Supporting Statement – Enrollment Application for Coverage in the Pre-Existing Condition Insurance Plan

A. Justification

1. Circumstances Making the Collection of Information Necessary

The Department of Health and Human Services (HHS) is requesting a renewal of this package by the Office of Management and Budget (OMB). This enrollment application instrument originally received OMB approval on 6/29/2010. HHS is now seeking a three-year approval for this collection. On March 23, 2010, the President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (Affordable Care Act), Public Law 111-148. Section 1101 of the law establishes a "temporary high risk health insurance pool program" (which has been named the Pre-Existing Condition Insurance Plan, or PCIP) to provide health insurance coverage to currently uninsured individuals with pre-existing conditions. The law authorizes HHS to carry out the program directly or through contracts with states or private, non-profit entities.

In order for individuals to be considered for eligibility into the federally-run PCIP program, they must submit a completed enrollment application to HHS. The enrollment application is used by HHS or it's designee to obtain information from potentially eligible individuals applying for coverage in the PCIP program. PCIP is also referred to as the temporary qualified high risk insurance pool program, as it is called in the Affordable Care Act, but we have adopted the term PCIP to better describe the program and avoid confusion with the existing state high risk pool programs.

2. Purpose and Use of Information Collection

The data collection will be used by HHS to obtain information from potential eligible individuals applying for coverage in the PCIP.

An individual is deemed to be eligible for coverage in the PCIP if such individual:

- Is a citizen or national of the United States or is lawfully present in the United States;
- Has not been covered under creditable coverage (as defined in section 2701(c)(1) of the Public Health Service Act as in effect on the date of enactment of this Act) during the 6-month period prior to the date on which such individual is applying for coverage through the PCIP; and
- Has a pre-existing condition, as defined by the Secretary.

3. Use of Improved Information Technology and Burden Reduction

Information collected, including the enrollment application and proof of eligibility, may be

submitted via United States mail or electronically, at the consumers discretion. Information will be collected from individuals with varying access to electronic devices and therefore requiring all individuals to submit information electronically would restrict individuals from being able to apply for coverage in the PCIP.

4. Efforts to Identify Duplication and Use of Similar Information

Since this is a new program that was created through the Affordable Care Act, the information that will be collected has never been collected before by the Federal government.

5. Impact on Small Businesses or Other Small Entities

No impact on small business.

6. Consequences of Collecting the Information Less Frequent Collection

Information collected is a one-time data collection per individual.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

No special circumstance.

8. Comments in Response to the Federal Register Notice/Outside Consultation

No comments.

9. Explanation of any Payment/Gift to Respondents

Not applicable.

10. Assurance of Confidentiality Provided to Respondents

All information will be kept private to the extent allowed by application laws/regulations.

11. Justification for Sensitive Questions

On March 23, 2010, the President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (Affordable Care Act), Public Law 111-148. Section 1101 of the law establishes a "temporary high risk health insurance pool program" (which has been named the Pre-Existing Condition Insurance Plan) to provide health insurance coverage to currently uninsured individuals with pre-existing conditions. Under this section, individuals applying for coverage in the Pre-Existing Condition Insurance Plan must be "a citizen or national of the United States or lawfully present in the United States (as determined in accordance with section 1411)." Section 1411 of the law establishes that in order to verify citizenship or immigration status the enrollee's social security number shall be provided.

12. Estimates of Annualized Burden Hours (Total Hours & Wages)

In order to complete the application for coverage, each applicant will be asked to complete information about the person applying for coverage, information about the applicant's state of residence, information about the applicant's citizenship or immigration status, information about the applicant's medical condition or diagnosis, information about the applicant's other insurance coverage. The applicant will also be asked to sign an attestation. The completed application in addition to proof of eligibility will be submitted to HHS or it's designated entity. Coverage will not begin until (1) the completed application and all required documentation are received and approved and (2) the applicant is billed for the first month's premium and the payment is received and processed.

The enrollment projections below take into consideration individuals within all age brackets and individuals moving from one state to another. These enrollment projections also include individuals who may apply more than once for the program. Applicants may apply more than once to the program if, for example, they elected to disenroll or were disenrolled for nonpayment and choose to reapply after they satisfy another six-month period without creditable coverage. We estimate that it will take approximately 1 hour per applicant to submit a completed application, proof of eligibility, and initial premium payment, as broken down below.

We anticipate within the first six months of the program receiving two applications for every one successful enrollment based on our experience implementing prior health care services. As the program progresses beyond 2010, we anticipate receiving three applications for every two successful enrollments based on our experience with existing state high risk pool programs. The key reasons an applicant would not result in a successful enrollment are (1) the applicant does not satisfy the eligibility criteria and/or (2) the approved applicant fails to pay the premium to activate coverage. Furthermore, historical data in existing state high risk pools show that an enrollee will remain enrolled in the program an average of three years. Therefore we do not anticipate substantial churning since the program terminates January 1, 2014 upon transition to the American Health Benefit Exchanges, established under sections 1311 or 1321 of the Patient Protection and Affordable Care Act. Based on the above, it is estimated that up to 250,000 applicants will apply for coverage over the life of the program, 100,000 projected applicants in the first six months of the program and 50,000 per year thereafter.

12A. Estimated Annualized Burden Hours

Estimated Annualized Burden Table for 2010

Forms (If necessary)	**Type of Respondent**	**Number of Respondents**	**Number of Responses per Respondent**	**Average Burden hours per Response**	**Total Burden Hours**
Application	Individual	100,000	1	.34	34,000
Eligibility	Individual	100,000	1	.5	50,000

Information					
Premium Payment	Individual	50,000	1	.16	8,000
Total				1	92,000

Estimated Annualized Burden Table for 2011

Forms (If necessary)	**Type of Respondent**	**Number of Respondents**	**Number of Responses per Respondent**	**Average Burden hours per Response**	**Total Burden Hours**
Application	Individual	50,000	1	.34	17,000
Eligibility Information	Individual	50,000	1	.5	25,000
Premium Payment	Individual	33,333	1	.16	5,333
Total				1	47,333

Estimated Annualized Burden Table for 2012

Forms (If necessary)	**Type of Respondent**	**Number of Respondents**	**Number of Responses per Respondent**	**Average Burden hours per Response**	**Total Burden Hours**
Application	Individual	50,000	1	.34	17,000
Eligibility Information	Individual	50,000	1	.5	25,000
Premium Payment	Individual	33,333	1	.16	5,333
Total				1	47,333

Estimated Annualized Burden Table for 2013

Forms (If necessary)	**Type of Respondent**	**Number of Respondents**	**Number of Responses per Respondent**	**Average Burden hours per Response**	**Total Burden Hours**
Application	Individual	50,000	1	.34	17,000
Eligibility Information	Individual	50,000	1	.5	25,000
Premium Payment	Individual	33,333	1	.16	5,333
Total				1	47,333

12B. Cost Estimate for All Respondents Completing the Letter of Intent and Contact Information

We have calculated the estimated burden hours associated with complying with this information collection request. However, we do not believe respondents will incur any cost burden beyond that associated with mailing the application.

Enrollment Application Process
In order to complete the enrollment application, each applicant will need to read the application, fill out the required information in the application, and submit the application with supporting documentation to HHS or it's designee. This burden estimate encompasses the entire process of filling out the application which includes completing information about the person applying for coverage, information about the applicants state of residence, information about the applicants citizenship or immigration status, information about the applicants medical condition or diagnosis, information about the applicants other insurance coverage, and signing the application. The completed application must be submitted to HHS or it's designee, by United States mail or an online enrollment application, in accordance with directions furnished in the application.

We estimate that it will take approximately 20 minutes per applicant to read, complete and submit their completed application to HHS or it's designee.

It is estimated that up to 250,000 respondents will submit an application.

Enrollment Eligibility Information
When applying for coverage, an applicant must demonstrate that he or she is a citizen or lawfully present in the United States and has a pre-existing condition. This burden estimate includes the process for verifying both.

To confirm an applicant is a citizen or lawfully present, the applicant must provide:

- his/her social security number in the case of a U.S. citizen, or
- a copy of acceptable documentation demonstrating U.S. national status or lawful presence.

To confirm an applicant is medically eligible, the applicant must provide:

- a letter of rejection from an insurance company or agent or broker in the State of residence that is dated within the past 6 months, or
- an offer of coverage from an insurance company in the State of residence that is dated within the past 6 months that has a rider that excludes coverage for the applicant's medical condition, or
- (for children who are under 19 years of age or for a person who lives in Massachusetts or Vermont) an offer of coverage from an insurance company for individual insurance coverage in their State of residence that is dated within the past 6 months where the premium for the coverage is at least twice as much as the PCIP premium for their State.

This burden estimate includes obtaining such information to demonstrate eligibility and submitting to HHS or it's designee, by United States mail or online enrollment application in accordance with directions furnished in the application.

We estimate that it will take approximately 30 minutes per applicant to obtain, review, copy and submit the above proof(s) of eligibility.

It is estimated that up to 250,000 respondents will submit proof of eligibility.

Premium Payment
Once a completed application and proof of eligibility has been received and approved, the eligible individual will be billed for the first month's premium and coverage will be activated once payment is received and processed. This burden estimate includes execution of payment such as writing a check, obtaining a money order , or providing EFT information and any associated burden if the eligible individual submits such remittance via United States mail.

We estimate that it will take approximately 10 minutes per applicant to obtain, complete, and submit the initial payment to activate the insurance coverage.

It is estimated that up to 150,000 respondents will submit a premium payment activating coverage.

13. Estimates of other Total Annual Cost Burden to Respondents or Record Keepers /Capital Costs

There are no additional record keeping/capital costs.

14. Annualized Cost to Federal Government

This is the cost to government to review the program.

Type Federal employee support	**Total Burden Hours**	**Hourly Wage Rate (GS 7 equivalent)**	**Total Federal Government Costs**
First level reviewer	1	$20.22	$20.22
Total	1		$20.22

Salaries are based on a 7 Grade/Step 1 in Washington DC area.

15. Explanation for Program Changes or Adjustments

There are no changes to the burden.

16. Plans for Tabulation and Publication and Project Time Schedule

Data collection began July 1, 2010 and will be collected daily, until January 1, 2014 when the program terminates upon transition to the American Health Benefit Exchanges, established under sections 1311 or 1321 of the Patient Protection and Affordable Care Act.

17. Reason(s) Display of OMB Expiration Date is Inappropriate

Not applicable.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

B. Collection of Information Employing Statistical Methods

Not applicable. The information collection does not employ statistical methods.