Supporting Statement for Marketplace Operations
(CMS-10637/OMB Control Number: 0938-NEW)

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, "Affordable Care Act"), expand access to health insurance for individuals and employees of small businesses through the establishment of new Affordable Insurance Exchanges (Exchanges), also called Marketplaces, including the Small Business Health Options Program (SHOP). The Exchanges, which became operational on January 1, 2014, enhance competition in the health insurance market, expand access to affordable health insurance for millions of Americans, and provide consumers with a place to easily compare and shop for health insurance coverage.

On June 19, 2013, HHS published the proposed rule CMS-9957-P: *Program Integrity: Exchanges, SHOP, Premium Stabilization Programs, and Market Standards* (78 FR 37302) (Program Integrity Proposed Rule). Among other things, the Program Integrity Proposed Rule sets forth financial integrity provisions and protections against fraud and abuse. On January 30, 2013, CMS published *Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges under the Affordable Care Act* (CMS-2334-P) (E&E II Proposed Rule). On August 30, 2013, HHS published the final rule CMS-9957-F*: Program Integrity: Exchanges, SHOP, Eligibility Appeals* (Program Integrity final rule), finalizing a number of the provisions from the Program Integrity and E&E II Proposed Rules. The third party disclosure requirements and data collections in the Program Integrity final rule support the oversight of qualified health plan (QHP) issuers in Federally-facilitated Exchanges (FFEs) and other provisions. This Information Collection Request (ICR) serves as the formal request for a new data collection clearance. The original approved ICR affiliated with this final rule (OMB #: 0938-1213) was titled *Program Integrity and Additional State Information Collections* and approved on 11/21/2013. This ICR also includes some of the information collection requirements from the previously approved final rule. The other ICRs from the final rule that are not included in this request will be submitted for OMB approval under separate collections.

B. Justification

1. Need and Legal Basis

Section 1321(c)(1) of the Affordable Care Act requires the Secretary to establish and operate an FFE within States that either: do not elect to operate an Exchange; or, as determined by the Secretary, will not have any required Exchange operational by January 1, 2014.

Section 1321(c)(2) of the Affordable Care Act authorizes the Secretary to enforce the Exchange standards using civil money penalties (CMPs) on the same basis as detailed in

section 2723(b) of the Public Health Service Act (PHS Act).[1] Section 2723(b) of the PHS Act authorizes the Secretary to impose CMPs as a means of enforcing the individual and group market reforms contained in Title XXVII, Part A of the PHS Act when a State fails to substantially enforce these provisions.

Section 1313 of the Affordable Care Act, combined with section 1321 of the Affordable Care Act, provides the Secretary with the authority to oversee the financial integrity, compliance with HHS standards, and efficient and non-discriminatory administration of State Exchange activities. Section 1313(a)(6)(A) of the Affordable Care Act specifies that payments made by, through, or in connection with an Exchange are subject to the False Claims Act (31 U.S.C. 3729, et seq.) if those payments include any Federal funds.

Section 1401 of the Affordable Care Act amended the Internal Revenue Code (26 U.S.C.) to add § 36B, allowing a refundable premium tax credit to help individuals and families afford health insurance coverage. Under sections 1401, 1411, and 1412 of the Affordable Care Act and 45 CFR part 155, subpart D, an Exchange will make a determination of advance payments of the premium tax credit for individuals who enroll in QHP coverage through an Exchange and seek financial assistance. Section 1402 of the Affordable Care Act provides for the reduction of cost sharing for certain individuals enrolled in a QHP through an Exchange, and section 1412 of the Affordable Care Act provides for the advance payment of these reductions to issuers.

Section 1411 of the Affordable Care Act, directs the Secretary to establish a program for determining whether an individual meets the eligibility standards for Exchange participation, advance payments of the premium tax credit, cost-sharing reductions, and exemptions from the shared responsibility payment.

Sections 1412 and 1413 of the Affordable Care Act and section 1943 of the Social Security Act (the Act), as added by section 2201 of the Affordable Care Act, contain additional provisions regarding eligibility for advance payments of the premium tax credit and cost-sharing reductions, as well as provisions regarding simplification and coordination of eligibility determinations and enrollment with other health programs.

The Affordable Care Act directs issuers offering non-grandfathered health insurance coverage in the individual and small group markets to ensure that plans meet an actuarial value (AV) level of coverage specified in section 1302(a)(3) of the Affordable Care Act and as defined in 45 CFR 156.140(b). Consistent with section 1302(d)(2)(A) of the Affordable Care Act, AV is calculated based on the provision of the essential health benefits (EHB) to a standard population and is a measure of the percentage of expected health care costs a health plan will cover for a standard population.

2. Information Users

[1] Section 1321(c) of the Affordable Care Act erroneously cites to section 2736(b) of the PHS Act instead of 2723(b) of the PHS Act.

The data collections and third-party disclosure requirements will assist HHS in determining Exchange compliance with Federal standards and monitoring QHP issuers in FFEs for compliance with Federal QHP issuer standards. The data collection will assist HHS in monitoring Web-brokers for compliance with Federal Web-broker standards. The data collected by health insurance issuers and Exchanges will help to inform HHS, Exchanges, and health insurance issuers as to the participation of individuals, employers, and employees in the individual Exchange, the SHOP, and the premium stabilization programs.

3. Use of Information Technology

HHS anticipates that a majority of the systems, notices, and information collection required will be automated. A majority of the information that is required by the collection of information will be submitted electronically. HHS staff will analyze or review the data in the same manner by which it was submitted and communicate with States, health insurance issuers, and other entities using e-mail, telephone, or other electronic means.

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 business.

6. Less Frequent Collection

Due to the required flow of information between multiple parties and flow of funds for payments for health insurance coverage within the Exchange, it is necessary to collect information according to the indicated frequencies. If the information is collected less frequently, the result would be less accurate, untimely or unavailable eligibility, enrollment or payment information for Exchanges, insurers, employers and individuals. This would lead to delayed payments to insurers; late charges to or payments by employers and enrollees; inaccurate or inappropriate payments of advance premium tax credits and cost sharing reductions; the release of misleading information regarding health care coverage to potential enrollees; and an overall stress on the organizational structure of the Exchanges. If the information is not collected in the timeframe, HHS will not be able to properly ensure the financial integrity of Federal funds.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

The 60-day Federal Register Notice was published on December 22, 2017 (82 FR 60745). No comments were received. A 30-day notice will publish in the Federal Register on XX/XX/18 for the public to submit written comment on the information collection requirements.

No additional outside consultation was sought.

9. Payments/Gifts to Respondents

No payments and/or gifts will be provided to respondents.

10. Confidentiality

To the extent of the applicable law and HHS policies, we will maintain respondent privacy with respect to the information collected. Nothing in the information collection should be interpreted as preventing a State from being allowed to disclose its own data.

11. Sensitive Questions

There are no sensitive questions included in this information collection effort.

12. Burden Estimates (Hours & Wages)

The following sections of this document contain estimates of burden imposed by the associated information collection requirements; however, not all of these estimates are subject to the data collection requirements under the PRA for the reasons noted. Salaries for the positions cited were mainly taken from the Bureau of Labor Statistics (BLS) web site (http://www.bls.gov/ooh/).

The salaries for the health policy analyst and the senior manager were taken from the Office of Personnel Management web site. Fringe Benefits estimates were taken from the BLS December 2015 Employer Costs for Employee Compensation Report.[2]

State Specific Standard Population (45 CFR 156.135)

This information collection is not directly tied to the provisions in the Program Integrity final rule. In 45 CFR 156.135(d), HHS established that beginning in 2015, a State may submit a State-specific standard population, to be used for AV calculations, so long as the criteria described in § 156.135(d)(1) through (6) are met. A State that applies must submit to HHS summary evidence that the requirements described in §156.135 are met and the dataset is in a format that will support the use of the AV calculator. We expect that for each State choosing this option, the data submission will require 15 hours from a database administrator at $78.58 an hour, 4 hours of actuarial work at $93.34 an hour, and 1 hour of management review at $118.44 an hour. Therefore, the total burden hours and cost associated with the reporting

[2] BLS December 2015 Employer Costs for Employee Compensation Report (March 10, 2016). Available at: http://www.bls.gov/news.release/pdf/ecec.pdf.

requirement for each State choosing this option will be 20 hours at a cost of $1,670.50. It is impossible to determine how many States will elect this option; therefore, we have estimated that 51 States elect it. The total burden across all 51 respondents is estimated to be 1,020 hours at an annual cost of $86,241.00.

Table A

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly rate + 100% Fringe benefits)	Burden Hours	Total Burden Costs (per Respondent)	Total Burden Cost (All Respondents)
Database Administrator	1	$78.58[3]	15	$1,178.70	
Actuary	1	$93.34[4]	4	$373.36	
Senior Manager	1	$118.44	1	$118.44	
Total			20	$1,670.50	$85,195.50

Enforcement Remedies in Federally-facilitated Exchanges (§156.800 to §156.810)

Subpart I of Part 156 discusses the enforcement remedies in the FFEs. Section 156.800 authorizes HHS to impose sanctions on QHP issuers in an FFE that are not in compliance with Federal standards. These sanctions may be in the form of a civil money penalty (CMP), as set forth in §156.805; or decertification of QHPs, as set forth in §156.810. The burden estimates for the collections of information in this Part reflect our assumption that there will be 739 QHP issuers and 8,891 QHPs in all FFEs.

Section 156.805(a) states the general process and bases for imposing a CMP on issuers offering QHPs in an FFE. CMPs will be imposed only for serious issues of non-compliance. We expect to provide technical assistance to issuers, as appropriate, to assist them in maintaining compliance with the applicable standards. We also plan to coordinate with States in our oversight and enforcement activities to avoid inappropriately duplicative enforcement efforts. Consequently, we anticipate that CMPs will occur infrequently. For purposes of calculating the estimated burden, we include the burden associated with the CMP in the burden estimate of the appeal of the CMP. We seek comment on these assumptions.

Section 156.810 sets forth the bases for the decertification of a QHP in an FFE and the general process for decertification. As with CMPs, HHS expects that decertification will be relatively infrequent, and reserved for only serious instances of non-compliance with applicable

[3] Bureau of Labor Statistics. Database Administrators. http://www.bls.gov/ooh/computer-and-information-technology/database-administrators.htm.
[4] Bureau of Labor Statistics. Actuaries. http://www.bls.gov/ooh/math/actuaries.htm.

standards. For purposes of this estimated burden, we include the burden associated with the decertification with the burden estimate of the appeal of the decertification action. We solicit comments on these assumptions.

Consumer Cases Related to Qualified Health Plans and Qualified Health Plan Issuers (§156.1010)

In subpart K of part 156, we describe the information collection requirements that pertain to the resolution of consumer cases related to QHPs and QHP issuers. Section 156.1010(g)(1) states that QHP issuers must include the date of case resolution, §156.1010(g)(2) states that QHP issuers must record a clear and concise narrative documenting the resolution of a consumer case in the HHS-developed casework tracking system, and §156.1010(g)(3) states that QHP issuers must provide information about compliance issues found by a State during the investigation of a case. The burden associated with this requirement would be the time and effort necessary for staff of a QHP issuer to gather the necessary information related to the consumer complaint, draft the narrative, and enter the narrative into the electronic HHS-developed case tracking system. For the purpose of estimating burden, we estimate 475 issuers. We estimate that, on average, each issuer will utilize 6 insurance caseworkers that will undertake this work for approximately 800 total burden hours annually at a cost of $291,072. This is a total of 2,280,000 burden hours and an annual burden cost of $138,259,200 for all issuers.

Table B

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly rate + 100% Fringe benefits)	Burden Hours	Total Burden Costs (per Respondent)	Total Burden Costs (All Respondents)
Insurance Caseworker	6	$60.64[5]	800	$291,072	
Total			800	$ 291,072	$138,259,200

Enrollment Process for Qualified Individuals (§156.1230)

Under finalized §156.1230(a)(1)(ii), issuers must provide information on available QHPs when they choose to use their Web site to directly enroll qualified individuals into QHPs in a manner considered to be through the Exchange. The QHP information required to be posted on the Web site includes premium and cost-sharing information, the summary of benefits and coverage, levels of coverage for each QHP, results of the enrollee satisfaction survey, quality ratings, medical loss ratio information, transparency of coverage measures, and a provider directory. In finalized §156.1230(a)(1)(i), an issuer is also required to direct an individual to complete an application with the Exchange and receive eligibility determinations from the

[5] Bureau of Labor Statistics. Insurance Claims Adjusters. http://www.bls.gov/ooh/business-and-financial/mobile/claims-adjusters-appraisers-examiners-and-investigators.htm.

Exchange to allow for an accurate plan selection process. Additionally, §156.1230(a)(1)(iv) requires the issuer Web site to inform applicants about the availability of other QHP products available through an Exchange through an HHS-approved universal disclaimer and to display a Web link to the appropriate Exchange Web site. Issuers are also required to distinguish between QHPs for which a consumer is eligible and other non-QHPs that an issuer may offer as finalized in §156.1230(a)(1)(iii). Finally, an issuer needs to submit enrollment information back to the Exchange including the APTC amount and attestation from an individual as proposed in §156.1230(a)(1)(v).

The burden for this requirement would be for the issuer to develop its own template and code and integrate it with the Exchange. After this initial step, the burden on the issuer would be to maintain the Internet Web site by populating the Web site with information collected per information collection requirements in this rule and future rulemaking by HHS.

We estimate a number of 80 issuers in 2017 and 100 issuers in 2018 will choose to utilize the direct enrollment approach subject to these third-party disclosure requirements. We expect that is will take two health policy analysts 50 hours at $73.10 an hour, two web developers 75 hours at $62.46 an hour, a senior manager 35 hours at $118.44 an hour, four database administers 100 hours at $78.58 an hour, and two computer programmers 350 hours at $76.48 an hour to set up and maintain their QHP information on their website following the requirements set out in final §156.1230(a)(1) each year. Therefore, we estimate that it will require a total of 610 hours at a cost of $47,110.90 per issuer to meet these third-party disclosure requirements.

Table C

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly rate + 100% Fringe benefits	Burden Hours	Total Burden Costs (All Respondents)
Health Policy Analyst	2	$73.10	25	$3,655
Web Developer	2	$62.46[6]	37.5	$4,684.50
Senior Manager	1	$118.44	35	$4,145.40
Network Administrator/ Database Administrator	4	$78.58	25	$7,858
Computer Programmer	2	$76.48	175	$26,768
Total	11		610	$47,110.90

[6] Bureau of Labor Statistics. Web Developers. http://www.bls.gov/ooh/computer-and-information-technology/web-developers.htm.

Finalized §156.1230(a)(2) would allow qualified individuals to apply for an eligibility determination or redetermination for coverage through the Exchange and insurance affordability programs with the assistance of an issuer application assister. In order for an issuer application assister to perform those functions, they must receive the proper training.

The burden for this requirement would include the time and effort necessary to develop training materials for the issuer application assister if the Exchange implements this provision.

The Exchange would be required to develop training materials for issuer staff. We assume that the 18 State Exchanges will implement this standard. However, we expect Exchanges would use training materials that will either be developed by HHS for other types of assister training, including agent/broker training or use their own training materials that they have already developed for other assisters. Therefore, we anticipate that the time and costs associated with developing a training program for issuers will be minimal. We estimate it will take a training specialist 10 hours at $55.98 an hour and a training and development manager 5 hours at $98.70 an hour to develop training materials for the application assisters, for a total burden of 15 hours. The estimated total burden cost for developing training materials for issuer customer service representatives for each Exchange is therefore $1,053.30 with a total annual total burden cost of $18,959.40 across all respondents if 18 State Exchanges undertake these activities. Since training may be updated on an annual basis, we expect the cost to remain consistent from year to year.

Table D

Labor Category	Number of Employees	Hourly Labor Costs (Hourly rate + 100% Fringe benefits	Burden Hours	Total Burden Costs (per Respondents)	Total Burden Costs (All Respondents)
Training Specialist	1	$55.98[7]	10	$559.80	$10,076.40
Training and Development Manager	1	$98.70[8]	5	$493.50	$8,883.00
Total	2		15	$1,053.30	$18,959.40

13. <u>Capital Costs</u>

[7] Bureau of Labor Statistics. Training and Development Specialists. http://www.bls.gov/ooh/business-and-financial/training-and-development-specialists.htm.

[8] Bureau of Labor Statistics. Training and Development Managers. http://www.bls.gov/ooh/management/training-and-development-managers.htm.

There are no anticipated capital costs associated with these information collections.

14. Cost to Federal Government

The initial burden to the Federal government for the establishing the systems and policies associated with this information collection is $283,311.00. The calculations for CCIIO employees' hourly salary was obtained from the OPM website: https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2016/DCB_h.pdf

Table 1 – Administrative Burden Costs for the Federal Government Associated with the Program Integrity and Additional State Collections

Task	Estimated Cost
Development of Program Integrity Information Collections	
15 GS-13: 15 x $44.15 x 200 hours	$132,450.00
Technical Assistance to States	
15 GS-13: 15 x $44.15 x 200 hours	$132,450.00
Managerial Review and Oversight	
2 GS-15: 2 x $61.37 x 150 hours	$18,411.00
Total Costs to Government	$283,311.00

15. Changes to Burden

There are no changes to the burden. This is a new data collection.

16. Publication/Tabulation Dates

The results of the collection will not be made public.

17. Expiration Date

XX/XX/2021

There are no instruments associated with this data collection.