SUPPORTING STATEMENT A
MEDICARE SECONDARY PAYER
(MSP)
MANDATORY INSURER REPORTING REQUIREMENTS OF SECTION 111 OF THE MEDICARE MEDICAID, AND SCHIP EXTENSION ACT OF 2007 (MMSEA) (P.L. 110-173)
See 42 U.S.C. 1395(b) (7) and (8).
(CMS 10265, OMB 0938-1074)

A. Background

We are requesting a revision of a reinstatement of Mandatory Insurer Reporting Requirements of Section 111 of the Medicare, Medicaid and SCHIP Act of 2007

The Centers for Medicare & Medicaid Services (CMS) collects various data elements from the applicable reporting entities (see supporting documents) for purposes of carrying out the mandatory MSP reporting requirements of Section 111 of the Medicare, Medicaid and SCHIP Extension Act. This information is used to ensure that Medicare makes payment in the proper order and/or takes necessary recovery actions. 42 U.S.C. 1395y(b)(7)(A)(i)(II) was updated by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. Section 4002 of the SUPPORT Act also applies to Section 111 that requires Group Health Plan (GHP) reporting of primary prescription drug coverage.

"MSP" refers to those situations where Medicare does not have primary responsibility for paying the medical expenses of a Medicare beneficiary. Under the law, Medicare is a secondary payer to Group Health Plans (GHPs) for certain beneficiaries, those:

- who are age 65 or older and working with coverage under an employer sponsored and/or contributed to GHP, for an employer with 20 or more employees (or if it is a multi-employer plan where at least one employer has 20 or more full or part-time employees);
- who are age 65 or older and with coverage under a working spouse's employer-sponsored and/or contributed to GHP, for an employer with 20 or more employees (the working spouse can be any age) (or if it is a multi-employer plan where at least one employer has 20 or more full or part-time employees);
- who have End Stage Renal Disease (ESRD) and are covered by a GHP on any basis (Medicare is secondary for a 30-month coordination period.); or
- who are disabled and have coverage under their own or a family member's GHP for an employer with 100 or more full or part-time (or if it is a multi-employer where at least one employer has 100 or more full or part-time employees.)

Medicare is also a secondary payer to liability insurance (including self-insurance), no-

fault insurance and workers' compensation for Medicare beneficiaries. This includes those:

- who are age 65 or older
- who are under age 65 with certain disabilities, and
- who are of any age with End-Stage Renal Disease (ESRD- permanent kidney failure requiring dialysis or a kidney transplant).

Medicare beneficiaries who receive a liability settlement, judgment, award or other payment have an obligation to refund any conditional payments made by Medicare within 60 days of such settlement, judgment, award or other payment. The liability insurers (including self-insurance), no-fault insurer and workers' compensation insurers are often collectively referred to as Non-Group Health Plan or NGHP insurers.

1. Purpose

The purpose of this submission is to renew the 2017 Supporting Statement, which set forth what information would be collected pursuant to Section 111 and the process for such collection. The information is collected from applicable reporting entities for the purpose of coordination of benefits and the recovery of mistaken and conditional payments. Section 111 mandates the reporting of information in the form and manner specified by the Secretary, DHHS. Data the Secretary collects is necessary for both pre-payment and post-payment coordination of benefit purposes, including necessary recovery actions.

Section 111 establishes separate mandatory reporting requirements for GHP arrangements as well as for liability insurance (including self-insurance), no-fault insurance, and workers' compensation. (For purposes of this document, these may collectively be referred to as "Non-GHP or NGHP.") The effective date for the implementation of reporting of Group Health Plan information was January 1, 2009 and for Non-Group Health Plan information it was July 1, 2009. Non-Group Health Plan information collection was implemented in phases. With the passage of Section 111, CMS has the authority to mandate the reporting of insurer MSP information. ***(See Attachment A – Definitions and Reporting Responsibilities)***

2. The Federal Role

The CMS is responsible for oversight and implementation of the MSP provisions as part of its overall authority for the Medicare program. The CMS accomplishes this through a combination of direct CMS action and work by CMS' contractors. The CMS efforts include policy and operational guidelines, including regulations (as necessary), as well as oversight over contractor MSP responsibilities.

As a result of litigation in the mid-1990, certain GHP insurers were mandated to report coverage information for a number of years. Subsequent to this litigation related

mandatory reporting, CMS instituted a Voluntary Data Sharing Agreement (VDSA) effort which expanded the scope of the GHP participants and added some NGHP participants. This VDSA process complemented the IRS/SSA/CMS Data Match reporting by employers, but clearly both did not include the universe of primary payers and had few NGHP participants.

Both GHP and NGHP entities have had and continue to have the responsibility for determining when they are primary to Medicare and to pay appropriately, even without the mandatory Section 111 process. Insurers should always collect the NGHP , GHP and GHP prescription drug information that CMS requires in connection with Section 111 of the MMSEA.

3. Current MSP Information Gathering Processes

MSP is generally divided into "pre-payment" and "post-payment" activities. Prepayment activities are generally designed to stop mistaken primary payments in situations where Medicare should be secondary. Medicare post-payment activities are designed to recover mistaken payments or conditional payments made by Medicare where there is a contested liability insurance (including self-insurance), no-fault insurance, or workers' compensation which has resulted in a settlement, judgment, award, or other payment. CMS specialty contractors perform most of the MSP activity.

Pre-payment activities include:

> Medicare's Claims Payment Process: Providers, physicians, and other suppliers submitting claims to Medicare include coordination of benefit information on the submitted claim.
>
> VDSAs: Information obtained through this voluntary process from employers is used to update CMS records.
>
> Self-Identification: Beneficiaries/beneficiaries representatives contact the appropriate CMS contractor to report changes in their GHP coverage or self-identify a NGHP occurrence.
>
> Section 111 Mandatory Reporting: Insurers must report situations where Medicare does not have primary payment responsibility, including both Group Health Plans, Non-Group Health Plans and Part D prescription drug information.

Post-payment activities include:

> Debt Recovery: A CMS specialty contractor is responsible for pursuing recoveries where CMS records identify mistaken payments as well as recovery claims due to conditional payments once there is a settlement, judgment, award or other payment.

B. Justification

1. Need and Legal Basis

The statutory basis for this information collection is Section 111 of the MMSEA which amended the MSP provisions found at 42 U.S.C. 1395y (b). See 42 U.S.C.1395y (b) (7) & (8) which adds separate mandatory reporting requirements for GHP arrangements, for NGHP (liability insurance including self-insurance, no-fault insurance and workers' compensation) and prescription drug reporting. The following laws/regulations describe existing MSP information collection:

LAW/REGULATION	EFFECT
42 U.S.C. 1395y(b)(7)	Mandatory reporting requirements for GHP and prescription drug reporting.
42 U.S.C. 1395y(b)(8)	Mandatory reporting requirements for NGHP (liability insurance including self-insurance, no-fault insurance and workers' compensation)
42 U.S.C. 1395w-102(b)(4)(D)(ii)	Allows Part D plans and plan sponsors to ask beneficiaries about what other coverage they may have, and states that material misrepresentation of such coverage by the beneficiary is grounds for termination from Part D
42 CFR 411.25	If a third party payer learns that CMS has made a Medicare primary payment for services for which the third party payer has made or should have made primary payment, it must provide notice to that effect
42 CFR 489.20(f) and (g)	Provider (defined in 489.2(b)) agrees to maintain a system that identifies payers primary to Medicare during the admissions process and to bill other payers primary to Medicare except when the primary payer is a liability insurer

The following laws contain MSP amendments or implications:

LAW	EFFECT
Original Title XVIII of the Social Security Act	Medicare is secondary to Workers' Compensation (including Black Lung).
§ 953 of the Consolidated Omnibus Reconciliation Act (COBRA) of 1980	Medicare is secondary to Automobile, Liability, and No-Fault coverage
COBRA 1981 § 2146 as amended	Medicare is secondary for beneficiaries with ESRD in their first 30 months of eligibility.
§ 116 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982	Medicare is secondary for working beneficiaries age 65 to 69 and their spouses age 65 to 69 who are covered by an Employer GHP
§ 2301 of the Deficit Reduction Act (DEFRA) of 1984	Medicare is secondary for beneficiaries age 65 to 69 regardless of working spouse's age
COBRA 1985 § 9201	Eliminates upper age limit of 69 for "working aged" MSP
COBRA 1986 § 9319	Medicare is secondary for disabled beneficiaries classified as "active individual" and covered by a Large GHP (LGHP)
COBRA 1987	Clarifies that COBRA 1986 applies to governmental entities
COBRA 1989	MSP uniformity provisions and IRS/SSA/CMS Data Match added
COBRA 1993	Changes basis of MSP for disabled beneficiaries from "active individual" to "current employment status"
MMA § 1860D-2(a)(4)	Applies MSP laws to the new Medicare Part D in the same manner as it applies to Part C (Medicare Advantage, formerly Medicare+ Choice)
§ 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (PL 110-173)	Mandatory reporting requirements for GHP arrangements and for NGHP (liability insurance including self- insurance, no-fault

	insurance and workers' compensation).

Section 4002 of the SUPPORT Act 42 U.S.C. 1395y(b)(7)(A)(i)(II)	The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. Section 4002 of the SUPPORT Act applies to Section 111 GHP reporting of primary prescription drug coverage.

These laws create a continuing need for information collection so that Medicare makes payment in the proper order and takes recovery actions as appropriate. **2. Information Users**

CMS contractors assist in the administration of the reporting requirements of Section 111. This effort is frequently referred to as "Mandatory Insurer Reporting" (MIR). The applicable reporting entities register on-line by logging on to a secure website at https://www.cob.cms.hhs.gov/Section111/ as a first step in complying with MIR. Once the applicable reporting entity submits its application via the secure website, CMS begins working with the entity to set up the data reporting and response process.

CMS and its contractors use this information to ensure that payment is made in the proper order and to pursue recovery activities.

3. Improved Information Technology (IT)

Mandatory insurer reporting is a 100 percent electronic reporting process, which leads to a reduced need for other paper based routine development activities. This includes Section 111 COBSW, along with Secure File Transfer Protocol (SFTP) and Direct Data Entry (DDE).

The CMS has a MIR webpage for Section 111 of the MMSEA and its continued implementation. Informational materials as well as instructions can be downloaded from this webpage. The materials include both draft and final documents, including information on how interested parties may comment on the documents and/or CMS' implementation of Section 111. The webpages are found at:

https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/MandatoryInsurer-Reporting-For-Group-Health-Plans/Overview.html

https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/MandatoryInsurer-Reporting-For-Non-Group-Health-Plans/Overview.html

All reporting entities have email and phone access to their designated Electronic Data Interchange (EDI) representative found at the CMS contractor that can assist in any questions or issues regarding reporting transmissions.

4. Duplication of Similar Information

These collection activities were created to reduce both burden and redundancy. Mandatory Insurer Reporting has allowed CMS to sunset other coordination of benefit (COB) data collection processes such as the IRS/SSA/CMS Data Match and the Initial Enrollment Questionnaire (IEQ). No other COB data collection processes have been sunset since the last CMS-10265 PRA package was finalized.

5. Small Business

Even though relatively few small businesses will be impacted by this legislation, CMS has made efforts to minimize the burden that this collection of information has on all submitting entities, including small businesses. To this end, CMS has made the application process completely electronic. The completion and submission of the MIR application takes place on-line via a CMS secure website. In addition, there is an on- line Direct Data Entry (DDE) option available to small NGHP and GHP reporters to simplify their reporting process. All Small Business reporting entities also have email and phone access to their designated EDI representative found at the CMS contractor that can assist in any questions or issues regarding reporting transmissions.

6. Collection Frequency

GHP and prescription drug data is submitted by the applicable reporting entity on an ongoing quarterly basis. NGHP data is submitted on an ongoing quarterly basis for noncontested no-fault insurance and workers' compensation insurance claims. NGHP data is submitted on a one-time basis for contested cases where there is a single settlement, judgment, award, or other payment.

Collecting information on a less frequent basis than is provided for in this submission will continue to create risk to the integrity of the Medicare trust funds. CMS has reduced duplicate or redundant collecting of MSP data by placing this responsibility with one contractor.

7. Special Circumstances

Five years is generally recognized as the standard for record retention in the industry. However, CMS recommends a record retention period of up to ten years for MSP related information. The CMS changed from "required ten years" to "recommended ten

years" in the MSP PRA Information Collection submission in July 2005. Absence of related information does not constitute a valid defense against an MSP recovery action.

Note: Administrative offset is permitted for 10 years. Additionally, False Claim Act (31 U.S.C. § 3729) actions can be brought for 10 years. However, on April 20, 2016, the United States Department of Justice lifted the Medicare Secondary Payer litigation hold. Accordingly, CMS no longer needs to preserve potentially responsive documents as directed by the May 6, 1992 letter from the Department of Justice to the Heath Care Financing Administration (HCFA) and the October 2, 1997 Bulletin from HCFA to all Medicare contractors.

8. Federal Register Notice/Outside Consultation

The 60-day Federal Register notice will be published on 09/18/2020 (85 FR 58360)
No comments were received.

The 30-day Federal Register notice will be published on 12/07/2020 (85 FR 78853).

The CMS holds listening sessions with affected groups and continues to hold open door forum calls with all GHP and NGHP reporting entities. This includes the GHP Recovery workgroup amongst CMS, the CRC and the Blue Cross Blue Shield Plans. Any reporting updates that occur resulting from these calls are identified in CMS alerts through an email and on the web age and to updates to the CMS Section 111 user guides. The CMS has an email link for interested parties to sign up to receive email alerts whenever the webpage is updated. This link is available on the MIR webpage cited above.

9. Payments/Gifts to Respondents

There are no payments or gifts to respondents.

10. Confidentiality

Laws, regulations and guidance associated with the Health Insurance Portability and Accountability Act (HIPAA) and the Privacy Act apply to any information CMS collects for purposes of this program. All data collected is the minimum necessary as defined under CMS' Privacy Act Routine Uses for coordination of benefits. The data collected is considered Protected Health Information as defined under HIPAA and codified at 45 CFR 160.103. A system of record notice (SORN) has been issued since the last PRA titled, "Medicare Advantage Prescription Drug System (MARx)" FR Citation: 70 FR 60530.

11. Sensitive Questions

There are no questions of a sensitive nature associated with these requirements.

12. Burden Estimate (hours and wages)

For both GHP and NGHP situations, there has been a longstanding obligation to determine the correct order of payment and to pay correctly. For example, see 42 C.F.R. and associated Federal Register General Notice published January 31, 1994 (Vol. 59, No. 20, Monday, January 31, 1994, p. 4285). Additionally, many of the data elements not required for coordination of benefit purposes are required for internal business purposes. Consequently, CMS does not believe that the collection of the required data elements causes an undue burden although for newly registering reporters there may be an initial effort involved in centralizing such information for reporting purposes.

Although CMS already routinely collects the Medicare Beneficiary Identifier (MBI), previously known as the Health Insurance Claim Number (HICN), and SSNs from many reporting entities on a voluntary basis, for purposes of this Burden Estimate we are calculating the burden on the assumption that, in order to comply with the MIR requirements, the responsible reporting entities will have to solicit the MBI and SSNs from most of their covered Medicare beneficiaries (newly covered, new Medicare beneficiaries, or Non-Group Health Plans). The following calculations represent CMS's best estimate of its share of the paperwork burden regarding this collection. Estimates have been revised from Supporting Statement of 2017 to reflect actual historical numbers, acknowledge prior MBI's/SSN collection for current beneficiaries, reflect that most responsible reporting entities (RRE's) "systems" have been set-up and are operational, and better estimates derived from experience. (***See Attachment B – The Need for Medicare Beneficiary Identifier (MBI), formerly known as Health Insurance Claim Numbers and/or Social Security Numbers***). It should be noted that obtaining and the retention of the SSN by the RRE is no more of a burden than and insurer obtaining and retaining the MBI. For the NGHP insurer it would be less of a burden for them to initially obtain the SSN from the beneficiary and keep this information on file until they provide the SSN to CMS. When the RRE sends an SSN to CMS the MBI is then returned to the RRE for retention and future use. Once an MBI is sent to the RRE it is expected that the RRE will no longer utilize the SSN.

GHP

Current Section 111 partners report that the management of coordination of benefit data through this process is a routine business procedure. All of GHP arrangements for which there is MSP involvement are already electronically reporting to CMS (See Attachment C – GHP Data Elements that are reported to CMS). CMS believes that 100% of all CMS GHP covered lives is now received each calendar quarter.

For GHP reporters we estimate on-going systems maintenance to be about 20 hours a year. In addition, based on experience with the current processes for each entity we estimate an average of 2 hours to perform the administrative work, including recertifying annually. The burden totals 22 hours. CMS estimates that approximately 1030 private GHP entities are required to/are reporting information annually to CMS under MIR. The 22 hours x 1030 private GHP entities = 22,660 burden hours.

Out of the 1030 GHP reporters, 790 GHP RREs confirmed they offer prescription drug coverage for their Medicare beneficiaries. CMS estimates that within the next reporting periods the 790 GHP RREs may report prescription drug information. As of July 21, 2020, 461 RREs have reported prescription drug coverage since the initial onset of reporting drug coverage beginning January 2020. It is feasible to say that potentially an additional 329 RREs will report prescription drug in the coming several months who have not yet reported. So the burden for prescription drug reporting will be based on 790 entities reporting and 11 hours will also be used to estimate burden hours. The full 22 hours will not be required as the RREs would already assume the burden for identifying the beneficiary personal information when reporting the GHP coverage. The burden to obtain the additional prescription drug information is 5 hours x 790 prescription drug entities = 3,950 burden hours.

Since starting the GHP data collection process in 2009, CMS has collected approximately 17,325,634 “new” GHP MSP records where the beneficiary has other health insurance coverage that is primary to Medicare. Based on current reporting, CMS estimates the annual number of “new” records where MBI collection is necessary will be 1.6 million per year.

CMS estimates that it currently has GHP data on approximately 98 percent of current beneficiaries where another GHP arrangement is primary to Medicare. CMS also estimates that approximately 100 percent of GHPs are currently reporting. System setup costs have been adjusted to reflect that the majority of “set-up” cost will be for maintenance, with very few GHPs required to set-up a new reporting system.

For MBI or SSN Collection, based on the most recent Bureau of Labor and Statistics Occupational and Employment Data (May 2019) for Category 43-9020 (Data Entry and Information Processing Workers), the mean hourly wage for a Data Entry Clerk is $17.37. [1] We have added 100% of the mean hourly wage to account for fringe and overhead benefits, which calculates to $34.74 ($17.37 + $17.37). We estimate the total annual cost to be:

MBI and SSN Collection: 5 minutes (.08333 hours) x 1.6 million responses = 133,333 hours x $34.74/hour = $4,631,988

For Systems Maintenance, based on the most recent Bureau of Labor and Statistics Occupational and Employment Data (May 2019) for Category 15-1142 (Network and

Computer Systems Administrators), the mean hourly wage for a Network and Computer Systems Administrator $42.51. We have added 100% of the mean hourly wage to account for fringe and overhead benefits, which calculates to $85.02 ($42.51 + $42.51). We estimate the total annual cost to be:

System Maintenance Costs for GHP: 20 hours x 1,030 = 20,600 hours x $85.02/hour = $1,751,412.

System Maintenance Costs for Prescription Drug: 5 hours x 790 entities = 3,950 hours x $85.02/hour = $335,829.

For Ongoing Administrative Burden, based on the most recent Bureau of Labor and Statistics Occupational and Employment Data (May 2019) for Category 15-1141 (Database Administrators), the mean hourly wage for a Database Administrator $46.21.[1]. We have added 100% of the mean hourly wage to account for fringe and overhead benefits, which calculates to $92.42 ($46.21 + $46.21). We estimate the total annual cost to be:

Ongoing Administrative Burden for GHP = 2 hours x 1,030 respondents = 2,060 hours x $92.42/hour=$190,385.

Ongoing Administrative Burden for Prescription Drugs = .50 hours x 790 respondents = 395 hours x $92.42/hour = $36,506.

Total GHP burden = 133,333 hours + 20,600 hours + 4,345 hours + 2,060 hours = 160,338 hours. This represents a decrease in both hours and costs from the 2018 Supporting Statement for GHP, but this amount includes the increase in hours and costs for obtaining prescription drug information due to Section 4002 of the SUPPORT Act which updated 42 U.S.C. 1395y(b)(7)(A)(i).

NGHPs

For most NGHPs, gathering the data required for MIR is not a considerable burden. Because the applicable reporting entities have had a long-standing obligation to coordinate claims payment with the Medicare program and to pay claims for health care in the proper order, and based on the experience of the last 3 years, CMS must assume the NGHP entities currently collect the data required for reporting. In addition, the effect of the initial burden of MIR has shown to not be very laborious since NGHP entities payers have obtained the data in order to properly conduct their own business operations.

Most NGHP entities are now reporting to CMS on a regular basis and have adopted the reporting methodology developed for them by CMS. Once a NGHP applicable reporting entity has registered with CMS, the common and readily available NGHP

1 https://www.bls.gov/oes/current/naics4_524100.htm

data elements (***See Attachment D – NGHP Data Elements***) are electronically submitted to CMS. Reporting for contested claims which have been resolved through a single settlement, judgment, award, or other payment is a one-time occurrence. For NGHP entities reporting ongoing payment information requiring coordination of benefit follow-up, ongoing management of coordination of benefit data through the established reporting process should be a routine business procedure.

Current NGHP RREs report that, once established, the management of coordination of benefit data through this process is a routine business procedure. For those required reporting entities that still will have to establish routine reporting to CMS, establishing the data exchange process initially takes, on average, the work of three employees five hours a day for 25 days, or a total of an average of 375 man hours. CMS estimates that 100 percent of NGHPs that would use file exchange are already reporting. If an RRE is already reporting via file exchange, the set-up burden is minimal (for maintenance). If choosing to use the Direct Data Entry, there is minimal set-up time required. In addition, based on experience, for each entity we estimate an average of 2 hours administrative work to assemble the applications, recertify annually and any other administrative tasks. CMS estimates that approximately 20,111 private NGHP entities are required to/are reporting information annually to CMS under MIR.

CMS estimates that of the 20,111 private NGHP entities registered to report, approximately 400 large NGHP entities are required to report information to CMS under MIR on an ongoing basis. CMS estimates that there will be approximately 3.618 million NGHP claims made annually by Medicare beneficiaries that may or may not be settled. CMS assumes 90 percent of the records are/will be reported by the approximately 400 large NGHP entities that are required to report information to CMS on an ongoing basis and some other smaller reporters, and that 10 percent of the records will be reported on an as needed basis through Direct Data Entry via the internet. Based on the Coordination of Benefit Contractor, reporting time via Direct Data Entry is approximately 18 minutes per record.

For MBI or SSN Collection, based on the most recent Bureau of Labor and Statistics Occupational and Employment Data (May 2019) for Category 43-9020 (Data Entry and Information Processing Workers), the mean hourly wage for a Data Entry Clerk is $17.37. [1] We have added 100% of the mean hourly wage to account for fringe and overhead benefits, which calculates to $34.74 ($17.37 + $17.37). We estimate the total annual cost to be:

MBI/SSN Collection: 5 minutes (.08333 hours) x 3.618 million responses = 301,500 hours x $42.51./hour = $12,816,765.

For Systems Maintenance, based on the most recent Bureau of Labor and Statistics Occupational and Employment Data (May 2019) for Category 15-1142 (Network and Computer Systems Administrators), the mean hourly wage for a Network and Computer Systems Administrator $42.51. We have added 100% of the mean hourly

wage to account for fringe and overhead benefits, which calculates to $85.02 ($42.51 + $42.51). We estimate the total annual cost to be:

System Maintenance Costs: 20 hours x 400 large reporters = 8,000 hours x $85.02/hour = $680,160.

For Direct Data Entry, based on the most recent Bureau of Labor and Statistics Occupational and Employment Data (May 2019) for Category 43-9011 (Data Entry and Information Processing Workers), the mean hourly wage for a Data Entry Clerk is $17.37[1]. We have added 100% of the mean hourly wage to account for fringe and overhead benefits, which calculates to $34.74 ($17.37 + $17.37). We estimate the total annual cost to be:

Direct Data Entry Costs: 18 minutes (.3 hours) x 360,000 responses = 108,000 hours x $34.74/hour = $3,751,920.

For Ongoing Administrative Burden, based on the most recent Bureau of Labor and Statistics Occupational and Employment Data (May 2019) for Category 15-1141 (Database Administrators), the mean hourly wage for a Database Administrator $46.21. We have added 100% of the mean hourly wage to account for fringe and overhead benefits, which calculates to $92.42 ($46.21 + $46.21). We estimate the total annual cost to be:

Ongoing Administrative Burden = 2 hours x 20,111 responses = 40,222 hours x $92.42/hour=$3,717,317.

Total NGHP burden hours = 301,500 hours + 8,000 hours + 108,000 + 40,222 hours = 457,722 hours.

This represents an increase in both hours and costs from the 2018 Supporting Statement. This increase is due to the increased number of NGHP records and TPOCs received.

The overall burden for completing MIR is primarily dependent upon the number of individuals for whom an insurer must report information. Other influencing factors may be:

- the accessibility and format of personnel and health plan(s) records;
- the number of GHPs offered by an organization;
- the frequency of changes between plans or in coverage elections; and
- the format the insurer uses in responding to the collection activity.

The majority of the burden for completing MIR is system/reporting related and includes the time taken to: 1) review the instructions; 2) search for and compile the needed data; and 3) complete the record/report.

Burden can also be attributed to insurer familiarity with the reporting process, data required on fewer covered individuals, and for more current periods of time, enhancements to the reporting system, and clarifications made to the instructional materials that address insurer questions or concerns.

13. Capital Costs

There are no capital costs. We have assumed that all required reporting entities will own at least one computer and have access to the internet.

14. Cost to Federal Government

CMS estimates that annual ongoing maintenance and support costs for this activity is approximately $19.166 million per year. This increase in costs is also due to the additional number of MSP records received, the number of TPOCs received from NGHP RREs and the GHP reporting of prescription drug plan information as required by Section 4002 or the SUPPORT Act and 42 U.S.C. 1395y(b)(7)(A)(i)(II).

15. Changes to Burden Cost to Federal Government

A slight incremental annual increase in cost to the federal government has primarily been due to systems and operational changes that have been implemented to reduce burden on reporting group health plans and non-group health plans and to facilitate more efficient use of data received in CMS recovery operations. Beginning in January 2020 CMS started to collect prescription drug information per the requirements cited in Section 4002 of the SUPPORT Act and 42 U.S.C. 1395y(b)(7)(A)(i)(II) which also applies to the increase in the burden cost for GHPs.

Burden on Group Health Plans (GHPs)

There are three reasons why GHP burden has been reduced. First, GHP set-up of reporting has been completed and they are only incurring administrative costs to support ongoing reporting.

Second, since the Section 111 reporting requirements were first implemented, there was an initial burden on the GHPs to report all outstanding information on their initial files. The number of records being reported now only includes maintenance of old records plus any new records that need to be reported. Therefore, the total volume of record transactions has been reduced from 3.7 million per year to 2.6 million per year.

Third, through industry consolidation, the total number of GHPs that report to CMS has been reduced from 1134 to 1030. This consolidation of resources resulted in fewer duplicative administrative costs.

However, beginning in January 2020 CMS started to collect RX Part D drug information per the requirements cited in Section 4002 of the SUPPORT Act and 42 U.S.C. 1395y(b)(7)(A)(i)(II) which applies to the increase in the burden for GHPs.

Burden on Non-Group Health Plans (NGHPs)

There are four reasons why NGHP burden has been reduced. First, NGHP set-up of reporting has been completed and they are only incurring administrative costs to support ongoing reporting.

Second, since the Section 111 reporting requirements were first implemented, there was an initial burden on the NGHPs to report all outstanding information on their initial files. The number of records being reported now only includes maintenance of old records plus any new records that need to be reported. Therefore, the total volume of record transactions has been increased from 2.4 million per year to 3.6 million per year.

Third, for the majority of reporting NGHPs, that are also very small, low volume reporters, CMS developed a simplified reporting process called the Direct Data Entry process that allows the bulk of NGHPs to use a web portal to manually report data. These small entities do not have to incur the higher costs of setting up and maintaining a system to system interface with CMS that only the very largest NGHPs find more cost effective for their reporting. However, the decrease in NGHP burden was only slight because the large number of low volume reporters using the manual Direct Data Entry process are not realizing the economies of scale that the few large NGHP insurers achieved. The larger insurers initially invested in setting up electronic file exchange systems with CMS, so their burden has decreased while, for the bulk of smaller NGHP reporters, hourly burden has remained more constant.

Fourth, through industry consolidation, the total number of NGHPs that report to CMS has been reduced from 21,091 to 18,114. The original estimated burden included potential reporting by state and local governments and federal agencies, as self-insured entities. In practice, private insurers are reporting data that includes data related to these government groups. This consolidation of resources and data reporting streams resulted in fewer duplicative administrative costs for NGHPs and the removal of burden estimates for state and local governments and federal agencies.

16. Publication and Tabulation

There are no plans to publish or tabulate the information collected for statistical use.

17. Expiration Date

CMS will display the expiration date as a PRA Disclosure Statements in the instructional User Guides CMS publishes to provide all official reporting instructions to those entities that must report data to C under this Statute.

18. Certification Statement

There are no exceptions to the certification statement.

C. Statistical Methods

This collection of information does not employ statistical methods.