

Supporting Statement Part A
Comprehensive Addiction and Recovery Act of 2016 (CARA) /
Medicare Prescription Drug Benefit Program
CMS-10141, OMB 0938-0964

BACKGROUND

The Centers for Medicare and Medicaid Services (CMS) published a final rule (CMS-4068-F; RIN 0938-AN08) to establish the Medicare Prescription Drug Benefit on January 28, 2005 (70 FR 4194). The PRA requirements referenced in this PRA submission, as reflected in the final regulation, assisted in the implementation of the provisions of the Social Security Act (the Act) to establish and regulate the Medicare Prescription Drug Benefit and support the administration of the program.

The May 23, 2019 (84 FR 7912) final rule (CMS-4180-F RIN 0938-AT92) require the inclusion of negotiated drug pricing information and lower cost alternatives in the Part D Explanation of Benefits beginning on 01/01/2021. The intent of the provision is to provide enrollees with greater transparency, thereby encouraging lower costs. 4180-F also added certain new requirements for when MA plans may apply step therapy as a utilization management tool for Part B drugs.

As explained in section 15 of this Supporting Statement, the May 23, 2019 (84 FR 23832) final rule (CMS-4180-F) revised § 423.120(d) for Part B Step Therapy and § 423.128(e)(5) for Part D Explanation of Benefits.

Revisions: Part B Step Therapy

Under § 423.120(d), CMS-4180-F provides protections to help ensure that beneficiaries maintain access to medically necessary Part B drugs while permitting MA plans to implement step therapy protocols. In order to implement a step therapy program for one or more Part B drugs, the rule requires that an MA plan establish and use a P&T Committee to review and approve step therapy programs used in connection with Part B drugs.

Revisions: Part D Explanation of Benefits

Part D sponsors must provide enrollees with EOB no later than the end of the month following any month in which the enrollee utilized their prescription drug benefit. This requires Part D sponsors to collect information on beneficiaries' prescription fills, in order to provide them with therapeutic alternatives for lower-cost drugs, based on their current prescription information.

A. JUSTIFICATION

1. Need and Legal Basis

A voluntary prescription drug benefit program was enacted into law on December 8, 2003, in section 101 of Title I of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173). Section 101 amended Title XVIII of the Act by establishing the

new Part D: the Voluntary Prescription Drug Benefit Program. Section 101 of Title I added sections 1860D-1 through D-42 and sections 102, 103, 104 and 109 to the Act. As specified in the MMA, the prescription drug benefit program became available to beneficiaries beginning on January 1, 2006.

On January 28, 2005 (70 FR 4194) CMS published a final rule (CMS-4068-F; RIN 0938-AN08) to implement the provisions of the Act and establish and regulate the Medicare Prescription Drug Benefit.

Section 1860D-4(a)(1)(A)(4) of the Act requires that Part D sponsors furnish to each of their enrollees a written explanation of benefits (EOB) and, when the prescription drug benefits are provided, a notice of the benefits in relation to the initial coverage limit and the out-of-pocket threshold for the current year.

As explained in sections 12 and 15 of this Supporting Statement, the May 23, 2019 (84 FR 23832) final rule (CMS-4180-F) revises § 423.120(d) for Part B Step Therapy and § 423.128(e)(5) for Part D Explanation of Benefits.

2. Information Users

CMS will use this information from plan sponsors and States to approve contract applications, monitor compliance with contract requirements, make proper payment to plans, and ensure that correct information is disclosed to potential and current enrollees.

ICRs Regarding Business Continuity Plans under §§ 422.504(o) and 423.505(p)

Part D sponsors are required to maintain for 6 years books, records, documents, and other evidence of accounting procedures and practices. Evidence of these mechanisms must be submitted to CMS, and must demonstrate the ability to restore business operations in case of a natural disaster, emergency, or any other disruption that would otherwise affect their ability to conduct business.

Additionally, sponsors that have existing business continuity plans that do not meet all the requirements must revise and document this information and changes to CMS.

ICRs Regarding Medicare Prescription Drug Benefit Program (Beneficiaries)

Those who wish to enroll in a Part D sponsors' plan must submit an enrollment form and an acknowledgement of disclosure of pertinent information to be shared between the Department of Health and Human Services and the Part D sponsor. The enrollee must also provide information regarding reimbursement for Part D costs through other insurance, group health plan or other third-party payment arrangement.

Medicare beneficiaries will use the information provided by the Part D sponsors to make decisions regarding Part D enrollment as well as grievance and appeal requests. This

information comes as written guidance provided to beneficiaries after enrollment, and indicates options available in case a beneficiary wants to appeal a coverage determination or file a grievance.

ICRs Regarding Medicare Prescription Drug Benefit Program (Plans)

Upon receipt of a potential beneficiary's enrollment form, the Part D plan sponsor must provide the individual with prompt notice of acceptance or denial of the individual's enrollment request, in a format and manner specified by CMS.

A beneficiary that has utilized their drug benefit receives an explanation of benefits indicating how cost-sharing is applied to their drugs based on their prescription drug benefit.

Part D sponsors will use information from beneficiaries' history of prescription to provide a list of therapeutic alternatives to drugs they are taking. Specifically, prescription information that is entered into a pharmacy at the point-of-sale shows the sponsor the type of medication is taking. They will use this to provide information on the explanation of benefits (EOB) of therapeutically equivalent medications that may cost less for the beneficiary.

In § 423.168(c), an accreditation organization approved by CMS must provide to CMS in written form and on a monthly basis copies of accreditation surveys, notices of accreditation decisions, notice of all complaints, information about any remedial or adverse action taken, and notice of any finalized changes to accreditation standards, requirements or survey processes.

ICRs Regarding State Eligibility Determinations (§423.904(b)) and Reporting (§423.910(d))

States are required to make available application forms for low-income subsidy, information on the nature of, and eligibility requirements for the subsidies under this section, and offer assistance with the completion of the application forms. Individuals or personal representatives applying for the low-income subsidy must complete all required elements, provide documents as necessary, and certify as to the accuracy of the information provided. State agencies are required to inform CMS of LIS eligibility for potential enrollees, and must inform CMS of these cases.

States must provide CMS with this information as specified in order to administer the Part D prescription drug benefit.

ICRs Regarding the Creation of Model Notices to the Medicare Beneficiaries and Prescribers

The Comprehensive Addiction and Recovery Act requires Part D sponsors that participate in a drug management program to develop notices to be sent to prescribers informing them of any beneficiary believed to be abusing opioids based on clinical criteria, as well as notifying the beneficiary of this.

In order to determine which beneficiaries would be included in their drug management programs, Part D plans will engage in case management of potential at-risk beneficiaries, through contact with their prescribers, when such beneficiary is found to be taking a specific dosage of opioids and/or obtaining them from multiple prescribers and multiple pharmacies who may not know

about each other.

The sponsor will provide an initial notice to a potential at-risk beneficiary if the sponsor intends to limit the beneficiary's access to coverage for frequently abused drugs, and the sponsor will provide a second notice to an at-risk beneficiary when it actually imposes a limit on the beneficiary's access to coverage for frequently abused drugs. Alternatively, the sponsor will provide an alternate second notice if it decides not to limit the beneficiary's access to coverage for frequently abused drugs

ICRs Regarding the Preparation and Issuance of the Model Notices to the Medicare Beneficiaries and Prescribers

To ensure patient protections and safety and to protect the Trust Funds from prescribers and providers identified as bad actors, a Part D plan sponsor must reject, or require its pharmacy benefit manager to reject, a pharmacy claim for a Part D drug if the individual who prescribed the drug is included on the "preclusion list."

CMS will issue an initial email notification to the impacted providers using the email addresses obtained from the Provider Enrollment, Chain and Ownership System (PECOS), the Medicare enrollment system of record, or the National Provider Plan and Enumeration System (NPDES). CMS or a Medicare Administrative Contractor (MAC) will follow up with a written notice through certified mail to the impacted provider in advance of his or her inclusion on the Preclusion List and their applicable appeal rights.

3. Improved Information Technology

Information collection may involve the use of automated or electronic mechanisms designed to reduce burden and increase efficiency.

Under 423.505 (p), Part D sponsors are required to develop business continuity plans with the goal of better ensuring beneficiary access to health care services and Part D drugs during and after interruptions to regular business operations. These strategies developing contingency plans to maintain the availability and, as applicable, the confidentiality of hard copy and electronic essential records, including a disaster recovery plan for IT and beneficiary communication systems.

Under 423.153 (f)(6)(i), which codified requirements in the Comprehensive Addiction and Recovery Act, the Part D sponsor will send a mailed written notice to indicate a beneficiary's at-risk status and whether any restrictions have been imposed on their access to opioids.

Enrollment requirements outlined in 423.32 indicate that all PDP sponsors must have, at minimum, a paper enrollment form available for potential enrollees to request enrollment in a PDP. PDP sponsors may also accept enrollment elections made via the on-line enrollment center hosted by CMS, as well as requests for enrollment as described. These requirements apply to any beneficiary wishing to enroll in LIS as well.

For appeals and grievances related to coverage determinations, guidance may be delivered by mail

or electronically, depending on the beneficiary's preference.

423.128(e) in 4180-F requires information on therapeutic alternatives to be included on a beneficiary's explanation of benefit when their drug benefit is utilized in a given month. This information can be mailed or delivered electronically, depending on the beneficiary's preferred method of delivery.

4. Duplication of Similar Information

This collection does not contain duplication of similar information.

5. Small Businesses

Some Part D sponsors and MA organizations are small businesses so they may be affected. They will have to comply with all the information requirements described in this supporting statement.

6. Less Frequent Collection

This information is collected on the least frequent basis necessary to support CMS' administration of the Part D and MA programs and plan sponsor's provision of benefits under their contracts with CMS. With less frequent collection, CMS would not have access to the data necessary to administer these programs and plan sponsors.

For example, under the information collection on business continuity plans, existing plan sponsors are required to annually test their plan and update these documents as needed. New plan sponsors without existing business continuity plans must develop and implement such plans. Business continuity plans ensure that plan sponsors are able to restore business operations after disruptions caused by events such as natural or man-made disasters, systems failures and emergencies. In another example information collected from beneficiaries is collected when an enrollment application is filed and when a coverage determination is requested. Other information, such as other payers reimbursing Part D costs on the enrollee's behalf, is collected from beneficiaries only annually. Information from Part D sponsors related, for example, to drug utilization management or dissemination of plan information, is an annually requirement; however, although bid information from sponsors is an annual collection, cost information is collected monthly. Information collected from the states pertaining to low-income subsidy determinations and redeterminations is collected monthly.

Conducting testing of business continuity plans less frequently than annually increases the risks associated with a service disruption to beneficiary access to care and coverage. Some other consequences of less frequent collection would be improper or erroneous payment to Part D plans, improper enrollment of beneficiaries in a Part D organization, release of misleading information regarding the health care coverage through a plan to potential members, and inadequate provision of patients' rights to Medicare-covered services.

7. Special Circumstances

There are no special circumstances that would require an information collection to be conducted in a manner that requires respondents to:

- Report information to the agency more often than quarterly;
- Prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study,
- Use a statistical data classification that has not been reviewed and approved by OMB;
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register Notice/Outside Consultation

The proposed rule (CMS-4180-P; RIN 0938-AT92) published in the Federal Register on November 30, 2018 (83 FR 62152). Comments were received and responded to accordingly.

In CMS-4180-P, under § 423.128(e)(5), we assumed it would take 4 hours per contract for a software programmer to link alternative prices to the EOB Model, resulting in 2240 burden hours (560 Part D contracts * 4 hours per contract. However, commenters pointed out that there might be numerous systems to update. As a result, in the final rule we revised our 4 hour estimate to 160 hours. The change now estimates it will take two software programmers 8 hours to revise 10 systems.

In the NPRM we also considered separate work for each contract. Upon internal review we now believe it is more appropriate to estimate burden by each parent organization. Based on bid information and trends we expect 295 Part D Sponsors and PDP parent organizations for 2020, which reduces the number of respondents that we based our burden on in the NPRM of 560 contracts. . In aggregate, our revised one-time burden estimate for updating systems is 47,200 hours (160 hr per response × 295 responses) at a cost of \$4,651,088 (47,200 hr × \$98.54/hr) or \$15,766 per respondent (\$4,651,088/295 sponsors and organizations). Over the course of OMB's anticipated 3-year approval period, we estimate an annual burden of 15,733 hours (47,200 hr/3 years) at a cost of \$1,550,363 (\$4,651,088/3 years). We are annualizing the one-time labor estimate since we do not anticipate any additional burden after the 3-year approval period expires.

Commenters also pointed out that there would be an added an ongoing burden since EOBs would contain additional information about alternatives. Although our regulations allow electronic submission of Part D EOBs upon request, informal communication from stakeholders indicates small usage. We are therefore assuming mailings to all enrollees. Since we do not require first

class postage for Part D EOBs, we are assuming that Part D sponsors will use the least expensive option, namely, the use of bulk mailing rates.

Finally, we note that Part D EOBs are sent out once per month to each enrollee summarizing drug transactions for the previous month, totaling 12 per calendar year.

The final rule (CMS-4180-F) published on May 23, 2019 (84 FR 23832).

9. Payments/Gifts to Respondents

Respondent receiving payment in any form must be in compliance with the information collection requirements set forth.

10. Confidentiality

CMS recognizes the potential confidential or proprietary nature of the information related to the information collection on business continuity plans. Plans are not required as a matter of course to submit these plans to CMS or to make such plans publicly available. If CMS requests the documents, we do not intend to voluntarily disclose them to any parties outside the government. Although the documents may be subject to release under the Freedom of Information Act (FOIA) plan sponsors may seek to protect their information from disclosure by claiming FOIA exemption 4 and taking the appropriate steps, including labeling the information in questions as “confidential” or “proprietary.”

The information collected from organizations for the purposes of disclosing to the potential enrollees their health care coverage choices is public information. The information is being collected for purposes of the National Medicare Education Program, the purpose of which is the broad public dissemination of objective, comparative information on benefits, program rules, and premiums of the contracting with organizations. The information collected from Medicare beneficiaries and contained in medical records and other health and enrollment information must conform to all requirements at 42 CFR Parts 417, 422, and 423 including all Federal and State laws regarding confidentiality and disclosure.

11. Sensitive Questions

There are no sensitive questions associated with this collection. Specifically, the collection does not solicit questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private.

12. Burden Estimate (Total Hours & Wages)

This section consists of the following subsections:

Wage Estimates

Requirements and Annual Burden Estimates

12.1 ICRs Regarding Business Continuity Plans under §§ 422.504(o) and 423.505(p)

(No Changes)

12.2 ICRs Regarding Medicare Prescription Drug Benefit Program (Beneficiaries)

(No Changes)

12.3 ICRs Regarding Medicare Prescription Drug Benefit Program (Plans)

(Revised)

12.4 ICRs Regarding State Eligibility Determinations (§423.904(b)) and Reporting

(§423.910(d))

(No Changes)

12.5 ICRs Regarding the Part D Sponsor's System Programming

(No Changes)

12.6 ICRs Regarding the Creation of Model Notices to the Medicare Beneficiaries and

Prescribers

(No Changes)

12.7 ICRs Regarding the Preparation and Issuance of the Model Notices to the Medicare Beneficiaries and Prescribers

(No Changes)

Summary of Requirements and Annual Burden Estimates

Information Collection Instruments, Instructions and Guidance Documents

ICRs Exempt from the Requirements of the Paperwork Reduction Act

ICRs Approved Under Other OMB Control Numbers

- **WAGE ESTIMATES**

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2017 National Occupational Employment and Wage Estimates for all salary estimates (https://www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents the mean hourly wage, the cost of fringe benefits and overhead (calculated at 100 percent of salary), and the adjusted hourly wage.

National Occupational Employment and Wage Estimates

BLS Occupation Title	Occupation Code	Mean Hourly Wage (\$/hr)	Fringe Benefits and Overhead (\$/hr)	Adjusted Hourly Wage (\$/hr)
Business Operations Specialist	13-1000	35.14	35.14	70.28
Computer Programmer	15-1131	42.08	42.08	84.16
Insurance Claim and Policy Processing Clerk	43-9041	19.76	19.76	39.52
Software Developers and Programmers	15-1130	49.27	49.27	98.54

- **REQUIREMENTS AND ANNUAL BURDEN ESTIMATES**

The following information collection requests consist of six Information Collection Requests (ICRs) that remain unchanged (see sections 12.1, 12.2, 12.4, 12.5, 12.6, and 12.7. Revisions to section 12.3 are limited to subsection to 12.3.8 for Part B Step Therapy and subsection 12.3.9 for

Part D Explanation of Benefits. As explained within this document, the changes are associated with the CMS-4180-F final rule.

12.1 ICRs Regarding Business Continuity Plans under §§ 422.504(o) and 423.505(p) (NO CHANGES)

12.1.1 Contract provisions (§§ 422.504 and 423.505)

Sections 422.504(o) and 423.505(p) require, respectively, MA organizations and Part D sponsors to develop, maintain, and implement business continuity plans that identify potential business disruptions and develop ways to maintain functions or restore them as soon possible thereafter. We believe many entities already have developed and are maintaining plans that meet these requirements for two reasons - 1) creating business continuity plans is a well-established practice across most industries; and 2) CMS finalized a regulation (80 FR 7912) that created flexibility for industry practices related to business continuity. Accordingly, the burden associated with the requirement is the time and effort necessary for Part D sponsors and MA organizations without plans to develop and maintain business continuity plans and the time and effort for entities that have existing business continuity plans that do not meet all the requirements to revise them. For the first year, we estimate 28 entities do not have the plans in place and it will take 240 hours each to fulfill the business continuity requirements, for a total burden of **6,720 hours** (28 plans x 240 hr). We also estimate that there are 57 entities with existing plans that need to be updated and it will take **120 hours** to revise their business continuity plans in the first year, for a total burden of **6,840 hours** (6,720 hr + 120 hr) at a cost of \$ 480,715.20 (6,840 hr x \$70.28) for a business operations specialist.

In subsequent years, we estimate there will be 9 new Part D sponsors and MA organizations that do not already have a business continuity plan based on our experience that most entities that create new plans each year are under parent organizations that already have business continuity plans in place. We estimate a burden of 240 hours for each of these 9 entities. We also estimate that 5 entities with existing plans will either experience a problem or for some other reason update their plan and it will take each plan 40 hours for these revisions. For each subsequent year, we estimate 9 entities will not have the plans in place and it will take 240 hours each to fulfill the business continuity requirements, for a total burden of **2,160 hours** (240 hr x 9 plans). We also estimate for each subsequent year 5 entities with existing plans will need to update their business continuity plans and it will take 40 hours for each plan to make these revisions, for a total burden of **200 hours** (40 hr x 5 plans) at a cost of \$ 14,056 (200 hr x \$70.28) for a business operations specialist.

Business Continuity Plans: Burden Summary (Subtotal)

CFR Section	Respondent Type	# Respondents	Time (hr per response)	# Responses (per respondent)	Total Responses (all respondents)	Total Annual Time (all respondents)
423.505(p) combined with	Private sector (Contracts)	28	240	1	28	6,720

422.504(o)		57	120	1	57	6,840
		9	240	1	9	2,160
		5	40	1	5	200
Subtotal		99	Varies	1	99	15,920

**12.2 ICRs Regarding Medicare Prescription Drug Benefit Program (Benes)
(NO CHANGE)**

The following ICRs are related to the enrollment process and creditable coverage.

12.2.1 Enrollment process (§ 423.32)

(a) A Part D eligible who wishes to enroll in a Part D plan may enroll during the enrollment periods specified in § 423.38, by submitting an enrollment request to the Part D plan through one of the mechanisms CMS determines are appropriate.

The burden associated with this requirement is the time and effort necessary for an individual to submit the enrollment request to a Part D plan sponsor. We estimate that it will take 30 minutes (0.5 hours) to complete and submit the request to the Part D plan. Since the inception of the Part D program in 2006, more than 30 million individuals are enrolled in the program. Once enrolled, individuals are not required to complete an enrollment request to remain enrolled in their chosen plan year-to-year. Generally individuals are limited to changing Part D plans during the annual coordinated election period, and enrollment data indicates that individuals typically stay with a plan once enrolled. In the Fall of 2017, about 1.9 million individuals newly enrolled in or switched stand-alone Medicare prescription drug plans (PDPs) during the annual coordinated election period; these enrollments took effect on January 1 of 2018. New PDP enrollments (not counting those with a January 1 effective date) average approximately 186,000 per month. Therefore, it is estimated that a total of 3.954 million individuals may newly enroll in or change their PDP annually. The total burden is calculated to be **1,975,000 hours** (3,954,000 million enrollments x 0.5 hours).

(b) Enrollment form or CMS-approved mechanism. The enrollment request must be completed by the individual and include an acknowledgement by the beneficiary for disclosure and exchange of necessary information between the U.S. Department of Health and Human Services (or its designees) and the Part D plans sponsor. Persons who assist beneficiaries in completing the enrollment, including authorized representatives, must indicate they have provided assistance and their relationship to the beneficiary. The burden associated with this requirement is reflected above under section 423.32(a).

A Part D plan sponsor must require Part D eligible individuals enrolling or enrolled in its Part D plan to provide information regarding reimbursement for Part D costs through other insurance, group health plan or other third-party payment arrangement, in a form and manner approved by CMS. All new enrollments require this information as part of the enrollment application (burden reflected under section 423.32(a)); however, plan sponsors may request currently enrolled members to provide this information upon indication of other insurance.

The burden associated with the requirement for individuals enrolled or enrolling in a Part D plan to provide information regarding reimbursement for Part D costs through other insurance, group health plan or other third-party payment arrangement is a total annual burden of 44,200 hours. We estimate that 2.6 million beneficiaries will need 1 minute (0.017 hours) to disclose reimbursement for Part D costs to the appropriate entity on an annual basis, for a total annual burden of **44,200 hours** (2,600,000 million beneficiaries x .017 hr).

12.2.2 Enrollment of full-benefit dual eligible individuals (§ 423.34)

Section 423.34(e) states that a full-benefit dual eligible beneficiary may decline automatic enrollment in a Part D plan or may enroll in a plan different than the plan into which CMS placed them.

The burden associated with this requirement is the time and effort put forth by the individual to actively decline enrollment or to actively enroll in a new, and for plans to process the enrollments and disenrollments. We estimate it will take an individual about 15 minutes (0.25 hours) to, either contact the plan to disenroll or contact the new plan to enroll (resulting in an automatic disenrollment from the plan into which the person was enrolled by CMS). Beneficiaries can contact plans in a number of ways, with varying amounts of time needed for the contact. A beneficiary will need to contact the plan only once. There are, on average, approximately 130,000 individuals who choose their own plan instead of the automatic enrollment each year so we estimate that it takes full dual beneficiaries 32,500 hours each year to decline the automatic enrollment or enroll in a different plan (causing a disenrollment). We further estimate the same amount of time for plans to receive and process these enrollments/disenrollments. The total number of hours is **32,500 hours** for the full dual beneficiaries (130,000 beneficiaries x .25 hr).

12.2.3 Enrollment periods (§ 423.38)

In paragraph (b), under the Special Enrollment Period provisions, an individual is eligible to enroll in a Part D plan or disenroll from a Part D plan and enroll in another Part D plan, if the individual demonstrates to CMS, in accordance with guidelines CMS issues, that the Part D plan sponsor offering the Part D plan substantially violated a material provision of its contract under this part that meets the requirements set forth in this section.

The burden associated with this requirement is the time and effort necessary for an individual to submit the required materials to CMS demonstrating that a Part D plan substantially violated a material provision of its contract. Based on our experience with the current Medicare Advantage program, we expect that fewer than 10 individuals, if any, will avail themselves of this option. Generally, in those instances where CMS has found that an MA organization has substantially violated a material provision of its contract, CMS has taken the necessary action on behalf of these individuals. Thus, we do not estimate any burden on individuals under this provision.

12.2.4 Procedures to document creditable status of prescription drug coverage (§ 423.56)

If an individual establishes to CMS that he or she was not adequately informed that he or she no longer had creditable prescription drug coverage or the coverage is involuntarily reduced, the

individual may apply to CMS to have the coverage treated as creditable coverage so as to not be subject to the late enrollment penalty described in § 423.46. The burden associated with this requirement is the time and effort necessary for an individual to apply to CMS to have such coverage treated as creditable coverage. Based on recent experience (i.e., 2012 – 2014, we estimate that on an annual basis it will take 100 individuals 15 minutes (0.25 hours) to apply to CMS, for a total of **25 hours** (100 beneficiaries x .25 hr).

12.2.5 Exceptions process (§ 423.578)

In paragraphs (a) and (b) an enrollee, the enrollee’s representative, or the enrollee’s prescribing physician or other prescriber (on behalf of the enrollee) may file a request for an exception that meets the requirements of this section.

The burden associated with this requirement is the time and effort necessary for an individual to submit an exception request. We estimate that that 3,185,000 exception requests will be received by 424 Part D plan sponsors. We further estimate it will take an individual an average of 15 minutes (0.25 hours) to provide the request for a total annual burden of **796,250 hours** (3,185,000 requests x .25 hr).

12.2.6 Burden Summary

Medicare Prescription Drug Benefit Program (Benes): Burden Summary (Subtotal)

CFR Section	Respondent Type	# Respondents	Time (hr per response)	# Responses (per respondent)	Total Responses (all respondents)	Total Annual Time (all respondents)
423.32(a) and (b)	Individual	3,954,000	0.5	1	3,954,000	1,975,000
423.32(b)	Individual	2,600,000	0.017 (1 min)	1	2,600,000	44,200
423.34(e)	Individual	130,000	0.25	1	130,000	32,500
423.56(f)	Individual	100	0.25	1	100	25
423.578(a) and (b)	Individual	3,185,000	0.25	1	3,185,000	796,250
Subtotal		9,869,100	-varies	1	9,869,100	2,847,975

**12.3 ICRs Regarding Medicare Prescription Drug Benefit Program (Plans)
(Revisions to section 12.3 are limited to Part B Step Therapy in 12.3.8 and Part D Explanation of Benefits under section 12.3.9)**

The notification of enrollment status to a beneficiary is a 3rd party disclosure by the Part D sponsor that is reflected in the plan burden.

12.3.1 Enrollment process (§ 423.32)

(d) Notice requirement. The Part D plan sponsor must provide the individual with prompt notice of acceptance or denial of the individual's enrollment request, in a format and manner specified by CMS.

The burden associated with this requirement is the time and effort necessary for a Part D plan sponsor to provide an individual notice of acceptance or denial of the individual's enrollment request. Every enrollment request requires a response from the Part D plan so that the individual knows if he or she will be covered under the plan. There were approximately 757 Part D plan sponsors in 2018. Each Part D plan creates the acceptance and denial notices, and most plans continue to use the same notice year-after-year, with some minor adjustments. Therefore, we estimate that it will take each Part D plan approximately 3 hours to produce each notice –an acceptance and a denial notice. $757 \text{ plan sponsors} \times (3 \text{ hours} \times 2 \text{ notices}) = 4,542$. We further estimate that on average, it will take each Part D plan sponsor 1 minute (0.017 hours) for a business operations specialist to assemble and disseminate the proper notice for each of the enrollment requests received annually. $3.954 \text{ million requests} \times 0.017 \text{ hours (1 minute each)} = 67,218 \text{ hours}$. The total number of hours is **71,760** ($4,542 + 67,218$) or 92.43 hours per sponsor annually. The estimated annual cost is \$5,043,293 ($\$70.28 / \text{hr} \times 71,760 \text{ hr}$).

12.3.2 Enrollment of full-benefit dual eligible individuals (§ 423.34)

As noted above, section 423.34(e) states that a full-benefit dual eligible beneficiary may decline automatic enrollment in a Part D plan or may enroll in a plan different than the plan into which CMS placed them.

The burden associated with this requirement is the time and effort put forth by the individual to actively decline automatic enrollment or to actively enroll in a new, and for plans to process the enrollments and disenrollments. We estimate it will take an individual about 15 minutes (0.25 hours) to, either contact the plan to decline the automatic enrollment or contact a different plan to enroll (resulting in an automatic disenrollment from the plan into which the person was enrolled by CMS). Beneficiaries can contact plans in a number of ways, with varying amounts of time needed for the contact. A beneficiary will need to contact the plan only once. There are on average approximately 130,000 individuals who choose their own plan instead of the automatic enrollment each year so we estimate that it takes full dual beneficiaries 32,500 hours a year to decline the automatic enrollment or enroll in a different plan (causing a disenrollment) each year. We further estimate the same amount of time for plans to receive and process these declinations/enrollments. The total burden is **32,500 hours** for a business operations specialist for the 757 Part D plan sponsors. The estimated annual cost is \$2,284,100 ($\$70.28 / \text{hr} \times 32,500 \text{ hr}$).

12.3.3 Disenrollment process (§ 423.36)

Section (b) requires the Part D plan sponsor to submit a disenrollment transaction to CMS within timeframes CMS specifies; provide the enrollee with a notice of disenrollment as CMS determines and approves; and file and retain disenrollment requests for the period specified in CMS instructions.

The burden associated with this requirement is the time and effort necessary for a Part D plan sponsor to provide an individual a notice of disenrollment, whether it is the result of the individual leaving the Part D program or switching plans during a valid enrollment period. Based on disenrollment data for January through August 2017, we estimate that on an annual basis it will require a total of 1,903,752 notices, affecting each Part D plan sponsors to some degree, as described below. There are approximately 757 Part D plan sponsors in 2017. Each Part D plan creates the disenrollment notice, and most plans continue to use the same notice year-after-year, with some minor adjustments. Therefore, we estimate that it will take each Part D plan sponsor approximately 1 hour for a business operations specialist to produce the notice. 757 plan sponsors x 1 hour = **757 hours**. We further estimate that on average, it will take each Part D plan sponsor 1 minute (0.017 hours) for a business operations specialist to assemble and disseminate the notice for each disenrollment. 1,903,752 notices x 0.017 hours (1 minute each) = **32,364 hours**. The total number of hours is **33,121 hours** (757 + 32,364) or 42.8 hours per sponsor annually. The estimated annual cost is \$2,327,744 (\$70.28 /hr x 33,121 hr).

12.3.4 Involuntary disenrollment by the Part D plan (§ 423.44)

If the disenrollment is for any of the reasons specified in paragraphs (b)(1), (b)(2)(i) or (b)(2)(iv) of § 423.44, the Part D plan sponsor must give the individual timely notice of the disenrollment with an explanation of why the Part D plan is seeking to disenroll the individual. Notices for these reasons must be provided to the individual before submission of the disenrollment notice to CMS; and include an explanation of the individual's right to a hearing under the Part D plan's grievance procedures.

A Part D plan sponsor may disenroll an individual from the Part D plan for failure to pay plan premiums following a minimum 2-month grace period and if the Part D plan sponsor can demonstrate to CMS that it made reasonable efforts to collect the unpaid premium amount.

The burden associated with this requirement is the time and effort necessary for a Part D plan sponsor to effectuate the disenrollment and provide an individual the notice of disenrollment. There were approximately 757 Part D plan sponsors in 2018. Each Part D plan creates the disenrollment notice, and most plans continue to use the same notice year-after-year, with some minor adjustments. Therefore, we estimate that it will take each Part D plan approximately 1 hour to produce the notice. 757 plan sponsors x 1 hour = **757 hours**. We estimate that it will take a Part D plan 5 minutes (0.083 hours) to submit the required transaction to CMS for each occurrence and 1 minute (0.017 hours) for a business operations specialist to assemble and disseminate the notice for each disenrollment. Based on disenrollment data for January through June 2017, we estimate that on an annual basis 496,344 individuals will be disenrolled for failure to pay premiums. 496,344 notices x 0.1 hours (6 minutes each) = **49,634 hours**. The total number of hours is **50,391** (757 + 49,634) or 63.6 hours per sponsor annually. The estimated annual cost is \$3,544,010 (\$70.28 /hr x 50,427 hr).

Following the enactment of section 3308 of the Affordable Care Act in 2011 which required additional premium amounts to be paid directly to the government by higher-income individuals when enrolled in Part D, CMS may disenroll individuals who do not pay their additional premium amounts, also known as Part D Income Related Monthly Adjustment Amount (Part D-IRMAA), to

the government within a 3-month grace period. If payment is not received timely, CMS processes the disenrollment and notifies Part D plans of the involuntary disenrollment, and the plan is required to notify their member of the disenrollment from their plan.

The burden associated with this requirement is the time and effort for the Part D plan sponsor to disclose to an individual the notice of disenrollment. There are approximately 757 Part D plan sponsors in 2017. Each Part D plan creates the disenrollment notices, and most plans continue to use the same notice year-after-year, with some minor adjustments. Therefore, we estimate that it will take each Part D plan approximately 1 hour to produce the notice. $757 \text{ plan sponsors} \times 1 \text{ hour} = \mathbf{757 \text{ hours}}$. We estimate that it will take a Part D plan 1 minute (0.017 hours) to assemble and disseminate the notice for each disenrollment. Based on data from January 1 through September 23, 2017, we estimate that on an annual basis 1,100 individuals will be disenrolled for failure to pay Part D-IRMAA. $1,100 \text{ notices} \times 0.017 \text{ hours} = \mathbf{18.7 \text{ hours}}$. The total number of hours is $\mathbf{775.7}$ ($757 + 18.7$) or 1.02 hours per sponsor annually. The estimated annual cost is $\$54,516$ ($\$70.28 / \text{hr} \times 775.7 \text{ hr}$).

An individual who is disenrolled for non-payment of plan premiums or non-payment Part D-IRMAA may be reinstated by the Part D sponsor or by CMS, respectively, if the individual shows good cause for not paying premiums timely. In this process, the plan or CMS determines if good cause is met based on the individual's request for review and his or her attestation of the unexpected and unforeseen event. Should an individual receive a favorable determination, the payment of all overdue premiums must be paid to the plan and CMS as applicable. Individuals are notified by the plan sponsor of the plan premium amount owed for reinstatement. CMS notifies individuals of any Part D-IRMAA amounts owed to the government.

The Part D plan sponsor burden associated with this requirement is the time and effort for the Part D plan sponsor to provide an individual the notice of the owed plan premium amount required for reinstatement. There are approximately 757 Part D plan sponsors in 2017. Each Part D plan creates the notice of the plan premium amount owed, and most plans continue to use the same notice year-after-year, with some minor adjustments. Therefore, we estimate that it will take each Part D plan approximately 1 hour to produce the notice. $757 \text{ plan sponsors} \times 1 \text{ hour} = \mathbf{757 \text{ hours}}$. We estimate that it will take a Part D plan 5 minutes (0.083 hours) to compile the arrearage information and 1 minute (0.017 hours) for a business operations specialist to assemble and disseminate the notice for each favorable determination. We estimate that on an annual basis 17,772 individuals will request and receive favorable good cause determinations. $17,772 \text{ notices} \times 0.1 \text{ hours} \text{ (6 minutes)} = \mathbf{1,777 \text{ hours}}$. The total number of hours is $\mathbf{2,534}$ ($757 + 1,777$) or 3.24 hours per sponsor annually. The estimated annual cost is $\$ 178,990$ ($\$70.28 / \text{hr} \times 2,534 \text{ hr}$).

A Part D plan may disenroll an individual whose behavior is disruptive, only after it meets the requirements described in guidance and after CMS has reviewed and approved the request. To disenroll an individual from its Part D plan, based on an individual's behavior, the Part D plan sponsor must document the enrollee's behavior, its own efforts to resolve any problems and any extenuating circumstances. The Part D plan must submit this information and any documentation received by the beneficiary to CMS. The Part D plan sponsor may request from CMS the ability to decline future enrollment by the individual.

The burden associated with this requirement is the time and effort necessary for a Part D plan to document and retain the documentation that meets the requirements set forth in guidance. We estimate that it will take a Part D plan 3 hours to capture and retain the required documentation for each occurrence. Based on actual experience, CMS receives approximately 1-2 total requests for involuntary disenrollment due to disruptive behavior annually. Thus, the burden to Part D plan sponsors is negligible.

In addition, the Part D plan must inform the individual of the right to use the Part D plan's grievance procedures. The burden associated with this requirement is captured under § 423.128.

When a Part D plan contract terminates as stipulated under §§ 423.507 and 423.510 the Part D plan sponsor must send a notice to the enrollee before the effective date of the plan termination. The notice must give provide an effective date of the plan termination and a description of alternatives for obtaining benefits under Part D. The burden associated with these requirements is discussed below under §§ §§ 423.507 and 423.510.

12.3.5 Late enrollment penalty (§ 423.46)

Section 423.46(b) states that Part D sponsors must obtain information on prior creditable coverage from all enrolled or enrolling beneficiaries and report this information to CMS in a form and manner determined by CMS. Individuals enrolling in Part D with 63 days or more without creditable coverage will be assessed a Part D late enrollment penalty.

The burden associated with this requirement is the time and effort put forth by the Part D sponsor to obtain the required information. There are approximately 757 Part D plan sponsors in 2017. To comply with this requirement, Part D sponsors will expend 15 minutes (0.25 hours) per new Part D enrollee to obtain the information and report it to CMS for calculation of the late enrollment penalty, if one is required. We estimate that a total of 3.954 million individuals may newly enroll in or change their Part D plans annually and, as such, approximately 3,954 million new Part D enrollees will need to provide this information on an annual basis. Therefore the total annual burden associated with this requirement will be 3.954 million new enrollees x 0.25 hours (15 minutes) = **988,500 hours**. The estimated annual cost is \$69,471,780 (\$70.28 /hr x 988,500 hr)..

Section 423.46(d) requires the Part D plan sponsor to retain all information collected concerning a credible coverage period determination in accordance with the enrollment records retention requirements described in subpart K, § 423.505(e)(1)(iii).

The burden associated with this requirement is the time and effort put forth by the Part D plan sponsor to retain the required information. To comply with this requirement, Part D sponsors will expend 5 minutes (0.083 hours) per new Part D enrollee. We estimate that a total of 3.954 million individuals may newly enroll in or change their Part D plan annually. We estimate the total annual burden associated with this requirement will be **328,182 hours** for all new Part D enrollees. The estimated annual cost is \$23,064,631 (\$70.28 /hr x 328,182 hr).

12.3.6 Information about Part D (§ 423.48)

Each Part D plan must provide, on an annual basis, and in a format and using standard terminology that CMS may specify in guidance, the information necessary to enable CMS to provide to current and potential Part D eligible individuals the information they need to make informed decisions among the available choices for Part D coverage.

The burden associated with this requirement is the time and effort necessary for a Part D sponsor to submit the required materials to CMS. We estimate that on an annual basis it will take 757 Part D sponsors 2 hours for a business operations specialist to submit the required documentation to CMS for a total annual burden of **1,514 hours**. The decrease in total annual burden from the previous estimate is due to the decreased number of respondents. The estimated annual cost is \$106,403 (\$70.28 /hr x 1,514 hr).

12.3.7 Requirements related to qualified prescription drug coverage (§ 423.104)

(g) A Part D plan sponsor is required to disclose to CMS data on aggregate negotiated price concessions obtained from pharmaceutical manufacturers, as well as data on aggregate negotiated price concessions obtained from pharmaceutical manufacturers that are passed through to beneficiaries, via pharmacies and other dispensers, in the form of lower subsidies, prices, and/or monthly beneficiary prescription drug premiums, in the manner and frequency specified by CMS.

The burden associated with this requirement is the time and effort necessary for a Part D plan sponsor to disclose to CMS the aggregate negotiated price data on concessions. Given the complexity of this reporting, we estimate the time and effort required will be similar to that associated with the payment-related reporting requirements. Therefore, we estimate that on an annual basis it will take each of the 757 respondents 10 hours for a business operations specialist to submit the required documentation to CMS for total annual burden of **7,570 hours**. The estimated annual cost is \$532,019 (\$70.28 /hr x 7,570 hr).

12.3.8 Access to covered Part D drugs (§ 423.120)

(Revised by adding requirements under paragraph (d))

(b) A Part D plan sponsor's formulary must be reviewed by a pharmacy and therapeutic committee that must maintain written documentation of its decisions regarding formulary development and revision.

The burden associated with this requirement is the time and effort necessary for a Part D sponsor's pharmacy and therapeutic committee to document and retain the documentation that meets the requirements set forth in this section. We estimate that it will take 757 respondents 2 hours each for a business operations specialist to capture and retain the required documentation on an annual basis for total annual burden of **1,514 hours**. The decrease in total annual burden from the previous estimate is due to the decreased number of respondents. The estimated annual cost is \$106,403 (\$70.28 /hr x 1,514 hr).

Prior to removing a covered Part D drug from its plan's formulary, or making any change in the preferred or tiered cost-sharing status of a covered Part D drug, a Part D plan sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs, entities

providing other prescription drug coverage (as described in § 423.464(f)(1)), authorized prescribers, network pharmacies, and pharmacists.

The burden associated with this requirement is the time and effort necessary for a Part D sponsor to provide notice of at least 60 days to CMS, State Pharmaceutical Assistance Programs, entities providing other prescription drug coverage, authorized prescribers, network pharmacies, and pharmacists of the removal of a covered Part D drug from its formulary.

Given that each entity has already created disclosure notices for mass mailings, we estimate that on an annual basis it will take on average, each of the 757 respondents 40 hours for a business operations specialist to disclose the required notice for a total annual burden of **30,280 hours**. The decrease in total annual burden from the estimate previously reported is due to the decreased number of respondents. The estimated annual cost is \$2,128,078 (\$70.28 /hr x 30,280 hr).

Paragraph (b)(3)(iv) requires sponsors to provide enrollees with appropriate notice regarding their transition process within three business days after providing a temporary supply of non-formulary Part D drugs (including Part D drugs that are on a sponsor's formulary but require prior authorization or step therapy under a sponsor's utilization management rules). The burden associated with this requirement is the time and effort necessary for a Part D plan sponsor to provide a notice to beneficiaries regarding the transition process. We estimate this will result in 19 million notices that will take an average of 5 minutes (0.083 hours) for a business operations specialist to prepare. Thus, we estimate the total burden to be **1,577,000 hours**. The estimated annual cost is \$110,831,560 (\$70.28 /hr x 1,577,000 hr).

Under paragraph (c)(1), a Part D sponsor must issue and reissue, as necessary, a card or other type of technology to its enrollees to use to access negotiated prices for covered Part D drugs.

The burden associated with this requirement is the time and effort necessary for an entity to provide each enrollee a card. The burden associated with this requirement is reflected in § 423.128.

Paragraph (d) (under CMS-4180-F) provides protections to help ensure that beneficiaries maintain access to medically necessary Part B drugs while permitting MA plans to implement step therapy protocols that support stronger price negotiation and cost and utilization controls. In order to implement a step therapy program for one or more Part B drugs, this rule requires that an MA plan establish and use a P&T Committee to review and approve step therapy programs used in connection with Part B drugs. The P&T Committee requirements are very similar to the requirements applicable to Part D plans under § 423.120(b). This rule allows MA-PD plans to use the Part D P&T Committee to satisfy the new requirements related to MA plans and Part B drugs. For MA plans that do not cover Part D benefits already, they may use the Part D P&T Committee of another plan under the same contract. Under § 422.4(c), every MA contract must have at least one plan offering Part D. Because of the small amount of work needed annually, we believe it is reasonable to assume that no new committees will be formed and that the added work will be performed by the existing P&T Committees.

Paragraphs (b)(4) and (9) (also under CMS-4180-F) requires that the P&T Committee “clearly articulate and document processes,” We estimate it would take 1 hour at \$72.84/hr for a P&T Committee business specialist to perform certain tasks and review and retain documentation and information The 1 hour estimate reflects half of the Part D P&T Committee burden (or 2 hours) that is currently approved by OMB under control number 0938-0964 (CMS-10141). We believe that the added hour is reasonable since the P&T Committee requires significantly less work for Part B than for Part D. In aggregate, we estimate an annual burden of 634 hours (1 hr x [697 plans - 63 Prescription Drug plans which do not offer Part B]) at a cost of \$46,181 (634 hr x \$72.84/hr).

Regulatory Reference	Provision Brief Title	Respondents	Total Responses	Hours per Respondent	Total Hours	Labor Cost (\$/hr)	Total Annual Cost (\$)
§ 423.128	Part D Explanation of Benefits (Updating Systems)	295	295	160	15,733	98.54	1,550,330
§ 423.128	Part D Explanation of Benefits (Extra mailings)*	295	571,200,000	n/a	n/a	n/a	5,733,706
§ §423.120, 422.136, 422.568, 422.570, 422.572, 422.584, 422.590, 422.618, and 422.619	Part B Step Therapy (use of PT Committee)	634	634	1	634	72.84	46,181
TOTAL		929	571,201,147	Varies	16,403	Varies	7,334,430

12.3.9 Dissemination of plan information (§ 423.128)

(Revised by adding requirements under paragraph (e)(5))

Under paragraph (a), part D sponsors must disclose information about its Part D plan(s) as required by this section to each enrollee of a Part D plan offered by the Part D sponsor under this part and to Part D eligible individuals. The burden associated with this requirement is the time and effort necessary for a Part D sponsor to disclose information and materials about its Part D plan(s). We estimate that it will require 757 respondents 80 hours on an annual basis to prepare the plan materials. We further estimate that, on average, it will require each entity 120 hours for a business operations specialist to disseminate the required materials to enrollees and eligible individuals for a total annual burden of **151,400 hours**. The decrease in total annual burden from the previously reported estimate is due to a correction in the number of respondents. The

estimated annual cost is \$10,640,392 (\$70.28 /hr x 151,400 hr).

Under paragraph (e), Part D sponsors must furnish directly to enrollees an explanation of benefits when prescription drug benefits are provided under qualified prescription drug coverage that meets the requirements set forth in this section. The burden associated with this requirement is the time and effort necessary for 757 respondents to provide an explanation of benefits when prescription drug benefits are provided to enrollees. We estimate that it will require each entity 160 hours for a business operations specialist to disseminate the required materials for total annual burden of **121,120 hours**. The decrease in total annual burden from the previously reported estimate is due to a correction in the number of respondents. The estimated annual cost is \$8,512,314 (\$70.28/hr x 121,120 hr).

In accordance with § 423.128(e)(5) of CMS-4180-F, sponsors will be required to include the cumulative percentage change in the negotiated price since the first day of the current benefit year for each prescription drug claim in the EOB. Sponsors will also be required to include information about drugs that are therapeutic alternatives with lower cost-sharing. The intent is to provide enrollees with greater transparency with respect to drug prices, leading to lower costs. Since plans use formularies, they already have the negotiated drug price and the lower cost alternatives in an existing information system. The cost of this provision consists of: programming systems to calculate and connect information to the Part D EOB production, and the cost of paper, toner, and postage.

We estimate it will take two software programmers 8 hours (16 hours total) to revise 10 systems at \$98.54/hr. We also believe it is appropriate to estimate burden by each parent organization since it is typically more efficient for major system changes to be performed once at the parent organizational level with the contracts of that parent organization sharing the updated system.

Based on bid information and trends we expect 295 Part D Sponsors and PDP parent organizations for 2020. In aggregate, our revised one-time burden estimate for updating systems is 47,200 hours (160 hr per response x 295 responses) at a cost of \$4,651,088 (47,200 hr x \$98.54/hr) or \$15,766 per respondent (\$4,651,088/295 sponsors and organizations). Over the course of OMB's anticipated 3-year approval period, we estimate an annual burden of 15,733 hours (47,200 hr/3 years) at a cost of \$1,550,363 (\$4,651,088/3 years). We are annualizing the one-time labor estimate since we do not anticipate any additional burden after the 3-year approval period expires.

We also estimate an ongoing burden since EOBs would contain additional information about alternatives possibly requiring more printed pages per EOB. Based on internal bid information and projection we expect 47.6 million Part D enrollees in 2020. For our estimates of paper, toner, and postage we are adopting the same estimates that we used on April 16, 2018 (83 FR 16440) for our CY 2019 MA (Part C)/Prescription Drug Benefit (Part D) final rule (CMS-4182-F, RIN 0938-AT08) found on page 16695. However, we are revising the postage rate to the updated 2019 bulk mailing rates.

Although our regulations allow electronic submission of Part D EOBs upon request, informal communication from stakeholders indicates small usage. We are therefore assuming mailings to all enrollees. Since we do not require first class postage for Part D EOBs, we are assuming that

Part D sponsors will use the least expensive option, namely, the use of bulk mailing rates. We also assume that the added information about alternatives is not started on a separate page as that could be costly; accordingly we assume the current Part D EOB on average ends mid-page and that adding 1-2 pages would on average add 1.5 pages of print requiring at most 1 page of paper (since the other half page of print would go on an already printed page). Furthermore, we assume that the Part D EOB is double-sided. In some cases the extra 1.5 pages may fit on the last printed page and on its other side not necessitating more paper. Bulk mailing rates vary by vendor; an informal survey on the web suggests \$0.19 for 2019 rates for 50 pounds (envelope weight is normally considered negligible when citing these rates). Other assumptions are possible but the main drivers of our added cost are paper and toner as opposed to postage. The following breaks down those costs:

- Paper costs \$0.005 per sheet (\$2.50 for a ream of paper with 500 sheets).
- Toner costs \$0.005 per sheet (\$50 for a toner cartridge lasting 10,000 sheets).
- Postage costs are \$0.000038 per page since--
 - ++ A sheet of paper weights 0.16 ounces (5 pounds/500 sheets x 16 ounces/pound).
 - ++ Commercial bulk postage rates for 2019 are \$0.19 for 200 pieces (50 pounds).
 - ++ There are 16 ounces in one pound.
 - ++ Postage cost per page is therefore \$0.000038 ($[\$0.19 \times 0.16 \text{ ounces per page}] / [50 \text{ pounds} \times 16 \text{ ounces/pound}]$).

Thus, the total cost per page is \$0.010038 (\$0.005 for paper + \$0.005 for toner + \$0.000038 for postage). Finally, we note that Part D EOBs are sent out once per month to each enrollee summarizing drug transactions for the previous month. Thus we estimate an annual cost of \$5,733,706 (47.6 million enrollees x 12 months x 1 page x \$0.010038 per page). We believe that after appropriate programming (as discussed previously) the 47.6 million mailings will be performed automatically and will not require extra staff time.

Combining the estimates for system updates and mailing we obtain an annual estimated cost of \$7,284,069 (\$1,550,363 for updating systems + \$5,733,706 for paper, printing, and mailing)

Regulatory Reference	Provision Brief Title	Control Number (CMS ID Number)	Respondents	Total Responses	Hours per Respondent	Total Hours	Labor Cost (\$/hr)	Total Annual Cost (\$)
§ 423.128	Part D Explanation of Benefits (Updating Systems)	0938-0964 (CMS-10141)	295	295	160	15,733	98.54	1,550,330
§ 423.128	Part D Explanation of Benefits (Extra mailings)*	0938-0964 (CMS-10141)	295	571,200,000	n/a	n/a	n/a	5,733,706*
TOTAL			295	571,200,295	Varies	15,733	Varies	7,284,036

*Non-labor requirements and costs

12.3.10 Drug Utilization Management, Quality Assurance, and Medication Therapy Management (MTM) (§ 423.153)

(b) A Part D plan sponsor or MA organization offering an MA-PD plan must provide CMS with information concerning the procedures and performance of its drug utilization management program, according to guidelines specified by CMS.

The burden associated with this requirement is the time and effort necessary for the Part D plan sponsor or MA organization offering an MA-PD plan to provide CMS with information concerning its drug utilization management program, according to guidelines specified by CMS. We estimate that it will require 757 respondents 30 minutes (0.5 hours) for a business operations specialist to provide the required material to CMS for consideration for a total annual burden of **378.5 hours**. The decrease in total annual burden from the previously reported estimate is due to the decrease in the number of Part D plans. The estimated annual cost is \$26,601 (\$70.28 /hr x 378.5 hr).

(c) A Part D plan sponsor or MA organization offering an MA-PD plan must provide CMS with information concerning its quality assurance measures and systems, according to guidelines specified by CMS.

The burden associated with this requirement is the time and effort necessary for the Part D plan sponsor or MA organization offering a MA-PD plan to provide CMS with information concerning its quality assurance measures and systems, according to guidelines specified by CMS. We estimate that it will require 757 respondents 30 minutes (0.5 hours) for a business operations specialist to provide the required material to CMS for consideration for a total annual burden of **378.5 hours**. The decrease in total annual burden from the previously reported estimate is due to the decrease in the mean wage for a business operations specialist. The estimated annual cost is \$26,601 (\$70.28 /hr x 378.5 hr).

(f) Finalized § 423.153(f) will implement provisions of section 704 of CARA, which allows Part D plan sponsors to establish a drug management program that includes “lock-in” as a tool to manage an at-risk beneficiary’s access to coverage of frequently abused drugs. Part D plan sponsors will be required to notify at-risk beneficiaries about their plan’s drug management program. Part D plan sponsors are already expected to send a notice to some beneficiaries when the sponsor decides to implement a beneficiary-specific POS claim edit for opioids (the § 423.153 provision is approved by OMB under this control number). However, we believe that the approved information collection request only accounts for the notices that are currently sent to beneficiaries who have a POS edit put in place to monitor opioid access (which will count as the initial notice described in the preamble and defined in § 423.153(f)(4)) and will not capture the second notice that at-risk beneficiaries receive confirming their determination as such or the alternate second notice that potentially at-risk beneficiaries will receive to inform them that they were not determined to be at risk.

Since 2013, there have been 4,617 POS edits submitted into MARx by plan sponsors for 3,961

unique beneficiaries as a result of the drug utilization review policy. That results in approximately 923 edits annually. If we assume that the number of edits or access to coverage limitations will double due to the addition of pharmacy and prescriber “lock-in” to OMS, to approximately 1,846 such limitations, we estimate 3,692 initial and, second notices (number of limitations (1,846) multiplied by the number of notices (2)) total corresponding to such edits/limitations. Once the templates have been developed, we estimate it will take an average of 5 minutes (0.083 hours) at \$39.22/hour for an insurance claim and policy processing clerk to prepare each notice. We estimate an annual burden of **306 hours** (3,692 notices x 0.083 hour) at a cost of \$12,093 (306 hr x \$39.52 /hr).

Part D plan sponsors are required to upload these new notice templates into their internal claims systems. We estimate that 219 Part D plan sponsors (31 PDP parent organizations and 188 MA-PD parent organizations, based on plan year 2017 plan participation) will be subject to this requirement. We estimate that it will take on average 5 hours at \$81.90/hour for a computer programmer to upload the notices into their claims systems. This will result in a total burden of **1,095 hours** (5 hour x 219 sponsors) at a cost of \$92,155 (1,095 hr x \$84.16 /hr).

In aggregate, the burden to upload and prepare these additional notices is **1,401 hours** (306 hours +1,095 hours) at a cost of \$104,248 (\$12,093 + \$92,155).

12.3.11 Accreditation Organizations and Treatment of Territories (§ 423.168, 423.171, and 423.907)

In § 423.168(c), an accreditation organization approved by CMS must provide to CMS in written form and on a monthly basis copies of accreditation surveys, notices of accreditation decisions, notice of all complaints, information about any remedial or adverse action taken, and notice of any finalized changes to accreditation standards, requirements or survey processes. Under 423.171 any organization applying for approval must furnish to CMS all of the information and materials set forth in this part.

Section 423.907(a) discusses the requirements on territories to submit plans for approval by the Secretary to receive increased grants. This paragraph states that a territory may submit a plan to the Secretary under which medical assistance is to be provided to low-income individuals for the provision of covered Part D drugs. Paragraph (b) describes what a plan must include. The burden associated with this requirement is the time and effort of territories to prepare and submit a plan for approval. We estimate that this requirement will affect 5 territories.

The burden associated with these requirement is the time and effort necessary for a sponsoring entity to submit the required information to CMS. On an annual basis it will take 7 accreditation organizations and 5 territories about 1.0 hour per month each for a business operations specialist to submit the required notification to CMS, for a total of approximately **144 hours** (12 responses/yr x (7 accreditation organizations + 5 territories)). The estimated annual cost is \$10,120 (\$70.28 /hr x 144 hrs).

12.3.12 Determination of payment (§ 423.329)

(b) Part D plan contracts must submit data regarding drug claims to CMS that can be linked at the individual level to Part A and Part B data in a form and manner similar to the process provided under § 422.310 and other information as CMS determines necessary.

The burden associated with this requirement is the time and effort necessary for Part D plan sponsors submit the required claims data to CMS. We estimate that on an annual basis it will take 70 stand-alone Part D plan contracts and 117 PACE contracts 52 hours for a business operations specialist to submit the required documentation to CMS for total annual burden of **9,724 hours**. The estimated annual cost is \$683,402 (\$70.28 /hr x 9,724 hr).

(b)(ii) MA organizations that offer MA–PD plans to submit data regarding drug claims that can be linked at the individual level to other data that the organizations are required to submit to CMS in a form and manner similar to the process provided under § 422.310 and other information as CMS determines necessary.

The burden associated with this requirement is the time and effort necessary for MA organizations submit the required claims data to CMS. We estimate that on an annual basis it will take 599 MA contracts 15 hours for a business operations specialist to submit the required documentation to CMS for total annual burden of **8,985 hours**. The estimated annual cost is \$631,466 (\$70.28 /hr x 8,985 hr).

12.3.13 Risk sharing arrangements (§ 423.336)

(a) A Part D plan sponsor may submit a bid that requests a decrease in the applicable first or second threshold risk percentages or an increase in the percent applied under paragraph (b) of this section.

The burden associated with this requirement is the time and effort necessary for Part D plan sponsors submit the required bid materials to CMS. We estimate that on an annual basis it will take 5 Part D plan sponsors 20 hours for a business operations specialist to submit the required documentation to CMS for total annual burden of **100 hours**. The estimated annual cost is \$ 7,028 (\$70.28 /hr x 100 hr).

(c) Within 6 months of the end of a coverage year, the Part D plan must provide the information that CMS requires.

The burden associated with this requirement is the time and effort necessary for Part D plan sponsors submit the required cost data to CMS. We estimate that on an annual basis it will take each of the 757 Part D plan sponsors 10 hours per month for a business operations specialist to submit the required documentation to CMS for total annual burden of **90,840 hours**. The estimated annual cost is \$6,384,235 (\$70.28 /hr x 90,840 hr).

12.3.14 Retroactive adjustments and reconciliations (§ 423.343)

(c) Within 6 months of the end of a coverage year, the Part D plan must provide the information

that CMS requires.

The burden associated with this requirement is the time and effort necessary for Part D only sponsors to submit the required data to CMS. We estimate that on an annual basis it will take each of the 757 Part D plan sponsors 10 hours for a business operations specialist to submit the required documentation to CMS for total annual burden of **7,570 hours**. The estimated annual cost is \$532,020 ($\$70.28 / \text{hr} \times 7,570 \text{ hr}$).

(d) Within 6 months of the end of a coverage year, the Part D plan must provide the information that CMS requires.

The burden associated with this requirement is the time and effort necessary for Part only sponsors to submit the required cost data to CMS. We estimate that on an annual basis it will take each of the 757 Part D plan sponsors 10 hours for a business operations specialist to submit the required documentation to CMS for total annual burden of **7,570 hours**. The estimated annual cost is \$532,020 ($\$70.28 / \text{hr} \times 7,570 \text{ hr}$).

12.3.15 Coordination of benefits with other providers of prescription drug coverage (§ 423.464)

(f) A Part D sponsor must exclude expenditures for covered Part D drugs made by insurance or otherwise, a group health plan, or other third party payment arrangements, including expenditures by plans offering other prescription drug coverage for purposes of determining whether a Part D plan enrollee has satisfied the out-of-pocket threshold provided under §423.104(d)(5)(iii). To ensure that this requirement is met, A Part D enrollee must disclose all these expenditures to a Part D plan in accordance with requirements under § 423.32(b)(ii).

The burden associated with this requirement is the time and effort necessary for a Part D enrollee to disclose all these expenditures to a Part D plan in accordance with requirements under § 423.32(b)(ii). The burden associated with this requirement is captured and discussed above under § 423.32(b).

12.3.16 Contract provisions (§ 423.505)

(d) The Part D sponsor agrees must maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that are sufficient to meet the requirements set forth in this section.

The burden associated with this requirement is the time and effort necessary for Part D sponsors and MA organizations to maintain the required documentation outlined in this section. We estimate that on an annual basis it will take 757 respondents 52 hours for a business operations specialist to maintain the required documentation on an annual basis, for total annual burden of **39,364 hours**. The estimated annual cost is \$2,719,265 ($\$70.28 / \text{hr} \times 39,364 \text{ hr}$).

(f) The Part D sponsor must submit to CMS certified financial information that must include the requirements set forth in this section.

The burden associated with this requirement is the time and effort necessary for Part D sponsors and MA organizations to submit the required certified data to CMS. We estimate that on an annual basis it will take 757 respondents 8 hours for a business operations specialist to submit the required documentation to CMS for total annual burden of **6,056 hours**. The estimated annual cost is \$425,616 (\$70.28 /hr x 6,056 hr).

12.3.17 Novation agreement requirements (§ 423.552)

(a) Discusses the conditions for CMS approval of a novation agreement. This paragraph requires the Part D plan sponsor to notify CMS at least 60 days before the date of the proposed change of ownership and requires them to provide CMS with updated financial information and a discussion of the financial solvency impact of the change of ownership on the surviving organization.

The burden associated with this requirement is discussed above in § 423.551 of the PRA section.

12.3.18 General Provisions (§ 423.562)

(a) A Part D plan sponsor must ensure that all enrollees receive written information about the grievance, coverage determination, and appeals procedures that are available to and the information must satisfy the requirements set forth in this section.

The burden associated with this requirement is the time and effort necessary for each of the 757 Part D plan sponsors to disclose the necessary information to enrollees. We estimate that it will require each of the 757 Part D plan sponsors 8 hours for a business operations specialist to disclose the information for a total annual burden of **6,056 hours**. The estimated annual cost is \$425,615 (\$70.28 /hr x 6,056 hr).

12.3.19 Grievance procedures (§ 423.564)

(e) A Part D plan sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee's health status, but no later than 30 days after the date the plan sponsor receives the oral or written grievance.

The burden associated with this requirement is the time and effort necessary for Part D plan sponsors to notify an enrollee of its decision as expeditiously as the case requires, based on the enrollee's health status, but no later than 30 days after the date the plan receives the oral or written grievance. We estimate that 757 Part D plan sponsors will provide notification of 55,334 grievance decisions. The Part D plan must provide written notification of the decision if the grievance was submitted in writing, if the enrollee requests a written response, or if the grievance relates to a quality of care issue. We estimate that the plan sponsor will have to provide written notification to enrollees in 13,200 grievances and oral notification in 118,800 grievances. We estimate it will take 30 minutes (0.5 hours) to provide written notification for a total annual burden of **6,600 hours**. We estimate it will take 15 minutes (0.25 hours) for a business operations specialist to provide oral notification to enrollees for a total annual burden of **29,700 hours**. The total number of hours is **36,300** (6,600 + 29,700) annually. The estimated annual cost is \$2,551,164 (\$70.28 /hr x 36,300 hr).

(g) The Part D plan must maintain records on all grievances received both orally and in writing, including, at a minimum, the date of receipt, final disposition of the grievance, and the date that the Part D plan notified the enrollee of the disposition.

The burden associated with this requirement is the time and effort necessary for Part D plans to maintain the required documentation outlined in this section. We estimate that on an annual basis it will take 757 Part D plan sponsors 52 hours for a business operations specialist to maintain the required documentation on an annual basis, for a total annual burden of **39,364 hours**. The estimated annual cost is \$2,766,502 (\$70.28 /hr x 39,364 hr).

12.3.20 Standard timeframe and notice requirements for coverage determinations (§ 423.568)

(a)(3) A Part D plan sponsor must accept requests for benefits orally or in writing and must establish and maintain a method of documenting all oral requests for standard coverage determinations and retain the documentation in the case file.

The burden associated with this requirement is the time and effort necessary for Part D plan sponsors to document oral requests and retain the documentation in the case file. We estimate that Part D plan sponsors will receive about 3,675,000 standard coverage determination requests annually and, of that number, 1,837,500 will be oral requests. We estimate that it will take a Part D plan sponsor 3 minutes (0.05 hours) for a business operations specialist to document and retain the required documentation in the case file. Thus, we estimate that it will take 757 Part D plan sponsors a total of **91,875 hours** to perform this function on an annual basis. The estimated annual cost is \$ 6,456,976 (\$70.28 /hr x 91,875 hr).

(b), (c), (d) and (f) When a party makes a request for a drug benefit, a Part D plan sponsor must notify the enrollee in writing of favorable and unfavorable decisions. Enrollees (and the enrollee's prescriber, as appropriate) must be notified of a coverage decision as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's or other prescriber's supporting statement. For payment requests, the plan sponsor must notify the enrollee of its decision and make any applicable payment no later than 14 calendar days after receiving the request.

The burden associated with this requirement is the time and effort necessary for the 757 Part D plan sponsors to provide written notice to the enrollee. We estimate it will take a plan sponsor 15 minutes (0.25 hours) to issue a written denial notice in 1,139,250 cases for a total estimate of **284,813 hours**. We estimate it will take a plan sponsor 15 minutes (0.25 hours) to issue a written notice for 2,535,750 favorable decisions for a total estimate of **633,938 hours**.

The total number of hours is **918,751** (284,813 + 633,938) annually. The estimated annual cost is \$64,569,820 (\$70.28 /hr x 918,751 hr).

12.3.21 Expediting certain coverage determinations (§ 423.570)

(c)(2) A Part D plan sponsor must document all oral requests in writing and maintain the documentation in the case file. The burden associated with this requirement is the time and effort

necessary for Part D plans to maintain the required documentation outlined in this section. We estimate that on an annual basis Part D plan sponsors will receive 1,225,000 expedited coverage determination requests, of which 1,163,750 will be received orally. We estimate it will take 3 minutes (0.05 hours) for a plan sponsor's business operations specialist to document an oral request for an expedited coverage determination. Thus, it will take 757 Part D plan sponsors **58,188 hours** to perform this function on an annual basis. The estimated annual cost is \$4,089,453 ($\$70.28 / \text{hr} \times 58,188 \text{ hr}$).

(d) If a Part D plan denies a request for expedited determination, it must give the enrollee prompt oral notice of the denial and subsequently deliver, within 3 calendar days, a written letter that explains the notice requirements set forth in this section.

The burden associated with this requirement is the time and effort necessary for each of the 757 Part D plan sponsors to disclose the necessary information to an enrollee. We estimate that 12,250 expedited requests will be transferred to the standard adjudication process. We estimate that it will take plan sponsors 15 minutes (0.25 hours) for a business operations specialist to provide this notice, for a total annual burden of **3,063 hours**. The estimated annual cost is \$215,268 ($\$70.28 / \text{hr} \times 3,063 \text{ hr}$).

12.3.22 Timeframes and notice requirements for expedited coverage determinations (§ 423.572)

(a) and (c) A Part D plan sponsor must notify the enrollee (and the prescribing physician or other prescriber involved, as appropriate) of its decision, whether adverse or favorable, as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's or other prescriber's supporting statement. Plan sponsors must notify enrollees in writing of favorable and unfavorable expedited coverage determinations.

The burden associated with this requirement is the time and effort necessary for each of the 757 Part D plan sponsors to disclose the necessary information to an enrollee and prescribing physician or other prescriber involved. We estimate it will take 15 minutes (0.25 hours) for a business operations specialist to provide notice of 1,212,750 expedited coverage determination decisions for a total estimated annual burden of **303,188 hours**. The estimated annual cost is \$21,303,133 ($\$70.28 / \text{hr} \times 303,118 \text{ hr}$).

12.3.23 Exceptions process (§ 423.578)

Exception requests must be supporting by a statement from the enrollee's prescriber and if the supporting statement is provided orally, a Part D plan sponsor may require a written follow-up. The burden associated with this requirement is the time and effort necessary for a prescribing physician or other prescriber to submit the written supporting statement or other medical documentation to the Part D plan sponsor. We estimate 2,388,750 requests will require written documentation and that it will take the physician or other prescriber 15 minutes (0.25 hours) to provide the supporting documentation. Therefore, we estimate a total annual burden of **597,188 hours**. The estimated annual cost is \$54,481,461 ($\$91.23/\text{hr} \times 597,188 \text{ hr}$).

12.3.24 Administration of subsidy program (§ 423.800)

Paragraph (b) of this section requires the Part D plan sponsor offering the Part D plan, or the MA organization offering the MA-PD plan, to reduce the individual’s premiums and cost-sharing as applicable and provide information to CMS on the amount of such reductions, in a manner determined by CMS. This paragraph also requires the Part D plan sponsor offering the Part D plan to maintain documentation to track the application of the low-income cost-sharing subsidies to be applied to the out-of-pocket threshold.

The burden associated with these requirements is the time and effort for the Part D plan sponsor offering the Part D plan to provide information to CMS and to maintain documentation. We estimate that it will take each of the 757 respondents approximately 52 hours for a business operations specialist to provide the information to CMS. We also estimate that it will take approximately 26 hours for each of the 757 respondents to maintain the information for tracking purposes. Therefore, we estimate a total annual burden of **59,046 hours** to comply with these requirements. The estimated annual cost is \$4,149,753 (\$70.28 /hr x 59,046 hr).

12.3.25 Change in Ownership (§ 423.892)

(c) A sponsor who is contemplating or negotiating a change of ownership must notify CMS. We estimate that approximately 1 percent of sponsors will fall into this category in a given year.

The burden associated with this requirement is the time and effort necessary for a sponsoring entity to submit the required notification to CMS. On an annual basis it will take 50 entities (1 percent of 5,000) about 1.0 hour for a business operations specialist to submit the required notification to CMS, for a total of approximately **50 hours**. The estimated annual cost is \$ 3,514 (\$70.28 /hr x 50 hr).

12.3.26 Burden Summary

Medicare Prescription Drug Benefit Program (Plans): Burden Summary (Subtotal)

CFR Section	Respondent Type	# Respondents	Time (hr per response)	# Responses (per respondent)	Total Responses (all respondents)	Total Annual Time (all respondents)
423.32(d)	Private Sector	757	3	2	1,514	4,542
			0.017 (1 min)	4,986	3,954,000	67,218
423.34(e)	Private Sector	757	0.25	164	130,000	32,500
423.36(b)	Private Sector	757	1.017	32,401	1,903,752	33,121
423.44(b)	Private Sector	757	1	1	757	757
			0.1 (6 min)	626	496,344	49,634

			1	1	757	757
			0.017 (1 min)	1.4	1,100	18.7
			1	1	757	757
			0.1 (6 min)	22	17,772	1,777
423.46(b)	Private Sector	757	0.25	4,542	3,954,000	988,500
423.46(d)	Private Sector	757	0.083 (5 min)	4,542	3,954,000	328,182
423.48	Private Sector	757	2	1	757	1,514
423.104(g)	Private Sector	757	10	1	757	7,570
423.120(b)	Private Sector	757	2	1	757	1,514
			40	1	757	30,280
			0.083 (5 min)	1	19,000,000	1,577,000
423.120(d) NEW STEP Therapy	Private Sector	634	1	1	634	634
423.128(a)	Private Sector	757	200	1	757	151,400
423.128(e)	Private Sector	757	160	1	757	121,120
423.128 (e)(5) NEW Part D EOB	Private Sector	295	160	1	295	15,733
423.128(e)(5) NEW Part D EOB Extra Mailing	Private Sector	295	n/a	n/a	571,200,000	varies
423.153(b)	Private Sector	757	0.5	1	757	378.5
423.153(c)	Private Sector	757	0.5	1	757	378.5
423.153(f)	Private Sector	219	0.083	17.4	3,692	307
423.153(f)	Private Sector	219	5	1	219	1,095
423.168 (c) 423.171 (a), 423.904(a)	Private Sector	12	1	12	144	144
423.329(b)	Private Sector	187	52	1	187	9,724
		599	15	1	599	8,985
423.336(a)	Private Sector	5	20	1	5	100

423.336(c)	Private Sector (Contracts)	757	10/month	12	9,516	95,160
423.343(c)	Private Sector (Contracts)	757	10	1	757	7,570
423.343(d)	Private Sector (Contracts)	757	10	1	757	7,570
423.505(d)	Private Sector	757	52	1	757	39,364
423.505(f)	Private Sector	757	8	1	757	6,056
423.562(a)	Private Sector	757	8	1	757	6,056
423.564(e)	Private Sector	757	0.5	16.6	13,200	6,600
			0.25	149.8	118,800	29,700
423.564(g)	Private Sector	757	52	1	757	39,364
423.568(a)(3)	Private Sector	757	0.05 (3 min)	2,317	1,837,500	91,875
423.568(b), (c), (d), and (f)	Private Sector	757	0.25	1436.6	1,139,250	284,813
			0.25	3,197.7	2,535,750	633,938
423.570(c)(2)	Private Sector	757	0.05 (3 min)	1,467.5	1,163,750	58,188
423.570(d)	Private Sector	757	0.25	15.4	12,250	3,063
423.572(a) and (c)	Private Sector	757	0.25	1,529.3	1,212,750	303,188
423.578(a) and (b)	Private Sector		0.25		2,388,750	597,188
423.800(b)	Private Sector	757	78	1	757	59,046
423.892(c)	Private Sector	50	1	1	50	50
Subtotal		757	--	--	615,063,305	5,704,430

12.4 ICRs Regarding State Eligibility Determinations (423.904(b)) and Reporting (423.910(d)) (No Changes)

12.4.1 Eligibility determinations for low-income subsidies (§ 423.904)

Paragraph (b) of this section states the State agency must inform CMS of cases where eligibility is established or redetermined.

The burden associated with the requirement on State agencies to inform CMS of cases where

eligibility is established or redetermined is estimated to total approximately **6,120 annual hours**. We estimate that there will be approximately 600,000 of these cases on an annual basis. We also estimate that it will take approximately 10 hours per month for the State agency to inform CMS of these cases.

Paragraph (d) of this section requires States to make available--low-income subsidy application forms, information on the nature of, and eligibility requirements for the subsidies under this section, and offer assistance with the completion of the application forms. States must require an individual or personal representative applying for the low-income subsidy to complete all required elements, provide documents as necessary, and certify as to the accuracy of the information provided. In addition, States must provide CMS with other information as specified by CMS that may be needed to carry out the requirements of the Part D prescription drug benefit.

The burden associated with the requirement on States to require the applicant of the low-income subsidy to complete all required elements, to provide documents, and to certify as to the accuracy of the information is subject to the PRA; however, the burden associated with this requirement is discussed in § 423.774 above.

The burden associated with the requirement on States to provide CMS with other information as specified by CMS is estimated to total approximately **1,020 annual hours**. Based on the experience to date, it will take on average 20 hours per State on an annual basis to provide CMS with the specified information.

12.4.2 Requirements (§ 423.910)

(d) The subpart also requires States to submit an electronic file, in a manner specified by the Secretary, identifying each full benefit dual eligible beneficiary enrolled in the State for each month with Part D drug coverage who is also determined to be full benefit eligible by the State for full Medicaid benefits.

The burden associated with the requirement on States to submit an electronic file identifying each full benefit dual eligible enrolled in the State for each month with Part D drug coverage is estimated to total approximately 120 hours per State on an annual basis. We estimate that it will take approximately 10 hours for each State’s business operations specialist to submit an electronic file on a monthly basis. Therefore, we estimate a total burden of **6,120 hours** on an annual basis. The estimated annual cost is \$430,114 ($\$70.28 / \text{hr} \times 6,120 \text{ hr}$).

Burden Summary (Subtotal)

CFR Section	Respondent Type	# Respondents	Time (hr per response)	# Responses (per respondent)	Total Responses (all respondents)	Total Annual Time (all respondents)
423.904(b)	State	51	10/month	12,000	600,000	6,120

			20	1	51	1,020
423.910(d)	State	51	10/month	12	51	6,120
Subtotal		51	varies	varies	600,102	13,260

**12.5 ICRs Regarding the Part D Sponsor’s System Programming (§ 423.120(c)(6))
(No Changes)**

For this provision the burden will include the time and effort for Part D adjudication systems to be programmed for the model notices. We estimate that it will take sponsors and PBMs with Part D adjudication systems approximately 93,600 hours in 2019 for software developers and programmers to program their systems to comply with the requirements of § 423.120(c)(6). The sponsors and PBMs will need approximately six to twelve months to perform system changes and testing. The total hour figures are based on a 6-month preparation and testing period. There are roughly 1,040 full-time working hours in a 6-month period. Using an estimate of 3 full-time Software Developers and Programmers at \$98.54 /hr amounts to **93,600 hours** (3 workers x 1,040 hr x 30 sponsors/PBMs) at a cost of **\$9,223,344** (93,600 hr x \$ 98.54/hr) for 2019. This is a one-time burden. There will be no burden associated with 2020 and 2021.

Burden Summary (Subtotal)

CFR Section	Respondent Type	# Respondents	Time (hr per response)	# Responses (per respondent)	Total Responses (all respondents)	Total Annual Time (all respondents)
423.120(c)(6)	Private Sector	30	3,120	1	30	93,600
Subtotal		30	3,120	1	30	93,600

**12.6 ICRs Regarding the Creation of Model Notices to the Medicare Beneficiaries and Prescribers (§ 423.120(c)(6))
(No Changes)**

The finalized provision will require that Part D sponsors provide written notice to the beneficiary and take reasonable efforts to furnish written notice to the prescriber.

For this provision the burden will include the time and effort for creating the model notices. We estimate that 212 parent organizations will need to create two model notices to notify beneficiaries and prescribers under finalized § 423.120(c)(6). We project that it will take each organization 3 hours at \$70.28 /hr for a business operations specialist to create the two model notices. In aggregate, we estimate a one-time burden of **636 hours** (212 organizations x 3 hr) at a cost of **\$44,698** (636 hr x \$70.28 /hr) or \$207.84 per organization (\$44,698 /212 organizations) in 2019. There will be no burden associated with 2020 and 2021.

Burden Summary (Subtotal)

CFR Section	Respondent Type	# Respondents	Time (hr per response)	# Responses (per respondent)	Total Responses (all respondents)	Total Annual Time (all respondents)
423.120(c)(6)	Private Sector	212	3	1	212	636
Subtotal		212	3	1	212	636

**12.7 ICRs Regarding the Preparation and Issuance of the Model Notices to the Medicare Beneficiaries and Prescribers (§ 423.120(c)(6))
(No Changes)**

For this provision we estimate that it will take an average of 5 minutes (0.083 hr) at \$39.22/hour for an insurance claim and policy processing clerk to generate and disseminate the aforementioned notice. We estimate that an average of approximately 800 prescribers will be on the Preclusion List in early 2019 with roughly 80,000 Part D beneficiaries affected; that is, 80,000 beneficiaries will receive prescriptions written by these prescribers and will therefore receive the notice referenced in § 423.120(c)(6). In aggregate, we estimate a burden of **6,640 hours** (0.083 hr/response x 80,000 responses) at a cost of **\$262,413** (6,640 hr x \$ 39.52/hr) or \$1,242 per organization (\$262,413 / 212 organizations) for an insurance claim and policy processing clerk to prepare and distribute the notices in 2019.

In 2020 and 2021, we estimate that roughly 150 prescribers will be added to the Preclusion List, though this will be largely offset by the same number of prescribers being updated to reflect a change in their preclusion status (for example, based on reenrollment after the expiration of a reenrollment bar) with 15,000 affected beneficiaries. In aggregate, we estimate an annual burden of **1,245 hours** (15,000 beneficiaries x 0.083 hr) at a cost of **\$49,202** (1,245 hr x \$39.52 /hr) or \$328.01 per prescriber (\$49,202 /150 prescribers).

Burden Summary (Subtotal)

CFR Section	Respondent Type	# Respondents	Time (hr per response)	# Responses (per respondent)	Total Responses (all respondents)	Total Annual Time (all respondents)
423.120(c)(6)	Private Sector	800	0.083 (5 min)	Varies	80,000	6,640
423.120(c)(6)	Private Sector	150	0.083 (5 min)	Varies	15,000	1,245
Subtotal		950	0.083 (5 min)	Varies	95,000	7,885

- SUMMARY OF REQUIREMENTS AND ANNUAL BURDEN ESTIMATES

Total Annual Burden Estimates

ICR Section	# Respondents	Time (hr per response)	# Responses (per respondent)	Total Responses (all respondents)	Total Annual Time (all respondents)
12.1. Business Continuity Plans (No Change)	99	Varies	1	99	15,920
12.3. Medicare Prescription Drug Benefit Program: Plans (Revised)	757	Varies	Varies	615,063,305	5,704,430
12.5. System Programming (No Change)	30	3,120	1	30	93,600
12.6. Creation of model notices (No Change)	212	3	1	212	636
12.7 Preparation and issuance of model notices (No Change)	950	0.083 (5 min)	Varies	95,000	7,885
<i>Subtotal (Private Sector)</i>	<i>2,048</i>	<i>varies</i>	<i>Varies</i>	<i>615,158,646</i>	<i>5,822,471</i>
12.2. Medicare Prescription Drug Benefit Program: Bene (No Change)	9,869,100	Varies	1	9,869,100	2,847,975
<i>Subtotal (Individuals and Households)</i>	<i>9,869,100</i>	<i>Varies</i>	<i>1</i>	<i>9,869,100</i>	<i>2,847,975</i>
12.4. State Eligibility Determinations (No Change)	51	Varies	Varies	600,102	13,260
<i>Subtotal (States)</i>	<i>51</i>	<i>varies</i>	<i>Varies</i>	<i>600,102</i>	<i>13,260</i>
TOTAL	9,871,199	varies	Varies	625,627,848	8,683,706

The revisions associated with the Medicare Prescription Drug Benefit Program (PLAN) includes the Part D sponsor’s system programming of the Preclusion List, creation of model notices to be issued to Medicare beneficiaries and prescribers when a prescriber is identified on the Preclusion List, and preparation and issuance of model notices to the Medicare beneficiaries and prescribers. The system programming and creation of model notices is a one-time burden and is not considered an annual burden.

- INFORMATION COLLECTION INSTRUMENTS, INSTRUCTIONS AND GUIDANCE DOCUMENTS

Attachment 1 (see section 12.1)- 2019 Compensation Certification (No Changes)

- 1a – Compensation Certification to be Completed by All Organizations
- 1b – Compensation Certification to be Completed by Any Organization with Renewal Commission

Attachment 2 (see section 12.1) – Structure Submission Form (No Changes)

- 2a – Compensation Structure for Plans
- 2b – Compensation Structure for Writing Agents

Attachment 3 (see section 12.1) – Covered Agent Information Sheet (No Changes)

Attachment 4 (see section 12.1) - 2019 Compensation Structure for Writing Agents by Contract/PBP Number (No Changes)

Attachment 5 (see section 12.1) – Instructions (No Changes)

- 5a – Instructions for MA and PDP Organizations
- 5b – Instructions for Writing Agents
- 5c – Compensation Workbook

Attachments 6a – 6d (see section 12.6) – Drug Management Program Model Notices (No Changes)

- 6a – Instructions for Drug Management Program Notices
- 6b – Initial Notice Sent to Potentially At-Risk Beneficiaries
- 6c – Second Notice Sent to Beneficiary Designating At-Risk Status
- 6d – Alternate Second Notice Sent to Beneficiary Not Considered At-Risk

Attachment 7 (see section 12.7) – Precluded Provider Model Notice (New)

Attachments 8a -8h (see section 12.3) – Part D Explanation of Benefits (New)

- 8a - 2020 Model Part D Explanation of Benefits
- 8b - Exhibit A: Example Cover Page of the Model Part D EOB
- 8c - Exhibit B: Examples of Section 1 (the List of Prescriptions)
- 8d - Exhibit C: Example of Section 2 (Drug Payment Stages)
- 8e - Exhibit D: Example of Section 3 (Amounts and Definitions for TrOOP and Total Drug Costs)
- 8f - Exhibit E: Example of Section 4 (Changes to the Formulary)
- 8g - Exhibit F: Example of Sections 5 and 6 (Information for Reference)
- 8h - Exhibit G: Example of a Part D EOB (All Sections Included)

- ICRS EXEMPT FROM THE REQUIREMENTS OF THE PRA (Revised)

Since we estimate fewer than ten annual respondents for the following information collections, the requirements and burden are exempt (see 5 CFR 1320.3(c)) from the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

In § 423.507(a), if a Part D sponsor does not intend to renew its contract, it must notify CMS in writing by the first Monday of June in the year in which the contract ends and notify, in a manner that meets the requirements of this section, each Medicare enrollee, at least 90 days before the date on which the nonrenewal is effective.

In § 423.508(b), if the contract is terminated by mutual consent, the Part D sponsor must provide notice to its Medicare enrollees and the general public as provided in paragraph (c) of this section.

In § 423.509(b), if CMS notifies the Part D sponsor in writing 90 days before the intended date of their termination the Part D plan sponsor must notify its Medicare enrollees of the termination by mail at least 30 days before the effective date of the termination. The Part D sponsor must also notify the general public of the termination at least 30 days before the effective date of the termination by publishing a notice in one or more newspapers of general circulation in each community or county located in the Part D sponsor's service area.

In § 423.510(a), if a Part D sponsor terminates its contract because CMS fails to substantially carry out the terms of the contract the Part D sponsor must give advance notice to CMS, its Medicare enrollees, and the general public in a manner that meets the requirements set forth in the section.

In § 423.551(c), states that a Part D plan sponsor that has a Medicare contract in effect under § 423.502 of this part and is considering or negotiating a change in ownership must notify CMS at least 60 days before the anticipated effective date of the change. The Part D plan sponsor must also provide updated financial information and a discussion of the financial and solvency impact of the change of ownership on the surviving organization.

In § 423.552(a), Part D plan sponsors are required to submit to CMS, at least 30 days before the proposed change of ownership date, 3 signed copies of the novation agreement containing the provisions specified in this section, and 1 copy of other relevant documents required by CMS.

In § 423.859(c), states that CMS may waive or modify the requirements of this part if an entity seeking to become a prescription drug plan in an area such, as a territory, other than the 50 States or the District of Columbia requests waiver or modification of any Part D in order to provide qualified prescription drug. The burden associated with this requirement is the time and effort for the Part D plan to make a request of waiver or modification to CMS. We estimate that approximately 2 Part D plans will request a waiver or modification on an annual basis.

Section 423.863(a) discusses the process CMS uses for the solicitation and approval of bids. CMS solicits bids from eligible fallback entities for the offering in all fallback service areas in one or more Part D plan regions of a fallback prescription drug plan. CMS specifies the form and manner in which fallback bids are submitted in separate guidance to bidders. The burden associated with this requirement is the time and effort for the fallback entities to prepare and submit a bid that meets the requirements of the section and related sections. We estimate fewer than 10 fallback entities will submit a bid every three years.

Section 423.863(b) discusses the procedures CMS uses to enter into contracts. CMS solicits bids from eligible fallback entities and uses competitive procedures to enter into contracts. The burden associated with this requirement is the time and effort for the fallback entities to enter into a contract with CMS that meets the requirements of this section and related sections. We estimate, as an upper limit, that approximately 5 fallback entities will enter into a contract with CMS on an annual basis.

Section 423.871(f) states that each contract for a fallback prescription drug plan requires an eligible fallback entity offering a fallback prescription drug plan to provide CMS with the information CMS determines is necessary to carry out the requirements of this section. The burden associated with this requirement is the time required of the fallback prescription drug plan to provide CMS with the information CMS determines necessary. We estimate that approximately 5 fallback prescription drug plans will enter into a contract with CMS.

The following information collection requirements are associated with an administrative action

(see 5 CFR 1320.4(a)(2) and (c)). Consequently, they are exempt from the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

In § 423.580, the requirements under Right to a Redetermination.

In § 423.582, the requirements under Request for a Standard Redetermination.

In § 423.584, the requirements under Expediting Certain Redeterminations.

In § 423.590, the requirements under Timeframes and Responsibility for Making redeterminations.

In Part 423, the requirements under subpart N (Medicare Contract Determinations and Appeals).

In § 423.756(a), CMS will allow the Part D plan sponsor to provide evidence that it has not committed an act or failed to comply with the requirements as described. In addition, CMS may allow additional time for the Part D plan sponsor to provide the evidence if the Part D plan sponsor sends a written request providing a credible explanation of why additional time is necessary.

We believe the burden associated with the following requirements is exempt from the PRA in accordance with 5 CFR 1320.3(b)(2). Specifically, we believe that the time, effort, and financial resources necessary to comply with the aforementioned requirements will be incurred by pharmacies during the normal course of their activities and, therefore, should be considered usual and customary business practices.

In § 423.132(a), a Part D sponsor must require a pharmacy that dispenses a covered Part D drug to inform an enrollee of any differential between the price of that drug and the price of the lowest priced generic version of that covered Part D drug that is therapeutically equivalent and bioequivalent and available at that pharmacy, unless the particular covered Part D drug being purchased is the lowest-priced therapeutically equivalent and bioequivalent version of that drug available at that pharmacy. Since the requirements will be incurred by pharmacies during the normal course of their business practices, we believe they are exempt from the PRA.

In § 423.136(c) and (d), for any medical records or other health and enrollment information it maintains with respect to enrollees, a Part D plan sponsor must maintain the records and information in an accurate and timely manner and provide timely access by enrollees to the records and information that pertain to them. The burden associated with this requirement is the time and effort necessary to maintain and disclose enrollee records.

Section 423.904(d) requires States to make available low-income subsidy application forms, information on the nature of, and eligibility requirements for the subsidies under this section, and offer assistance with the completion of the application forms. States must require an individual or personal representative applying for the low-income subsidy to complete all required elements, provide documents as necessary, and certify as to the accuracy of the information provided. In addition, States must provide CMS with other information as specified by CMS that may be needed to carry out the requirements of the Part D prescription drug benefit.

Since the following requirements is associated with an affirmation and certification, the requirements and burden are exempt (5 CFR 1320.3(h)(1)) from the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.)

Section 423.505(k)(5) states that the Chief Executive Officer, Chief Financial Officer, or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to the officer, must certify that the information provided is accurate, complete, and truthful and fully conforms to the requirements in §§ 423.336 and 423.343 and acknowledge that this information will be used for the purposes of obtaining Federal reimbursement.

13. Capital Costs

All states and Part D plan sponsors are fully operational and equipped to fulfill these requirements. Therefore no additional capital or equipment costs will result from the collection of information.

14. Cost to the Federal Government

We estimate that on an annual basis 200 individuals will be required to pay arrearages for Part D-IRMAA to CMS in order to be reinstated. We estimate that it will take a CMS staff person 5 minutes (0.083) to compile the arrearage information and 1 minute (0.017 hours) to assemble and disseminate the notice for each Part D-IRMAA favorable determination. 200 notices x 0.1 hours (6 minutes) = 20 hours. The estimated annual cost is \$778. This is based upon the 2019 Washington-Baltimore-Northern VA Locality Pay Area hourly rate for a GS-11/step 6 of \$38.90/hr (https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2019/DCB_h.pdf) multiplied by the number of burden hours (20).

15. Changes to Burden

The CMS-4180-F final rule's revisions can be found above under Supporting Statement section 12.3 and are limited to subsection 12.3.8 for Part B Step Therapy (§ 423.120(d)) and subsection 12.3.9 for Part D Explanation of Benefits (§ 423.128(e)(5)).

In addition, we have accounted for burden associated with Accreditation Organizations and grant requests in U.S. territories. This accounts for a total burden of 144 hours based on the requirements laid out in 423.168, 423.171, and 423.907 ((7 accreditation organizations + 5 territories) x 1 hr/response x 12 responses/yr = 144 hours).

Part B Step Therapy

Under § 423.120(d) as codified in, CMS-4180-F provides protections to help ensure that beneficiaries maintain access to medically necessary Part B drugs while permitting MA plans to implement step therapy protocols that support stronger price negotiation and cost and utilization controls. In order to implement a step therapy program for one or more Part B drugs, the rule requires that an MA plan establish and use a P&T Committee to review and approve step therapy programs used in connection with Part B drugs. The P&T Committee requirements are very similar to the requirements applicable to Part D plans under § 423.120(b).

The rule allows MA-PD plans to use the Part D P&T Committee to satisfy the new requirements related to MA plans and Part B drugs. For MA plans that do not cover Part D benefits already,

they may use the Part D P&T Committee of another plan under the same contract. Under § 422.4(c), every MA contract must have at least one plan offering Part D. Because of the small amount of work needed annually, we believe it is reasonable to assume that no new committees will be formed and that the added work will be performed by the existing P&T Committees.

The finalized §422.136(b)(4) and (9) requires that the P&T Committee “clearly articulate and document processes,” We estimate it will take 1 hour at \$72.84/hr for a P&T Committee business specialist to perform certain tasks and review and retain documentation and information The 1 hour estimate reflects half of the Part D P&T Committee burden (or 2 hours) that is currently approved by OMB under this control number. We believe that the added hour is reasonable since the P&T Committee requires significantly less work for Part B than for Part D. In aggregate, we estimate an annual burden of 634 hours (1 hr x [697 plans - 63 Prescription Drug plans which do not offer Part B]) at a cost of \$46,181 (634 hr x \$72.84/hr).

Regulatory Reference	Provision Brief Title	Respondents	Total Responses	Hours per Respondent	Total Hours	Labor Cost (\$/hr)	Total Annual Cost (\$)
§ 423.120, 422.136, 422.568, 422.570, 422.572, 422.584, 422.590, 422.618, and 422.619	Part B Step Therapy (use of PT Committee)	634	634	1	634	72.84	46,181

Under § 423.128(e)(5), CMS-4180-F requires that sponsors include the cumulative percentage change in the negotiated price since the first day of the current benefit year for each prescription drug claim in the EOB. Sponsors will also be required to include information about drugs that are therapeutic alternatives with lower cost-sharing. The intent is to provide enrollees with greater transparency with respect to drug prices, leading to lower costs. Since plans use formularies, they already have the negotiated drug price and the lower cost alternatives in an existing information system. The cost of this provision consists of: programming systems to calculate and connect information to the Part D EOB production, and the cost of paper, toner, and postage.

We estimate it will take two software programmers 8 hours (16 hours total) to revise 10 systems at the same hourly wage. We also believe that it is appropriate to estimate burden by each parent organization since it is typically more efficient for major system changes to be performed once at the parent organizational level with the contracts of that parent organization sharing the updated system.

Based on bid information and trends we expect 295 Part D Sponsors and PDP parent organizations for 2020. In aggregate, our revised one-time burden estimate for updating systems is 47,200 hours (160 hr per response x 295 responses) at a cost of \$4,651,088 (47,200 hr x \$98.54/hr) or \$15,766 per respondent (\$4,651,088/295 sponsors and organizations). Over the course of OMB's anticipated 3-year approval period, we estimate an annual burden of 15,733 hours (47,200 hr/3

years) at a cost of \$1,550,363 (\$4,651,088/3 years). We are annualizing the one-time labor estimate since we do not anticipate any additional burden after the 3-year approval period expires.

As discussed, commenters pointed out that there would be an added ongoing burden since EOBs would contain additional information about alternatives possibly requiring more printed pages per EOB. Based on internal bid information and projection we expect 47.6 million Part D enrollees in 2020. For our estimates of paper, toner, and postage we are adopting the same estimates that we used on April 16, 2018 (83 FR 16440) for our CY 2019 MA (Part C)/Prescription Drug Benefit (Part D) final rule (CMS-4182-F, RIN 0938-AT08) found on page 16695. However, we are revising the postage rate to the updated 2019 bulk mailing rates. Although our regulations allow electronic submission of Part D EOBs upon request, informal communication from stakeholders indicates small usage. We are therefore assuming mailings to all enrollees. Since we do not require first class postage for Part D EOBs, we are assuming that Part D sponsors will use the least expensive option, namely, the use of bulk mailing rates. We also assume that the added information about alternatives is not started on a separate page as that could be costly; accordingly we assume the current Part D EOB on average ends mid-page and that adding 1-2 pages would on average add 1.5 pages of print requiring at most 1 page of paper (since the other half page of print would go on an already printed page). Furthermore, we assume that the Part D EOB is double-sided. In some cases the extra 1.5 pages may fit on the last printed page and on its other side not necessitating more paper. Bulk mailing rates vary by vendor; an informal survey on the web suggests \$0.19 for 2019 rates for 50 pounds (envelope weight is normally considered negligible when citing these rates). Other assumptions are possible but the main drivers of our added cost are paper and toner as opposed to postage. The following breaks down those costs:

- Paper costs \$0.005 per sheet (\$2.50 for a ream of paper with 500 sheets).
- Toner costs \$0.005 per sheet (\$50 for a toner cartridge lasting 10,000 sheets).
- Postage costs are \$0.000038 per page since--
 - ++ A sheet of paper weights 0.16 ounces (5 pounds/500 sheets x 16 ounces/pound).
 - ++ Commercial bulk postage rates for 2019 are \$0.19 for 200 pieces (50 pounds).
 - ++ There are 16 ounces in one pound.
 - ++ Postage cost per page is therefore \$0.000038 ($[\$0.19 \times 0.16 \text{ ounces per page}] / [50 \text{ pounds} \times 16 \text{ ounces/pound}]$).

Thus, the total cost per page is \$0.010038 (\$0.005 for paper + \$0.005 for toner + \$0.000038 for postage). Finally, we note that Part D EOBs are sent out once per month to each enrollee summarizing drug transactions for the previous month. Thus we estimate an annual cost of \$5,733,706 (47.6 million enrollees x 12 months x 1 page x \$0.010038 per page). We believe that after appropriate programming (as discussed previously) the 47.6 million mailings will be performed automatically and will not require extra staff time.

Combining the estimates for system updates and mailing we obtain an annual estimated cost of \$7,284,069 (\$1,550,363 for updating systems + \$5,733,706 for paper, printing, and mailing)

Regulatory Reference	Provision Brief Title	Respondents	Total Responses	Hours per Respondent	Total Hours	Labor Cost (\$/hr)	Total Annual Cost (\$)
§ 423.128	Part D	295	295	160	15,733	98.54	1,550,33

	Explanation of Benefits (Updating Systems)						0
§ 423.128	Part D Explanation of Benefits (Extra mailings)*	295	571,200,000	n/a	n/a	n/a	5,733,706*
SUBTOTAL		295	571,200,295	160	15,733	varies	7,284,036

*Non-labor requirements and costs.

Accreditation Organizations

In § 423.168(c), an accreditation organization approved by CMS must provide to CMS in written form and on a monthly basis copies of accreditation surveys, notices of accreditation decisions, notice of all complaints, information about any remedial or adverse action taken, and notice of any finalized changes to accreditation standards, requirements or survey processes. Under 423.171 any organization applying for approval must furnish to CMS all of the information and materials set forth in this part.

The burden associated with these requirement is the time and effort necessary for a sponsoring entity to submit the required information to CMS. On an annual basis it will take 7 accreditation organizations and 5 territories about 1.0 hour per month for a business operations specialist to submit the required notification to CMS, for a total burden of approximately 144 hours (12 total hours/org x 12 organizations/territories). The estimated annual cost is \$ 10,120 (\$70.28 /hr x 144 hrs).

Regulatory Reference	Provision Brief Title	Respondents	Total Responses	Hours per Respondent	Total Hours	Labor Cost (\$/hr)	Total Annual Cost (\$)
§ 423.168 (c) and 423.171	Accreditation Organizations	7	84	1	84	70.28	5,904
§ 423.904	Territories	5	60	1	60	70.28	4,216
SUBTOTAL	n/a	12	144	1	144	n/a	10,120

Burden Reconciliation

The currently approved package sets out 8,667,195 total hours. We are revising this figure to include the burden set forth with the addition of the EOB provisions §423.128, submission requirements for Accreditation Organizations and Territories, and the Part B Step Therapy provision for an additional 16,511 hours or a total of 8,683,706 hours (8,667,195 hr + 16,511 hr)

The currently approved package also sets out 54,426,919 total responses. We are revising this figure to include the burden set forth with the addition of the EOB provisions §423.128, the requirements for Accreditation Organizations and Territories, and the Part B Step Therapy provision for an additional 571,201,023 responses or a total of 625,627,942 responses (54,426,919 + 571,201,023).

Regulatory Reference	Provision Brief Title	Control Number (CMS ID Number)	Respondents	Total Responses	Hours per Respondent	Total Hours	Labor Cost (\$/hr)	Total Annual Cost (\$)
§ 423.128	Part D Explanation of Benefits (Updating Systems)	0938 - 0964 (CMS-10141)	295	295	160	15,733	98.54	1,550,330
§ 423.128	Part D Explanation of Benefits (Extra mailings) *	0938 - 0964 (CMS-10141)	295	571,200,000	n/a	n/a	n/a	5,733,706*
§423.168, 423.171, and 423.907	Accreditation Organizations and Territories	0938 - 0964 (CMS-10141)	12	144	1	144	70.28	10,120
423.120	Part B Step Therapy	0938 - 0964 (CMS-10141)	634	634	1	634	72.84	46,181
TOTAL			295	571,201,073	Varies	16,511	Varies	7,340,337

*Non-labor requirements and costs.

Other

The following attachments had been inadvertently submitted under IC Medicare Prescription Drug Benefit Program (Plans). This 2019 iteration corrects that error by moving the attachments under IC Business Continuity Plans. There are no changes to any of the attachments other than moving them to their correct IC location.

Attachments 1a and 1b - 2019 Compensation Certification (No Changes)

Attachments 2a and 2b – Structure Submission Form (No Changes)

Attachment 3 – Covered Agent Information Sheet (No Changes)

Attachment 4 - 2019 Compensation Structure for Writing Agents by Contract/PBP Number (No Changes)

Attachments 5a – 5c – Instructions (No Changes)

Attachment 7 (Precluded Provider Model Notice) and Attachments 8a -8h (Part D Explanation of Benefits) are new.

16. Publication and Tabulation Dates

There are no publication or tabulation dates. Subsequent PRA packages may include these requirements, which will be addressed, as required, when packages are submitted to OMB for approval.

17. Expiration Date

The expiration date is displayed on the collection instruments (see section 12, above).

18. Certification Statement

There are no exceptions to the certification statement.

B. COLLECTIONS OF INFORMATION EMPLOYING STATISTICAL METHODS

Not applicable.