Supporting Statement For Paperwork Reduction Act Submissions: Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

A. Background

The Patient Protection and Affordable Care Act, Public Law 111-148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, Public Law 111-152, enacted on March 30, 2010 (collectively, the "Affordable Care Act"), provides for three premium stabilization programs – a reinsurance program, a risk corridors program, and a risk adjustment program – to mitigate the negative impacts of adverse selection and market uncertainty.

The transitional reinsurance program and the temporary risk corridors program are designed to provide issuers with greater payment stability as insurance market reforms begin. The reinsurance program serves to reduce the uncertainty of insurance risk in the individual market in each State by making payments for high-cost enrollees. The HHS-administered risk corridors program serves to protect against rate-setting uncertainty with respect to qualified health plans by limiting the extent of issuer losses (and gains). The permanent risk adjustment program is intended to protect health insurance issuers that attract a disproportionate number of higher risk enrollees (*e.g.*, those with chronic conditions). These programs will support the effective functioning of the American Health Benefit Exchanges ("Exchanges"), which will become operational by January 1, 2014. The Exchanges are individual and small group health insurance marketplaces designed to enhance competition in the health insurance market and to expand access to affordable health insurance for millions of Americans. The reporting and data collection provisions described below apply to States and health plans both inside and outside of an Exchange.

B. Justification

1. Need and Legal Basis

Section 1341 of the Affordable Care Act provides that each State must establish a transitional reinsurance program to help stabilize premiums for coverage in the individual market during the first three years of Exchange operation. Section 1342 provides for the establishment of a temporary risk corridors program that will apply to qualified health plans in the individual and small group markets for the first three years of Exchange operation. Section 1343 provides for a program of risk adjustment for all non-grandfathered plans in the individual and small group market both inside and outside of the Exchange. These risk-spreading programs, which will be implemented by HHS and/or States, are designed to mitigate adverse selection and provide stability for health insurance issuers in the individual and small group markets as market reforms and Exchanges are implemented.

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Section 1321(a) also provides broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, reinsurance, risk adjustment, and other components of title I of the Affordable Care Act.

2. Information Users

The data collection and reporting requirements described below will enable States and/or HHS to implement these programs, which will mitigate the impact of adverse selection in the individual and small group markets both inside and outside the Exchange.

3. Use of Information Technology

Information collected for this rule will be submitted electronically. HHS staff will communicate with States and the District of Columbia using standardized reporting, e-mail or telephone.

4. Duplication of Efforts

This information collection does not duplicate any other Federal effort.

5. Small Businesses

This information collection will not have a significant impact on small businesses.

6. Less Frequent Collection

The anticipated flows of funds for these programs require the collection of information as indicated. A less frequent collection could result in cash flow difficulties for issuers and logistical difficulties for issuers and the entities operating premium stabilization programs.

7. Special Circumstances

In order for payments to be made in a timely manner for these premium stabilization programs, it is necessary to collect information according to timeframes established by the State or HHS on behalf of the State.

8. Federal Register/Outside Consultation

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The proposed version of this rule was published on July 15, 2011. The period for comment for the proposed rule closed on October 31, 2011. We received no comments on the collection of information proposed. We are therefore finalizing the collection of information requirements as proposed, with modifications based on changes to the final rule. We have consulted with contractors, academia, States, and industry on the feasibility of this information collection. We have based many of the requirements in this information collection on those consultations.

9. Payments/Gifts to Respondents

No payments or gifts will be provided to respondents.

10. Confidentiality

We will maintain respondent privacy with respect to the information collected to the extent required by applicable law and HHS policies.

11. Sensitive Questions

There are no sensitive questions included in this information collection effort.

12. Burden Estimates (Hours & Wages)

Below is a summary of the information collection requirements set forth in the final rule. Throughout this summary, the frequency of data collection is assumed to be the frequency discussed in the preamble to the rule.

Our estimates of paperwork burden for States reflect full participation by all States and the District of Columbia in operating the reinsurance and risk adjustment programs. These estimates should be considered an upper bound, because not all States will elect to operate these programs.

A number of assumptions are made regarding the wages of personnel needed to accomplish the proposed collection of information. Wage rates are based on the Employer Costs for Employee Compensation report by U.S Bureau of Labor Statistics and represent a national average. Some States or employers may face higher or lower wage burdens. Wage rates estimates include a 35% fringe benefit estimate for State employees and a 30% fringe benefit estimate for private sector employees.

I. State Notice of Insurance Benefits and Payment Parameters (§153.100-§153.110)

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Supporting Statement For Paperwork Reduction Act Submissions: Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

Within Part 153, subpart B, a State is required to issue an annual notice of benefits and payment parameters specific to that State in certain circumstances if it is operating reinsurance or a risk adjustment program. As estimated in the proposed rule, we assume that all 50 States and the District of Columbia will be subject to these requirements. This figure should be considered an upper bound because some States may not operate reinsurance or risk adjustment programs. Reinsurance parameters published in the State notice of benefit and payment parameters will be published for each of the three years of the transitional program. Risk adjustment is a permanent program, so risk adjustment parameters will be published annually.

According to §153.100(a), a State establishing a reinsurance program must issue an annual notice of benefit and payment parameters specific to the State if it elects to:

1. Modify the data requirements or data collection frequency for health insurance issuers to receive reinsurance payment from those specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year;
2. Collect reinsurance contributions pursuant to §153.220(a)(1);
3. Collect additional reinsurance contributions pursuant to §153.220(g);
4. Use more than one applicable reinsurance entity, including any geographic area designations; or
5. Modify any reinsurance payment parameters from those specified in the HHS notice for the applicable benefit year.

Paragraphs 153.110(a)-(e) provide standards for the State notice with regard to each of the above elections.

We estimate a minimal baseline burden for the development of the State notice because States have the option to adopt the data requirements and data collection frequency specified by HHS in the annual HHS notice of benefit and payment parameters, forgo the collection of reinsurance contributions, use a single applicable reinsurance entity, or use the reinsurance payment parameters established in the annual HHS notice of benefit and payments parameters. In such a case, a State would only have to indicate those intentions in its State notice of benefit and payment parameters. We estimate that it will take each State approximately 163 hours each year to meet the requirements of this subpart, with a total estimated burden of 8,313 hours. We estimate that it will take a financial analyst 122 hours (at an average wage rate of $62 an hour) and a senior manager 41 hours (at $77 an hour) to meet these requirements. The cost estimate for each State is $10,721 for a total estimated cost burden of $546,771.

A State may make any of the elections described in paragraphs 153.110(a)-(e). Below, we provide estimates for the burden of these elections. These burdens are in addition to the baseline burden for the development of the State notice.

If a State elects to modify the data requirements or data collection frequency for reinsurance

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payments, it must specify those modifications in the State notice. We estimate that 5 States will elect to make these modifications. We estimate that it will take each State approximately 2 hours each year to describe this collection in its State notice, with a total estimated burden of 10 hours. We estimate that it will take an operations analyst 1 hour (at an average wage rate of $55 an hour) and a senior manager 1 hour (at $77 an hour) to meet these requirements. The cost estimate for each State is $132, for a total estimated cost burden of $660.

If a State elects to collect reinsurance contributions pursuant to §153.220(a), then the State must announce its intention to do so in the State notice. We estimate that 5 States will elect to collect contributions from the fully insured market to operate their reinsurance program. We estimate that it will take each State approximately 2 hours each year to describe this collection in its State notice, with a total estimated burden of 10 hours. We estimate that it will take an operations analyst 1 hour (at an average wage rate of $55 an hour) and a senior manager 1 hour (at $77 an hour) to meet these requirements. The cost estimate for each State is $132, for a total estimated cost burden of $660.

Paragraph 153.220(g) permits a State to collect additional contributions for its reinsurance program. A State choosing to collect additional reinsurance funds must include in its State notice a description of the purpose of the additional collection, including whether it will be used to cover reinsurance payments, administrative costs, or both. We estimate that it will take each State approximately 2 hours each year to describe the purpose of the collection of additional reinsurance funds in its State notice, with a total estimated burden of 10 hours. We estimate that it will take an operations analyst 1 hour (at an average wage rate of $55 an hour) and a senior manager 1 hour (at $77 an hour) to meet these requirements. The cost estimate for each State is $132, for a total estimated cost burden of $660.

If a State chooses to establish or contract with more than one reinsurance entity, as described in §153.210(a)(2), paragraph 153.110(d) requires that the State publish in its annual notice, for each applicable reinsurance entity –

1. The geographic boundaries for that entity;
2. An estimate of the number of enrollees in fully insured plans within those boundaries;
3. An estimate of the number of enrollees in the individual market within those boundaries;
4. An estimate of the reinsurance contributions that will be collected by the applicable reinsurance entity;
5. The percentage of reinsurance contributions received from HHS for the State to be allocated to the applicable reinsurance entity; and
6. An estimate of the amount of reinsurance payments that will be made to issuers with respect to enrollees within those boundaries.

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We estimate that 2 States will elect to use multiple reinsurance entities to operate their reinsurance program. We estimate that it will take each State approximately 5 hours each year to determine these elements for each reinsurance entity with a total estimated burden of 10 hours. We estimate that it will take a financial analyst 4 hours (at an average wage rate of $62 an hour) and a senior manager 1 hour (at $77 an hour) to meet these requirements. The cost estimate for each State is $325, for a total estimated cost burden of $650.

If a State elects to modify the attachment point, reinsurance cap, or coinsurance rate from those specified in the HHS notice, the State must describe those modifications in the State notice, pursuant to § 153.230(d)(2). We estimate that 5 States will elect to make these modifications. We estimate that it will take each State approximately 2 hours each year to describe this modification in its State notice, with a total estimated burden of 10 hours. We estimate that it will take an operations analyst 1 hour (at an average wage rate of $55 an hour) and a senior manager 1 hour (at $77 an hour) to meet these requirements. The cost estimate for each State is $132, for a total estimated cost burden of $660.

Paragraph 153.100(b) requires a State establishing a risk adjustment program to issue an annual notice of benefit and payment parameters specific to that State setting forth the risk adjustment methodology and data validation standards it will use. A State using a Federally certified methodology other than the methodology used by HHS when operating a risk adjustment program on behalf of a State must publish that methodology in its notice of benefit and payment parameters. Subsection 153.110(f) provides standards for the State notice with regards to risk adjustment content – a State operating a risk adjustment program must provide the information set forth in §153.330(a) and the data validation standards set forth pursuant to §153.350 in the State notice.

The burden estimate for this requirement is minimal, as States will already have submitted the information to HHS as part of the alternate methodology approval process. As discussed below in part III, we estimate that 5 States will be subject to this requirement. We estimate that it will take each State approximately 5 hours each year to publish the details of its risk adjustment methodology, with a total estimated burden of 25 hours. We estimate that it will take a financial analyst 4 hours (at an average wage rate of $62 an hour) and a senior manager 1 hour (at $77 an hour) to meet these requirements. The cost estimate for each State is $325, for a total estimated cost burden of $1,625.

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Supporting Statement For Paperwork Reduction Act Submissions: Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

Information Collection Requirement	Type of Respondent	Frequency and Duration	Number of Respondents	Number of Responses per Respondent	Average Burden Hours per Response	Total Burden Hours
State Notice	State	Annually, Permanent	51	1	163	8,313
State Notice – Modify Reinsurance Data Requirements	State	Annually, 2014-2016	5	1	2	10
State Notice – Collect from fully insured market	State	Annually, 2014-2016	5	1	2	10
State Notice – Additional reinsurance funds	State	Annually, 2014-2016	5	1	2	10
State Notice – Multiple Reinsurance Entities	State	Annually, 2014-2016	2	1	5	10
State Notice – Modify Reinsurance Parameters	State	Annually, 2014-2016	2	1	5	10
State Notice – Alternate Risk Adjustment Methodology	State	Annually, Permanent	5	1	5	25

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Type of Respondent	Hourly Labor Cost of Reporting ($)	Total Burden Hours	Average Labor Cost per Response	Number of Respondents	Total Labor Costs (All Respondents)
State Notice					
Financial Analysts	$62.00	122	$7,564	51	$385,764
Senior Manager	$77.00	41	$3,157	51	$161,007
Total		**5**	**$10,721**		**$546,771**
State Notice – Modify Reinsurance Data Requirements					
Financial Analysts	$62.00	4	$248	2	$496
Senior Manager	$77.00	1	$77	2	$144
Total		**5**	**$325**		**$650**
State Notice -- Intention to Collect Reinsurance Contributions					
Financial Analysts	$55.00	1	$55	5	$310
Senior Manager	$77.00	1	$77	5	$385
Total		**2**	**$132**		**$660**
State-Notice – Additional Reinsurance Funds					
Financial Analysts	$55.00	1	$55	5	$310
Senior Manager	$77.00	1	$77	5	$385
Total		**2**	**$132**		**$660**
State Notice -- Multiple Reinsurance Entities					
Financial Analysts	$62.00	4	$248	2	$496
Senior Manager	$77.00	1	$77	2	$144
Total		**5**	**$325**		**$650**
State Notice – Modify Reinsurance Parameters					
Financial Analysts	$62.00	4	$248	2	$496
Senior Manager	$77.00	1	$77	2	$144
Total		**5**	**$325**		**$650**
State Notice -- State Alternate Methodology					
Financial Analysts	$62.00	4	$248	5	$1,240
Senior Manager	$77.00	1	$77	5	$385
Total		**5**	**$325**		**$1,625**

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II. State Standards for the Transitional Reinsurance Program in the Individual Market (§153.210-§153.220, §153.240)

Within Part 153, subpart C we described State reporting and record maintenance requirements for reinsurance.

As described in §153.210(a)(2)(iii), a State must notify HHS of the percentage of reinsurance contributions received from HHS for the State to be allocated to each applicable reinsurance entity. Because this information must also be published in the State notice of benefit and payment parameters, HHS will consider publication in the State notice to be notification of HHS. We are therefore not estimating additional burden for this notification.

As described in §153.220(b), a State must notify HHS of its intention to collect contributions from the fully insured market. We are modifying this collection of information requirements to reflect this change from the proposed rule. These requirements are subject to Paperwork Reduction Act requirements, and will be collected by HHS on the Exchange Blueprint Application. The burden associated with these notifications is included in the PRA package associated with that application (OMB 0938-1172).

As described in §153.220(h)(1), a State must notify HHS of its intention to collect additional administrative expenses. While these information reporting requirements are subject to the Paperwork Reduction Act, the associated requirements and instruments are currently under development. Upon their completion, we will seek OMB approval and solicit public comments.

States that establish a reinsurance program will also be required to maintain any records associated with the reinsurance program, as stipulated in §153.240(c). For this requirement, we estimate that it will take approximately 52 hours annually for States to maintain records. This is a broad estimate that includes not only the maintenance of data for the reinsurance program, but all books, records, documents, and other evidence of accounting procedures and practices related to the reinsurance program. This estimate is similar to that under the Medicare Part D rule, where it was estimated that it will take 52 hours on an annual basis for plan sponsors to maintain books, records, and documents on accounting procedures and practices required under §423.505.

We assume that 50 States and the District of Columbia will be subject to the reporting requirements in this subpart. This estimate is an upper bound of the burden. As described above, we estimate that it will take each State approximately 52 hours each year to meet the information collection requirements of this subpart, with a total estimated burden of 2,652 hours. We estimate that it will take a financial analyst 44 hours (at $62 an hour) and a senior manager 8 hours (at $77 an hour) to meet these requirements. The cost estimate for each State is $3,344, for a total estimated cost burden of $170,544.

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Among the records to be kept pursuant to the record maintenance requirement is the contract with the applicable reinsurance entity. We estimate that it will take approximately 320 hours for each State to establish the contract with the applicable reinsurance entity, with a total estimated one-time burden of 16,320 hours. We estimate it will take a contracts administrator 250 hours (at $40 per hour), an attorney 50 hours (at $77 an hour) and a senior manager 20 hours (at $77 an hour). The cost estimate for each State is $15,390, for a total estimated cost burden of $784,890. This burden estimate is included in the estimate for recordkeeping requirements specified in §153.240(c).

Forms (if necessary)	Type of Respondent	Frequency and Duration	Number of Respondents	Number of Responses per Respondent	Average Burden Hours per Response	Total Burden Hours
Maintenance of records	State	Annually, 2014-2016	51	1	372	18,972

Type of Respondent	Hourly Labor Cost of Reporting ($)	Total Burden Hours	Average Labor Cost per Response	Number of Respondents	Total Labor Costs (All Respondents)
Recordkeeping Requirements					
Contracts administrator	$40.00	250	$10,000	51	$510,000
Attorney	$77.00	50	$3,850	51	$196,350
Financial Analyst	$62.00	44	$2,728	51	$139,128
Senior Manager	$77.00	28	$2,156	51	$109,956
Recordkeeping Total			**$19,508**		**$955,434**

III. State Standards for the Risk Adjustment Program (§153.310, §153.330)

Within Part 153, subpart D, we described reporting requirements for States related to the risk adjustment program.

As described in §153.310, States will be required to submit annual summary reports of their risk adjustment program to HHS. These reports must include information such as:

1. Plan metal level;

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2. Plan average actuarial risk score and corresponding payments and charges for every risk adjustment covered plan in the State;
3. Trends in risk scores over time
4. Evidence of upcoding;
5. Months per enrollee by issuer and plan;
6. Proportion of enrollees with rating variation factors by issuer and plan;
7. Premium amounts per enrollee by plan; and
8. Any other elements we deem necessary to support risk adjustment methodology determination.

We estimate a minimal burden for the completion of these reports as we anticipate that most of the information collected will be available and disseminated as part of the risk adjustment program operations. While these information reporting requirements are subject to the Paperwork Reduction Act, the associated requirements and instruments are currently under development. Upon their completion, we will seek OMB approval and solicit public comments.

As discussed in §153.330, States must submit a request to HHS for review and approval of an alternate risk adjustment methodology. States will be required to submit the following information as a part of their alternate methodology certification package:

1. The underlying clinical and predictive logic and organization of the alternate risk adjustment model, in particular:
    a. The explanatory factors – demographics, diagnoses, and others – that will be used in the risk adjustment model;
    b. The qualifying criteria used to determine whether an individual enrollee is assigned any particular factor;
    c. The data, sample, and measure of health expenditures or resource use employed to calibrate the alternative risk adjustment model, and the frequency of that calibration;
    d. Estimated risk factor weights for all explanatory factors; and
    e. The method and schedule for calculating individual risk scores.
2. A complete description of how each plan’s average actuarial risk will be calculated.
3. A complete description of any prior implementation experience or examples of the proposed alternate risk adjustment model.
4. The schedule for the risk adjustment methodology.
5. The following statistical model performance metrics.
    a. The R-squared statistic;
    b. Predictive ratios, including age/sex cells;
    c. Deciles of predicted expenditure to test model calibration; and
    d. Major chronic diagnoses.

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6. A written evaluation of how the alternate risk adjustment methodology:
    a. Explains variation in health care costs for the relevant population;
    b. Links risk factors to daily clinical practice and is clinically meaningful to providers;
    c. Encourages favorable (and discourages unfavorable) behavior among providers and health plans;
    d. Uses data that is complete, high quality, and available in a timely fashion;
    e. Is easy for issuers to understand and implement;
    f. Provides stable risk scores over time and across plans; and
    g. Minimizes administrative costs.
7. A complete description of the risk adjustment data collection approach, including:
    a. The type of approach that will be utilized (distributed, intermediate, or other);
    b. The timeframe for collecting data and the schedule for assessing payments and charges;
    c. A validation process that ensures that a statistically valid sample of risk adjustment data from each issuer is validated annually; and
    d. The privacy and security standards that will be used to protect any risk adjustment data that is collected.
8. A complete description of the data elements required to implement the alternate risk adjustment method. Please see Appendix A for a chart containing SAMPLE data elements that a State might consider for use in their alternate risk adjustment methodology.

As described in §153.330(a)(2), the information collected by HHS as part of this requirement is needed to evaluate the extent to which the model:

1. Accurately explains the variation in health care costs of a given population;
2. Links risk factors to daily clinical practice and is clinically meaningful to providers;
3. Encourages favorable behavior among providers and health plans and discourages unfavorable behavior;
4. Uses data that is complete, high in quality, and available in a timely fashion;
5. Is easy for stakeholders to understand and implement;
6. Provides stable risk scores over time and across plans; and
7. Minimizes administrative costs.

We estimate that 5 States will request an approval for an alternate risk adjustment methodology. We assume all States requesting approval of an alternative risk adjustment methodology will update their methodology once. We estimate it will take each State approximately 38 hours to meet these requirements, with a total estimated one-time burden of 190 hours. We estimate it will take an operations analyst 22 hours (at $55 an hour) and a senior manager 6 hours (at $77 an hour) to meet these requirements. Updating the methodology is expected to take an operations analyst 8 hours and a senior manager 2 hours. The cost estimate for each State is $2,266, for a total estimated cost burden of $11,330.

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Forms (if necessary)	Type of Respondent	Frequency and Duration	Number of Respondents	Number of Responses per Respondent	Average Burden Hours per Response	Total Burden Hours
Request for alternate methodology	State	One time only	5	1	28	140
Update alternate methodology	State	One time only	5	1	10	50
Total					**38**	**190**

Type of Respondent	Hourly Labor Cost of Reporting ($)	Total Burden Hours	Average Labor Cost per Response	Number of Respondents	Total Labor Costs (All Respondents)
State Alternate Methodology					
Operations Analyst	$55.00	30	$1,650	5	$8,250
Senior Manager	$77.00	8	$616	5	$4,928
Total		**38**	**$2,266**		**$13,178**

IV. Health Insurance Issuer Standards Related to the Transitional Reinsurance Program (§153.400-§153.410)

Within Part 153, subpart E we discussed reporting requirements for health insurance issuers related to the transitional reinsurance program. Based on data from the healthcare.gov website, we estimate there are approximately 1,827 issuers in the individual and small group markets.

As described in §153.400(d), all contributing entities both inside and outside of the Exchange will be required to provide enrollment data (covered lives and member months) to the applicable reinsurance entity or the Federal reinsurance contributions entity to substantiate contribution amounts. While these information reporting requirements are subject to the Paperwork Reduction Act, the associated requirements and instruments are currently under development. Upon their completion, we will seek OMB approval and solicit public comments.
As described in §153.410(a), health insurance issuers of reinsurance-eligible plans seeking reinsurance payment must make the request for payment in accordance with the requirements in

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the HHS notice of benefit and payment parameters or the State notice of benefit and payment parameters, as applicable. To the greatest extent possible, we wish to minimize burden for issuers. The data collected, and the manner in which that data will be collected, will be identical for both the reinsurance and risk adjustment programs. HHS has determined that issuers will need to maintain data elements identified in Appendix A in order to make reinsurance payment requests. A subset of issuers (specifically, issuers operating reinsurance-eligible plans in the individual market) subject to the risk adjustment data collection requirements are eligible to make reinsurance payment requests. As such, we anticipate minimal burden associated with this provision; the burden associated with this provision is described in Part VI of this section.

Forms (if necessary)	Type of Respondent	Frequency and Duration	Number of Respondents	Number of Responses per Respondent	Average Burden Hours per Response	Total Burden Hours
Submit enrollment data for reinsurance contributions	Issuer	Annually, 2014-2016	1,827	1	12	21,924
Total					**12**	**21,924**

Type of Respondent	Hourly Labor Cost of Reporting ($)	Total Burden Hours	Average Labor Cost per Response	Number of Respondents	Total Labor Costs (All Respondents)
Financial Analysts	$57.00	16	$912	1,827	$1,666,224
Senior Manager	$72.00	8	$576	1,827	$1,052,352
Total		**24**	**$1,488**		**$2,718,576**

V. Health Insurance Issuer Standards Related to the Temporary Risk Corridors Program (§153.520-§153.530)

Within Part 153, subpart F we discussed reporting and recordkeeping requirements for QHP issuers related to the risk corridors program. As described in §153.520(e), QHP issuers will be required to maintain data and supporting information used to make the required allocations and attributions of revenues and expenses, and to determine that the methods and bases detailed in the

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report described below were accurately implemented. As described in §153.520(c), we will require all QHP issuers to submit to HHS a detailed description of the methods and specific bases used to attribute revenues and expenses in allowable costs and target amount to each QHP and across plans. Under § 153.530, we will also require all QHP issuers to submit data on premiums earned, allowable costs, and allowable administrative costs. While these information collection requirements are subject to the Paperwork Reduction Act, the associated requirements and instruments are currently under development. Upon their completion, we will seek OMB approval and solicit public comments.

VI. Health Insurance Issuer Standards for the Risk Adjustment Program (§153.610-§153.620)

Within Part 153, subpart G, we described reporting requirements for health insurance issuers related to the risk adjustment program.

As described in §153.610, health insurance issuers will be required to maintain risk adjustment data in order for HHS to operate risk adjustment on behalf of the State. HHS has determined that issuers will need to maintain data elements identified in Appendix A. HHS intends to employ a distributed data approach when running risk adjustment on behalf of a State. Under a distributed data approach, the required data is accessed and stored separately from other issuer data pursuant to formats specified by HHS. HHS will revise this package if additional data elements are required.

We estimate that it will take an issuer approximately 20 hours each year to maintain data elements necessary to operate the risk adjustment program, with a total estimated burden of 36,540 hours.[1] We estimate that it will take a financial analyst 16 hours (at $57 an hour) and a senior manager 4 hours (at $72 an hour) to meet these requirements. The cost estimate for each issuer is $1,200, for a total estimated cost burden of $2,192,400.

As described in §153.620, we will require health insurance issuers to comply with data validation activities as specified by HHS or States. While these information reporting requirements are subject to the Paperwork Reduction Act, the associated requirements and instruments are currently under development. Upon their completion, we will seek OMB approval and solicit public comments.

1 These burden estimates do not include estimates of the costs associated with deployment of the edge server.

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Forms (if necessary)	Type of Respondent	Frequency and Duration	Number of Respondents	Number of Responses per Respondent	Average Burden Hours per Response	Total Burden Hours
Risk adjustment data maintenance	Issuer	Annually, Permanent	1,827	1	20	36,540
Total					**20**	**36,540**

Type of Respondent	Hourly Labor Cost of Reporting ($)	Total Burden Hours	Average Labor Cost per Response	Number of Respondents	Total Labor Costs (All Respondents)
Financial Analysts	$57.00	16	$912	1,827	$1,666,224
Senior Manager	$72.00	4	$288	1,827	$526,176
Total		**20**	**$1,200**		**$2,192,400**

13. Capital Costs

Regardless of the data format and specifications for the reinsurance and risk adjustment programs, issuers will need to extract and, for purposes of audit, store the necessary data elements separately from data used during the normal course of business. Therefore, we estimate that each of the 1,827 issuers will incur a one-time cost of $1,500 per program to purchase the hardware necessary to maintain the required data elements. The total cost of these capital requirements is $3,000 per issuer, for a total estimated cost burden of $5,481,100.

14. Cost to Federal Government

The initial burden to the Federal Government for the establishment of the risk-related programs is $274,936. The calculations for CCIIO employees' hourly salary was obtained from the OPM website: http://www.opm.gov/oca/10tables/html/dcb_h.asp.

Task	Estimated Cost
Development of HHS notice of benefit and payment parameters	
15 GS-13: 15 x $42.66 x 160 hours	$102,384
Technical Assistance to States	
15 GS-13: 15 x $42.66 x 240 hours	$153,576

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Managerial Review and Oversight	
2 GS-15: 2 x $59.30 x 160 hours	$18,976
Total Costs to Government	**$274,936**

15. Explanation for Program Changes or Adjustments

There are no changes to the burden. This is a new data collection.

16. Publication/Tabulation Dates

The following information described in part 12 of this document will be published annually in the HHS notice of benefit and payment parameters:

- The percentage of reinsurance contributions received from HHS for the State to be allocated to each applicable reinsurance entity (as described in §153.210(a)(2)(iii)).
- List of States electing to collect reinsurance contributions from the individual market (as described in 153.220(b)).
- Approved State alternate risk adjustment methodologies (as described in §153.330).

States publishing a State notice of benefit and payment parameters described in §153.100-110 will include the following annually in that notice, as applicable.

- Modifications, if any, to the data collection requirements or data collection frequency for health insurance issuers to receive
- Intention to collect reinsurance contributions pursuant to §153.220(a).
- Collection of additional contributions, if any, for its reinsurance program, as set forth in §153.220(g)
- If a State chooses to establish or contract with more than one reinsurance entity, as described in §153.210(a)(2), for each applicable reinsurance entity it will describe –
  1. The geographic boundaries for that entity;
  2. An estimate of the number of enrollees in fully insured plans within those boundaries;
  3. An estimate of the number of enrollees in the individual market within those boundaries;
  4. An estimate of the reinsurance contributions that will be collected by the applicable reinsurance entity;
  5. The percentage of reinsurance contributions received from HHS for the State to be allocated to the applicable reinsurance entity; and
  6. An estimate of the amount of reinsurance payments that will be made to issuers with respect to enrollees within those boundaries.

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- Modifications from the parameters set forth in the annual HHS notice of benefit and payment parameters, if any, to the coinsurance rate, attachment point, and cap for the transitional reinsurance program.
- The risk adjustment methodology that will be used if the State is operating the risk adjustment program.
- The data validation standards, as described in §153.350, that will be used when operating the risk adjustment program.

Finally, States will publish information about their risk adjustment program in an annual summary report to be submitted to HHS. HHS intends that these reports will be made public soon after they are submitted. The burden associated with completing these reports is not included in this supporting statement, and will be submitted to OMB for approval and solicitation of public comment in the future.

17. Expiration Date

    Not applicable.

18. Certification Statement

    There is no exception to the certification statement identified in Item 19, "Certification for Paperwork Reduction Act Submissions," of OMB Form 83-I.

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Supporting Statement For Paperwork Reduction Act Submissions: Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

Appendix A

Data Elements for Risk Adjustment and Reinsurance	
Data Category	Data Elements
Enrollee-level data	Enrollment effective dates Enrollment plan Premium amount Date of birth Cost-sharing reductions Sex Tobacco use Pharmacy data Medical claims data for diagnosis selection Location (e.g. zip code)
Geographic data	Metal level Actuarial value Benefit year Individual versus small-group
Market level data	State average actuarial risk (HHS-sourced) State rating curve
Claims Level Data	Issuer ID Plan ID Bill Type Current Claim ID Procedure Code Diagnosis Code From Date Thru Date Admit Date Discharge Date Discharge Status Code Unique Enrollee ID Provider ID

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Data Elements for Risk Adjustment and Reinsurance	
Data Category	Data Elements
	Total Charges Plan Allowable Amount
	Plan Paid Amount Patient Paid Amount Place of Service Payment Date Original Claim ID

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