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B-325654

March 25, 2014

The Honorable Ron Wyden
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 2015*

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 2015" (RIN: 0938-AR89). We received the rule on March 11, 2014. It was published in the *Federal Register* as a final rule on March 11, 2014, with an effective date of May 12, 2014. 79 Fed. Reg. 13,744.

The final rule sets forth payment parameters and oversight provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost sharing parameters and cost-sharing reductions; and user fees for federally-facilitated exchanges. It also provides additional standards with respect to composite premiums, privacy and security of personally identifiable information, the annual open enrollment period for 2015, the actuarial value calculator, the annual limitation in cost sharing for stand-alone dental plans, the meaningful difference standard for qualified health plans offered through a federally-facilitated exchange, patient safety standards for issuers of qualified health plans, and the Small Business Health Options Program.

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

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 2015"
(RIN: 0938-AR89)

(i) Cost-benefit analysis

The Department of Health and Human Services (HHS) analyzed the costs and benefits of this final rule. The qualitative benefits of this rule identified by HHS are (1) increased enrollment in the individual market 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; (2) a common marketing standard covering the entire insurance market, reducing adverse selection and increasing competition; (3) robust oversight of programs that use federal funds to ensure proper use of taxpayer dollars; (4) access to higher quality health care through the establishment of patient safety standards; and (5) increasing coverage options for small employers and part-time employees while mitigating the effect of adverse selection.

The quantitative costs of this rule identified by HHS are costs incurred by issuers and contributing entities to comply with provisions in this rule and costs incurred by states for complying with audits of state-operated reinsurance programs. HHS estimates that the annual monetized costs in 2014 dollars for 2014 to 2017 to be \$2.35 million at both a 7 percent and a 3 percent discount rate. Additionally, HHS estimates that this rule will result in annual monetized transfers of between -\$16.76 million and -\$17.25 million from contributing entities and health insurance issuers to the federal government.

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

For purposes of the RFA, HHS expects health insurance issuers, group health plans, and reinsurance entities to be affected by this rule. HHS believes that health insurance companies offering comprehensive health insurance policies generally exceed the size thresholds for small entities. In contrast, this final rule also establishes requirements for employers that choose to participate in a Small Business Health Options Program (SHOP) Exchange. HHS expects that many employers who would be affected by the rule will be small entities. HHS does not believe that the provisions in this final rule impose requirements on employers offering health insurance through SHOP that are more restrictive than the current requirements on small employers offering employer-sponsored insurance. Additionally, HHS believes the policy will provide greater choice for both employees and employers. HHS believes the processes that it established constitute the minimum requirements necessary to implement the SHOP program and accomplish its policy goals, and that no appropriate regulatory alternatives could be developed to further lessen the compliance burden. HHS also believes that a substantial number of sponsors of self-insured group health plans could qualify as small entities. This rule provides HHS with the authority to audit these entities. However, HHS does not believe that the burden of these audits is likely to reflect more than 3 to 5 percent of such an entity's revenues.

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

The Act requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a final rule that includes any federal mandate that may result in expenditures in any one year by a state, local, or tribal governments, in the aggregate, or by the private sector, of \$100 million (\$141 million adjusted for inflation). Although HHS was not able to quantify the user fees that will be associated with this final rule, it did determine that the combined administrative cost and user fee impact on state, local, or tribal governments and the private sector may be above the Act's threshold. HHS stated that its Regulatory Impact Analysis, as summarized above, constitutes its actions taken to comply with the Act.

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

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

On December 2, 2013, HHS published a proposed rule. 78 Fed. Reg. 72,322. HHS received 129 comments from various stakeholders, including states, health insurance issuers, consumer groups, labor entities, industry groups, provider groups, patient safety groups, national interest groups, and other stakeholders, to which it responded in the final rule. In addition, on June 19, 2013, HHS published a different proposed rule. 78 Fed. Reg. 37,032. HHS received 99 comments on this proposed rule from various stakeholders, including states, health insurance issuers, consumer groups, agents and brokers, provider groups, Members of Congress, individuals, tribal organizations, and other stakeholders. In this final rule, HHS is finalizing the provisions of the June 2013 proposed rule related to standards for SHOP to require all qualified health plan issuers to make any change to rates at a uniform time.

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

HHS determined that this final rule contains information collection requirements under the Act. According to HHS, eight regulation sections from this final rule contain information collection requirements with a total of 3,245 unique respondents. HHS estimates that the total cost of these information reporting requirements to be \$2,346,099. HHS has submitted these requirements to the Office of Management and Budget (OMB) for review.

Statutory authorization for the rule

HHS promulgated this final rule under the authority of sections 2701 through 2763, 2791, and 2792 of the Public Health Service Act and sections 1301 through 1304, 1311, 1312, 1321, 1322, 1324, 1331, 1332, 1334, 1342, 1343, 1401, 1402, 1412, and 1413 of the Affordable Care Act, as amended. 42 U.S.C. §§ 300gg-300gg-63, 300gg-91, 300gg-92, 18021-18024, 18031-18033, 18041-18042, 18044, 18051, 18054, 18061, 18063, 18071, 18081-18083; 26 U.S.C. § 36B; 31 U.S.C. § 9701.

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

OMB determined that this is an economically significant rule under the Order because it is likely to have an annual effect of \$100 million in any one year.

Executive Order No. 13,132 (Federalism)

In HHS's view, while this final rule does not impose substantial direct requirement costs on state or local governments, this rule does have federalism implications due to direct effects on the distribution of power and responsibilities among the state and federal governments. These effects relate to determining standards relating to health insurance that is offered in the individual and small group markets.

Each state electing to establish an exchange must adopt the federal standards contained in the Affordable Care Act and this final rule, or have in effect a state law or regulation that implements these federal standards. However, HHS anticipates that the federalism implications (if any) are substantially mitigated because under the statute, states have choices regarding the structure and governance of their exchanges and risk adjustment and reinsurance programs. Additionally, the Affordable Care Act does not require states to establish these programs; if a state elects not to establish any of these programs or is not approved to do so, HHS must establish and operate the programs in that state.

In compliance with the Order, HHS 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. HHS noted that throughout the process of developing this final rule, it attempted to balance the states' interests in regulating health insurance issuers, and Congress' intent to provide access to Affordable Insurance Exchanges for consumers in every state. By taking these actions, HHS's concluded that it complied with the requirements of the Order.