U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

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May 12, 2022

The Honorable Patty Murray
Chairwoman
The Honorable Richard Burr
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Frank Pallone, Jr.
Chairman
The Honorable Cathy McMorris Rodgers
Republican Leader
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 2023*

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 2023" (RIN: 0938-AU65). We received the rule on May 5, 2022. It was published in the *Federal Register* as a final rule on May 6, 2022. 87 Fed. Reg. 27208. The effective date is July 1, 2022.

The final rule, according to HHS, includes payment parameters and provisions related to the risk adjustment and risk adjustment data validation programs, as well as 2023 user fee rates for issuers offering qualified health plans (QHPs) through federally-funded Exchanges and state-based Exchanges on the federal platform. Also, HHS stated that the rule includes requirements related to guaranteed availability; the offering of QHP standardized plan options through Exchanges on the federal platform; requirements for agents, brokers, and web-brokers; verification standards related to employer sponsored coverage; Exchange eligibility determinations during a benefit year; special enrollment period verification; cost-sharing requirements; Essential Health Benefits; Actuarial Value; QHP issuer quality improvement strategies; accounting for quality improvement activity expenses and provider incentives for medical loss ratio reporting and rebate calculation purposes; and re-enrollment. Lastly, HHS stated that the rule responds to comments on how HHS can advance health equity through QHP certification standards and otherwise in the individual and group health insurance markets, and how HHS might address plan choice overload in the Exchanges.

The Congressional Review Act (CRA) 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). This final rule was published on May 6, 2022. 87 Fed. Reg. 27208. The *Congressional Record* does not yet reflect receipt of the rule by either

the House of Representatives or the Senate. The rule has a stated effective date of July 1, 2022. Based on the date of publication of the rule, the rule does not have the required 60-day delay in its effective date.

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. 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 Shari Brewster, Assistant General Counsel, at (202) 512-6398.

Shirley A. Jones
Managing Associate General Counsel

Enclosure

cc: Calvin E. Dukes II
Regulations Coordinator
Centers for Medicare & Medicaid 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;
HHS NOTICE OF BENEFIT AND PAYMENT PARAMETERS FOR 2023"
(RIN: 0938-AU65)

(i) Cost-benefit analysis

The Department of Health and Human Services (HHS) summarized HHS's assessment of the benefits, costs, and transfers associated with this final rule. According to HHS, qualitative benefits include increased access to health insurance coverage for individuals who are currently unable to enroll in coverage because of past-due premiums; and quantitative benefits include a reduction in costs for states related to annual reporting of state-required benefits, estimated to be a one-time savings of $100,829 in program year 2022 and annual savings of $45,817 each year thereafter. According to HHS, qualitative costs include a potential administrative burden on states and regulated entities that would need to take action to come into compliance with the updated nondiscrimination policies (for example, regulated entities under section 156.125 of title 45 of the Code of Federal Regulations). Annualized monetized costs per year, according to HHS, are estimated to be -$119 million in 2021 dollars, at the seven percent discount rate, for the period 2022–2026; and -$120.3 million in 2021 dollars, at the three percent discount rate, for the period 2022–2026.

HHS also stated that qualitative transfers include a potential transfer from issuers who would have been able to recoup unpaid premiums from enrollees to those enrollees who would now be able to enroll in coverage from the same issuer or another issuer in the same controlled group without having to pay past-due premiums; and quantitative transfers include federal transfers to consumers in an increase in premium tax credit payments due to changes in the actuarial value *de minimis* range, estimated to be approximately $0.73 billion in 2023, $0.77 billion in 2024, $0.77 billion in 2025, and $0.76 billion in 2026. Additionally, HHS stated that annualized monetized transfers per year are estimated to be $631.9 million in 2021 dollars, at the seven percent discount rate, for the period 2022–2026; and $645.3 million in 2021 dollars, at the three percent discount rate, for the period 2022–2026.

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

HHS stated that it believed that insurance firms offering comprehensive health insurance policies generally exceed the size thresholds for "small entities" established by the Small Business Administration, and so it did not believe that an initial regulatory flexibility analysis was required for such firms. HHS also stated that it does not expect the medical loss ratio provisions finalized in the rule to affect a substantial number of small entities. Lastly, HHS stated that the Secretary of HHS has determined that the rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

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

HHS stated that although it has not been able to quantify all costs, it expects the combined impact on state, local, or tribal governments and the private sector does not meet the Act's definition of an unfunded mandate.

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

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

On January 5, 2022, HHS published a proposed rule. 87 Fed. Reg. 584. HHS considered all public input and written comments received in response to the proposed rule as it developed the policies in this final rule.

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

HHS stated that this final rule contains information collection requirements that are subject to review by the Office of Management and Budget (OMB). HHS summarized annual burden estimates for the proposed requirements as follows:

- Sections 153.610 and 153.710 of title 45 of the Code of Federal Regulations (OMB Control Number 0938-1155), 19,500 hours and $1,884,870;
- Section 155.220 of title 45 of the Code of Federal Regulations (OMB Control Number 0938-1349), 200 hours and $18,360;
- Sections 156.230 and 156.235 of title 45 of the Code of Federal Regulations (OMB Control Number 0938-NEW), 1,080 hours and $78,732;
- Sections 156.230 and 156.235 of title 45 of the Code of Federal Regulations (OMB Control Number 0938-NEW), 4,300 hours and $313,470;
- Sections 155.220 and 156.265 of title 45 of the Code of Federal Regulations (OMB Control Number 0938-1329), 55 hours and $4,009.50;
- Sections 155.220 and 156.265 of title 45 of the Code of Federal Regulations (OMB Control Number 0938-1329), 220 hours and $20,196;
- Section 153.320 of title 45 of the Code of Federal Regulations (OMB Control Number 0938-1155), reduction of 1,440 hours and reduction of $126,345;
- Section 155.420 of title 45 of the Code of Federal Regulations (OMB Control Number 0938-1207), reduction of 38,800 hours and $1,811,960; and
- Section 156.111 of title 45 of the Code of Federal Regulations (OMB Control Number 0938-1174), reduction of 533 hours and reduction of $45,817.

Statutory authorization for the rule

HHS promulgated this final rule pursuant to section 36B of title 26, United States Code; sections 300gg through 300gg-63, 300gg-91, 300gg-92, 300gg-111 through 300gg-139, 18021 through 18024, 18031 through 18033, 18041 through 18042, 18044, 18051, 18054, 18061 through 18063, 18071, and 18081 through 18083 of title 42, United States Code; and Public Law 116-136.

Executive Order No. 12866 (Regulatory Planning and Review)

OMB determined this final rule is economically significant, and OMB reviewed the rule.

Executive Order No. 13132 (Federalism)

HHS stated that this final rule will not impose substantial direct requirement costs on state and local governments, but the rule has federalism implications due to potential 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. For example, according to HHS, the repeal of the risk adjustment state flexibility policy (with an exception for prior participants) may have federalism implications, but they are mitigated because states have the option to operate their own Exchange and risk adjustment program if they believe the HHS risk adjustment methodology does not account for state-specific factors unique to the state's markets.

In addition, according to HHS, the rule has federalism implications due to the proposal for Exchanges to design a new risk-based verification process for enrollment in or eligibility for employer sponsored plan coverage that meets minimum value standards, that is based on the Exchange's assessment of risk for inappropriate advance payment of the premium tax credit/cost-sharing reduction payments. However, HHS stated the federalism implications are mitigated because the proposed requirement provides Exchanges with the flexibility to determine the best process to verify employer sponsored coverage and they may choose not to implement such a risk-based verification process.