U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

B-325314

November 26, 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, Centers for Medicare & Medicaid Services: Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014*

Pursuant to section 801(a)(2)(A) of title 5, United States Code, this is our report on a major rule promulgated by the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) entitled "Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014" (RINs: 0938-AR82; 0938-AR74). We received the rule on October 29, 2013. It was published in the *Federal Register* as a final rule on October 30, 2013. 78 Fed. Reg. 65,046.

The final rule outlines financial integrity and oversight standards with respect to Affordable Insurance Exchanges, qualified health plan (QHP) issuers in federally-facilitated exchanges (FFEs), and states with regard to the operation of risk adjustment and reinsurance programs. It also establishes additional standards for special enrollment periods, survey vendors that may conduct enrollee satisfaction surveys on behalf of QHP issuers, and issuer participation in an FFE, and makes certain amendments to definitions and standards related to the market reform rules. This final rule also amends and adopts as final interim provisions set forth in the Amendments to the HHS Notice of Benefit and Payment Parameters for 2014, an interim final rule related to risk corridors and cost-sharing reduction reconciliation.

Enclosed is our assessment of CMS's compliance with the procedural steps required by section 801(a)(1)(B)(i) through (iv) of title 5 with respect to the rule. Our review of the procedural steps taken indicates that CMS complied with the applicable requirements.

If you have any questions about this report or wish to contact GAO officials responsible for the evaluation work relating to the subject matter of the rule, please contact Shirley A. Jones, Assistant General Counsel, at (202) 512-8156.

signed

Robert J. Cramer
Managing Associate General Counsel

Enclosure

cc: Ann Stallion
Program Manager
Department of Health and Human Services

ENCLOSURE

REPORT UNDER 5 U.S.C. § 801(a)(2)(A) ON A MAJOR RULE
ISSUED BY THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
CENTERS FOR MEDICARE & MEDICAID SERVICES
ENTITLED
"PATIENT PROTECTION AND AFFORDABLE CARE ACT;
PROGRAM INTEGRITY: EXCHANGE, PREMIUM STABILIZATION PROGRAMS,
AND MARKET STANDARDS; AMENDMENTS TO THE HHS NOTICE OF
BENEFIT AND PAYMENT PARAMETERS FOR 2014"
(RINs: 0938-AR82; 0938-AR74)

(i) Cost-benefit analysis

The Centers for Medicare & Medicaid Services (CMS) discussed the costs and benefits of this final rule and concluded that the benefits of this rule justify the costs. The benefits identified by CMS include (1) ensuring integrity of the reinsurance and risk adjustment programs and smooth functioning of state exchanges and federally-facilitated exchanges, (2) preventing fraud and abuse, (3) ensuring prompt refund of any excess premium or cost-sharing paid, and (4) safeguarding the use of federal funds provided as cost-sharing reductions and advance payments of the premium tax credit and provide value for taxpayers' dollars.

CMS estimates that the rule will have an annualized monetized cost of $15.4 million from 2014 to 2017 in 2013 dollars at a 7 percent discount rate and $15.3 million at a 3 percent discount rate. In this context, annual costs relate to financial oversight, maintenance of records and reporting requirements for state exchanges and state-operated reinsurance and risk-adjustment programs; record retention requirements for contributing entities and issuers of reinsurance-eligible plans; audit costs for state exchanges and state-operated risk adjustment and reinsurance programs; and costs for qualified health plan (QHP) issuers related to reporting requirements, record maintenance, audits, and training for customer service representatives.

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

CMS determined that this final rule will not have a significant economic impact 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

CMS determined that this final rule directs states to undertake oversight activities for state exchanges, state-operated reinsurance and risk adjustment programs. The costs related to oversight activities, recordkeeping, reporting, and audits are estimated to be approximately $2.8 million in 2014. CMS also determined that the rule contains no mandates on local or tribal governments. According to CMS, the private sector will incur costs to comply with the record maintenance and reporting requirements set forth in this final rule. The related costs are estimated by CMS to be approximately $14.2 million in 2014. However, CMS also expects QHP issuers to experience a cost savings of approximately $57.7 million by adopting the simplified methodology to calculate cost sharing reductions during a transitional period and postponing

costly IT implementation. Consistent with the policy embodied in the Act, CMS stated that it designed this final rule to be a low-burden alternative for state, local, and tribal governments, and the private sector while achieving the objectives of the authorizing statute.

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

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

On June 19, 2013, CMS published a proposed rule. 78 Fed. Reg. 37,032. In total CMS received approximately 99 public comments on the proposed rule from various stakeholders including states, health insurance issuers, consumer groups, agents and brokers, provider groups, Members of Congress, tribal organizations, and other stakeholders. On March 11, 2013, CMS also published an interim final rule. 78 Fed. Reg. 15,541. CMS received seven comment letters on the interim final rule from issuers, advocacy organizations, and tribal organizations. In the final rule, CMS provided a summary of each proposed or interim provision, a summary of the public comments received and its responses to those comments, and the provisions that it is finalizing.

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

CMS discussed 11 information collection requirements (ICRs) in this final rule. According to CMS, although the final rule contains estimates of the burden imposed by the ICRs associated with this rule, not all of these estimates are subject to the Act. For three ICRs, CMS concluded that fewer than 10 entities would be affected and, therefore, did not seek approval from the Office of Management and Budget (OMB) under the Act. For one ICR, CMS did not include the burden estimate in its calculation of the overall burden because it estimates only one issuer per year would be affected. For one ICR, CMS is developing a survey in order to collect the necessary information to develop a burden estimate. For the remaining six ICRs, CMS estimated that the burden would be (1) 19,000 hours for a cost of $731,310, (2) 468 hours for a cost of $24,626.88, (3) an incremental savings of $57,676,164, (4) 26,400 hours for a cost of $1,154,772, (5) 40 hours for a cost of $1,075, and (6) a cost of $1,108,512.

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 Service Act and sections 1301 through 1304, 1311 through 1313, 1321, 1322, 1331, 1332, 1334, 1341 through 1343, 1402 through 1402, 1411, 1412, 1413, of Public Law 111-148. 42 U.S.C. §§ 300gg through 300gg–63, 300gg–91, 300gg–92, 18021 through 18024, 18031 through 18033, 18041 through 18042, 18051, 18054, 18061, 18063, 18071, and 18081 through 18083.

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

CMS determined that this final rule is a significant regulatory action under the Order.

Executive Order No. 13,132 (Federalism)

CMS concluded that it complied with the requirements of the order and certifies that the CMS Center for Consumer Information and Insurance Oversight has complied with the requirements of the Order in a meaningful and timely manner.