



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

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March 23, 2016

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

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

The Honorable Kevin Brady
Chairman
The Honorable Sander M. Levin
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 2017*

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 2017" (RIN: 0938-AS57). We received the rule on March 7, 2016. It was published in the *Federal Register* as a final rule on March 8, 2016. 81 Fed. Reg. 12,204.

This final rule sets forth payment parameters and 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 amendments regarding the annual open enrollment period for the individual market for the 2017 and 2018 benefit years; essential health benefits; cost sharing; qualified health plans; exchange consumer assistance programs; network adequacy; patient safety; the Small Business Health Options Program; stand-alone dental plans; third-party payments to qualified health plans; the definitions of large employer and small employer; fair health insurance premiums; student health insurance coverage; the rate review program; the medical loss ratio program; eligibility and enrollment; exemptions and appeals; 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 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: 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 2017"
(RIN: 0938-AS57)

(i) Cost-benefit analysis

The Department of Health and Human Services (HHS) analyzed the costs and benefits of this final rule. HHS identified four qualitative benefits of this rule: (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) continuous quality improvement among qualified health plan (QHP) issuers to reduce patient harm and improve health outcomes at lower costs; (3) more informed Exchange QHP certification decisions; and (4) increased coverage options for small businesses and employees with minimal adverse selection. HHS estimates the annualized monetized costs to be \$11.67 million per year for 2016 through 2020. Costs reflect administrative costs incurred by issuers and states to comply with provisions in this rule. HHS also estimated annualized monetized transfers of \$25.86 million per year over the same timeframe. Transfers reflect a decrease in annual cost of risk adjustment user fees (the total risk adjustment user fee amount for 2016 was \$50 million and \$24 million for 2017 according to HHS), which are transfers from health insurance issuers to the federal government. HHS's estimation of transfers also reflect an increase of \$30 million in 2017 and \$65 million in future years, in the amount of user fees collected from state-based exchanges that use the federal platform for eligibility and enrollment which are transfers from issuers to the federal government. HHS also estimated that for the risk adjustment, reinsurance, and risk corridors program, total outlays by the federal government will be \$80 billion and collections will be \$78 billion from 2016 to 2020.

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

HHS determined that a regulatory flexibility analysis is not required for insurance firms offering comprehensive health insurance policies. HHS also determined that this rule will not affect a substantial number of small health insurance issuers or group health plans. However, HHS further noted that this rule imposes requirements, including information collection requirements, on Navigators, non-Navigator assistance personnel, and certified application counselor organizations. HHS believes that the effects on such small employers participating are difficult to quantify, but will not result in substantial additional burden, since they will simply permit certain small employers greater choice in the qualified health plans they may make available. HHS's estimated burden for Navigators, non-Navigator assistance personnel, and certified application counselor organizations is in the final rule.

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

HHS determined that, although it has not been able to quantify all costs, the combined administrative cost and user fee impact on state, local, or tribal governments and the private sector may be above the Act threshold (\$144 million after adjusting for inflation).

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

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

On December 2, 2015, HHS published a proposed rule. 80 Fed. Reg. 75,487. It received 524 comments, including 112 substantially similar letters, regarding its solicitation for comment on whether the substance use disorder requirement in essential health benefits needs additional clarification regarding medication-assisted treatment for opioid addiction. Comments were received from the National Association of Insurance Commissioners, state departments of insurance, state exchanges, a Member of Congress, health insurance issuers, providers, consumer groups, labor entities, industry groups, patient safety groups, national interest groups, and other stakeholders. In this final rule, HHS provided a summary of each proposed provision, a summary of those public comments received that directly related to proposals, its responses to them, and a description of the provisions it is finalizing.

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

HHS determined that this final rule contains information collection requirements under the Act. HHS identified eight provisions of the rule that have a total annual burden of 86,769 hours and a total annual cost of \$11,506,243. These requirements have Office of Management and Budget (OMB) Control Numbers 0938-1157, 0938-1164, 0938-1172, 0938-NEW, and 0938-1249.

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. 42 U.S.C. §§ 300gg through 300gg-63, 300gg-91, 300gg-92.

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

HHS determined that this final rule is economically significant 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)

HHS determined that this final rule 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. To comply with the Order, HHS 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 (NAIC), and consulting with state insurance officials on an individual basis. Following review of comments from state insurance officials and the NAIC, HHS made changes to its network adequacy policies in this final rule. HHS stated that throughout the process of developing the proposed and 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.