



Health Plans' Estimated Costs of Compliance with Expanded Federal Rate Review and with Data Collection for Risk Adjustment and Reinsurance

December 2012

In December 2012, AHIP conducted two surveys of member health plans regarding new regulatory guidelines released by the Department of Health & Human Services (HHS) for implementation of the Affordable Care Act. Plans were asked to submit responses to surveys concerning: 1) the proposed expansion of the federal rate review and data submission process, and 2) the proposed risk adjustment and reinsurance data collection process.

In the proposed rules, HHS specifically asked for input from health plans on the cost estimates of these proposals; this report provides a preliminary response to that request. The two surveys asked plans about the expected costs associated with these proposed regulations, and allowed for open-ended comments and contextual responses.

In general, health plans estimated that the incremental cost of rate filing and data submission for federal rate review purposes would be roughly 70 percent higher than the HHS estimate. Health plans estimated that the cost per filing would be about \$4,300.

Plans estimated that the cost of the data collection process for risk adjustment and reinsurance could range from about \$1.3 million (median estimate) to over \$5 million (average estimate) per plan. HHS had estimated that the cost would be approximately \$300,000 per plan and that the total system-wide cost would be just under \$600 million. However, based on the health plans' estimates, the total system-wide cost could be well over \$1 billion.

1. FEDERAL RATE REVIEW SURVEY

Under current regulations, health plans are required to submit rate filings to the federal government for any comprehensive, major medical coverage in the small group and individual markets if the annual premium would increase by 10 percent or more.

Under the proposed rule and associated Paperwork Reduction Act package, insurers would be required to file their rates for *all* products in these markets with the federal government, regardless of the magnitude of the rate increase. Thus, the new policy expands the breadth of the federal rate filing process to include products with rate reductions, with rate

increases less than 10 percent, and those with static rates.

The proposed rule also requires that each rate filing include a much more extensive data submission than the current federal rate filings require. The expanded data submission requirements would be reported in a new standardized format developed by HHS.

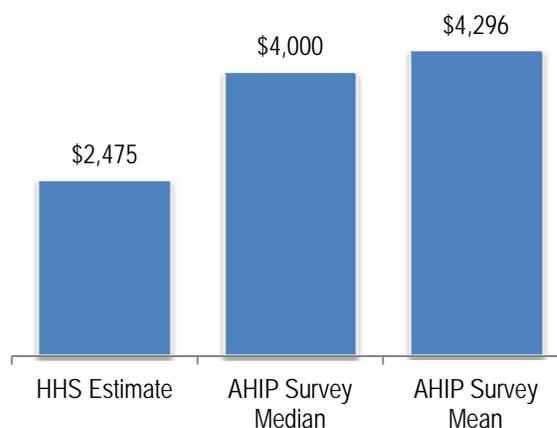
The proposed changes to the federal rate review rule were formally published in the Federal Register on November 26, 2012.¹ HHS estimates the new requirement that health plans file all rates with the federal government will increase the total number of filings and data submission episodes by about 6,450 per year at an average direct cost of \$2,475 per submission.

AHIP surveyed health plans on the number of additional rate filings they expect, their estimated direct administrative costs per filing, and likely one-time systems costs of compliance with the proposed rule. Responding plans reported a wide variety of enrollment levels and geographic representations; combined small group and individual market enrollment among the responding plans ranged from approximately 1,000 to nearly 1 million (total covered lives). Responses were received from large multi-state plans, single-state plans, and local or regional plans.

Among responding plans, the median number of federal rate review filings under current regulations

¹ Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review; Proposed Rule, Federal Register 77:227, (26 November 2012) <http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf>. Paperwork Reduction Act Submission: Rate Review Information Collection, 45 CFR Part 154, CMS Form Number: 10379 (November 20, 2012).

Figure 1. HHS and AHIP Member Survey Estimates on Direct Administrative Cost per Rate Review Submission



Source: AHIP Center for Policy and Research (2012).

was approximately 2 or 3 in 2012 (for coverage with premium increases of 10 percent or more). However, plans' expectations for future submissions under the proposed rule requiring filings for all products varied widely, ranging from a few (between 0 and 4) additional submissions per plan to dozens more (between 20 and 40).

Based on the survey responses, there was no obvious correlation between the size of a plan (number of covered lives) and the number of additional rate review submissions expected. Although the survey did not ask plans for a rationale for responses to this question, it is possible that some responding plans may not have been required to file rates to the federal government under the current regulation, because they have not had rate increases of 10 percent or more. Thus, there may be considerable uncertainty in their estimates of the number of new filings required.

The HHS cost estimate for the direct administrative costs of each additional submission (\$2,475) is comprised of an estimated 11 hours of additional

actuarial work time at a rate of \$225 per hour.² This estimate works out to an expected cost of \$7,000 per issuer, based on an average of about 2.8 additional filings from 2,294 health plans.

The HHS estimates appear to be somewhat lower than the estimates of direct administrative costs made by the responding plans, which ranged from \$2,000 to \$10,000 per submission. Among responding plans, the median expected average cost for each additional filing was about \$4,000 and the average was \$4,296, approximately 70 percent higher than the HHS estimate (see Figure 1). Most plans stated that the additional costs stemmed mostly from actuarial staff and peer review, as well as information technology (IT) resources. Plans also indicated that another cost driver would be the time and resources invested in follow-up questions or requests from regulators regarding the new data submissions, although those costs were uncertain.

The proposed rule also notes that in order to meet the new rate filing and data submission guidelines, plans would have to implement one-time upgrades to their current IT systems to “provide the data required in the standardized data template.”³

In the proposed rule, HHS asked for input regarding the cost of one-time systems cost of automating the new data submissions for each federal rate review. According to our survey, plans’ estimates of these one-time systems costs varied widely. Some plans surveyed estimated costs between \$500,000 and \$1 million for IT changes, and the estimated time frame to implement the system changes ranged from 100 to 1,000 hours. One plan mentioned having to hire a

new staff member at an annual cost of \$100,000. Another plan indicated that it did not intend to re-automate its filing and data submission system.

Based on open-ended comments received, plans generally agreed that much IT involvement will be needed to comply with the new regulation. Plans also agreed that revising the current rate filing process would consume many resources and could be viewed as inefficient, compared with other uses of IT department time and resources, because it duplicates other processes already in place. One comment noted that plans’ administrative costs are already being federally monitored under the minimum loss ratio (MLR) process, and that this new filing requirement would raise their administrative costs in contradiction to the MLR requirement’s stated goal of reducing administrative costs. Another plan noted that the format for the new federal rate filing and data submission system (called HIOS, for Health Insurance Oversight System, which is administered by HHS) is not the same as the common system used by the states (called SERFF, for System for Electronic Rate and Form Filing, which is maintained by the National Association of Insurance Commissioners), causing a duplication of effort and additional costs.

Selected Open-Ended Comments. The following are direct quotes from the open-ended survey questions regarding the proposed rate review rule.

“This is a source of additional administrative costs and appears to be a serious contradiction to proposed goals of increasing efficiency as seen in the MLR requirements.”

“[A]ctuarial resources may be tied up in filling out templates that may or may not be consistent with current rating practices.”

² Federal Register 77:22, (26 November 2012) p.70608

³ Federal Register 77:22, (26 November 2012) p.70609

“Several of the data elements contained in the new rate template are not currently nor expected to be derived as a part of our normal rate review process. Therefore, additional data will need to be pulled and new reporting and data storage processes, as well as new cost allocation methods, will need to be developed and maintained with no business purpose other than to complete this template. This will add significantly to the actuarial time needed to complete a rate filing particularly in the first year.”

“We have serious concerns about the increased burdens this will create on carriers while not adding any value for consumers, especially in states that have already been designated as effective rate review states. In addition, the duplicative reporting through a second system—HIOS instead of SERFF—requires carriers to report the same information in 2 different places. And given that the federal templates are completely different from state reporting

requirements, it requires carriers to report the same information in a different format. The reporting should continue to be at the state level, through SERFF, and in order to meet the requirements of Section 2794 of the PHS Act, the Secretary should obtain this information from the states through the reporting they get through SERFF.”

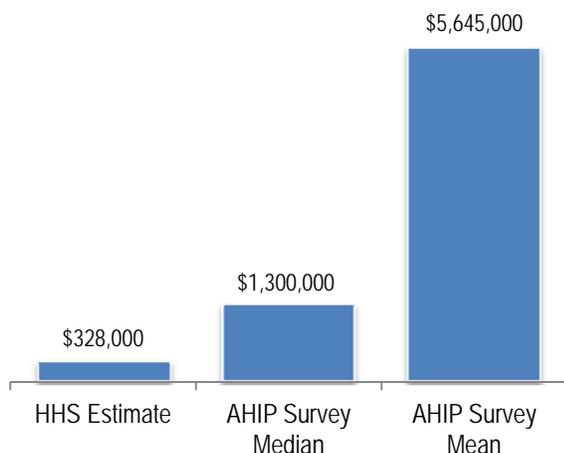
2. RISK ADJUSTMENT AND REINSURANCE SURVEY

The proposed risk adjustment and reinsurance data preparation rule was formally published in the Federal Register on December 7, 2012.⁴ Under this rule, insurers would be required to comply with new regulations concerning the data elements required for risk adjustment and reinsurance.

According to the proposed rule, HHS estimates that the new requirements

“...will affect 1,800 issuers, and will cost each issuer approximately \$327,600 in total labor and capital costs (including the average cost of \$15,000 for a data processing server) during the start-up year. This cost will be lower in future years when fixed costs decrease. This cost reflects an estimate of 3 full-time equivalent employees (5,460 hours per year) at an average hourly rate of \$59.39 per hour. We anticipate that approximately 400 data processing servers will be established across the market in 2014, and these servers will process approximately 9

Figure 2. HHS and AHIP Member Survey per Plan Estimates for Capital and Labor Costs of the Proposed Rule



Source: AHIP Center for Policy and Research (2012).

⁴ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014; Federal Register 77:236, (7 December 2012) <http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29184.pdf>

billion claims and enrollment files. Therefore, we estimate an aggregate burden, including labor and capital costs, of \$589,680,000 for all issuers as a result of these requirements.”⁵

On a per-plan basis, responding companies estimated the labor and capital costs of the proposed rule would be significantly higher than the HHS estimate of \$327,600. Cost estimates of the plans ranged from \$391,500 to \$25 million, with the median cost of about \$1.3 million and the average cost being approximately \$5.6 million (see Figure 2). Thus, it would follow that the overall compliance cost of this regulation would likely be far higher than the \$589 million cited by HHS. (In this survey, costs appeared to be directly related to the size of the plan.) Plans estimated the hourly cost for full-time employees performing tasks related to data submission requirements would range from \$60 to \$100 per hour compared to the HHS estimate of \$59.39 per hour. Plans also anticipated the need of hiring contract staff at a higher rate of \$120.00 per hour. One plan estimated having to hire over 60 additional employees to fulfill these requirements.

Selected Open-Ended Comments. Plans responding to the risk adjustment and reinsurance data submission survey included several open-ended comments, often specifying their detailed IT costs. One company noted expenses in the following areas:

“Ongoing license fees for software to manage the system, job scheduler, and back up. Ongoing resources to review the files, work errors, and resubmit files. Possible development costs to change claims processing, premium billing,

rating, and other up streams to meet HHS file submission requirements.”

DISCUSSION

Due to the short time frames between the publication of the two proposed rules and the deadline for comments, some of the results in this report should be considered preliminary. For example, we noted that several responding health plans indicated uncertainty about how many additional rate filings they would be required to submit to the federal government; other responses indicated a degree of uncertainty with regard to compliance with the broader data submission requirements that would accompany those filings.

Because of its very high cost, one key recommendation in AHIP’s formal comments on these new regulations is that the minimum loss ratio (MLR) regulations be amended to allow the data collection costs associated with the risk adjustment and reinsurance system—which could amount to considerably more than the HHS estimate of \$589 million—to be excluded from the definition of premium revenue. Since these costs are essentially mandated by regulation, they are not discretionary, and therefore should be considered to be more like a regulatory fee rather than the sort of administrative cost that would typically be subject to the MLR regulation.

A precedent for AHIP’s recommended treatment of these costs would be treatment of other regulatory fees like the Patient-Centered Outcomes Research Institute (PCORI) fee, the federally-facilitated exchange user fee, the risk adjustment user fee, and state and federal taxes such as the Health Insurance Tax, which is a new federal premium tax imposed on certain types of health insurance coverage (small group, individual market, health insurance exchange,

⁵ Federal Register 77:236, (7 December 2012) p.73191

Medicare and Medicaid managed care). These fees and taxes are not discretionary administrative costs for the purposes of the MLR calculations.

It is important to keep in mind that the all costs associated with these and other regulations are ultimately paid by consumers and employers in the form of higher premiums. Additional expenditures for regulatory compliance, on top of rising costs for medical benefits and other taxes and fees, will ultimately add to the cost of coverage for health care purchasers.

ACKNOWLEDGEMENTS

The survey results were compiled and analyzed by Cameron Lloyd, Research Analyst for AHIP's Center for Policy and Research.

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