Supporting Statement for Paperwork Reduction Act Submission: Health Care Reform Insurance Web Portal and Supporting Authority Contained in Sections 1103 and 10102 of The Patient Protection and Affordability Care Act, Pub. L. 111-148 (2010) [CMS-10320/OMB Control Number: 0938-1086]

A. Background

In accordance with Sections 1103 and 10102 of The Patient Protection and Affordability Care Act, Pub. L. 111-148 (2010) (Affordable Care Act) the U.S. Department of Health and Human Services (HHS) is tasked with developing and implementing an Internet website portal to assist consumers with identifying affordable and comprehensive health insurance coverage options that are available in their State. Consistent with minimizing burden and providing consistency in data collection, the Centers for Medicare & Medicaid Services (CMS) updates its HealthCare.gov collection requirements as regulatory developments occur. There have been no developments since the last approved collection that require changes to the Paperwork Reduction Act (PRA) package.

The Departments of Health and Human Services, Labor and the Treasury (the Departments) published a final regulation implementing the Section 2715 consumer disclosure provisions of the ACA. (77 Fed. Reg. 8668 (Feb. 14, 2012), codified at 45 CFR 147.200). These final regulations set forth the requirements for group health plans (plans) and health insurance issuers (issuers) to provide the Summary of Benefits and Coverage (SBC) and the uniform glossary of medical and insurance terms. Under these regulations, plans and issuers must provide in the SBC information about covered services, cost sharing, limitations and exceptions of the coverage, coverage examples, and other disclosures. The final regulation also clarifies the timing and format for providing these documents.

CCIIO is requesting approval to implement this provision for the collection of information to assist consumers in making educated decisions on their health care options. This collection was initially approved under Office of Management and Budget (OMB) control number 0938-1086. Various elements discussed within this package have already been through comment periods and have been authorized for collection under OMB control number 0938-1157. These elements are included here so that the public can identify how the efforts are integrated and get a consistent view of the collection.

The reinsurance and risk adjustment programs outlined by the Affordable Care Act, detailed in the Standards for Reinsurance, Risk Corridors, and Risk Adjustment Rule (77 FR 17220, March 23, 2012), have general information reporting requirements that apply to qualified health plans (QHPs) offered through the Exchanges and to non-Exchange plans in the outside market. For the reinsurance program, administrative information will be used to identify all entities – health insurance issuers and self-insured group health plans- required to contribute to the reinsurance program. In addition, non-Exchange plan information such as plan type and location will be used to identify non-grandfathered individual market plans inside and outside the exchange eligible for reinsurance payments. For the risk adjustment program, administrative information will be used to identify all non-grandfathered small group and individual market plans inside and outside the

exchange eligible for the program. Risk adjustment also requires select data such as rating area, rating factors and actuarial value (AV) level, to perform calculation of payments and charges.

Non-Exchange Plan Information Collection: Reinsurance and Risk Adjustment
Section 1341 of the Affordable Care Act provides that each state will establish a transitional reinsurance program to help stabilize premiums for coverage in the individual market from 2014 through 2016. Section 1343 provides that each state will establish a permanent program of risk adjustment for all non-grandfathered plans in the individual and small group markets. If a state chooses not to actively participate in reinsurance and/or risk adjustment, CMS will be responsible for implementation. The requirements for issuers with plan offerings outside of the Exchanges are codified at 45 CFR Part 153.

Reinsurance Reporting Requirements for Non-Exchange Plans
The transitional reinsurance program will reduce the uncertainty of insurance risk in the individual market by making payments for high-cost enrollees in non- grandfathered individual market plans. Health insurance issuers and self-insured group plans are required to remit contributions on behalf of enrollees in major medical coverage, and thus are collectively referred to as "contributing entities." Self-insured group health plans may remit their reinsurance contributions through a third party administrator or an administrative services only contractor. Non-grandfathered individual market plans are eligible to request and receive reinsurance payments.

CMS will collect all contributions under the uniform reinsurance contribution rate, regardless of whether a state is operating a reinsurance program. CMS will operate reinsurance payment functions for a state when the state defers operation of the program to CMS.

In order to effectively identify and contact "contributing entities" and third party administrators, (and administrative services only contractors) administrative information, such as name, location, and contact for company, is needed. In addition, in order to identify eligible plans for reinsurance payments, plan-level information is needed for non-grandfathered, non-Exchange plan offerings in the individual market as well as QHPs.

Additionally, states operating the transitional reinsurance program will be required to register in HIOS in order for HHS to distribute reinsurance payments to the state. The state will then allocate those reinsurance payments to the issuers in their state.

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

A "risk adjustment covered plan" includes most health insurance plans offered in the individual or small group market. The exceptions are grandfathered health plans, group health insurance

coverage described in 45 CFR 146.145(c), individual health insurance coverage described in 45 CFR 148.220, and any other plan determined not to be a risk adjustment covered plan in the applicable Federally-certified risk adjustment methodology. States, or CMS on behalf of a state, will require basic identifying information about all risk adjustment covered plans, whether or not they are QHPs.

B. Justification

1. Need and Legal Basis

This information is mandated by Sections 1103 and 10102 of the Affordable Care Act. A copy of this mandate is provided in Appendix B. Additionally, the collection covers information required in Sections 1302 and 2715 of the Affordable Care Act regarding transparency and the provision of SBC.

2. Information Users

Once all of the information is collected from the States, State health benefits high risk pools, and insurance issuers (hereon referred to as issuers), this information is processed by contractors for display on the HealthCare.gov website. The information that is provided helps the general public make educated decisions about their choice in organizations providing private health care insurance. Information collected quarterly from insurance issuers is used to populate the Plan Finder application to show individuals their options, to provide some profile information, and to coordinate the data collection with Oversight collections to reduce the burden on issuers and the Federal Government. Collecting information consistent with the SBC standards allows consumers to access this information in a consistent manner.

3. Use of Information Technology

CCIIO has created a system where insurance issuers and their States log into the web portal using a custom user ID and password validation. The States were asked to provide information on issuers in their State and various websites (see Appendix E). Issuers have been downloading a basic information template to enter data then upload into the portal. Information to be collected on issuers and products can be found in Appendix C. Additionally, for purposes of this collection, we will collect information consistent with both QHPs and the Federally-facilitated Exchange within one consolidated template. The requirements and data elements of this collection can be found in OMB Control No. 0938-1187. Information to be collected can be found in the following Appendices: Plans and Benefits and Service Area Templates can be found in Appendices D and I; Rating Tables and Issuer Business Rules data can be found in Appendices G and H. Additionally, beginning with the Plan Year 2021 collection, Rates and Benefits Information (RBIS) URL collection template will be included in future collections, and can be found in Appendix G of this Information Collection Request.

CCIIO will be using drop down menus and error checks wherever possible to minimize burden on plans and issuers. Once the data is submitted, the plans and issuers can later log in to update information they provided instead of having to re-upload all plan/product information.

4. Duplication of Efforts

CMS will make every effort to reduce the burden on issuers and reuse the information that is collected under the various provisions of the Affordable Care Act. As such, data obtained under other authorized collections that implement provisions of the Affordable Care Act will be utilized to meet some Exchange requirements, for example Rate Increase Disclosure and Review Requirements (45 CFR Part 154),OMB Control Number 0938-1141. Additionally, the implementation of the Affordable Care Act section 2715 requirement's for specific standards for reporting information to consumers, we have aligned our data collection with the structure for a SBC as recommended by the National Association of Insurance Commissioners (NAIC).

5. Small Business

Small Businesses are not significantly affected by this collection.

6. Less Frequent Collection

CCIIO has been operating with an approximately 45 day refresh schedule to obtain changes in plan benefits and pricing as well as comprehensive lists of products approved within a State for sale to the public. In the event that an issuer enhances its existing plans, proposes new plans, or deactivates plans, the organization would be required to update the information in the web portal using the edit function or uploading an updated template within an open window period. In response to the desire to decrease burden as much as possible, CMS has adjusted the Rates and Benefits System (RBIS) data collection period requirement to an annual collection. CMS will continue to provide four submission windows per year in case changes or updates are required to submitted data. Through the use of effective dates and periodic windows of opportunity for changes, CMS anticipates that we can decrease the overall burden for the data collection significantly. Per current CMS policy, issuers will still be required to provide quarterly product enrollment numbers during each of the four data collection windows.

7. Special Circumstances

Dependent on the frequency with which an issuer enhances, eliminates, or adds options to their products, additional submissions may be necessary.

Information that is to be collected from State health benefits high risk pools (Appendix F) has been collected from the National Association of State Comprehensive Health Insurance Plans (NASCHIP) at this time. Administrators have been voluntarily entering changes as they develop, so no general call for the collection of data from these groups is currently contemplated. Information from State Insurance Commissioners was collected in 2010, and no current plans exist to continue that collection during the period covered by this document. CMS reserves the right to continue to request this information, however, as the nature of these markets is highly changeable.

8. Federal Register/Outside Consultation

The 60-Day Federal Register Published on September 28, 2020 (FR 2020-21383). CMS received two comments that were out of context of the subject data collection.

9. Payments/Gifts to Respondents

There are no payments/gifts to respondents.

10. Confidentiality

To the extent provided by law, we will maintain respondent privacy with respect to the information being collected. HealthCare.gov collects issuer opinions regarding confidentiality of any new data elements for review by the Freedom of Information Act (FOIA) office at CMS. Certain fields have been determined as confidential on the basis of this review and are redacted from public files.

11. Sensitive Questions

There are no sensitive questions included in this collection effort.

12. Burden Estimates (Hours & Wages)

Table 1: Wage Rate Data

Average labor costs (including 100 percent fringe benefits) used to estimate the costs are calculated using data available from the May 2019 National Industry-Specific Occupational Employment and Wage Estimates (Bureau of Labor Statistics (BLS). Hourly wage rates include the costs of fringe benefits (calculated at 100 percent of salary) and the adjusted hourly wage.
https://www.bls.gov/oes/current/oes_nat.htm#31-0000

Labor Category	Occupational Code	Mean Hourly Wage ($/hour)	100% Fringe Benefits and ($/hour)	Adjusted Hourly Wage ($/hour)
Computer and Information Systems Manager	11-3021	$70.37	$70.37	$140.74

Issuer Burden

The estimated hour burden on issuers for the PlanFinder data collection is estimated as 78,675 total burden hours. This estimate is based on an assumed average of 450 individual plan issuers, 500 small group plan issuers (288 issuers offering both individual and small group plans) per each of the four quarterly collection. It includes 30 hours per organization for training and communication. Additionally, for each of the issuers it includes 13 hours of preparation time, one hour of login and upload time, two hours of troubleshooting and data review, and one half hour for attestation per organization. Burden hours have increased as a result of requirements associated with the addition of a 5th template (Appendix G of this ICR). While the PlanFinder data collection continues to operate on a quarterly basis, RBIS has moved to an annual collection with the option to make plan changes during each submission quarter. We assume this will decrease the overall burden on issuers significantly.

Table 2: Burden Hours for Insurance Issuers

Explanation	Respondents	Responses	Hours per Response	Total	Xs	Annual Hours	Hourly Labor Costs (Hourly Rate + 100% Fringe Benefits)	Total Burden Cost
Training and Communication	700	1	30	21,000	1	21,000	$140.74	$ 29,955,540
Submission Preparation Individual	450	450	13	5850	4	23,400	$140.74	$ 3,293,316
Submission Preparation- Small Group	500	500	13	6500	4	26,000	$140.74	$ 3,659,240
Data Entry- Individual	450	450	1	450	4	1800	$140.74	$ 253,332
Data Entry- Small Group	500	500	1	500	4	2000	$140.74	$ 281,480
Troubleshoot- Individual	450	450	2	900	4	3600	$140.74	$ 506,664
Troubleshoot- Small Group	500	500	2	1000	4	4000	$140.74	$ 562,960
Attest- Individual	450	450	0.5	225	1	225	$140.74	$ 31,666.50
Attest-Small Grp.	500	500	0.5	250	1	250	$140.74	$ 35,185
Total			63			78,675		$ 38,062,719.50

State Burden

The estimated hour burden on the States for the PlanFinder data is informed by the fact that they have already submitted the data once and only need to update their submissions. The overall hours estimate is 525, or 10.5 per Department of Insurance. This is premised on 2 hours of training and communication, 8 hours for data collection, and one half hour for submission.

Table 3: Burden on States

Explanation	Respondents	Responses	Hours Per Response	Total	Xs	Annual Hours	Hourly Labor Costs (Hourly Rate + 100% Fringe Benefits)	Total Cost
Training	50		2	100	4	100	$140.74	$14,074
Data Collection		50	8	400	4	400	$140.74	$56,296
Submission		50	0.5	25	4	25	$140.74	$3518.50
Total						525		$73,888.50

13. Capital Costs

There is no capital costs needed for this collection effort.

14. Cost to Federal Government

We estimate that the operations and maintenance costs for the data collection tool and the data collection support for a total cost of $2,213,159 per year. The calculations for CCIIO employees' hourly salary was obtained from the OPM website: https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2020/DCB_h.pdf

Software Development and Hosting	$ 2,032,000.00
Managing and Coordinating Contracts	
GS-13(Step 2) : 3 x $50.83 x 416 hours	$ 63,436
Analysis and Q&A	
GS-13(Step 2): 4 x 50.83 x 416 hours	$84,581
Overhead Costs	
$110,472.00 * 30%	$33,142.00
Total Cost to Government	$ 2,213,159.00

15. Changes to Burden

Issuer burden hours have slightly increased as a result of requirements associated with the addition of the RBIS URL template (Appendix G). Based on historical data of collection activity, the number of respondents (issuer submissions) has decreased from 700 to 500 for small group. Additionally, the total number of respondents (issuers) decreased from 750 to 700. Although PlanFinder submissions are required 4x per year to capture quarterly product enrollment changes, with the RBIS annual model, submissions 4x per year are no longer required. CMS will continue to provide four submission windows per year in case of changes or updates to submitted data, but some issuers may be able to provide data only once for the entire plan year. For Costs to Government has decreased (from $15,161,494 to $2,213,159) due to transitioning over to Amazon Web Services (AWS) thus significantly decreasing the Software and Hosting Cost.

16. Publication/Tabulation Dates

The collection of detailed information from issuers to post on Finder.healthcare.gov is anticipated under this request for collection in August 2020.

17. Expiration Date

The expiration date and OMB control number will be displayed on each instrument.