Supporting Statement for Paperwork Reduction Act Submission

Rate Increase Disclosure and Review Requirements (45 CFR Part 154)

A. Background

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010; the Health Care and Education Reconciliation Act (Pub. L. 111–152) was enacted on March 30, 2010. In this statement, we refer to the two statutes collectively as the Affordable Care Act. The Affordable Care Act reorganizes, amends, and adds to the provisions of Part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets.

Section 1003 of the Affordable Care Act adds a new section 2794 of the PHS Act which directs the Secretary of the Department of Health and Human Services (the Secretary), in conjunction with the States, to establish a process for the annual review of "unreasonable increases in premiums for health insurance coverage." The statute provides that this process shall require health insurance issuers to submit to the Secretary and the applicable State justifications for unreasonable premium increases prior to the implementation of the increases.

B. Justification

1. Need and Legal Basis

On December 23, 2010, CMS published a proposed rule entitled "Rate Increase Disclosure and Review. CMS reviewed the comments received on the proposed rule (75 FR 81004; RIN 0950-AA03) and subsequently published the final rate review rule on May 23, 2011 (76 FR 29964; RIN 0938-AQ68). The final rate review rule took effect on September 1, 2011.

On September 6, 2011, CMS published an amendment to the Rate Increase Disclosure and Review Regulation (45 CFR Part 154). The amendment changes the definition of individual and small group markets as follows:

> *Individual market* has the meaning given the term under the applicable State's rate filing laws, except that:
> (1) Where State law does not define the term, it has the meaning given in section 2791(e)(1)(A) of the PHS Act; and
> (2) Coverage that would be regulated as individual market coverage (as defined in section 2791(e)(1)(A)) if it were not sold through an association is subject to rate review as individual market coverage.
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> *Small group market* has the meaning given under the applicable State's rate filing laws, except that:
> (1) Where State law does not define the term, it has the meaning given in section 2791(e)(5) of the PHS Act; provided, however, that for the purpose of this definition, ''50'' employees applies in place of ''100'' employees in the definition of ''small employer'' under section 2791(e)(4); and
> (2) Coverage that would be regulated as small group market coverage (as defined in section 2791(e)(5)) if it were not sold through an association is subject to rate review as small group

market coverage.

Under the amended definitions for the terms individual market and small group market, health insurance issuers will be required to report on rate increases for association products sold to individuals or small groups that are considered to be large group products under State law or have been otherwise excluded from a State's existing definition of individual and small group coverage. The effective date of the amendment is November 1, 2011.

The amendment expands the applicability of the reporting requirements to include certain types of association coverage previously not included in the final rule. However, it did not include any changes to the existing data collection reporting instruments or the burden associated with meeting the reporting requirements. In other words, issuers will submit information on more rate increases as a consequence of the amendment, but the information that is collected will be consistent with the current rate review reporting requirements.

The May 23, 2011 rate review regulation establishes a rate review program to ensure that all rate increases that meet or exceed an established threshold are reviewed by a State or CMS to determine whether the rate increases are unreasonable. Under the regulation, if CMS determines that a State has an Effective Rate Review Program in a given market, using the criteria set forth in the rule, CMS will adopt that State's determinations regarding whether rate increases in that market are unreasonable, provided that the State reports its final determinations to CMS and explains the bases of its determinations. For all other States or markets, CMS will conduct its own review of rates that meet or exceed the applicable threshold to determine whether they are unreasonable.

Section 2794 directs the Secretary to ensure the public disclosure of information and justification relating to unreasonable rate increases. The regulation therefore develops a process to ensure the public disclosure of all such information and justification. Section 2794 requires that health insurance issuers submit justification for an unreasonable rate increase to CMS and the relevant State prior to its implementation. To that end the regulation establishes various reporting requirements for health insurance issuers, including a Preliminary Justification for a proposed rate increase, a Final Justification for any rate increase determined by a State or CMS to be unreasonable, and a notification requirement for unreasonable rate increases which the issuer will not implement.

Health insurance issuers will be required to provide a Preliminary Justification to both CMS and States, if it is seeking to implement a rate increase that meets or exceeds the threshold described in §154.200. The Preliminary Justification includes data supporting the potential rate increase as well as a written explanation of the rate increase. For those rates CMS will be reviewing, issuers' submissions must also include data and information that CMS will need to make a valid actuarial determination regarding whether a rate increase is unreasonable.

The Preliminary Justification consists of three Parts. Part I consists of summary-level quantitative data, collected in a standardized format. Part II of the Preliminary Justification is a brief written explanation of the rate increase. Issuers would be required to submit Parts I and II to both CMS and the applicable State prior to implementation of a rate increase that is subject to review, regardless of whether CMS is reviewing the rate increase or adopting the State's review. Issuers will be required to complete Part III of the Preliminary Justification only when CMS is reviewing a rate increase to determine whether it is unreasonable. The information provided under Part III is typical of the information included in a rate filing reviewed by State regulators. The information will allow CMS to make a valid actuarial determination as to whether the rate increase is unreasonable or not.

For each rate increase that is under review, either CMS or the State will prepare a final determination as to whether the proposed rate increase is unreasonable or not, as well as a brief explanation of relevant review findings. If a rate increase is determined to be unreasonable and the health insurance issuer plans to implement the increase, the issuer is required to submit a Final Justification of the increase to CMS and to the relevant State. The issuer also must display the justification on its website. If an issuer is legally permitted to implement an unreasonable rate increase and declines to implement the increase, the issuer will provide notice to CMS that it will not implement the increase.

2. Information Users

CMS will post on its website the information contained in each Preliminary Justification for each rate increase subject to review under §154.200. States will either post the Preliminary Justification on their websites or will provide a link to the postings on CMS' website. For consumer clarity, CMS also will post on its Website the final disposition of each rate increase reviewed under the regulation by either CMS or a State. As required by the statute and noted above, issuers will also be required to post on their websites Final Justifications for unreasonable rate increases they plan to implement. These disclosures are intended to provide consumers with information about the rate increases that are reviewed under this program.

As noted above, issuers will be required to submit Part III of the Preliminary Justification when CMS is reviewing a rate increase. HHS will use the data provided under this section to conduct a thorough actuarial review of the rate increase and to make an unreasonable rate increase determination.

3. Use of Information Technology

Health insurance issuers and States will provide rate review information via the Health Insurance Oversight System (HIOS)—a web-based data collection system that it already being used by States and issuers to provide information for the healthcare.gov website (additional PRA-related information regarding HIOS is provided in the Web Portal PRA package (0938-1086). CMS has developed a new module in HIOS for rate review. All data submissions will be made electronically and no paper submissions are required.

Issuers and States will use HIOS to upload their rate review reporting submissions (these submissions are described in detail below). The burden estimates provided in this Statement include the time and effort that will be dedicated to uploading information in HIOS. For example, the 11 hour issuer burden estimate for completing and submitting the preliminary justification includes the time associated with uploading the record in HIOS (2-3 minutes).
The rate review information that is uploaded and stored in HIOS will be used to provide consumer-oriented information about rate increases on the Healthcare.gov website. During both of the PRA public comment periods, we released website mock-ups showing how the information provided by issuers and States will be visualized on Healthcare.gov (this document was referred to as the Consumer Disclosure in both of the PRA Notices). The information specific to each plan that is contained in the Consumer Disclosure is automatically populated from the information stored in HIOS. For example, when an issuer provides information on the components of the rate increase to HIOS (e.g. increases in administrative or medical trends), that information populates the rate information about that plan in the Consumer Disclosure. Because the information in the Consumer Disclosure is auto-populated from the information in HIOS, there is no separate or additional reporting burden on issuers or States.

4. Duplication of Similar Information

The addition of association plans to the previously approved PRA package estimate is a new collection required in the Affordable Care Act. The per issuer burden is the same as the collection currently required by non-association, non-grandfathered individual and small group health insurance issuers.

5. Small Businesses

Small businesses are not affected by this collection. The Excel format of the rate review notification form is a common business application and no capital costs are required for this effort. The electronic submission of information also should ease any burden imposed by the requirement. The information used to populate the preliminary justification format is readily available to issuers, as it is used to develop premium rates. Finally, health insurance carriers are not small businesses, so small businesses are not affected by this collection.

6. Less Frequent Collection

Health insurance issuers that provide association coverage to individuals and small groups must provide the Preliminary Justification prior to implementing any proposed rate increase that is subject to review. Issuers may not deviate from this collection schedule or provide the information on a less frequent basis given the time-sensitive nature of the information that is provided (the statute requires health insurance issuers to provide justifications for rate increases prior to implementation).

7. Special Circumstances

No special circumstances exist for this information collection.

8. Federal Register Notice/Outside Consultation

The emergency Federal Register notice displayed on October 7, 2011.

9. Payments/Gifts To Respondents

There will be no payments or gifts to respondents.

10. Confidentiality

CMS promptly will make available to the public on its website the information contained in Parts I and II of each Preliminary Justification. CMS will make available to the public on its website the information contained in Part III of each Preliminary Justification that is not a trade secret or confidential commercial or financial information as defined in CMS's Freedom of Information Act regulations.

11. Sensitive Questions

There are no sensitive questions included in this collection effort. HHS does not propose to collect any private information.

12. Burden Estimate

a. Burden Estimate for 2011

With inclusion of association coverage called for in the September 6, 2011 association amendment, CMS estimates that there will be an additional 227 filings that are subject to review. The May 23, 2011 final rule stated that there would be 417 issuer respondents. This updated estimate of the number of subject to review filings is based on CMS' review of 2010 National Association of Health Insurance Commissioners (NAIC) rate filing data for association coverage.

All of the cost and time assumptions associated with preparation and submission of the preliminary justification are unchanged from the May 23, 2011 final rule. However, all estimates have been updated to take into account the updated estimate for the number of subject to review filings (1,201 rate filings).

2011 Estimate of Rate Increases Above the Rate Review Reporting Threshold

	Individual	Small Group	Total
Estimated number of filings for 2011*	1,948	6,335	8,283
Percent of filings subject to review (non-grandfathered)	54%	30%	
Number of filings subject to review	1,052	1,901	2,953
Estimated percentage of filings meeting or exceeding threshold	60%	30%	
Estimated number of filings meeting or exceeding threshold	631	570	1,201

*An additional 1,550 rate filings were added to this estimate to account for filings submitted for association products. The non-grandfathered filings and threshold assumptions are unchanged from the May 23, 2011 final rule.

Health Insurance Issuer Submission of the Preliminary Justification

Based on discussions with the National Association of Insurance Commissioners and industry experts, CMS estimates that it will take a senior actuary ($200/hour) 11 hours to prepare the Preliminary Justification (includes minimal time allotment associated with record retention). As calculated above, the number of product filings estimated to meet or exceed the threshold is 1201. Therefore, CMS estimates that health insurance issuers will have to prepare 1,201Preliminary Justifications in the first year of the rate review program.

Burden hours: 1,201 filings x 11 hours preparation time per record = 13,211 hours.
Costs: 2,497 hours x $200 = $2,642,200 in preparation costs for the addition of association coverage products.
The addition of the 227 filings represented by association plans accounts for an additional 2,497 hours, or $499,400 in cost.

Health Insurance Issuer Submission of Final Justification for Unreasonable Rate Increases

The final rule requires health insurance issuers to submit to CMS and the relevant State a Final Justification for any unreasonable rate increase that would be implemented and to display this information on their websites. If an issuer is legally permitted to implement an unreasonable rate increase and declines to implement the increase, the issuer will provide notice to CMS that it will not implement the increase. This submission will consist of a short, free response narrative that will take a senior actuary ($200) approximately 60 minutes to prepare and post. The burden hours and cost are calculated under the conservative assumption that issuers of association coverage products would undergo in order to provide this information for all rate increases above the reporting threshold.

Burden Hours: Assuming all increases are determined to be unreasonable and issuers implement all unreasonable increases (an extremely conservative estimate) 1201 rate increases x 1 hour to prepare and post = 1201 hours
Costs: 1201hours x $200/hour = 240,200$45,400

The addition of the 227 filings represented by the association plans accounts for an additional 227 hours, or $499,400 in cost.

One-Time Health Insurance Issuer Start-Up Costs

Based on discussions with NAIC and industry experts, health insurance issuers will have to spend approximately 150 hours at the start of the program to review the reporting requirements and to develop processes for data collection.

Burden Hours: 150 hours x 419 health insurance issuers = 62,550.
Costs: 62,550 hours x $200/hour (Senior Actuary) = $12,510,000

There is no change to the May 23, 2011 final rule estimate for per issuer one-time start-up costs. However, for purposes of this amendment, the total number of providers used in the previous PRA is used here, with the proviso that the additional cost associated with the September 1 amendment will apply *only* to those issuers that offer association coverage exclusively.

State Unreasonable Rate Increase Determinations

Under the final rule, if CMS determines that a State has satisfied specific criteria for an Effective Rate Review Program provided in the rule, CMS would adopt the State's determinations regarding whether a rate increase that meets or exceeds the established threshold is unreasonable, providing that, for each increase at or above the threshold, the State reports its final determination to CMS and explains the basis of its determination. In those cases where a State does not have an Effective Rate Review Program, CMS will make its own determinations regarding whether a rate increase that meets or exceeds the established threshold is unreasonable. As discussed in the regulatory impact analysis CMS estimates that of the 1,201rate increases that will be reviewed, 661 rate increases will be reviewed by States. The remaining 540 will be reviewed by CMS.

States will not have to modify their existing review practices in order to make unreasonable rate increase determinations and therefore will not incur any new costs associated with reviewing these rate increases. States with Effective Rate Review Programs will be required to report on their rate review activities to

the Secretary. CMS believes that this reporting requirement will involve minimal cost. CMS estimates that it will take an actuary ($200/hour) approximately 20 minutes to prepare and submit this information to CMS.

Burden Hours: 661 determinations x .33 hours = 218 hours
Costs: 218 hours x $200/hour = $43,600

The addition of the 125 filings represented by association plans accounts for an additional 41 hours, or $8,200.

b. 2012 and 2013 Burden Estimates

Ongoing compliance costs were estimated by trending labor upward 3 percent per year. These estimates assume that the number of filings subject to review will remain constant.

2012: Total Burden Hours = 13,832. Total Cost = $2,721,466. This is an increase of 1,930 hours and $269,654 compared to the May 23, 2011 final rule issuer burden estimate (11,902 hours and $2,451,812).

2013: Total Burden Hours = 14,247. Total Cost = $2,803,110. This is an increase of 2,345 hours and $277744 compared to the May 23, 2011 final rule issuer burden estimate (11,902 hours and $2,525,366).

13. Capital Costs

The industry and the States are not required to incur capital costs to fulfill these requirements.

14. Cost to the Federal Government

If a State does not have an Effective Rate Review Program in place for all or some markets, CMS will review rate increases that meet or exceed the review threshold in those markets. This activity could be conducted with in-house resources and/or with the use of contracted services. As noted above CMS estimates that it will reviw540 rate increases in the program's first year.. The following table provides the cost and burden for completion of these reviews.

Contractor Actuarial Rates and Time Associated with Conducting Rate Review

	Estimated Actuarial Rates
Principal Actuaries	$350.00
Support Actuaries	$234.00
Actuarial Analyst	$150.00
Administrative Support	$100.00
Estimated Time to Complete Average Review	**Average Time Required**
Principal Actuaries	5.50
Support Actuaries	9.50
Actuarial Analyst	14.00
Administrative Support	9.50
Actuarial Staff Hours	29.00
Total Staff Hours	38.5
Estimated Contractor Cost per Review	$7,198

Burden Hours: 540 reviews x 38.5 hours = 20,790
Costs: 540 reviews x $7,198 (cost per review) = $3,886,920

Additionally, CMS will determine whether a State's rate review program meets the requirements of an Effective Rate Review Program set forth in the rule based on information received from the State through the grant process, a through review of applicable State law, and through any other information available to CMS. The information collection for the ''Grants to States for Health Insurance Premium Review'' is approved under OMB Control number 0938–1121. Since CMS does not believe additional data from States are necessary to make these determinations, we assume the additional burden from this provision is zero. In addition to the costs to the Federal government of conducting rate reviews in States that do not conduct effective reviews, there will be a nominal, largely one-time cost to the Federal government to determine whether States are conducting effective reviews.

15. Program Changes/Adjustment

The September 6, 2011 amendment to the rate review final rule updated the applicability of the rate review requirements to include products that would be considered part of the individual or small group market had they not been sold through associations, including those that are consider to be large group products under State law or have been otherwise excluded from State's existing definitions for individual and small group products. As discussed throughout this statement, this change will result in an increase in the total number of rate increases that are subject to the rate review reporting requirements. The amendment did not propose any changes to the information that issuers must submit for each rate increase. Thus, burden associated with each rate increase submission remains unchanged from the final rate review rule.

16. Publication and Tabulation Dates

As part of consumer transparency and disclosure, a consumer friendly disclosure form (populated from the information provided in the Preliminary Justification) will be posted by HHS for all rates that meet or

exceed the threshold. A final disposition of the rate review will also be posted and, if the rate is identified as unreasonable and implemented by the carrier, the carrier must also post a final justification as defined in the NPRM within 10 business days.

17. Expiration Date

HHS has no objections to displaying the expiration date.

18. Certification Statement

There are no exceptions to the certification statement.

C. Collections of Information Employing Statistical Methods

Not Applicable. No statistical methods will be used in this collection effort. The data collection tool has built in formulas that require carriers to input data.