implements provisions related to fair health insurance premiums, guaranteed availability, guaranteed renewability, single risk pools, and catastrophic plans, consistent with title I of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, referred to collectively as the Affordable Care Act. The final rule clarifies the approach used to enforce the applicable requirements of the Affordable Care Act with respect to health insurance issuers and group health plans that are nonfederal governmental plans. This final rule also amends the standards for health insurance issuers and states regarding reporting, utilization, and collection of data under the federal rate review program, and revises the timeline for states to propose state-specific thresholds for review and approval by the Centers for Medicare & Medicaid Services (CMS).

The final rule is effective on April 29, 2013, except for 45 C.F.R. § 147.103 and the amendments to 45 C.F.R. part 154, which are effective on March 29, 2013. The provisions of the final rule generally apply to health insurance coverage for plan or policy years beginning on or after January 1, 2014. The provisions of 45 C.F.R. § 147.103 apply on March 29, 2013. The amendments to 45 C.F.R. part 154 apply on April 1, 2013. The Congressional Review Act requires a 60-day delay in the effective date of a major rule from the date of publication in the *Federal Register* or receipt of the rule by Congress, whichever is later. 5 U.S.C. § 801(a)(3)(A). However, notwithstanding the 60-day delay requirement, any rule that an agency for good cause finds that notice and public procedures are impractical, unnecessary, or contrary to the public interest is to take effect when the promulgating agency so determines. §§ 553(d)(3), 808(2). Accordingly, HHS believes it has good cause for making 45 C.F.R. § 147.103 and the amendments to 45 C.F.R. part 154 effective 30 days from the date of publication of this rule.

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

ENCLOSURE

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;
HEALTH INSURANCE MARKET RULES; RATE REVIEW"
(RIN: 0938-AR40)

(i) Cost-benefit analysis

In accordance with OMB Circular A–4, CMS has quantified the benefits, costs, and transfers where possible, and has also provided a qualitative discussion of the benefits, costs, and transfers that may stem from this final rule. CMS states that qualitative benefits include increased enrollment in the individual and small group 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. According to CMS, additional benefits include a common marketing standard covering the entire insurance market, reducing adverse selection, improving market oversight and competition and reducing search costs for consumers and a decrease in administrative costs for issuers due to elimination of medical underwriting and coverage exclusions. CMS notes that the final rule will prevent duplication of efforts for rate review filings subject to review by setting forth a unified rate review template for all issuers offering health insurance coverage in the small group or individual markets and provide state departments of insurance with more capacity to conduct meaningful rate review and approval of products sold inside and outside Affordable Insurance Exchanges (Exchanges) by using a unified rate review template. CMS also believes the final rule will extend the availability and affordability of student health coverage as a transitional policy.

CMS estimates that the annualized monetized costs will be $17.3 million in 2012 dollars at a discounted rate of 7 percent and 3 percent for the period covering 2013-2017. CMS notes that the administrative costs are related to the submission of data by issuers seeking rate increases below the rate review threshold, one-time fixed costs to issuers related to rate review data extraction, disclosure of state rating requirements, and costs incurred by states choosing to establish rating areas and age rating curves. CMS also notes that qualitative costs include additional costs incurred by issuers to comply with provisions in the final rule, costs related to possible increases in utilization of health care for the newly insured, and costs incurred by states for disclosure of rate increases, if applicable.

CMS states that qualitative costs for transfers will include lower rates for individuals in the individual and small group market who are older and/or in relatively poor health, and women; and potentially higher rates for some young men that will be mitigated by provisions such as premium tax credits, risk stabilization programs, access to catastrophic plans, and the minimum essential coverage provision. According to CMS, additional costs include reduction in uncompensated care for providers who treat the uninsured and increase in payments from issuers and decrease in out-of-pocket expenditures by the newly insured and increase in health care spending by issuers, which may be more than offset by an increase in premium revenue.

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

As discussed in the Web Portal final rule published on May 5, 2010 (75 Fed. Reg. 24,481), CMS examined the health insurance industry in depth in the Regulatory Impact Analysis it prepared for the final rule on the establishment of the Medicare Advantage program. 69 Fed. Reg. 46,866. CMS explains that in that analysis it was determined that there were few, if any, insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the size thresholds for "small" business established by the Small Business Association (currently $7 million in annual receipts for health issuers). In addition, CMS used the data from Medical Loss Ratio (MLR) annual report submissions for the 2011 MLR reporting year to develop an estimate of the number of small entities that offer comprehensive major medical coverage. These estimates may overstate the actual number of small health insurance issuers that would be affected, since they do not include receipts from these companies' other lines of business. According to CMS, it is estimated that there are 22 small entities each with less than $7 million in earned premiums that offer individual or group health insurance coverage and would therefore be subject to the requirements of this final regulation. CMS notes that these small entities account for less than 5 percent of the estimated 466 companies offering health insurance coverage in the individual or group markets in different states that would be affected by the provisions of this rule. Additionally, CMS states that 36 percent of these small entities belong to holding groups, and many, if not all, of these small entities are likely to have other lines of business that would result in their revenues exceeding $7 million.

For these reasons, CMS expects that this final rule will not affect small issuers. CMS notes that the requirements in this final rule may affect health insurance premiums in the small group market. CMS expects that many employers that purchase health insurance coverage in the small group market would meet the Small Business Administration standard for small entities. As mentioned in the impact analysis, CMS believes that the impact on premiums is likely to be small and

may even lead to lower rates in the small group market. CMS will monitor premium changes in the small group market through the rate review program.

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

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 requires that agencies assess anticipated costs and benefits before issuing any final rule that includes a federal mandate that could result in any expenditure in any one year by state, local, or tribal governments, in the aggregate, or by the private sector, of $100 million in 1995 dollars, updated annually for inflation. In early 2013, that threshold level is approximately $139 million.

The final rule gives state governments the option to establish rating areas within the state and uniform age rating curves. According to CMS, there are no mandates on local or tribal governments. CMS notes that state governments may incur administrative costs related to the option of establishing rating areas and uniform age rating curves. However, if the state government does not act, CMS will establish the rating areas and uniform age rating curve in that state. CMS states that state governments will also incur administrative costs related to disclosure of rating and pooling requirements to CMS, which are estimated to be $279 per state. According to CMS, the private sector (for example, health insurance issuers) will incur administrative costs related to the implementation of the provisions in this final rule. CMS states that this final rule does not impose an unfunded mandate on local or tribal governments. However, CMS explains that consistent with policy embodied in UMRA, the final rule has been designed to be a low-burden alternative for state, local, and tribal governments, and the private sector while achieving the objectives of the Affordable Care Act.

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

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

HHS published standards under the statutory provisions of the Affordable Care Act in a November 26, 2012, *Federal Register* proposed rule entitled ‘‘Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review.’’ 77 Fed. Reg. 70,584. HHS received approximately 500 comment letters in response to the November 26, 2012, proposed rule. Commenters represented a wide variety of stakeholders, including states, tribal organizations, consumers, health insurance issuers, health care providers, employers, members of the public, and others. Additionally, HHS consulted with the National Association of Insurance Commissioners through its Health Care Reform Actuarial (B) Working Group to define permissible age bands and consulted with and requested formal, written comments from tribal leaders and representatives about the provisions of this rule that impact tribes.

HHS also notes that it found good cause for making 45 C.F.R. § 147.103 and the amendments to 45 C.F.R. part 154 effective 30 days from the date of publication of this rule. According to HHS, section 147.103 directs states to report to HHS within 30 days after publication of this rule certain rating factors required by § 147.102. HHS states that it is imperative that it receive these data from the states within 30 days of publication of this final rule in order to timely implement the risk adjustment methodology set forth in section 1343 of the Affordable Care Act and its implementing regulations. Should these data not be received within 30 days of publication of this final rule, HHS's risk adjustment scores for use on January 1, 2014, would have to be calculated using assumed rating factors based on the limitations set forth in this final rule, which could result in inaccurate risk adjustment payments to health insurance issuers in states that have developed different rating factors. HHS believes this may in turn lead to imbalance in the insurance markets in those states with different rating factors. Furthermore, HHS notes that health insurance issuers are required to submit their applications by April 30, 2013, to the Exchanges to be certified as qualified health plans in 2014. In order to submit accurate information on their applications, HHS states that the issuers will need to know what rating factors in a state will be effective starting January 1, 2014.

The amendments to 45 C.F.R. part 154 revise the timeline for states to propose state-specific thresholds for review and approval by HHS. The amendments also direct health insurance issuers to submit data relating to proposed rate increases in a standardized format specified by the Secretary of HHS, and modify criteria and factors for states to have an effective rate review program. HHS believes that these changes are necessary to reflect the new market reform provisions and to fulfill the statutory requirement beginning in 2014 that the Secretary, in conjunction with the states, monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange. The provisions are also designed to streamline data collection for issuers, states, Exchanges, and HHS. Since health insurance issuers will be submitting their 2014 rate filings in states starting April 1, 2013, these amendments must be effective at that point for consumers to experience the full benefits in 2014 of the rate review process both inside and outside the Exchanges. Furthermore, HHS and the states must have the ability to collect, beginning April 1, 2013, rate data from health insurance issuers relating to the 2014 market reforms to ensure effective implementation of the market reforms starting January 1, 2014. For example, if the data submission requirement for all rate increases is not in place by April 1, 2013, states and HHS will have very little ability to gauge whether issuers have combined all of their products into a single risk pool in either the individual or small group markets. According to HHS, issuers could, therefore, implement different index rates and allowable modifiers without fear of being observed by a regulator for some time, which would have the potential effect of issuers continuing to rate for health status in 2014. Accordingly, for the reasons stated above, HHS states that 45 C.F.R. § 147.103 of this final rule and the

amendments to 45 C.F.R. part 154 are effective 30 days after publication of this final rule.

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

In the November 26, 2012 proposed rule, CMS solicited public comments on each of the sections identified as containing information collection requirements (ICRs). 77 Fed. Reg. 70,584. In this final rule, CMS restates its summary of the information collection requirements and provides summaries of the comments received and its responses to those comments. Regarding wage data, CMS states that it generally used data from the Bureau of Labor Statistics to derive average labor costs (including fringe benefits) for estimating the burden associated with the ICRs. CMS states that it submitted an information collection request to the Office of Management and Budget (OMB) for review and approval of the ICRs contained in this final rule and notes that the requirements are not effective until approved by OMB and assigned a valid OMB control number.

Statutory authorization for the rule

HHS states that the final rule is authorized by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, referred to collectively as the Affordable Care Act.

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

OMB has designated this final rule as a "significant regulatory action." Even though it is uncertain whether it is likely to have economic impacts of $100 million or more in any one year, CMS has provided an assessment of the potential costs, benefits, and transfers associated with this final regulation.

Executive Order No. 13,132 (Federalism)

In compliance with the requirement of Executive Order 13,132 that agencies examine closely any policies that may have federalism implications or limit the policymaking discretion of the states, CMS has engaged in efforts to consult with and work cooperatively with affected states, including consulting with the National Association of Insurance Commissioners. Throughout the process of developing this final rule, CMS has attempted to balance the states' interests in regulating health insurance issuers and Congress's intent to provide uniform protections to consumers in every state. By doing so, it is CMS's view that it has complied with the requirements of Executive Order 13,132. Under the requirements set forth in section 8(a) of Executive Order 13,132, and by the signatures affixed to this rule, HHS certifies that the CMS Center for Consumer Information and Insurance Oversight has complied with the requirements of Executive Order 13,132 for the final rule in a meaningful and timely manner.