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

A. Justification

1. Circumstances Making the Collection of Information Necessary

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.

The Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services Center for Consumer Information and Insurance Oversight is requesting clearance by the Office of Management and Budget for modifications to this previously approved collection package. These changes are being requested to (1) provide a mechanism for a PCIP enrollee who has moved from a state-administered PCIP to quickly and efficiently enroll into the federally-administered PCIP (2) provide a mechanism for a PCIP applicant to identify a third party entity will pay their premium to ensure appropriate premium billing (3) provide a mechanism whereby a licensed insurance agent or broker may identify their referral of an applicant (4) request employer information to expand ways to identify and prevent instances of insurer dumping and (5) make clarifications to existing application language.

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 determined in a manner consistent with guidance issued 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

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 applicant's social security number or other information related to

establishing the individual's lawful presence 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 (1) information about the person applying for coverage, (2) information about the applicant's state of residence, (3) information about prior enrollment in another PCIP, (4) information about the applicant's citizenship or immigration status, (5) information about the applicant's medical condition or diagnosis, (6) information about the applicant's other insurance coverage, (7) information about the applicant's employer, (8) what plan to enroll in, and (9) information about any third party payment of the applicant's monthly premium. The applicant will also be asked to verify their understanding of the application and sign an attestation. As an optional section, the applicant may also indicate how they heard about the PCIP program. Also, if a licensed insurance agent or broker assisted the applicant in applying to the PCIP program, the insurance agent or broker may provide their information to receive compensation for the application. 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 1.25 hours (one hour and fifteen minutes) 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 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

In terms of OMB review, annualized burden for 2011, 2012 and 2013 is 1.09 hours per applicant to complete an enrollment application and submit eligibility information. Annualized burden for 2011, 2012 and 2013 is .16 hours per enrollee to submit premium payment.

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 Information	Individual	100,000	1	.5	50,000
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	.59	29,500
Eligibility Information	Individual	50,000	1	.5	25,000
Premium Payment	Individual	33,333	1	.16	5,333
Total				1.25	59,833

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	.59	29,500
Eligibility Information	Individual	50,000	1	.5	25,000
Premium Payment	Individual	33,333	1	.16	5,333
Total				1.25	59,833

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	.59	29,500
Eligibility Information	Individual	50,000	1	.5	25,000

Premium Payment	Individual	33,333	1	.16	5,333
Total				1.25	59,833

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 instructions and the actual 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 (1) information about the person applying for coverage, (2) information about the applicant's state of residence, (3) information about prior enrollment in another PCIP, (4) information about the applicant's citizenship or immigration status, (5) information about the applicant's medical condition or diagnosis, (6) information about the applicant's other insurance coverage, (7) information about the applicant's employer, (8) what plan to enroll in, (9) information about any third party payment of the applicant's monthly premium, (10) optional section if a licensed insurance agent or broker assisted the applicant in applying to the PCIP program, the insurance agent or broker may provide their information to receive compensation for the application, (11) optional section asking how the applicant heard about the PCIP program 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. The application may also be completed telephonically by calling the PCIP call center and speaking with a customer service representative who will complete the application with the individual over the telephone.

We estimate that it will take approximately 35 minutes per applicant to read, complete and submit their completed application to HHS, including obtaining a licensed insurance agent or broker's information and signature if that agent or broker seeks compensation for the application.

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 regardless if the individual is a new applicant or has moved out of one PCIP service area into another PCIP service area.

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 or an agent or broker 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 individual insurance coverage from an insurance company 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 the Standard Option in 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 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.)

If an applicant was previously enrolled in another state's PCIP during the past six months in lieu of submitting the above proof of citizenship and pre-existing condition they may instead submit proof of prior enrollment in another state's PCIP.

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

Burden Adjustments

The per task burden associated with this information collection request has slightly increased. The burden associated with submitting an application has increased from .34 hours to .59 hours. However, the total burden for which we are seeking approval has been adjusted downward. Previous submissions of this ICR did not accurately reflect the estimated annual burden. Specifically, previously approved versions of this ICR were quadruple counting the burden. We entered the burden four times in the submission rather than one time. The error

has been corrected and the estimated annual burden is 59,883 hours as compared to the previously approved 233,999 hours.

Other Changes

In addition to burden changes, we have made several other changes that do not affect the burden associated with this collection. 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.

Additional changes are being requested to (1) provide a mechanism for a PCIP enrollee who has moved from a state-administered PCIP to quickly and efficiently enroll into the federally-administered PCIP (2) provide a mechanism for a PCIP applicant to identify a third party entity will pay their premium to ensure appropriate premium billing (3) provide a mechanism whereby a licensed insurance agent or broker may identify their referral of an applicant (4) request employer information to expand ways to identify and prevent instances of insurer dumping and (5) make clarifications to existing application language.

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.