# Supporting Statement for Continuation of Data Collection to Support QHP Certification and other Financial Management and Exchange Operations (CMS-10433/OMB control number: 0938-1187)

## A. Background

The Patient Protection and Affordable Care Act (PPACA) established new competitive private health insurance markets called Affordable Insurance Exchanges (Exchanges), or Marketplaces, which give millions of Americans and small businesses access to affordable, quality insurance options. By providing a place for one-stop shopping, Exchanges make purchasing health insurance easier and more transparent, and put greater control and more choice in the hands of individuals and small businesses. Additionally, the risk adjustment program provides market stabilization to lower costly premiums associated with individual and small business coverage.

As directed by the rule *Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers* (77 FR 18310) (Exchange rule), each Exchange is responsible for the certification and offering of Qualified Health Plans (QHPs). To offer insurance through an Exchange, a health insurance issuer must have its health plans certified as QHPs by the Exchange. A QHP must meet certain minimum certification standards, such as network adequacy, inclusion of Essential Community Providers (ECPs), and non-discrimination. The Exchange is responsible for ensuring that QHPs meet these minimum certification standards as described in the Exchange rule under 45 CFR 155 and 156, based on the PPACA, as well as other standards determined by the Exchange.

Issuers can offer individual and small group market plans outside of the Exchanges that are not QHPs. Such plans are referred to in this document as "non-Exchange." For the risk adjustment program, administrative information is used to identify all non-grandfathered small group and individual market non-Exchange plan offerings eligible for the program. Risk adjustment also requires select data such as rating area, rating factors, and actuarial value (AV) level, to perform calculation of payments and charges.

This information collection request serves as a formal request for the extension of the data collection clearance. We intend to use the instruments in this information collection for the 2020 certification process and beyond and believe that providing these instruments now will give issuers and other stakeholders more opportunity to familiarize themselves with the instruments before releasing the 2020 application. While we intend to use these instruments in 2020, we may propose further revisions to this data collection in the future as necessary which will include seeking comments through the full 60/30-day comment period.

## B. Justification

1. Need and Legal Basis

**QHP Information Collection: Certification and Standards**

An Exchange certifies, recertifies, and decertifies QHPs. The PPACA authorizes QHP certification as well as other operational standards for the Exchange in following sections: 1301- 1304, 1311-1312, 1321-1322, 1324, 1334, 1401-1402, 1411 and 1412. Standards for QHP issuers are codified at 45 CFR parts 155 and 156.

An Exchange needs to collect data from issuers as part of QHP certification and recertification, and to monitor compliance with QHP certification standards on an ongoing basis. QHP issuer and plan data also supports additional operational activities, including the calculation of each individual's advance payment of the premium tax credit (APTC), the display of plan information on the Exchange website, and managing the ongoing relationships between QHP issuers and the Exchange. Feedback about the QHP certification and recertification process is collected from issuers in an effort to improve the efficiency and effectiveness of data collection. Much of the information collected for QHP certification purposes supports these operational activities on an ongoing basis.

**Stand-Alone Dental Plan Information Collection**

Section 1311 of the Affordable Care Act and 45 CFR 155.1065 direct each Exchange to permit issuers to offer limited scope dental benefits as stand-alone dental plans or in conjunction with a QHP. All reasonably applicable QHP certification requirements apply to stand-alone dental plans offered in an Exchange, and dental issuers are required to complete the same application as all other QHPs. An Exchange needs to collect data from dental issuers in order to certify and recertify standalone dental plans, and to monitor ongoing compliance with applicable QHP certification standards. This data allows the Exchange to understand the difference between an estimated and actual rate or to calculate the portion of an individual's premium tax credit allocated to a stand-alone dental plan, and display plan and premium information for these plans.

**Necessary Data for QHP Certification**

The data collected for QHP certification, recertification, ongoing QHP oversight, financial management, and eligibility and enrollment functions (including HealthCare.gov) are reflected in the categories identified below and in the attached appendices. This data could also be used to support other Exchange business functions such as determinations of the second-lowest-cost-silver plan, payments for cost-sharing reductions (CSRs), APTCs, and the display of information on HealthCare.gov. The data collection requirements apply to stand-alone dental plans as applicable and discussed in template instructions that accompany the release of the final templates annually. CMS also seeks approval to collect issuers' logos; data to support and apply state-specific laws and requirements, such as premium payment method requirements, premium payment grace period nonAPTC requirements, dependent age limits, fraud definitions and termination data parameters, and state provisions that allow consumers to have a "free look" at coverage documents and cancel coverage within a specified time frame for a full refund of premium; and other information as needed to support QHP certification. CMS also collects information from Small Business Health Options Program (SHOP) QHP issuers on whether they will allow plan year rates to be established based on composite (or average) rates of employees and dependents at the time of initial application. CMS collects information from SHOP QHP and dental issuers on whether benefits are based on a plan year or calendar year.

CMS will collect the following data to support these functions. The QHP certification templates are provided in Appendices A-K.

**Issuer Application Data**

- **Issuer Administrative Data Elements:** Basic information required to identify issuers and the Exchange markets they intend to serve, and to facilitate communications with and payment to issuers. The data elements may include issuer contact information and banking information.

- **Network Adequacy/Essential Community Provider (NA/ECP) Data Elements:** Number of participating Essential Community Providers participating in an issuer's provider network or other documentation necessary to demonstrate that an issuer has an adequate range of ECPs for the intended service areas. CMS proposes capturing the number of practitioners with whom the issuer has contracted to identify more than one provider at a single facility.

- **Accreditation Data Elements:** If applicable, an issuer must provide information about whether it is accredited by a recognized accrediting entity, including URAC, the National Committee for Quality Assurance (NCQA), or the Accreditation Association for Ambulatory Health Care (AAAHC). An issuer must also authorize the release of accreditation survey data to an Exchange.

- **Network ID and Provider Directory URL Data Elements:** Network ID numbers identifying each provider network for purposes of plan-to-network mapping and specific URLs associated with the provider directory for each plan.

- **State Licensure Documentation:** Documentation necessary to demonstrate that an issuer is licensed and has authority to sell all applicable products in all states in which it intends to offer a QHP.

- **Documentation of Good Standing:** Documentation necessary to demonstrate that an issuer is in compliance with all applicable state solvency requirements and other relevant state regulatory requirements.

- **Supporting Documentation:** Additional documentation required by the Exchange for oversight purposes such as a compliance plan including an organization chart.

- **Attestations:** Attestations regarding compliance with applicable regulation.

**Benefit and Service Area Data**

- **High-level Plan Data**: Basic plan-level information for plans and products including information necessary for in-network and out-of-network deductibles and maximum out-of-pocket cost by benefit category.

- **Benefits and Associated Cost Sharing and Limits:** Data necessary to describe benefits offered by a plan including covered services, co-payments, coinsurance, tiers, intervals, and limits. CMS proposes capturing whether each plan has a particular cost sharing design,

benchmark plan type, and information about whether a certain number of mental health, substance abuse, or specialist visits are subject to different cost sharing. In addition, CMS proposes capturing the Essential Health Benefit (EHB) category for each service and capturing visit and service limitations for EHB. CMS also proposes capturing a plan marketing name for each variant, capturing additional Summary of Benefits and Coverage (SBC) scenarios, collecting cost share and limitations for Mental Health/Substance Use office visits, and collecting cost share information for Emergency Mental Health and Substance Use services.

- **Summary of Benefits and Coverage Data Reporting Requirements:** Data elements from the Summary of Benefits and Coverage scenarios for display on the Exchange website.

- **Formulary Information including Tiers and Classes:** Formulary information including RxNorm Concept Unique Identifiers (RxCUIs), pricing tiers, co-insurance, co-payment information, drugs included in the formulary, formulary version number, and its effective date. CMS proposes capturing quantity limits, fill limits and pharmacy restrictions for each RxCUI listed, as well as Over-the-Counter (OTC) step therapy protocol.

- **Service Area:** Information identifying a plan's geographic service area.

- **Additional Supporting Documentation**: Additional documentation required by the Exchange such as discrimination/cost sharing outlier justifications. Information to support the completion of the Mental Health Parity review may be required for submission by the issuer in the future.

**Rating Tables and Issuer Business Rules Data**
CMS does not propose changes to these data.

- **Premium Rating Information and Business Rules:** Rating tables, factors and business rules required to perform rate review, populate the premium calculator and perform calculations for risk adjustment. Information will include collecting secondary eligibility criteria, such as grandchild, adult child, disabled dependent, spouse, and life partner.

- **Partial Month Premium Calculation Rule:** Rules and/or formulas to support the calculation of partial month premiums.

The following information will be collected for QHP certification and the burden is defined, as applicable, in Rate Increase Disclosure and Review Requirements (45 CFR Part 154), OMB Control Number CMS-10379. CMS does not propose changes to these data.

- **EHB and Additional Coverage Data including Allocation of Premium Information:** Data required to determine the allocation of premiums for EHB and those services offered in excess of EHB.

- **CSR Advance Payments and Justification:** Data to support the payments for CSRs. The information will also support the variations in AV levels for CSR silver plan variations.

- **Actuarial Memorandum:** Actuarial narrative and certification required for the review of rates for rate review, premium allocation for APTCs, and CSR payment.

**Non-Exchange Plan Information Collection: Risk Adjustment**
Section 1343 provides that each state will establish a permanent program of risk adjustment for all non-grandfathered plans in the individual and small group markets. If a state chooses not to actively participate in risk adjustment, CMS will be responsible for implementation. The requirements for issuers with plan offerings outside of the Exchanges are codified at 45 CFR 153.

**Risk Adjustment Reporting Requirements for Non-Exchange Plans**
The permanent risk adjustment program provides payments to health insurance issuers that disproportionately attract high-risk populations (such as those with chronic conditions), thereby reducing the incentives for issuers to avoid higher-risk enrollees. Under this program, funds are transferred from issuers with lower-risk enrollees to issuers with higher-risk enrollees.

A "risk adjustment covered plan" includes most health insurance plans offered in the individual or small group market. The exceptions are grandfathered health plans, group health insurance coverage described in 45 CFR 146.145(c), individual health insurance coverage described in 45 CFR 148.220, and any other plan determined not to be a risk adjustment covered plan in the applicable Federallycertified risk adjustment methodology. States, or CMS on behalf of a state, will require basic identifying information about all risk adjustment covered plans, whether or not they are QHPs.

**Necessary Data for Risk Adjustment Operations**
Frequency of collection and types of information to be collected is determined by CMS.

**Risk Adjustment Operations Data**
CMS does not propose any changes to these data. (See Appendix F, RA Programs and Payment Ops Data Requirements.) CMS finalized changes to data necessary for risk adjustment operations include:

- **Administrative Data Elements:** Basic information required to facilitate communications regarding risk adjustment charges and payments, and other financial program payments. The data elements may include issuer contact information and banking information.

- **EDGE Server Registration and Provisioning Data Elements:** Data elements related to EDGE Server registration activities, including applicable attestations and agreements, and provisioning of the Amazon Web Services (AWS) EDGE Server and the Issuer On-Premise EDGE server.

- **State Licensure Data Elements**: Documentation necessary to demonstrate that an issuer is licensed and has authority to sell all applicable products in all states in which they intend to offer plan.

- **Plan Level and Additional Coverage Data Entities:** Plan information to include market participation, plan type, and basic plan characteristics such as location.

Data for risk adjustment operations include:

- **Premium Rating Information and Business Rules:** Factors, rating areas and business rules required to perform calculations for risk adjustment.

2. Information Users

The Exchange collects plan- and issuer-level data from issuers to facilitate the certification and recertification of QHPs, Exchange operations, other Federal operations, QHP oversight, and ongoing market analysis. All of this data is leveraged across multiple business areas in the Exchange to facilitate other operational tasks such as plan comparisons on the insurance portal and various payment activities, such as determination of the second lowest cost silver plan, APTCs, or risk adjustment.

In addition, CMS will collect organizational and plan-level data from issuers, self-insured group health plans and third party administrators (and administrative services only contractors). The data will include administrative data, financial data, and rate and benefit data. This data will be used to remit payments and to operate the premium stabilization programs.

3. Use of Information Technology

CMS has and continues to engage with states, issuers, and the National Association of Insurance Commissioners (NAIC) in the effort to develop data standards for QHP certification, risk adjustment, and other plan management activities that would make reporting to the Exchanges more streamlined for issuers across the country, and allow them to submit information in a manner that is standardized to the greatest extent possible.

4. Duplication of Efforts

CMS will make every effort to reduce the burden on issuers and reuse the information that is collected under the various provisions of the PPACA. As such, data obtained under other authorized collections implementing provisions of the PPACA will be utilized to meet some Exchange requirements, for example in Rate Increase Disclosure and Review Requirements (45 CFR Part 154), OMB control number CMS-10379. CMS will make every effort to avoid duplication of data collections with any other efforts. CMS is developing an integrated modular collection instrument and database system to support these various needs.

5. Small Businesses

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

6. Less Frequent Collection

QHPs will be certified utilizing an annual certification process. We will continue to reassess the certification and recertification burden and make every effort to minimize burden as much as possible in the future.

Non-Exchange plans that are risk adjustment covered plans must submit data for the purposes of facilitating program operations. This information is submitted once annually and then updated when applicable throughout the year.

7. Special Circumstances

Issuers submitting in the SHOP Exchange have the option to submit formulary, rate and benefit information more frequently; therefore, additional submissions may be necessary.

8. Federal Register/Outside Consultation

A 60-day notice published in the Federal Register on October 23, 2018 (83 FR 53474). No comments were received. A 30-day notice will publish in the Federal Register on XX/XX/2019.

The goal of this data collection is to inform the QHP certification and recertification process, as well as non-Exchange plan reporting requirements needed for the risk adjustment program. CMS has also continued to receive extensive feedback from key stakeholders. This included discussions, such as webinars and user groups calls with the NAIC, states, issuer associations, and issuers on the data elements and collection. It is the goal of CMS and stakeholders to identify shared data points and improve the validity of data. CMS will continue to work with states to minimize any required document submission to streamline and reduce duplication.

9. Payment/Gifts to Respondents

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

10. Confidentiality

CMS believes that some of the information collected for plan management and risk adjustment contains proprietary information, trade secret, commercial and/or financial information. Therefore it is privileged, private to the extent permitted by law, and protected from disclosure. Some information included in this collection, however, must necessarily be made public during Open Enrollment so that consumers can make informed choices.

11. Sensitive Questions

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

12. Burden Estimates (Hours & Wage)

The burden associated with this data collection can be attributed to QHP issuers, non-Exchange plan issuers, larger group issuers, self-insured, third party-administrators, and states. We developed these burden estimates based on experience with QHP certification to date. The burden for each of these entities was considered when developing these burden estimates. The mean hourly wage for the position of compliance officer is from the Bureau of Labor Statistics (BLS) Web site: https://www.bls.gov/oes/current/oes131041.htm. The adjusted hourly wage of $68.78 is the total of the mean hourly wage of $34.39 plus 100% fringe benefit rate of $34.39, see Table 1.

**Table 1. Adjusted Hourly Wages Used in Burden Estimates**

| Occupation Title | Occupational Code | Mean Hourly Wage ($/hour) | Fringe Benefits & Overhead (100%)($/hour) | Adjusted Hourly Wage ($/hour) |
|---|---|---|---|---|
| Compliance Officer | 13-1041 | $34.39 | $34.39 | $68.78 |

**Burden for QHP Issuers: QHP Certification**

The burden on issuers for the QHP certification (including issuer application, rate and benefit submission, and formulary submission) per year is estimated to be 39,200 burden hours, or 196 hours per issuer. This estimate is based on an assumed 200 issuers each offering 16 plans. At an adjusted hourly wage rate of $68.78 (includes 100% fringe benefit), the total cost was estimated to be $13,481 per issuer. The burden estimate includes data required for QHP certification and risk adjustment. We have adjusted the burden to account for feedback on the certification and recertification process. We have further revised these estimates, in terms of the number of issuers. We estimate 200 issuers will incur costs for QHP certification and risk adjustment. We developed this number based upon the number of applications received from issuers for the 2019 plan year.

**Table 2. Burden for QHP Issuers: QHP Certification**

| **Year** | **Number of Issuers** | **Hours Per Issuer** | **Total Hours** | **Total Burden Cost Per Issuer** |
|---|---|---|---|---|
| 2019 | 200 | 196 | 39,200 | $13,481 |
| 2020 | 200 | 196 | 39,200 | $13,481 |
| 2021 | 200 | 196 | 39,200 | $13,481 |

**Burden for Stand-Alone Dental Issuers: QHP Certification**

The burden on stand-alone dental issuers for the QHP certification each year is estimated to be 21,600 total burden hours, or 80 hours per issuer. It is estimated that 270 issuers offering 3 plans each will participate in an Exchange or go through the certification process to offer an Exchange-certified SADP off the Exchange. The number of issuers is based on the number of applications for 2019. At an adjusted hourly wage rate of $68.78 (includes 100% fringe benefit), the total cost was estimated to be $5,502 per issuer. The estimates also include recertification for SADP issuers.

**Table 3. Burden for Stand-Alone Dental Issuers: QHP Certification**

| Year | Number of Issuers | Hours Per Issuer | Total Hours | Total Burden Cost Per Issuer |
|---|---|---|---|---|
| 2019 | 270 | 80 | 21,600 | $5,502 |
| 2020 | 270 | 80 | 21,600 | $5,502 |
| 2021 | 270 | 80 | 21,600 | $5,502 |

**Burden for Non-QHP Issuers and QHP Issuers (for plans outside the Exchange) Offering Plans in the Individual and Small Group Market: Risk Adjustment**

All issuers in the individual and small group market are required to submit reference data, to include but not be limited to administrative information about the issuer and its non-QHP offerings, AV levels for those plans, which will be used for the risk adjustment program. It is estimated there are 2,400 issuers in the individual and small group market that will not be offering any QHPs through an Exchange. The total estimated burden for the submission for these issuers is 7,800 hours or 3.25 hours per issuer. At an adjusted hourly wage rate of $68.78 (includes 100% fringe benefit), the total cost was estimated to be $224 per issuer per year.

**Table 4. Burden for Non-QHP Issuers and QHP Issuers Offering Plans in the Individual and Small Group Market: Risk Adjustment**

| Year | Number of Issuers | Hours Per Issuer | Total Hours | Total Burden Cost Per Issuer |
|---|---|---|---|---|
| 2019 | 2,400 | 3.25 | 7,800 | $224 |
| 2020 | 2,400 | 3.25 | 7,800 | $224 |
| 2021 | 2,400 | 3.25 | 7,800 | $224 |

**Burden for States: State-based Exchanges using the Federal Platform and Partnership States**
Those states that are engaged with CMS as a State Partner will have an identical Plan Management burden as those operating a State-based Exchange using the Federal Platform since they will be performing all of the Plan Management activities, including QHP certification. It is assumed that the majority of states in State-based Exchanges using the Federal Platform and Partnerships will continue to leverage their existing systems that are used by the state departments of insurance. We have also taken into consideration the fact that there can be variation in what the states do from year to year. The state will have a burden of 3 hours to submit data to the Federal government for a total burden of $206 per state per year.

**Table 5. Burden for States: State-based Exchanges using the Federal Platform and Partnership States**

| Year | Number of States | Hours Per State | Total Hours | Total Burden Cost Per State |
|---|---|---|---|---|
| 2019 | 22 | 3 | 66 | $206 |
| 2020 | 22 | 3 | 66 | $206 |
| 2021 | 22 | 3 | 66 | $206 |

13. Capital Costs

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

14. Cost to Federal Government

We estimate that the operations and maintenance costs for the data collection tool and the data collection support for a total cost of $227,166.24 per year. The calculations for CCIIO employees' hourly salary was obtained from the OPM website: https://www.opm.gov/policydata-oversight/pay-leave/salaries-wages/salary-tables/pdf/2018/GS_h.pdf

Table 6 - Administrative Burden Costs for the Federal Government Associated with the Continuation of Data Collection to Support QHP Certification and other Financial Management and Exchange Operations

| Task | Estimated Cost |
|---|---|
| Operations, maintenance, and data collection support | |

| | |
|---|---|
| GS-13 (step 7): 4.2 x $111.52[1] x 485 hours | $227,166.24 |
| | |
| Total Costs to Government | $227,166.24 |

15. Changes to Burden

The reduction in burden is primarily due to the removal of provisions related to the reinsurance program, because that program ended in 2016. Any reinsurance data that is still needed for the Risk Adjustment process is collected as part of the premium stabilization programs PRA, OMB control number 0938-1155. This removal reduced the number of burden hours by 119,000 hours and respondents by 23,800 entities. The burden on issuers for the QHP certification is reduced from 450 to 200 issuers, accompanied by a small increase in the number of stand-alone dental issuers from 250 to 270, and a decrease in the number of state-based exchanges using the federal platform and partnership states from 51 to 22 states. Therefore, the current ICR burden is for 26,951 respondents and the proposed ICR estimates 2,892 respondents.

The estimated burden hours for this data collection is currently approved for 235,153 hours. With this ICR, the estimated annualized burden hours are 68,666 hours. This is a reduction of 166,487 burden hours compared to the previously approved clearance.

In addition, the change in burden is due to the lack of start-up hours that were a part of the previously approved clearance as well as adjustments to the data collection instruments. The estimated annual costs decreased from $18,106,181 to $4,722,848. This is a reduction in annual costs of $13,383,333.

16. Publication/Tabulation Dates

Some of the results of the collection will be made public on www.healthcare.gov as part of display to consumers for Open Enrollment.

17. Expiration Date

The expiration date and OMB control number will appear on the first page of the instrument (topright corner).

1 Hourly basic rate x 100% fringe benefit rate.