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DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 153

[CMS-9920-F]

RIN 0938-AT65

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

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This 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 is issuing this final rule to allow charges to be collected and payments to be made for the 2017 benefit year. We hereby adopt 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.

DATES: These provisions of this final rule are effective on [Insert date of publication in the **Federal Register**].

FOR FURTHER INFORMATION CONTACT:

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SUPPLEMENTARY INFORMATION:

I. Background

A. Legislative and Regulatory Overview

The Patient Protection and Affordable Care Act (Pub. L. 111–148), was enacted on March 23, 2010; the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) was enacted on March 30, 2010. These statutes are collectively referred to as “PPACA” in this final rule. Section 1343 of the PPACA established an annual permanent risk adjustment program under which payments are collected from health insurance issuers that enroll relatively low-risk populations, and payments are made to health insurance issuers that enroll relatively higher-risk populations. Consistent with section 1321(c)(1) of the PPACA, the Secretary is responsible for operating the risk adjustment program on behalf of any state that elected not to do so. For the 2017 benefit year, HHS is responsible for operation of the risk adjustment program in all 50 states and the District of Columbia.

HHS sets the risk adjustment methodology that it uses in states that elect not to operate the program in advance of each benefit year through a notice-and-comment rulemaking process with the intention that issuers will be able to rely on the methodology to price their plans appropriately (45 CFR 153.320; 76 FR 41930, 41932 through 41933; 81 FR 94058, 94702 (explaining the importance of setting rules ahead of time and describing comments supporting that practice)).

In the July 15, 2011 **Federal Register** (76 FR 41929), we published a proposed rule outlining the framework for the risk adjustment program. We implemented the risk adjustment program in a final rule, published in the March 23, 2012 **Federal Register** (77 FR 17219) (Premium Stabilization Rule). In the December 7, 2012 **Federal Register** (77 FR 73117), we published a proposed rule outlining the proposed Federally certified risk adjustment methodologies for the 2014 benefit year and other parameters related to the risk adjustment

program (proposed 2014 Payment Notice). We published the 2014 Payment Notice final rule in the March 11, 2013 **Federal Register** (78 FR 15409). In the June 19, 2013 **Federal Register** (78 FR 37032), we proposed a modification to the HHS-operated methodology related to community rating states. In the October 30, 2013, **Federal Register** (78 FR 65046), we finalized the proposed modification to the HHS-operated methodology related to community rating states. We published a correcting amendment to the 2014 Payment Notice final rule in the November 6, 2013 **Federal Register** (78 FR 66653) to address how an enrollee's age for the risk score calculation would be determined under the HHS-operated risk adjustment methodology.

In the December 2, 2013 **Federal Register** (78 FR 72321), we published a proposed rule outlining the Federally certified risk adjustment methodologies for the 2015 benefit year and other parameters related to the risk adjustment program (proposed 2015 Payment Notice). We published the 2015 Payment Notice final rule in the March 11, 2014 **Federal Register** (79 FR 13743). In the May 27, 2014 **Federal Register** (79 FR 30240), the 2015 fiscal year sequestration rate for the risk adjustment program was announced.

In the November 26, 2014 **Federal Register** (79 FR 70673), we published a proposed rule outlining the proposed Federally certified risk adjustment methodologies for the 2016 benefit year and other parameters related to the risk adjustment program (proposed 2016 Payment Notice). We published the 2016 Payment Notice final rule in the February 27, 2015 **Federal Register** (80 FR 10749).

In the December 2, 2015 **Federal Register** (80 FR 75487), we published a proposed rule outlining the Federally certified risk adjustment methodology for the 2017 benefit year and other parameters related to the risk adjustment program (proposed 2017 Payment Notice). We

published the 2017 Payment Notice final rule in the March 8, 2016 **Federal Register** (81 FR 12204).

In the September 6, 2016 **Federal Register** (81 FR 61455), we published a proposed rule outlining the Federally certified risk adjustment methodology for the 2018 benefit year and other parameters related to the risk adjustment program (proposed 2018 Payment Notice). We published the 2018 Payment Notice final rule in the December 22, 2016 **Federal Register** (81 FR 94058).

In the November 2, 2017 **Federal Register** (82 FR 51042), we published a proposed rule outlining the benefit and payment parameters for the 2019 benefit year, and to further promote stable premiums in the individual and small group markets. We proposed updates to the risk adjustment methodology and amendments to the risk adjustment data validation process (proposed 2019 Payment Notice). We published the 2019 Payment Notice final rule in the April 17, 2018 **Federal Register** (83 FR 16930). We published a correction to the 2019 risk adjustment coefficients in the 2019 Payment Notice final rule in the May 11, 2018 **Federal Register** (83 FR 21925).

B. The New Mexico Health Connections Court's Order

On February 28, 2018, in a suit brought by the health insurance issuer New Mexico Health Connections, the United States District Court for the District of New Mexico (the district court) vacated the use of statewide average premium in the HHS-operated risk adjustment methodology for the 2014, 2015, 2016, 2017, and 2018 benefit years. The district court reasoned that HHS had not adequately explained its decision to adopt a methodology that used the statewide average premium as the cost-scaling factor to ensure that amounts collected from issuers equal payments made to issuers for the applicable benefit year, that is, a methodology

that maintains the budget neutrality of the program for the applicable benefit year.¹ The district court otherwise rejected New Mexico Health Connections' arguments. HHS's reconsideration motion remains pending with the district court.

HHS recently announced the collection and payment amounts for the 2017 benefit year as calculated under the HHS-operated risk adjustment methodology that uses the statewide average premium.² However, without this administrative action (that is, issuing this final rule), HHS would be unable to make those collections or distribute the payments for the 2017 benefit year, which total billions of dollars.³ Uncertainty and delay in the distribution of those payments, which issuers anticipated when they set premiums for the 2017 benefit year, could add uncertainty to the market, as issuers are now in the process of determining the extent of their market participation and the rates and terms of plans they will offer for the 2019 benefit year.

II. Provisions of the Final Rule

This final rule adopts the HHS-operated risk adjustment methodology previously published at 81 FR 12204 for the 2017 benefit year with an additional explanation regarding the use of statewide average premium and the budget neutral nature of the program. This rule does not make any changes to the previously published HHS-operated risk adjustment methodology for the 2017 benefit year.

¹ *New Mexico Health Connections v. United States Department of Health and Human Services et al.*, No. CIV 16-0878 JB/JHR (D.N.M. 2018).

² See, *Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year*, available at <https://downloads.cms.gov/cciiio/Summary-Report-Risk-Adjustment-2017.pdf>.

³ See, July 7, 2018 *United States District Court Ruling Puts Risk Adjustment On Hold*, available at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-07-07.html> and the July 9, 2018, *Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year* <https://downloads.cms.gov/cciiio/Summary-Report-Risk-Adjustment-2017.pdf>. Also see the CMS Memo: *Implications of the Decision by United States District Court for the District of New Mexico on the Risk Adjustment and Related Programs* (July 12, 2018), available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Implications-of-the-Decision-by-United-States-District-Court-for-the-District-of-New-Mexico-on-the-Risk-Adjustment-and-Related-Programs.pdf>.

The risk adjustment program provides payments to health insurance issuers that enroll higher risk populations, such as those with chronic conditions, thereby reducing incentives for issuers to structure their plan benefit designs or marketing strategies in order to avoid these enrollees and lessening the potential influence of risk selection on the premiums that issuers charge. Instead, issuers are expected to set rates based on average risk and compete based on plan features rather than selection of healthier enrollees. The program applies to any health insurance issuer offering plans in the individual or small group markets, with the exception of grandfathered health plans, group health insurance coverage described in 45 CFR 146.145(c), individual health insurance coverage described in 45 CFR 148.220, and any plan determined not to be a risk adjustment covered plan in the applicable Federally certified risk adjustment methodology.⁴ In 45 CFR part 153, subparts A, B, D, G, and H, HHS established standards for the administration of the permanent risk adjustment program. In accordance with §153.320, any risk adjustment methodology used by a state, or by HHS on behalf of the state, must be a Federally certified risk adjustment methodology.

As stated in the 2014 Payment Notice final rule, the Federally certified risk adjustment methodology developed and used by HHS in states that elect not to operate the program is based on the premise that premiums for this market should reflect the differences in plan benefits, quality, and efficiency – not the health status of the enrolled population.⁵ HHS developed the risk adjustment payment transfer formula that calculates the difference between the revenues required by a plan based on the projected health risk of the plan’s enrollees and the revenues that a plan can generate for those enrollees. These differences are then compared across plans in the state market risk pool and converted to a dollar amount based on the statewide average premium. HHS

⁴ See the definition for “risk adjustment covered plan” at 45 CFR 153.20.

⁵ See 78 FR 15409 at 15417.

chose to use statewide average premium and normalize the risk adjustment transfer formula to reflect state average factors so that each plan's enrollment characteristics are compared to the state average and the total calculated payment amounts equal total calculated charges in each state market risk pool. Thus, each plan in the risk pool receives a risk adjustment payment or charge designed to compensate for risk for a plan with average risk in a budget neutral manner. 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. Such incentives could arise if HHS used each issuer's plan's own premium in the risk adjustment payment transfer formula, instead of statewide average premium.

As explained above, the district court vacated the use of statewide average premium in the HHS-operated risk adjustment methodology for the 2014 through 2018 benefit years on the ground that HHS did not adequately explain its decision to adopt that aspect of the risk adjustment methodology. The district court recognized that use of statewide average premium maintained the budget neutrality of the program, but concluded that HHS had not adequately explained the underlying decision to adopt a methodology that kept the program budget neutral, that is, that ensured that amounts collected from issuers would equal payments made to issuers for the applicable benefit year. Accordingly, HHS is providing additional explanation herein.

First, Congress designed the risk adjustment program to be implemented and operated by states if they choose to do so. Nothing in section 1343 of the PPACA requires a state to spend its own funds on risk adjustment payments or allows HHS to impose such a requirement. Thus, while section 1343 may have provided leeway for states to spend additional funding on the

program if they voluntarily chose to do so, HHS could not have required additional funding within the HHS-operated risk adjustment methodology.

Second, while the PPACA did not include an explicit requirement that the risk adjustment program be operated in a budget-neutral manner, it also does not proscribe designing the program in a budget-neutral manner. In fact, although the statutory provisions for many other PPACA programs appropriated or authorized amounts to be appropriated from the U.S. Treasury, or provided budget authority in advance of appropriations,⁶ the PPACA neither authorized nor appropriated additional funding for risk adjustment payments beyond the amount of charges paid in, nor authorized HHS to obligate itself for risk adjustment payments in excess of charges collected.⁷ Indeed, unlike the Medicare Part D statute, which expressly authorizes the appropriation of funds and provides budget authority in advance of appropriations to make Part D risk-adjusted payments, the PPACA's risk adjustment statute makes no reference to additional appropriations whatsoever.⁸ Because Congress omitted from the PPACA any provision appropriating independent funding or creating budget authority in advance of an appropriation for the risk adjustment program, HHS could not – absent another source of appropriations – have designed the risk adjustment program in a way that required payments in excess of collections consistent with binding appropriations law. Thus, as a practical matter, Congress did not give HHS discretion to implement a program that was not budget neutral.

⁶ For examples of PPACA provisions appropriating funds, *see* PPACA secs. 1101(g)(1), 1311(a)(1), 1322(g), 1323(c). For examples of PPACA provisions authorizing the appropriation of funds, *see* PPACA secs. 1002, 2705(f), 2706(e), 3013(c), 3015, 3504(b), 3505(a)(5), 3505(b), 3506, 3509(a)(1), 3509(b), 3509(e), 3509(f), 3509(g), 3511, 4003(a), 4003(b), 4004(j), 4101(b), 4102(a), 4102(c), 4102(d)(1)(C), 4102(d)(4), 4201(f), 4202(a)(5), 4204(b), 4206, 4302(a), 4304, 4305(a), 4305(c), 5101(h), 5102(e), 5103(a)(3), 5203, 5204, 5206(b), 5207, 5208(b), 5210, 5301, 5302, 5303, 5304, 5305(a), 5306(a), 5307(a), 5309(b).

⁷ *See* 42 U.S.C. 18063.

⁸ *Compare* 42 U.S.C. 18063 (failing to specify source of funding other than risk adjustment charges), *with* 42 U.S.C. 1395w-116(c)(3) (authorizing appropriations for Medicare Part D risk adjusted payments); 42 U.S.C. 1395w-115(a) (establishing “budget authority in advance of appropriations Acts” for risk adjusted payments under Medicare Part D).

Furthermore, if HHS had elected to adopt a HHS-operated risk adjustment methodology that was contingent on appropriations from Congress in the annual appropriations process that would have created uncertainty for issuers in the amount of risk adjustment payments they could expect. That uncertainty would undermine one of the central objectives of the risk adjustment program, which is to assure issuers in advance that they will receive risk adjustment payments if, for the applicable benefit year, they enroll a high risk population compared to other issuers in the state market risk pool. The budget-neutral framework spreads the costs of covering higher-risk enrollees across issuers throughout a given state market risk pool, thereby reducing incentives for issuers to engage in risk-avoidance techniques such as designing or marketing their plans in ways that tend to attract healthier individuals, who cost less to insure. Moreover, relying on the possibility in each year's budget process for appropriation of additional funds to HHS that could be used to supplement risk adjustment transfers would have required HHS to delay setting the parameters for any risk adjustment payment proration rates until well after the plans were in effect for the applicable benefit year.⁹ Without the adoption of a budget-neutral framework, HHS would have needed to assess a charge or otherwise collect additional funds, or prorate risk adjustment payments to balance the calculated risk adjustment transfer amounts. The resulting uncertainty would have conflicted with one of the overall goals of the risk adjustment program – to reduce incentives for issuers to avoid enrolling individuals with higher than average actuarial risk.

⁹ It has been suggested that the annual lump sum appropriation to CMS for program management was potentially available for risk adjustment payments. The lump sum appropriation for each year was not enacted until after the applicable rule announcing the methodology to calculate payments for the applicable benefit year. Moreover, HHS does not believe that the lump sum is legally available for risk adjustment payments. As the underlying budget requests reflect, the lump sum is for program management expenses, such as administrative costs for various CMS programs such as Medicaid, Medicare, the Children's Health Insurance Program, and the PPACA's insurance market reforms – not for the program payments themselves. CMS would have elected to use the lump sum for these important program management expenses even if CMS had discretion to use all or part of the lump sum for risk adjustment payments.

In light of the budget-neutral framework discussed above, HHS also chose not to use a different parameter for the payment transfer formula under the HHS-operated methodology, such as each plan's own premium, that would not have automatically achieved equality between risk adjustment payments and charges in each benefit year. As set forth in prior discussions,¹⁰ use of the plan's own premium or some similar parameter would have required the application of a balancing adjustment in light of the program's budget neutrality – either reducing payments to issuers owed a payment, increasing charges on issuers due a charge, or splitting the difference in some fashion between issuers owed payments and issuers assessed charges. Such adjustments would have impaired the risk adjustment program's goals, discussed above, of encouraging issuers to rate for the average risk in the applicable risk pool and avoiding the creation of incentives for issuers to operate less efficiently, set higher prices, develop benefit designs or create marketing strategies to avoid higher-risk enrollees. Use of an after-the-fact balancing adjustment is also less predictable for issuers than a methodology that can be calculated in advance of a benefit year. Such predictability is important to serving the risk adjustment program's goals of premium stabilization and reducing issuer incentives to avoid enrolling higher-risk populations. Additionally, using a plan's own premium to scale transfers may provide additional incentive for plans with high-risk enrollees to increase premiums in order to receive additional risk adjustment payments. As noted by commenters to the 2014 Payment Notice proposed rule, transfers may be more volatile from year to year and sensitive to anomalous premiums if they were scaled to a plan's own premium instead of the statewide average premium. Scaling the risk adjustment transfers by the statewide average premium promotes

¹⁰ See, e.g., September 12, 2011, *Risk Adjustment Implementation Issues* White Paper, available at: https://www.cms.gov/CCIIO/Resources/Files/Downloads/riskadjustment_whitepaper_web.pdf.

premium stabilization by encouraging pricing to average risk in a risk pool, and results in a calculation of equal payments and charges.

In the risk adjustment methodologies applicable to the 2018 and 2019 benefit years, HHS has adjusted statewide average premium by reducing it by 14 percent to account for an estimated proportion of administrative costs that do not vary with claims. HHS is not applying this adjustment retroactively to the 2017 benefit year, but is instead maintaining the definition of statewide average premium previously established for the 2017 benefit year. As discussed above, HHS has repeatedly stressed the importance of providing a risk adjustment methodology in advance of the benefit year to which it applies to provide issuers the opportunity to price their plans accordingly.¹¹ To protect the settled expectations of issuers that have structured their pricing and offering decisions in reliance on the previously promulgated 2017 benefit year methodology, this rule maintains for the 2017 benefit year the description of statewide average premium set forth in the 2017 Payment Notice.

Therefore, for the 2017 benefit year, we are issuing this final rule that adopts the HHS-operated risk adjustment methodology previously established for the 2017 benefit year in the **Federal Register** publications cited above, including use of statewide average premium. As set forth in reports previously issued, HHS has completed final risk adjustment calculations for the 2017 benefit year, but has not yet collected or paid risk adjustment amounts to issuers of risk adjustment covered plans. The provisions of this final rule adopt the methodology that applies to collection and payment of risk adjustment amounts for the 2017 benefit year. Because this final rule does not alter any previously announced risk adjustment methodology, the amounts previously calculated by HHS have not changed by virtue of this rule's issuance.

¹¹ See 76 FR 41930, 41932–33. Also see 81 FR 94058, 94702.

HHS will begin collection of the 2017 benefit year risk adjustment charge amounts announced in the *Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year*¹² through netting pursuant to 45 CFR 156.1215(b) and subsequently issuing invoices if an amount remains outstanding in the September 2018 monthly payment cycle. HHS will begin making the 2017 benefit year risk adjustment payments outlined in the *Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year* as part of the October 2018 monthly payment cycle, continuing on a monthly basis as collections are received. Under this timeline, issuers would receive invoices on or about September 11-13, 2018 and payments would begin to be made around October 22, 2018.

III. Adoption of the Methodology for the HHS-operated Permanent Risk Adjustment Program under the Patient Protection and Affordable Care Act

This rule adopts the final rules set out in the publication in the March 23, 2012 **Federal Register** (77 FR 17220 through 17252) and publication in the March 8, 2016 **Federal Register** (81 FR 12204 through 12352). For the 2017 benefit year, in states where HHS is operating the risk adjustment program under section 1343 of the PPACA, HHS will use the criteria and methods as specified in the publication in the March 23, 2012 **Federal Register** (77 FR 17220 through 17252) and publication in the March 8, 2016 **Federal Register** (81 FR 12204 through 12352).

IV. Waiver of Proposed Rulemaking and Delay in Effective Date

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. We also ordinarily provide a 30-day delay in the effective date of the provisions of a

¹² <https://downloads.cms.gov/cciiio/Summary-Report-Risk-Adjustment-2017.pdf>.

rule in accordance with the 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. See 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. As discussed above, immediate administrative action is imperative to maintain the 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.¹³ 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

¹³ The risk adjustment methodology for those benefit years was published at the February 27, 2015 **Federal Register** (80 FR 10749) and the March 8, 2016 **Federal Register** (81 FR 12203).

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, 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. The combination of these effects could lead to significant, involuntary coverage losses in certain state market risk pools.

Additionally, HHS's 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 has 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.

There is also good cause to proceed without notice and comment for the additional reason that such procedures are unnecessary here. HHS has received and considered comments in issuing the 2014 through 2017 Payment Notices. In each of these rulemaking processes, 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 this 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, we received a number of comments in support of our 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 we had considered the use of a plan's own premium instead of the statewide average premium and chose to use statewide average premium. As 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.

V. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping, or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501, *et seq.*).

VI. Regulatory Impact Analysis

A. Statement of Need

This final rule adopts the HHS-operated risk adjustment methodology for the 2017 benefit year set forth in the 2017 Payment Notice final rule to ensure that the risk adjustment program works as intended to protect consumers from the effects of adverse selection and premium increases due to issuer uncertainty. The Premium Stabilization Rule and previous Payment Notices noted above provided detail on the implementation of the risk adjustment program, including the specific parameters applicable for the 2017 benefit year.

B. Overall Impact

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96– 354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs. Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any one year).

OMB has determined that this final rule is “economically significant” within the meaning of section 3(f)(1) of Executive Order 12866, because it is likely to have an annual effect of \$100

million in any 1 year. In addition, for the reasons noted above, OMB has determined that this is a major rule under the Congressional Review Act.

This final rule offers a further explanation on budget neutrality and the use of statewide average premium in the risk adjustment payment transfer formula when HHS is operating the permanent risk adjustment program established in section 1343 of the PPACA on behalf of a state for the 2017 benefit year. We note that we 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, we also adopt the RIA in the 2017 Payment Notice proposed and final rules.

Dated: July 23, 2018.

Seema Verma,

Administrator,

Centers for Medicare & Medicaid Services.

Dated: July 24, 2018.

Alex M. Azar II,

Secretary,

Department of Health and Human Services.