Supporting Statement – Part A
for Information Collection Requirements for QHP Issuer Notices
CMS-10595/OMB Control Number: 0938-1301

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 qualified health plans (QHPs), including stand-alone dental plans (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 proposed 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 proposed to require entities that make third party payments of premiums under this section to notify HHS, in a format and timeline specified in guidance. After careful evaluation, and based on public comments received to the proposed rule, we are removing the information collection e. We believe it would unduly burden Indian tribes and federal, state, and local government programs to be required to provide such notification to HHS. We also believe that the proposed information collection from these entities would be unlikely to inform the impacts on the risk pool that may result from expanding the requirement at §156.1250 to third party payments made by non-profit, charitable organizations.

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 issuer is informed by an Federally-facilitated Exchange (FFE) that the error is corrected, 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 QHP issuers to provide notifications to enrollees.

B. Justification

1. Need and Legal Basis

Under proposed §156.1256, a QHP issuer on an FFE 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 issuer is informed by the FFE that the error is corrected, 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 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 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

Notices to enrollees under proposed §156.1256 do not duplicate any other Federal effort.

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 QHP issuers in an FFE notifying enrollees about the plan's incorrect plan display. Additionally, accurate plan data is needed 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 calendar days after the issuer is informed by the FFE that the error entitling affected enrollees to a special enrollment period has been corrected.

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 proposed 45 CFR 156.1250 and 156.1256 and did not receive comments on the proposed information collection. CMS has also solicited comments during a 60-day comment period for this information collection. CMS will consider any additional comments that are received during the 30-day comment period for this information collection. We do not anticipate any significant public reaction to 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)

ICRs Regarding Other Notices (§ 156.1256)

CMS is adding a new section at § 156.1256 to require that, in the event of a plan or benefit display error, QHP issuers notify their enrollees within 30 calendar days after the issuer is informed by the FFE that the error has been fixed, if directed to do so by the FFE, 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, as well as all QHPs in the SBE-FPs, which includes 475 issuers. We anticipate that issuers will need to notify multiple enrollees of the same display error, and therefore estimate that one form notice would cover approximately 100 of the enrollees receiving such a notice. For each group of 100 form notices, we estimate that it would take approximately 30 minutes for an issuer's mid-level health policy analyst (at an hourly wage rate of $54.87) to amend, add SEP language provided by the FFE, and send the information. We estimate that approximately 4 percent of enrollees would receive such a notice. Assuming approximately 19 million FFE and SBE-FP enrollees in 2017,[72] we

estimate QHPs in the FFEs and SBE-FPs would send approximately 760,000 total notices (4 percent of the estimated 19 million FFE and SBE-FP enrollees), for a total hours of 3,800, with a total cost of $208,506.

Labor Category	Hourly Labor Costs (Hourly rate + 35% Fringe benefits	Total Annual Burden Hours	Number of Notices	Total Annual Burden
Health Policy	**$54.87**	**3,800**	**760,000**	**$208,506**

13. Capital Costs

There are no additional capital costs.

14. Cost to Federal Government

There are no costs to the Federal Government.

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.