Supporting Statement For Paperwork Reduction Act Submission: Health Care Reform Insurance Web Portal and Supporting Authority Contained in Sections 1103 and 10102 of The Patient Protection and Affordability Care Act, Pub. L. 111-148 (2010) [CMS-10320]

A. Background

In accordance with Sections 1103 and 10102 of The Patient Protection and Affordability Care Act, Pub. L. 111-148 (2010) (Affordable Care Act) the U.S. Department of Health and Human Services (HHS) is tasked with developing and implementing an Internet website portal to assist consumers with identifying affordable and comprehensive health insurance coverage options that are available in their State. Consistent with minimizing burden and providing consistency in data collection, the Centers for Medicare & Medicaid Services (CMS) updates its HealthCare.gov collection requirements as regulatory developments occur. There have been two developments since the last approved collection that require changes to the Paperwork Reduction Act (PRA) package.

The Departments of Health and Human Services, Labor and the Treasury (the Departments) published a final regulation implementing the Section 2715 consumer disclosure provisions of the ACA. (77 Fed. Reg. 8668 (Feb. 14, 2012), codified at 45 CFR 147.200). These final regulations set forth the requirements for group health plans (plans) and health insurance issuers (issuers) to provide the Summary of Benefits and Coverage (SBC) and the uniform glossary of medical and insurance terms. Under these regulations, plans and issuers must provide in the SBC information about covered services, cost sharing, limitations and exceptions of the coverage, coverage examples, and other disclosures. The final regulation also clarifies the timing and format for providing these documents.

CCIIO is requesting approval to implement this provision for the collection of information to assist consumers in making educated decisions on their health care options. This collection was initially approved under Office of Management and Budget (OMB) control number 0938-1086. Various elements discussed within this package have already been through comment periods and have been authorized for collection under OMB control number 0938-1146. These elements are included here so that the public can identify how the efforts are integrated and get a consistent view of the collection.

The reinsurance and risk adjustment programs outlined by the Affordable Care Act, detailed in the Standards for Reinsurance, Risk Corridors, and Risk Adjustment Rule (77 FR 17220, March 23, 2012), have general information reporting requirements that apply to qualified health plans (QHPs) offered through the Exchanges and to non-Exchange plans in the outside market. For the reinsurance program, administrative information will be used to identify all entities – health insurance issuers and self-insured group health plans- required to contribute to the reinsurance program. In addition, non-Exchange plan information such as plan type and location will be used to identify non-grandfathered individual market plans inside and outside the exchange eligible for reinsurance payments. For the risk adjustment program, administrative information will be used to identify all non-grandfathered small group and individual market plans inside and outside the exchange 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.

Non-Exchange Plan Information Collection: Reinsurance and Risk Adjustment
Section 1341 of the Affordable Care Act provides 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 Part 153.

Reinsurance Reporting Requirements for Non-Exchange Plans
The transitional reinsurance program will reduce the uncertainty of insurance risk in the individual market by making payments for high-cost enrollees in non- grandfathered individual market plans. Health insurance issuers and self-insured group plans are required to remit contributions on behalf of enrollees in 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 reinsurance 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 operation 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 as well as QHPs.

Additionally, states operating the transitional reinsurance program will be required to register in HIOS in order for HHS to distribute reinsurance payments to the state. The state will then allocate those reinsurance payments to the issuers in their state.

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 within a risk pool within a market within a state 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.

B. Justification

1. Need and Legal Basis

This information is mandated by Sections 1103 and 10102 of the Affordable Care Act. A copy of this mandate is provided in Appendix B. Additionally, the collection covers information required in Sections 1302 and 2715 of the Affordable Care Act regarding transparency and the provision of SBC.

2. Information Users

Once all of the information is collected from the States, State health benefits high risk pools, and insurance issuers (hereon referred to as issuers), this information is processed by contractors for display on the HealthCare.gov website. The information that is provided helps the general public make educated decisions about their choice in organizations providing private health care insurance. Information collected quarterly from insurance issuers is used to populate the Plan Finder application to show individuals their options, to provide some profile information, and to coordinate the data collection with Oversight collections to reduce the burden on issuers and the Federal Government. Collecting information consistent with the SBC standards allows consumers to access this information in a consistent manner.

3. Use of Information Technology

CCIIO has created a system where insurance issuers and their States log into the web portal using a custom user ID and password validation. The States were asked to provide information on issuers in their State and various websites (see Appendix E). The issuers have been downloading a basic information template to enter data then upload into the portal. Information to be collected on issuers and products can be found in Appendix C. Additionally, for purposes of this collection, we will collect information consistent with both QHPs and the Federally-facilitated Exchange within one consolidated template. The requirements and data elements of this collection can be found in **OMB Control No. 0938-1156.** Information to be collected can be found in the following Appendices: Plans and Benefits and Service Area Templates can be found in Appendices B1 and B3; Rating Tables and Issuer Business Rules data can be found in Appendices C1 and C2; Pricing and Benefits data can be found in Appendix D.

CCIIO will be using drop down menus and error checks wherever possible to minimize burden on plans and issuers. Once the data is submitted, the plans and issuers can later log in to update information they provided instead of having to re-upload all plan/product information.

4. Duplication of Efforts

CMS will make every effort to reduce the burden on issuers and reuse the information that is collected under the various provisions of the Affordable Care Act. As such, data obtained under other authorized collections that implement provisions of the Affordable Care Act will be utilized to meet some Exchange requirements, for example Rate Increase Disclosure and Review Requirements (45 CFR Part 154),OMB Control Number CMS – 10379. Additionally, the

implementation of the Affordable Care Act section 2715 requirement's for specific standards for reporting information to consumers, we have aligned our data collection with the structure for a SBC as recommended by the National Association of Insurance Commissioners (NAIC).

5. Small Business

Small Businesses are not significantly affected by this collection.

6. Less Frequent Collection

CCIIO has been operating with an approximately 45 day refresh schedule to obtain changes in plan benefits and pricing as well as comprehensive lists of products approved within a State for sale to the public. In the event that an issuer enhances its existing plans, proposes new plans, or deactivates plans, the organization would be required to update the information in the web portal using the edit function or uploading an updated template within an open window period.
In response to the desire to decrease burden as much as possible, CMS has adjusted the collection period to quarterly. Through the use of effective dates and periodic windows of opportunity for changes, CMS anticipates that we can decrease the overall burden for the data collection significantly.

7. Special Circumstances

Dependent on the frequency with which an issuer enhances, eliminates, or adds options to their products, additional submissions may be necessary.

Information that is to be collected from State health benefits high risk pools (Appendix F) has been collected from the National Association of State Comprehensive Health Insurance Plans (NASCHIP) at this time. Administrators have been voluntarily entering changes as they develop, so no general call for the collection of data from these groups is currently contemplated. Information from State Insurance Commissioners was collected in 2010, and no current plans exist to continue that collection during the period covered by this document. CMS reserves the right to continue to request this information, however, as the nature of these markets is highly changeable.

8. Federal Register/Outside Consultation

CMS received 1 public comment regarding the notice of the Health Care Reform Insurance Web Portal and Supporting Authority Contained in Sections 1103 and 10102 of the Patient Protection and Affordability Care Act, Pub. L.11-148. The PRA package published in the Federal Register on January 31, 2014 (78 FR 6197) with comments due by April 1, 2014.

The PRA package contains the requirements to minimize the burden on issuers The comment CMS received is summarized immediately below. Most of the concerns addressed the templates and data being collected pertaining to the Affordable Care Act's premium stabilization programs, the authority to collect the confidentially of the data, and the burden of the collection is such that it should be delayed until late 2014. The summary below sets our response

. Comments on the 2014 Issuer Data Collection

Accessibility and Use of Plan Finder on Healthcare.gov

CMS is committed to implementing a consolidated data collection effort which minimizes the overall burden on insurers. As a result, the Plan Finder collection does incorporate needs of other efforts when it seems least burdensome to incorporate those needs. While the timing and design of the Plan Finder collection specified in the Information Request do take into consideration the requirements of the Affordable Care Act's premium stabilization programs, the primary goal and principle design is to provide consumers with information on their affordable care options as required under Section 1103 of the Act.

The Plan Finder web site has not been updated to reflect the new market rules adopted in January 2014. The templates specified for adoption include rate collection rules consistent with the 2014 market rules, as opposed to the earlier templates which did not. The benefits template captures essential health benefit (EHB) defined categories which the prior templates did not. Changes to the coverage area template are also required due to the interaction of coverage areas and rating areas having changed with the 2014 market rules.

CMS agrees with the commenter that CMS needs to provide comprehensive information to consumers on their Health Insurance options which is accurate. The changes proposed allow for the capture of the appropriate level of information which consumers use to make decisions, and does so in a manner consistent with how the data is reported and displayed on the federally facilitated marketplace (FFM). The commenter's recommendations for the web site will be taken into consideration, but it should be noted that creating an integrated site will be very difficult without consistent reporting of the data.

The commenter also requests more information on how small group premiums will be presented to consumers. Web site design has not been finalized, but CMS will engage industry representatives in presenting the proposed approaches.

Confidentiality

The commenter expresses concerns regarding the ability to designate that certain collected fields are considered proprietary. The Plan Finder collection will include a template by which issuers can designate such belief, and provide explanation. This is consistent with prior collections, and no data will be released via FOIA request or Pro-active release prior to those comments being reviewed, initial determinations made, and response notifications sent.

The commenter raises specific concerns regarding base rates and rating factors associated with the premium stabilization requirements. The data collection instruments will be consistent with the QHP rate tables and business rules associated with policy construction, and not expanded to those factors collected in unified rate review or the edge servers.

Alternative Ways to Collect 3Rs Information

In general, we agree with the commenter that premium stabilization information be obtained via the edge server design. CMS does not intend to expand the Plan Finder collection to cover claims, detailed enrollment, or paid premiums. These elements are not covered under the information request.

The connection between the PlanFinder collection and premium stabilization is less than perceived by the commenter, and the concerns raised will be included in future considerations by CMS. However, system design of the premium stabilization efforts does require a frame of reference for what plans are currently being offered, as well as information on claims and premiums of what has been sold. The PlanFinder collection is the only collection by the Federal government which has collected the full range of plans offered to consumers off of the facilitated marketplaces. CMS intends to use this data solely for purposes of cross referencing and validation.

Risk Corridors

As the commenter notes, federal risk corridors require identifying equivalent products to those offered on the exchange. As they also note, the designated equivalents were not captured for the 2014 QHP submission. Additionally, while issuers may be able to indicate that they believe a separate plan is equivalent to a given QHP for 2015, oversight and review of such indications requires detailed benefit and cost sharing information which would be obtained via the PlanFinder collection. We understand the commenter's concern regarding changes to the 2014 templates, and the redesigned PlanFinder collection allows for review of this data for 2014 as well as for future years.

While the commenter notes that final determinations do not need to be made until summer of 2015, CMS again notes that this is insufficient to meet the consumers' needs being addressed by the PlanFinder. Duplicative collections seem more onerous than modifying the collection. The specific requirements associated with the risk corridors are appreciated, and it is intended that use of a collection design consistent with that used to report QHPs would minimize any additional burden during final submission in 2015.

Regulatory Authority

The commenter suggests that CMS should not extend the data collection beyond what is required to support the PlanFinder and questions our regulatory authority to do so. It is important to note that the commenter never addresses any specific elements as being outside the requirements of Section 1103 of the Patient Protection and Affordable Care Act (Pub.L. 111-148), however. The clear application of the requirement for benefits, cost sharing and pricing information to plans in the individual and small group markets is further specified in 45 CFR Part 159. By limiting the changes to the specific templates covering where plans are available, what their benefits and cost shares are, and how pricing is determined, CMS believes the collection is fully authorized under Section 1103. Since most of this data is also required for oversight of Premium stabilization and a substantial portion is responsive to the Summary of Benefits and Coverage, we argue that we have authority under Sections 1302, 2715 and 10102.

The changes summarized by the information request bring the data collection into alignment with the collection of QHPs, thus allowing direct comparisons between plans on the facilitated marketplace and those which are not. It is difficult to understand how CMS would meet the specified desire for comprehensive information without these changes. We recognize that the use of particular data elements for more than one purpose could create some confusion regarding under what authority the data is being collected. CMS will attempt to clearly indicate the authority under which elements are collected moving forward.

Recommendations and Timing

In addition to the general concerns regarding the premium stabilization efforts, the commenter asks that CMS consider allowing for re-use of data already submitted to either CMS or State DOIs, and recommends delaying the collection until July or August of 2014. CMS is appreciative of both these recommendations.

As the commenter acknowledges, many issuers used the 2014 QHP templates to submit both facilitated marketplace plans and non-facilitated marketplace plans to their state DOIs. In general, that process required resubmission of the templates whenever changes were required. Thus, those issuers should have extant sets of templates with the data subject to this request. CMS has committed to use the same version of those templates. This will allow for upload of those same templates to HIOS for the PlanFinder collection. The commenter requests that these templates be collected via the State DOIs. Creating the technical possibility to do so is something CMS is already considering for future enhancements. However, that functionality would still require the currently planned functionality being built. CMS cannot require states to collect and submit that data under existing authority.

As regards the timing of the submission, CMS recognizes the concerns. It should be noted, however, that a number of issuers have already entered the data into the templates being requested. Additionally, in those States which did not require the use of these templates for non-marketplace plans, any small group plans being offered through a facilitated marketplace were submitted via these templates. CMS has been providing training on these templates for over a year, has materials available for training at this time, has already provided copies of the templates, and has communicated to issuers that this was likely to be the direction communicated through the information request. These steps should create a degree of familiarity with the templates and some existing systemic ability to generate the appropriate documents.

CMS will take into consideration the possible need for extending the collection windows. We believe the recommendation for a phased approach allowing for the submission of individual and family plans prior to small group plans is a good one, and we will adopt that recommendation. CMS has determined that we will need the data for consumers and to allow for use of the data to support premium stabilization efforts in the early Fall. CMS has communicated a June date for opening the submission windows, but will work with issuers to allow for sufficient time to submit their data unimpeded by other reporting requirements.

9. Payments/Gifts to Respondents

There are no payments/gifts to respondents.

10. Confidentiality

To the extent provided by law, we will maintain respondent privacy with respect to the information being collected. HealthCare.gov collects issuer opinions regarding confidentiality of any new data elements for review by the Freedom of Information Act (FOIA) office at CMS. Certain fields have been determined as confidential on the basis of this review and are redacted from public files.

11. Sensitive Questions

There are no sensitive questions included in this collection effort.

12. Burden Estimates (Hours & Wages)

The estimated hour burden on issuers for the PlanFinder data collection in the first year is estimated as 29,733 total burden hours, or 119 hours per organization. This estimate is based on an assumed average of 450 individual plan issuers and 700 small group plan issuers (750 total, as some issuers offer both individual and small group plans) per each of the four quarterly collections. It includes 30 hours per organization for training and communication. Additionally, for each of the issuers it includes 11 hours of preparation time, one hour of login and upload time, two hours of troubleshooting and data review, and one half hour for attestation per organization per quarterly refresh.

Insurance Issuers:

Issuers	Submissions	Hours	Total	Xs	Annual Hours	Per Hour	Total Cost	Explanation
750		30	22,500	1x	22,500	$100	$2,250,000	Training and Communication
	450	11	4950	4	19800	$65	$1,287,000	Submission Preparation- Individual
	700	11	7700	4	30800	$65	$2,002,000	Submission Preparation- Small Group
	450	1	450	4	1800	$65	$117,000	Data Entry- Individual
	700	1	700	4	2800	$65	$182,000	Data Entry- Small Group
	450	2	900	4	3600	$65	$234,000	Troubleshoot- Individual

	700	2	1400	4	5600	$65	$364,000	Troubleshoot-Small Group
	450	0.5	225	4	900	$100	$90,000	Attest- Individual
	700	0.5	350	4	1400	$100	$140,000	Attest-Small Grp.
						Total	$6,666,000	

State Burden

The estimated hour burden on the States for the PlanFinder data is informed by the fact that they have already submitted the data once and only need to update their submissions. The overall hours estimate is 575, or 10.5 per Department of Insurance. This is premised on 2 hours of training and communication, 8 hours for data collection, and one half hour for submission.

States	Submissions	Hours	Total	Xs	Annual Hours	Per Hour	Total Cost	Explanation
50		2	100	1	100	$100	$10,000	Training
	50	8	400	1	400	$65	$26,000	Data Collection
	50	0.5	25	1	25	$65	$1,625	Submission
					525	$100	$37,625	

13. Capital Costs

There is no capital costs needed for this collection effort.

14. Cost to Federal Government

The initial burden to the Federal Government for the development and implementation of the collection of basic, pricing, and benefits information of issuers on the web portal is **$15,161,494**. The calculations for CCIIO employees' hourly salary was obtained from the OPM website: http://www.opm.gov/oca/10tables/html/dcb_h.asp.

Software Development and Hosting	$15,000,000
Managing and Coordinating Contracts	
3 GS – 13: 3 x $42.66 x 416	$53,240.00
Analysis and QA	
4 GS – 13:4 x $42.66 x 416	$70,986.00
Overhead Costs	

84,978.72 * 30%	$37,267.80
Total Cost to Government	$15,161,494

15. Changes to Burden

The included burden estimates are premised on the opinion that costs for the current collection materials will not change dramatically, and does not include a reduction in cost associated with anticipated system changes taken by issuers. A one hour addition has been made to the submission time to include the new elements associated with the SBC. A decrease in the overall burden is due to a decrease in the number of issuers reporting from 800 to 750.

16. Publication/Tabulation Dates

The collection of detailed information from issuers to post on HealthCare.gov's PlanFinder is anticipated under this request for collection in June 2014.

17. Expiration Date

CCIIO has no objections to displaying the expiration date.

18. Certification Statement

There are no exceptions to the certification statement.