Supporting Statement for Paperwork Reduction Act Submissions: SHOP Effective Date and Termination Notice Requirements

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 implements various policies that will make health insurance coverage more accessible to consumers. 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.

The Centers for Medicare and Medicaid Services (CMS) is creating a new Paperwork Reduction Act package (PRA). Collections related to 45 CFR §155.720 and §156.285 are currently under a previously approved PRA package from March 25, 2013 entitled: *Establishment of Qualified Health Plans and American Health Benefit Exchanges* (OMB control number 0938-1156). However, this request is for a new collection as it is being separated from the original PRA package. The new requirements for reconciling enrollment information between qualified health plan (QHP) issuers and the Small Business Health Options Program (SHOP) enable CMS to expand the notice requirement under the revised definition of an enrollee pursuant to 45 CFR §155.20 as discussed in the final rule for the *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016* (CMS-9944-P). The burden estimate included in this package for 45 CFR §155.720 reflects the additional time and effort to develop the notice and to distribute it through an automated process to enrollees. The existing burden estimates discussed in OMB control number 0938-1156 for 45 CFR §155.720 (h) and §156.285 (c)(5) describing the development processes for the collection, retention of record information, and information pertaining to the reconciling enrollment information with CMS will remain the same.

To aid in understanding levels of awareness and customer services needs associated with the Small Business Health Options Program (SHOP) associated with the Exchanges established by the Affordable Care Act, CMS will engage in collecting primary qualitative and quantitative research from Exchange target audiences. CMS has designed three surveys to target different audiences, specifically agents and brokers, employers, and employees, see Attachments 1-3. These surveys are part of a broader data collection effort designed to support the program goal to improve customer satisfaction for people and small businesses that are eligible for coverage through the SHOP.

The brief surveys will provide CMS with helpful information regarding the types of outreach and marketing that will be needed to enhance awareness of and knowledge of SHOP, as well as how to improve the consumer experience. Cognitive testing was performed with individuals who

would be target participants in the surveys to ensure that question intent and response options are not confusing or frustrating to potential participants.

B. Justification

1. Need and Legal Basis

Section 1311(d) of the Affordable Care Act requires that an Exchange identifies some of the minimum functions that an Exchange must perform. On March 27, 2012, HHS published the rule CMS-9989-F: *Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers*. The Exchange rule contains provisions that mandate reporting and data collections necessary to ensure that Exchanges, health insurance issuers, and employers are meeting the requirements of the Affordable Care Act. These information collection requirements are set forth in 45 CFR Parts 155, 156, and 157.

45 CFR §155.720 requires that for plan years beginning before January 1, 2017, the SHOP must ensure that a QHP issuer notifies a qualified employee enrolled in a QHP of the effective date of his or her coverage. For plan years beginning on or after January 1, 2017, the SHOP must ensure that a QHP issuer notifies any enrollee and new enrollees pursuant to 45 CFR §156.285, enrolled in a QHP through the SHOP of the effective date of coverage.

Section 155.735 requires if any enrollee's coverage through the SHOP is terminated due to non-payment of premiums or a loss of the enrollee's or employer group's eligibility to participate in the SHOP, the SHOP must notify the enrollee or the qualified employer of the termination of such coverage. In the termination of coverage the SHOP must include the termination date and reason for termination to the enrollee or qualified employer.

We specify that for required notices under 155.720(e) and 155.735(g), when a primary subscriber and his or her dependents live at the same address, a separate notice need not be sent to each dependent at that address, so long as the notice sent to each primary subscriber at that address contains all the required information about the coverage effective date for the primary subscriber and each of his or her dependents at that address. When dependents live at a different address, from the primary subscriber, a separate notice must be sent to those dependents.

The surveys in this clearance will allow CMS to develop and continually improve upcoming information products and marketing campaigns which promote the goals of legislation related to health literacy, cultural sensitivity, and effective use of Exchange program benefits. The surveys will also enhance and improve a consumer's experience in applying for coverage through the SHOP, including ongoing customer service. This research is important to gauge the extent to which information and education around health insurance benefits, options, and other related information is being received in a way that encourages informed choices, as mandated in the legislation.

This work contributes to CMS' efforts to achieve the mandates of the ACA. The law includes provisions to communicate health and health care information clearly; promote prevention;

provide patient-centered care; assure equity and cultural competence; and deliver high-quality care. All of these general goals can be enhanced through timely consumer research.

2. Information Uses

The information provided in notice requirements are used by CMS, SHOPs, issuers, employers, qualified employees, and enrollees to inform and maintain the status of SHOP enrollment information.

The information from the surveys will be used to improve program operations and will be useful and minimally burdensome for the public as required by the Paperwork Reduction Act.

3. Use of Information Technology

HHS anticipates that the creation of notices required by this rule will be automated. Exchanges and health insurance issuers are expected to develop automated notice templates for many of the required notices. The entities issuing notices will develop the initial template after which the templates will be automatically populated with the appropriate information for the receiving party. We believe the automatically populated templates will reduce the burden for both issuers and States.

The surveys will be conducted using online methods. CMS will develop the initial, customizable template after which the templates will be automatically populated with the appropriate information for the receiving party. The automated population of survey questions for each target audience will reduce the burden on consumers.

4. Duplication of Efforts

Notices of effective date of coverage do not duplicate any other Federal effort. Where QHP issuers are required by State law to send all notices of termination, the SHOP is not required to send such notices, thus avoiding duplication of efforts.

The survey information collection does not duplicate any other effort, and the information cannot be obtained from any other source.

5. Small Businesses

CMS is mindful of the need to minimize any burden on small businesses. The surveys will be conducted online so that small business owners, agents and brokers that serve small businesses, and small business employees may complete the survey when time permits and at their leisure.

6. Less Frequent Collection

The burden from this PRA package is associated with QHP issuers developing and submitting notices annually. QHP issuers will not be required to collect information, but will be distributing

the notices to enrollees and employers. Since the notices require a flow of information between multiple parties such as for payments for SHOP coverage, it is necessary to collect information annually.

Survey information will be collected from the consumer twice (upon initial enrollment and six months following initial enrollment) to minimize burden placed on the consumer. The first survey distribution will focus on the consumer's enrollment experience while the second distribution will focus on ongoing account management.

7. Special Circumstances

There are no anticipated special circumstances.

8. Federal Register/Outside Consultation

No public comments were received during the public comment period published on March 9, 2015 under CMS-2015-0029.

In the Draft Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 (CMS-9944-P), CMS proposed and solicited comment on 45 CFR §155.720 and §155.735. The provisions discussed in CMS-9944-P require QHP issuers to send a coverage effective date notice to the amended definition of an enrollee, therefore, the two termination notice provision previously required will be shifted from QHP issuers to SHOPs. CMS received a number of comments on the proposed rules.

We have consulted with States, issuers, and industry regarding the feasibility of these notice requirements. Many of the requirements are based from consultations of outside entities.

For the surveys, we have consulted with an outside entity for cognitive testing and feasibility of the survey instruments and have revised questions and responses based on feedback received during cognitive testing.

9. Payments/Gifts to Respondents

No payments and/or gifts will be provided. The consumer survey will not use incentives and 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 consumer privacy with respect to the information disclosed.

Respondents to the survey tool will be informed that their responses will be kept private to the extent provided by law, under the Privacy Act of 1974, as amended (45 CFR 5b).

11. Sensitive Questions

No sensitive questions are included in the notice requirements or the surveys.

12. Burden Estimates (Hours & Wages)

For purposes of presenting an estimate or paperwork burden for distribution of the notices, we reflect the participation of fifty States and the District of Columbia operating an Exchange. Salaries for the positions cited in the respondent type of the burden tables are derived from the mean hourly wage from the May 2014 National Occupational Employment and Wage Estimates United States.[1] The burden estimates used in this notice were updated to include more recent data available.

Enrollment of Employees into QHPs under SHOP (§155.720)

Section 155.720 contains the requirements for enrollment of employees into QHPs under SHOP, which includes issuers providing a coverage effective date notice to anyone enrolled in coverage through the SHOP. The rule *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016* (CMS-9944-F) amends the definition of an enrollee to include dependents, former employees of a qualified employer, and certain business owners, who might be enrolled in coverage through the SHOP. The amendments to the definition of enrollee may expand the universe of individuals who must receive this notice.

The burden estimate associated with 45 CFR §155.720 expands the previous discussion in OMB control number 0938-1156. Section 155.720 now includes the time and effort needed to develop the notice and to distribute it through an automated process to enrollees, as appropriate. We estimate that approximately 445 QHP issuers (including dental issuers) will participate on the SHOP in all States. On average, we estimate that it will take a health policy analyst 4 hours (at $43.68 an hour), an operations analyst 3 hours (at $39.88), computer programmer 25 hours (at $39.75), fulfillment manager 2 hours (at$52.99), and senior manager an hour (at$86.88) to fulfill these requirements. We estimate that it will take approximately 35 hours annually for QHP issuers participating in the SHOP to develop and transmit this notice for an aggregate burden of 15, 575 hours and $659,031.65.

Type of Respondents	Number of Respondents	Annual Burden Hours	Hourly Wage Rate	Total Burden Cost per Respondent	Total Annual Burden Cost
Health Policy Analyst	1	4	$43.68	$174.72	
Operations Analyst	1	3	$39.88	$119.64	
Computer Programmer	1	25	$39.75	$993.75	

[1] The source for the base hourly rates is the May 2014 National Occupational Employment and Wage Estimates United States, http://www.bls.gov/oes/current/oes_nat.htm

Fulfillment Manager	1	2	$52.99	$105.98	
Senior Manager	1	1	$86.88	$86.88	
Total		35		$1,480.97	$ $659,031.65

Termination of SHOP Enrollment (§155.735)

Section 155.735 contains the requirements for termination of SHOP enrollment, including any notices of termination. As finalized in the rule *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016* (CMS-9944-F), certain existing notice requirements under 45 CFR 155.735(g) are shifting the burden of notifying qualified employers and enrollees of terminations due to loss of eligibility or nonpayment of premiums to the SHOP from QHP issuers.

The burden estimate associated with this requirement includes the time and effort needed to develop each of the two notices and to distribute them through an automated process to enrollees, as appropriate. We estimate that approximately 445 QHP issuers (including dental issuers) will participate on the SHOP in all States. On average, we estimate that it will take a health policy analyst 4 hours (at $43.68 an hour), an operations analyst 3 hours (at $39.88), computer programmer 25 hours (at $39.75), fulfillment manager 2 hours (at $52.99), and senior manager an hour (at $86.88) to fulfill these requirements. We estimate that it will take approximately 35 hours annually to develop and transmit each notice for a total of 70 hours annually. We estimate a total of 15,575 hours for each notice across all QHP issuers participating in the SHOP, with a total of 31,150 hours for both required notices.

Type of Respondents	Number of Respondents	Annual Burden Hours	Hourly Wage Rate	Total Burden Cost per Respondent	Total Annual Burden Cost (
Health Policy Analyst	1	4	$43.68	$174.72	
Operations Analyst	1	3	$39.88	$119.64	
Computer Programmer	1	25	$39.75	$993.75	
Fulfillment Manager	1	2	$52.99	$105.98	
Senior Manager	1	1	$86.88	$86.88	
Total		35		$1,480.97	$659,031.65

Based on the above per-notice development wage rates and hours, we believe that each State-based SHOP will spend roughly 70 hours annually to prepare the 2 termination notices (35 hours per notice), for a total cost of $2,962 to design and implement the notices finalized under 45 CFR 155.825(g). We estimate that there will be approximately 18 State-based SHOPs, and that all State-based SHOPs will be subject to this requirement. Therefore, we estimate an aggregate burden of 1,260 hours and $63,900 for State-based SHOPs as a result of this requirement.

Burden estimates for the FF-SHOP are based on the per-notice development wage rates and hours above and are detailed under the Cost to the Federal Government section.

SHOP Satisfaction Surveys

The labor category most appropriate to the respondent population is 41-3020, Insurance Sales Agents. On average, we estimate that it will take each insurance sales agent (at $30.64 an hour), employer ($46.77), and employee ($17.09) approximately 30 minutes to complete the survey twice per year – once at initial enrollment and once during the plan year. We estimate a total of 2,440 hours annually. The estimated cost by respondent is as follows: $9,192 for insurance sales agent/broker, $6,547.80 for employers, and $34,180 for employees. The total annual burden cost is $49,919.80.

Type of Respondents	Number of Respondents	Annual Burden Hours	Hourly Wage Rate	Total Burden Cost per Respondent	Total Annual Burden Cost
Insurance Sales Agent/Broker	300	300	$30.64	$9,192.00	
Employers	140	140	$46.77	$6,547.80	
Employees	2,000	2,000	$17.09	$34,180.00	
Total		2,440			$49,919.80

13. Capital Costs

There are no additional capital costs.

14. Cost to Federal Government

Where a notice is required for termination due to non-payment of premium or a loss of the group's eligibility in the Federally-facilitated SHOP, the Federally-facilitated SHOP will be required to send notices to enrollees and employers, unless a QHP issuer is required by State law to send these notices.

We estimate the Federally-facilitated SHOP will spend roughly 70 hours annually, per State, to prepare the 2 termination notices (35 hours per notice), for a total cost of $2,962, per State, to design and implement the notices proposed under 45 CFR 155.725(g). We estimate that there will be approximately 33 States operating under the Federally-facilitated SHOP and all will be subject to this requirement. Therefore, we estimate an aggregate burden of 2,310 hours and $97,746 for the FF-SHOP as a result of this requirement.

15. Changes to Burden

The burden has increased for QHP issuers as it relates to notice of coverage effective date with the modified definition of an enrollee to include dependents. The burden has also increased for SHOPs shifting certain termination notice requirements from QHP issuers to SHOPs.

16. Publication/Tabulation Dates

As required by the Paperwork Reduction Act of 1995 (44 U.S.C.2506 (c)(2)(A)), CMS published notices in the Federal Register requesting a 60-day public comment process on the proposed modification of the information collection requirements in the final rule for the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 (CMS-9944-P). CMS did not receive any comments during the 60-day public comment period.

Results from the survey analysis data will be presented in reports and briefings for senior CMS Management and others involved in the development of CMS' SHOP program, including operations and marketing. There are no publication dates and no plans to disseminate the results publicly.

17. Expiration Date

Not applicable.

18. Certification Statement

There are no exceptions to the certification statement.