Supporting Statement for Information Collection Requirements for Provider Network Coverage

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 final rule, the *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017* (CMS-9937-P), we finalized 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 45 CFR 156.230(d) and 156.230(e), we require 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 ancillary 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 45 CFR 156.230(d), 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 45 CFR 156.230(e), beginning for the 2018 and later benefit years,), for a network to be deemed adequate, each QHP issuer must, notwithstanding 45 CFR 156.130(c), count the cost sharing paid by an enrollee for an out-of-network essential health benefit (EHB) provided by an out-of-network ancillary provider in an in-network setting towards the enrollee's annual limitation on cost sharing or provide a notice to the enrollee by the longer of when the issuer would typically respond to a prior authorization request timely submitted, or 48 hours before the provision of the benefit, that additional costs may be incurred for an EHB provided by an out-of-network ancillary

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 notification, the information could be used by consumers to understand their cost sharing obligations if they receive care from an out-of-network ancillary provider. These 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 as the requirements under 45 CFR 156.230(d) are not intended to, and do not, preempt State provider transition notices requirements. 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 a 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 the advance notice provision will help provide transparency and ensure that consumers receive notice of the possible consequences where an out-of-network ancillary provider may be seen and are provided some mitigation of these consequences where proper, timely notice is not provided by the issuer.

7. Special Circumstances

There are no anticipated special circumstances.

8. Federal Register/Outside Consultation

In the proposed rule, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017 (CMS-9944-P),* CMS sought comment on policies in 45 CFR 156.230(d) and (e). We have considered comments received to the policies in the proposed rulemaking and did not receive any comments to the proposed ICRs.

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)

Section 156.230(d) requires 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 being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal. This is a third-party disclosure requirement. The notification requirement under §156.230(d) is a common practice in the current market as several States, Medicare Advantage, Medicaid Managed Care, and the National Association of Insurance Commissioners' Network Adequacy Model Act have standards regarding enrollee notification of a provider leaving a network. As discussed in the final rule preamble, under State laws, many QHP issuers will already be under this obligation, and therefore, our notification requirements will apply in a more limited fashion. Additionally, we have incorporated stand-alone dental plans (SADPs) into our calculations, but we recognize given the requirements that SADPs may rarely meet the requirements to send a notification.

We estimate that a total of 475 issuers participate in the FFE and would be required to comply with the standard. We estimated that 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.

We are clarifying that our assumption is that the database manager will receive notification from the issuer's contracting team that a provider contract is being discontinued. From that notification, the database manager would aggregate the claims data associated with the provider to develop the list of effected enrollees with associated enrollee information for the notice. This list of affected enrollees and associated enrollee information would be sent to an administrative assistant to aggregate into a notification template to be sent to the enrollee. Assuming 375 notifications per a year, we believe that this task would be a routine process for the administrative assistant to undertake that would need little to no oversight to produce. As the issuer has the discretion to define regular basis and that the number of notifications are likely to widely varying between scope of network and type of provider, we did not estimate based on the number of individual notifications, but rather the number of provider discontinuations. For each provider discontinuation, we estimate that it will take a database administrator 30 minutes for data analysis to produce the list of affected enrollees, at $55.37 an hour, and an administrative assistant 30 minutes to develop the notification and send the notification to the affected enrollees, at $29.93 an hour. We are also clarifying these hourly rates include 35 percent adjustment for fringe benefits and overhead costs. The total costs per issuer would be $15,993.75. The total annual costs estimate would be $7,597,031. Because we are already collecting information regarding network classifications as part of the existing QHP certification process, we do not believe that this network classification described in the preamble will result in additional information collection requirements for issuers.

Labor Category	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Number of Notices	Total Burden Costs (Per Year)
Database Administrator	$55.37	0.5	375	$10,381.875
Administrative Assistant	$29.93	.5	375	$5,611.875
Total for the 475 QHP Issuers				$15,993.75

In §156.230(e), we require QHP issuers to provide a notice to enrollees of the possibility of out-of-network charges from an ancillary out-of-network provider in an in-network setting prior to the benefit being provided, to avoid counting the out-of-network costs against the annual limitation on cost sharing. This provision applies to all QHPs, which includes 575 issuers, and would start in 2018. We estimate it would take an issuer's mid-level health policy analyst (at an hourly wage rate of $54.87) approximately 6 minutes to create a notification and send the information. We are clarifying the hourly rates include 35 percent adjustment for fringe benefits and overhead costs. We estimate that approximately two notices would be sent for every 100 enrollees. Assuming

approximately 24 million enrollees in QHPs for 2018, we estimate QHPs would send approximately 320,000 total notices annually, for a total 21,334.40 hours, at a total cost of $1,170,619.

Labor Category	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Number of Notices	Total Burden Cost (Per Year)
Health Policy Analyst	$54.87	21,334.40	320,000	$1,170,619

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 information collection request.

16. Publication/Tabulation Dates

Not applicable.

17. Expiration Date

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

1 We used the most recent CBO estimates for enrollment from March 2015 available at https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf.