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May 1, 2018

The Honorable Orrin G. Hatch  
Chairman  
The Honorable Ron Wyden  
Ranking Member  
Committee on Finance  
United States Senate

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

The Honorable Kevin Brady  
Chairman  
The Honorable Richard Neal  
Ranking Member  
Committee on Ways and Means  
House of Representatives

Subject: *Department of Health and Human Services: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019*

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 2019" (RIN: 0938-AT12). We received the rule on April 10, 2018. It was published in the *Federal Register* as a final rule on April 17, 2018. 83 Fed. Reg. 16,930. These regulations are effective on June 18, 2018.

According to HHS, the final rule sets forth payment parameters and provisions related to the risk adjustment and risk adjustment data validation programs; cost-sharing parameters; and user fees for Federally-facilitated Exchanges and State Exchanges (Exchanges) on the federal platform. It also states that it finalizes changes that provide additional flexibility to states to apply the definition of essential health benefits (EHB) to their markets; enhances the role of states regarding the certification of qualified health plans (QHPs); and provides states with additional flexibility in the operation and establishment of Exchanges, including the Small Business Health Options Program (SHOP) Exchanges. The final rule also includes changes to standards related to Exchanges, the required functions of the SHOPS, actuarial value for stand-alone dental plans, the rate review program, the medical loss ratio program, eligibility and enrollment, exemptions, 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 agency's submissions to us 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;  
HHS NOTICE OF BENEFIT AND PAYMENT  
PARAMETERS FOR 2019”  
(RIN: 0938-AT12)

(i) Cost-benefit analysis

The Department of Health and Human Services (HHS) summarized the costs, benefits, and transfers of the final rule. HHS provided an accounting table describing the annualized monetized costs. According to HHS, the final rule implements standards for programs that will have numerous effects, including providing consumers with access to affordable health insurance coverage, reducing the impact of adverse selection, and stabilizing premiums in the individual and small group health insurance markets and in Federally-facilitated Exchanges and State Exchanges (Exchanges).

HHS summarized in a table the qualitative impacts and estimated direct monetary costs and transfers resulting from the provisions of this final rule for health insurance issuers. The annualized monetized costs described in the table reflect direct administrative costs to health insurance issuers as a result of the finalized provisions, and include administrative costs associated with states requesting a reduction in risk adjustment transfers for the state’s individual, small group, or merged market; the reduction in costs relating to issuers and states having to no longer submit rate increases for student health insurance plans to HHS; and costs associated with states seeking an adjustment to the medical loss ratio (MLR) standard in the state’s individual market that are estimated in the Collection of Information section of the final rule. The annual monetized transfers described in the summary table include costs associated with State Exchange on the Federal platform (SBE–FP) user fees, the risk adjustment user fee paid to HHS by issuers, and reductions in rebate payments from issuers to consumers related to quality improvement activity (QIA) and MLR adjustments. HHS finalized a risk adjustment user fee to collect \$1.80 per enrollee per year from risk adjustment issuers to operate the risk adjustment program on behalf of states, which HHS expects to cost approximately \$40 million, similar to the \$40 million in contract costs expected for benefit year 2018 when HHS established a \$1.68 per-enrollee-per-year risk adjustment user fee rate. As in 2018, the risk adjustment user fee contract costs for 2019 include additional costs for risk adjustment data validation; however, HHS expects reduced costs related to issuer outreach and education as issuers gain familiarity with the risk adjustment program, and lower enrollment in risk adjustment covered QHPs, and additional costs to include administrative and personnel costs related to the risk adjustment program that were inadvertently excluded in prior years’ cost estimation, which together results in a slightly higher risk adjustment user fee rate than the benefit year 2018 rate. HHS states that it generally expects similar risk adjustment user fee costs as the 2018 benefit year and that there are no changes to the risk adjustment user fee transfers to include in the table. Also, HHS states that it expects a decrease in Federally-Facilitated Exchanges (FFE) user fee collections necessary as it estimates lower contract costs due to streamlining of FFE operations and an increase in premiums but also lower enrollment, resulting in a proposed user fee rate of 3.5 percent for 2019, which is the same as the FFE user fee rate established for

2014 through 2018 benefit years. However, the decrease in user fee collections required to support FFE functions for the 2019 benefit year will be similar to the updated costs for the 2018 benefit year, and the user fee rate will yield the same amount of transfers from FFE issuers to the federal government as in the prior benefit year. Therefore, according to HHS, there are no changes to the FFE user fee transfers to include. HHS also proposed an SBE–FP user fee rate to be set at 3.0 percent for benefit year 2019, which is higher than the 2.0 percent SBE–FP user fee rate it finalized for the 2018 benefit year. In the final rule, HHS also finalized a proposal to cease charging user fees on SHOP issuers offering plans through an FFE or SBE–FP starting for plan years beginning on and after January 1, 2018.

HHS stated that the benefits of this final rule include enhancing the role of states in these programs and providing states with additional flexibilities, reducing unnecessary regulatory burden on stakeholders, empowering consumers, and improving affordability. HHS further states that the final rule provides states with an additional tool to help stabilize, innovate, and provide relief in their individual markets. According to HHS, the provisions within the final rule are integral to the goal of expanding coverage. HHS states that it anticipates that the provisions of this final rule will help further HHS’s goal of ensuring that all consumers have access to quality and affordable health care and are able to make informed choices, that Exchanges operate smoothly, that the risk adjustment program works as intended, and that states have more control and flexibility over essential health benefits (EHBs), QHP certification and the operation and establishment of Exchanges. HHS noted additional benefits that it was unable to quantify.

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

HHS stated that it believes that insurance firms offering comprehensive health insurance policies generally exceed the size thresholds for “small entities” established by the Small Business Administration (SBA) and that it does not believe that an initial regulatory flexibility analysis is required for such firms. Further, HHS states that for purposes of RFA, it expects that health insurance issuers and group health plans will be affected by the final rule. It believes that few, if any, insurance companies selling comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) fall below these size thresholds. HHS states that it expects that many employers who will be affected by the finalized policies will meet the SBA standard for small entities. HHS states that it does not believe that the finalized policies impose requirements on employers offering health insurance through a SHOP that are more restrictive than the current requirements on small businesses offering employer sponsored insurance. HHS said that it believes the processes it has established constitute the minimum amount of requirements necessary to implement the SHOP program and accomplish policy goals and that no appropriate regulatory alternatives can be developed to further lessen the compliance burden. HHS estimates that 57 of 92 potentially small entities may experience a decrease in the rebate amount owed to consumers under the amendments to the quality improvement activity reporting provisions in part 158, and 27 of these 57 entities are part of larger holding groups. In addition, HHS estimates that no small entities will be impacted by the amendments to 45 CFR part 158, subpart C. Therefore, HHS states that it believes that the provisions of this final rule regarding MLR will not affect a substantial number of small entities, and further, the impact of the proposed QIA provisions on small entities will be positive.

(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 to be below the \$146 million (\$100 million adjusted for inflation) threshold established by 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 2, 2017, HHS published a proposed rule entitled, the “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019” in the *Federal Register*. 82 Fed. Reg. 51,052. HHS received 416 comments, including 99 comments that were substantially similar to one of four different letters, each regarding the proposals on EHBs, one addressing EHBs and the Navigator program, and one addressing proposals related to EHBs, Navigators, SHOPS, and network adequacy. Comments were received from state entities, such as departments of insurance and state Exchanges; health insurance issuers; providers, both individuals and provider groups; consumer groups; industry groups; national interest groups; and other stakeholders. HHS summarized each proposed provision, summarized public comments received that directly related to the proposals, and provided their responses to them and a description of the provisions which were finalized. HHS noted that commenters suggested that HHS adopt a comment period of at least 30 days from rule publication and to fully comply with notice-and-comment requirements under the Administrative Procedure Act. HHS responded that the timeline for publication of the final rule accommodates issuer filing deadlines for the 2019 benefit year and that a longer comment period would have delayed the publication and created significant challenges for states, Exchanges, issuers, and other entities in meeting deadlines related to implementing these rules. HHS states that it will continue to try to expand the comment period for the annual HHS notice of benefit and payment parameters while also providing industry and other stakeholders with more time to implement the final rule.

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

The final rule contains information collection requirements that are subject to review by the Office of Management and Budget (OMB) for its review of the rule's information collection and recordkeeping requirements. The requirements are not effective until they have been approved by OMB. HHS described the provisions of these information collection requests in the final rule. HHS also provided a table in the final rule summarizing the annual reporting, recordkeeping, and disclosure burdens.

Statutory authorization for the rule

HHS stated that it promulgated the final rule under 42 U.S.C. §§ 300gg-300gg-63, 300gg-91, 300gg-92, 300gg-94; 42 U.S.C. §§ 18021-18024, 18031-18033, 18041-18042, 18044, 18051, 18054, 18061, 18063, 18071, and 18081-18083; 26 U.S.C. § 36B; and 31 U.S.C. 9701. Title I of the Patient Protection and Affordable Care Act, sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1332, 1334, 1341-1343, 1402, 1411, 1412, 1413; Pub. L. 111-148, 124 Stat. 119.

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

OMB determined that this final rule is economically significant within the meaning of section 3(f)(1) of the Order. HHS prepared a Regulatory Impact Analysis that presents the costs and benefits of the final rule.

Executive Order No. 13,132 (Federalism)

According to HHS, while this final rule will not impose substantial direct requirement costs on state and local governments, this regulation 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. In compliance with the Order, HHS stated that it has 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. While developing the final rule, HHS states that it attempted to balance the states' interests in regulating health insurance issuers with the need to ensure market stability. HHS also states that it has complied with the requirements of Executive Order 13,132.