Supporting Statement for Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations
(OMB Control No. 0938-1187)

A. Background

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (P.L. 111-148). On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was signed into law. The two laws are collectively referred to as the Affordable Care Act. The Affordable Care Act (ACA) establishes new competitive private health insurance markets called Affordable Insurance Exchanges (Exchanges) which give millions of Americans and small businesses access to affordable, quality insurance options. By providing a place for one-stop shopping, Exchanges make purchasing health insurance easier and more transparent, and put greater control and more choice in the hands of individuals and small businesses. Additionally, reinsurance, risk corridors, and risk adjustment programs provide market stabilization to lower costly premiums associated with individual and small business coverage.

As directed by the rule *Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers* (77 FR 18310) (Exchange rule), each Exchange will assume responsibilities related to the certification and offering of Qualified Health Plans (QHPs). To offer insurance through an Exchange, a health insurance issuer must have its health plans certified as QHPs by the Exchange. A QHP must meet certain minimum certification standards, such as network adequacy, inclusion of Essential Community Providers (ECPs), and non-discrimination. The Exchange is responsible for ensuring that QHPs meet these minimum certification standards as described in the Exchange rule under 45 CFR 155 and 156, based on the ACA, as well as other standards determined by the Exchange.

Issuers can offer individual and small group market plans outside of the Exchanges that are not QHPs. Such plans are referred to in this document as "non-Exchange." The reinsurance and risk adjustment programs outlined by the ACA, detailed in the rule *Standards for Reinsurance, Risk Corridors, and Risk Adjustment* (77 FR 17220), have general information reporting requirements that apply to QHPs offered through the Exchanges and non-Exchange plans in the outside market. For the reinsurance program, administrative information is used to identify all entities required to contribute to the reinsurance program by state. In addition, non-Exchange plan information such as plan type and location is used to identify non-grandfathered individual market plans eligible by state for reinsurance payments. For the risk adjustment program, administrative information is used to identify all non-grandfathered small group and individual market non-Exchange plan offerings eligible for the program. Risk adjustment also requires select data such as rating area, rating factors, and actuarial value (AV) level, to perform calculation of payments and charges.

On March 13, 2013, the Office of Management and Budget (OMB) granted approval to the data collection *Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations* (OMB Control Number 0938-1187). This certification is valid for three years and expires on March 31, 2016. Based on changing needs of the Exchange program, revisions to this data collection to be applicable for 2015 certification and beyond were proposed through a Federal Register notice published on November 1, 2013 (78 FR 65656) and again on February 10, 2014 (79 FR 7674). These notices provided 60-day and 30-day public comment periods, respectively. The Centers for Medicare & Medicaid Services (CMS) is now finalizing these templates based on the comments received. Several of these templates will be used for 2015 QHP certification, in conjunction with some of the templates that were previously approved under this information

collection last year. We intend to use the templates in this information collection for the 2016 certification process and believe that providing these templates now will give issuers and other stakeholders more opportunity to familiarize themselves with the templates before the 2016 application. While we intend to use these templates in 2016, we may propose further revisions to this data collection in the future as necessary, including for 2016, and also reserve the ability to use the templates that were previously approved in 2013.

B. Justification

1. Circumstances Making the Collection of Information Necessary

QHP Information Collection: Certification and Standards

An Exchange certifies, recertifies and decertifies QHPs. The ACA authorizes QHP certification as well as other operational standards for the Exchange in following sections: 1301- 1304, 1311-1312, 1321-1322, 1324, 1334, 1401-1402, 1411 and 1412. Standards for QHP issuers are codified at 45 CFR parts 155 and 156.

An Exchange needs to collect data from issuers as part of QHP certification and recertification, and to monitor compliance with QHP certification standards on an ongoing basis. QHP issuer and plan data also supports additional operational activities, including the calculation of each individual's advance payment of the premium tax credit (APTC), the display of plan information on the Exchange website, and managing the ongoing relationships between QHP issuers and the Exchange. Feedback about the QHP certification and recertification process is be collected from issuers in an effort to improve the efficiency and effectiveness of data collection. Much of the information collected for QHP certification purposes supports these operational activities on an ongoing basis.

Stand-Alone Dental Plan Information Collection

Section 1311 of the Affordable Care Act and 45 CFR 155.1065 direct each Exchange to permit issuers to offer limited scope dental benefits as stand-alone dental plans or in conjunction with a QHP. All reasonably applicable QHP certification requirements apply to stand-alone dental plans offered in an Exchange, and dental issuers are required to complete the same application as all other QHPs. However, dental issuers will only be required to complete applicable data elements such as: Licensure and Good Standing; Network Adequacy; Essential Community Providers; and Actuarial Value. An Exchange needs to collect data from dental issuers in order to certify and recertify stand-alone dental plans, and to monitor ongoing compliance with applicable QHP certification standards. This data allows the Exchange to understand the difference between an estimated and actual rate or to calculate the portion of an individual's premium tax credit allocated to a stand-alone dental plan, and display plan and premium information for these plans.

Necessary Data for QHP Certification

The data collected for QHP certification, recertification, ongoing QHP oversight, financial management, and eligibility and enrollment functions (including the Exchange website) are reflected in the categories identified below and in the attached appendices. This data is also used to support other Exchange business functions such as determinations of the second-lowest-cost-silver plan, payments for cost-sharing reductions (CSRs), APTCs, and the display of information on the Exchange website. The data collection requirements apply to stand-alone dental plans as applicable. The Exchange is establishing a process for recertification of QHPs that, at a minimum, includes a review of the general certification criteria as outlined in § 155.1000(c), including data collection requirements as applicable. Feedback about the QHP certification and recertification process, including information regarding the data collection and templates, has and will be collected from issuers in an effort to improve the efficiency and effectiveness of the process. CMS will also collect

issuers' logos to display on HealthCare.gov and data to support and apply state-specific laws and requirements, such as premium payment method requirements, premium payment grace period non-APTC requirements, dependent age limits, fraud definitions and termination data parameters, and state provisions that allow consumers to have a "free look" at coverage documents and cancel coverage within a specified time frame for a full refund of premium. Collecting data from issuers also supports transparency of coverage in accordance with §156.220. CMS also collects information from Small Business Health Options Program (SHOP) QHP issuers on whether they will allow plan year rates to be established based on composite (or average) rates of employees and dependents at the time of initial application. CMS collects information from SHOP QHP and dental issuers on whether benefits are based on a plan year or calendar year. QHP issuers need to provide information that demonstrates that they meet patient safety standards if requested by an Exchange.

CMS will collect the following data to support these functions:

Appendix A: Issuer Application Data

- **Issuer Administrative Data Elements:** Basic information required to identify issuers and the Exchange markets they intend to serve, and to facilitate communications with and payment to issuers. The data elements may include issuer contact information and banking information.

- **State Licensure Documentation:** Documentation necessary to demonstrate that an issuer is licensed and has authority to sell all applicable products in all states in which it intends to offer a QHP, including submission of the state certification form.

- **Documentation of Good Standing:** Documentation necessary to demonstrate that an issuer is in compliance with all applicable state solvency requirements and other relevant state regulatory requirements, including submission of the state certification form.

- **Network Adequacy Data Elements:** Documentation necessary to demonstrate compliance with state network adequacy rules or, in the absence of such standards, documentation necessary to demonstrate that an issuer has an adequate range of providers for the intended service areas.

- **Network ID and Provider Directory URL Data Elements:** Network ID numbers identifying each provider network for purposes of plan-to-network mapping and specific URLs associated with the provider directory for each plan.

- **Essential Community Provider (ECP) Data Elements:** Number of participating Essential Community Providers participating in an issuer's provider network or other documentation necessary to demonstrate that that an issuer has an adequate range of ECPs for the intended service areas.

- **Provider File:** Information detailing the QHP issuer's provider network, including information such as provider name, county, and type.

- **Accreditation Data Elements:** If applicable, an issuer must provide certain data elements about accreditation conducted by any recognized accrediting entity, including URAC, the National Committee for Quality Assurance (NCQA), or the Accreditation Association for Ambulatory Health Care (AAAHC). Issuer must also authorize the release of accreditation survey data to an Exchange.

- **Supporting Documentation:** Additional documentation required by the Exchange for oversight purposes such as a compliance plan including an organization chart.

- **Attestations:** Attestations regarding compliance with applicable regulation.

Appendix B: Benefit and Service Area Data

- **Service Area:** Information identifying a plan's geographic service area.

- **Additional Supporting Documentation:** Additional documentation required by the Exchange such as discrimination/cost sharing outlier justifications.

- **Benefits and Associated Cost Sharing and Limits:** Data necessary to describe benefits offered by a plan including covered services, co-payments, coinsurance, tiers, intervals, and limits.

- **Summary of Benefits and Coverage Data Reporting Requirements:** Data elements from the Summary of Benefits and Coverage scenarios for display on the Exchange website.

- **High-level Plan Data**: Basic plan- level information for plans and products including information necessary for in-network and out-of-network deductibles and maximum out-of-pocket cost by benefit category.

- **Formulary Information including Tiers and Classes:** Formulary information including RxNorm Concept Unique Identifiers (RxCUIs), pricing tiers, co-insurance, co-payment information, drugs included in the formulary, formulary version number, and its effective date.

Appendix C: Rating Tables and Issuer Business Rules Data

- **Premium Rating Information and Business Rules:** Rating tables, factors and business rules required to perform rate review, populate the premium calculator and perform calculations for risk adjustment. Information will include collecting secondary eligibility criteria, such as grandchild, adult child, disabled dependent, spouse, and life partner.

- **Partial Month Premium Calculation Rule:** Rules and/or formulas to support the calculation of partial month premiums.

The following information will be collected for QHP certification and the burden is defined, as applicable, in Rate Increase Disclosure and Review Requirements (45 CFR Part 154),OMB Control Number CMS – 10379.

- **Rate Review Data Elements:** Financial information by market and product necessary for rate review and the evaluation of CSR payments. This could include: base period claims experience, projected period medical trend factors, and projected period administrative factors.

- **Essential Health Benefits (EHB) and Additional Coverage Data including Allocation of Premium Information:** Data required to determine the allocation of premiums for EHB and those services offered in excess of EHB.

- **CSR Advance Payments and Justification:** Data to support the payments for CSRs. The information will also support the variations in AV levels for CSR silver plan variations.

- **Actuarial Memorandum:** Actuarial narrative and certification required for the review of rates for rate review, premium allocation for APTCs, and CSR payment.

Non-Exchange Plan Information Collection: Reinsurance and Risk Adjustment
Section 1341 of the ACAprovides that each state will establish a transitional reinsurance program to help stabilize premiums for coverage in the individual market from 2014 through 2016. Section 1343 provides that each state will establish a permanent program of risk adjustment for all non-grandfathered plans in the individual and small group markets. If a state chooses not to actively participate in reinsurance and/or risk adjustment, CMS will be responsible for implementation. The requirements for issuers with plan offerings outside of the Exchanges are codified at 45 CFR 153. Please note the below information amends this collection for year one.

Reinsurance Reporting Requirements for non-Exchange Plans
The temporary reinsurance program will reduce the uncertainty of insurance risk in the individual market by making payments for high-cost enrollees. Health insurance issuers and self-insured group plans are required to remit contributions on behalf of certain enrollees in certain major medical coverage, and thus are collectively referred to as "contributing entities." Self-insured group health plans may remit their reinsurance contributions through a third party administrator or an administrative services only contractor. Non-grandfathered individual market plans are eligible to request and receive payments.

CMS will collect all contributions under the uniform reinsurance contribution rate, regardless of whether a state is operating a reinsurance program. CMS will operate reinsurance payment functions for a state when the state defers operating of the program to CMS.

In order to effectively identify and contact "contributing entities" and third party administrators (and administrative services only contractors) administrative information, such as name, location, and contact for company, is needed. In addition, in order to identify eligible plans for reinsurance payments, plan-level information is needed for non-grandfathered, non-Exchange plan offerings in the individual market.

Risk Adjustment Reporting Requirements for Non-Exchange Plans
The permanent risk adjustment program provides payments to health insurance issuers that disproportionately attract high-risk populations (such as those with chronic conditions), thereby reducing the incentives for issuers to avoid higher-risk enrollees. Under this program, funds are transferred from issuers with lower risk enrollees to issuers with higher risk enrollees.
A "risk adjustment covered plan" includes most health insurance plans offered in the individual or small group market. The exceptions are grandfathered health plans, group health insurance coverage described in 45 CFR 146.145(c), individual health insurance coverage described in 45 CFR 148.220, and any other plan determined not to be a risk adjustment covered plan in the applicable Federally-certified risk adjustment methodology. States, or CMS on behalf of a state, will require basic identifying information about all risk adjustment covered plans, whether or not they are QHPs.

Necessary Data for Reinsurance and Risk Adjustment Operations
Frequency of collection and types of information to be collected is determined by CMS.

Appendix D: Transitional Reinsurance and Risk Adjustment Operations Data
Data necessary for reinsurance and risk adjustment operations include:

- **Administrative Data Elements:** Basic information required to facilitate communications regarding reinsurance contributions and payments, risk adjustment charges and payments, and other financial program payments. The data elements may include issuer contact information and banking information.

- **State Licensure Data Elements**: Documentation necessary to demonstrate that an issuer is licensed and has authority to sell all applicable products in all states in which they intend to offer plan, including the state certification form.

- **Plan Level and Additional Coverage Data Entities:** Plan information to include market participation, plan type, and basic plan characteristics such as location.

Data for risk adjustment operations includes:

- **Premium Rating Information and Business Rules:** Factors, rating areas and business rules required to perform calculations for risk adjustment.

People with disabilities may contact Danielle Chestang at (410) 786-7815 or danielle.chestang@cms.hhs.gov if they require assistance in reading the appendices.

2. Purpose and Use of Information Collection

The Exchange collects plan- and issuer-level data from issuers to facilitate the certification and recertification of QHPs, Exchange operations, other Federal operations, QHP oversight, and ongoing market analysis. The data includes administrative data, enrollment data, financial data, issuer information, rate and benefit data and information, and process-related feedback data. All of this data is leveraged across multiple business areas in the Exchange to facilitate other operational tasks such as plan comparisons on the insurance portal and various payment activities, such as determination of the second lowest cost silver plan, APTCs, or risk adjustment.

In addition, CMS will collect organizational and plan-level data from issuers, self-insured group health plans and third party administrators (and administrative services only contractors). The data will include administrative data, financial data, and rate and benefit data. This data will be used to remit payments and to operate the premium stabilization programs.

3. Use of Improved Information Technology and Burden Reduction

CMS has and continues to engage with states, issuers, and the National Association of Insurance Commissioners (NAIC) in the effort to develop data standards for QHP certification, reinsurance, risk adjustment, and other plan management activities that would make reporting to the Exchanges more streamlined for issuers across the country, and allow them to submit information in a manner that is standardized to the greatest extent possible. We encourage states to leverage existing infrastructure to the extent possible and CMS is aware that states are hoping to incorporate their current data collection systems for Exchange operations including the NAIC's System for Electronic Rate and Form Filing (SERFF). In this spirit, CMS and the NAIC have jointly worked to enhance SERFF, which is currently used by many state Departments of Insurance for its traditional regulatory activities. CMS and the NAIC's technical teams have pursued a collaborative

development approach such that the data submission interfaces are very similar, if not identical. We believe that this initiative will ease the burden on both issuers and states.

4. Efforts to Identify Duplication and Use of Similar Information

CMS will make every effort to reduce the burden on issuers and reuse the information that is collected under the various provisions of the ACA. As such, data obtained under other authorized collections implementing provisions of the ACA will be utilized to meet some Exchange requirements, for example in Rate Increase Disclosure and Review Requirements (45 CFR Part 154),OMB Control Number CMS – 10379. CMS will make every effort to avoid duplication of data collections with these other efforts. CMS is developing an integrated modular collection instrument and database system to support these various needs.

5. Impact on Small Businesses or Other Small Entities

Small businesses are not significantly affected by this collection.

6. Less Frequent Collection

QHPs will be certified utilizing an annual certification process. The year two and three burden estimates include estimates for recertification, as noted below. We will continue to reassess the certification and recertification burden and make every effort to minimize burden as much as possible in the future.

Non-Exchange plans that are reinsurance-eligible plans, reinsurance contributing entities, or risk adjustment covered plans must submit data for the purposes of facilitating program operations. This information is submitted once annually and then updated when applicable throughout the year.

7. Special Circumstances

Issuers submitting in the SHOP Exchange have the option to submit formulary, rate and benefit information more frequently; therefore, additional submissions may be necessary.

8. Outside Consultation

The goal of this data collection is to inform the QHP certification and recertification process, as well as, non-Exchange plan reporting requirements needed for the reinsurance and risk adjustment programs. This is an amendment to a PRA package that previously went through a 60-day and 30-day public comment process. Throughout the first year of certification activities in the spring and summer of 2013, CMS has received extensive feedback from key stakeholders. This included discussions, such as webinars and user groups calls with the NAIC, states, issuer associations, and issuers on the data elements and collection.

It is the goal of CMS and stakeholders to identify shared data points and improve the validity of data. CMS will continue to work with states to minimize any required document submission to streamline and reduce duplication.

9. Explanation of any Payment/Gift to Respondents

There are no payments or gifts to respondents.

10. Assurance of Confidentiality Provided to Respondents

Information collected for plan management, reinsurance and risk adjustment contains proprietary information, trade secret, commercial and/or financial information. Therefore it is privileged, private to the extent permitted by law, and protected from disclosure.

These data are protected from disclosure under Exemption 4 of the Freedom of Information Act (FOIA). Exemption 4 is provided below and is part of the HHA FOIA implementation regulation (45 CFR 5.65) available at http://www.hhs.gov/foia/45cfr5.html#Subf.

11. Justification for Sensitive Questions

No sensitive questions are asked in this PRA package.

12. Burden Estimates (Hours and Wages)

The burden associated with this data collection can be attributed to QHP issuers, non-Exchange plan issuers, larger group issuers, self-insured, third party-administrators, and states. We developed these burden estimates based off CMS's experience collecting similar categories of data from issuers in the Medicare Advantage and Prescription Drug Benefit Programs, Federal Rate Review Program, and Healthcare.gov reporting. The burden for each of these entities was considered when developing these burden estimates. We have modified the burden estimates that were approved in the initial package on March 13, 2013. The revised figures reflect projections based on actual experience since receiving the initial approval. We have included information on the original year-one estimates in footnotes.

Burden for QHP Issuers: QHP Certification[1]

The burden on issuers for the QHP certification (including issuer application, rate and benefit submission, and formulary submission) per year is estimated to be 69,825 burden hours, or 147 hours per issuer. This estimate was based on an assumed 475 issuers each offering 15 plans as potential QHPs. The burden estimate included data required for QHP certification, risk adjustment, and reinsurance. We have adjusted the burden to account for feedback on the certification and recertification process. We have further revised these estimates, in terms of the number of issuers. We estimate 475 issuers will incur costs for QHP certification, risk adjustment, and reinsurance. We developed this number based upon the number of applications received from issuers for the 2014 plan year in addition to the expectation that additional issuers will apply in future years.

Table 1. Burden for QHP Issuers: QHP Certification

Year	Number of Issuers	Hours Per Issuer	Total Hours	Total Burden Cost Per Issuer
One	475	147	69,825	$11,319
Two	475	147	69,825	$11,319

[1] In the original package for this data collection, as approved March 13, 2013, for year one we estimated a total of 1,200 issuers and a total of 175 hours per issuer, for a total burden of $13,475 per issuer and 210,000 hours across all issuers. This reflected a higher number of burden hours based on initial start-up hours.

Three	475	147	69,825	$11,319

Burden for Stand-Alone Dental Issuers: QHP Certification[2]

The burden on stand-alone dental issuers for the QHP certification each year is estimated to be 20,000 total burden hours, or 40 hours per issuer. It was estimated that 500 issuers offering 2 plans each will participate in an Exchange or go through the certification process to offer an Exchange-certified SADP off the Exchange. At an hourly billing rate of $77, the total cost was estimated to be $, or $3,080 per issuer. The estimates also include recertification for SADP issuers.

Table 2. Burden for Stand-Alone Dental Issuers: QHP Certification

Year	Number of Issuers	Hours Per Issuer	Total Hours	Total Burden Cost Per Issuer
One	500	40	20,000	$3,080
Two	500	40	20,000	$3,080
Three	500	40	20,000	$3,080

Burden for Non-QHP Issuers and QHP Issuers (for plans outside the Exchange) Offering Plans in the Individual and Small Group Market: Reinsurance and Risk Adjustment[3]

All issuers in the individual and small group market are required to submit reference data, to include but not be limited to administrative information about the issuer and its non-QHP offerings, AV levels for those plans, which will be used for the reinsurance and risk adjustment programs. It is estimated there are 2,400 issuers in the individual and small group market that will not be offering any QHPs through an Exchange. The total estimated burden for the submission for these issuers is 7,200 hours or 3 hours per issuer at a cost of $231 per issuer per year.

Table 3. Burden for Non-QHP Issuers and QHP Issuers Offering Plans in the Individual and Small Group Market: Reinsurance and Risk Adjustment

Year	Number of Issuers	Hours Per Issuer	Total Hours	Total Burden Cost Per Issuer
One	2,400	3	7,200	$231

[2]In the original package for this data collection, as approved March 13, 2013, we estimated the total year-one cost to be $462 per issuer for a total of 6 hours per issuer and estimated that 40 issuers would participate.

[3] In the original package for this data collection, as approved March 13, 2013, we estimated the total year-one cost to be $1001 per issuer for a total of 13 hours per issuer, which included startup hours.

Two	2,400	3	7,200	$231
Three	2,400	3	7,200	$231

Burden for Large Group Issuers, and Self- Insured Group Plans and Third-Party Administrators: Reinsurance[4]

Some issuers in the large group market, self-insured group plans, and third-party administrators on behalf of either will be required to submit administrative information for reinsurance contributions. It is estimated that 23,800 entities are eligible reinsurance contributors. The total estimated burden for this submission is 119,000 or 5 hours per entity, at a cost of $385 per entity.

Table 4. Burden for Large Group Issuers, and Self- Insured Group Plans and Third-Party Administrators: Reinsurance

Year	Number of Entities	Hours Per Entity	Total Hours	Total Burden Cost Per Entity
One	23,800	5	119,000	$385
Two	23,800	5	119,000	$385
Three	23,800	5	119,000	$385

Burden for States: State-based Exchanges and Partnership States[5]

CMS projects that all states that have received any type of Exchange grant funding (Planning, Innovator, Level 1, or Level 2 Establishment) from CMS will pursue a State Partnership or a State-based Exchange. Those states who are engaged with CMS as a State Partner will have an identical Plan Management burden as those operating a State-based Exchange since they will be performing all of the Plan Management activities, including QHP certification. It is assumed that the majority of states in State-based Exchanges and Partnerships will continue to leverage their existing systems that are used by the state departments of insurance. The state will have a burden of 3 hours to submit data to the Federal government for a total burden of $157 per state per year.

Table 5. Burden for States: State-based Exchanges and Partnership States

Year	Number of States	Hours Per State	Total Hours	Total Burden Cost Per State

[4] In the original package for this data collection, as approved March 13, 2013, we estimated the total year-one cost to be $1,155, because we estimated a total of 15 hours per entity, which included startup hours.

[5] In the original package for this data collection, as approved March 13, 2013, we estimated the total year-one cost to be $20,157 per year, because we estimated a one-time $20,000 expense for system upgrades.

One	50	3	150	$157
Two	50	3	150	$157
Three	50	3	150	$157

13. Capital Costs

There is no capital cost associated with this collection effort.

14. Cost to Federal Government[6]

We estimate that the operations and maintenance costs for the data collection tool will be $204,880.00 on an annual basis and an additional 485 burden hours for data collection support for a cost of $22,580.90, for a total cost of $227,460.90 per year.

15. Changes to the Burden

Since finalizing this PRA package and receiving an OMB control number, we have updated the burden on QHP and SADP issuers in our calculations as noted above.

16. Publication/Tabulation Dates

The information collection from issuers is anticipated under this request to occur in the first quarter of 2013.

17. Expiration Date

CMS has no objections to displaying the expiration date.

[6] In the original package for this data collection, as approved March 13, 2013, we estimated an initial, one-time cost to the Federal government of $2,433,860.90 to develop and implement the data collection tool. We do not re-estimate this one-time cost in this package.