

# **Supporting Statement – 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 emergency action for this clearance by the Office of Management and Budget no later than June 18, 2010. We are requesting emergency processing procedures for this application because the application needs to be available online and in hard copy by July 1, 2010, to assure eligible individuals may timely and effectively apply for coverage in the Pre-Existing Condition Insurance Plan (PCIP). Thus, both printing and programming need to be carried out by July 1, 2010.

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.

### **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 fax, 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.

**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**

Due to the emergency nature of the program announce OMB has waived the Federal Register notice requirements for this collection.

**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**

No sensitive information will be collected.

**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. 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.

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 enrollment criteria and/or (2) the applicant fails to pay the premium to activate enrollment. 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. 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

<b>Forms (If necessary)</b>	<b>Type of Respondent</b>	<b>Number of Respondents</b>	<b>Number of Responses per Respondent</b>	<b>Average Burden hours per Response</b>	<b>Total Burden Hours</b>
Application	Individual	100,000	1	.34	34,000
Eligibility Information	Individual	100,000	1	.5	50,000
Premium Payment	Individual	50,000	1	.16	8,000
<b>Total</b>				<b>1</b>	<b>92,000</b>

Estimated Annualized Burden Table for 2011

<b>Forms (If necessary)</b>	<b>Type of Respondent</b>	<b>Number of Respondents</b>	<b>Number of Responses per Respondent</b>	<b>Average Burden hours per Response</b>	<b>Total Burden Hours</b>
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
<b>Total</b>				<b>1</b>	<b>47,333</b>

Estimated Annualized Burden Table for 2012

<b>Forms (If necessary)</b>	<b>Type of Respondent</b>	<b>Number of Respondents</b>	<b>Number of Responses per Respondent</b>	<b>Average Burden hours per Response</b>	<b>Total Burden Hours</b>
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

<b>Forms (If necessary)</b>	<b>Type of Respondent</b>	<b>Number of Respondents</b>	<b>Number of Responses per Respondent</b>	<b>Average Burden hours per Response</b>	<b>Total Burden Hours</b>
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 the respondents will incur any cost burden above that associated with mailing the application.

**Application Process**

In order to complete the application, each applicant will need to read the application, fill out the required information in the application, and submit the application to HHS. 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 an attestation. The completed application must be submitted to HHS, either by fax, United States mail or electronically, 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.

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

### **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.

In recognition of the absence of carriers issuing child-only policies in the individual market, we have added an additional option by which a child may now qualify for the federally-administered PCIP on the basis of having a condition that was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date, provided that he or she is a U.S. citizen or national or otherwise lawfully present in the U.S. and has been without creditable coverage for at least 6 months. This will not impact our current burden estimates for completing a PCIP enrollment application because we are not requiring additional proof but instead are providing an additional option by which someone under age 19 may prove a pre-existing condition. Additionally, the current burden estimate calculates an individual's time to comply with only one of the current three options to prove eligibility. This change will not alter that estimate but instead will simply give an applicant under the age of 19 one of four options to prove eligibility.

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

- his/her social security number, or
- a copy of acceptable documentation demonstrating lawful presence.

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

- a letter of rejection from an insurance company in the State of residence that is dated within the past 12 months, or
- an offer of coverage from an insurance company in the State of residence that is dated within the past 12 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 Maine, Massachusetts, New Jersey, New York 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 12 months where, because of the applicant's medical condition, the premium for the coverage is at least twice as much as the PCIP premium for their State.
- (applicable for a child under age 19) a document dated within the past 12 months from a physician, physician assistant, or nurse practitioner who is licensed in their state that says the applicant used to have or presently has a condition. (Applicant must provide a copy of a document dated within the past 12 months that includes their condition, their name, the name, license number, and signature of a physician, physician assistant, or nurse practitioner licensed in their state.)

This burden estimate includes obtaining such information to demonstrate eligibility and submitting to HHS, either by fax, United States mail or electronically, 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 or obtaining a money order 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**

This is a new data collection.

In recognition of the absence of carriers issuing child-only policies in the individual market, we have added an additional option by which a child may now qualify for the federally-

administered PCIP on the basis of having a condition that was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date, provided that he or she is a U.S. citizen or national or otherwise lawfully present in the U.S. and has been without creditable coverage for at least 6 months. This will not impact our current burden estimates for completing a PCIP enrollment application because we are not requiring additional proof but instead are providing an additional option by which someone under age 19 may prove a pre-existing condition. Additionally, the current burden estimate calculates an individual's time to comply with only one of the current three options to prove eligibility. This change will not alter that estimate but instead will simply give an applicant under the age of 19 one of four options to prove eligibility.

**16. Plans for Tabulation and Publication and Project Time Schedule**

Data collection which will begin as soon as clearance is received 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.