Supporting Statement Part A
Good Cause Processes
CMS-10544, OCN 0938-New

This package is rule-related and is associated with our February 12, 2015 (80 FR 7912), final rule (RIN 0938-AS20; CMS-4159-F2, entitled, "Medicare Program; Contract Year 2016 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs."

Background

Medicare Advantage (MA) organizations, §1876 cost plans and Part D plan sponsors may terminate the enrollment of individuals who fail to pay basic and supplemental premiums after a grace period established by the plan. An MA organization or Part D plan sponsors that chooses to disenroll beneficiaries for failure to pay premiums must be able to demonstrate that it made a reasonable effort to collect the unpaid amounts by notifying the beneficiary of the delinquency, providing the beneficiary a period of no less than 2 months in which to resolve the delinquency, and advising the beneficiary of the termination of coverage if the amounts owed are not paid by the end of the grace period. A cost plan must be able to demonstrate that it made a reasonable effort in collecting unpaid premiums or other charges and that it provided the member with a written notice of disenrollment at least 20 days before the disenrollment effective date.

In January 2012, CMS codified regulations (76 FR 21432) to permit reinstatement of enrollment of individuals who lost MA or Part D coverage due to non-payment of premiums if they met the criteria for good cause. Under these regulations, only CMS had the authority to effectuate the good cause processes and reinstate individuals. In January 2013, this opportunity was expanded to cover §1876 cost plans (77 FR 22071).

In February 2015, CMS codified a change to these regulations (CMS-4159-F2) to provide CMS the authority to assign responsibility for effectuating these good cause processes to another entity. This collection of information outlines the estimated administrative burden of MA organizations, Part D plan sponsors and §1876 cost plans that disenroll individuals for nonpayment of premiums (or other charges, as applicable) should CMS delegate these processes to such entities.

A. Justification

1. Need and Legal Basis

Section 1851(g)(3)(B)(i) of the Act provides that MA organizations may terminate the enrollment of individuals who fail to pay basic and supplemental premiums after a grace period established by the plan. Section 1860D-1(b)(1)(B)(v) of the Act generally directs us to establish rules related to enrollment, disenrollment, and termination for Part D plan sponsors

that are similar to those established for MA organizations under section 1851 of the Act. Consistent with these sections of the Act, subpart B in each of the Parts C and D regulations sets forth requirements with respect to involuntary disenrollment procedures at 42 C.F.R. §§ 422.74 and 423.44, respectively. In addition, section 1876(c)(3)(B) establishes that individuals may be disenrolled from coverage as specified in regulations. Thus, current regulations at 42 C.F.R. 417.460 specify that a cost plan, specifically a Health Maintenance Organization (HMO) or competitive medical plan (CMP), may disenroll a member who fails to pay premiums or other charges imposed by the plan for deductible and coinsurance amounts.

Within these regulatory provisions, individuals disenrolled for nonpayment of premiums are afforded a grace period in which to request reinstatement. As part of the reinstatement request process, they must demonstrate good cause for failure to pay within the initial grace period that led to their involuntary disenrollment and pay all overdue premiums within three calendar months after the disenrollment date.

While disenrollment due to non-payment of premiums is currently voluntary for such plans, in 2014, approximately 200 plans effectuated such disenrollments. This resulted in an average of 20,000 disenrollments each month.

2. Information Users

These good cause provisions authorize CMS to reinstate a disenrolled individual's enrollment without interruption in coverage if the non-payment is due to circumstances that the individual could not reasonably foresee or could not control, such as an unexpected hospitalization. Since its inception, the process of accepting, reviewing, and processing beneficiary requests for reinstatement for good cause has been carried out exclusively by CMS. However, we received feedback on ways to improve the good cause process and make it more efficient for both the plans and CMS, including that many plans prefer to be the initial point of contact for such requests since they have the relationship with the individual.

In February 2015, CMS published a regulatory change (CMS-4159-F2) to provide CMS the authority to assign responsibility for effectuating these good cause processes to another entity. This regulatory change allows CMS to designate another entity, specifically a plan (MA organization, Part D plan sponsor, or entity offering a cost plan), to carry out some or all of the good cause reinstatement process. We envision an expanded role for plans to accept incoming requests for reinstatement directly from former enrollees, which would allow them to be more responsive to their current and former members.

Therefore, if CMS delegates responsibility to conduct this administrative activity, plans that disenroll individuals for non-payment of premiums (or other costs, as applicable), would be responsible for receiving requests for reinstatement from prior members, determining the individual’s eligibility for good cause, and submit the reinstatement transaction to CMS following full payment of the arrearage based on the parameters and processes outlined in

regulation and subregulatory guidance.

3. Use of Information Technology

Information provided by individuals requesting reinstatement under the good cause process is not collected electronically.

Plans will submit the reinstatement request electronically to CMS following existing processes for other types of reinstatements permissible under subregulatory guidance. One hundred percent of the reinstatements are submitted to CMS electronically.

4. Duplication of Efforts

The information collection requirements for the good cause processes are not duplicated through any other effort.

5. Small Businesses

There is not a significant impact on small businesses that comply with these information collection requirements. Based on CMS experience since the inception of the good cause policy implementation in 2012, the expected percentage of reinstatement requests for plans is approximately 3.49 percent. Thus, for a small business that exercises the voluntary policy to disenroll for non-payment of premiums and disenrolls 10 or less individuals a month for this reason, it is expected that it would receive about three requests for reinstatement each month.

6. Less Frequent Collection

This information is collected as needed and requested by the disenrolled individual. If it were to be collected less frequently, plans would not be able to obtain these data for determining reinstatement for good cause, process requests and reinstate coverage for individuals within the regulatory requirements. If not collected at all, individuals would not be provided a regulatory protection and would not have the ability to access necessary health coverage.

7. Special Circumstances

There are no special circumstances associated with this collection of information.

8. Federal Register/Outside Consultation

Federal Register

Through notice of proposed rulemaking (January 10, 2014; 79 FR 2009), CMS proposed to amend § 417.460(c)(3), § 422.74(d)(1)(v), and § 423.44(d)(1)(vi) to provide CMS the authority to delegate responsibility for effectuating the good cause processes. As part of that

proposal, we outlined the Collection of Information (COI) (79 FR 2028) that would be the administrative burden by plans should CMS delegate this process to them. Through the rulemaking process, CMS solicited comments on the information collection prior to submission to OMB. CMS received no comments to the COI proposal.

Outside Consultation

Since the inception of the good cause regulations and processes, the process of accepting, reviewing, and processing beneficiary requests for reinstatement for good cause has been carried out exclusively by CMS. However, in the Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2014 Call Letter (the Call Letter) released on February 15, 2013, CMS requested input from plans on transferring the responsibility for processing good cause requests to the plans and other ways to improve the good cause process. Through the feedback submitted from the Call Letter, CMS received consultation from plans and organizations on ways to make the process more efficient for both the plans and CMS. Based on this feedback, we updated a number of operational processes in Chapter 2 and Chapter 17, Subchapter D, of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Benefit Manual to increase efficiency.

9. Payments/Gifts to Respondents

There are no payments or gifts to respondents related to the collection of this information.

10. Confidentiality

The information collected from plan members must conform to the requirements at 42 CFR 422.74 and 423.44, and in all Federal and State laws regarding confidentiality and disclosure.

11. Sensitive Questions

There are no sensitive questions included in this collection effort.

12. Burden Estimates (Hours & Wages)

If an entity operating a cost plan, an MA organization, or a Part D plan sponsor is assigned responsibility for implementing the good cause process, the plan would already have the enrollment data necessary to make the determinations required by the process. In addition, the former enrollee is already required by the applicable regulations to provide a credible statement to establish good cause for the failure to make timely payments. Thus, no additional data would be collected by the plan. However, if CMS designates plans to implement good cause processes, there would be additional burden to each plan; the burden consists of completing the operational process, such as receiving requests for reinstatement from former members, gathering the attestation from the individual regarding his or her

reason for not paying the plan premiums within the grace period, making the determination as to whether the individual meets the good cause criteria, submitting the reinstatement action to CMS once full payment of arrearages is made, and maintaining the case notes and documentation to support its determination. Plans already provide customer service to their current and past members, therefore, we estimated that this burden would be approximately 30 minutes for each reinstatement request. According to the most recent wage data provided by the Bureau of Labor Statistics (BLS) for May 2013, the mean hourly wage for the category of "Customer Service Representatives" – which we believe, considering the common point of entry for all issues at the plan, is the most appropriate category is $16.04. With fringe benefits and overhead, the per hour rate is $23.74. It is calculated that the cost for 30 minutes would be $11.87.

Not all plans disenroll for nonpayment of premiums. However, for those that do implement this voluntary policy, it results in an average of 20,000 disenrollments each month. In response, we receive an average of 698 requests for reinstatement per month, or **8,376 requests annually**. The plan representative cost of $11.87 for each case is multiplied by 698 cases. Therefore, based on the proposed change, handling of these requests would result in a total monthly cost of $8,285.26, or annual cost of $99,423.12 for all plans in the MA, Part D, and cost plan programs.

In 2014, approximately **200 plans** effectuated this voluntary policy. The 698 requests received per month is divided by 200 plans, totaling **3.49 requests per plan per month**. Based on the estimated burden of **30 minutes for each case**, the expected hour burden for 3.49 cases each month is 1.745 hours, or **4,188 hours** annually for all plans in the MA, Part D, and cost plan programs.

13. Capital Costs

As plans are already required to maintain documentation of enrollees for possible review, there are no additional capital or equipment costs to CMS resulting from the collection of information.

14. Cost to Federal Government

There are no additional costs to the government.

15. Changes to Burden

This is a new request and thus there are no changes in burden.

16. Publication/Tabulation Dates

There are no publication or tabulation dates.

17. Expiration Date

This collection does not lend itself to the displaying of an expiration date.

18. Certification Statement

There are no exceptions to the certification statement.

B. Collections of Information Employing Statistical Methods

This collection of information does not employ statistical methods.