Supporting Statement for Paperwork Reduction Act Submission
Rate Increase Disclosure and Review Requirements (45 CFR Part 154)
(CMS – 10379)

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 health insurance issuers must submit to the Secretary and the applicable state justifications for unreasonable premium increases prior to the implementation of the increases. Section 2794 also specifies that beginning with plan years beginning in 2014, the Secretary, in conjunction with the states, shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

B. Justification

1. Need and Legal Basis

On May 23, 2011, CMS published a final rule with comment period (76 FR 29964) to implement the annual review of unreasonable increases in premiums for health insurance coverage called for by section 2794. The regulation established 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.

The final rule titled "Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review" amends the standards under the rate review program. The amendments revise the timeline for states to propose state-specific thresholds for review and approval by CMS. The amendments also direct health insurance issuers to submit data relating to proposed rate increases in a standardized format specified by the Secretary of HHS (the Secretary), and modify criteria and factors for states to have an effective rate review program. These changes were necessary to reflect the new market reform provisions discussed above and to fulfill the statutory requirement beginning in 2014 that the Secretary, in conjunction with the states,

monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange. Additionally, CMS collects premium and claims data broken out by Essential Health Benefit (EHB) and non-EHB to support the single risk pool and market rating rules validations for effective rate review

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. Additionally, section 2794 requires that rate increases effective in 2014 (submitted for review in 2013) be monitored by the Secretary, in conjunction with the states. To those ends 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.

On November 14, 2013, CMS issued a letter to State Insurance Commissioners outlining transitional policy for non-grandfathered coverage in the small group and individual health insurance markets. If permitted by applicable State authorities, health insurance issuers may choose to continue coverage that would otherwise be terminated or cancelled, and affected individuals and small businesses may choose to re-enroll in such coverage. Under this transitional policy, non-grandfathered health insurance coverage in the individual or small group market that is renewed for a policy year starting between January 1, 2014, and October 1, 2014, will not be considered to be out of compliance with certain market reforms if certain specific conditions are met. These transitional plans continue to be subject to the requirements of section 2794, but are not subject to 2701 (market rating rules), 2702 (guaranteed availability), 2704 (prohibition on health status rating), 2705 (prohibition on health status discrimination) and 2707 (requirements of essential health benefits) and the because the single risk pool (1311(e)) is dependent on all of the aforementioned sections (2701, 2702, 2704, 2705 and 2707), the transitional plans are also exempt from the single risk pool The Unified Rate Review Template and system are exclusively designed for use with the single risk pool plan, and any attempt to include non-single risk pool plans in the Unified Rate Review template or system will create errors, inaccuracies and limitations on submissions that would prevent the effectiveness of reviews of both sets of non-grandfathered plans (single risk pool and transitional). For these many reasons, CMS is requiring issuers with transitional plans that experience rate increases subject to review to use the Rate Review Justification system and templates which were required and utilized prior to April 1, 2013.

Health insurance issuers that choose to continue coverage that would otherwise be terminated or cancelled will be required provide a Preliminary Justification to both CMS and states, if they are seeking to implement rate increases that meet or exceed the reporting 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, it 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 reported 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 will also 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. CMS 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 is 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)) including all current rate review submissions exceeding the review threshold since September 1, 2011. All data submissions will be made electronically and no paper submissions are required.

Issuers and states will continue to use HIOS to upload their rate review reporting submissions. 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 also be used to provide consumer-oriented information about rate increases on the Healthcare.gov website.

4. Duplication of Similar Information

It does not duplicate any other collection.

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 issuers are generally not small businesses, so small businesses are not affected by this collection.

6. Less Frequent Collection

Health insurance issuers must provide the Preliminary Justification prior to implementing any proposed rate increase. 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

A Federal Register notice was published on December 27, 2013 (78 FR 78968), providing the public with a 60-day period to submit written comments on the Information Collection Request (ICR). CMS received two comments. One commenter requested that CMS utilize the prior Rate Review Justification System and templates for transitional plans that experience rate increases subject to review, which is consistent with CMS' approach. The other comment was unrelated.

9. Payments/Gifts To Respondents

There will be no payments or gifts to respondents.

10. Confidentiality

CMS will make available to the public on its website the information contained in each Preliminary Justification that is not a trade secret or confidential commercial or financial information and is approved for release under the Freedom of Information Act.

11. Sensitive Questions

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

12. Burden Estimates (Hours & Wages)

Health Insurance Issuer Submission of Preliminary Justification

It is estimated that about 65 issuers in the individual and small group markets will need to file a Preliminary Justification. Based on current experience, we estimate that each issuer in a market, on average, will have 2.5 submissions each year and each submission will require 11 hours of work by an actuary (at a cost of $225 per hour) including minimal time required for recordkeeping. As shown in Table 12.1 below, the burden per issuer in each market is estimated to be 27.5 hours and estimated cost per issuer in each market is $6,188 each year. The total annual burden and costs are estimated to be 1,788 hours and $402,188 respectively. .

Table 12.1 Estimated Annualized Burden Hours and Costs for Preliminary Justification

Number of Respondents	Number of Submissions per Respondent	Total Number of Submissions	Burden Hours per Respondent	Cost per Respondent	Total Burden Hours	Total Cost
65	2.5	162.5	27.5	$6,188	1,787.5	$402,187.50

Health Insurance Issuer Submission of Final Justification for Unreasonable Rate Increases

Health insurance issuers are required 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 ($225/hour) approximately 60 minutes to prepare and post. Based on current experience, we estimate that there will be approximately 41 justifications submitted and posted annually.

Total Annual Burden Hours: 41 justifications x 1 hour to prepare and post = 41 hours
Total Annual Costs: 41hours x $225/hour = $9,225

State Unreasonable Rate Increase Determinations

If CMS determines that a state has satisfied specific criteria for an Effective Rate Review Program, CMS will 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. CMS estimates that 155 rate increases will be reviewed by states.

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 ($225/hour) approximately 20 minutes to prepare and submit this information to CMS.

Total Annual Burden Hours: 155 determinations x .33 hours = 51.15 hours
Total Annual Costs: 51.15 hours x $225/hour = $11,508.75

13. Capital Costs

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

14. Cost to 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. Based on current experience, CMS estimates that it will review 8 rate increases annually. The following table provides the cost and burden for completion of these reviews.

Table 14.1 Estimated Cost to Federal Government per Review

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

Total Annual Burden Hours: 8 reviews x 38.5 hours = 308 hours
Total Annual Costs: 8 reviews x $7,198 (cost per review) = $57,584

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 thorough 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. Changes to Burden

The overall reduction in burden is due to the fact that this requirement will apply to a limited number of issuers – only issuers that choose to continue coverage that would otherwise be terminated or cancelled – thereby reducing the number of submissions and reviews. For issuer submission of Preliminary Justification, total burden is estimated to decrease by approximately 11,424 hours. For state unreasonable rate increase determinations the burden is estimated to decrease by approximately 167 hours. The number of issuer submissions of final justification for unreasonable rate increases will be lower and the related burden is estimated to decrease by 1,160 hours. The cost to federal government is estimated to decrease by approximately 20,482 hours or approximately $3,829,336 due to a decrease in the estimated number of reviews performed.

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 CMS 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 previous regulation within 10 business days.

17. Expiration Date

CMS 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.