Supporting Statement for Information Collection Requirements for Provider Network Coverage
CMS-10594/OMB Control Number 0938-NEW

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) established new competitive private health insurance markets called Marketplaces, or Exchanges, which gave millions of Americans and small businesses access to affordable, quality insurance options that meet certain requirements. These requirements include ensuring sufficient choice of providers and providing information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers.

In the proposed rule, the *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017* (CMS-9937-P), we propose network adequacy standards for qualified health plan (QHP) issuers, including stand-alone dental plans (SADPs) mostly focused on issuers in QHPs in the federally-facilitated Exchanges (FFE). This information collection notice is for two of the standards from the rule; one applying in the FFE and one applying to all QHPs. Specifically, under proposed 45 CFR 156.230(e) and 156.230(f), we propose notification requirements for enrollees in cases where a provider leaves the network and for cases where an enrollee might be seen by an out of network provider in in-network setting. These new standards will help inform consumers about his or her health plan coverage to better make cost effective choices. The Centers for Medicare and Medicaid Services (CMS) is creating a new information collection request (ICR) in connection with these standards. The burden estimate for this new ICR included in this package reflects the additional time and effort for QHP issuers to provide these notifications to enrollees.

B. Justification

1. Need and Legal Basis

Under proposed 45 CFR 156.230(e), a QHP issuer on a Federally-facilitated Exchange must--(1) Make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is discontinuing, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal.

Under proposed 45 CFR 156.230(f), regarding application of cost sharing to out-of-network

EHB and notwithstanding 45 CFR 156.130(c), for a network to be deemed adequate, each QHP issuer must count the cost sharing that it charges an enrollee for an out-of-network essential health benefit (EHB) provided by an out-of-network provider in an in-network setting towards the enrollee's annual limitation on cost sharing or provide a notice to the enrollee at least ten business days before the provision of the benefit that additional costs may be incurred for an EHB provided by an out-of-network provider in an in-network setting, including balance billing charges, unless such costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on cost sharing.

2. Information Users

The notifications that the QHP issuers will be required to send under this information collection will be sent to the QHP issuers' enrollees who are affected by a provider leaving the network. For the second proposal, the information could be used by a consumer to understand their cost sharing obligations if they receive care from an out-of-network provider. The notifications are intended to inform the consumer about his or her health insurance coverage to better make cost effective choices.

3. Use of Information Technology

CMS anticipates that QHP issuers will use their claims data systems to identify enrollees or use the plan's preauthorization process. The notification can be sent to the enrollee electronically or by mail.

4. Duplication of Efforts

We anticipate no duplication of efforts for QHP issuers. We believe that any issuer that is already notifying enrollees about a provider leaving the network or about an enrollee's cost sharing will be able to adjust their processes, timing and notification template to comply with our requirements.

5. Small Businesses

QHP issuers will incur costs to develop and send the notifications to enrollees. However, CMS does not have reason to believe that any issuers are small businesses.

6. Less Frequent Collection

The burden associated with this information collection consists of QHP issuers in the FFE notifying enrollees about the plan's network coverage. QHP issuers need to make this information available to the plan's enrollees.

We recognize that the notification of the provider leaving network is a good faith effort as

there are certain situations that the issuer cannot anticipate. For these reasons, the regulation requires the notification 30 days prior to the effective date of the change or otherwise as soon as practicable.

We believe that the 10-business days' advance notice provision may allow the enrollee to arrange for an in-network provider to provide the EHB services. If the notices are provided less than 10 business days, the QHP issuer is required to count the out-of-network cost sharing towards the annual limitation on cost sharing.

7. Special Circumstances

There are no anticipated special circumstances.

8. Federal Register/Outside Consultation

In the proposed rule, the *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017 (CMS-9937-P),* CMS is proposing 45 CFR 156.230(e) and (f) and will consider comments received on the proposed rule.

9. Payments/Gifts to Respondents

No payments and/or gifts will be provided.

10. Confidentiality

To the extent of the applicable law and HHS policies, we will maintain consumer privacy with respect to the information disclosed.

11. Sensitive Questions

No sensitive questions are included in these notice requirements.

12. Burden Estimates (Hours & Wages)

Proposed §156.230(e)(1) would require that QHP issuers make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is discontinuing. This is a third-party disclosure requirement. We estimate that a total of 475 issuers participate in the FFE and would be required to comply with the proposed standard. We propose an estimate of 5 percent of providers discontinue contracts per year and that an issuer in the FFE

covers 7,500 National Provider Identifiers, which means that we estimate an issuer would have 375 provider discontinuations in a year. For each provider discontinuation, we propose an estimate that it will take a database administrator half of an hour for data analysis to produce the list of effected enrollees at $55.37 an hour and an administrative assistant half of an hour to develop the notification and send the notification to the effected enrollees, at $29.93 an hour. The total burden per an issuer is 375 hours and the total costs per an issuer would be $15,993.75. The total annual burden for all issuers is 178,125 hours and the total annual costs estimate would be $7,597,031.

Labor Category	Hourly Labor Costs (Hourly rate + 35% Fringe benefits	Burden Hours	Number of Notices	Total Burden Costs	Total Burden Cost (Per Year)
Database Administrator	$55.37	.5	375	$10,381.875	
Administrative Assistant	$29.93	.5	375	$5,611.875	
Total for the 475 QHP Issuers				$15,993.75	$7,597,031

Proposed 156.230(f) would require QHP issuers to provide a notice to enrollees of the possibility of out-of-network charges from an out-of-network provider in an in-network setting at least 10 business days prior to the service being provided to avoid counting the out-of-network costs against to the annual limitation on cost sharing. This provision would apply to all QHPs, which includes 575 issuers. We estimate it would take approximately 6 minutes to create a notification and send the proposed information by an issuer's mid-level health policy analyst (at an hourly wage rate of $54.87). We estimate that approximately 2 notices would be sent for every 100 enrollees. Assuming approximately 9 million enrollees in QHPs 2017, we estimate QHPs would send approximately 180,000 total notices, for a total hours of 18,000, with a total cost of $987,660.

Labor Category	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Number of Notices	Total Burden Costs	Total Burden Cost (Per Year)
Health Policy Analyst	$54.87	18,000	180,000	$987,660	$987,660

13. Capital Costs

Issuers are expected to keep records of notices sent to enrollees. It is assumed that this will be done electronically so the burden is not estimated. There are no additional capital costs.

14. Cost to Federal Government

There are no additional costs to the federal government.

15. Changes to Burden

This is a new collection of information.

16. Publication/Tabulation Dates

Not applicable.

17. Expiration Date

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

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