Supporting Statement For Paperwork Reduction Act Submissions: Standards Related to Reinsurance, Risk Corridors, Risk Adjustment, and Payment Appeals

A. Background

The Patient Protection and Affordable Care Act, Public Law 111-148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, Public Law 111-152, enacted on March 30, 2010 (collectively, the "Affordable Care Act"), provides for three premium stabilization programs – a reinsurance program, a risk corridors program, and a risk adjustment program – to mitigate the negative impacts of adverse selection and market uncertainty. On March 23, 2012, The Centers for Medicare & Medicaid Services (CMS) published the Premium Stabilization Rule (77 FR 17220) to implement and set standards for these premium stabilization programs. On March 11, 2013, CMS published the final Notice of Benefit and Payment Parameters for 2014 ("2014 Payment Notice") (78 FR 15410), to implement requirements for various programs established by the Affordable Care Act, establish standards for the cost-sharing reduction program and the premium tax credit program, to provide for the collection of user fees from issuers to fund operations of the Federally-facilitated Exchange and the risk adjustment program in States where HHS operates risk adjustment, and to expand on standards set forth in the Premium Stabilization Rule. CMS published a proposed Notice of Benefit and Payment Parameters for 2015 ("2015 Payment Notice") on December 02, 2013, to expand upon, modify, and clarify the provisions of the Premium Stabilization Rule, the 2014 Payment Notice, and the first and second final Program Integrity Rules (78 FR 54070 and 78 FR 65046).

The transitional reinsurance program and the temporary risk corridors program are designed to provide issuers with greater payment stability as insurance market reforms begin. The reinsurance program serves to reduce the uncertainty of insurance risk in the individual market in each State by making payments for high-cost enrollees. The HHS-administered risk corridors program serves to protect against rate-setting uncertainty with respect to qualified health plans by limiting the extent of issuer losses (and gains). The permanent risk adjustment program is intended to protect health insurance issuers that attract a disproportionate number of higher risk enrollees (*e.g.*, those with chronic conditions). These programs will support the effective functioning of the American Health Benefit Exchanges ("Exchanges"), which will become operational by January 1, 2014. The Exchanges are individual and small group health insurance marketplaces designed to enhance competition in the health insurance market and to expand access to affordable health insurance for millions of Americans. Individuals who enroll in qualified health plans (QHPs) through individual market Exchanges may receive premium tax credits to make health insurance more affordable and financial assistance to reduce cost sharing for health care services. The reporting and data collection provisions described below apply to States and health plans both inside and outside of an Exchange.

B. Justification

1. Need and Legal Basis

Section 1341 of the Affordable Care Act provides that each State must establish a transitional reinsurance program to help stabilize premiums for coverage in the individual market during the first

three years of Exchange operation. Section 1342 provides for the establishment of a temporary risk corridors program that will apply to qualified health plans in the individual and small group markets for the first three years of Exchange operation. Section 1343 provides for a program of risk adjustment for all non-grandfathered plans in the individual and small group market both inside and outside of the Exchange. Sections 1402 and 1412 of the Affordable Care Act establish a program for reducing cost sharing for individuals with lower household income and Indians. Sections 1401 and 1411 of the Affordable Care Act provide for advance payments of the premium tax credit for low- and moderate-income enrollees in a QHP through an Exchange.

Section 1321(a) also provides broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, reinsurance, risk adjustment, and other components of title I of the Affordable Care Act. These risk-spreading and insurance affordability programs, which will be implemented by HHS and/or States, are designed to mitigate adverse selection, to provide stability for health insurance issuers in the individual and small group markets as market reforms and Exchanges are implemented, and to make health insurance more affordable and accessible to millions of Americans who currently do not have affordable options available to them.

2. Information Users

The data collection and reporting requirements described below will enable States and/or HHS to implement these programs, which will mitigate the impact of adverse selection in the individual and small group markets both inside and outside the Exchange.

3. Use of Information Technology

Information collected for this rule will be submitted electronically. HHS staff will communicate with States and the District of Columbia using standardized reporting, e-mail or telephone.

4. Duplication of Efforts

This information collection does not duplicate any other Federal effort.

5. Small Businesses

This information collection will not have a significant impact on small businesses.

6. Less Frequent Collection

The anticipated flows of funds for these programs require the collection of information as indicated. A less frequent collection could result in cash flow difficulties for issuers and logistical difficulties for issuers and the entities operating premium stabilization programs.

7. Special Circumstances

In order for payments to be made in a timely manner for these premium stabilization programs, it is necessary to collect information according to timeframes established by the State or

HHS on behalf of the State.

8. Federal Register/Outside Consultation

A Notice published in the Federal Register on September 8, 2017 (82 FR 42555). A comment was asking for an additional 60-day period to comment since this supporting statement was not made publicly available. As described in the notice of comment for this collection, the extension contains no change to the existing data elements and is proposed only to allow CMS time to revise the collection and data elements. This document will be posted for 30-day public comment and OMB review. Subsequently, CMS will post another 60-day public comment period immediately, proposing a revision to this data collection, at which time issuers may comment on any proposed changes to actual data elements collected for risk adjustment and other programs.

No outside consultation was sought.

9. Payments/Gifts to Respondents

No payments or gifts will be provided 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 included in this information collection effort.

12. Burden Estimates (Hours & Wages)

Below is a summary of the information collection requirements set forth in the final rule. Throughout this summary, the frequency of data collection is assumed to be the frequency discussed in the preamble to the rule.

A number of assumptions are made regarding the wages of personnel needed to accomplish the proposed collection of information. Wage rates are based on the 2016 Employer Costs for Employee Compensation report by U.S Bureau of Labor Statistics and represent a national average. Some States or employers may face higher or lower wage burdens. In this request for an extension, we have updated wage rates estimates to include a 100% fringe benefit estimate for all employees. The original estimate was based on a 35% fringe benefit. We present an annualized estimate of the burden associated with these information collection requirements below.

I. Health Insurance Issuer Standards Related to the Transitional Reinsurance Program (§153.400-§153.420)

Within Part 153, subpart E we discussed reporting requirements for health insurance issuers related

to the transitional reinsurance program. Based on data from the healthcare.gov website, we estimate there are approximately 2,400 issuers in the individual and small group markets. Based on 2014 data from the Department of Labor, we estimate that 22,900 entities (including self-insured and partially insured entities) will make reinsurance contributions.

Calculation of Reinsurance Contributions (§153.405)

As described in §153.400(b) all contributing entities both inside and outside of the Exchange will be required to provide enrollment data (covered lives and member months) to HHS to calculate contribution amounts. As described in §153.405, we require contributing entities to provide annual counts of their enrollment and reinsurance contributions to HHS based on modified counting methods used for Patient-Centered Outcome Trust Fund (PCORTF) reporting. The burden associated with this requirement is the time and effort required by an issuer or self- insured group health plan to derive an annual enrollment count. Because issuers and self-insured group health plans will already be under an obligation to determine a count of covered lives using a PCORTF method, the burden associated with this requirement is the additional burden of conducting these counts using the slightly modified counting methods specified in the final Payment Notice. On average, we estimate it will take each issuer 1 hour to reconcile and submit final enrollment counts to HHS. Assuming an hourly wage rate of $57.02 for an insurance operations analyst, we estimate an aggregate burden of $1,305,758 for 22,900 reinsurance contributing entities subject to this requirement. In §153.405(i), we propose that HHS or its designee would have the authority to audit reinsurance contributing entities to assess compliance with the requirements of subparts E, G and H of Part 153, as applicable. For contributing entities, we estimate that or approximately 37 hours at a cost of approximately $2,109 for each contributing entity. Because we have not finalized the audit protocols, it is difficult to accurately estimate an audit rate. However, we estimate that approximately 1 percent of contributing entities would be audited, representing 226 contributing entities. Therefore, we estimate an aggregate burden of 8,362 hours, or $476,801 as a result of this proposed requirement.

All health insurance issuers, group health plans, and third party administrators are required to register in a Federal system in order to access the module or form for the reinsurance contributions process. The “Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations” (OMB Control No. 0938-1187) details data submission required when an entity is remitting payment for an invoice or receiving a payment from HHS. The data elements that will be requested through the reinsurance contribution module or form are detailed in Appendix C.

Request for Reinsurance Payments (§153.410)

As described in §153.410(a), health insurance issuers of reinsurance-eligible plans seeking reinsurance payment must make a request for payment in accordance with the requirements in the HHS notice of benefit and payment parameters or the State notice of benefit and payment parameters, as applicable. To the greatest extent possible, we wish to minimize burden for issuers. The data collected, and the manner in which that data will be collected, will be identical for both the reinsurance and risk adjustment programs. HHS has determined that issuers will need to maintain data elements identified in Appendix A in order to make reinsurance payment requests. A subset of issuers (specifically, issuers operating reinsurance-eligible plans in the individual market)

subject to the risk adjustment data collection requirements are eligible to make reinsurance payment requests. As such, we anticipate minimal burden associated with this provision; the burden associated with this provision is described in Part III of this section.

As described in §153.420(a), to be eligible for reinsurance payments, an issuer must submit or make accessible all required reinsurance data in accordance with the reinsurance data collection approach established by the State or HHS on behalf of the State. As described in 153.420(b) the submission deadline is April 30 of the year following the applicable benefit year.

In §153.410(d), we propose that HHS or its designee would have the authority to audit issuers of risk adjustment covered plans or reinsurance-eligible plans to assess compliance with the requirements of subparts E, G and H of Part 153, as applicable. For issuers of reinsurance- eligible plans, these provisions would result in a third party disclosure requirement for issuers to prepare and compile the financial and programmatic information necessary to comply with the audit. Because we are conducting an audit of risk adjustment covered issuers that would include issuers of reinsurance-eligible plans, we discuss the audit burden for reinsurance-eligible plans along with the audit burden for risk adjustment covered plans in section III of this supporting statement. As discussed in section III of this supporting statement, we estimate it will take 145 hours at a cost of approximately $8,267 for each issuer to make information available to HHS for an onsite review.

II. Health Insurance Issuer Standards Related to the Temporary Risk Corridors Program (§153.520-§153.530)

Within Part 153, subpart F we discussed reporting and recordkeeping requirements for QHP issuers related to the risk corridors program. As described in §153.520(e), QHP issuers will be required to maintain data and supporting information used to make the required allocations and attributions of revenues and expenses, and to determine that the methods and bases detailed in the report described below were accurately implemented. As described in §153.520(c), we will require all QHP issuers to submit to HHS a detailed description of the methods and specific bases used to attribute revenues and expenses in allowable costs and target amount to each QHP and across plans. Under §153.530, we will also require all QHP issuers to submit data on premiums earned, allowable costs, and allowable administrative costs. For the 2014 benefit year, we propose to collect risk corridors data by using the same form as is used for MLR data collection, at the same time (July 31st of the year following the applicable benefit year). We intend to modify the MLR collection form for benefit year 2015, approved under OMB control number 0938-1164, to add reporting elements (for example, QHP-specific premium amounts) that are required under the risk corridors data submission requirements under §153.530. We intend to include these data elements in an amendment to the information collection approved under OMB control number 0938-1164 for MLR data submission that we will publish for public comment and advance for OMB approval in the future.

In §§153.530 and 153.540 we propose a data validation process for risk corridors data submissions. Because the MLR program and the risk corridors program will require similar data, we estimate that submitting the data elements required for the risk corridors program will impose limited additional burden on issuers. We estimate that it will take each QHP issuer approximately 1.5 hours, representing 1 hour for an insurance analyst (at an hourly wage rate of $57.02) and 30 minutes for a senior manager (at an hourly wage rate of $114.07), to input and review data that is

specific to the risk corridors program in the MLR and risk corridors reporting form for benefit year 2015. We estimate that 1,200 QHP issuers will submit risk corridors data for the 2014 benefit year in the 2015 risk corridors and MLR reporting cycle. Therefore, we estimate an aggregate burden of 1,800 hours (at a total cost of approximately $102,636) for QHP issuers as a result of this requirement.

In §153.540(a), we propose that HHS or its designee would have the authority to audit QHP issuers to assess compliance with the requirements of subpart F of Part 153. We intend to align the risk corridors audit process with the audits conducted for the MLR program. Therefore, we believe that the burden on QHP issuers associated with the risk corridors audit proposed in §153.540(a) is already accounted for as part of the Supporting Statement for the MLR program approved under OMB control number 0938-1164.

For the 2014 benefit year, we are considering adjustments to the premium stabilization programs that would help to further mitigate unexpected losses for QHP issuers with plans that are affected by the transitional policy. To effectuate potential adjustments, we must estimate the State-specific effect on average claims costs. This submission would occur in 2015 prior to the risk corridors July 31, 2015 data submission deadline. HHS would analyze that enrollment data, and publish the State-specific adjustments that issuers would use in the risk corridors calculations for the 2014 benefit year. We estimate that there will be approximately 2,400 issuers in the individual and small group market in the 2014 benefit year, and that it would take an insurance analyst approximately 30 minutes (at an hourly wage rate of $57.02) to estimate enrollment in transitional plans and non-transitional plans and submit this information to HHS. Therefore, we estimate a cost of approximately $28.51 for each issuer, and an aggregate cost of $68,424 for all individual and small group market issuers (though this cost may be lower depending upon the data collection method we adopt). To reduce the burden on issuers, we are considering coordinating this data collection with other data collections for the premium stabilization programs. Because we anticipate collecting this information in 2015, and because we expect to issue additional clarifying guidance on this proposed policy, will seek OMB approval and solicit public comment on this information collection requirement at a future date.

III. Health Insurance Issuer Standards for the Risk Adjustment Program (§153.610-§153.630; and §153.700-730)

Within Part 153, subpart G, we described reporting requirements for health insurance issuers related to the risk adjustment program.

Distributed Data and Risk Adjustment Data Submission Requirements (§153.610, §153.700(a), and §153.720)

As described in §153.610, health insurance issuers will be required to maintain risk adjustment data in order for HHS to operate risk adjustment on behalf of the State. HHS has determined that issuers will need to maintain data elements identified in Appendix A. HHS intends to employ a distributed data approach when running risk adjustment on behalf of a State and will also use this data for the purpose of determining the risk adjustment user fee for each issuer.

Under §153.610(f), we establish a user fee to support Federal operation of risk adjustment. This per capita monthly fee will be charged to issuers of risk adjustment covered plans based on enrollment estimates provided to HHS in the distributed data environment. HHS will calculate user

fees owed, and issuers will remit the fee owed only once, in June of the year following the benefit year, in connection with processing of payments and charges for risk adjustment.

We estimate that 2,400 issuers will be required to pay risk adjustment user fees, and the additional cost associated with this requirement is the time and effort for an issuer to provide monthly enrollment data and remit fees. Because HHS will utilize existing data collection and payments and charges processing, we do not anticipate that this provision will alter the collection cost.

Under a distributed data approach, the required data is accessed and stored separately from other issuer data pursuant to formats specified by HHS. In §153.700(a), we require that an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State where HHS is operating the risk adjustment or reinsurance program on behalf of the State, as applicable, must provide HHS, through the dedicated data environment, access to enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data as specified by HHS. We estimate that this data submission requirement will affect 2,400 issuers, and will cost each issuer approximately $506,822.40 in total labor costs. This cost estimate reflects the wages of 3 full-time equivalent employees (5,760 hours per year) at an average hourly rate of $87.99 per hour for a technical employee. We anticipate that 400 data processing servers will be established across the market in 2014 (at an average cost of $15,000) and issuers will process approximately 9 billion claims and enrollment files in 2014. Therefore, we estimate an aggregate burden, including labor and capital costs (as described in section 13 below), of $1,216,373,760 for all issuers as a result of these requirements. We are proposing to clarify the timeframe for this data submission by proposing that an issuer must make good faith efforts to make complete, current enrollment and claims files accessible through its dedicated distributed data environments no less frequently than quarterly, once the issuer's dedicated distributed data environment is established. This proposed clarification will not affect the burden associated with this information collection requirement.

HHS has issued guidance indicating that we will provide issuers with the option of uploading supplemental diagnoses to the dedicated distributed data environment in addition to the other enrollee, claims, and medical data elements (see Appendix A) that are required for the risk adjustment program. If an issuer chooses to submit supplemental diagnosis information, HHS has determined that issuers will need to maintain data elements identified in Appendix B. The burden associated with this requirement will be the additional effort for an issuer to gather and submit supplemental diagnoses to HHS. We estimate that all 2,400 issuers of risk adjustment covered plans will submit this information for 30% of their enrollees. In the 2014 Payment Notice, we estimated the time and effort associated with submitting risk adjustment and reinsurance data through the distributed data environment. Because issuers will only submit supplemental diagnoses for 30% of their enrollees, we believe that the time and effort associated with this process will be approximately 30% of the time and effort associated with uploading information to the distributed data environment. We estimate that it will take 3 full-time equivalent employees (at an average hourly wage rate of $87.99 for a technical employee) approximately 1,728 hours per year to submit supplemental diagnoses to HHS. For 2,400 issuers, we estimate an aggregate burden of 4,147,200 hours and $364,912,128 associated with this option.

As described in §153.720(a), an issuer of a risk adjustment covered plan or reinsurance-eligible plan in a State in which HHS operates risk adjustment or reinsurance, as applicable, must establish a unique masked enrollee identification number for each enrollee, in accordance with HHS-

defined requirements, and maintain the same masked enrollee identification number for an enrollee across enrollments or plans within the issuer, within the State, during a benefit year.
Under §153.720(b), an issuer of a risk adjustment covered plan or reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, may not include an enrollee's personally identifiable information in the masked enrollee identification number or use the same masked enrollee identification number for different enrollees enrolled with the issuer. As discussed in OMB Memorandum M-07-16, the term "personally identifiable information" is a broadly used term across Federal agencies, and has been defined in the Office of Management and Budget Memorandum M-07-16 (May 22, 2007).[1]

We estimate that 2,400 issuers will be affected by the requirement to maintain a masked enrollee identification number for each enrollee. The cost of setting up a masked identity for each enrollee would be the time and effort required to assign an identification number to each enrollee and remove other identifying factors from the enrollee's profile or claims information as submitted to HHS. We estimate it would cost each issuer approximately $263.97 per year, based on three hours of work by a technical analyst at $87.99 per hour. Therefore, we estimate an aggregate cost of $633,528 for all issuers to maintain a masked enrollee identification number.

We propose in §153.710(d) that within 30 calendar days of the date of an interim dedicated distributed data environment report from HHS, an issuer of a reinsurance-eligible or risk adjustment covered plan must either confirm to HHS that the information in the interim reports for the risk adjustment and reinsurance programs accurately reflect the data to which the issuer has provided access to HHS through its dedicated distributed data environment in accordance with §153.700(a) for the timeframe specified in the report, or describe to HHS any inaccuracy it identifies in the interim report. Similar to the interim report process, we propose in §153.710(e) that the issuer either confirm to HHS that the information in the final dedicated distributed data environment report accurately reflects the data to which the issuer has provided access to HHS through its dedicated distributed data environment in accordance with §153.700(a) for the benefit year specified in the report, or describe to HHS any inaccuracy it identifies in the final dedicated distributed data environment report within 15 calendar days of the date of the report.

We estimate that 2,400 issuers of risk adjustment covered plans and reinsurance-eligible plans will be subject to this requirement, and that issuers will compare enrollee condition codes with risk scores and analyze claims costs to confirm information in the interim and final dedicated distributed data environment reports. On average, we estimate that it will take an insurance operations analyst (at an hourly wage rate of $57.02) approximately 2 hours to respond to an interim report and 6 hours to respond to the final dedicated distributed data environment report.
Therefore, we estimate an aggregate burden of 19,200 hours and $1,094,784 or 2,400 issuers as a result of this requirement.

Data Validation Requirements when HHS Operates Risk Adjustment (§153.630)

As described in §153.630, we will require health insurance issuers to comply with data validation activities as specified by HHS or States. The burden associated with this requirement is the issuer's time and effort to provide HHS with source claims, records, and enrollment information to

[1] Available at: http://www.whitehouse.gov/sites/default/files/omb/memoranda/fy2007/m07-16.pdf.

validate enrollee demographic information for initial and second validation audits, and the issuer's cost to employ an independent auditor to perform the initial validation audit on a statistically valid sample of enrollees. We estimate that each issuer sample will consist of approximately 300 enrollees, with approximately two-thirds of the sample consisting of enrollees with HCCs. We also anticipate that this audit burden will affect about 2,400 issuers. Based on Truven Health Analytics 2010 MarketScan® data, we have determined that for enrollees with HCCs, the average number of HCCs to be reviewed by an auditor per enrollee is approximately two. Additionally, based on HHS audit experience, we estimate that it may cost approximately $266.66 ($133.33 per hour for 2 hours) for an auditor to review the medical record documentation for one enrollee with roughly two HCCs. We expect that it may cost approximately $44.44 per enrollee ($133.33 per hour for 20 minutes) to validate demographic information for all enrollees in the audit sample, totaling approximately $311.10 per enrollee with HCCs and $44.44 per enrollee with no HCCs. We assume that an initial validation audit will be performed on 180,000 enrollees without HCCs, and 360,000 enrollees with HCCs. For 2,400 issuers, we anticipate that the total burden of conducting initial validation audits will be approximately $120 million.

In §153.630(b)(1), we propose that an issuer of a risk adjustment covered plan must engage one or more independent auditors to perform an initial validation audit of a sample of its risk adjustment data selected by HHS. This provision also proposes that the issuer provide HHS with the identity of the initial validation auditor, and attest to the absence of conflicts of interest between the initial validation auditor (or the members of its audit team, owners, directors, officers, or employees) and the issuer (or its owners, directors, officers, or employees), in a timeframe and manner to be specified by HHS. The additional burden associated with this proposed reporting requirement is the time and effort necessary to report the auditor's identity to HHS. We estimate it will take an insurance operations analyst (at an hourly wage rate of $57.02) and a senior manager (at an hourly wage rate of $114.07) each approximately 15 minutes to prepare and send an electronic report to HHS. Therefore, for 2,400 risk adjustment covered issuers, the aggregate burden associated with this requirement is 1,200 hours, at an approximate cost of $102,672.

In §153.630(b)(8), we propose that the initial validation auditor measure and report to the issuer and HHS, in a manner and timeframe specified by HHS, its inter-rater reliability rates among its reviewers. Also in this provision, we propose that the initial validation auditor to achieve a minimum consistency measure of 95 percent for demographic, enrollment, and health status review outcomes. We believe establishing inter-rater reliability among reviewers is standard practice in the industry and will not result in extra cost for the initial validation auditor. Therefore, the burden associated with this reporting requirement is the time and effort for the initial validation auditor to report the inter-rater reliability rate to the issuer and to HHS. We estimate it will take an insurance operations analyst (at an hourly wage rate $57.02) and a senior manager (at an hourly wage rate of $114.07) each approximately 15 minutes to report the inter-rater reliability rate to the issuer and to HHS. Therefore, for 2,400 issuers risk adjustment covered issuers, the aggregate burden associated with this requirement is 1,200 hours, at an approximate cost of $102,672.

Table 1 - Burden Estimates for Risk Adjustment Data Collection and Data Validation

Forms (if necessary)	Type of Respondent	Frequency and Duration	Number of Respondents	Number of Responses per Respondent	Average Burden Hours per Response	Total Burden Hours
Risk adjustment and reinsurance distributed data collection	Issuer	Annually, Permanent	2,400	1	5,760	13,824,000
Supplemental Diagnoses	Issuer	Annually, Permanent	2,400	1,500,000	0.001	4,147,200
Masked enrollee information	Issuer	Annually, Permanent	2,400	1	3	7,200
Risk adjustment data validation	Issuer	Annually, Permanent	2,400	300	1.78	1,281,600
Initial Validation Audit Identification and Inter-rater Reliability Report	Issuer	Annually, Permanent	2,400	2	0.50	2,400
Confirmation of Interim Reports	Issuer	Annually, Permanent	2,400	1	8	19,200
Total			**2,400**			**19,281,600**

Table 2 - Burden Estimates for Risk Adjustment Data Collection and Data Validation by Labor Category

Type of Respondent	Hourly Labor Cost of Reporting ($)	Total Burden Hours	Average Labor Cost per Response	Number of Respondents	Total Labor Costs (All Respondents)
Insurance Operations Analyst	$57.02	1,200	$28.51	2,400	$68,424
Technical Analyst	$87.99	16,154,400	$263.97	7,200	$1,583,820,000
Senior Manager	$114.07	1,200	$57.04	2,400	$136,884
Auditor	$133.33	1,281,600	$236	2,400	$170,875,728
Total		**13,291,200**		**2,400**	**$1,754,901,036**

Administrative Burden Related to Audits of the Risk Adjustment Covered Issuers (§153.410(d); §153.620(c))

We propose that HHS or its designee would have the authority to audit issuers of risk adjustment covered plans or reinsurance-eligible plans to assess compliance with the requirements of subparts G and H of Part 153, as applicable. For issuers of risk adjustment covered plans and issuers of reinsurance-eligible plans, these provisions would result in a third party disclosure requirement for issuers to prepare and compile the financial and programmatic information necessary to comply with the audit. For each onsite review we estimate that it will take an average of 40 hours for administrative work to assemble the requested information, 19.5 hours to review the information for completeness, and 30 minutes to submit the information to HHS in preparation for an onsite review. We estimate that an onsite review would require an additional 2 hours to schedule the onsite activities with the compliance reviewer (at an hourly wage rate of $57.02, 4 hours for introductory meeting, 8 hours to tour reviewers onsite, 10 hours of interview time, 2 hours to walk through processes with the reviewer, and 4 hours for concluding meetings, resulting in a total of approximately 60 hours of preparation time and an additional 30 hours for onsite time for each issuer. We estimate it will take 90 hours at a cost of approximately $5,131 for each issuer to make information available to HHS for an onsite review. Although it is difficult to accurately estimate an audit rate because we have not finalized out audit protocols, we believe that it would be reasonable to assume that approximately 120 issuers, representing roughly 5 percent of issuers of risk adjustment covered plans or reinsurance-eligible plans would be audited. Therefore, we estimate an aggregate burden of 10,800 hours and $615,816 for issuers as a result of this requirement.

IV. Administrative Appeals for Premium Stabilization Programs, Federal Exchange User Fees, Premium Tax Credits, and Cost-sharing Reductions (§156.1220)

In §156.1220, we propose an administrative appeals process to address unresolved discrepancies for advance payment of the premium tax credit, advance payment and reconciliation of cost-sharing reductions, FFE user fees, and the premium stabilization programs, as well as any assessment under §153.740(b) of a default risk adjustment charge. In §156.1220(a), we propose that an issuer may file a request for reconsideration to contest an incorrect loading or use of data, an incorrect application of the relevant methodology, or a mathematical error for the amount of: (1) advance payment of the premium tax credit, advance payment of cost-sharing reductions or Federally-facilitated user fees charge for a particular month; (2) risk adjustment payments or charges for a benefit year, including an assessment of risk adjustment user fees; (3) reinsurance payments for a benefit year; (4) a risk adjustment default charge for a benefit year; (5) a reconciliation payment or charge for cost-sharing reductions for a benefit year; or (6) risk corridors payments or charges for a benefit year. While the hours involved in a request for reconsideration may vary, for the purpose of this burden estimate we estimate that it will take an insurance operations analyst 1 hour (at an hourly wage rate of $57.02) to make the comparison and submit a

request for reconsideration to HHS. We estimate that 24 issuers, representing approximately 1

percent of all issuers that may be eligible for reinsurance payments, risk adjustment payments or charges (including any assessment of risk adjustment user fees or a default risk adjustment charge), advance payment and reconciliation of cost-sharing reductions, advance payment of the premium tax credit, and FFE user fees, will submit a request for reconsideration for a total aggregate burden of approximately $1,368

We note that, in some circumstances, reinsurance contributing entities may receive two invoices, and would be required to remit payments associated with each invoice received. However, we do not believe that responding to these invoices will impose an additional burden on contributing entities, because this process is already accounted for as part of their standard business practices. Additionally, in §156.1220(b), we propose that an issuer dissatisfied with the reconsideration decision regarding: (1) risk adjustment payments and charges, including an assessment of risk adjustment user fees, (2) reinsurance payments, (3) default risk adjustment charge, (4) reconciled cost-sharing reduction amounts, (5) risk corridors payments or charges, provided under paragraph (a) of §156.1220, is entitled to an informal hearing before a CMS hearing officer, if a request is made in writing within 15 calendar days of the date the issuer receives the reconsideration decision. Further review is available from the CMS Administrator. However, because we believe these processes will occur extremely infrequently, we are not estimating the burden related to this requirement.

13. Capital Costs

Regardless of the data format and specifications for the reinsurance and risk adjustment programs, issuers will need to extract and, for purposes of audit, store the necessary data elements separately from data used during the normal course of business. We anticipate that approximately 400 data processing servers will be established across the market in 2014 to process the required data elements at an average one-time cost of $15,000 each. Therefore, we estimate a total capital burden of $6,000,000 for all issuers subject to this requirement. This estimate does not include the labor costs associated with data and server maintenance, which are estimated separately.

14. Cost to Federal Government

The initial burden to the Federal Government for the establishment of the risk-related programs is $274,936. The calculations for CCIIO employees' hourly salary was obtained from the OPM website: http://www.opm.gov/oca/10tables/html/dcb_h.asp.

Table 3 – Administrative Burden Costs for the Federal Government Associated with the Reinsurance, Risk Adjustment, and Risk Corridors Programs

Task	Estimated Cost
Development of HHS notice of benefit and payment parameters	
15 GS-13: 15 x $85.32 x 160 hours	$204,768
Technical Assistance to States	
15 GS-13: 15 x $85.32 x 240 hours	$307,152
Managerial Review and Oversight	
2 GS-15: 2 x $118.60 x 160 hours	$37,952
Cost of Contracts for HHS-operated Reinsurance and Risk Adjustment	$27,300,000
Total Costs to Government	**$27,849,872**

15. Explanation for Program Changes or Adjustments

There are no changes or adjustments in burden hours. However, this extension includes updated wage rates to reflect a 100 fringe benefit estimate for all employees. The previous estimate was based on a 35% fringe benefit. We expect to revise burden and cost downward significantly in a future request to renew this data collection.

16. Publication/Tabulation Dates

The data collection will not be published for this extension.

17. Expiration Date

The expiration date and OMB control will be displayed on each instrument (first page, top right corner).

OMB Control Number 0938-1155
Expiration Date: XX/2021

Appendix A

Data Elements for Risk Adjustment and Reinsurance		
Data Category	Data Elements	Submitting Entity
Geographic Data	• Metal level • Actuarial value • Benefit year • Individual versus small-group	State
Market Level Data	• State average actuarial risk (HHS-sourced) • State Rating Curve	State
Enrollee level data	Includes header, issuer, and enrollee data elements: • File ID • Execution Zone • Run Date • Report Type • Total Number of Enrollee Records • Total Number of Enrollment Periods • Record ID • Issuer ID • De-Identified (Masked) Enrollee ID • Enrollee DOB • Enrollee Gender • Enrollment Period Activity • Subscriber Indicator • Subscriber ID • Plan ID • Enrollment start date • Enrollment end date • Premium Amount • Geographic Rating area • Interface Control Release Number	Issuers

Data Category	Data Elements	Submitting Entity
Pharmacy Claims	Includes header, issuer, plan and claim data elements: • File ID • Execution Zone • Run Date • Report Type • Total Claims • Total Plan Paid Amount • Issuer ID • Record ID • Plan ID • De-Identified (Masked) Enrollee ID • Claim ID • Claim Processed Date/Time • Fill Date • Paid Date • Prescription/Service Reference Number • Product/Service ID • Dispensing Provider Service ID Qualifier • Dispensing Provider Service ID • Fill Number • Dispensing Status • Void/Replace Indicator • Total Allowed Cost • Derived Amount Indicator • Interface Control Release Number • Plan Paid Amount	

Data Category	Data Elements	Submitting Entity
Medical Claims	Includes header, issuer, plan and claim header and claim line data elements: • File ID • Execution Zone • Run Date • Report Type • Total Claims • Total Claim Lines • Total Plan Paid Amount • Record ID • Issuer ID • Plan ID • De-Identified (Masked) Enrollee ID • Interface Control Release Number **Claim Header Level Data Elements** • Form Type • Claim ID • Original Claim ID • Claim Processed Date/Time • Bill type • Date Paid • Void/Replace Indicator • Discharge Status Code • Statement Covers From • Statement Covers Through • Billing Provider ID Qualifier • Billing Provider ID • Total Amount Allowed • Total Amount Paid • Derived Amount Indicator • Diagnosis Code Qualifier • Diagnosis Code	

Data Category	Data Elements	Submitting Entity
Medical Claims (continued)	**Claim Line Level Data Elements** • Record ID • Claim Line Sequence Number • Date of Service - From • Date of Service - To • Revenue Code • Service Code Qualifier • Service Code • Service Code Modifier • Place of Service • Rendering Provider ID Qualifier • Rendering Provider ID • Amount Allowed • Amount Paid • Derived Amount Indicator	

OMB Control Number 0938-1155
Expiration Date: XX/2021

Appendix B

Supplemental Diagnoses for HHS Operated Risk Adjustment	
Data Elements	Submitting Entity
Includes header, issuer, plan and claim header and claim line data elements: • File ID • Execution Zone • Run Date • Report Type • Total Claims • Total Claim Lines • Total Plan Paid Amount • Record ID • Issuer ID • Plan ID • De-Identified (Masked) Enrollee ID • Interface Control Release Number **Claim Header Level Data Elements** • Form Type • Claim ID • Original Claim ID • Claim Processed Date/Time • Bill type • Date Paid • Void/Replace Indicator • Discharge Status Code • Statement Covers From • Statement Covers Through • Billing Provider ID Qualifier • Billing Provider ID • Total Amount Allowed • Total Amount Paid • Derived Amount Indicator • Diagnosis Code Qualifier • Diagnosis Code	Issuer

OMB Control Number 0938-1155
Expiration Date: XX/2021

Appendix C

Data Elements for Reinsurance Contributions Reporting

The transitional reinsurance program requires that health insurance issuers, self-insured group health plans (including a group health plan that is partially self-insured and partially insured) or third party administrators on behalf of them submit to HHS an annual enrollment count no later than November 15 of calendar year 2014, 2015 and 2016 respectively. The annual enrollment count submission will be used to calculate the applicable benefit year's annual reinsurance contribution.

All health insurance issuers, group health plans, and third party administrators are required to register in a Federal system in order to access the module or form for the reinsurance contributions process. The "Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations" (OMB Control No. 0938-1187) details data submission required when an entity is remitting payment for an invoice or receiving a payment from HHS. This PRA details the data elements that will be requested through the reinsurance contribution module or form.

General

1. HIOS ID
2. Benefit Year applicable to the reported Gross Annual Enrollment Count (2014, 2015, 2016)
3. Are you a contributing entity?
   a. Yes. If yes and using Third Party Administrator (TPA) or parent company to complete the reinsurance contributions process, please provide the TPA's or parent company's HIOS ID.
   b. No (Excepted). If no, please select:
      - Not major medical
      - Self-insured, self-administered
      - Other. If other, please explain.

Entity Information *(to be completed by contributing entity or Third Party Administrator/Parent Company on behalf of issuer or group health plan*)

1. HIOS ID (**submitter** of enrollment information)
2. Legal Business Name (**submitter** of enrollment information)
3. Federal TIN (**submitter** of enrollment information)
4. Address (**submitter** of enrollment information)
   a. Address Line 1, Address Line 2, City, State, Zip Code+4, State
5. Contact 1, Contact 2, Contact 3 (**submitter** of enrollment information)

a. First Name, Last Name, Title, E-mail, Phone Number, Phone Number Extension

6. Authorizing Official for Acknowledgment (**submitter** of enrollment information)
   a. First Name, Last Name, Title, E-mail, Phone Number, Phone Number Extension
7. Is submitting entity a Third Party Administrator or Parent Company on behalf of issuer(s) or group health plan(s) pursuant to the definition of "contributing entity" at 45 CFR 153.20?
8. Gross Annual Enrollment Count
9. Provide for the following for each contributing entity represented in the 'Gross Annual Enrollment Count' (repeat many times, select one for each entity):
   a. Select Type of Entity :
      - Health insurance issuer (§153.405(d));
      - Self-insured group health plan (including a group health plan with a self-insured coverage option and fully insured coverage option) (§153.405(e));
      - Group health plans with a self-insured coverage option and an insured coverage option (§153.405(f))
        o NOTE: Pursuant to §153.405(f)(2), a plan with multiple coverage options may use any of the counting methods specified for health insurance issuers or self-insured group health plans, as applicable to each coverage option, if it determines the number of covered lives under each coverage option separately as if each coverage option provided major medical coverage
      - Multiple group health plans maintained by the same plan sponsor, that collectively provide major medical coverage for the same covered lives simultaneously, which are treated as a single group health plan including an insured plan (§153.405(g)(4)(i)); or
      - Multiple group health plans maintained by the same plan sponsor, that collectively provide major medical coverage for the same covered lives simultaneously, which are treated as a single group health plan NOT including an insured plan (§153.405(g)(4)(ii)).
        o NOTE: Pursuant to §153.405(g)(1), if there are multiple group health plans maintained by the same plan sponsor, the plan sponsor may treat the multiple plans as separate group health plans if the plan sponsor determines the number of covered lives under each separate group health plan as if the separate group health plan provided major medical coverage (i.e. is its own plan for which reinsurance contributions are required).
   b. Entity HIOS ID
   c. Entity Legal Business Name
   d. Entity Federal Tax Identification Number
   e. Entity Address

- Address Line 1, Address Line 2, City, State, Zip Code+4, State

f. For each entity being reported, please complete the applicable section below based on the 'Entity Type' selected above.

Health Insurance Issuer

1. Annual enrollment count
   a. Total Count
      - Net to exclude any excepted coverage types/plans/enrollees *(count to be used for assessing reinsurance contributions due for the reporting benefit year)*
      - Number of policy holders represented in the net enrollment count
      - Number of employer groups represented in the net enrollment count
   b. Count for each Group Health Plan:
      - Not Applicable (select when issuer does not provide plans/coverage in the group health market)
      - Yes, issuer provides coverage in the individual market. If yes, complete the following for each Group Health Plan:
        - Name of Plan
        - Gross enrollment count to include all coverage types
        - Net enrollment count to exclude any excepted coverage types/plans/enrollees
        - Provide information for the excepted coverage types/plans/enrollees
   c. Count for Individual Market:
      - Not Applicable (select when issuer does not provide plans/coverage in the individual market)
      - Yes, issuer provides coverage in the individual market. If yes, complete the following:
        - Gross enrollment count to include all coverage types
        - Net enrollment count to exclude any excepted coverage types/plans/enrollees
        - Provide information for the excepted coverage types/plans/enrollees
2. Select method used for calculation of enrollment count
   a. Actual Count
      - Dates used to add up total of covered lives
   b. Snapshot Count
      - Specific date or date(s) were used for each quarter
      - Number of enrollees on the specific date or date(s) that were used for each quarter
   c. Member Months or State Form
      - Date of the NAIC Supplemental Health Care Exhibit or from the most recent form filed with the issuer's State of domicile
      - Upload form

Self-Insured Group Health Plan

1. Annual enrollment count
   a. Total Count
      - Net enrollment count to exclude any excepted coverage types/plans/enrollees *(count to be used for assessing reinsurance contributions due for the reporting benefit year)*
   b. Count by Coverage Type:
      - Not Applicable (select when self-insured group health plan provides all coverage through major medical plan)
      - Coverage Type
        - Gross enrollment count to include all coverage types
        - Net enrollment count to exclude any excepted coverage types/plans/enrollees
        - Provide information for the excepted coverage types/plans/enrollees
2. Select method used for calculation of enrollment count
   a. Actual Count
      - Dates used to add up total of covered lives
   b. Snapshot Count
      - Specific date or date(s) were used for each quarter
      - Number of enrollees on the specific date or date(s) that were used for each quarter
   c. Snapshot Factor
      - Specific date or date(s) were used for each quarter
      - Number of enrollees on the specific date or date(s) that were used for each quarter
   d. Form 5500 Schedule A
      - Date of the Form 5500 Schedule A
      - Number of total participants covered at the beginning and end of the benefit year as reported on the Form 5500 Schedule A
      - Upload form

Group Health Plan with a Self-insured Coverage Option and Fully Insured Coverage Option

[45 CFR 153.405(f)(1)]

1. Are you combining coverage options for reporting of annual enrollment count under 45 CFR 153.405(f)(1)?
   a. Yes. If Yes, complete the below as applicable.
   b. No. If No [45 CFR 153.405(f)(2)], treat each plan as providing major medical coverage with contributing entity completing the 'Health Insurance Issuer' and 'Self-insured Group Health Plan' section as applicable.
2. Annual enrollment count
   a. Total Count
      - Gross enrollment count to include all coverage types/plans

3. Net enrollment count to exclude any excepted coverage types/plans *(count to be used for*

*assessing reinsurance contributions due for the reporting benefit year)*Select method used for calculation of annual enrollment count

a. Actual Count
- Dates used to add up total of covered lives

b. Snapshot Count
- Specific date or date(s) were used for each quarter
- Number of enrollees on the specific date or date(s) that were used for each quarter

4. If combining, provide for all plans and/or options (insured and self-insured) for purposes of calculating the annual enrollment count (repeated for each option):

a. Name of issuer or self-insured group health plan

b. HIOS ID (situational)

c. Gross enrollment count for option

d. Net enrollment count for option

e. Provide information for enrollment under excepted coverage option

Multiple Group Health Plans Maintained by the Same Plan Sponsor *[45 CFR 153.405(g)] (One or more group health plans under the same plan sponsor)*

1. Are you aggregating multiple group health plans under 45 CFR 153.405(g)?

a. Yes. If Yes, which entity type are you for purposes of reporting?
- Self-insured. If selected, complete the below as applicable.
- Fully-insured. If selected, complete the below as applicable.
- Mixed. If selected, complete the below as applicable.

b. No. If No, treat each plan as providing major medical coverage with contributing entity completing the 'Health Insurance Issuer' and 'Self-insured Group Health Plan' section as applicable.

2. Annual enrollment count

a. Total Count
- Gross enrollment count to include all coverage types/plans
- Net enrollment count to exclude any excepted coverage types/plans *(count to be used for assessing reinsurance contributions due for the reporting benefit year)*

3. Select method used for calculation of enrollment count

a. Actual Count
- Dates used to add up total of covered lives

b. Snapshot Count
- Specific date or date(s) were used for each quarter
- Number of enrollees on the specific date or date(s) that were used for each quarter

c. Snapshot Factor
- Specific date or date(s) were used for each quarter

- Number of enrollees on the specific date or date(s) that were used for each quarter

d. Form 5500
- Date of the Form 5500
- Number of total participants covered at the beginning and end of the benefit year as reported on the Form 5500
- Upload form

e. Member Months or State Form
- Date of the NAIC Supplemental Health Care Exhibit or from the most recent form filed with the issuer's State of domicile
- Upload form

4. If aggregating, provide for the plans being treated as a single group health plan for purposes of calculating the annual enrollment count (repeated for each plan):
   a. Name of group health plan
   b. HIOS ID (situational)
   c. Gross enrollment count for group health plan
   d. Net enrollment count for group health plan
   e. Provide information for enrollment under excepted coverage

Attestation

The following attestation must be signed by a certifying official of the contributing entity that has the authority to submit the enrollment count and related data:

I attest that the data provided for the Reinsurance Contributions Process for the current reporting year is accurate to the best of my knowledge.

<signature of certifying official>

Acknowledgement

1. Yes or No. The gross annual enrollment count entered in this form matches the aggregate enrollment count by entity in the supporting documentation.

2. Yes or No. I acknowledge that the data provided in this form is accurate to the best of my knowledge and that I have the authority to submit such data on behalf of the contributing entity which I represent. I acknowledge that the provisions of the Affordable Care Act specifically make payments made by or in connection with an Exchange subject to the False Claims Act if those payments include any Federal funds. This includes, but is not limited to, the transitional reinsurance program established under Section 1341 of the Affordable Care Act.