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

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. On January 30, 2013, CMS published *Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges under the Affordable Care Act* (CMS-2334-P) (E&E II Proposed Rule). On August 30, 2013, HHS published the final rule CMS-9957-F*: Program Integrity: Exchanges, SHOP, Eligibility Appeals* (Program Integrity final rule), finalizing a number of the provisions from the Program Integrity and E&E II Proposed Rules. The third party disclosure requirements and data collections in the Program Integrity final rule support the oversight of qualified health plan (QHP) issuers in Federally-facilitated Exchanges (FFEs) and other provisions.

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 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 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 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.

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 1401 of the Affordable Care Act amended the Internal Revenue Code (26 U.S.C.) to add § 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 1411 of the Affordable Care Act, directs the Secretary to establish a program for determining whether an individual meets the eligibility standards for Exchange participation, advance payments of the premium tax credit, cost-sharing reductions, and exemptions from the shared responsibility payment.

Sections 1412 and 1413 of the Affordable Care Act and section 1943 of the Social Security Act (the Act), as added by section 2201 of the Affordable Care Act, contain additional provisions

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

regarding eligibility for advance payments of the premium tax credit and cost-sharing reductions, as well as provisions regarding simplification and coordination of eligibility determinations and enrollment with other health programs.

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

2. Information Users

The 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.

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.

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, HHS will not be able to properly ensure the financial integrity of Federal funds.

7. Special Circumstances

Section 155.535 states that the appeals entity must send written notice, electronically or in hard copy, to the appellant of the date, time and location of the hearing no later than 15 days prior to the date of the hearing. We anticipate that 15 days will provide the applicant enough time to contact the appeals entity if the date and time are prohibitive of participation.

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 essential health benefit (EHB) provisions, including §§156.115 and 156.135, have been subject to substantial discussion and consultation with the public and the affected industry through a proposed rule (CMS-9965-P) released November 26, 2012. 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, we 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

[2] Available at: http://www.gpo.gov/fdsys/pkg/FR-2012-07-20/pdf/2012-17831.pdf.

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 Related to the Risk Corridors Program (§153.500)

In this final rule, we amend the definition of a QHP in §153.500 for the purposes of the risk corridors program. We provide that a plan will be subject to the risk corridors program if it is (a) a QHP, as defined in 45 CFR 155.20; (b) a plan offered outside the Exchange that is the same plan as a QHP, as defined in 45 CFR 155.20, offered through the Exchange by the same issuer, pursuant to the criteria finalized in Part C(1)(a) of this rule; or (c) a plan offered outside the Exchange that is substantially the same as a QHP, as defined in 45 CFR 155.20, offered through the Exchange by the same issuer, pursuant to the criteria finalized in Part B(1)(a) of this rule.

In this final rule, we note that we intend to issue guidance on the operational aspects of this standard, including with respect to how HHS and issuers will identify plans submissions (including those submitted for the 2014 benefit year) that are "substantially the same" as a QHP offered through an Exchange for the purposes of determining whether the plan will participate in the risk corridors program. QHP issuers may be required to submit plan identification information to HHS as part of HHS's determination of which plans offered outside of the Exchange will participate in the risk corridors program. We intend to account for this information collection requirement in a PRA package that we will publish for public comment and advance for OMB approval in the future. Information related to the requirement will not be effective until comment is sought and the collection is approved by OMB.

ICRs Related to the 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(c)(3)(vii) requires each Web-broker in FFE states to display on its Web site a standardized disclaimer provided by HHS and a link to the FFE Web site. To comply with

[3] BLS March 2013 Employer Costs for Employee Compensation Report (March 12, 2013). Available at: http://www.bls.gov/news.release/ecec.toc.htm.

this requirement, each Web-broker will have to program its Web site to display the standardized disclaimer and a Web link to the Exchange Web site. We estimate that it will take up to 12 hours at an hourly cost of $52.50 for a computer programmer to perform the necessary programming, and 4 hours at an hourly cost of $79.08 for a senior manager to review the Web site display, for a total cost of approximately $946.32 per Web-broker. At this time, we anticipate that all Web-brokers will be participating in FFE states. Assuming that approximately 50 Web-brokers elect to access the FFE's application programming interface and that each Web-broker will have to display the standardized disclaimer language and Web link, we estimate that this provision would increase the burden estimate by approximately $47,316.00.

Labor Category	Number of Employees	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Total Burden Costs	Total Burden Costs (All Respondents)
Computer Programmer	1	$52.50	12	$630.00	
Senior Manager	1	$79.08	4	$316.32	
Total			16	$946.32	$47,316.00

Section 155.220(c)(4) requires a Web-broker to comply with several standards when the Web-broker permits other agents and brokers to use its Web site to enroll a consumer through the FFE, pursuant to a contractual or other arrangement between the Web-broker and the other agent or broker. One of the standards requires the Web-broker to provide to the FFE a list of agents or brokers who enter into such an arrangement, if requested by HHS. We understand that Web-brokers who work with other agents and brokers typically obtain and manage information on each of its agents or brokers as part of an agent onboarding process. As a result, Web-brokers already have the necessary data to list each of their agents or brokers that it contracts with under such arrangements. We estimate that it will take up to 48 hours at an hourly cost of $52.50 for a computer programmer to perform the necessary programming, and 4 hours at an hourly cost of $79.08 for a senior manager to develop a listing of affiliated third-party agents and brokers, $2,836.32 per Web-broker. Assuming that approximately 50 Web-brokers elect to access the FFE's application programming interface and that each has allows third-party agents to access their Web sites, we estimate that this provision would increase the burden estimate by approximately $141,816.00.

Labor Category	Number of Employees	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Total Burden Costs	Total Burden Costs (All Respondents)
Computer Programmer	1	$52.50	48	$2,520.00	
Senior	1	$79.08	4	$316.32	

Manager					
Total			52	$2,836.32	$141,816.00

Section 155.220 authorizes 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. Additionally, when a Web-broker permits other agents and brokers to use its Internet Web site to enroll individuals in an FFE it must comply with the standards established in §155.220(c)(4). The data elements for §155.220 can be seen Appendix A to this supporting statement. Section 155.220(g) sets forth the process whereby an agent or broker can request reconsideration of HHS's termination. Specifically, 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 §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.

Labor Category	Number of Employees	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Total Burden Costs	Total Burden Costs (All Respondents)
Brokerage Clerk	1	$28.81	10	$288.10	
Insurance Sales Agent	1	$41.15	8	$329.20	
Total			18	$617.30	$1,234.60

ICRs Related to Non-Exchange Entities: Privacy and Security Policies and Procedures (§155.260 (b))

This information collection is not directly tied to the provisions in the Program Integrity final rule. Various types of non-Exchange entities will assist consumers as they enroll in coverage in the FFEs, including State Partnership Marketplaces. These entities include agents, brokers, certified application counselors, Navigators, and other in-person assistors, all of which will need to enter into privacy and security agreements with the FFE, pursuant to 45 CFR 155.260(b). The agreements require these entities to implement privacy and security policies and procedures, which include developing training and awareness programs, implementing breach and incident handling procedures, creating a privacy disclosure statement, maintaining accounting of disclosures, and obtaining informed consent from individuals for any use or disclosure that is not permissible within the scope of the privacy notice statement or any relevant agreements.

Navigators

The burden on Navigator Project Managers and Navigator Senior Executives for 2013 to develop and adhere to the policies and procedures outlined above will be an estimated 5 hours per Project Manager and 1 hour per Senior Executive. Each Navigator Project Manager's wage is estimated $29.00 per hour, for a total of $145.00 per Navigator Project Manager. We estimate there will 264 Navigator Project Managers, for a total of $38,280 for all Navigator Project Managers in 2013. For 2014, Navigator Project Managers and Senior Executives will not need to develop additional policies and procedures but will need to continue with implementing the polices estimated and procedures estimated for 2013, for an estimated total of 2 hours per Project Manager and 1 hour per Senior Executive. Each Navigator Project Manager's wage is an estimated $29.00 per hour for a total of $58.00 per each Navigator Project Manager. We estimate there will be 264 Navigator Project Managers, for a total of $15,312. Each Navigator Senior Executive's wage is an estimated $48.00 per hour, for a total of $48.00 per each Senior Executive. We estimate there will be 264 Navigator Senior Executives, for a total of $12,672. We expect the number of Navigator Project Managers and Senior Executives to change over time as the number

of Navigator grantees is not likely to remain constant from one grant cycle to the next.

2013

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Total Burden Costs (per respondent)	Total Burden Costs (all respondents)
Navigator Project Manager	264	$29.00	5	$145.00	$38,280

2014

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Total Burden Costs (per respondent)	Total Burden Costs (all respondents)
Navigator Project Manager	264	$29.00	2	$58.00	$15,312
Navigator Senior Executive	264	$48.00	1	$48.00	$12,672

Certified Application Counselors

The burden on senior managers at certified application counselor organizations or on certified application counselors to develop and adhere to the policies and procedures outlined above will be an estimated 5 hours. Each senior manager's wage is an estimated $79.08 per hour, for a total of $395.40 per senior manager in 2013. We estimate there will be 3,000 senior managers at certified application counselor organizations, for a total of $1,186,200 for all senior managers to create policies and procedures in 2013. For 2014, senior managers will not need to develop additional policies and procedures but will need to continue with implementing the policies estimated and procedures estimated for 2013, for an estimated total of 1 hour. Each senior manager's wage is estimated at $79.08 per hour, for a total of $79.08 per senior manager. We estimate there will be 3,000 senior managers at certified application counselor organizations, for a total of $237,240 in 2014.

2013

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Total Burden Costs (per respondent)	Total Burden Costs (all respondents)
Navigator Senior Manager	3,000	$79.08	5	$395.40	$1,186,200

2014

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Total Burden Costs (per respondent)	Total Burden Costs (all respondents)
Navigator Senior Manager	3,000	$79.08	1	$79.08	$237,240

Agents and Brokers

The burden on licensed agents and brokers for 2013 to develop and adhere to the policies and procedures outlined above will be an estimated 5 hours. Each agent or broker's wage is an estimated $30.48 per hour, for a total of $152.40 per agent or broker in 2013. We estimate there will be 254,095 agents and brokers, for a total of $38,724,078 for all agents and brokers. For 2014 and 2015, agents and brokers will not need to develop additional policies and procedures but will need to continue with implementing the policies and procedures, for an estimated total 1 hour. Each agent or broker's wage is an estimated $30.48 per hour, as noted previously, for a total of $30.48 per agent or broker. We again estimate there will be 254,095 agents/brokers, for a total of $7,744,816.

2013

Labor Category	Number of Agents/Brokers	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Total Burden Costs (per respondent)	Total Burden Costs (all respondents)
Agent or broker	254,095	$30.48	5	$152.40	$38,724,078

2014 and 2015

Labor Category	Number of Agents/Brokers	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Total Burden Costs (per respondent)	Total Burden Costs (all respondents)
Agent or broker	254,095	$30.48	1	$30.48	$7,744,816

ICRs Related to the Eligibility Process (§155.310)

Section 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 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.

Labor Category	Burden Hours (per respondent)

Applicant	1

ICRs Regarding Appeals (§§155.505, 155.510, 155.520, 155.530, 155.535, 155.540, 155.545, 155.550, 155.555, 155.740)

The eligibility appeals provisions in subparts F and H include requirements for the collection of information that will support processing and adjudicating appeals for individuals, employers facing potential tax liability, and SHOP employers and employees. Data elements for these provisions are set forth in Appendix B. The information collection will be largely the same for each type of appeal and includes the appeal request, expedited appeal request, appeal withdrawal, request to vacate, request for additional information, special considerations form, and appointment and removal of authorized representative. We anticipate most appellants will opt to accept and respond to these forms and notices electronically; however, appeals entities will be equipped to handle the sending and submission of paper forms and documents. Appellants providing information to the appeals entity will likely need to search their personal files at home or obtain documentation from employers or government entities to support their appeal. If the appellant is an employer, it is likely that the employer may rely on human resources personnel or an attorney to provide information during the appeal. Appeal entities will rely on office clerks and paralegals or legal assistants to process the information submitted. Finally, the use of many of these forms and notices is dependent on the trajectory of each appeal; therefore, not every form will be implicated in each appeal.

The appeal request form will be available to each appellant type in hard copy and some cases electronically but appellants may also request an appeal telephonically. Regardless of the mode of transmission, some basic information will be required to initiate an appeal, including the identity of the appellant and the appellant's contact information. Appellants are encouraged, but not required, to also submit information detailing why they are appealing and evidence to support their appeal. We anticipate that most appellants will choose to submit more than the base-level of information. We estimate that most appellants, including employers, will complete the form within one hour. Large and SHOP employers will require up to two hours to process the form, which includes one hour for a human resources manager, at an hourly cost of $71.24 and one hour for a lawyer, at an hourly cost of $103.05. Across employer appeals, we estimate a total of 19,020 appeals requests which will require 38,040 labor hours, at a total cost of $3,314,995.80 for employers for 51 Exchanges.

Labor Category	Number of Employees	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Total Burden Costs (per respondent)	Total Burden Costs (all respondents)

Human Resources Manager	1	$71.24	1	$71.24	
Lawyer	1	$103.05	1	$103.05	
			2	$174.29	$3,314,995.80

The appeals entity will require up to 1.5 hours to process the form, which includes 0.5 hours for an office clerk, at an hourly cost of $19.97, to digitize and link the form to the appellant's account, and one hour for a paralegal or legal assistant, at an hourly cost of $34.51, to review the information submitted, and notify the appropriate appeals workers of a new appeal request. Across all types of appeals, we estimate a total of 77,314 appeals requests for the first year, which will require 77,314 hours to complete for all appellants including individuals and employers, and 115,971 hours for the appeals entities, at a total cost of $3,440,086.43 for 18 Exchanges.

Labor Category	Number of Employees	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Total Burden Costs (per respondent)	Total Burden Costs (all respondents)
Office Clerk	1	$19.97	0.5	$9.98	
Paralegal/Legal Assistant	1	$34.51	1	$34.51	
			1.5	$44.49	$3,440,086.43

Appellants will receive an acknowledgement of his or her appeal request that includes the invitation to submit evidence to support the appeal in the form of the request for additional information form. Completing this form is optional for all appellants. However, we anticipate that many appellants will use the opportunity to send additional information to the appeals entity. Much like the appeal request, the appeals entity will be responsible for digitizing the submitted information, placing it in the proper account, and reviewing it. The burden on the appellant is dependent on how easily he or she can access information relevant eligibility. We estimate this may require up to two hours for the appellant. To process additional information submitted, we estimate that the appeals entity will require 0.5 hours for an office clerk, at an hourly cost of $19.97, to digitize and link the form to the appellant's account, and 0.5 hours for a paralegal or legal assistant, at an hourly cost of $34.51, to review the information submitted, and notify the appropriate appeals workers of the updated information, for a total cost of about $27 per appellant.

Labor Category	Number of Employees	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Total Burden Costs (per respondent)
Office Clerk	1	$19.97	0.5	$9.98
Paralegal/Legal Assistant	1	$34.51	0.5	$17.25
			1.5	$27.23

Other forms the appellant may encounter during the appeals process include the appeal withdrawal form, request to vacate a dismissal, special considerations form, and appointment of authorized representative form. Each of these include information collections that are initiated by the appellant when he or she, for example, wishes to withdraw an appeal or intends to have another person act on his or her behalf. In most cases, the information submitted for these actions will require little more than acknowledging the appellant's intentions and including contact information. The request to vacate a dismissal will entail slightly more effort because, to successfully vacate a dismissal, the appellant must show good cause. We anticipate that these forms may require as little as 15 minutes or up to 2 hours for the appellant to complete and approximately 30 minutes to 1.5 hours for the appeals entity to process for a cost of approximately $10-$45 per submission.

The appeals process also includes several instances where notice of appeals actions must be sent to the Exchange, the SHOP, or Medicaid or CHIP agencies. For example, the appeals entity is required to notify the Exchange or the SHOP when an appeal request has been submitted and when an appeal decision has been issued. This notice will be sent via secure electronic interface. In addition, eligibility records and, in some instances, appeals records must be transmitted electronically to the appeals entity from the Exchange, the SHOP, or the Medicaid or CHIP agency. To accommodate these electronic notifications and transfers of records, we estimate the Exchange will need to include language in agreements with other agencies administering insurance affordability programs. We estimate that the creation of the necessary agreements will necessitate 35 hours from a health policy analyst at an hourly cost of $49.35, and 35 hours from an operations analyst at an hourly cost of $54.45 to develop the agreement; and 30 hours from an attorney at an hourly cost of $90.14 and five hours from a senior manager at an hourly cost of $79.14 to review the agreement. Accordingly, the total burden on the Exchange associated with the creation of the necessary agreements will be approximately 105 hours and $6,730.90 per Exchange, for a total cost of $121,156.20 for 18 Exchanges.

Labor Category	Number of Employees	Hourly Labor Costs (Hourly rate + 35% Fringe	Burden Hours	Total Burden Costs (per respondent)	Total Burden Costs (all respondents)

		benefits)			
Health Policy Analyst	1	$49.35	35	$1,725.25	
Operations Analyst	1	$54.45	35	$1,905.75	
Lawyer	1	$90.14	30	$2,704.20	
Senior Manager	1	$79.14	5	$395.70	
			105	$6,730.90	$121,156.20

We also propose that appeals entities maintain appeals records and provide the appellant and the public access to those records, subject to applicable state and federal privacy and confidentiality laws. We estimate that an individual requesting access to appeal records may require up to 30 minutes to submit the request form. An employer submitting a similar request may require up to an hour to complete the form at a maximum cost of $62.65, which includes 0.5 hours of time from a human resources specialist at an hourly cost of $40.68 to complete the record request; and 0.25 hours of time from an attorney at an hourly cost of $90.14 and 0.25 hours from a senior manager at an hourly cost of $79.08 to review the request before submission. In order to process record requests, we anticipate the appeals entity will require two hours for a total cost of $42.98 with an additional dollar for the cost of printing and mailing hard copy records. The number of individuals and employers requesting access to appeal records is unknown. We estimate that the development of the records storage system will necessitate 15 hours from a health policy analyst at an hourly cost of $49.35, and 20 hours from an operations analyst at an hourly cost of $54.45 to provide specifications for the records that need to be maintained; 20 hours from an attorney at an hourly cost of $90.14 and 5 hours from a senior manager at an hourly cost of $79.14 to provide oversight and supervision; and 120 hours from a computer programmer at an hourly cost of $52.50 to conduct the necessary system development. Accordingly, the total burden on the Exchange associated with the development of the records storage system will be 180 labor hours with a cost of approximately $9,159 per Exchange and a total cost of $185,899.50 for 18 Exchanges.

Labor Category	Number of Employees	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Total Burden Costs (per respondent)	Total Burden Costs (all respondents)
Health Policy Analyst	1	$49.35	15	$740.25	
Operations Analyst	1	$54.45	20	$1,089.00	

Lawyer	1	$90.14	20	$1,802.80	
Senior Manager	1	$79.14	5	$395.70	
Computer Programmer	1	$52.50	120	$6,300.00	
			180	$9,159.00	$185,899.50

Finally, the appeals process will require the sending of notices to the appellant and other parties throughout the process. Notices include acknowledgement of appeal request form, notice of dismissal, notice of hearing, notice of denial of an expedited hearing request, notice of action by an authorized representative, notice of invalid appeal request, notice of pended eligibility, and notice of appeals decision. We expect that the appeal decision notice will be dynamic and include information tailored to the appellant's case. HHS is currently developing model appeals notices and forms which will decrease the burden on Exchanges to establish such notices. We estimate that the development of each of the necessary notices will necessitate 44 hours from a health policy analyst at an hourly cost of $49.35 to learn appeals rules and draft notice text; 20 hours from an attorney at an hourly cost of $90.14 and four hours from a senior manager at an hourly cost of $79.08 to review the notice; and 32 hours from a computer programmer at an hourly cost of $52.50 to conduct the necessary development. In total, we estimate that the development of each notice specified as part of the appeals process will require 100 hours to complete in the first year, at a cost of $5,970.76 per Exchange, for a total of $107,473.68 for 18 Exchanges.

Labor Category	Number of Employees	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Total Burden Costs (per respondent)	Total Burden Costs (all respondents)
Health Policy Analyst	1	$49.35	44	$2,171.40	
Lawyer	1	$90.14	20	$1,802.80	
Senior Manager	1	$79.14	4	$316.56	
Computer Programmer	1	$52.50	32	$1,680.00	
			100	$5,970.76	$107,473.68

The cost estimates for the sending of notices is based on that assumption that the 77,314 appellants will receive two notices each in the first year at a rate of $.50 per notice. In total, we estimate that the sending of notice will cost $77,314 for 18 Exchanges.

ICRS Related to Habilitative Services (45 CFR 156.115)

This information collection is not directly tied to the provisions in the Program Integrity final rule. 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 data elements associated with 45 CFR 156.115(a)(4) can be seen in Appendix C to this supporting statement.

Labor Category	Number of Employees	Hourly Labor Costs	Burden Hours	Number of Respondents	Total Burden Costs
Database Administrator	1	$47.70	1	50	$2,385

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

This information collection is not directly tied to the provisions in the Program Integrity final rule. 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 $1,690.65. It is impossible to determine how many States will elect this option; therefore, we have estimated that 51 States elect it. The burden across all 51 respondents is estimated to be 1,020 hours at a cost of $86,241.00. The data elements associated with 45 CFR 156.135 can be seen in Appendix D to this supporting statement.

Labor Category	Number of Employees	Hourly Labor Costs	Burden Hours	Total Burden Costs	Number of Respondents	Total Burden Cost
Database Administrator	1	$47.70	15	$715.50		

Actuary	1	$225.00	4	$900.00		
Senior Manager	1	$75.15	1	$75.15		
Total			20	$1690.65	51	$86, 241.0

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

Subpart I of Part 156 discusses the enforcement remedies in the FFEs. Section 156.800 authorizes 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) states 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 sets forth 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.

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 information collection requirements that pertain to the resolution of consumer cases related to QHPs and QHP issuers. Section 156.1010(g)(1)

states that QHP issuers must include the date of case resolution, §156.1010(g)(2) states that QHP issuers must record a clear and concise narrative documenting the resolution of a consumer case in the HHS-developed casework tracking system, and §156.1010(g)(3) states that QHP issuers must provide information about compliance issues found by a State during the investigation of a case. The burden associated with this requirement would be the time and effort necessary for staff of 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, on average, each issuer will utilize 6 insurance caseworkers that will undertake this work for approximately 60 total hours annually at a cost of $8,582.40. This is a total of 72,000 hours and a cost of $10,298,880.00 for all issuers.

Labor Category	Number of Employees	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Total Burden Costs	Total Burden Costs (All Respondents)
Insurance Caseworker	6	$23.84	60	$8,582.40	
Total			60	$8,582.40	$10,298,880.00

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

Under finalized §156.1230(a)(1)(ii), issuers must provide information on available QHPs when they choose to use their Web site to directly enroll qualified individuals into QHPs in a manner considered to be through the Exchange. The QHP information required to be posted on the Web site includes 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. In finalized §156.1230(a)(1)(i), an issuer is also 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) requires the issuer Web site to inform applicants about the availability of other QHP products available through an Exchange through an HHS-approved universal disclaimer and to display a Web link to the appropriate Exchange Web site. Issuers are also required to distinguish between QHPs for which a consumer is eligible and other non-QHPs that an issuer may offer as finalized in §156.1230(a)(1)(iii). Finally, an issuer needs to submit enrollment information back to the Exchange including the APTC amount and attestation from an individual as proposed in §156.1230(a)(1)(v).

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 expect that is will take two health policy analysts 50 hours at $58.05 an hour, two web developers 75 hours at $51.52 an hour, a senior manager 35 hours at $103.95 an hour, four database administers 100 hours at $46.86 an hour, and two computer programmers 350 hours at $48.61 an hour to set up and maintain their QHP information on their website following the requirements set out in final §156.1230(a)(1) each year. Therefore, we estimate that it will require a total of 610 hours at a cost of $32,104.25 per issuer to meet these third-party disclosure requirements.

Labor Category	Number of Employees	Hourly Labor Costs (Hourly rate + 35% Fringe benefits	Burden Hours	Total Burden Costs (per respondent)
Health Policy Analyst	2	$58.05	50	$2,902.50
Web Developer	2	$51.52	75	$3,864.00
Senior Management	1	$103.95	35	$3,638.25
Network Administrator/Database Administrator	4	$46.86	100	$4,686.00
Computer Programmer	2	$48.61	350	$17,013.50
Total	11		610	$32,104.25

Finalized §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 with the assistance of an issuer application assister. In order for an issuer application assister to perform those functions, they must receive the proper training.

The burden for this requirement would include the time and effort necessary to develop training materials for the issuer application assister 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 application assisters, 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. Since training may be updated on an annual basis, we expect the cost to remain consistent from year to year.

Labor Category	Number of Employees	Hourly Labor Costs (Hourly rate + Fringe benefits	Burden Hours (per respondent)	Total Burden Costs (per response)	Total Burden Costs (All Respondents)
Training Specialist	1	$26.64	10	$266.40	$4,795.20
Training and Development Manager	1	$64.43	5	$322.15	$5,798.70
Total	2		15	$588.55	$10,593.90

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 and Additional State Collections

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

We also anticipate costs to the Federal government to include costs related to the Federal appeals process. As the FFE, costs related to implementation would be the same as the costs, described in the burden estimates for each Exchange above and would vary depending on the number of States that opt to participate as an FFE. The burden estimates provided in this analysis apply independently of those of the appeals entity. Costs related to the Federal appeals process are difficult to estimate for several reasons. We are unable to decipher at this point the precise burden on the Federal appeals entity versus the State-based appeals entity because 1) we do not have a clear understanding of how many States will establish their own Exchanges, 2) for the States that choose to establish their own their Exchange, we are unable to predict how many States can establish a State-based appeals entity and, 3) we are unable to predict how many individuals who appeals within a State Exchange will exercise their right to a secondary appeals at the Federal appeals entity.

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.