Program Integrity and Additional State Information Collections - Supporting Statement – Part A

Supporting Statement For Paperwork Reduction Act Submissions

A. Background

The Patient Protection and Affordable Care Act, Public Law 111-148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, Public Law 111-152, enacted on March 30, 2010 (collectively, "Affordable Care Act"), expand access to health insurance for individuals and employees of small businesses through the establishment of new Affordable Insurance Exchanges (Exchanges), also called Marketplaces, including the Small Business Health Options Program (SHOP). The Exchanges, for which enrollment will become operational by October 1, 2013 and coverage will become effective as early as January 1, 2014, will enhance competition in the health insurance market, expand access to affordable health insurance for millions of Americans, and provide consumers with a place to easily compare and shop for health insurance coverage.

On June 19, 2013, HHS published the proposed rule CMS-9957-P: *Program Integrity: Exchanges, SHOP, Premium Stabilization Programs, and Market Standards* (78 FR 37302) (Program Integrity Proposed Rule). Among other things, the Program Integrity Proposed Rule sets forth financial integrity provisions and protections against fraud and abuse. The third party disclosure requirements and data collections proposed in the Program Integrity Proposed Rule support the oversight of premium stabilization programs (transitional reinsurance, risk corridors and risk adjustments), State Exchanges, and qualified health plan (QHP) issuers in Federally-facilitated Exchanges (FFEs).

B. Justification

1 . Need and Legal Basis

Section 1311(c)(4) of the Affordable Care Act directs the Secretary of Health and Human Services (Secretary) to establish an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction of members in each QHP offered through an Exchange with more than 500 enrollees in the previous year.

Section 1321(a) of the Affordable Care Act provides general authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs, and other components of Title I of the Affordable Care Act.

Section 1321(c)(1) of the Affordable Care Act requires the Secretary to establish and operate an FFE within States that either: do not elect to operate an Exchange; or, as determined by the Secretary, will not have any required Exchange operational by January 1, 2014.

Section 1321(c)(2) of the Affordable Care Act authorizes the Secretary to enforce the Exchange standards using civil money penalties (CMPs) on the same basis as detailed in section 2723(b) of the Public Health Service Act (PHS Act).[1] Section 2723(b) of the PHS Act authorizes the Secretary to impose CMPs

[1] Section 1321(c) of the Affordable Care Act erroneously cites to section 2736(b) of the PHS Act instead of 2723(b) of the PHS Act. This was clearly a typographical error, and we have interpreted section 1321(c) of the Affordable

as a means of enforcing the individual and group market reforms contained in Title XXVII, Part A of the PHS Act when a State fails to substantially enforce these provisions.

Section 1311(e)(1)(B) of the Affordable Care Act specifies that an Exchange may certify a health plan as a QHP if the Exchange determines that making available such a health plan is in the interests of qualified individuals and qualified employers in the State or States in which the Exchange operates.

Section 1312(e) of the Affordable Care Act directs the Secretary to establish procedures under which a State may permit agents and brokers to enroll qualified individuals and qualified employers in QHPs through an Exchange, and to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions.

Section 1341 of the Affordable Care Act establishes a transitional reinsurance program which begins in 2014 and is designed to provide issuers with greater payment stability as insurance market reforms are implemented and Exchanges facilitate increased enrollment. Section 1342 of the Affordable Care Act establishes a temporary risk corridors program which permits the Federal government and QHPs to share in gains or losses resulting from inaccurate rate setting from 2014 through 2016. Section 1343 of the Affordable Care Act establishes a permanent risk adjustment program which is intended to provide increased payments to health insurance issuers that attract higher-risk populations, such as those with chronic conditions, and eliminate incentives for issuers to avoid higher-risk enrollees.

Section 1401 of the Affordable Care Act amended the Internal Revenue Code (26 U.S.C.) to add section 36B, allowing a refundable premium tax credit to help individuals and families afford health insurance coverage. Under sections 1401, 1411, and 1412 of the Affordable Care Act and 45 CFR part 155, subpart D, an Exchange will make a determination of advance payments of the premium tax credit for individuals who enroll in QHP coverage through an Exchange and seek financial assistance. Section 1402 of the Affordable Care Act provides for the reduction of cost sharing for certain individuals enrolled in a QHP through an Exchange, and section 1412 of the Affordable Care Act provides for the advance payment of these reductions to issuers.

Section 1313 of the Affordable Care Act, combined with section 1321 of the Affordable Care Act, provides the Secretary with the authority to oversee the financial integrity, compliance with HHS standards, and efficient and non-discriminatory administration of State Exchange activities. Section 1313(a)(6)(A) of the Affordable Care Act specifies that payments made by, through, or in connection with an Exchange are subject to the False Claims Act (31 U.S.C. 3729, et seq.) if those payments include any Federal funds.

The Program Integrity Proposed Rule contains provisions that mandate third-party disclosure and data collections necessary to protect Federal funds and ensure that States Exchanges, premium stabilization programs, and QHP issuers in FFEs are in compliance with the Affordable Care Act. These information collection requirements are proposed for 45 CFR Parts 153, 155, and 156.

The Affordable Care Act directs issuers offering non-grandfathered health insurance coverage in the individual and small group markets to ensure that plans meet an actuarial value (AV) level of coverage specified in section 1302(a)(3) of the Affordable Care Act and as defined in 45 CFR 156.140(b). Consistent with section 1302(d)(2)(A) of the Affordable Care Act, AV is calculated based on the provision of the essential health benefits (EHB) to a standard population and is a measure of the percentage of expected

Care Act to incorporate section 2723(b) of the PHS Act.

health care costs a health plan will cover for a standard population.

As set forth in 45 CFR 156.135(a), issuers are required to use the AV calculator developed by HHS to determine the level of coverage as set forth in 45 CFR 156.140(b). The AV calculator uses one or more sets of national claims data reflecting plans of various levels of generosity as the underlying standard population. The AV calculator has been developed using a set of claims data weighted to reflect the standard population projected to enroll in the individual and small group markets for the identified year of enrollment. A methodology document including both the logic behind the calculator and a description of the development of the standard population is represented in the calculator as tables of aggregated data called continuance tables. The template for the continuance table should be populated with the State data. The template can be seen in Appendix B to this supporting statement. The calculator allows health plan issuers to devise a compliant plan without the burden of making the assumptions needed or paying for the analysis for an AV calculation.

HHS established that the default standard population provided by HHS would be used, unless the state submits its own standard population data. Consistent with 45 CFR 156.135(d)-(e), beginning in years 2015 and after, State-specific data may be used as the standard population. The data set may be approved by HHS if the data:

1. Supports the calculation of AVs for the full range of health plans available in the market;
2. Is derived from a non-elderly population and estimates those likely to be covered by private health plans on or after January 1, 2014;
3. Is large enough that the demographic and spending patterns are stable over time and includes a substantial majority of the state's insured population;
4. Is a statistically reliable and stable basis for area-specific calculations; and
5. Contains claims data on health care services typically offered in the then-current market.

The state data set should be submitted in a format that can support the AV calculator, along with evidence that the above criteria are met. Because HHS will use continuance tables to support the development of the AV calculator, we anticipate that states will also submit any state-specific data sets in the form of continuance tables.

This data will be collected via the tools supporting HealthCare.gov, and is information which will be used to inform consumers regarding their affordable Health Care options.

2. Information Users

The program integrity data collections and third-party disclosure requirements will assist HHS in determining Exchange compliance with Federal standards. The data collection and third-party disclosure requirements will also assist HHS in monitoring QHP issuers in FFEs for compliance with Federal QHP issuer standards. The data collected by health insurance issuers and Exchanges will help to inform HHS, Exchanges, and health insurance issuers as to the participation of individuals, employers, and employees in the individual Exchange, the SHOP, and the premium stabilization programs.

The State specific data will be used by HHS to determine if States' claims data meets requirements established in 45 CFR 156.135(d) and (e) and can be approved by HHS to support the use of the AV

calculator. Ultimately, issuers in States that submit State-specific data will use this data in AV calculations.

3. Use of Information Technology

HHS anticipates that a majority of the systems, notices, and information collection required by this rule will be automated. A majority of the information that is required by the collection of information for this rule will be submitted electronically. HHS staff will analyze or review the data in the same manner by which it was submitted and communicate with States, health insurance issuers, and other entities using e-mail, telephone, or other electronic means.

HHS will be leveraging existing IT systems for the collection of the State specific data set forth in the information collection requirements in 45 CFR 156.135. HHS aims to lessen the burden on states and minimize the need for any start-up costs for the required submission by using existing IT systems.

4. Duplication of Efforts

This information collection does not duplicate any other Federal effort.

5. Small Businesses

This information collection will not have a significant impact on small business.

6. Less Frequent Collection

Due to the required flow of information between multiple parties and flow of funds for payments for health insurance coverage within the Exchange, it is necessary to collect information according to the indicated frequencies. If the information is collected less frequently, the result would be less accurate, untimely or unavailable eligibility, enrollment or payment information for Exchanges, insurers, employers and individuals. This would lead to delayed payments to insurers; late charges to or payments by employers and enrollees; inaccurate or inappropriate payments of advance premium tax credits and cost sharing reductions; the release of misleading information regarding health care coverage to potential enrollees; and an overall stress on the organizational structure of the Exchanges. If the information is not collected in the timeframe proposed, HHS will not be able to properly ensure the financial integrity of Federal funds.

7. Special Circumstances

HHS proposes maintenance of records requirements in §§153.240, 153.310, 153.405, 153.410, 155.1210, and 156.705. In these sections, HHS is proposing to require States and QHP issuers in FFEs to maintain records for a time period of ten years. This time frame is necessary for HHS to be consistent with the statute of limitations under the False Claims Act and the record retention requirements set forth in 45 CFR 153.620(b).

In proposed §156.905, HHS proposes to provide respondents with the right to request a hearing if the request complies with proposed §156.907 within 30 days after the date of issuance of either HHS' notice of proposed assessment under proposed §156.805, notice of decertification of a QHP under §156.810(c) or §156.810(d). The timeline is necessary to provide entities with the protections provided by the

Administrative Procedure Act, 5 U.S.C. 554 and 556.

8. Federal Register/Outside Consultation

The 60 day Federal Register notice soliciting comments was published on June 19, 2013 (78 FR 37032). HHS has consulted with stakeholders on many of the requirements in this information collection, and has based many of the requirements in this information collection on those consultations. HHS consulted with stakeholders through regular meetings with the National Association of Insurance Commissioners (NAIC), regular contact with States through the Exchange grant process, and meetings with other stakeholders including consumer advocates, employers, agents, brokers, and other interested parties. The EHB provisions, including §§156.115 and 156.135, have been subject to substantial discussion and consultation with the public and the affected industry. Review and comment was managed primarily through publication of the EHB Bulletin on December 16, 2011. Additional comment was collected through the publication of the proposed regulation (CMS-9965-P). That proposed rule was finalized and published in the Federal Register on July 20, 2012 (78 FR 12832).[2]

9. Payments/Gifts to Respondents

No payments and/or gifts will be provided to respondents.

10. Confidentiality

To the extent of the applicable law and HHS policies, HHS will maintain respondent privacy with respect to the information collected. Nothing in the information collection should be interpreted as preventing a State from being allowed to disclose its own data.

11. Sensitive Questions

There are no sensitive questions included in this information collection effort.

12. Burden Estimates (Hours & Wages)

The following sections of this document contain estimates of burden imposed by the associated information collection requirements (ICRs); however, not all of these estimates are subject to the ICRs under the PRA for the reasons noted. Salaries for the positions cited were mainly taken from the Bureau of Labor Statistics (BLS) Web site (http://www.bls.gov/oco/ooh_index.htm).

The salaries for the health policy analyst and the senior manager were taken from the Office of Personnel Management Web site. Fringe Benefits estimates were taken from the BLS March 2013 Employer Costs for Employee Compensation Report.[3]

ICRs Regarding Maintenance of Records for Contributing Entities and Reinsurance-eligible Plans (§153.405(h) and §153.410(c))

[2] Available at: http://www.gpo.gov/fdsys/pkg/FR-2012-07-20/pdf/2012-17831.pdf.
[3] BLS March 2013 Employer Costs for Employee Compensation Report (March 12, 2013). Available at: http://www.bls.gov/news.release/ecec.toc.htm.

In §153.405(h) and §153.410(c), we propose record retention standards for contributing entities and reinsurance-eligible plans. In proposed §153.405(h), we would require contributing entities to maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the enrollment count submitted pursuant to this section for a period of at least 10 years, and must make that evidence available upon request to HHS, the OIG, the Comptroller General, or their designees, to any such entity, for purposes of verification of reinsurance contribution amounts. This requirement, if finalized, may be satisfied if the contributing entity archives the documents and records and ensures that they are accessible if needed in the event of an investigation or audit.

We estimate that 26,200 contributing entities would be subject to this requirement, based on the Department of Labor's (DOL) estimated count of self-insured plans and the number of fully insured issuers that we estimate will make reinsurance contributions.[4] We believe that most of these contributing entities will already have the systems in place for record maintenance, and that the additional burden associated with this requirement is the time, effort, and additional labor cost required to maintain the records. On average, we estimate that it will take each contributing entity approximately 5 hours annually to maintain records. We estimate that it will take an insurance operations analyst 5 hours (at $38.49 an hour) to meet these requirements. On average, the cost for each contributing entity would be approximately $192.45 annually. Therefore, for 26,200 contributing entities, we estimate an aggregate burden of $5,042,190 and 131,000 hours as a result of this requirement.

In proposed §153.410(c), we would require issuers of reinsurance-eligible plans to maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the requests for reinsurance payments made pursuant to this section for a period of at least 10 years, and to make that evidence available upon request to HHS, the Office of the Inspector General [OIG], the Comptroller General, or their designees, (or, in the case of a State operating reinsurance, the State or its designees), to any such entity, for purposes of verification of reinsurance payment requests. We estimate that 1,900 issuers of reinsurance-eligible plans would be subject to this requirement, based on HHS's most recent estimate of the number of fully insured issuers that will submit requests for reinsurance payments. On average, we estimate that it will take each issuer of a reinsurance-eligible plan approximately 10 hours annually to maintain records. We estimate that it will take an insurance operations analyst 10 hours (at $38.49 an hour) to meet these requirements. On average, the cost estimate for each issuer is approximately $384.90 annually. Therefore, for 1,900 issuers, we estimate an aggregate burden of $731,310 and 19,000 hours as a result of this requirement.

The burden estimates for these two recordkeeping requirements are broad estimates that include not only the maintenance of data, but all records and documents that may be necessary to substantiate the enrollment count and requests for reinsurance payments made pursuant to 45 CFR 153.405 and 153.410, respectively. Because the scope of these requirements is substantially less than the scope of the recordkeeping requirement applicable to a State operating reinsurance, these estimates are lower than those that were set forth for State-operated reinsurance programs record maintenance requirement (45 CFR 153.240(c)) in the Premium Stabilization Rule published March 23, 2012 (77 FR 17220), and the associated information collection request approved under OMB Control Number 0938-1155. We note that we will

[4] We use an estimate of self-insured entities published by the DOL in the March 2013 "Report to Congress: Annual Report of Self-insured Group Health Plans," which reflects only those self-insured health plans (including 19,800 self-insured plans and 4,000 plans that mixed self-insurance and insurance) that are required to file a Form 5500 with the DOL. We are estimating 2,400 fully insured issuers would make reinsurance contributions.

account for the additional burden associated with submitting this information to HHS in a future information collection request that will go through the requisite notice and comment period and subsequent OMB review and approval process.

ICRs Related to Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in Qualified Health Plans in the Federally-facilitated Exchange (§155.220)

Section 155.220 of the Program Integrity Proposed Rule would authorize HHS to terminate an agent's or broker's agreement with an FFE if HHS determines that the agent or broker is out of compliance with the standards outlined in 45 CFR 155.220. The proposed data elements for §155.220 can be seen Appendix A to this supporting statement. Section 155.220(g) sets forth the proposed process whereby an agent or broker can request reconsideration of HHS's termination. Specifically, as proposed, the agent or broker would be required to submit the request for reconsideration within 30 calendar days of receipt of the date of the notice of termination.

The burden estimates for the reporting requirements in §155.220 reflect our assumption that there will be 254,095 agents and brokers registered in an FFE. The NAIC indicates that there are between 600,000 and 700,000 total licensed brokers selling health insurance at any point in time in the United States. We selected the midpoint, 650,000, as our estimate of the number of licensed brokers. We estimate that 37 percent of these brokers are in States with State Exchanges. This means an estimated 63 percent, or 409,500, are in States in which an FFE will be operating. We estimate that 85 percent, or 348,000, will be registered in an FFE. States have traditionally overseen agents and brokers in the health insurance market and we expect that States will continue in that regulatory role and be the primary regulator of agents and brokers in their respective States. Given that our oversight of agents and brokers will be narrowly tailored to FFE-specific standards, we expect terminations to be infrequent, especially in the first plan year. For purposes of this burden estimate, we assume that two agents or brokers will have their access suspended or revoked and that both agents or brokers will appeal these actions.

As stated in proposed §155.220(g)(2), an agent or broker would be required to submit a request for reconsideration of any termination decision by HHS within 30 calendar days of notification of the decision. We assume the need to terminate an agent's or broker's agreement with an FFE will occur only rarely. For purposes of this initial burden estimate we estimate that revocation notices will be sent to 2 agents or brokers each year. The hour burden associated with this action is the time and effort needed by the agent or broker to create the written request and submit it electronically to HHS. The associated costs are labor costs for gathering the necessary background information and then preparing and submitting the request.

We assume that all agents and brokers who receive a notice of termination will submit a request for reconsideration. We expect the request to address the issues presented in the original notice of termination from HHS. The hours involved in preparing and submitting this request may vary. For the purpose of this burden estimate we estimate that it will take 18 hours for an agent or broker to prepare and submit this request: 10 hours (at $28.81 an hour) for the brokerage clerk to gather and assemble necessary background materials and 8 hours (at $41.15 an hour) for the agent or broker to prepare the written request and submit it electronically. This is a total of 18 hours annually at a cost of $617.30 per agent or broker. Therefore, we estimate an aggregate burden of 36 hours at a cost of $1,234.60 for the two agents or brokers. We solicit comments on these estimates.

ICRs Related to the Eligibility Process (§155.310)

Proposed §155.310(k) would provide that if an Exchange does not have enough information to conduct an eligibility determination for advance payments of the premium tax credit or cost-sharing reductions, the Exchange must provide notice to the applicant regarding the incomplete application. We anticipate that this notice requirement would not be a separate notice to an individual but text within the eligibility determination notice described in §155.310(g) and discussed in a separate information collection request that is associated with the CMS-2234-P: *Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeals Processes for Medicaid and Exchange Eligibility Appeals* (79FR 4594). We therefore do not include a separate burden estimate to develop this notice but the time and cost associated with this notice is included within the estimate in §155.310(g).

Section 155.310(k)(2) would provide that the Exchange must provide the applicant with a period of no less than 15 days and no more than 90 days from the date on which the notice is sent to the applicant to provide the information needed to complete the application to the Exchange.

Given the fact that the Exchange eligibility process is entirely new and involves the use of new electronic data sources in combination with a new application, it is not possible to provide estimates for the number of applicants for whom we expect to have an incomplete application. However, we anticipate that this number will decrease as applicants become more familiar with the eligibility process, as more data become available electronically, and as customer service resources evolve based on experience.

Therefore, we estimate the time and effort for one individual to comply with this proposed provision. We expect that this will take an individual one hour to gather the relevant documentation and enter the missing information online or contact the call center to provide the necessary information. Our estimate that it will take an individual one hour to gather the relevant documentation depends on whether or not the individual already has the necessary documentation on hand, or whether the documents are presently unavailable and the individual needs to spend additional time to gather the documentation. As such, it could take significantly less time if an individual already had the documents on hand, or potentially more time if certain documents were unavailable at the time an individual needed to complete the application.

ICRs Related to Oversight and Financial Integrity Standards for State Exchanges (§155.1200 to §155.1210)

In subpart M of part 155, we describe the proposed information collection and third-party disclosure standards related to the oversight and financial integrity of State Exchanges. The data elements associated with the information collection requirements are proposed in Appendix B to this supporting statement.

Proposed §155.1200(a)(1)-(3) would require the State Exchange to follow generally accepted accounting principles (GAAP) and to monitor and report to HHS all Exchange-related activities. This would include keeping an accurate accounting of all Exchange receipts and expenditures. The burden associated with this reporting requirement would be the time and effort needed to develop and submit Exchange-related activities to HHS. The State Exchanges will electronically maintain the information as a result of normal business practices; therefore, the burden does not include the time and effort needed to maintain the Exchange-related activity information. State Exchanges most likely will already have accounting systems in place to store accounting information. The burden associated with this requirement includes a computer programmer taking 8 hours (at $48.61 an hour) to modify the system to maintain and monitor the information required under §155.1200(a)(1) through (3), an analyst taking 8 hours (at $58.05 an hour) to pull the necessary data under §155.1200(a)(1) through (3) in the State Exchange accounting system, and a senior manager taking 2 hours (at $77.00 an hour) to oversee the development and transmission of the

reported data. We estimate that it will take 18 total hours at a cost of $1,007.28 for each State Exchange. We estimate the total burden to be 324 hours for a total cost of $18,131.04 for all State Exchanges.

Proposed §155.1200(b)(1) would require the State Exchange to submit a financial statement, in accordance with GAAP to HHS. The information under §155.1200(b) would be required to be submitted at least annually by April 1 to HHS and to be publicly displayed. The burden associated with this reporting requirement would be the time and effort needed to develop and submit the financial statement to HHS. The State Exchanges will electronically submit the information. Therefore, the burden would be the time and effort needed to develop and publically display the financial statement. The State Exchanges will electronically maintain the information as a result of normal business practices, therefore the burden does not include the time and effort needed to develop and maintain the financial information. The burden associated with this proposed requirement would include a computer programmer taking 40 hours (at $48.61 an hour) to design the financial statement report, an analyst taking 8 hours (at $58.05 an hour) pulling the necessary data and inputting it into the financial statement report, and a senior manager taking 2 hours (at $77.00 an hour) overseeing the development and transmission of the reported data. We estimate a burden of 50 total hours for each State Exchange at a cost of $2,562.80, for a total cost of $45,410.40 for all Exchanges.

Section 155.1200(b)(2), as proposed, would require the State Exchange to submit eligibility and enrollment reports to HHS. The State Exchanges will electronically maintain the information as a result of normal business practices, therefore the burden does not include the time and effort required to develop and maintain the source information. The burden associated with this proposed reporting requirement would include the time and effort necessary for a computer programmer taking 40 hours (at $48.61 an hour) to design the report template, an analyst taking 8 hours (at $58.05 an hour) to compile the statistics for the report for submission to HHS, a privacy officer taking 8 hours (at $64.98 an hour) and senior manager taking 2 hours (at $77.00 an hour) overseeing the development and submission of the reported data. The burden also includes the time and effort necessary to post the data on the State Exchange Web site. We estimate an initial year burden of 58 hours at a cost of $3,082.64 to each State Exchange and a total burden of 1,044 hours at a cost of $55, 487.52 for all State Exchanges.

As proposed in §155.1200(b)(3), the State Exchange will report performance monitoring data to HHS. The performance monitoring data includes information on financial sustainability, operational efficiency, and consumer satisfaction which will be reported on an annual basis. The State Exchanges will electronically maintain the information as a result of normal business practices developed under Establishment Grants from HHS for this purpose. Therefore the burden does not include the time and effort needed to develop and maintain the performance data. The burden associated with meeting the proposed reporting requirement includes the time and effort necessary for a computer programmer taking 40 hours (at $48.61 an hour) to design the report, for an analyst taking 12 hours (at $58.05 an hour) to pull data into the report and prepare for submission to HHS and for a senior manager taking 2 hours (at $77.00 an hour) to oversee the development and transmission of the reported data. Section 155.1200(b) would require the State Exchange to submit to HHS and to display publicly financial, eligibility and enrollment reports and performance data at least annually. For those measures reported annually, we estimate that in the initial year a burden of 54 hours for the State Exchanges at a cost of $2,795.00 each and a total burden of $50,031.00.

Section 155.1200(c) (1) through (3), as proposed, would direct the State Exchange to engage an independent audit/review organization to perform an external financial and programmatic audit of the State Exchange. The State Exchange would be required to provide the results of the audit and identify any material weakness or significant deficiency and any intended corrective action. The burden associated with

meeting this proposed third party disclosure requirement would include the burden for an analyst level employee taking 3 hours (at $48.61 an hour) to pull data into a report, the time and effort necessary for a health policy analyst taking 2 hours (at $58.05 an hour) to prepare the report of the audit results, and the time for senior management taking 1 hours (at $77.00 an hour) to review and submit to HHS. We estimate a burden of 6 hours for each State Exchange at a cost of $338.93 and a total burden of $6,100.74.

As stated in proposed §155.1210(a), the State Exchange and its contractors and subcontractors would be required to maintain for 10 years, books, records, documents, and other evidence of accounting procedures and practices. Section 155.1210(b), as proposed, specifies that these records contain information concerning management and operation of the State Exchange's financial and other record keeping systems. The records must include financial statements, including cash flow statements, and accounts receivable and matters pertaining to the costs of operation. Additionally, the records must contain any financial report filed with other Federal programs or State authorities. Finally, the records must contain data and records relating to the State Exchange's eligibility verifications and determinations, enrollment transactions, appeals, plan variation certifications, QHP contracting data, consumer outreach, and Navigator grant oversight information. State Exchanges most likely already have systems in place to store records. The burden associated with this proposed record keeping requirement would include the time and effort necessary for a network administrator taking 16 hours (at $46.86 an hour) to modify the State systems to maintain the information required under §155.1210(b), for a health policy analyst taking 8 hours (at $58.05 an hour) to enter the data under §155.1210(b) into the State Exchange record retention system, and for senior management taking 2 hours (at $73.41 an hour) to oversee record collection and retention. We estimate that it will take 26 hours for the State Exchange to comply with this requirement for a total of 468 hours. We estimate one year burden for the State Exchanges at a cost of $1360.98 each and a total burden of $24,497.64.

ICRS Related to Habilitative Services (45 CFR 156.115)

Pursuant 45 CFR 156.115(a)(4), if a State's base-benchmark plan did not include coverage of habilitative services and that State did not define the habilitative services category of EHB, a health insurance issuer must either provide parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services or deciding which habilitative services to cover and report on that coverage to HHS. We anticipate that the data submission for issuers who define habilitative services will require 1 hour from a database administrator at $47.70. We expect that it will take one hour for a health insurance issuer to meet this submission requirement. This estimate is based on current industry surveys collected to monitor the burden of submission of similar data in the Medicare Advantage and Prescription Drug Programs. Given that only issuers who choose to define their own habilitative services will need to submit data, the total number of respondents required to report will be 50, for a total burden of $2,385.00. The proposed data elements associated with 45 CFR 156.115(a)(4) can be seen in Appendix C to this supporting statement.

ICRs Related to State Specific Standard Population (45 CFR 156.135)

In 45 CFR 156.135(d), HHS established that beginning in 2015, a State may submit a State-specific standard population, to be used for AV calculations, so long as the criteria described in § 156.135(d)(1) through (6) are met. A State that applies must submit to HHS summary evidence that the requirements described in §156.135 are met and the dataset is in a format that will support the use of the AV calculator. We expect that for each State choosing this option, the data submission will require 15 hours from a database administrator at $47.70 an hour, 4 hours of actuarial work at $225 an hour, and 1 hour of

management review at $75.15 an hour. Therefore, the total burden and cost associated with the reporting requirement for each State choosing this option will be 20 hours at a cost of $1,691. The burden across all respondents is estimated to be 1,020 hours at a cost of $86,241.00. The proposed data elements associated with 45 CFR 156.135can be seen in Appendix D to this supporting statement.

ICRs Related to Change of Ownership (§156.330)

We have proposed that the QHP issuer must notify HHS of the change in a manner to be specified by HHS and provide the legal name and tax identification number of the new owner of the QHP and the effective date of the change of ownership. As proposed, the information would be required to be submitted at least 30 days prior to the effective date of the change of ownership. The burden associated with the QHP issuer notifying HHS of a change of ownership includes a health policy analyst taking 1 hour to draft a notice of change of ownership and 1 one hour for a senior manager to review the notice and transmit it electronically to HHS. We estimate that it would cost a QHP issuer $128.43 to comply with this proposed reporting requirement. At this time, we cannot estimate the number of QHP issuers that will be reporting changes of ownership. When it becomes clearer as to the potential number that may report a change of ownership, we will update our estimates to reflect the potential number.

ICRs Related to Oversight of Cost-sharing Reductions and Advance Payments of the Premium Tax Credit (§156.480)

In proposed §156.480(a), we propose to extend the standards set forth in proposed §156.705 concerning maintenance of records to a QHP issuer in the individual market on State Exchange with respect to cost-sharing reductions and advance payments of the premium tax credit. We believe that the burden of maintaining records related to cost-sharing reductions and advance payments of the premium tax credit for QHP issuers in an FFE is already accounted for in the burden for proposed §156.705, described elsewhere in the Collection of Information section of the Program Integrity Proposed Rule. On average, we estimate each QHP issuer in a State Exchange will incur a cost of approximately $2,232.54 to comply with this record maintenance requirement. This reflects 46 hours of work by an insurance operations analyst (at $38.49 an hour) and 6 hours by a senior manager (at $77 an hour), for a total of 52 burden hours. Based on our most recent estimates, we assume that there will be approximately 791 QHP issuers in the individual market on State Exchanges in 2014. Therefore, we estimate an aggregate burden of 41,132 hours and a total cost of approximately $1,765,939.10 as a result of this requirement.

In §156.480(b), we propose that, for each benefit year, an issuer that offers a QHP in the individual market through a State Exchange or an FFE report to HHS annually, in a timeframe and manner required by HHS, summary statistics with respect to cost-sharing reductions and advance payments of the premium tax credit. This proposed provision will permit HHS to obtain critical information regarding cost-sharing reductions and advance payments of the premium tax credit across a broad range of issuers to identify systemic problems and errors, without requiring intrusive annual investigations. We believe that QHP issuers will already have the information and data systems in place necessary to generate a summary report, and that there will only be a small additional burden as a result of this submission requirement. We estimate that it will take an insurance operations analyst 16 hours (at $38.49 an hour) annually and one senior manager 2 hours (at $77 an hour) to gather summary information and prepare a report for submission to HHS. Therefore, we estimate an additional burden of 21,600 hours and total costs of approximately $923,808 for 1,200 QHP issuers ($769.84, on average, for each QHP issuer) as a result of this requirement.

ICRs Related to Oversight and Financial Integrity Standards for Issuers of Qualified Health Plans in the

Federally-facilitated Exchange (§156.705 to §156.715)

The burden estimates for the collections of information in Part 156, Subpart H, of the proposed regulation reflect the assumption that an FFE will include 409 QHP issuers.

Section 156.705 proposes to require issuers that offer QHPs in an FFE must maintain all documents and records (whether paper, electronic or other media), and other evidence of accounting procedures and practices necessary for HHS to conduct activities necessary to safeguard the financial and programmatic integrity of the FFEs. Such activities include: (1) periodic auditing of the QHP issuer's financial records, including data related to the QHP issuer's ability to bear the risk of potential financial losses; and (2) compliance reviews and other monitoring of a QHP issuer's compliance with all Exchange standards applicable to issuers offering QHPs in the FFEs listed in part 156. These standards would be limited to Exchange-specific records as applicable to the FFEs, and are not enforced by States as primary regulators. This standard mirrors the proposed maintenance of records standard applicable to State Exchanges and set forth in §155.1210. The burden includes utilizing existing technology and systems to process and maintain this information. We estimate that it will take 100 hours at a cost of $4,420.60 for a QHP issuer to maintain these records for a total of 30,000 hours and $1,326,180.00.

Section 156.705(d), as proposed, provides that QHP issuers must make all records described in paragraph (a) of this section available to HHS, the OIG, the Comptroller General, or their designees, upon request. In estimating the annual hour and cost burden on QHP issuers of making these records available to such authorities upon request, we assumed that such requests would normally be made in connection with a formal audit or compliance review or a similar process. Our burden estimates for this section address the hour and cost burden of making records available to HHS, the OIG, the Comptroller General, or their designees, for audit. Our estimates reflect our assumptions that about 47 QHP issuers would be subject to a formal audit in a given year and that the burden on issuers of making the records available would include the time, effort, and associated cost of compiling the information, reviewing it for completeness, submitting it to the auditor(s), and participating in telephone or in-person interviews. We anticipate using a risk-based approach to selection of the majority of QHP issuers for compliance review so that burdens to the issuer community would generally be linked to the QHP issuers' risk. We estimate it will take 90 hours at a cost of $4,221.20 for an issuer to make their records available for an audit for a total of 9,000 hours and $422,120.00 across all QHP issuers subject to this requirement, which we estimate at an upper end as 100 issuers.

Section 156.715 proposes to establish the general standard that QHP issuers are subject to compliance reviews. Our burden estimates for proposed §156.715 address the estimated annual hour and cost burden on QHP issuers of complying with the records disclosure requirements associated with compliance reviews conducted by an FFE.

Section 156.715 proposes to provide standards for compliance reviews in the FFEs, stating that QHP issuers offering QHPs in the FFEs may be subject to compliance reviews. This section also describes the categories of records and information issuers would be required to make available to an FFE in conducting such reviews.

Compliance reviews would evaluate a QHP issuer's compliance with the Affordable Care Act and applicable regulations. Compliance reviews will target high-risk QHP issuers and not every issuer will be reviewed each year. The results of compliance reviews will also provide insight into trends across the compliance statuses of QHP issuers, enabling HHS to prioritize areas of oversight and technical assistance.

We assume that HHS will conduct desk reviews of 31 QHP issuers each year. For each QHP issuer desk review we estimate an average of 40 hours for administrative work to assemble the requested information, 19.5 hours to review the information for completeness, and 30 minutes to submit the information to HHS. There will also be an additional 10 hours to spend on phone interviews conducted by the reviewer and 2 hours to spend speaking through processes with the reviewer. We estimate it will take 72 hours at a cost of $2,877.40 for an issuer to make information available to HHS for a desk review for a total of 2,232 hours and $89,199.40 across all issuers that may be subject to this information collection requirement.

We assume that HHS will conduct onsite reviews of 16 QHP issuers each year. For each onsite review we estimate it will take an average of 40 hours for administrative work to assemble the requested information, 19.5 hours to review the information for completeness and 30 minutes to submit the information to HHS in preparation for an onsite review. An onsite review requires an additional 2 hours to schedule the onsite activities with the compliance reviewer, 4 hours for introductory meeting, 8 hours to tour reviewers onsite, 10 hours of interview time, 2 hours to walk through processes with the reviewer, and 4 hours for concluding meetings. This is a total of approximately 60 hours of preparation time and an additional 30 hours for onsite time for each QHP. We estimate it will take 90 hours at a cost of $3,566.84 for an issuer to make information available to HHS for an onsite review. We estimate that the burden for all respondents that may be subject to this information collection will be 1,440 hours at a cost of $57,069.44.

In cases in which HHS could potentially require clarification around submitted information, HHS may need to contact QHP issuers within 30 days of information submission. This would be the case for approximately 20 issuers. We estimate it will take an issuer 2 hours at a cost of $53.75 to respond to questions for a total of 40 hours and $1,075.00.

ICRs Regarding Enforcement Remedies in Federally-facilitated Exchanges (§156.800 to §156.810)

Subpart I of Part 156 of the Program Integrity Proposed Rule discusses the enforcement remedies in the FFEs. Proposed data elements for Subpart I can be seen in Appendix E to this supporting statement. Section 156.800 proposes to authorize HHS to impose sanctions on QHP issuers in an FFE that are not in compliance with Federal standards. These sanctions may be in the form of a CMP, as set forth in §156.805; or decertification of QHPs, as set forth in §156.810. The burden estimates for the collections of information in this Part reflect our assumption that there will be 409 QHP issuers and 12,000-18,000 QHPs in all FFEs.

Section 156.805(a) proposes the general process and bases for imposing a CMP on issuers offering QHPs in an FFE. As explained in the preamble to Subpart I, HHS intends to work collaboratively with QHP issuers, where possible, especially during the first plan year, when problems arising concerning compliance with applicable standards. CMPs will be imposed only for serious issues of non-compliance. We expect to provide technical assistance to issuers, as appropriate, to assist them in maintaining compliance with the applicable standards. We also plan to coordinate with States in our oversight and enforcement activities to avoid inappropriately duplicative enforcement efforts. Consequently, we anticipate that CMPs will be rare, especially in the first benefit year. For purposes of calculating the estimated burden, we assume that one issuer each year will be subject to a CMP and that the issuer will request an appeal of the enforcement action. We seek comment on these assumptions.

Section 156.810 proposes the bases for the decertification of a QHP in an FFE and the general process for decertification. As with CMPs, HHS expects that decertification will be relatively infrequent,

and reserved for only serious instances of non-compliance with applicable standards. Therefore, for purposes of this estimated burden, we assume that only one QHP in an FFE will be decertified each year. We assume that the issuer offering the decertified QHP will appeal the decertification action. We solicit comments on these assumptions.

Because we anticipate that fewer than 10 issuers would be subject to a decertification or CMP in a given year, we have not calculated a burden estimate. If the number of issuers approaches 10, we will submit a burden estimate at that time. We solicit comments on this section and these assumptions.

ICRs Regarding Administrative Review of QHP Issuer Sanctions in a Federally-facilitated Exchange (§156.901 to §156.963)

Subpart J of Part 156 proposes the administrative process for issuers subject to a CMP or decertification of a QHP offered by the issuer to appeal the enforcement action. In this process, an ALJ would decide whether there is a basis for HHS to assess a CMP against the issuer and whether the amount of an assessed penalty is reasonable, or whether there is a basis for decertifying a QHP offered by the issuer, as applicable. Section 156.905 (intended to parallel 45 CFR 150.405), as proposed, provides that a party has a right to a hearing before an ALJ if it files a valid request for a hearing within 30 days after the date of issuance of HHS's notice of proposed assessment decertification. An issuer's request for a hearing must include the information listed in §156.907. Proposed data elements associated with Subpart J can be seen in Appendix F to this supporting statement.

The burden associated with this request would include the time and effort needed by the issuer to create the written request and submit it electronically to the appropriate entity. The associated costs are labor costs for gathering the necessary background information and then preparing and submitting the written statement. The burden estimates for the collections of information in Part 156, Subpart J, of the regulation reflect the assumption that there will be a total of 409 QHP issuers in all FFEs.

We base our burden estimate on the assumptions that one issuer will be subject to CMPs and that one issuer will have a QHP that it offers in an FFE decertified. We assume that both issuers will choose to exercise their right to a hearing and will submit a valid request for hearing. The hours involved in preparing this request may vary; for the purpose of this burden estimate we estimate an average of 24 hours will be needed: 10 hours for the compliance officer to gather and assemble necessary background materials and prepare the written request, 12 hours for an attorney to review the background materials and written request and provide recommendations to the senior manager, and 2 hours for the senior manager to discuss the attorney's recommendations and submit the written request electronically. We estimate that it will take 24 hours at a cost of $1,649.02 for an issuer to prepare and submit a request for a hearing for a total of 48 hours and $3,298.04 for both issuers. This estimate includes any statement of good cause under §156.805(e)(3), if applicable. We solicit comments on these assumptions.

As stated in proposed §156.905, an issuer would have the right to a hearing before an ALJ if the issuer files a request for a hearing that complies with §156.907(a) within 30 days of the issuance of a notice of proposed assessment or decertification from HHS under §156.805 or §156.810. The request for a hearing would be required to identify any factual or legal bases for the assessment or decertification with which the issuer disagrees. It must also describe with reasonable specificity the basis for the disagreement, including any affirmative facts or legal arguments on which the respondent is relying. The request must also identify the relevant notice of assessment or decertification by date and attach a copy of the notice.

An issuer's request for a hearing would also be required to include the information listed in proposed §156.907. The burden associated with this request would include the time and effort needed by the issuer to create the written request and submit it electronically to the appropriate entity. The only associated costs are labor costs for gathering the necessary background information and then preparing and submitting the written request.

Because we only estimate that one issuer per year would appeal a CMP and one issuer will have its QHP offered in an FFE decertified, we do not include this burden estimate in our overall calculation of burden for the Program Integrity Proposed Rule.

ICRs Regarding Consumer Cases Related to Qualified Health Plans and Qualified Health Plan Issuers (§156.1010)

In subpart K of part 156, we describe the proposed information collection requirements that pertain to the resolution of consumer cases related to QHPs and QHP issuers. Section 156.1010(e) proposes that QHP issuers must record a clear and concise narrative documenting the resolution of a consumer case in the HHS-developed casework tracking system. The burden associated with this requirement would be the time and effort necessary for a QHP issuer to gather the necessary information related to the consumer complaint, draft the narrative, and enter the narrative into the electronic HHS-developed case tracking system. For the purpose of estimating burden, we estimate 1,200 issuers. We estimate that it will take approximately 60 hours annually at a cost of $8,580.87 for the time and effort to develop and submit the narrative to HHS for a total of 72,000 hours and a cost of $10,297,044.00 for all respondents.

ICRs Related to Quality Standards (§156.1105)

In subpart L of part 156, we describe the proposed information collection and disclosure requirements that pertain to the approval of enrollee satisfaction survey vendors. The burden estimate associated with these disclosure requirements would be the time and effort required for survey vendors to develop, compile, and submit the application information and any documentation necessary to support oversight in the form and manner required by HHS. HHS is developing a model enrollee satisfaction survey vendor application that will include data elements necessary for HHS review and approval. In the near future, HHS will publish the model application and will solicit public comment. At that time, and per the requirements outlined in the PRA, we will estimate the burden on survey vendors for complying with this provision of the regulation. We solicit comment on the burden for the application and review process for these entities.

ICRs Related to Confirmation of Payment and Collection Reports (§156.1210)

In §156.1210, we propose that, within 15 calendar days of the date of a payment and collections report from HHS, the issuer must, in a format specified by HHS, either confirm to HHS that the payment and collections report accurately lists for the timeframe specified in the report applicable payments owed by the issuer to HHS and the payments owed to the issuer by HHS; or describe to HHS any inaccuracy it identifies in the payment and collections report. We believe that issuers will generally be able to perform this confirmation automatically, and that there will only be a small additional burden as a result of this requirement. We estimate that it will take an insurance operations analyst 1 hour (at $38.49 an hour) monthly to make the comparison and note any discrepancies to HHS (approximately $461.88 for each issuer annually). Based on our most recent estimates, we believe that 2,400 issuers will be affected by this requirement, resulting in aggregate burden of approximately $1,108,512. The proposed data elements associated with this information collection can be seen in Appendix G to this supporting statement.

ICRs Related to Enrollment Process for Qualified Individuals (§156.1230)

Proposed §156.1230(a)(1)(ii) would require issuers who pursue the option to use their Web site to enroll qualified individuals into QHPs directly, to provide information on available QHPs. The QHP information required to be posted on the Web site would include premium and cost-sharing information, the summary of benefits and coverage, levels of coverage for each QHP, results of the enrollee satisfaction survey, quality ratings, medical loss ratio information, transparency of coverage measures, and a provider directory. Under proposed §156.1230(a)(1)(i), an issuer would also be required to direct an individual to complete an application with the Exchange and receive eligibility determinations from the Exchange to allow for an accurate plan selection process. Additionally, §156.1230(a)(1)(iv) would require the issuer Web site to inform applicants about the availability of other QHP products available through an Exchange and to display a Web link to the appropriate Exchange Web site. Finally, an issuer would submit enrollment information back to the Exchange.

The burden for this requirement would be for the issuer to develop its own template and code and integrate it with the Exchange. After this initial step, the burden on the issuer would be to maintain the Internet Web site by populating the Web site with information collected per information collection requirements in this rule and future rulemaking by HHS. We do not have an estimate on the number of issuers who will choose to utilize the direct to enrollment approach subject to these third-party disclosure requirements. We estimate that it will take 610 hours at a cost of $32,104.25 for an issuer to meet these third-party disclosure requirements.

Proposed §156.1230(a)(2) would allow qualified individuals to apply for an eligibility determination or redetermination for coverage through the Exchange and insurance affordability programs, and select QHPs with the assistance of an issuer customer service representative if the issuer customer service representative complies with the terms of an agreement between the issuer and the Exchange. The agreement would ensure that an issuer customer service representative receives training and provide additional standards governing the conduct of issuer customer service representatives.

The burden for this requirement would include the time and effort necessary to develop training materials for the customer service representative and the time and effort necessary to amend the agreement between the issuer and the Exchange if the Exchange implements this provision.

The Exchange would be required to develop training materials for issuer staff. We assume that the 18 State Exchanges will implement this standard. However, we expect Exchanges would use training materials that will either be developed by HHS for other types of assister training, including agent/broker training or use their own training materials that they have already developed for other assisters. Therefore, we anticipate that the time and costs associated with developing a training program for issuers will be minimal. We estimate it will take a training specialist 10 hours at $26.64 an hour and a training and development manager 5 hours at $64.43 an hour to develop training materials for the customer service representative, for a total time burden of 15 hours. The estimated cost burden for developing training materials for issuer customer service representatives for each Exchange is therefore $588.55 with a total cost of $10,593.90 across all respondents if 18 State Exchanges undertake these activities.

As specified in proposed §156.1230(a)(2), each Exchange would amend its agreement with every issuer wanting its staff to assist consumers. We assume that the 18 State Exchanges will implement this standard. We estimate it will take a health policy analyst 20 hours at $49.35 an hour and a senior manager 10

hours at $79.08 an hour to amend an agreement with the issuer, for a total time burden of 30 hours. The estimated burden for amending the agreements for each Exchange is therefore 30 hours at a cost of $1,777.87 and a total cost of $32,001.66.

13. Capital Costs

There are no anticipated capital costs associated with these information collections.

14. Cost to Federal Government

The initial burden to the Federal government for the establishing the systems and policies associated with this information collection is $272,850.00. The calculations for CCIIO employees' hourly salary was obtained from the OPM website: http://www.opm.gov/oca/10tables/html/dcb_h.asp.

Table 1 – Administrative Burden Costs for the Federal Government Associated with the Program Integrity NPRM

Task	Estimated Cost
Development of Program Integrity Information Collections	
15 GS-13: 15 x $42.66 x 200 hours	$127,980.00
Technical Assistance to States	
15 GS-13: 15 x $42.66 x 200 hours	$127,980.00
Managerial Review and Oversight	
2 GS-15: 2 x $59.30 x 150 hours	$16,890.00
Total Costs to Government	$272,850.00

15. Changes to Burden

There are no changes to the burden. This is a new data collection.

16. Publication/Tabulation Dates

TBD.

17. Expiration Date

Not applicable.

18. Certification Statement

There is no exception to the certification statement identified in Item 19, "Certification for Paperwork Reduction Act Submissions," of OMB Form 83-I.