

Supporting Statement for Paperwork Reduction Act Submission
Rate Increase Disclosure and Review Requirements (45 CFR Part 154)
(CMS – 10379/OMB Control Number 0938-1141)

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 added 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 justifications for unreasonable premium increases to the Secretary and the applicable state prior to the implementation of the increases. Section 2794 also specifies that the Secretary, in conjunction with the states, shall monitor premium increases of health insurance coverage.

B. Justification

1. Need and Legal Basis

45 CFR Part 154 implements 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. Pursuant to Section 154.301, if CMS determines that a state has an Effective Rate Review (ERR) 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.

Section 154.200 establishes the timeline for states to propose state-specific thresholds for review and approval by CMS. Section 154.215 directs health insurance issuers to submit a rate filing justification and section 154.301 lists the criteria and factors for states to have an ERR program. These regulations are necessary to fulfill the statutory requirement to monitor premium increases of health insurance coverage. 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.

45 CFR 154.230 establishes a process to ensure the public disclosure of rate filing information and justification. The regulation establishes various reporting requirements for health insurance issuers, including a Rate Filing Justification for a proposed rate increase, and a Final Justification for any rate increase determined by a state or CMS to be unreasonable. 45 CFR 154.220 requires health insurance issuers to provide a Rate Filing Justification to both CMS and states if the issuer is seeking to implement rate increases. The Rate Filing Justification includes data supporting the requested 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). 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, the Unified Rate Review Template (URRT), is intended to capture information needed to monitor rate increases and ensure compliance with the single risk pool methodology and other federal rating requirements. Part I was previously only required for rate increases but will be required for all plans in the single risk pool (whether a plan's rate has increased, decreased or remained the same) starting with the 2017 plan year. This change was proposed to 45 CFR 154.215 in the HHS Notice of Benefit and Payment Parameters for 2017 (CMS-9937-P) and allows CMS to monitor premiums as required by Section 2794. Part II of the Rate Filing Justification is a written description justifying the rate increase, and is only required for rate increases exceeding the review threshold. Part III of the Rate Filing Justification consists of an Actuarial Memorandum providing the actuarial reasoning and assumptions, justifications, and methodologies that support the entries in Part I. Parts I and III are required to be completed and submitted for all rate increases the issuer has in a state. Part II, along with Parts I and III, 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, the issuer is required to submit a Final Justification of the increase to CMS and to the relevant state. The issuer must also 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.

By collecting rate change information for all single risk pool plans 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 went 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 proposed rate increase. States have the option to post at least the information in the Rate Filing

Justification that CMS makes available on its website or provide a hyperlink to the publically available portions posted on the CMS website. For consumer clarity, CMS will also post on its website the final disposition of each rate increase that was subject to review 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 I of the Rate Filing Justification (Unified Rate Review Template) was only required when an issuer was submitting a rate increase. CMS has expanded the information collection so Part I will be required for all rate changes. Part III, also known as the Actuarial Memorandum, is only required when a single risk pool plan is subject to a rate increase. All three parts (Unified Rate Review Template, Actuarial Memorandum and Written Description Justifying the Rate Increase) are required if a plan within a product has a rate increase that meets or exceeds the threshold and is therefore subject to review.

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 Part I of 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

There is no duplication of information requirements in 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

A Federal Register Notice will publish on XXXXXXXX, providing the public with a 60-day period to submit written comments on the information collection requirements contained in this notice.

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)

WAGE DATA INFORMATION

Wage Estimate

To derive average costs, we used data from the U.S. Bureau of Labor Statistics’ May 2014 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents the mean hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage.

Occupation	Occupation	Mean Hourly	Fringe	Adjusted Hourly
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Title	Code	Wage	Benefit	Wage
Actuary	15-2011	\$51.00	\$51.00	\$102.00

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Health Insurance Issuer Submission of Rate Filing Justification

All health insurance issuers will be required to file information and data using the unified rate review template (URRT) for all single risk pool plans in the individual and small group markets. Each issuer will submit only one file for all of their products in the same market. Issuers will be required to file an Actuarial Memorandum when a single risk pool plan is subject to a rate increase. Issuers will be required to file all three parts of the Rate Filing Justification (URRT, Actuarial Memorandum and Written Description Justifying the Rate Increase) if a plan within a single risk pool product has a rate increase that meets or exceeds the review threshold.

Submission of Unified Rate Review Template (Part I of Rate Filing Justification)

For the 2017 plan year, we expect the number of URRT submissions to increase by 1% (1606 submissions to 1622 submissions). This estimate is based on the new requirement for an issuer to submit a URRT for a product that has no rate change or a rate decrease and the fact that most issuers already have to provide a URRT to their respective states or HHS.¹ Using the same standardized template for all rates prevents significant duplication of effort for issuers. Based on current experience, we estimate that approximately 1081 issuers will have 1.5 submissions each year and each submission will require 11 hours of work by an actuary (at a cost of \$102 per hour) including minimal time required for recordkeeping. The burden per issuer is estimated to be 16.5 hours and estimated cost per issuer is an estimated \$1,683 each year. The total annual burden and costs are estimated to be 17,837 hours and \$1,819,374 respectively.

Submission of Written Description Justifying the Increase (Part II of Rate Filing Justification)

In the 2017 plan year, we estimate that the number of written justifications that will be submitted will increase by 11%. That estimate is based on the requirement to file a written justification for a product that includes any plan with an increase subject to review rather than filing when the product itself has an increase subject to review. We estimate that each written justification will require 1 hour of work by an actuary. The burden per issuer is estimated to be 1.5 hours and the estimated cost per issuer (\$102 per hour) is an estimated \$153 per year.

¹ Issuers already provide a URRT when: 1) a plan within the issuer’s single risk pool has a rate increase; 2) the issuer’s State regulator requires submission of the URRT; 3) the issuer is seeking to offer a QHP through a Federally-Facilitated or State Partnership Exchange; or 4) the issuer chooses to use the URRT to satisfy the requirement to annually set an index rate.

Submission of Actuarial Memorandum (Part III of Rate Filing Justification)

For the 2016 plan year, issuers submitted 1606 actuarial memoranda. Since issuers must submit an Actuarial Memorandum for rate increases only and there are no changes to that requirement, we estimate that the number of Actuarial Memoranda that will be submitted going forward will not increase. We estimate that each Actuarial Memorandum requires 14 hours of work by an actuary. The burden per issuer is estimated to be 21 hours and the estimated cost per issuer (\$102 per hour) is an estimated \$2,142 per year.

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
Unified Rate Review Template (Part I)	1081	1.5	1621	16.5	\$1,683	17,837	\$1,819,32
Written Justification (Part II)	1081	0.4	446	1.5	\$153	675	\$165,39
Actuarial Memorandum (Part III)	1081	1.5	1606	21	\$ 2,142	22,701	\$2,315,50

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

Health Insurance Issuer Submission of Final Justification for Unreasonable Rate Increases

Pursuant to §154.230(c), if a health insurance issuer implements a rate increase that has been determined to be unreasonable, the issuer is required to submit to CMS and the relevant state a Final Justification and to display this information on their websites. Based on current experience, we estimate there will be approximately 3 justifications submitted and posted annually.

Total Annual Burden Hours: 3 justifications x 1 hour to prepare and post = 3 hours

Total Annual Costs: 3 hours x \$102/hour = \$306

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 (\$102 per hour) approximately 1 hour to prepare and post. Based on current experience, we estimate that there will be approximately 16 justifications submitted and posted annually.

Total Annual Burden Hours: 16 justifications x 1 hour to prepare and post = 16 hours

Total Annual Costs: 16 hours x \$102 per hour = \$1,632

State Unreasonable Rate Increase Determinations

If CMS determines that a state has satisfied specific criteria for an Effective Rate Review (ERR) 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 ERR Program, CMS will make its own determinations regarding whether a rate increase that meets or exceeds the established threshold is unreasonable. For the 2017 plan year, CMS estimates that the number of rate reviews by States will increase by 11% due to the change in policy that applies the review threshold at the plan level rather than product level. We estimate that the states will review an additional 402 submissions that have at least one plan that meets or exceeds the review threshold.

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 ERR 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 (\$80 per hour) approximately 20 minutes to prepare and submit this information to CMS.

Total Annual Burden Hours: 402 determinations x .33 hours = 133 hours

Total Annual Costs: 133 hours x \$80 per hour = \$10,640

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 ERR 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. For the 2017 plan year, CMS estimates that it will review 44 rate increases annually (11% more than the number reviewed in the 2016 plan year). 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	Average Time

Complete Average Review	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: 44 reviews x 38.5 hours = 1,709 hours

Total Annual Costs: 44 reviews x \$7,198 (cost per review) = \$319,591

Additionally, CMS will determine whether a state’s rate review program meets the requirements of an ERR Program set forth in the rule based on information received from the state through the grants 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.

15. Changes to Burden

There is an overall decrease in burden hours associated with this information collection (from 84,990 hours to 41,213 hours) . We expect the number of submissions to increase slightly (1%) because most issuers offering single risk pool coverage already submit the Template. The URRT is required when: 1) a plan within the issuer’s single risk pool has a rate increase; 2) the issuer’s State regulator requires submission of the URRT; 3) the issuer is seeking to offer a QHP through a Federally-Facilitated or State Partnership Exchange; or 4) the issuer chooses to use the URRT to satisfy the requirement to annually set an index rate. We believe that requiring the submission of the URRT for all rates, rather than requiring submission of a new document for products with no rate change or rate decreases, will reduce administrative burden for issuers while providing the Secretary and the States with the information necessary to more effectively carry out their responsibilities to monitor rate increases inside and outside of Exchanges.

The change in burden for health insurance issuer submission of a Written Description Justifying the Rate Increase for products that contain a plan with a rate increase that meets or exceeds the review threshold is due to regulatory changes finalized in the HHS Notice of Benefit and Payment Parameters for 2016 Final Rule (80 FR 39, February 27, 2015). Total cost to issuers is estimated to increase by approximately \$6,732 in plan year 2017. For state unreasonable rate increase determinations the total burden is estimated to increase by approximately \$2,040.

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 proposed rate increases and for all final rates. A final disposition of the rate review will also be posted and, if the rate is identified as unreasonable and implemented by the issuer, the issuer 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.