Supporting Statement for Information Collection Requirements for Third Party Payment of QHP Premiums and Additional Notices for QHP Issuers

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 QHPs and SADPs—private health and dental insurance plans that have been certified as meeting certain standards.

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 to amend 45 CFR 156.1250 to make clarifications on standards related to the acceptance of third party payments. As part of these revisions, we propose to require entities that make third party payments of premiums under this section to notify HHS, in a format and timeline specified in guidance. We expect that the notification would reflect information like the entity's intent to make payments of premiums under this section and the number of consumers for whom it intends to make payments, or the number of consumers served in prior years. CMS will use the information to assess changes to insurance risk pools resulting from third party payments.

In §156.1256, we are also proposing to require QHP issuers, in the case of a plan or benefit display error included in 45 CFR 155.420(d)(4), to notify their enrollees within 30 calendar days after the error is identified, if directed to do so by the FFE. This new requirement will provide notification to QHP enrollees of errors that may have impacted their QHP selection and enrollment and any associated monthly or annual costs, as well as the availability of a special enrollment period, under §155.420(d)(4), for the enrollee to select a different QHP, if desired.

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 third party payer entities to provide this information to HHS and for QHP issuers to provide notifications to enrollees.

B. Justification

1 . Need and Legal Basis

Under proposed §156.1250, we are proposing to require entities that make third party payments of premiums on behalf of Qualified Health Plan enrollees to notify HHS, in a format and timeline specified in guidance. We expect that the notification would reflect the entity's

intent to make payments of premiums under this section and the number of consumers for whom it intends to make payments. We are considering whether we should expand the list of entities from whom issuers are required to accept payment under §156.1250 to include not-for-profit charitable organizations, beginning in 2018. In making this determination, we intend to carefully review the data provided by entities currently making third party premium payments to better understand the impact of these payments. We anticipate that any requirement to accept payments from not-for-profit charitable organizations would be limited to organizations that satisfy several criteria designed to minimize adverse selection.

Under proposed §156.1256, a QHP issuer on a Federally-facilitated Exchange must, in the case of a plan or benefit display error included in §155.420(d)(4), notify their enrollees within 30 calendar days after the error is identified, if directed to do so by the FFE. We believe that enrollees should be made aware of any error that may have impacted their QHP selection and enrollment and any associated monthly or annual costs. Therefore, we are proposing a requirement for issuers to notify their enrollees of such error, should such error occur, as well as the availability of a special enrollment period, under §155.420(d)(4), for the enrollee to select a different QHP, if desired.

2. Information Users

The notifications that the third party payers will be required to send under this information collection will be used by HHS to determine future third party payment policy.

The notifications that the QHP issuers will be required to send under this information collection will be sent to the QHP issuers' enrollees who may be adversely affected by an error in plan or benefit data displayed during their QHP selection. The notifications are intended to inform the consumer about his or her health insurance coverage to make choices based on accurate plan data.

3. Use of Information Technology

CMS anticipates that third party payers will send this information electronically or by mail to HHS. CMS anticipates that QHP issuers will use their claims data systems to identify enrollees that need to be notified. The notification can be sent to the enrollee electronically or by mail.

4. Duplication of Efforts

Where Ryan White HIV/AIDS Program (RWHAP) grantees elect to make third party payments for insurance premiums and/or cost-sharing, their annual reporting requirements to HRSA include the number of consumers served and the amount of grant funds allocated to such payments. To avoid potential burden and duplication that the proposed "notice of intention" may cause for the RWHAP grantees, the data collection would exempt third party

payer entities that are already providing the information to other HHS agencies, such as to the Health Resources and Services Administration (HRSA) or to the Indian Health Service (IHS).

5. Small Businesses

We do not anticipate that small businesses will be significantly burdened by this data collection.

6. Less Frequent Collection

The burden associated with this information collection consists of entities that make third party payments of premiums under this section to notify HHS, in a format and timeline specified in guidance. We are proposing to require each entity to send this information annually in order for HHS to assess the annual impact on premiums and changes to insurance risk pools resulting from third party payments.

QHP issuers in the FFE notifying enrollees about the plan's incorrect plan display, and accurate plan data need to make this information available to the plan's enrollees. We recognize that the notification of the plan display error 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 after the FFE directs the issuer that the error has been identified as entitling affected enrollees to a special enrollment period.

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 156.1250 and 156.1256 and will consider comments received on the proposed rule. We will also amend this information collection to align with any changes in the final rule. CMS will also receive comments during the 60-day comment period for this information collection.

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)

We estimate that to comply with proposed §156.1250(b), it would take an entity approximately four hours to analyze the number of consumers the entity intends to make payments of premiums on behalf of, draft a notification and send the proposed information by a mid-level health policy analyst (at an hourly wage rate of $ 54.87). Assuming 500 entities exist that make third party payments and each would send one notice, we estimate a total annual burden of 2,000 hours resulting in an annual cost of $109,740.

Labor Category	Hourly Labor Costs (Hourly rate + 35% Fringe benefits	Total Annual Burden Hours	Number of Notices	Total Annual Burden
Health Policy Analyst	$54.87	2,000	500	$109,740

Proposed §156.1256 would require that, in the event of a plan or benefit display error, QHP issuers notify their enrollees within 30 calendar days after the error is identified, both of the plan or benefit display error and of the opportunity to enroll in a new QHP under a special enrollment period at §155.420(d)(4), if directed to do so by the FFE. This provision would apply to all QHPs in the FFEs, which includes 475 issuers. We estimate it would take approximately 30 minutes to amend a form notice, add SEP language provided by the FFE, 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 4 percent of enrollees would receive such a notice. Assuming approximately 7 million FFE enrollees, we estimate QHPs in the FFEs would send approximately 280,000 total notices, for a total hours of 140,000, with a total cost of $7,681,800.

Labor Category	Hourly Labor Costs (Hourly rate + 35% Fringe benefits	Total Annual Burden Hours	Number of Notices	Total Annual Burden
Health Policy Analyst	$54.87	140,000	280,000	$7,681,800

13. Capital Costs

There are no additional capital costs.

14. Cost to Federal Government

    $2,263.04

15. Changes to Burden

    There are no changes to burden.

16. Publication/Tabulation Dates

    Not applicable.

17. Expiration Date

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