Supporting Statement – Part A

Disclosure of State Rating Requirements
(CMS-10454/OMB Control Number: 0938-1258)

A. Background

The Patient Protection and Affordable Care Act, Pub. L. 111-148, was enacted on March 23, 2010; and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, was enacted on March 30, 2010 (collectively known as the "Affordable Care Act"). The Affordable Care Act reorganizes, amends, and adds to the provisions 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.

The final rule "Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review"[1] implements important consumer protections included in sections 2701, 2702, and 2703 of the PHS Act, as added and amended by the Affordable Care Act, and sections 1302(e) and 1312(c) of the Affordable Care Act.

PHS Act section 2701 provides that health insurance issuers may vary premium rates for non-grandfathered health insurance coverage in the individual and small group markets based on a limited set of factors. The factors are, with respect to a particular plan or coverage: (1) whether the plan or coverage applies to an individual or family; (2) rating area; (3) age, limited to a variation of 3:1 for adults; and (4) tobacco use, limited to a variation of 1.5:1. The final rule standardizes rating methodologies, particularly with respect to age rating and certain aspects of family rating and allows flexibility for states when it comes to certain aspects of family, tobacco, age, geography, and small group rating. The final rule requires health insurance issuers in a market in a state to use a uniform age rating curve. A default age curve established by CMS will apply in a state, unless a state adopts a different uniform age curve. The HHS Notice of Benefits and Payment Parameters for 2018 Final Rule ("2018 Payment Notice")[2] amends the provisions related to age rating for children for plan or policy years beginning on or after January 1, 2018.

The uniform age bands for rating purposes under section 2701, as amended by the 2018 Payment Notice, are as follows:

- Children: A single age band for individuals age 0 through 14; and one-year age bands for individuals age 15 through 20.
- Adults: One-year age bands for individuals age 21 through 63.
- Older adults: A single age band for individuals age 64 and older.

A state may also elect to have a narrower age rating ratio than 3:1 and a narrower tobacco use rating ratio than 1.5:1. PHS Act section 2701(a)(2) requires a state to establish one or more rating areas within that state. In the event that a state does not establish rating areas consistent with the standards, the default will be one rating area for each metropolitan

1 78 FR 13405 (February 27, 2013)
2 81 FR 94058 (December 22, 2016)

statistical area (MSA) and one rating areas comprising all non-MSAs of the state. In addition, the final rule permits a state to require issuers to use a standard family tier methodology if the state requires pure community rating, without any adjustments for age or tobacco use. These rules will apply to the large group market, if, beginning in 2017, a state permits issuers that offer coverage in the large group market in the state to offer such coverage through the Exchange pursuant to section 1312(f)(2)(B) of the Affordable Care Act. The final rule also requires that issuers calculate rates for employee and dependent coverage in the small group market on a per-member basis, in the same manner that they calculate rates for persons in the individual market, and then calculate the group premium by totaling the premiums attributable to each covered individual. However, a state may require issuers to offer to a group premiums that are based on average enrollee amounts (composite premiums), provided that the total group premium equals the premium that would be derived through the per-member-rating approach.

Section 1312(c) of the Affordable Care Act provides that a health insurance issuer must consider all of its enrollees in all health plans (other than grandfathered health plans) offered by the issuer to be members of a single risk pool in the individual market and small group market, respectively. A state may also elect to merge its individual and small group market risk pools.

B. Justification

1. Need and Legal Basis

Statutory Basis: Section 2701 of the PHS Act, as added by the Affordable Care Act, and section 1312(c) of the Affordable Care Act.

Section 2701 of the PHS Act requires health insurance issuers to limit premium variation charged for non-grandfathered coverage in the individual and small group markets (and, if a state elects, the large group market starting in 2017) to certain factors (i.e., age, tobacco use, geography, and family size). In addition, this section applies in conjunction with section 1312(c) of the Affordable Care Act, which requires issuers to develop premiums based on a single risk pool in the individual and small group markets.

States will be permitted under section 2701 to establish state-specific rules relating to age rating ratios for adults that are less than 3:1, age curves applying the relevant age factors as amended in the 2018 Payment Notice, tobacco use rating ratios that are less than 1.5:1, geographic rating areas, and, in states that do not permit rating variation based on age or tobacco use, family tier structures and corresponding multipliers. States also will be able to merge their individual and small group market risk pools and require premiums to be based on average enrollee amounts (composite premiums) in the small group (or large group) market. CMS will need information on the state application of these factors in their individual and small group markets in order to determine whether state-specific rules or Federal default rules apply. CMS will also need this information in order to accurately implement the risk adjustment provisions of section 1343 of the Affordable Care Act for health plans in the states. Accordingly, states will need to disclose to CMS the rating factors and requirements applicable to their individual and small group markets.

2. Information Users

CMS will use the information on state rating requirements to determine whether state-specific rules or Federal default rules apply and to accurately implement the risk adjustment methodology for health plans in the states.

3. Use of Information Technology

States are expected to submit rating information to CMS electronically.

4. Duplication of Efforts

This collection does not duplicate other state reporting. The initial reporting has already occurred, and states only need to inform CMS of any changes in their rating requirements. Therefore, there is no duplication of efforts.

5. Small Businesses

Small businesses are not affected by this collection.

6. Less Frequent Collection

If states do not submit information to CMS on the application of state rating and risk pooling standards, CMS will not be able to determine whether state-specific rules or Federal default rules apply. CMS will also not be able to accurately implement the federal risk adjustment methodology for health plans in the states.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

A Notice was published in the Federal Register on July 26, 2017 (82 FR 24350), providing the public with a 60-day period to submit written comments on the ICRs. No comments were received.

9. Payments/Gifts to Respondents

No payments or gifts are associated with these ICRs.

10. Confidentiality

CMS will protect privacy of the information provided to the extent provided by law.

11. Sensitive Questions

These ICRs involve no sensitive questions.

12. Burden Estimates (Hours & Wages)

States are required to provide to CMS information on their rating ratios for age and tobacco use, geographical rating areas, age rating curves, and family tier structures, as applicable. They are also required to submit information to CMS if they require premiums to be based

on average enrollee amounts in the small group market and if they require merger of individual and small group market risk pools. The burden associated with this requirement is the time involved for states to provide to CMS information on the rating factors and requirements applicable to their small group and individual markets. The burden estimates have been updated based on experience. Based on past experience we expect, at most, 47 states will submit information on one or more rating factors. These estimates are considered to be upper-bound estimates as we expect the actual burden to be much lower since states only need to inform CMS of any changes in their rating requirements. Starting in 2017, if a state elects to allow issuers to offer QHPs in the large group market through the Exchange in the state, it will need to provide information for this market as well. We believe that few, if any, states currently allow this and the reporting will not add to the burden. We generally used data from the Bureau of Labor Statistics to derive average labor costs (all wage estimates have been adjusted by 100 percent to include fringe benefits)[3] for estimating the costs associated with the ICRs. We assume that the reports are prepared by clerical staff (at a cost of $55.68 per hour) and are reviewed by a senior manager (at a cost of approximately $117.40 per hour) prior to submission to CMS.

If a state adopts narrower rating ratios for age or tobacco use, or chooses to merge their individual and small group market risk pools, the state will inform CMS. We estimate that it will take 20 minutes for a state to prepare and submit a report to CMS for each of these disclosures. The total burden for 8 states reporting age rating ratios, 12 state reporting tobacco rating ratios and 4 states reporting merging of risk pools is estimated to be 8 hours at a total cost of approximately $445.

The final rule provides that a state's rating areas must be based on the geographic divisions of counties, three-digit zip codes, or MSAs and non-MSAs and will be presumed adequate if either of the following conditions are met: (1) As of January 1, 2013, the state had established by law, rule, regulation, bulletin, or other executive action uniform geographic rating areas for the entire state; or (2) After January 1, 2013, the state establishes by law, rule, regulation, bulletin, or other executive action for the entire state no more geographic rating areas than the number of MSAs in the state plus one. We anticipate that states that currently have geographic rating areas will retain them. For states that establish new or modified rating areas, we estimate that it will take one hour for a state to prepare and submit a report to CMS on its geographical rating areas. The total burden for 42 states submitting reports on rating areas is estimated to be 42 hours at a total cost of approximately $2,339.

If a state develops an age rating curve, the state will report the state's age rating curve to CMS. HHS's default standard age rating curve will apply in most states. We expect that 7 states will report having a different age curve. For states that designate their own curve, we estimate that it will take three hours for each state to prepare and submit a report on its age rating curve. The total burden for 7 states submitting reports on age rating curves is 21 hours at a total cost of approximately $1,169.

If a state is community rated and designates a uniform family tier structure with corresponding multipliers, the state will report family tier structure information to CMS.

3 May 2016 National Occupational Employment and Wage Estimates United States found at https://www.bls.gov/oes/current/oes_nat.htm.

We estimate it will take one hour to prepare and submit a report to CMS. The total burden for 5 states reporting family tier structure information is estimated to be 5 hours, at a total cost of approximately $278.

If a state requires premiums in the small group market (or large group market, if applicable) to be based on average enrollee amounts, it will submit that information to CMS. We estimate that it will take one hour for a state to prepare and submit the report on small group market premiums to CMS. The total burden for 10 states submitting reports on small group market premiums is estimated to be 10 hours at a total cost of approximately $557.

We assume that each report will be reviewed by a senior manager prior to submission to CMS and that it will take approximately one hour to review all reports, if a state needs to prepare and submit information in all of these areas. In total, the estimated burden for management review of all disclosures from 47 states is estimated to be 47 hours at a total cost of approximately $5,518.

Table 12.1 Estimated Annualized Burden Hours for Disclosure of State Rating Requirements

Forms (if necessary)	**Type of Respondent**	**Number of Respondents**	**Estimated Burden Hours per response**	**Total Estimated Burden Hours**	**Wage per Hour (including 100% fringe benefits rate)**	**Total Estimated Cost**
Disclosure of Age Rating Curve	State Government	7	3	21	$55.68	$1,169
Disclosure of Geographical Rating Areas	State Government	42	1	42	$55.68	$2,339
Disclosure of Family Tier Structure	State Government	5	1	5	$55.68	$278
Disclosure of Composite Premiums	State Government	10	1	10	$55.68	$557
Disclosure of Age Rating Ratio	State Government	8	0.33	2.6	$55.68	$149
Disclosure of Tobacco Rating Ratio	State Government	12	0.33	4	$55.68	$223
Disclosure of Merged Individual and Small Group Market Risk Pools	State Government	4	0.33	1.3	$55.68	$74
Management	State	47	1	47	$117.40	$5,518

Review (of all reports)	Government					
Total		47		133		$10,306

We expect that states that already have established a narrower age or tobacco rating ratio, family tier structure and requirements for small (or large) group market premiums to be based on average enrollee amounts, will retain them and simply incur the burden of reporting them. Based on our interactions with state officials and review of publicly available studies prepared by actuarial firms on the impact of the Affordable Care Act on the health insurance market in various states, we believe that many states have already studied the issue of merging their individual and small group market risk pools and will only incur the burden of reporting.

We estimate that 7 states will establish their own age rating curve and 42 states will establish geographical rating areas and incur related administrative costs. If a state chooses to establish its own age rating curve, it is likely to engage an actuarial consultant. We estimate that it will require approximately 100 hours of effort by an actuary (at a cost of $225 per hour) and 23 hours of combined labor by state actuaries (10 hours at a cost of approximately $110 per hour) and senior management (13 hours at a cost of approximately $117 an hour) to establish an age curve. The total burden for one state will be 123 hours and approximately $25,124. The estimated burden for 7 states will is 861 hours at a cost of approximately $175,865.

If a state chooses to establish new or modified geographic rating areas, staff actuaries are likely to conduct an analysis and prepare a report for management (30 hours at a cost of approximately $110 per hour) and senior management will review the reports and make a decision (2 hours at a cost of approximately $117 an hour). The total burden for one state would be 32 hours and approximately $3,527. The estimated burden for 42 states is 1,344 hours at a cost of approximately $148,134.

Table 12.2 Estimated One-time Burden Hours for Establishing State-specific Age Rating Curve and Geographical Rating Area

Forms (if necessary)	**Type of Respondent**	**Number of Respondents**	**Estimated Burden Hours per respondent**	**Total Estimated Burden Hours**	**Average Wage per Hour (including fringe)**	**Total Cost for all Respondents**
Age Rating Curve	State Government	7	123	861	$204	$175,865
Geographical Rating Area	State Government	42	32	1,344	$110	$148,134

13. Capital Costs

States are not expected to incur capital costs to fulfill these requirements.

14. Cost to Federal Government

CMS staff is expected to review the rating information submitted by states. We anticipate that a reviewer will need 4 hours to review each submission from a state, if the submission

includes all seven disclosures.

Table 14.1 Estimated Cost to Federal Government

Type of Federal Employee Support	Burden Hours per Review	Total Number of reviews	Total hours	Hourly Wage Rate (GS 14 equivalent) – (includes fringe)	Total Federal Government Costs
Review of state rating information	4	47	188	$107	$20,184

Salaries are based on a 14 Grade/Step 1 in the Washington DC area with a benefit allowance for a total annual salary of $224,042.

15. Changes to Burden

Total burden for reporting increased by 260 hours (from 2,078 hours to 2,338 hours) due to an increase in the number of states that establish and report age rating curves. The cost to the federal government increased by $6,360 due to use of updated labor cost and an increase in the number of states submitting notification they have developed their own age rating curve (from 5 to 7).

16. Publication/Tabulation Dates

There are no plans to publish the outcome of the data collection associated with these ICRs.

17. Expiration Date

The expiration date will be displayed on each instrument (top, right-hand corner).