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Washington, DC 20548

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May 9, 2019

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

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

The Honorable Richard Neal  
Chairman  
The Honorable Kevin Brady  
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 2020*

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 and Medicaid Services (CMS) entitled "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020" (RIN: 0938-AT37). We received the rule on April 25, 2019. It was published in the *Federal Register* as a final rule on April 25, 2019. 84 Fed. Reg. 17454. The effective date of the rule is June 24, 2019.

This 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-based exchanges on the federal platform. According to HHS, this final rule will allow greater flexibility related to the duties and training requirements for the Navigator program<sup>1</sup> and changes that will provide greater flexibility for direct enrollment entities, while strengthening program integrity oversight over those entities. HHS also stated that this final rule is intended to reduce the costs of prescription drugs. Lastly, this final rule changes exchange standards related to eligibility and enrollment; exemptions; and other related topics.

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<sup>1</sup> Exchanges are required to establish Navigator programs under which they award grants to entities to conduct public education activities to raise awareness of the availability of qualified health plans, among other things.

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 Janet Temko-Blinder, Assistant General Counsel, at (202) 512-7104.

signed

Shirley A. Jones  
Managing Associate General Counsel

Enclosure

cc: Calvin E. Dukes II  
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 2020”  
(RIN: 0938-AT37)

(i) Cost-benefit analysis

The Department of Health and Human Services (HHS) identified qualitative benefits of this final rule. Those qualitative benefits include (1) greater market stability resulting from updates to the risk adjustment methodology; (2) potential increased enrollment in the individual market stemming from lower premiums due to expansion of direct enrollment opportunities, leading to improved access to health care for the previously uninsured, especially individuals with medical conditions, which will result in improved health and protection from the risk of catastrophic medical expenditures; (3) greater continuity of coverage for consumers related to the special enrollment period; (4) reduced Navigator training compliance burden and increased flexibility in training design for exchanges by streamlining the existing training topics into four broad categories; (5) reduced burden to federally-facilitated exchange Navigators by making the duties listed in statute permissible for federally-facilitated exchange Navigators, not required; (6) strengthened program integrity related to agents and brokers and direct enrollment entities; (7) reduction in burden associated with risk adjustment data validation for issuers eligible for the liquidation exemption; and (8) potential reduction in economic distortions, and improvement in economic efficiency as a result of the reduction in exchange enrollment due to the change in the method of calculating the premium adjustment percentage.

HHS also identified costs of this final rule, both qualitative and quantitative. The quantitative costs identified by HHS are: (1) costs incurred by issuers and consumers to comply with provisions related to special enrollment periods; (2) reduction in burden and costs for consumers applying for hardship exemptions through the Internal Revenue Service; (3) reduction in burden and cost for direct enrollment entities that choose to use direct enrollment entity application assisters to carry out responsibilities currently performed by agents or brokers; and (4) regulatory familiarization costs. HHS estimates the annual monetized cost of this final rule for 2019 to 2023 to be -\$14.042 million in 2018 dollars at a 7 percent discount rate and -\$14.037 million at a 3 percent discount rate. The qualitative costs identified by HHS are: (1) costs to issuers due to increases in providing medical services if health insurance enrollment increases and (2) potential costs to exchanges that opt to implement the special enrollment period for qualified individuals who experience a decrease in household income and are newly determined eligible for advance payment of the premium tax cut and to issuers for processing related enrollments and terminations.

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

In its submission to us, HHS indicated that it had not certified that this final rule would not have a significant economic impact on a substantial number of small entities and that HHS prepared a Final Regulatory Flexibility Analysis under the Act. In the final rule HHS states that it believes that insurance firms offering comprehensive health insurance policies generally exceed the size

thresholds for small entities. HHS also determined that this final 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

Although HHS was not able to quantify all costs, it expects the combined impact on state, local, or tribal governments and the private sector to be below the \$154 million threshold (\$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 January 24, 2019, HHS published a proposed rule. 84 Fed. Reg. 227. HHS received 26,129 comments, including 25,632 comments that were substantially similar to one of eight different letters. Comments were received from state entities, such as departments of insurance and state exchanges; health insurance issuers; providers and provider groups; consumer groups; industry groups; national interest groups; and other stakeholders. HHS responded to comments in the final rule.

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

HHS determined this final rule contains information collection requirements under the Act. HHS estimates the information collection requirements associated with this final rule will impose a total of 4,700 annual burden hours for a total cost of \$228,796 under Office of Management and Budget (OMB) Control Number 0938-1207.

Statutory authorization for the rule

HHS promulgated this final rule under the authority of sections 300gg through 300gg-63, 300gg-91, 300gg-92, 18021–18024, 18031–18033, 18041–18042, 18044, 18051, 18054, 18061–18063, 18071, and 18081–18083 of title 42, and section 36B of title 26, United States Code.

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

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

Executive Order No. 13,132 (Federalism)

HHS stated that it 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 this final rule, HHS stated that it attempted to balance the states' interests in regulating health insurance issuers with the need to ensure market stability. In HHS's view, while this final rule will not impose substantial direct requirement costs on state and local governments, this regulation has federalism implications because it finalizes a change to the Alabama risk adjustment program in the small group market based upon a proposal provided by the state.