



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

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August 14, 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: Adoption of the Methodology for the HHS-Operated Permanent Risk Adjustment Program Under the Patient Protection and Affordable Care Act for the 2017 Benefit Year*

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), Centers for Medicare and Medicaid Services (CMS) entitled "Adoption of the Methodology for the HHS-Operated Permanent Risk Adjustment Program Under the Patient Protection and Affordable Care Act for the 2017 Benefit Year" (RIN: 0938-AT65). We received the rule on July 26, 2018. It was published in the *Federal Register* as a final rule July 30, 2018. 83 Fed. Reg. 36,456. The effective date of the final rule was July 30, 2018.

The final rule adopts the risk adjustment methodology that HHS previously established for the 2017 benefit year. In February 2018, a district court vacated the use of statewide average premium as a basis for the HHS-operated risk adjustment methodology for the 2014, 2015, 2016, 2017, and 2018 benefit years. Accordingly, HHS states that it issued this final rule to allow charges to be collected and payments to be made for the 2017 benefit year. HHS further states that it adopted the final rules set out in the publication in the *Federal Register* on March 23, 2012, and the publication in the *Federal Register* on March 8, 2016.

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 has a stated effective date of July 30, 2018. We received the final rule on July 26, 2018, and it was published in the *Federal Register* on July 30, 2018. 83 Fed. Reg. 36,456. Therefore, this final rule does not have a 60-day delay in effective date.

However, any rule which an agency for good cause finds “that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest, may take effect at such time as the agency determines.” 5 U.S.C. § 808(2). As set forth in the enclosed report, HHS found good cause to waive publication of a proposed rule and solicitation of public comment and thus the 60-day delay requirement does not apply.

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 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
CENTERS FOR MEDICARE AND MEDICAID SERVICES
ENTITLED
“ADOPTION OF THE METHODOLOGY FOR THE
HHS-OPERATED PERMANENT RISK ADJUSTMENT PROGRAM
UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT
FOR THE 2017 BENEFIT YEAR”
(RIN: 0938-AT65)

(i) Cost-benefit analysis

The Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services (HHS), states that it examined the costs and benefits of the final rule. The final rule incorporates the analysis by reference to the final rules published in the *Federal Register* on March 23, 2012, and on March 8, 2016. 77 Fed. Reg. 17,220; 81 Fed. Reg. 12,204.

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

CMS states that it examined the impact of this rule as required by the Regulatory Flexibility Act. The final rule incorporates the analysis by reference to the final rules published in the *Federal Register* on March 23, 2012, and on March 8, 2016. 77 Fed. Reg. 17,220; 81 Fed. Reg. 12,204.

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

CMS states that it examined the impact of this rule as required by section 202 of the Unfunded Mandates Reform Act of 1995. The final rule seems to incorporate the analysis by reference to the final rules published in the *Federal Register* on March 23, 2012, and on March 8, 2016. 77 Fed. Reg. 17,220; 81 Fed. Reg. 12,204.

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

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

CMS states that the final rule adopts the final rules set out in the publication in the March 23, 2012, *Federal Register* (77 Fed. Reg. 17,220) and publication in the March 8, 2016, *Federal Register* (81 Fed. Reg. 12,204). For the 2017 benefit year, in states where HHS is operating the risk adjustment program under section 1343 of the Patient Protection and Affordable Care Act, HHS will use the criteria and methods as specified in the publication in the March 23, 2012, *Federal Register* (77 Fed. Reg. 17,220) and publication in the March 8, 2016, *Federal Register* (81 Fed. Reg. 12,204). Further, according to CMS, under the Administrative Procedure Act (APA) (5 U.S.C. § 553), a notice of proposed rulemaking and an opportunity for public comment are generally required before issuing a regulation. CMS also states that it ordinarily provides a 30-day delay in the effective date of the provisions of a rule in accordance with APA (5 U.S.C. 553(d)), unless the rule is a major rule and subject to the 60-day delayed effective date required by the Congressional Review Act (5 U.S.C. 801(a)(3)). However, these procedures can be waived if the agency, for good cause, finds that notice and public comment and delay in

effective date are impracticable, unnecessary, or contrary to public interest and incorporates a statement of the finding and its reasons in the rule issued. 5 U.S.C. 553(d)(3); 5 U.S.C. 808(2).

HHS has determined that issuing this rule in proposed form, such that it would not become effective until after public comments are submitted, considered, and responded to in a final rule, would be impracticable, unnecessary, and contrary to the public interest. In support of this determination, HHS states as follows:

Immediate administrative action is imperative to maintain stability and predictability in the individual and small group insurance markets. It is also consistent with settled expectations in that this rule adopts the risk adjustment methodology previously established for the 2017 benefit year. (These were published on February 27, 2015, in the *Federal Register* (80 Fed. Reg. 10,749) and the March 8, 2016, *Federal Register* (81 Fed. Reg. 12,203)). Under normal operations, risk adjustment invoices for the 2017 benefit year would be issued beginning in August 2018 and risk adjustment payments for the 2017 benefit year would be made beginning in the September 2018 monthly payment cycle. Accordingly, it is now less than 2 months until risk adjustment payments for the 2017 benefit year, expected to total \$5.2 billion, are due to begin. Immediate action is also necessary to maintain issuer confidence in the HHS-operated risk adjustment program. Issuers have already accounted for expected risk adjustment transfers in their rates for the 2017 benefit year and uncompensated payments for the 2017 benefit year could lead to higher premiums in future benefit years as issuers incorporate a risk premium into their rates. Issuers file rates for the 2019 benefit year in the summer of 2018, and if a projected \$5.2 billion in risk adjustment payments is unavailable or there is uncertainty as to whether payments for the 2018 benefit year will be made, there is a serious risk issuers will substantially increase 2019 premiums to account for the uncompensated risk associated with high-risk enrollees. Consumers enrolled in certain plans could see a significant premium increase, which could make coverage in those plans particularly unaffordable for unsubsidized enrollees. Furthermore, issuers are currently making decisions on whether to offer qualified health plans (QHPs) through the Exchanges for the 2019 benefit year, and, for the Federally-facilitated Exchange (FFE), this decision must be made before the August 2018 deadline to finalize QHP agreements. In states with limited Exchange options, according to HHS, a QHP issuer exit would restrict consumer choice and put additional upward pressure on Exchange premiums, thereby increasing the cost of coverage for unsubsidized individuals and federal spending for premium tax credits. And, according to HHS, the combination of these effects could lead to significant, involuntary coverage losses in certain state market risk pools.

Additionally, HHS states its failure to make timely risk adjustment payments could impact the solvency of plans providing coverage to sicker (and costlier) than average enrollees that require the influx of risk adjustment payments to continue operations. When state regulators determine issuer solvency, any uncertainty surrounding risk adjustment transfers jeopardizes regulators' ability to make decisions that protect consumers and support the long-term health of insurance markets. Therefore, HHS determined that delaying the effective date of the use of statewide average premium in the payment transfer calculation under the HHS-operated risk adjustment methodology for the 2017 benefit year to allow for proposed rulemaking and comment is impracticable and contrary to the public interest because consumers would be negatively impacted by premium changes should risk adjustment payments be interrupted or confidence in the program undermined.

HHS states in the rule that there is also good cause to proceed without notice and comment for the additional reason that such procedures are unnecessary here, and that it has received and considered comments in issuing the 2014 through 2017 Payment Notices. In each of these

rulemaking processes, HHS states that parties had the opportunity to comment on HHS's use of statewide average premium in the payment transfer formula under the HHS-operated risk adjustment methodology. Because the final rule adopts the same HHS-operated risk adjustment methodology issued in the 2017 Payment Notice final rule, the comments received in those rulemakings are sufficiently current to indicate a lack of necessity to engage in further notice and comment. In the 2014 Payment Notice final rule, HHS received a number of comments in support of the proposal to use the statewide average premium as the basis for risk adjustment transfers. In subsequent benefit year rulemakings, some commenters expressed a desire for HHS to use a plan's own premium. HHS addressed those comments by reiterating that it had considered the use of a plan's own premium instead of the statewide average premium and chose to use statewide average premium. HHS states that this approach supports the overall goal of the risk adjustment program to encourage issuers to rate for the average risk in the applicable state market risk pool and avoids the creation of incentives for issuers to operate less efficiently, set higher prices, develop benefit designs or create marketing strategies to avoid high risk enrollees.

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

CMS states that the final rule does not impose information collection requirements. Consequently, they state that there is no need for review by the Office of Management and Budget (OMB) under the authority of PRA.

Statutory authorization for the rule

CMS promulgated the rule under sections 1343 and 1321(c)(1) of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152). These statutes are collectively referred to as "PPACA" in the final rule.

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

According to CMS, it estimated that the final rule is "economically significant" as measured by the \$100 million threshold under Regulatory Planning and Review, and hence is also a major rule under the Congressional Review Act. In addition, OMB has determined that the actions are significant within the meaning of section 3(f)(1) of Regulatory Planning and Review. Accordingly, it prepared a Regulatory Impact Analysis (RIA) that presents the costs and benefits of the rulemaking. CMS noted that it previously estimated transfers associated with the risk adjustment program in the Premium Stabilization Rule and the 2017 Payment Notice and that the provisions of this final rule do not change the risk adjustment transfers previously estimated under the HHS-operated risk adjustment methodology established in those final rules. The approximate risk adjustment transfers for the 2017 benefit year are \$5.179 billion. As such, CMS stated that it also adopts the RIA in the 2017 Payment Notice proposed and final rules published respectively on December 2, 2015, and March 8, 2016, in the *Federal Register*. 80 Fed. Reg. 75487; 81 Fed. Reg. 12,204.

Executive Order No. 13,132 (Federalism)

CMS states that it examined the impact of this rule as required by Executive Order 13,132 on Federalism. The final rule incorporates the analysis by reference to the final rules published in the *Federal Register* on March 23, 2012, and on March 8, 2016. 77 Fed. Reg. 17,220; 81 Fed. Reg. 12,204.