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April 28, 2017

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

The Honorable Greg Walden
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; Market Stabilization*

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; Market Stabilization" (RIN: 0938-AT14). We received the rule on April 19, 2017. It was published in the *Federal Register* as a final rule on April 18, 2017. 82 Fed. Reg. 18,346. The rule is effective on June 19, 2017.

The final rule makes changes that HHS expects will help stabilize the individual and small group markets and affirm a state regulator role. This final rule amends standards relating to special enrollment periods, guaranteed availability, and the timing of the annual open enrollment period in the individual market for the 2018 plan year; standards related to network adequacy and essential community providers for qualified health plans; and the rules around actuarial value requirements.

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: Agnes Thomas
Regulations Coordinator
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;
MARKET STABILIZATION"
(RIN: 0938-AT14)

(i) Cost-benefit analysis

The Department of Health and Human Services (HHS) discussed the benefits and costs of this final rule. The benefits identified by HHS include improved health and protection from the risk of catastrophic medical expenditures for the previously uninsured, especially individuals with medical conditions (if health insurance enrollment increases) or cost savings due to reduction in providing medical services (if health insurance enrollment decreases). HHS noted that enrollment may increase due to decreases in premiums resulting from pass-through of administrative cost savings (as listed in the final rule) and savings associated with reductions in special enrollment period or the shortened open enrollment period or enrollment may decrease due to lessened consumer appeal of insurance with reduced actuarial value and less access to essential community providers (ECPs), increases in premiums resulting from pass-through of administrative costs, former special enrollment period users discontinuing participation, or due to shortened enrollment periods and therefore the net effect on enrollment is ambiguous.

HHS also identified cost savings to issuers from not having to process claims while enrollment is "pending" during pre-enrollment verification of eligibility for special enrollment periods as a benefit, but observed that does not take into account the fact that uninsured individuals are relatively likely to obtain healthcare through high-cost providers (for example, visiting an emergency room for preventive services). HHS also identified as benefits of this rule: (1) cost savings to the government and plans associated with the reduced open enrollment period and (2) costs savings to consumers and issuers due reduced administrative costs to issuers.

The costs identified by HHS of this final rule include: (1) harms to health and reduced protection from the risk of catastrophic medical expenditures for the previously uninsured, especially individuals with medical conditions (if health insurance enrollment decreases); (2) cost due to increases in providing medical services (if health insurance enrollment increases); (3) possible decrease in quality of medical services (for example, reductions in continuity of care due to lower ECP threshold); (4) administrative costs incurred by the federal government and by states that start conducting verification of special enrollment period eligibility; (5) costs to issuers of redesigning plans; (6) costs to the federal government and issuers of outreach activities associated with shortened open enrollment period; and (7) administrative costs to stakeholders to read, comprehend, and comply with provisions of the final rule. HHS estimates that this final rule will result in transfer from the federal government to issuers and providers and transfers from enrollees and issuers to the federal government of between \$200 million and \$400 million annually.

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

HHS certified 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

Although HHS did not quantify all costs of this final rule, it stated that it expects the combined impact on state, local, or tribal governments and the private sector to be below \$146 million (\$100 million, adjusted for inflation).

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

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

On February 17, 2017, HHS published a proposed rule. 82 Fed. Reg. 10,980. HHS received 4,005 timely comments. HHS addressed some comments in the final rule, but noted that other comments and suggestions were outside the scope of the proposed rule and therefore were not addressed in the final rule.

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

HHS determined that this final rule contains information collection requirements under the Act. HHS revised the information collection currently approved under *Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment* (Office of Management and Budget (OMB) Control Number OMB 0938-1207) to account for this additional burden. HHS estimated that HHS eligibility support staff members will conduct pre-enrollment verification for an additional 650,000 individuals. Once individuals have submitted the required verification documents, HHS estimated that it will take approximately 12 minutes (at an hourly cost of \$40.82) to review and verify submitted verification documents. HHS estimates the verification process will result in an additional annual burden for the federal government of 130,000 hours at a cost of \$5,306,600.

Statutory authorization for the rule

HHS promulgated this final rule under the authority of sections 2701–2763, 2791, and 2792 of the Public Health Service Act, as amended, and sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1332, 1334, 1402, 1411, 1412, and 1413 of the Patient Protection and Affordable Care Act. 42 U.S.C. §§ 10821–18024, 18031–18033, 18041–18042, 18051, 18054, 18071, 18081–18083.

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

HHS concluded that this final rule is likely to have economic impacts of \$100 million or more in at least 1 year, and therefore, meets the definition of significant rule under the Order.

Executive Order No. 13,132 (Federalism)

In HHS's view, while this final rule will not impose substantial direct requirement costs on state and local governments, 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 relating to health insurance that is offered in the individual and small group markets. However, HHS anticipates that the federalism implications will be substantially mitigated because states have choices regarding the structure, governance, and operations of their exchanges. HHS engaged in efforts to consult with and work cooperatively with affected states, including participating in conference calls with and attending conferences of the National Association of Insurance Commissioners, and consulting with state insurance officials on an individual basis. HHS stated that, in its view, it complied with the Order.