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 area 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 Federal Register notice was published on March 13, 2024 (89 FR 18413), providing the public with a 60-day period to submit written comments on this information collection request (ICR). We received two comments, both of which were out-of-scope for this ICR.

9. Payments/Gifts to Respondents

No payments or gifts are associated with this collection.

10. Confidentiality

All information collected will be kept private in accordance with the Privacy Act of 1974 ((5 U.S.C. §552(a)) and Freedom of Information Act ((5 U.S.C. §552(b)).

11. Sensitive Questions

This collection does not involve any 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. States have already incurred the one-time costs of conducting necessary studies and submitting information on their rating factors to CMS. Based on past experience we expect that at most 3 States will submit information on one or more rating factors annually, since States only need to inform CMS of any changes in their rating requirements.

We generally used data from the Bureau of Labor Statistics to derive the median labor costs (all wage estimates have been adjusted by 100 percent to include fringe benefits)[3] for estimating the costs associated with the information collection.

TABLE 12.1: Adjusted Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Median Hourly Wage ($/hr.)	Fringe Benefits and Overhead ($/hr.)	Adjusted Hourly Wage ($/hr.)
Executive Secretaries and Executive Administrative Assistants	43-6011	$31.36	$31.36	$62.72
General and Operations Manager	11-1021	$61.95	$61.95	$123.90

We assume that the reports are prepared by clerical staff (at a cost of $62.72 per hour) and are reviewed by a senior manager (at a cost of approximately $123.90 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. Based on previous experience, we estimate that it will take 20 minutes for clerical staff in each State to prepare and submit a report to CMS for each of these disclosures. We anticipate that only 1 State will submit a report on merging risk pools and no State will submit a report on rating ratios for age or tobacco use. The total burden for 1 State to prepare a report on merging of risk pools is estimated to be 20 minutes at a total cost of approximately $21.

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. For States that establish new or modified rating areas, based on previous experience, we estimate that it will take 1 hour for clerical staff the State to prepare and submit a report to CMS on its geographical rating areas. The total burden for 1 State to submit a report on rating areas is estimated to be 1 hour at a total cost of approximately $63.

3 May 2023 National Occupational Employment and Wage Estimates United States - Federal, State, and local government, found at https://www.bls.gov/oes/current/999001.htm.

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. Based on previous experience, we expect that no more than 1 State will report having a different age curve. For the State that designate their own curve, we estimate that it will take 3 hours for clerical staff in that State to prepare and submit a report on its age rating curve. The total burden for 1 State to submit a report on age rating curves is 3 hours at a total cost of approximately $188.

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. Based on previous experience, we estimate it will take 1 hour for clerical staff to prepare and submit a report to CMS. However, based on experience, CMS does not expect any State to submit a report on the family tier structure information and thus does not expect there to be any burden or cost to any State.

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 3 hours for clerical staff in each State to prepare and submit the report on small group market premiums to CMS. However, based on previous experience CMS does not expect any State to submit a report on small group market premiums so we do not expect there to be any burden or associated cost to any State.

Based on previous experience, we believe that each report will be reviewed by a senior manager prior to submission to CMS and that it will take approximately 1 hour to review all reports, if a State needs to prepare and submit information to CMS. In total, the estimated burden for management review of disclosures for 3 States is estimated to be 3 hours at a total cost of approximately $372.

Table 12.2 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 fringe benefits rate)**	**Total Estimated Cost**
Disclosure of Age Rating Curve	State Government	1	3	3	$62.72	$188.16
Disclosure of Geographical Rating Areas	State Government	1	1	1	$62.72	$62.72
Disclosure of Family Tier Structure	State Government	0	1	0	$0	$0
Disclosure of Composite Premiums	State Government	0	3	0	$0	$0
Disclosure of Age Rating Ratio	State Government	0	0.33	0	$0	$0

Disclosure of Tobacco Rating Ratio	State Government	0	0.33	0	$0	$0
Disclosure of Merged Individual and Small Group Market Risk Pools	State Government	1	0.33	0.33	$62.72	$20.91
Management Review (of all reports)	State Government	3	1	3	$123.90	$371.70
Total		3		7.33		$643.49

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. The average salary of an employee who would be completing this task, which includes the locality pay adjustment for the area of Washington-Baltimore-Arlington, is listed in the table below.[4] We anticipate that a CMS staff member will need 1 hour to review each submission. We estimate the total burden to review 3 submissions will be 3 hours, and the estimated cost of the review will be approximately $401.

Table 14.1 Estimated Cost to Federal Government to Review Rating Information

Employee GS-Level	Responses	Burden per Response	Total Burden Hours	Hourly Wage Rate	Annual Cost to the Government
GS-14, Step 1	3	1	3	$134	$401

15. Changes to Burden

Total burden for reporting decreased by 9.67 hours (from 17 hours to 7.33 hours) because states will only incur the burden of reporting changes to their rating factors.

16. Publication/Tabulation Dates

Data from these data collections are published and accessible to the public. State geographic rating areas can be found at: https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/state-gra and information related to State specific rating variations is available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-

4 *See* OPM 2024 General Schedule (GS) Locality Pay Tables, available at https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/24Tables/html/DCB_h.aspx.

Insurance-Market-Reforms/state-rating.

17. Expiration Date

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