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 are 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. The provisions are also designed to streamline data collection for issuers, states, Exchanges, and HHS. Additionally, CMS will collect 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 Rate Filing 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 provide a Rate Filing 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 Rate Filing Justification includes data supporting the potential rate increase(s), and the impacts to all other products in the single risk pool for that health insurance issuer in that market for that state as well as an Actuarial Memorandum explaining the actuarial reasoning for any rate increase(s) when the reporting threshold is exceeded. A consumer friendly written explanation of the rate increase is also required when the review threshold is exceeded.

The Rate Filing Justification consists of three Parts. Part I consists of detailed claims and premium quantitative data, collected in a unified rate review template to actuarially represent any rate increase and justify proposed increases above the review threshold. Part II of the Rate Filing Justification is a brief written explanation of any rate increase exceeding the review threshold. Part III of the Rate Filing Justification consists of an Actuarial Memorandum providing narrative reasoning of the assumptions and methods utilized to complete Part I. Parts I and III are required to be completed and submitted any time for all rate increases the issuer has in a state. Part II, along with Parts I and II, is only submitted to CMS and the applicable state when the review threshold is exceeded.

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.

Pursuant to the authority established in §156.470(e), a QHP issuer must submit an actuarial

memorandum with a detailed description of the methods and specific bases used to perform the allocations that would be required under paragraph (a) of that section, and demonstrating that the allocations meet the standards set forth in paragraph (c) of that section. QHP issuers will be required to submit these allocations and justifications through the Effective Rate Review program. Therefore, there will be no additional burden on QHP issuers that submit their rates through the Effective Rate Review program.

By collecting information in a consistent, data driven format, CMS and the states will be able to monitor an issuer's rate activity market wide, both inside and outside of the Exchanges, as required by section 2794 of the Affordable Care Act. These modifications will also ensure that as health insurance markets shift to accommodate changes that go into effect in 2014, state and federal regulators will be able to appropriately and adequately monitor issuers' products and plans within the market, minimizing any potential market disruptions.

2. Information Users

CMS will post on its website the information contained in each Rate Filing Justification for each rate increase reported under §154.200. States have the option to either post a portion or all of the Rate Filing Justification Part I, commonly referred to as the Unified Rate Review Template, on their websites (as determined by state public disclosure laws) or provide a hyperlink to the publically available portions posted 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.

Previously, Part III of the Rate Filing Justification was only required when CMS was responsible for conducting the rate increase review. CMS has expanded the elements of this section and Part III will no longer be required for only CMS reviewed submissions, but instead will be required for all submissions. Currently, every Effective Rate Review jurisdiction receives an actuarial memorandum (or its equivalent) with a proposed increase, subject to review. The new Part III actuarial memorandum requirement will support the data provided in Part I of the Rate Filing Justification portion of the submission and create greater consistency of the actuarial reasoning required to adequately support the actuarial information provided in Part I.

In addition to effective rate review, Financial Management and Exchange QHP will utilize the information in the actuarial memorandum to conduct their business.

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 (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 Rate Filing 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

This is a change to an existing data collection required in the Affordable Care Act. 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 Rate Filing 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 Rate Filing 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

The 60-day Federal Register notice was published as part of a notice of proposed rulemaking on November 26, 2012 (77 FR 70584).

A few commenters remarked that the costs related to rate review template submission have been underestimated. An industry group also provided estimates of the number of submissions and related costs. According to industry feedback received by CMS, the current rate review template being used requires only one to four hours of actuarial labor to complete. The unified rate review template includes more data and we estimate that it would take an actuary 11 hours, on average, to complete. Issuers will have to submit only one consolidated report for all their

products in a market, unlike the current template in use which requires a separate submission for each product.

One commenter provided a range of anticipated costs for systems changes obtained from an industry survey. However, we do not expect issuers to undertake major systems changes to prepare the rate review submissions. Most of the data elements specified in the new template are currently captured by issuers and most of the changes will involve categorizing the data into new categories and aggregating the information to the market level.

Based on comments received and discussions with issuers and states, we have made changes to the proposed template to address concerns that have been raised. We have both removed data elements from the unified rate review template and identified information that will be optional in the first two years of applicability. We estimate that through these changes we have reduced the number of required data elements by approximately 45 percent, reducing issuer burden. States may collect additional information above this baseline. We expect that the unified rate review template will not significantly increase the burden on states or industry; rather, the data requested in the template will assist states and industry in complying with the market rules.
Some commenters expressed concern about the public release of information. Commenters recommended disclosing only a minimal amount of information and that such disclosure not include confidential or proprietary information. As mentioned in the preamble of the November 26, 2012 proposed rule, we will release only information collected that is determined not to include trade secrets and is approved for release under the Freedom of Information Act (FOIA). In general, all information collected by HHS is subject to FOIA. In accordance with the HHS's FOIA implementing regulations at 45 CFR 5.65(c), health insurance issuers may designate part or all of the information submitted as exempt from disclosure under Exemption 4 of the FOIA if the issuer believes the information is commercial or financial information that is confidential or privileged. If there is a FOIA request, we will follow the pre-disclosure notification procedures found at 45 CFR 5.65(d) through (e) to seek issuer input on the applicability of Exemption 4 before disclosure is made. If the information has previously been published or made generally available to the public, it will not be considered confidential or privileged for purposes of Exemption 4. In addition, as discussed in section II.E.1.a. of the preamble, issuers will set their index rates and plan-specific pricing once per year upon filing their rates with state insurance departments, and information would only be released after the QHP submission process. Accordingly, we believe that public disclosure of certain rate review information will not undermine competitive market dynamics.

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 Rate Filing 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. HHS does not propose to collect any private information.

12. Burden Estimates (Hours & Wages)

Health Insurance Issuer Submission of Rate Filing Justification (Rate Review Template)

All health insurance issuers will be required to file information and data using the standardized rate review template for all rate increases for their products in the individual and small group markets. Each issuer will now need to submit only one file for all their products in the same market. Based on CMS's experience with the 2011 MLR reporting year, there are 2010 health insurance issuers (company/state combinations) offering coverage in the individual market and 1,050 issuers offering coverage in the small group market, while there are 2,294 unique issuers offering products in one or both markets. Most issuers would already have to provide this information to their respective states. However, using the same standardized template for both non-QHPs and QHPs would prevent significant duplication of effort for issuers. 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. The burden per issuer in each market is estimated to be 27.5 hours and estimated cost per issuer in each market is an estimated $6,188 each year. The total annual burden and costs are estimated to be 84,150 hours and $18,933,750 respectively. Details by market are summarized in the table below.

Table 12.1 Estimated Annualized Burden Hours and Costs for Rate Filing 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
Individual Market	2,010	2.5	5,025	27.5	$6,188	55,275	$12,436,875
Small Group Market	1,050	2.5	2,625	27.5	$6,188	28,875	$6,496,875
Total *	2,294		7,650			84,150	$18,933,750

*Note: The total number of respondents takes into account duplication across markets.

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 413 justifications submitted and posted annually.

Total Annual Burden Hours: 413 justifications x 1 hour to prepare and post = 413 hours
Total Annual Costs: 413hours x $225/hour = $92,925

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. Based on current experience, CMS estimates that 1293 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: 1,293 determinations x .33 hours = 426.69 hours
Total Annual Costs: 426.69 hours x $225/hour = $96,005.25

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 360 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: 360 reviews x 38.5 hours = 13,860 hours
Total Annual Costs: 360 reviews x $7,198 (cost per review) = $2,591,280

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 change in burden for health insurance issuer submission of rate review template is due to a change in the rate review program. Total cost is estimated to increase by approximately $16,300,000 and total burden is estimated to increase by 71,000 hours due to an increase in the estimated number of submissions and an increase in hourly cost. For state unreasonable rate increase determinations the burden is estimated to increase by approximately 209 hours and total costs are estimated to increase by approximately $52,400. This is due to an increase in the estimated number of reviews performed by states, based on experience with the current program and an increase in hourly cost. Based on current experience with the program, the number of issuer submissions of final justification for unreasonable rate increases have been lowered and

the related cost is estimated to decrease by approximately $147,000 and burden is estimated to decrease by 788 hours. The cost to federal government has been adjusted based on current experience and is estimated to decrease by approximately $1,300,000 and 6,930 hours due to a decrease in the estimated number of reviews performed by the federal government.

16. Publication and Tabulation Dates

As part of consumer transparency and disclosure, a consumer friendly disclosure form (populated from the information provided in the Rate Filing 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 previous regulation 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.