Supporting Statement Part A

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Affordable Care Act Internal Claims and Appeals and External Review Procedures for Non-grandfathered Group Health Plans and Issuers and Individual Market Issuers for Paperwork Reduction Act Submission

(CMS-10338/OMB Control Number 0938-1099)

A. Background

The Patient Protection and Affordable Care Act, Public Law 111-148, (the Affordable Care Act) was enacted by President Obama on March 23, 2010. As part of the Act, Congress added PHS Act section 2719, which provides rules relating to internal claims and appeals and external review processes. On July 23, 2010 an interim final rule (IFR) implementing section 2719 of the PHS Act was published. The interim final rule was amended in June 24, 2011. The amended IFR specified rules governing the internal claims and appeals and external review processes. The Departments of Health and Human Services, Labor and Treasury (the Departments) finalized the IFR on November 18, 2015. The 2015 final rule (FR) clarifies consumer rights and aligns the appeals process across all types of plans, starting in 2018. The 2015 final rule will be hereinafter referred to as the Appeals regulation.

B. Justification

1. Need and Legal Basis

With respect to internal claims and appeals processes for group health coverage, PHS Act section 2719 and paragraph (b)(2)(i) of the Appeals regulation provide that group health plans and health insurance issuers offering group health insurance coverage must comply with the internal claims and appeals processes set forth in 29 CFR 2560.503-1 of the Department of Labor (DOL) claims procedure regulation, and update such processes in accordance with standards established by the Secretary of Labor in paragraph (b)(2)(ii) of the regulation. Paragraph (b)(3)(i) requires issuers offering coverage in the individual health insurance market to also comply with the DOL claims procedure regulation as updated by the Secretary of Health and Human Services (HHS) in paragraph (b)(3)(ii) of the Appeals regulation for their internal claims and appeals processes.

The DOL claims procedure regulation requires plans to provide participants and beneficiaries (claimants) who are denied a claim with a written or electronic notice that contains the specific reasons for the denial, a reference to the relevant plan provisions on which the denial is based, a description of any additional information necessary to perfect the claim, and a description of steps to be taken if the participant or beneficiary wishes to appeal the denial. The DOL claims procedure regulation also requires that any adverse benefit determination made upon review be in writing (including electronic means) and include specific reasons for the decision, as well as references to relevant plan provisions. Paragraph (b)(3)(ii)(C) of the Appeals regulation adds an additional requirement that non-grandfathered ERISA-covered group health plans provide to the claimant, free of charge, any new oradditional evidence considered or relied upon, or

generated by the plan or issuer in connection with the claim[1]. PHS Act section 2719 also requires that non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual coverage comply with either a state external review process or a federal external review process. The Appeals regulation provides a basis for determining when plans and issuers must comply with an applicable state external review process and when they must comply with the federal external review process.

The Appeals regulation provided temporary rules to permit states to operate their external processes until January 1, 2018 to avoid unnecessary disruption while states worked to adopt the consumer protections set forth by the PHS Act section 2719 and the Appeals regulation. Starting in 2018, all issuers are required to comply with the federal consumer protection standards for the appeals process. To the extent the state in which the issuer operates does not meet the minimum federal external review standards, or the plan or issuer is not subject to a state external review process, the plan or issuer may choose to either contract with Independent Review Organizations (IROs) (also referred to as Private, Accredited IROs), as described in section 45 CFR 147.136(d)(2) of the Appeals regulation, or participate in the HHS-administered federal external review process described in section 45 CFR 147.136(d)(4) of the Appeals regulation.

Claimants may submit a request via a web-based portal, mail, email, or fax directly to HHS, if claimants belong to plans that elect to participate in the HHS-administered federal external review process. The web-based portal may be used to request an external review of a plan or issuer's determination and to check on the status of their submitted request. Claimants who request a review online are required to attach documentation that supports their request.

The DOL claims procedure regulation imposes information collection requirements as part of the reasonable procedures that an employee benefit plan must establish regarding the handling of a benefit claim. These requirements include third-party notice and disclosure requirements that the plan must satisfy by providing information to participants and beneficiaries of the plan. The Appeals regulation includes additional requirements that must be met or exceeded.

2. Information Users

The information collection requirements included in the DOL claims procedure regulation and the Appeals regulation ensure that claimants receive adequate information regarding the plan's claims procedures and the plan's handling of specific benefit claims. Claimants need to understand plan procedures and plan decisions in order to appropriately request benefits and/or appeal benefit denials. The information collected in connection with the HHS-administered federal external review process is collected by HHS, and is used to provide claimants with an independent external review.

3. Use of Information Technology

[1] Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. Additionally, before the plan or issuer can issue an adverse benefit determination on review based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit

The DOL claims regulation and the Appeals regulation do not restrict plans' use of electronic technology to process and pay claims, to maintain information on the basis for claim determination, and to generate correspondence related to claims processing decisions.

Starting in 2018, the Appeals regulation provides consumers a secure, online portal, which may be used as an additional tool to request and process HHS-administered federal external review requests.

This burden estimate incorporates the Departments' assumptions, which are described in the response to item 12 below, concerning the rate of use by plans and issuers, and claimants, of electronic means of communication.

4. Duplication of Efforts

No duplication with other federal statutes exists. In some circumstances, states may require substantially similar information to be provided to insured persons. However, no duplication occurs because the same information disclosure may be used to satisfy duplicative or overlapping requirements.

5. Small Businesses

The regulation applies to all employee benefit plans and therefore is likely to affect small entities that provide benefits. For the purposes of the FR, small entities that fall under HHS' regulatory authority would include small health insurance insurers and small self-insured nonfederal governmental health plans.

We believe that few, if any, insurance companies underwriting comprehensive health insurance policies are small entities. Using data from the 2009 Current Population Survey, HHS estimates that the Appeals regulation will affect an estimated 5.73 percent of nonfederal governmental health plans that qualify as small plans. The Departments took into account the potential burden on small entities in structuring the regulation by permitting plan sponsors the maximum possible flexibility in designing their plans, including the possibility of hiring third-party service providers to carry out these administration responsibilities in order to make use of the lowest cost method of compliance available. A large majority of small plans purchase claims administration services from insurers, HMOs, and other service providers, and the Departments has taken this fact into account in deriving its burden estimates. These service providers typically develop a single claims processing system to service a large number of customers, including small entities. The cost of revising and implementing the procedures is therefore spread widely over a large number of small plans, minimizing burden on those plans. Moreover, small plans and their respective enrollees benefit equally from the service provider's expertise and ability to provide improved accuracy and timeliness in claims and appeals determinations.

6. Less Frequent Collection

The information collection requirements arise in connection with the occurrence of individual claims for benefits, and consist of third-party notices and disclosures. No information is reported to the federal government other than that which is necessary for HHS to facilitate an external review. The information collection provisions of the regulation ensure that sufficient information is provided to claimants so that

they may fully exercise their rights under their coverage. The information collection is necessary to ensure that claimants in plans or policies in states whose external review processes do not meet the requirements of 2719(b)(1) and 2719(b)(2), as well as plans not subject to a state external review process across the country, can access their rights as described in PHS Act Section 2719.

7. Timing of Notification

The DOL claims procedure regulation, the Appeals regulation and federal external review process guidelines together impose special timing requirements for the handling of claims in the fully insured and small group markets, self-funded nonfederal governmental health plans, and plans not subject to a state external review process in cases where the state does not have an external review process that meets federal requirements. 45 CFR 147.136(b)(2) of the Appeals regulation also provides a basis for special timing requirements set forth by the DOL claims procedure regulation.

First, for claims involving "urgent care", the Appeals regulation provides processes set forth by the DOL claims procedure regulation, which requires, in general, that claimants be notified of health benefit determinations "as soon as possible, but not later than 72 hours after receipt of the claim by the plan. . . ." 45 CFR 147.136(b)(2)(ii)(B). In cases involving urgent care where the health claim is a request to extend the time period or number of treatments of ongoing medical care, this period is 24 hours,

Second, for "pre-service" claims, the Appeals regulation, incorporates the requirement that claimants be notified of health benefit determinations "within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan." 45 CFR 147.136(b)(1). Pre-service claims involve plan requirements that a claimant obtain approval from the plan prior to receiving health care services or products in order to maintain eligibility for benefits.

Third, for "post-service" health benefit claims, the Appeals regulation requires that notification of an adverse benefit determination "within a reasonable period of time, but not later than 30 days after receipt of the claim." Even though 30 days is the maximum response time for these claims, a plan must provide a determination sooner if it is reasonable to do so. Disability benefit claims are subject to a similar construct, except that the maximum response time is 45 days. 45 CFR 147.136(b)(1)

To facilitate external review for claimants in plans or coverage not subject to a state external review process, the plans or issuers are required to electronically notify HHS as to whether they are subject to a federal external review process under PHS Act 2719 and to specify the insurance package(s) to which it applies. If the package is subject to a federal external review process under PHS Act Section 2719, the plan or issuer is required to notify HHS which federal external review process they are using and provide contact information for designated personnel in their appeals department, including names, mailing address, telephone numbers, facsimile numbers and electronic mail addresses. Issuers and self-funded nonfederal governmental health plans that elect to use the HHS-administered federal external review process will also be required to provide the claimants' relevant files to the HHS external review contractor in fewer than five days, upon request.

These timing requirements are related to policy objectives in an area of important public concern. For example, the shortest time frame for "urgent care" claims applies only under circumstances in which

delay could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or where delay would subject the claimant to severe pain. The next shortest time frame applies under pre-service claims in which medical care, while not urgent, has not been provided to a claimant who needs treatment for a medical problem, and where the plan itself requires pre-approval of the medical care before providing coverage. Post-service health claims and disability claims also involve important concerns relating to the sick and disabled, but under these circumstances plans may take at least 30 days to respond if it is reasonably necessary to do so.

Another reason why these time frames are important is that these notices relate to the payment of money by a plan to claimants to whom fiduciary responsibilities are owed. Without enforcement of reasonable deadlines, payers could be given a financial incentive to delay the payments, and this would likely be inconsistent with appropriate fiduciary standards.

8. Federal Register/Outside Consultation

A 60-day notice published in the Federal Register on August 15, 2019 (84 FR 41723). No comments were received.

The 30-day Federal Register notice will be published on [xx xx, 2019].

9. Payments/Gifts to Respondents

No payments or gifts are associated with these ICRs.

10. Confidentiality

This information collection request (ICR) involves disclosures of information by issuers to enrollees. Issues of confidentiality between third parties do not fall within the scope of this information collection request.

11. Sensitive Questions

These ICRs involve no sensitive questions.

12. Burden Estimates (Hours & Wages)

The Department estimates that this information collection will affect an average 109,653 respondents per year, over the next three years. HHS expects the number of respondents will increase over time as more plans relinquish grandfathered status and must comply with the regulations. The frequency of response will be on occasion, mirroring the frequency of benefit claims that require responses, resulting in an estimated average hourly burden of 1,195,529 hours and with an associated average cost of $184 million per year over the next three years. It is expected that there will be an increase in the hour burden and associated cost as grandfathered plans continue to lose that status in future years.

Under PHS Act section 2719, all sponsors of non-grandfathered group health plans and health insurance

issuers offering group or individual health insurance coverage must comply with all requirements of the DOL claims regulation as well as the new standards that are established by the Secretary of Labor and the Secretary of Health and Human Services in paragraphs (b)(2) and (b)(3) of the 2015 FR. These estimates include only ongoing costs of compliance with the statute, the DOL claims regulation, and the Appeals regulation. Average labor costs are calculated using data from the Bureau of Labor Statistics[2].

Adjusted Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Mean Hourly Wage ($/hour)	Adjusted Hourly Wage ($/hour)
Secretaries and Administrative Assistants, Except Legal, Medical, and Executive	43-6014	$17.38	$52.09
Family and General Practitioner	29-1062	$95.54	$162.63
Lawyer	23-1011	$67.5	$133.29
Human Resources Manager	13-1070	$31.20	$78.73
Medical Secretaries	43-6013	$16.85	$42.55

Ongoing burdens are a function of claims volume, as well as the denial and appeal rates of all plans. Each covered individual was estimated to generate 10.2 claims on average per year[3], 82 percent of which were filed electronically. The Departments then assumed that 15 percent of these claims were denied.[4] The Departments assume that three percent of these claims were pre-service with the remaining being post-service claims. The number of post-service claims extended was based on the share of ''clean'' claims that took more than 30 days to complete processing. The share of denials expected to be appealed, 0.2 percent, was based on a RAND study.[5] The Departments expect half of these appeals to be reversed, and those not reversed were divided between ''medical claims'' (28.9 percent) and ''administrative claims'' (71.1 percent).

The transaction burden will vary widely with the type and complexity of the claim in question, but the mix of claims and associated burdens generally are expected to be similar across plans of the same type. The average time required for the information collection associated with any particular type of health benefit claim transaction will range from one minute for certain routine automatic notices to four and a half hours for certain disclosures on requests related to adverse benefit determinations.

[2] May 2016 Occupational Employment Statistics found at https://www.bls.gov/oes/2016/may/oes_stru.htm#43-0000. Adjusted hourly wages are calculated as follows: (2016 BLS mean wage rate)/(ECEC ratio)*(Overhead load factor)*(inflation rate)^2(inflated 2 years from base year).[PLEASE CHECK THIS WITH DOL]

[3] Used previous estimates of 10.2 claims per enrollee to find number of claims and 3% as the share pre-service. Electronic vs. Paper based on AHIP's May 2006 study

[4] Share of denials based on HIAA (now AHIP) March 2003 report on Claims Payment Processes (and EBSA assumptions on appeals)

[5] Share of denials appealed based on RAND 2004 study entitled "Inside the Black Boc of Managed Care Decisions"

The Departments attributed costs to notifying individuals of denied claims and processing appeals. Initial denials were assumed to only take a few minutes for a clerical worker to draft and send an adverse benefit determination notice based on the model notice issued by the Departments that does not require any information to be included that cannot be auto-populated. Appealed denials deemed "medical" in nature will require a physician 4.5 hours (at a rate of $162.63) to review relevant appeals materials, make a determination, and draft a one page response, resulting in an estimated cost of $731.84 per "medical" denial. Appealed denials deemed "administrative" in nature will require a legal professional (at a rate of $133.29) approximately 2 hours to review the relevant materials and make a decision related to a reversal or approval of a denial and draft a two page response, resulting in an estimated cost of $266.58. Each notice of adverse benefit determination and notice of the decision of an internal appeal will incur a mailing cost estimated at $0.65 per notice including, printing ($0.05 per page), and postage costs ($0.55 postage).

The Departments estimates that approximately 93 percent of large group health and all small group health plans administer claims using a third-party provider. Approximately 5 percent of individuals covered by group health insurance, as well as all people covered in the individual market insurance claims, are administered in-house. In-house administration burdens are accounted for as hours, while purchased services are accounted for as dollar costs. The hourly burden as well as mailing costs for plans processing claims in-house is described below:

TABLE 1.--*Hour and Cost Burden (in thousands)*

	Claims Government Sector ESI	Claims Individual Market	In-House Burden Hours	In-House Burden Hours Equivalent Costs	In-House Burden Mailing Costs	Out-House Burden Mailing Cost	Out-House Burden Labor Costs	In and Out House Cost Burden Total Cost Burden
Pre-Service Claim Approved	9,635	3,530	58.8	$3,065	$413.0	$1,066	$7,906	$4,895.9
Pre-Service Claim Denied	1,700	623	20.8	$1,082	$72.9	$188	$2,791	$1,537.3
Post-Service Claim Denied	54,977	20,144	671.5	$34,976	$2,356.8	$6,080	$90,226	$49,707.5
Post-Service Claim Extended	13,634	6,422	107.0	$5,575	$751.4	$1,508	$11,188	$7,013.9
Denial Appeal Total	77.8	36.6	186.8	$21,870	$23.8	$80	$43,887	$51,714.0

	Claims Government Sector ESI	Claims Individual Market	In-House Burden Hours	In-House Burden Hours Equivalent Costs	In-House Burden Mailing Costs	Out-House Burden Mailing Cost	Out-House Burden Labor Costs	In and Out House Cost Burden Total Cost Burden
Appeal Upheld	51.9	24.4	47.9	$7,776.2	$17.7	$31.9	$13,978	$14,0276
Appeal Denied	77.8	36.6	160.6	$24,414.9	$26.6	$41.8	$43,887	$43,955.4
Medical Sub-Total	37.5	17.6	149.7	$24,352.0	$12.8	--	$43,774	$43,786.8
Claim Upheld	15.0	7.1	47.3	$7,690.1	$5.1	--	$13,823	$13,828.1
Claim Denied	22.5	10.6	102.5	$16,661.9	$7.7	--	$29,951	$29,958.7
Admin Sub Total	92.2	43.4	58.8	$7,839.2	$31.5	--	$14,091	$14,122.5
Claim Upheld	36.9	17.4	0.6	$86.1	$12.6	--	$155	$167.6
Claim Denied	55.3	26.1	58.2	$7,753.0	$18.9	--	$13,936	$13,954.9
Fair and Full Review	90.8	42.8	4.0	$207.2	$16.6	$29.9	$304.2	$323.7
Notice of Decision External Review	2.2	0.2	0.1	$15.9	$0.2	$1.4	$103.0	$104.6
Total	80,415	30,939	1,671	$163,157	$3,751.00	$8,997	$329,696	$415,023

- Assumed that 7 percent of large plan process these claims in-house in the Group Market. Large plans account for 69.5 percent of policy-holders and therefore 4.9 percent of claims are processed in-house.

Used previous estimates of 10.2 claims per enrollee to find number of claims and 3% as the share pre-service. Electronic vs. Paper based on AHIP's May 2006 study

- Share of denials based on HIAA (now AHIP) March 2003 report on Claims Payment Processes (and EBSA assumptions on appeals)
- Share of denials appealed based on RAND 2004 study entitled "Inside the Black Boc of Managed Care Decisions"
- Share requesting external review and the reversal statistics taken from the January 2006 AHIP report on State External Review Programs
- Share of claims requiring extension based on the number of claims requiring more than 30 day to process, taken from AHIP January 2010 study "A Survey of Health Care Claims Receipt and Processing Times, 2009."

Non-English Language Assistance

As a result of the Appeals final regulation, plans and issuers must provide claimants who reside in a county where ten percent or more of the population residing in the county is literate only in the same non- English language with a one-sentence statement in all notices written in the applicable non-English language about the availability of language services. In addition to including the statement, plans and issuers are required to provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request.

The Departments expects that the largest cost associated with the rules for culturally and linguistically appropriate notices will be for plans and issuers to provide notices in the applicable non-English language upon request. Based on the American Community Survey (ACS),[6] the Departments estimates that there are about 9.3 million individuals living in covered counties that are literate only in a non-English Language. The ACS does not have insurance coverage information. Therefore, to estimate the percentage of the 8.7 million affected individuals who were insured, the Departments used the percent of the population in the state that reported being insured by nonfederal government employer insurance from the 2014 CPS.[7] This results in an estimate of approximately 2.1 million individuals who are eligible to request translation services.

In discussions with the regulated community, the Departments found that experience in California, which has a state law requirement for providing translation services, indicates that requests for translations of written documents average 0.098 requests per 1,000 members. While the California law is not identical to the federal regulations, and the demographics for California do not match other counties nationally, for purposes of this analysis, the Departments used this percentage to estimate the number of translation service requests that plans and issuers can expect to receive. Industry experts also told the Departments that while the cost of translation services varies, $500 per document is a reasonable approximation of translation cost.

Using the ACS and the CPS, the Departments estimate that there are 11.6 million individuals insured through nonfederal governmental employer sponsored insurance or through the individual insurance market living in the affected counties. Based on the foregoing, the Departments estimate that the cost to provide translation services will be approximately $567,251 annually (11,576,541 lives * 0.098/1000 * $500).

External Review Process

This ICR also accounts for the added burden of the disclosure requirements of the federal external

[6] Data are from the 2009-2013 American Community Survey, view more data here. Individuals counted reside in counties where at least 10 percent of the county speak a particular non-English language and speak English less than "very well" are counted.

[7] Please note that using state estimates of insurance coverage could lead to an over estimate if those reporting in the ACS survey that they speak English less than "very well" are less likely to be insured than the state average.

review process for health insurance issuers in states where state external review processes do not meet the (b)(1) or (b)(2) standard of PHS Act 2719 [see "Guidance on External Review for Group Health Plans and Health Insurance Issuers Offering Group and Individual Health Coverage and Guidance for States on State External Review Processes" on the CCIIO website at http://cciio.cms.gov], and self-funded nonfederal governmental plans not subject to a compliant state or territory external review process [see "Instructions for Self Insured Non- Federal Governmental Health Plans and Health Insurance Issuers Offering Group and Individual Health Coverage on How to Elect a federal external review process" on the CCIIO website at http://cciio.cms.gov]. Note that both health insurance issuers and self-funded nonfederal governmental health plans have an option of contracting with Independent Review Organizations (IROs) as described in the HHS Technical Release 2011-02[8].

Both health insurance issuers in states that are non-compliant with federal external review process standards, and plans not subject to a state external review process must disclose electronically to HHS whether they will use the HHS-administered federal external review process or are following the process outlined in HHS Technical Release 2011-02. This burden is accounted for in this ICR.

Health insurance issuers in states that do not have a compliant external review process and plans not subject to a state external review process that have opted to use the HHS-administered federal external review process or the Department of Labor's federal external review process ("applicable plans and issuers") will be required to notify HHS as to which federal external review process they will be using via the Health Insurance Oversight System (HIOS). If they are using the HHS-administered federal external review process, they will also be required to electronically submit to HHS all notices pertaining to external review rights including the notice of adverse benefit determinations and the notice of final internal adverse benefit determinations. If these notices are updated at any time, updated copies of these notices will need to be submitted to HHS.

The HHS-administered federal external review process also requires that; 1) the CMS appointed examiner ("the examiner") must conduct a preliminary review of a claimant's eligibility for external review; 2) applicable plans and issuers must provide the examiner with documentation and other information considered in making adverse benefit determinations or final adverse benefit determinations; 3) the examiner must notify the claimants who are ineligible for external review that they are ineligible; 4) the examiner must forward to the applicable plan or issuer any information submitted by the claimant;
5) that if the applicable plan or issuer reverses its decision, it must notify the claimant and the examiner; 6) the examiner must notify claimant and the applicable plan or issuer of result of final external review (burden previously accounted for); and 7) the examiner must maintain records for six years.

Health insurance issuers and self-funded nonfederal governmental plans in states where the state external review processes do not meet the (b)(1) or (b)(2) standard of PHS Act 2719 that decide to follow the external review process will be subject to the following different set of requirements as

[8] Guidance on External Review for Group Health Plans and Health Plans and Health Insurance Issuers Offering Group and Individual Health Coverage, and Guidance for States on States on State External Review Processes here.

described in section 45 CFR 147.136(d)(2) of the Appeals regulation,: 1) Issuers must conduct a preliminary review of claimant requests for external review in order to determine eligibility; 2) following the preliminary review, issuers must notify the claimant whether or not they are eligible for external review; 3) if the claimant is eligible, the issuer must forward to the IRO all documentation and other information considered when making its adverse benefit determination; 4) the IRO must forward all information submitted by the claimant back to the issuer; 5) next, the IRO must notify claimant and the applicable plan or issuer of the result of the final external review; and 6) finally, the IRO must retain its records for six years.

It is estimated that there will be 4,049 external reviews conducted in a year for the affected population.[9] The total hour burden associated with the federal external review process for affected self-funded nonfederal governmental health plans and health insurance issuers is 1,788 with an equivalent cost of $128,876. HHS made reasonable estimates for the amount of time it would take for each of the steps outlined above, assuming that a clerical worker could prepare most of the documents that would need to be sent forward. HHS used salary data provided by the Department of Labor National Occupational Employment Survey.

There is no record retention burden placed on self-funded nonfederal governmental plans and health insurance issuers that elect the HHS process because CMS's contractor retains all records.

Summary

Total burden hours are estimated at 1,195,626 hours annually for 2018, 2019 and 2020. Equivalent costs are estimated at $83,629,389 million annually for 2018 2019 and 2020.

TABLE 2. -- *Summary of Burden*

Number of respondents (issuers and Plans)	109,653
Number of responses (Notice)	516,626,544
Total hour burden	1,195,626
Equivalent costs of total hour burden	$83,629,389
Total cost burden	$184,134,300

13. Capital Costs

As indicated in question 12, the bulk of Group Market claims will be processed by third-party service providers. Total cost is estimated by multiplying the number of responses by the amount of time required to prepare the documents and then multiplying this by the appropriate hourly cost of

[9] Rate of external reviews is 0.013%. AHIP Center for Policy Research, "An Update on State External Review Programs, 2006," July 2008. North Carolina Department of Insurance "Healthcare Review Program: Annual Report," 2013.

either clerical workers ($52.09).[10], doctors ($162.63) [11]or lawyers ($ 133.29)[12], and then adding the cost of copying and mailing responses ($0.65)[13] each for those not sent electronically) . These costs are described in Table 1 in answer 12. The total estimated cost burden for those plans that use service providers, including the cost of mailing all responses (including mailing costs for those prepared in-house listed in Table 1), is $184.1 million annually. [14]

Federal External Review Process

It is estimated that there will be an annual administrative cost burden of $59,826 on average over the next three years associated with the federal external review process. This administrative cost burden is a result of sending the files and notices required by the proposal to the independent examiner for health insurance issuers and self-funded nonfederal governmental health plans using the federal external review process.

14. Cost to Federal Government

Government program staffing costs, to provide technical assistance to respondents, are based on one 14 Grade/Step 1 in the Washington D.C. area.

GS-14: hourly rate $52 at 1.3 hours a week: Annual cost: $ 66,545

15. Changes to Burden

The overall burden has decreased from 1,702,817 hours to 1,195,626 hours, resulting in a total burden decrease of -507,191 hours. The decrease is mainly attributed to the decrease in the time it takes to complete the review process.

[10] Secretaries, Except Legal, Medical, and Executive (43-6014): $17.38(2016 BLS Wage rate)/0.675(ECEC ratio) *1.2(Overhead Load Factor) *1.023(Inflation rate) ^2(Inflated 2 years from base year) = $52.09

[11] Family and General Practitioner (29-1062): $96.54(2016 BLS Wage rate) /0.69(ECEC ratio) *1.35(Overhead Load Factor) *1.023(Inflation rate) ^2(Inflated 2 years from base year) = $162.63

[12] The Department's estimated 2015 hourly labor rates include wages, other benefits, and overhead are calculated as follows: mean wage from the 2013 National Occupational Employment Survey (April 2014, Bureau of Labor Statistics cost of copying and mailing responses (0.54 each for those not sent electronically)[11] . These costs are described in Table 1 in answer 12

[13] $0.55 for USPS First Class Postage and $0.05 per page of materials costs for two pages of paper.

[14] http://www.bls.gov/news.release/pdf/ocwage.pdf); wages as a percent of total compensation from the Employer Cost for Employee Compensation (June 2014, Bureau of Labor Statistics http://www.bls.gov/news.release/ecec.t02.htm); overhead as a multiple of compensation is assumed to be 25 percent of total compensation for paraprofessionals, 20 percent of compensation for clerical, and 35 percent of compensation for professional; annual inflation assumed to be
2.3 percent annual growth of total labor cost since 2013 (Employment Costs Index data for private industry, September 2014 http://www.bls.gov/news.release/eci.nr0.htm).[14]

16. Publication/Tabulation Dates

There are no plans to publish the outcome of the information collection.

17. Expiration Date

The collection of information will display a valid expiration date and OMB control number.