Supporting Statement for Paperwork Reduction Act Submissions
Issuer Reporting Requirements for Selecting a Cost-Sharing Reductions Reconciliation Methodology
(CMS-10469/OMB: 0938-1214)

A. Background

On March 23, 2010, the President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (Affordable Care Act), Public Law 111-148. Sections 1402 and 1412 of the Affordable Care Act provide for reductions in cost sharing on essential health benefits for low- and moderate-income enrollees in silver level qualified health plans (QHP) on individual market Exchanges. It also provides for reductions in cost sharing for Indians enrolled in QHPs at any metal level. These cost-sharing reductions will help eligible individuals and families afford the out-of-pocket spending associated with health care services provided through Exchange-based QHP coverage.

The law directs QHP issuers to notify the Secretary of the Department of Health and Human Services (HHS) of cost-sharing reductions made under the statute for qualified individuals, and directs the Secretary to make periodic and timely payments to the QHP issuer equal to the value of those reductions. Further, the law permits advance payment of the cost-sharing reduction amounts to QHP issuers based upon amounts specified by the Secretary.

Under established HHS regulations, QHP issuers will receive advance payments of the cost-sharing reductions throughout the year. Each issuer will then be subject to one of two reconciliation processes after the year to ensure that HHS reimbursed each issuer the correct advance cost-sharing amount. This PRA establishes the data collection requirements for a QHP issuer to report to HHS which reconciliation reporting option the issuer will be subject to for a given benefit year.

B. Justification

1. Need and Legal Basis

On December 7, 2012, HHS published a proposed rule entitled "HHS Notice of Benefit and Payment Parameters for 2014." This rule proposed a payment approach under which CMS would make monthly advance payments to issuers to cover projected cost-sharing reduction amounts, and then reconcile those advance payments after the end of the benefit year to the actual cost-sharing reduction amounts. The reconciliation process described in the rule would require that QHP issuers provide CMS the amount of cost-sharing paid by each enrollee, as well as the level of cost-sharing that enrollee would have paid under a standard plan without cost-sharing reductions. To determine the amount of cost-sharing an enrollee receiving cost-sharing reductions would have paid under a standard plan, QHP issuers would need to re-adjudicate each claim for these

enrollees under a standard plan structure. HHS finalized the proposed notice of benefit and payment parameters for 2014 and this approach on March 11, 2013.

During the comment period to the proposed rule, HHS received numerous comments suggesting that the reporting requirements of the reconciliation process for QHP issuers would be operationally challenging for some issuers. In response to these comments, HHS issued an interim final rule with comment period on March 11, 2013 entitled "Amendments to the HHS Notice of Benefit and Payment Parameters for 2014," which laid out an alternative approach that QHP issuers may elect to pursue with respect to the reporting requirements. This alternative approach would allow a QHP issuer to estimate the amount of cost-sharing an enrollee receiving cost-sharing reductions would have paid under a standard plan in the Exchange, rather than re-adjudicating each of the enrollee's claims. This approach is intended to permit a reasonable transitional period in which QHP issuers will be allowed to choose the methodology that best aligns with their operational practices, which should reduce the administrative burden on issuers in the initial years of the Exchanges. The interim final rule describes the estimation methodology in sufficient detail to allow QHP issuers to make an informed decision of which reporting approach to pursue.

Under this PRA, we are requesting authority to collect data associated with choosing either the actual option or the transitional estimated option to reporting information for reconciliation. Prior to the start of each coverage year, QHP issuers must notify HHS of the methodology it is selecting for the benefit year. The QHP issuer must select the same methodology for all plan variations it offers on the Exchange for a benefit year. Moreover, as the estimated methodology is intended as a transition to the actual methodology, the QHP issuer may not select the estimated methodology if it selected the actual methodology for the prior benefit year.

A description of the data elements to be collected are included in Appendix A of this package.

2. Information Users

The information collected will be used by HHS to determine which approach, actual or estimated, each QHP issuer will use to determine the amount of cost-sharing that each enrollee receiving cost-sharing reductions would have been responsible for if enrolled in a standard plan in the Exchange.

3. Use of Information Technology

QHP issuers will provide information on which option they choose via a designated email address. All submissions will be made electronically and no paper submissions are required.

4. Duplication of Efforts

This is a new data collection required under HHS final rules. It does not duplicate any other collection.

5. Small Businesses

Small businesses are not affected by this collection.

6. Less Frequent Collection

QHP issuers must elect which option they prefer prior to the start of each benefit year. This election must occur only once annually. Issuers may not deviate from this collection schedule or provide the information on a more or less frequent basis.

7. Special Circumstances

No special circumstances exist for this information collection.

8. Federal Register/Outside Consultation

A Federal Register notice was published on May 16, 2016 (81 FR 30308), providing the public with a 60-day period to submit written comments on ICRs. CMS received no public comments. No individuals outside the Agency were consulted on either the data collection or analysis associated with this collection activity.

9. Payments/Gifts to Respondents

There are no payments or gifts to respondents.

10. Confidentiality

We will maintain respondent privacy with respect to the information collected to the extent required by applicable law and HHS policies.

11. Sensitive Questions

There are no sensitive questions associated with this collection.

12. Burden Estimates (Hours & Wages)

HHS estimates that for the first benefit year it will take a senior actuary ($173.56/hr) 10 hours to read through the final rules pertaining to the reporting options and assess which option is most appropriate considering the issuer's claims processing system. Additionally, it should take approximately 1 hour for the senior actuary to select which option the issuer will pursue via email. HHS assumes that approximately 575 QHP issuers will participate in the Federally Facilitated Exchange. Each QHP issuer will be responsible for submitting this data by email.

As the estimated approach is intended to act as a transition to the actual methodology, issuers that elect to use the actual approach in any benefit year may not select the estimated approach for any subsequent benefit year. Therefore, once an issuer chooses to implement the actual approach, that issuer will no longer be required to make any data submission to HHS under this PRA. Only issuers that continue to choose the estimation option will need to annually reassess whether to continue with that approach, as well as submit the chosen reporting option to HHS by email as appropriate. HHS estimates that it will take approximately 2 hours each subsequent year for a senior actuary to accomplish that reassessment and submit the approach by email.

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2015 National Occupational Employment and Wage Estimates for the senior actuary (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents the 90th percentile hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage.

Occupation Title	**Occupation Code**	**Senior Actuary (90th percentile) Hourly Wage**	**Fringe Benefit**	**Adjusted Hourly Wage**
				173.56
Actuary	15-2011	$86.78	$86.78	

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Burden hours: 10 hours reading and analysis time + 1 hour submission time = 11 hours per issuer
Cost: 11 hours x $173.56/hour x 575 issuers = $ 1,097,767

Total Hours: 11 hours per issuer x 575 issuers = 6,325 total hours.

13. Capital Costs

The health insurance industry is not required to incur capital costs to fulfill these requirements.

14. Cost to Federal Government

The creation of an email account and the review of issuer data submissions will be incorporated into already established HHS staff responsibilities. Therefore, this data collection should impose no additional costs to the Federal government.

15. Changes to Burden

As result in a reduction of the number of respondents from 1,200 to 575, there is an overall decrease in the number of burden hours from 13,200 to 6,325. The Agency was able to provide a more updated and accurate estimate based on current data.

16. Publication/Tabulation Dates

There are no plans to publish or tabulate the information collected.

17. Expiration Date

The expiration date and OMB control number will be displayed on each data collection form.