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United States Government Accountability Office
Washington, DC 20548

B-324567

March 26, 2013

The Honorable Max Baucus
Chairman
The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate

The Honorable Fred Upton
Chairman
The Honorable Henry A. Waxman
Ranking Member
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 2014*

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 2014" (RIN: 0938-AR51). We received the rule on March 1, 2013. It was published in the *Federal Register* as a final rule on March 11, 2013. 78 Fed. Reg. 15,410.

The final rule provides detail and parameters related to: the risk adjustment, reinsurance, and risk corridors programs; cost-sharing reductions; user fees for federally-facilitated Exchanges; advance payments of the premium tax credit; the federally-facilitated Small Business Health Option Program; and the medical loss ratio program. Cost-sharing reductions and advance payments of the premium tax credit, combined with new insurance market reforms, are expected to significantly increase the number of individuals with health insurance coverage, particularly in the individual market. In addition, HHS expects the premium stabilization programs—risk adjustment, reinsurance, and risk corridors—to protect against the effects of adverse selection. These programs, in combination with the medical loss ratio program and market reforms extending guaranteed availability (also known as guaranteed issue) and prohibiting the use of factors such as health status, medical

history, gender, and industry of employment to set premium rates, will help to ensure that every American has access to high-quality, affordable health insurance.

The final rule is effective April 30, 2013. 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). We received the rule on March 1, 2013; however, it was not published in the *Federal Register* until March 11, 2013. Therefore, 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. 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: Ann Stallion
Program Manager
Department of Health and
Human 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 2014"
(RIN: 0938-AR51)

(i) Cost-benefit analysis

The Department of Health and Human Services (HHS) analyzed the benefits and costs of this final rule. According to HHS, the provisions of this final rule, combined with other provisions in the Affordable Care Act, will improve the individual insurance market by making insurance more affordable and accessible to millions of Americans who currently do not have affordable options available to them, and will improve the functioning of both the individual and the small group markets while stabilizing premiums. The transitional reinsurance program will help to stabilize premiums in the individual market. Reinsurance will attenuate individual market rate increases that might otherwise occur because of the immediate enrollment of higher risk individuals, potentially including those currently in state high-risk pools. In 2014, it is anticipated that reinsurance payments will result in premium decreases in the individual market of between 10 and 15 percent relative to the expected cost of premiums without reinsurance.

HHS also states that the risk corridors program will protect Qualified Health Plan (QHP) issuers in the individual and small group market against inaccurate rate setting and will permit issuers to lower rates by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets. The risk adjustment program protects against the potential of adverse selection by allowing issuers to set premiums according to the average actuarial risk in the individual and small group market without respect to the type of risk selection the issuer would otherwise expect to experience with a specific product offering in the market. This should lower the risk issuers would otherwise price into premiums in the expectation of enrolling individuals with unknown health status. In addition, it mitigates the incentive for health plans to avoid unhealthy members. HHS states that the risk adjustment program also serves to level the playing field inside and outside of the Exchange. According to HHS, provisions addressing advance payments of the premium tax credit and cost-sharing reductions will help provide financial assistance for certain eligible individuals enrolled in QHPs through the Exchanges. This assistance will help many low- and moderate-income individuals and families obtain health insurance. HHS states that for many people, cost sharing is a significant barrier to obtaining needed health care. HHS believes that the availability of

premium tax credits and cost-sharing reductions through Exchanges starting in 2014 will result in lower net premium rates for many people currently purchasing coverage in the individual market, and will encourage younger and healthier enrollees to enter the market, leading to a healthier risk pool and to reductions in premium rates for current policyholders.

HHS states that the provisions addressing Small Business Health Options Program (SHOP) Exchanges will reduce the burden and costs of enrolling employees in small group plans, and give small businesses many of the cost advantages and choices that large businesses already have. Additionally, according to HHS, the SHOP Exchanges will allow for small employers to preserve control over health plan choices while saving employers money by spreading issuers' administrative costs across more employers.

HHS asserts that the provisions addressing the Medical Loss Ratio (MLR) program will result in a more accurate calculation of MLR and rebate amounts, since it will reflect issuers' claims-related expenditures, after adjusting for the premium stabilization programs. HHS states that issuers may incur some one-time fixed costs to comply with the provisions of the final rule, including administrative and hardware costs. However, issuer revenues and expenditures are also expected to increase substantially as a result of the expected increase in the number of people purchasing individual market coverage. In addition, states may incur administrative and operating costs if they choose to establish their own programs. HHS believes that in accordance with Executive Orders 12,866 and 13,563, the benefits of this regulatory action would justify the costs.

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

HHS believes that few insurance firms offering comprehensive health insurance policies fall below the size thresholds for ''small entities'' established by the Small Business Administration (SBA). Consequently, HHS stated that it does not believe that a final regulatory flexibility analysis is required with respect to such firms.

HHS believes that a number of sponsors of self-insured group health plans could qualify as ''small entities.'' This final rule specifies that third-party administrators may incur the operational costs associated with submitting reinsurance contributions to HHS. HHS does not believe that the reinsurance contribution amount or the operational cost associated with submitting the contribution are likely to result in a change in revenues of more than 3 to 5 percent for a substantial number of self-insured group health plans or third-party administrators that meet the definition of a small entity. HHS states that it believes the processes that it has established constitute the minimum amount of requirements necessary to implement statutory mandates and accomplish its policy goals, and that no

appropriate regulatory alternatives could be developed to further lessen the compliance burden.

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

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 requires that agencies assess anticipated costs and benefits before issuing any final rule that includes a federal mandate that could result in any expenditure in any one year by state, local, or tribal governments, in the aggregate, or by the private sector, of $100 million in 1995 dollars, updated annually for inflation. In 2013, that threshold level is approximately $141 million. HHS has not been able to quantify the user fees that will be associated with this rule, the combined administrative cost and user fee impact on state, local, or tribal governments and the private sector may be above the threshold.

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

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

HHS published a December 7, 2012, *Federal Register* proposed rule entitled ‘‘Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014’’ (77 Fed. Reg. 73,118). Numerous other related proposed regulations were published in the *Federal Register*, such as the Premium Stabilization Rule implementing the health insurance premium stabilization programs (that is, risk adjustment, reinsurance, and risk corridors) (Premium Stabilization Rule) (77 Fed. Reg. 17,220) (March 23, 2012.)

Following publication of the proposed rule (77 Fed. Reg. 73,118), HHS issued a letter to tribal leaders seeking input on the provisions of the proposed rule. HHS also discussed the provisions of the proposed rule in an all-tribes webinar and conference call and in two meetings with the Tribal Technical Advisory Group. HHS considered the comments offered during these discussions in developing the provisions in this final rule.

HHS received approximately 420 comments from consumer advocacy groups, health care providers, employers, health insurers, health care associations, and individuals. The comments ranged from general support or opposition to the proposed provisions to very specific questions or comments regarding proposed changes. HHS states that it has carefully considered these comments in finalizing this rule.

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

The final rule contains 13 information collection requirements subject to the Paperwork Reduction Act (PRA). In the proposed rule HHS solicited comments on the need for the information collection; the accuracy of the agency's burden estimate; the quality, utility, and clarity of the information to be collected; and recommendations to minimize the burden. HHS states, however, that not all of the estimates are subject to the information collection requirements (ICRs) under the PRA for the reasons HHS noted in the final rule. HHS responded to comments received on these issues in the final rule. In several instances, HHS will need to revise, update, amend, or clarify the Premium Stabilization Rule Supporting Statement to account for additional information or updated estimates, whereas in other instances, the burden associated with the requirement is already accounted for under the Premium Stabilization Rule Supporting Statement under Office of Management and Budget (OMB) control number 0938-1155, with an October 31, 2015, expiration date. Revisions to the supporting statement published under Centers for Medicare & Medicaid Services (CMS) form number 10433, which is pending OMB approval will be made. HHS is issuing an interim final rule with comment elsewhere in the same issue of the *Federal Register* where this final rule appeared in order to provide QHP issuers with the option to submit data about the actual amount of cost-sharing reductions using an alternate methodology for purposes of payment reconciliation. HHS addresses the burden associated with the alternate approach in the Collection of Information section of the interim final rule with comment. Another burden associated with this final rule was described in the 30-day *Federal Register* Notice for the Initial Plan Data Collection published on November 21, 2012 (77 Fed. Reg. 69,846). Regarding wage data, HHS states that it generally used data from the Bureau of Labor Statistics to derive average labor costs (including fringe benefits) for estimating the burden associated with the ICRs in the few requirements where a modest estimate was included. HHS also clarified that it intends to provide further detail in later guidance and rulemaking and will seek OMB approval and solicit public comment at a future date.

Statutory authorization for the rule

HHS states that the final rule is authorized by the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), referred to collectively as the Affordable Care Act.

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

HHS asserts that this notice is economically significant under the Order and has been reviewed by the Office of Management and Budget.

Executive Order No. 13,132 (Federalism)

HHS's view is that this final rule does not impose substantial direct requirement costs on state and local governments, but that 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. Each state electing to establish a risk adjustment or reinsurance program or an Exchange must adopt the federal standards contained in the Affordable Care Act and in this final rule, or have in effect a state law or regulation that implements these federal standards. However, HHS states that it anticipates that the federalism implications (if any) are substantially mitigated because under the statute, states have choices regarding the structure and governance of these programs. Additionally, the Affordable Care Act does not require states to establish these programs; if a state elects not to establish these programs (or the state's risk adjustment program or Exchange is not approved), HHS must establish and operate these programs in that state.

HHS asserts that in compliance with the requirement of Executive Order 13,132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the states, 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.

Throughout the process of developing this final rule, HHS says that it has attempted to balance the states' interests in regulating health insurance issuers, and Congress's intent to provide access to Affordable Insurance Exchanges for consumers in every state. By doing so, it is HHS's view that it has complied with the requirements of Executive Order 13,132.