Billing Code: 4120-01-U-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS-10180, CMS-R-199, CMS-10379 and CMS-10418]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS) is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. Type of Information Collection Request: Extension of a currently approved collection; Title of Information Collection: Children's Health Insurance Program (CHIP) Report on Payables and Receivables; Use: Collection of CHIP data and the calculation of the CHIP Incurred But Not Reported (IBNR) estimate are pertinent to CMS' financial audit. The CFO auditors have reported the lack of an estimate for CHIP IBNR payables and receivables as a reportable condition in the FY 2005 audit of CMS's financial statements. It is essential that CMS collect the necessary data from State agencies in FY 2006, so that CMS continues to

receive an unqualified audit opinion on its financial statements. Program expenditures for the CHIP have increased since its inception; as such, CHIP receivables and payables may materially impact the financial statements. The CHIP Report on Payables and Receivables will provide the information needed to calculate the CHIP IBNR.; Form Number: CMS-10180 (OMB#: 0938–0988); Frequency: Reporting – Annually; Affected Public: State, Local or Tribal governments; Number of Respondents: 56; Total Annual Responses: 56; Total Annual Hours: 392. (For policy questions regarding this collection contact Michele Myers at 410-786-7911. For all other issues call 410-786-1326.)

2. Type of Information Collection Request: Extension of a currently approved collection; Title of Information Collection: Medicaid Report on Payables and Receivables; Use: The Chief Financial Officers (CFO) Act of 1990, as amended by the Government Management Reform Act (GMRA) of 1994, requires government agencies to produce auditable financial statements. Because the Centers for Medicare & Medicaid Services (CMS) fulfills its mission through its contractors and the States; these entities are the primary source of information for the financial statements. There are three basic categories of data: expenses, payables, and receivables. The CMS-64 is used to collect data on Medicaid expenses. The CMS-R-199 collects Medicaid payable and receivable accounting data from the States. Form Number: CMS-R-199 (OMB#: 0938–0697); Frequency: Reporting – Annually; Affected Public: State, Local or Tribal governments; Number of Respondents: 56; Total Annual Responses: 56; Total Annual Hours: 336. (For policy questions regarding this collection contact Michele Myers at 410-786-7911. For all other issues call 410-786-1326.)

3. Type of Information Collection Request: Extension of a currently approved collection;

Title of Information Collection: Rate Increase Disclosure and Review Reporting Requirements (45 CFR Part 154). Use: Under the Section 1003 of the Affordable Care Act (Section 2794 of the Public Health Service Act), The Secretary, in conjunction with the States, is required to establish a process for the annual review, beginning with the 2010 plan year, of unreasonable increases in premiums for health insurance coverage. Section 2794 directs the Secretary to ensure the public disclosure of information of unreasonable rate increases and justification for those increases.

On December 23, 2010, CMS published a proposed rate review regulation in the Federal Register for public comment (Rate Increase Disclosure and Review Rule, 75 FR 81004). CMS revised the proposed rule based on the public comments and published the final rate review regulation in the Federal Register on May 19, 2011. The final rule defines the unreasonable rate review process and issuer reporting and disclosure requirements (Rate Increase Disclosure and Review Rule, 76 FR 29964). The regulation establishes the following reporting requirements:

- The Preliminary Justification: This data collection is required of all health insurance issuers for all rate increases that exceed the "subject to review"' reporting threshold as defined in the rule. This information will be posted on an HHS website.
- Rate Review Final Determination: This data collection requires States with effective rate review programs and CMS to report their review findings and unreasonable rate increase determinations on all rate increases that are subject to review. This information will be posted on an HHS website.
- The Final Justification for An Unreasonable Rate Increase: This data collection is required of health insurance issuers that elect to implement a rate increase that is determined to be

unreasonable based on State or CMS review. This information will be posted on the Health Insurance Issuer's website and on a CMS website.

1. Preliminary Justification

The Preliminary Justification consists of three parts, Part I: Rate Increase Summary, Part II: Written Explanation of the Rate Increase, and Part III: Rate Filing Documentation. Issuers must complete Parts I and II for all rate increases that exceed the reporting threshold as defined in the rule. As described in the preamble of the rule, this information would be collected to provide consumers with basic information on all rate increases that are subject to review under the rate review program.

Under the rule, "subject to review" rate increases would be reviewed by either States or CMS , depending on whether a State has an effective rate review program. Issuers would only be required to submit Part III of the Preliminary Justification when CMS is conducting the review of a rate increase that is "subject to review." Accordingly, Part III requires health insurance issuers to provide detailed rate data that would be used for the purposes of conducting thorough actuarial reviews and for making determinations about whether rate increases are unreasonable. This Notice contains the following information about the Preliminary Justification:

- Preliminary Justification Issuer Instructions: health insurance issuer instructions for completing all three parts of the Preliminary Justification.
- Part I Worksheet: a standardized Excel worksheet that must be used to complete Part I of the Preliminary Justification.
- Sample internet display of the Rate Review Consumer Disclosure: Information provided in the Preliminary Justification would be posted on an HHS website. This sample display

shows how the information contained in the Part I Worksheet would be displayed to consumers.

2. Rate Review Final Determination

Under the rule, States and CMS would have to provide a Rate Review Final Determination at the close of their review of all "subject to review" rate increases. The Rate Review Final Determination must provide the State's or CMS' determination on whether a rate increases is 'unreasonable'. Section 154.301(a)(3) of the rule provides a list of actuarial review elements that must be taken into account as part of the rate review process. The Final Determination must provide a brief statement explaining how the review of elements set forth in § 154.301(a)(3) caused the State or CMS to arrive at its determination that the rate is unreasonable.

The Rate Review Final Determination will be entered into a data entry text box in the Rate Review Data Collection System. CMS is estimating that this statement would be approximately a paragraph in length. There is no specific form or set of instructions associated with this reporting requirement, apart from the reporting requirements provided in the rule. The information provided in the Rate Review Final Determination will be posted as part of the rate review consumer disclosure information on an HHS website.

3. Final Justification for An Unreasonable Rate Increase

The rule states that if a health insurance issuer implements a rate increase determined by CMS or a State to be unreasonable, the health insurance issuer must provide a Final Justification for an Unreasonable Rate Increase. In the Final Justification, issuers would have to provide a short statement about why they are electing to implement an unreasonable rate increase. This statement would be entered into a data entry text box in the Rate Review Data Collection System

and would not need to be more than a paragraph or two in length. There is no form or instructions associated with this statement apart from the requirements provided in the regulation.

The Final Justification Statement will be posted on an HHS website in the same location as the Preliminary Justification and Rate Review Final Determination. Additionally, health insurance issuers implementing rate increases that were determined to be unreasonable, must post all of this information—the Preliminary Justification, the Rate Review Final Determination, and the Final Justification Statement on their websites for a period of 3 years.

In addition to the aforementioned requirements, we revised the information collection request as a result of an amendment to the regulation discussed in the final rule that published September 6, 2011 (76 FR 54969). The amendment to the rate review final rule updated the applicability of the rate review requirements to include products that would be considered part of the individual or small group market had they not been sold through associations, including those that are consider to be large group products under State law or have been otherwise excluded from State's existing definitions for individual and small group products. This change resulted in an increase in the total number of rate increases that are subject to the rate review reporting requirements. The amendment did not propose any changes to the information that issuers must submit for each rate increase. Thus, burden associated with each rate increase submission remains unchanged from the final rate review rule. The revised association product reporting requirements took effect on November 1, 2011. CMS received a 6 month Emergency PRA approval for the revised association reporting requirements on October 31, 2011 (OMB-0938-1141). CMS is now requesting a 3-year OMB approval of these collection requirements. Form

Number: CMS-10379; (OCN: 0938-1141) Frequency: Annually; Affected Public: Private Sector and States; Number of Respondents: 452; Number of Responses: 3,571; Total Annual Hours: 14,630. (For policy questions regarding this collection, contact Sally McCarty at (301) 492-4489. For all other issues call 410-786-1326.)

4. Type of Information Collection Request: New information collection; Title of Information Collection: Medical Loss Ratio Annual Reporting and Rebate Calculation; Use: Under Section 2718 of the Affordable Care Act and implementing regulations at 45 CFR Part 158 (75 FR 74864, December 1, 2010 (Interim Final Rule); 75 FR 82277, December 30, 2010 (Technical Correction); and 76 FR 76574, December 7, 2011 (Final Rule with comment period), a health insurance issuer (issuer) offering group or individual health insurance coverage must submit a report to the Secretary concerning the amount the issuer spends each year on claims, quality improvement expenses, non-claims costs, Federal and State taxes and licensing and regulatory fees, and the amount of earned premium. An issuer must provide an annual rebate to enrollees if the amount it spends on certain costs compared to its premium revenue (excluding Federal and States taxes and licensing and regulatory fees) does not meet a certain ratio, referred to as the medical loss ratio (MLR). An interim final rule (IFR) implementing the MLR was published on December 1, 2010 (75 FR 74865) and modified by technical corrections on December 30, 2010 (75 FR 82277), which added Part 158 to Title 45 of the Code of Federal Regulations. The IFR is effective January 1, 2011. A final rule regarding selected provisions of the interim final rule was published on December 7, 2011 (76 FR 76574) and an interim final rule regarding an issue not included in issuers' reporting requirements (distribution of rebates by non-federal governmental plans) was also published on December 7, 2011 (76 FR 76596). Each

issuer is required to submit MLR data annually, including information about any rebates it must provide, on a form prescribed by CMS for each large group market, small group market, and individual market within each State in which the issuer conducts business. Data is to be submitted electronically through CMS' Health Insurance Oversight System (HIOS). Additionally, each issuer is required to maintain for a period of seven years all documents, records and other evidence that support the data included in each issuer's annual report to the Secretary. Form Number: CMS-10418; Frequency: Annually; Affected Public: Private Sector: Business or other for-profits and not-for-profit institutions; Number of Respondents: 527; Number of Responses: 5,530; Total Annual Hours: 352,563. (For policy questions regarding this collection, contact Carol Jimenez at (301) 492-4457. For all other issues, call (410) 786-1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web Site address at http://www.cms.hhs.gov/PaperworkReductionActof1995, or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov, or call the Reports Clearance Office on (410) 786-1326.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by **[OFR—insert date 60 days after date of publication in the Federal Register]**:

1. Electronically. You may submit your comments electronically to http://www.regulations.gov. Follow the instructions for "Comment or Submission" or "More

Search Options" to find the information collection document(s) accepting comments.

2. By regular mail. You may mail written comments to the following address:

CMS, Office of Strategic Operations and Regulatory Affairs

Division of Regulations Development

Attention: Document Identifier/OMB Control Number _____

Room C4-26-05

7500 Security Boulevard

Baltimore, Maryland 21244-1850.

Dated: December 13, 2011

Martique Jones,

Director, Regulations Development Group, Division B

Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2011-32290 Filed 12/15/2011 at 8:45 am; Publication Date: 12/16/2011]