(D) Inability to electronically prescribe due to local, State or Federal law or regulation.

(E) Limited prescribing activity.

(F) Insufficient opportunities to report the eRx measure due to limitations of the measure's denominator.

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(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: August 25, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: August 26, 2011.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 154

[CMS–9999–F]

RIN 0938–AR26

Rate Increase Disclosure and Review: Definitions of ''Individual Market'' and ''Small Group Market''

AGENCY: Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule amends a May 23, 2011, final rule entitled ''Rate Increase Disclosure and Review''. The final rule provided that, for purposes of rate review only, definitions of ''individual market'' and ''small group market'' under State rate filing laws would govern even if those definitions departed from the definitions that otherwise apply under title XXVII of the Public Health Service Act (PHS Act). The preamble to the final rule requested comments on whether this policy should apply in cases in which State rate filing law definitions of ''individual market'' and ''small group market'' exclude association insurance policies that would be included in these definitions for other purposes under the PHS Act. In response to comments, this final rule amends the definitions of ''individual market'' and ''small group market'' that apply for rate review purposes to include coverage sold to individuals and small groups through associations even if the State does not include such coverage in its definitions of individual and small group market. This final rule also updates standards for health insurance issuers regarding disclosure and review of unreasonable premium increases under section 2794 of the Public Health Service Act.

DATES: *Effective date.* This rule is effective on November 1, 2011.

FOR FURTHER INFORMATION CONTACT: Sally McCarty, (301) 492–4489 (or by e-mail: *ratereview@hhs.gov*).

SUPPLEMENTARY INFORMATION:

I. 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 preamble, 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 adds 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 to the Secretary and the applicable State justifications for unreasonable premium increases prior to the implementation of the increases. Section 2794 of the PHS Act does not apply to grandfathered health insurance coverage, nor does it apply to self-funded plans.

On December 23, 2010, we published a Notice of Proposed Rulemaking to implement section 2794. Among other things, because of unique characteristics of State rate review and for purposes of administrative efficiency, we proposed to adopt definitions of the individual and small group markets that would defer to definitions set forth in State rate filing laws. We did not discuss in the proposed rule, or anticipate, how association policies would be treated under the proposal. Regardless, we received a number of comments objecting to the definitions as they would apply to association plans. On May 23, 2011, we published a final rule with comment period (76 FR 29964), in which we specifically solicited further comments on amending the definitions of ''individual market'' and ''small group market'' in § 154.102 to include coverage sold to individuals and small groups through associations in all cases.

We received 30 comments in the comment period. Commenters included the National Association of Insurance Commissioners (NAIC); a State insurance regulator; many consumer and public interest organizations; associations sponsoring insurance plans for their individual and employer members; health care providers; health insurance issuers and related trade associations (collectively, ''industry''); and others. After consideration of the comments, we are amending the May 23, 2011 final rule to provide that individual and small employer policies sold through associations will be included in the rate review process, even if a State otherwise excludes such coverage from its definitions of individual and small group market coverage.

II. Provisions of the May 23, 2011 Final Rule With Comment and Responses to Comments

In the May 23, 2011 final rule, we solicited comments regarding whether to amend the definitions of ''individual market'' and ''small group market'' in § 154.102 to include coverage sold to individuals and small groups through associations in the rate review process, even if the State excludes such coverage from its definitions of individual and small group market coverage. Additionally, we solicited comments to address the following questions:

1. Do States currently review rate increases for association and out-of-State trust coverage sold to individuals and small groups, regardless of whether the policies are sitused in or outside of their States?

2. How many rate filings do States receive for association and out-of-State trust coverage?

3. How prevalent are association and out-of-State trust coverage arrangements? What percentage of individual market and small group market business is sold through associations and out-of-State trusts?

4. In which States is association and out-of-State trust coverage commonly purchased by individuals and small groups? Where are out-of-State trusts typically situated?

5. Why do some individuals and small employers purchase coverage through associations and out-of-State trusts rather than through the traditional markets? Are there particular groups of individuals or types of small employers that typically purchase coverage through associations and out-of-State

trusts? What organizations (other than issuers) typically sponsor, endorse, or market association and out-of-State trust arrangements?

6. How do rate increases for association and out-of-State trust coverage sold to individuals and small groups compare to rate increases in the traditional market? What explains the differences (if any) between rate increases for association and out-of-State trust coverage and traditional market coverage?

Comment: Most commenters, including State regulators, consumer advocates, the insurance industry representatives, and three affected associations, supported including individual and small group association coverage in the definitions of ''individual market'' and ''small group market'' in § 154.102, even where such coverage was not included in those definitions under State rate filing laws, so that more individuals and small employers would benefit from rate review. According to comments from consumer advocates and some of the affected associations, if association coverage was not included in the rate review rule, the association coverage market would be treated differently from traditional markets in some States, and consumers in these plans would not benefit from the Affordable Care Act's rate review process. State regulators and consumer advocates noted that, in the past, State law exceptions for association health plans had allowed them to avoid market reforms such as guaranteed issue and community rating and permitted them to ''cherry pick'' individuals and groups with favorable risk profiles. A State regulator also noted that exempting coverage sold through the associations from the regulatory process leads to a concentration of poorer risk in non-association coverage in community rating States. Based on past State experience with association coverage exceptions, the NAIC advised against allowing exceptions for association coverage under the market definitions of § 154.102. Moreover, consumer advocates and one issuer emphasized the importance of having consistent standards across association health plans and the rest of the market to ensure that issuers competed on a level playing field.

Many comments also discussed the importance of encouraging States to regulate association plans in the same way as the traditional market. Several consumer advocates and State insurance officials cited a study [1] concluding that two-thirds of the States regulate associations differently from other plans in the same market and about one-half of the States entirely or partially exempt national associations from State regulation. In States where associations are not regulated, this differential treatment gives residents little recourse if their association health plan changes its terms of coverage, denies claims, or completely ceases operation. One consumer advocate further highlighted that individuals and small businesses often buy health plans through associations with little knowledge of the protections that they do or do not have in these plans. In addition, the consumer noted that many States cede the regulatory and oversight roles to other States when an association is headquartered elsewhere, allowing association health plans to operate without as much oversight as plans in the traditional market. This can result in different consumers in the same State being subject to different levels of protections depending on whether the coverage is sold through an association and also on where the association is situsted.

While most comments were in favor of including association coverage in the rate review process even where State rate filing laws did not include such coverage in definitions of individual market and small group market, CMS received five comments that opposed changing the current policy under § 154.102. Four of these comments came from associations, and one comment came from an association professional membership organization. Three associations discussed the history of associations in their State and indicated that their State treats association health plans as large group plans not subject to individual or small group requirements for all purposes, not just rate review. These associations expressed concern about potential logistical and administrative burdens for association plans were they to be regulated as small group market coverage at the State and Federal levels. (We note that even if we were not making this amendment to the final rate review rule, this State practice would differ from longstanding guidance on the treatment of association coverage for all other purposes under title XXVII of the PHS Act.) In addition, all five commenters asserted that, because association health plans have a larger insurance pool, they should not be regulated the same as plans and policies in individual and small group markets. However, a regulator from the same State as three of the associations opined that successful implementation of the Affordable Care Act depended on having a stable health insurance market, which could be jeopardized if issuers could avoid the various individual and small group market requirements by offering coverage through associations.

Response: In light of these comments, we are amending the definitions of ''individual market'' and ''small group market'' in this final rule to include individual and small group coverage sold through associations in the rate review process. This amendment applies to rates for association coverage that are filed, or are effective in States without filing requirements, on or after November 1, 2011. The majority of commenters supported extending the rate review rule to include such association coverage; no commenter offered a persuasive reason why associations should be treated differently in connection with the review of rate increases than they are treated generally under the PHS Act. To the extent that issuers set premiums for members within an association differently based on their own health status or other factors, these association members are essentially purchasing individual or small group coverage and should not be treated differently than other individuals or small groups not buying coverage through an association. Further, excluding individual and small group coverage sold through associations from the rate review process creates an unlevel playing field between issuers that sell coverage through associations and those that do not. Lastly, excluding association coverage from the rate review process raises the risk of creating incentives that could lead to adverse selection. We note that nothing in this amended rule prevents individuals and employers from enjoying the benefits of belonging to an association and obtaining health insurance coverage as a benefit of their association membership.

All other requirements in title XXVII of the PHS Act (for example, section 2718's medical loss ratio requirements) are governed by the individual and small group market definitions in section 2791 of the PHS Act. Under section 2791's definitions, individuals and employers who purchase health insurance coverage through associations generally have been and continue to be entitled to the same rights and protections as those who purchase coverage in the individual and group markets. CMS Insurance Standards Bulletin 02–02 (August 2002) stated that

[1] Mila Kofman, Kevin Lucia, Eliza Banget, Karen Politz, ''Association Health Plans: What's All the Fuss About?'' *Health Affairs*, Vol. 25, No. 6, 2006.

''the test for determining whether health insurance coverage offered through an association is group market coverage or individual market coverage, for purposes of [PHS Act] title XXVII, is the same test as that applied to health insurance offered directly to employers or individuals.''

The decision to propose somewhat different definitions of individual and small group market for the purposes of rate review was based on the discretion under section 2794 of the PHS Act to specify which markets are subject to this rate review rule, and our desire to minimize disruption for the States and enable as many of them as possible to have Effective Rate Review Programs. In proposing to follow State filing law definitions, we did not take into account the substantial difference this could make with respect to association coverage in States with filing law definitions of individual market and small group market that exclude association coverage.[2] However, we are amending the regulation to make clear that for purposes of rate review, the treatment of association coverage is identical to how it is treated for other title XXVII requirements, so that individuals and small employers who purchase coverage through an association have the same set of protections they would receive if they had purchased coverage outside of an association. We note that in amending these definitions, we do not change the role offered to States to conduct Effective Rate Review Programs under the final rule which aims to minimize disruption of State rate review processes.

Comment: A trade association noted that section 3(5) of the Employee Retirement Income Security Act (ERISA) defines the term ''employer'' so that an association of employers could be deemed an ''employer'' sponsoring a group health plan under some circumstances. In such a case, the commenter recommended that the association coverage should be treated as one group health plan for purposes of the rate review process.

Response: As indicated by the commenter, the market definitions in section 2791 of the PHS Act are derived from definitions of employer and employee welfare benefit plan in ERISA section 3. While the proposed rule and current final rule adopt a different policy for rate review purposes with respect to association coverage than would apply under the PHS Act for other purposes, we are amending the final rule to apply the general PHS Act policy on association coverage under the rate review regulation, as an exception to the general rule that State definitions govern. Accordingly, if an association is, in fact, sponsoring a group health plan subject to ERISA, the association coverage should be considered to be one group health plan and the number of employees covered by the association would determine the group size for purposes of determining whether the group health plan is sponsored by a small employer and subject to the rate review process.

In most situations involving association coverage, the group health plan will exist at the individual employer level and not at the association level, in which case the size of the individual employers in the association will determine whether the association coverage is subject to the rate review process. The Department of Labor (DOL) has jurisdiction over ERISA group health plans and, for private sector entities, the determination of whether the group health plan exists at the association level or the employer level is made under ERISA. DOL has prepared a booklet in an effort to address questions that have been raised under ERISA concerning ''multiple employer welfare arrangements.'' This booklet may assist stakeholders in identifying situations where an ERISA group health plan may exist at the association level. See DOL MEWA Guide (*http://www.dol.gov/ebsa/Publications/mewas.html).* Several DOL Advisory Opinions may also be helpful. *See* DOL Advisory Opinions 2001–04A (*http://www.dol.gov/ebsa/regs/aos/ao2001-04a.html*); 2008-07A (*http://www.dol.gov/ebsa/regs/aos/ao2008-07a.html*) and 2003-13A (*http://www.dol.gov/ebsa/regs/aos/ao2003-13a.html*). For example, in DOL Advisory Opinion 2008–07A, DOL stated:

''A determination whether there is a bona fide employer group or association for this ERISA purpose must be made on the basis of all the facts and circumstances involved. Among the factors considered are the following: how members are solicited; who is entitled to participate and who actually participates in the association; the process by which the association was formed, the purposes for which it was formed, and what, if any, were the preexisting relationships of its members; the powers, rights, and privileges of employer members that exist by reason of their status as employers; and who actually controls and directs the activities and operations of the benefit program. The employers that participate in a benefit program must, directly or indirectly, exercise control over the program, both in form and in substance, in order to act as a bona fide employer group or association with respect to the program.

The definition of 'employee welfare benefit plan' in ERISA is grounded on the premise that the person or group that maintains the plan is tied to the employers and employees that participate in the plan by some common economic or representation interest or genuine organizational relationship unrelated to the provision of benefits.''

For more information, State regulators and other stakeholders can contact the Department of Labor's Employee Benefits Security Administration.

Comment: An association advised that a group policy for an association is issued to a trust in the State where the trust is domiciled and certificates are issued to insured parties who may reside in other States. In such a case, the association indicated that if the State where the trust is domiciled has a rate review process, that State should be responsible for the rate review of the entire program and should apply the same rating principles to the entire association, thus making it easier for compliance. Consumer advocates and a health insurance issuer, on the other hand, advised that rate increases of all individual and small group coverage sold in a State should be reviewed by that State, regardless of where the association is domiciled, to ensure that the individuals and employers in the State are protected by their local insurance department.

Response: A State's ability to review rate increases of coverage sold through associations domiciled in another State is dependent solely upon State law. Accordingly, it will be up to each individual State to determine whether its laws provide the authority to review proposed rate increases of individual and small group health insurance coverage sold through associations domiciled in another State. It should be noted that the rate review process set forth in the May 23, 2011 final rule sets standards so that the reporting and review process is similar in all States which should decrease the burden of having to file a rate increase in multiple States.

Comment: One insurance issuer commented that CMS should keep bona

[2] As noted above, there is a long, consistent history of how associations have been treated with respect to the requirements added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). However, prior to enactment of the Affordable Care Act, none of those requirements related to rate review, and for HIPAA purposes it was irrelevant how a State defined its markets for rate review purposes. Therefore we were not familiar with the possible ramifications for associations.

fide associations out of the rate review process because the bona fide association marketplace operates much like the large group market, in that trustees of associations are sophisticated purchasers who exercise their fiduciary responsibility to their members. This commenter therefore felt that, to prevent an undue burden on the rate review process, bona fide associations should be regulated differently from non-bona fide associations. An association indicated that, if bona fide association individual and small group coverage were included in the rate review process, it would subject the affected insurance premiums to review by as many as 40 different States.

Response: Although the PHS Act recognizes bona fide associations as defined by section 2791(d)(3) [3] of the PHS Act and currently exempts them from guaranteed renewability of coverage and guaranteed availability of coverage, individual and small group coverage provided through bona fide associations are subject to every other provision and protection of title XXVII of the PHS Act without exception. Therefore, the rate review process applies to individual and small group coverage provided through bona fide associations and non-bona fide associations. It should be noted that the rate review process set forth in the May 23, 2011 rule sets standards so that the reporting and review process is similar in all States which should decrease the burden of having to file a rate increase in multiple States.

Comments: Consumer advocates commented that States should be required to review an issuer's premium-rate increases on individuals and small groups purchasing insurance through an association or out-of-State trust as a condition of having an Effective Rate Review Program. These commenters also suggested that, to the extent possible, adequate regulation of associations should be a factor in awarding Cycle II grants of the Health Insurance Rate Review Program.

Response: A State that meets the criteria for an Effective Rate Review Program, as outlined in § 154.301 will be determined to have Effective Rate Review Programs; with this amendment, this review will apply to rate increases of association coverage sold directly to individuals and small groups in that State. A State's status as an Effective Rate Review Program State in other market segments will not be affected by its status as it relates to the effective review of association coverage rate increases. For purposes of this determination, we will not take into account whether the State where an association plan has its situs reviews the rates. In order to be an Effective Rate Review Program State for association coverage, a State will have to meet the criteria specified in § 154.301(a) and (b) for review of rate filings in its State for association coverage. If a State fails to meet the criteria for association coverage, CMS will review the rate filings above the threshold for the association coverage in that State.

The Cycle II funding opportunity announcement (FOA) was posted in February of this year and applications were due August 15, 2011. In order to be eligible for an award under Cycle II, for either Phase I or II awards, a State must be able to demonstrate at the time of application that it already meets the criteria for an Effective Rate Review Program, or that with the funding resources from the grant it can achieve an Effective Rate Review Program.

To the extent that association coverage is one product type in which a State can be effective or not, it is a consideration, but effective review of association coverage is not a requirement for a Cycle II grant.

III. Provisions of This Final Rule

This final rule amends the definition of ''individual market'' and ''small group market'' in § 154.102 as follows:

We amended the definition of ''individual market'' to include coverage that would be regulated as individual market coverage (as defined in section 2791(e)(1)(A)) if it were not sold through an association. We also amended the definition of ''small group market'' to include coverage that would be regulated as small group market coverage (as defined in section 2791(e)(5)) if it were not sold through an association. This approach follows the definition that applies for other PHS Act purposes (under which an association itself will only be considered to be a group health plan if it complies with and is regulated under ERISA).

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

The Collection of Information Requirements associated with the May 23, 2011 final rule were approved under OMB control number 0938–1141, with an expiration date of August 31, 2014. In the May 23, 2011 final rule, we solicited comments on whether individual and small group coverage sold through associations should be included in the rate review process. At that time, we did not include an estimate of the number of rate review filings of association coverage for the burden estimates in the PRA section of the final rule. We are now amending the burden estimates in the PRA section to reflect the additional number of filings resulting from amending this final rule.

As indicated in RIA section below, we estimate that 229 additional rate filings will be subject to the rate review process as a result of including individual and small group coverage sold through associations in the process. This increases the total number of filings subject to review from 974 to 1,203. All other estimates, including number of respondents and burden per response, have not changed from the final rule. Accordingly, the language from the PRA section of the May 2011 final rule is incorporated in this final rule and the changes in the estimates are reflected in the Revised Table A, with revised numbers highlighted in bold.

[3] *Bona fide association* means, with respect to health insurance coverage offered in a State, an association that meets the following conditions: (1) Has been actively in existence for at least 5 years. (2) Has been formed and maintained in good faith for purposes other than obtaining insurance. (3) Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of any employee). (4) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members (or individuals eligible for coverage through a member). (5) Does not make health insurance coverage offered through the association available other than in connection with a member of the association. (6) Meets any additional requirements that may be imposed under State law.

Revised Table A – Estimated Annual Burden

Regulation Section(s)	OMB Control No.	Number of Respondents	Number of Responses	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting ($)	Total Labor Cost of Reporting ($)	Total Capital/ Maintenance Costs ($)	Total Cost ($)
§154.210 ICRs Regarding State Determinations	0938-New	35	**801**	0.33	**264**	200	**52,800**	0	**52,800**
§§154.215 , and 154.220, ICRs Regarding the Rate Review Preliminary Justification Form	0938-New	417	**1,203**	11	**13,233**	200	**2,646,600**	0	**2,646,600**
§154.230 ICRs Regarding the Final Justification	0938-New	417	**1,203**	0.5	**601**	200	**120,200**	0	**120,200**
§154.230 ICRs Regarding the Final Notification	0938-New	417	**1,203**	0.5	**601**	200	**120,200**	0	**120,200**
Total		452	**4,410**		**14,699**		**2,939,800**		**2,939, 800**

V. Response to Comments

Because of the large number of public comments we receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. A discussion of the comments we received is included in the preamble of this document.

VI. Regulatory Impact Analysis

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

A. Summary

In the regulatory impact analysis (RIA) for the May 23, 2011 final rule, we discussed the proposal to amend the definitions of individual and small group markets in order for individual and small group coverage sold through associations to be subject to rate review. Although we did not include the burden of including coverage sold through associations in the final numbers for the PRA package or the RIA, an estimate was provided in the RIA for the purpose of soliciting comments on the potential burden of including individual and small group coverage sold through associations in the rate review process.

We reviewed data submitted by health insurance issuers to the NAIC and estimated that there would be 986 filings annually that would have to be submitted for individual or small group coverage sold through associations. We in turn applied the factors for non-grandfathered coverage (0.42) and filings above the 10 percent threshold (0.45), which resulted in a total of 186 additional filings that would be subject to rate review. We further estimated that 34 percent of these filings would occur in States that require prior approval before a rate increase can be implemented, in which case the rate filings are already subject to review by a State. This resulted in a final estimate of 123 additional filings above the 10 percent threshold occurring if coverage sold through associations were subject to the rate review process.

In response to our solicitation of comments on the association issue, we received from the NAIC a survey of State regulators in which the following question was asked: ''How many such rate filings does your State receive for association and out-of-State trust coverage?'' Thirty-two States responded to the survey and 14 States provided estimates that totaled 440 rate filings for association coverage on an annual basis. Most of these estimates did not distinguish between the individual and small group markets. One State indicated that no rate filings were received from associations, and the other 17 indicated that they did not track association rate filings. This data was provided by State regulators who review rate filings, as opposed to the prior data that was provided by health insurance issuers. Since State regulators are positioned to review the rate filings of all the issuers in their States, we chose to use the State data for the purpose of updating the burden estimates in this RIA. Extrapolating the 440 number from 14 States to 50 States provides an estimate of 1,570 rate filings annually for association coverage in the individual and small group markets. Using the percentages from the final rule numbers (76% small group market, 24 percent individual market), this breaks out to 377 additional filings in the individual market and 1,193 filings

in the small group market. Applying the factors for non-grandfathered coverage and filings above the 10 percent threshold results in a mid range estimate of 229 additional filings being subject to rate review.

Since this final rule directs that individual and small group coverage sold through associations be included in the rate review process, we are amending the burden estimates in the RIA to reflect the additional number of filings. The estimated number of affected entities, the burden estimates for the start-up costs and the amount of time to review each rate filing do not change from what was estimated in the RIA for the May 23, 2011 final rule. Accordingly, the RIA from the May 23, 2011 final rule is incorporated into this final rule with the only the changes being the additional number of filings discussed here and in the Federalism Statement in section D. All ranges of filing estimates were increased by 1,570, the estimated number of rate filings for association coverage, as explained above. This results in the number of 2011 filings in Table 3 for the low range estimate being increased from 6,121 to 7,691; the mid range was increased from 6,733 to 8,303; and the high range from 7,343 to 8,913. In the tables, the amended numbers are highlighted in bold.

B. Estimated Number of Rate Filings

This section of the regulatory impact assessment provides estimates of the number of filings that would be subject to review under this final rule. Below we are revising Table 3, Table 4, and Table 5 of the May 23, 2011 final rule (see 76 FR 29980 through 29982) to read as follows:

Revised Table 3: Estimated Number of Filings Subject to Review

		Individual	Small Group	Total
Estimated number of filings for 2011				
Low Range		**1772**	**5,919**	**7,691**
Mid Range		**1,948**	**6,355**	**8,303**
High Range		**2,123**	**6,790**	**8,913**
Percent of filings subject to review (non-grandfathered)				
Low Range		40%	20%	
Mid Range		54%	30%	
High Range		67%	42%	
Number of filings subject to review				
Low Range		**709**	**1184**	**1,893**
Mid Range		**1,052**	**1,906**	**2,958**
High Range		**1,422**	**2,852**	**4,274**
Estimated percentage of filings meeting or exceeding threshold				
Low Range		50%	20%	
Mid Range		60%	30%	
High Range		70%	40%	
Estimated number of filings meeting or exceeding threshold				
Low Range		**354**	**236**	**590**
Mid Range		**631**	**572**	**1,203**
High Range		**995**	**1,141**	**2,136**

C. Estimated Administrative Costs Related to Rate Review Provisions

Revised Table 4: Estimated Costs for Reporting, Record Retention, and Website Notification (Actual Dollars)

Description	Total Number of Issuers	Total Number of Reports	Estimated Total Hours (1)	Estimated Average Cost Per Hour (2)	Estimated Total Cost	Estimated Average Cost Per Issuer	Estimated Average Cost Per Report
LOW RANGE ASSUMPTIONS							
One-Time Costs	417	**590**	52,125	$200	$10,425,000	$25,000	**$17,669**
Ongoing Costs	417	**590**	2,808	$200	$561,600	$1,347	**$952**
Total Year One Costs	417	**590**	54,933	$200	$10,986,600	$26,347	**$18,621**
MID RANGE ASSUMPTIONS							
One-Time Costs	417	**1,203**	62,550	$200	$12,510,000	$30,000	**$10,399**
Ongoing Costs	417	**1,203**	**14,699**	$200	**$2,939,800**	**$7,050**	**$2,444**
Total Year One Costs	417	**1,203**	**77,249**	$200	**$15,449,800**	**$37,050**	**$12,843**
HIGH RANGE ASSUMPTIONS							
One-Time Costs	417	**2,136**	72,975	$200	$14,595,000	$35,000	**$6,833**
Ongoing Costs	417	**2,136**	27,568	$200	$5,513,600	$13,222	**$2,581**
Total Year One Costs	417	**2,136**	100,543	$200	$20,108,600	$48,222	**$9,414**

Notes: Estimated costs are stated in 2010 dollars.

(1) Estimated number of one-time start up hours and annual ongoing hours.

(2) Actuary salary/fee.

(3) Estimated Costs to the States and Federal Government Related to Rate Review Provisions.

Revised Table 5: Estimated Actuarial Rates

Estimated Actuarial Rates				
		Low	**Mid**	**High**
Principal Actuaries		$340.00	$350.00	$360.00
Support Actuaries		$200.00	$234.00	$275.00
Actuarial Analyst		$120.00	$150.00	$180.00
Administrative Support		$80.00	$100.00	$120.00
Estimated Time to Complete Average Review		**Average Time Required**		
Principal Actuaries		4.25	5.50	6.75
Support Actuaries		8.50	9.50	11.00
Actuarial Analyst		12.00	14.00	15.00
Administrative Support		9.00	9.50	12.00
Actuarial Staff Hours		24.75	29.00	32.75
Total Staff Hours		33.75	38.5	44.75
		Low	**Mid**	**High**
Estimated Cost per Review		$5,305	$7,198	$9,595
Number of Rate Reviews		**165**	**396**	**769**
Total Expected Contracting Cost		**$875,325**	**$2,850,408**	**$7,378,555**

1. Estimated Costs to States

CMS recognizes that States have significant experience reviewing rate increases. As discussed earlier in this preamble, most States have existing Effective Rate Review Programs that will meet the requirements of this regulation. Rate review grants provided by CMS are expected to increase the effectiveness of State rate review processes, but they are not a direct measure of the cost of this regulation.

CMS estimates that the cost impact on States will be small because most States currently conduct rate review. For these States, the incremental costs and requirements of this regulation will be minimal. Some States do not already have a rate review process or have a process that applies to only a portion of the individual and small group markets that this regulation addresses. In these States, the implementation costs to develop Effective Rate Review Processes at the State level can be offset by the rate review grants provided by CMS. For States not currently conducting effective rate review, HHS will conduct the review.

States with Effective Rate Review 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 reporting information from the State to CMS will require approximately 20 minutes per filing. Based on an actuary's fee of $200 per hour, CMS estimates an average cost per filing of $66. Including association coverage, the estimated cost of reporting the two-thirds of filings meeting or exceeding the 10 percent threshold (801), which are reviewed by States, is $52,866.

D. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. In CMS' view, while the requirements proposed in this final rule would not impose substantial direct costs on State and local governments, this final rule has federalism implications due to direct effects on the distribution of power and responsibilities among the State and Federal governments relating to determining the reasonableness of rate increases for coverage that State-licensed health insurance issuers offer in the individual and small group markets.

CMS recognizes that there are federalism implications with regard to CMS' evaluation of Effective Rate Review Programs and its subsequent review of rate increases. Under Subpart C of this final rule, CMS outlines those criteria that States would have to meet in order to be deemed to have an Effective Rate Review Program. If CMS determines that a State does not meet those criteria, then CMS would review a rate increase subject to review to determine whether it is unreasonable. If a State does meet the criteria, then CMS would adopt that State's determination of whether a rate increase is unreasonable.

As indicated earlier in this preamble, we received comments from consumer advocates and State insurance officials citing a study concluding that two-thirds of the States regulate associations differently from other plans in the individual and small group market and about one-half of the States entirely or partially exempt coverage sold through national associations from State regulation. In States where individual and small group coverage sold through associations is not subject to the rate review process, we indicate in this preamble that CMS will review the rate filings for such coverage that meet the threshold. We also state that the fact that a State may not review rate filings of association coverage will not be considered in determining whether that State has an effective rate review program.

States would continue to apply State law requirements regarding rate and policy filings. State rate review processes that are similar to the Federal requirements likely would be deemed effective and satisfy the requirements under this final rule. Accordingly, States have latitude to impose requirements with respect to health insurance issuers that are more restrictive than the Federal law.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the States, CMS has engaged in efforts to consult with and work cooperatively with affected States, including participating in conference calls with and attending conferences of the National Association of Insurance Commissioners (NAIC), participating in a NAIC workgroup on rate reviews and consulting with State insurance officials on an individual basis.

Throughout the process of developing this final rule, CMS has attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide uniform protections to consumers in every State. By doing so, it is CMS' view that it has complied with the requirements of Executive Order 13132. Under the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this regulation, CMS certifies that the Center for Consumer Information and Insurance Oversight has complied with the requirements of Executive Order 13132 for the attached final rule in a meaningful and timely manner.

List of Subjects in 45 CFR Part 154

Administrative practice and procedure, Claims, Health care, Health insurance, Health plans, Penalties, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR Subtitle A, Subchapter B, by amending part 154 as follows:

PART 154—HEALTH INSURANCE ISSUER RATE INCREASES: DISCLOSURE AND REVIEW REQUIREMENTS

■ 1. The authority citation for part 154 continues to read as follows:

Authority: Section 2794 of the Public Health Service Act (42 U.S.C. 300gg–94).

Subpart A—General Provisions

■ 2. In § 154.102, revise the definitions of ''individual market'' and ''small group market'' to read as follows:

§ 154.102 Definitions.

* * * * *

Individual market has the meaning given the term under the applicable State's rate filing laws, except that:

(1) Where State law does not define the term, it has the meaning given in section 2791(e)(1)(A) of the PHS Act; and

(2) Coverage that would be regulated as individual market coverage (as defined in section 2791(e)(1)(A)) if it were not sold through an association is subject to rate review as individual market coverage.

* * * * *

Small group market has the meaning given under the applicable State's rate filing laws, except that:

(1) Where State law does not define the term, it has the meaning given in section 2791(e)(5) of the PHS Act; provided, however, that for the purpose of this definition, ''50'' employees applies in place of ''100'' employees in

the definition of ''small employer'' under section 2791(e)(4); and

(2) Coverage that would be regulated as small group market coverage (as defined in section 2791(e)(5)) if it were not sold through an association is subject to rate review as small group market coverage.

* * * * *

Dated: August 16, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: August 29, 2011.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. 2011–22663 Filed 9–1–11; 11:15 am]

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FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 90

[PS Docket 06–229; WT Docket 06–150; WP Docket 07–100; FCC 11–6]

Implementing a Nationwide, Broadband, Interoperable Public Safety Network in the 700 MHz Band

AGENCY: Federal Communications Commission.

ACTION: Final rules; announcement of effective date.

SUMMARY: In this document, the Commission announces that the Office of Management and Budget (OMB) has approved, for a period of three years, the information collection requirements contained in the *Third Report and Order* in PS Docket 06–229, FCC 11–6. The information collection requirements were approved on August 18, 2011 by OMB.

DATES: The information collections contained in 47 CFR 90.1407(f), published at 76 FR 51271, August 18, 2011, are effective on September 6, 2011.

FOR FURTHER INFORMATION CONTACT: For additional information contact Cathy Williams on (202) 418–2918 or via e-mail to: *cathy.williams@fcc.gov.*

SUPPLEMENTARY INFORMATION: This document announces that, on August 18, 2011, OMB approved, for a period of three years, the information collection requirements contained in 47 CFR 90.1407(f). The Commission publishes this document to announce the effective date of this rule section. See, Implementing a Nationwide, Broadband, Interoperable Public Safety Network in the 700 MHz Band, PS Docket 06–229; WT Docket 06–150; WP Docket 07–100; FCC 11–6, 76 FR 51271, August 18, 2011.

Synopsis

As required by the Paperwork Reduction Act of 1995, (44 U.S.C. 3507), the Commission is notifying the public that it received OMB approval on August 18, 2011, for the information collection requirement contained in 47 CFR 90.1407(f). Under 5 CFR part 1320, an agency may not conduct or sponsor a collection of information unless it displays a current, valid OMB Control Number.

No person shall be subject to any penalty for failing to comply with a collection of information subject to the Paperwork Reduction Act that does not display a valid OMB Control Number.

The OMB Control Number is 3060–1152 and the total annual reporting burdens for respondents for this information collection are as follows:

Title: Implementing a Nationwide, Broadband, Interoperable Public Safety Network in the 700 MHz Band (Third Report and Order, PS Docket 06–229, FCC 11–6).

Form Number: Not applicable.

Type of Review: New collection.

OMB Control Number: 3060–1152.

OMB Approval Date: 08/18/2011.

OMB Expiration Date: 06/30/2014.

Respondents: Not-for-profit institutions; state, local and tribal governments.

Number of Respondents: 100 respondents; 100 responses.

Estimated Time per Response: 5 hours.

Frequency of Response: One-time reporting requirement.

Obligation to Respond: Required to obtain or retain benefits. Statutory authority for this information collection is contained in 47 U.S.C. 4(i), 201, 303, 309, and 332 of the Communications Act of 1934, as amended.

Total Annual Burden: 500 hours.

Annual Cost Burden: None.

Privacy Act Impact Assessment: N/A.

Nature and Extent of Confidentiality: There is no need for confidentiality with this information collection.

Needs and Uses: The *Third Report and Order* in PS Docket 06–229, adopted by the Commission on January 25, 2011 and released on January 26, 2011, codifies, as 47 CFR 90.1407(f), the requirement that public safety broadband network operators to certify to the Public Safety and Homeland Security Bureau before deployment that their networks will support required interfaces in compliance with Release 8 or higher of 3GPP standards prior to the date their networks achieve service availability. This certification requirement will enable the Bureau to ensure that public safety broadband networks support all of the interfaces necessary to achieve interoperability from day one of service operation.

Federal Communications Commission.

Bulah P. Wheeler,

Deputy Manager, Office of the Secretary, Office of Managing Director.

[FR Doc. 2011–22617 Filed 9–2–11; 8:45 am]

BILLING CODE 6712–01–P