

Supporting Statement for Provider Network Coverage Data Collection (CMS-10594/OMB control number: 0938-1302)

A. Background

The Patient Protection and Affordable Care Act (P.L. 111-148) was signed into law on March 23, 2010. On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was signed into law. The two laws are collectively referred to as the Affordable Care Act (ACA). The ACA established competitive private health insurance markets called Marketplaces, or Exchanges, which gave millions of Americans and small businesses access to affordable, quality insurance options that meet certain requirements. These requirements include ensuring sufficient choice of providers and providing information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers.

In the final rule, the *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017* (CMS-9937-P), we finalized network adequacy standards for qualified health plan (QHP) issuers, including stand-alone dental plans (SADPs) mostly focused on issuers in QHPs in the Federally-facilitated Exchanges (FFE). This information collection notice is for two of the standards from the rule: one applying in the FFE and one applying to all QHPs. Specifically, under 45 CFR 156.230(d) and 156.230(e), we require notification requirements for enrollees in cases where a provider leaves the network and for cases where an enrollee might be seen by an out of network ancillary provider in in-network setting. These standards will help inform consumers about his or her health plan coverage to better make cost effective choices. The Centers for Medicare and Medicaid Services (CMS) is updating an information collection request (ICR) in connection with these standards. The burden estimates for this ICR included in this package reflects the additional time and effort for QHP issuers to provide these notifications to enrollees.

B. Justification

1. Need and Legal Basis

Under 45 CFR 156.230(d), a QHP issuer in an FFE must make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is discontinuing, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal.

Under 45 CFR 156.230(e), beginning for the 2018 and later benefit years, for a network to be deemed adequate, each QHP issuer must, notwithstanding 45 CFR 156.130(c), count the cost sharing paid by an enrollee for an out-of-network essential health benefit (EHB) provided by an out-of-network ancillary provider in an in-network setting towards the enrollee's annual limitation on cost sharing or provide a notice to the enrollee by the longer of when the issuer would typically respond to a prior authorization request timely submitted, or 48 hours before the provision of the benefit, that additional costs may be incurred for an EHB provided by an out-of-network ancillary

provider in an in-network setting, including balance billing charges, unless such costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on cost sharing.

2. Information Users

The notifications that the QHP issuers will be required to send under this information collection will be sent to the QHP issuers' enrollees who are affected by a provider leaving the network. For the second notification, the information could be used by consumers to understand their cost sharing obligations if they receive care from an out-of-network ancillary provider. These notifications are intended to inform the consumer about his or her health insurance coverage to better make cost effective choices.

3. Use of Information Technology

CMS anticipates that QHP issuers will use their claims data systems to identify enrollees or use the plan's preauthorization process. The notification can be sent to the enrollee electronically or by mail.

4. Duplication of Efforts

This information collection does not duplicate any other Federal effort.

5. Small Businesses

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

6. Less Frequent Collection

The burden associated with this information collection consists of QHP issuers in the FFE notifying enrollees about the plan's network coverage. QHP issuers need to make this information available to the plan's enrollees.

We recognize that the notification of the provider leaving a network is a good faith effort as there are certain situations that the issuer cannot anticipate. For these reasons, the regulation requires the notification 30 days prior to the effective date of the change or otherwise as soon as practicable.

We believe the advance notice provision will help provide transparency and ensure that consumers receive notice of the possible consequences where an out-of-network ancillary provider may be seen and are provided some mitigation of these consequences where proper, timely notice is not provided by the issuer.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

A 60-day notice published in the Federal Register on June 26, 2019 (84 FR 30123). No comments were received. A 30-day notice will publish in the Federal Register on August 28, 2019.

No additional outside consultation was sought.

9. Payments/Gifts to Respondents

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

10. Confidentiality

To the extent of the applicable law and HHS policies, we will maintain consumer privacy with respect to the information disclosed.

11. Sensitive Questions

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

12. Burden Estimates (Hours & Wages)

The following section of this document contain estimates of burden imposed by the associated information collection requirements. Salaries for the positions cited were taken from the Bureau of Labor Statistics (BLS) web site (<https://www.bls.gov>). The labor categories most appropriate to the respondent populations are 15-1141 Database Administrators; 43-6010 Secretaries and Administrative Assistants, Except Legal, Medical, and Executive; and 15-2031 Operations Research Analyst. According to the May 2018 Bureau of Labor Statistics, the mean wage for 15-1141 Database Administrators was \$44.25 per hour (+ 100% fringe benefit = \$88.50); the mean wage for 43-6010 Secretaries and Administrative Assistants, Except Legal, Medical, and Executive was \$18.28 per hour (+ 100% fringe benefit = \$36.56); and the mean wage for 15-2031 Operations Research Analyst was \$42.48 (+ 100% fringe benefit = \$84.96).

Section 156.230(d) requires that QHP issuers make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal. This is a third-party disclosure requirement. The notification requirement under §156.230(d) is a common practice in the current market as several States, Medicare Advantage, Medicaid Managed Care, and the National Association of Insurance Commissioners' Network Adequacy Model Act have standards regarding enrollee notification of a provider leaving a network. As discussed in the final rule preamble, under State laws, many QHP issuers will already be under this obligation, and therefore, our notification requirements will apply in a more limited fashion. Additionally, we have incorporated stand-alone dental plans (SADPs) into our

calculations, but we recognize given the requirements that SADPs may rarely meet the

requirements to send a notification.

We estimate that a total of 470 issuers participate in the FFE and would be required to comply with the standard. We estimated that 5 percent of providers discontinue contracts per year, and that an issuer in the FFE covers 7,500 providers, which means that we estimate an issuer would have 375 provider discontinuations in a year.

Our assumption is that the database manager will receive notification from the issuer’s contracting team that a provider contract is being discontinued. From that notification, the database manager would aggregate the claims data associated with the provider to develop the list of affected enrollees with associated enrollee information for the notice. This list of affected enrollees and associated enrollee information would be sent to an administrative assistant to aggregate into a notification template to be sent to the enrollee. Assuming 375 notifications per a year, we believe that this task would be a routine process for the administrative assistant to undertake that would need little to no oversight to produce. As the issuer has the discretion to define regular basis and that the number of notifications is likely to widely varying between scope of network and type of provider, we did not estimate based on the number of individual notifications, but rather the number of provider discontinuations. For each provider discontinuation, we estimate that it will take a database administrator 30 minutes for data analysis to produce the list of affected enrollees, at \$88.50 an hour, and an administrative assistant 30 minutes to develop the notification and send the notification to the affected enrollees, at \$36.56 an hour. We are also clarifying these hourly rates include 100 percent adjustment for fringe benefits and overhead costs. The total costs per issuer are \$23,448.75. The total annual costs estimate for all FFE issuers is \$11,020,912.50.

Table 1. Burden for Issuers: Written Notice of Provider Discontinuation

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly rate + 100% Fringe benefits)	Burden Hours	Total Burden Costs (Per Respondent)	Total Burden Costs (All Respondents)
Database Administrator	470	\$88.50	187.5	\$16,593.75	
Administrative Assistant	470	\$36.56	187.5	\$6,855.00	
Total Annual			176,250		\$11,020,912.50
Total – Three Years			528,750		\$33,062,738.50

In §156.230(e), we require issuers to provide a notice to enrollees of the possibility of out-of-network charges from an ancillary out-of-network provider in an in-network setting prior to the benefit being provided, to avoid counting the out-of-network costs against the annual limitation on cost sharing. This provision applies to all 470 issuers. We estimate it would take an issuer’s mid-

level health policy analyst at an hourly wage rate of \$84.96 approximately 6 minutes to create a notification and send the information. We are clarifying the hourly rates include 100 percent adjustment for fringe benefits and overhead costs. We estimate that approximately two notices would be sent for every 100 enrollees. Assuming approximately 9.0 million enrollees in QHPs for 2020¹, we estimate QHPs would send approximately 180,000 total notices annually, for a total 18,000 hours, at a total cost of \$1,529,280.

Table 2. Burden for Issuers: Written Notice of the Possibility of Out-of-Network Charges

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly rate + 100% Fringe)	Burden Hours	Total Burden Costs (Per Respondent)	Total Burden Costs (All Respondents)
Health Policy Analyst	470	\$84.96	38.3	\$3,253.97	
Total - Annual			18,000		\$1,529,280
Total – Three Years			54,000		\$4,587,840

13. Capital Costs

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

14. Cost to Federal Government

There are no additional costs to the federal government.

15. Changes to Burden

The number of burden hours have been reduced from 21,334 to 17,439, a total reduction of 3,895 burden hours. These changes are due to the decrease in the number of respondents.

16. Publication/Tabulation Dates

¹ We used the 2019 enrollment numbers available at <https://www.cms.gov/newsroom/fact-sheets/final-weekly-enrollment-snapshot-2019-enrollment-period>

Results of the collection will not be made public.

17. Expiration Date

There are no instruments associated with this data collection.