Supporting Statement Part-A
Good Cause Processes
(CMS-10544, OMB 0938-1271)

Background

Medicare Advantage (MA) organizations, §1876 cost plans and Part D plan sponsors may terminate the enrollment of individuals who fail to pay basic and supplemental premiums after a grace period established by the plan. An MA organization or Part D plan sponsor that chooses to disenroll beneficiaries for failure to pay premiums must be able to demonstrate that it made a reasonable effort to collect the unpaid amounts by notifying the beneficiary of the delinquency, providing the beneficiary a period of no fewer than 2 months in which to resolve the delinquency, and advising the beneficiary of the termination of coverage if the amounts owed are not paid by the end of the grace period. A cost plan must be able to demonstrate that it made a reasonable effort to collect unpaid premiums or other charges and that it provided the member with a written notice of disenrollment at least 20 days before the disenrollment effective date.

In January 2012, CMS codified regulations (76 FR 21432) to permit reinstatement of enrollment of individuals who lost MA or Part D coverage due to non-payment of premiums if they met the criteria for good cause. Under these regulations, only CMS had the authority to effectuate the good cause processes and reinstate individuals. In January 2013, this opportunity was expanded to cover §1876 cost plans (77 FR 22071).

In February 2015, CMS codified a change to these regulations (CMS-4159-F2) to provide CMS the authority to assign responsibility for effectuating these good cause processes to another entity. As part of that final rule, we outlined the Collection of Information (COI) (79 FR 2028) that would be the administrative burden by plans should CMS delegate this process to them. Starting in January 2016, MA organizations, Part D plan sponsors and §1876 cost plans are responsible for processing good cause requests from individuals involuntarily disenrolled for failure to pay plan premiums (or other charges, as applicable).

This collection of information provides an update to the estimated administrative burden of MA organizations, Part D plan sponsors and §1876 cost plans that disenroll individuals for nonpayment of premiums (or other charges, as applicable).

CMS is requesting for this package's OMB# (0938-1271) to be reinstated. The lapse in time was due to administrative delays.

A. Justification

1. Need and Legal Basis

Section 1851(g)(3)(B)(i) of the Act provides that MA organizations may terminate the enrollment of individuals who fail to pay basic and supplemental premiums after a grace period established by the plan. Section 1860D-1(b)(1)(B)(v) of the Act generally directs us to establish rules related to enrollment, disenrollment, and termination for Part D plan sponsors that are similar to those established for MA organizations under section 1851 of the Act. Consistent with these sections of the Act, subpart B in each of the Parts C and D regulations sets forth requirements with respect to involuntary disenrollment procedures at 42 C.F.R. §§ 422.74 and 423.44, respectively. In addition, section 1876(c)(3)(B) establishes that individuals may be disenrolled from coverage as specified in regulations. Thus, current regulations at 42 C.F.R. 417.460 specify that a cost plan, specifically a Health Maintenance Organization (HMO) or competitive medical plan (CMP), may disenroll a member who fails to pay premiums or other charges imposed by the plan for deductible and coinsurance amounts.

Within these regulatory provisions, individuals disenrolled for nonpayment of premiums are afforded a grace period in which to request reinstatement. As part of the reinstatement request process, they must demonstrate good cause for failure to pay within the initial grace period that led to their involuntary disenrollment and pay all overdue premiums within three calendar months after the disenrollment date.

While disenrollment due to non-payment of premiums is currently voluntary for such plans, in 2019, 312 plans effectuated such disenrollment's. This resulted in an average of 26,414 disenrollment's each month.

2. Information Users

These good cause provisions authorize CMS to reinstate a disenrolled individual's enrollment without interruption in coverage if the non-payment is due to circumstances that the individual could not reasonably foresee or could not control, such as an unexpected hospitalization. At its inception, the process of accepting, reviewing, and processing beneficiary requests for reinstatement for good cause was carried out exclusively by CMS. However, we received feedback on ways to improve the good cause process and make it more efficient for both the plans and CMS, including that many plans prefer to be the initial point of contact for such requests since they have an established relationship with the individual.

In February 2015, CMS published a regulatory change (CMS-4159-F2) to provide CMS the authority to assign responsibility for effectuating these good cause processes to another entity. This regulatory change allows CMS to designate another entity, specifically a plan (MA organization, Part D plan sponsor, or entity offering a cost plan), to carry out some or all of the good cause reinstatement process. Starting in January 2016, we expanded the role for plans in the good cause reinstatement process, such that they, as of this date, accept incoming requests for reinstatement directly from former enrollees.

Given that CMS has delegated responsibility to conduct this administrative activity, plans that disenroll individuals for non-payment of premiums (or other costs, as applicable), are responsible for receiving requests for reinstatement from prior members, determining the individual's eligibility for good cause, and submitting the reinstatement transaction to CMS following full payment of the arrearage, based on the parameters and processes outlined in regulation and sub-regulatory guidance.

3. Use of Information Technology

Information provided by individuals requesting reinstatement under the good cause process is not collected electronically. Requests are submitted to plans either orally or in writing.

Plans submit the reinstatement request electronically to CMS following existing processes for other types of reinstatements permissible under sub-regulatory guidance. One hundred percent of the reinstatements are submitted to CMS electronically.

4. Duplication of Efforts

The information collection requirements for the good cause processes are not duplicated through any other effort.

5. Small Businesses

There is not a significant impact on small businesses that comply with these information collection requirements. Based on calendar year 2019 data, the expected percentage of reinstatement requests for plans is approximately 13 percent. Thus, for a small business that exercises the voluntary policy to disenroll for non-payment of premiums and disenrolls 100 or fewer individuals a month for this reason, it is expected that it would receive about 13 requests for reinstatement each month.

6. Less Frequent Collection

This information is collected as needed and requested by the disenrolled individual. If it were to be collected less frequently, plans would not be able to obtain these data for determining reinstatement for good cause, process requests and reinstate coverage for individuals within the regulatory requirements. If not collected at all, individuals would not be provided a regulatory protection and would not have the ability to access necessary health coverage.

7. Special Circumstances

Plans disenroll for nonpayment of premiums or other costs on a monthly basis. As such, requests for good cause and reinstatements resulting from approved requests also occur monthly. Plans submit reinstatement transactions to CMS via normal operating processes for individuals that were approved and meet the other requirements outlined in regulation each month.

8. Federal Register/Outside Consultation Federal Register

The 60-day Federal Register Notice published in the Federal Register 02/22/2022 (87 FR 9627).
No comments have been received.

The 30-day Federal Register Notice published in the Federal Register 05/05/2022 (87 FR 26760).

9. Payments/Gifts to Respondents

There are no payments or gifts to respondents related to the collection of this information.

10. Confidentiality

The information collected from plan members must conform to the requirements at 42 CFR 422.74 and 423.44, and in all Federal and State laws regarding confidentiality and disclosure.

11. Sensitive Questions

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

12. Burden Estimates (Hours & Wages)

Not all plans disenroll for nonpayment of premiums. However, for those that do implement this voluntary policy, information available for calendar year 2019 showed that it resulted in an average of 26,414 disenrollment's each month and an average of 3,441 requests for reinstatement per month, or **41,289 requests annually**.

Beneficiaries that are disenrolled for nonpayment of premiums must request to be reinstated on the basis of good cause. For those who make such requests, we estimate that the average completion time is 10 minutes.

The burden to beneficiaries is computed as follows:
There are 41,289 respondents taking 10 minutes per response. 41,289 x 0.166 hours (10 minutes) = 6,853.97 total burden hours, rounded to **6,854 hours annually**.

While there may be some cost to the respondents, there are individuals completing this form who are working currently, may not be working currently or never worked. Therefore, we used the current federal minimum wage outlined by the U.S. Department of Labor (https://www.dol.gov/whd/minimumwage.htm). The burden for all beneficiaries is estimated at 6,854 hours (41,289 beneficiaries x 0.166 hr) at a cost of $49,691.50 (6,854 hrs x $7.25/hr) or $1.20 per beneficiary ($49,691.50 / 41,289 beneficiaries).

An entity operating a cost plan, an MA organization, or a Part D plan sponsor that has a policy of involuntary disenrollment for failure to pay plan premium and is therefore responsible for implementing the good cause process, already has the enrollment data necessary to make the determinations required by the process. The burden to each plan consists of completing the operational process, such as receiving requests for reinstatement from former members, obtaining the attestation from the individual regarding his or her reason for not paying the plan premiums within the grace period, making the determination as to whether the individual meets the good cause criteria, submitting the reinstatement action to CMS once full payment of arrearages is made, and maintaining the case notes and documentation to support its determination.

Plans already provide customer service to their current and past members; therefore, we estimate that this burden would be approximately 30 minutes for each reinstatement request. There are 312 MA, Part D and cost plan organizations that disenroll members for nonpayment of premiums in 2019. With approximately 3,441 requests each month, or 41,289 annually, we estimate the burden to plans to be as follows:

There are 41,289 responses taking 30 minutes per response. 41,289 x 0.5 hours (30 minutes) = **20,645 total burden hours** annually or 66.17 per plan. (20,645 / 312 plans)

According to the most recent wage data provided by the Bureau of Labor Statistics (BLS) for May 2020, the median hourly wage for the category of "Project Management Specialists and Business Operations Specialists, All Other" – which we believe is the most appropriate category, is $37.22 (Bureau of Labor Statistics, U.S. Department of Labor, Occupational Employment and Wages, May 2020, Project Management Specialists and Business Operations Specialists, All Other, Occupation Code 13-1198, on this page of the Bureau of Labor Statistics website). We have added 100% of the median hourly wage to account for fringe and overhead benefits ($37.22+$37.22=$74.44). With fringe benefits and overhead, the hourly rate is $74.44.

The annual burden is estimated at 20,645 hours (41,289 beneficiaries x 0.5 hr) at a cost of $1,536,813.80 (20,645 hrs x $74.44/hr) for all plans in the MA, Part D and cost plan programs, or $4,925.69 per plan ($1,536,813.80 / 312 plans).

The total cost to beneficiaries and plans for this activity is estimated at $1,586,505.30 annually. ($49,691.50 estimated annual burden for all beneficiaries + $1,536,813.80 estimated annual burden for all plans in the MA, Part D and cost plan programs)

The total annual burden to beneficiaries and plans for both activities is **27,499 hours** (**6,854 +20,645**).

13. Capital Costs

As plans are already required to maintain documentation of enrollees for possible review, there are no additional capital or equipment costs to CMS resulting from the collection of information.

14. Cost to Federal Government

There are no additional costs to the government.

15. Changes to Burden

The burden from the 2016 approved submission increased in cost from $344,210.77 to $1,586,505.30 for respondent costs – an increase of $1,242,294.53. This is a result of our determination that the burden should be based on the wages for “Business Operations Specialists, All Other” instead of "Customer Service Representatives." In the currently approved collection, which was based on wage data provided by the Bureau of Labor Statistics (BLS) for May 2016, the mean hourly wage for the category of “Business Operations Specialists, All Other” was $33.19. With fringe benefits and overhead, the per hour rate was $66.38. According to wage data provided by the BLS for May 2020, the median hourly wage for the category of “Project Management Specialists and Business Operations Specialists, All Other” – which includes the category of “Business Operations Specialists, All Other” used in our 2016 approved submission, is $37.22. Adding 100% of the median hourly wage to account for fringe and overhead benefits, the per hour rate is $74.44.

The number of respondents increased from 10,008 to 41,289 and the Annual Burden hours increased from 6,665 to 27,499.

The higher costs are also the result of the increased number of plans that are disenrolling members for nonpayment of premiums, the increased number of beneficiaries disenrolled under these policies and the increased number of beneficiaries requesting reinstatement.

16. Publication/Tabulation Dates

There are no publication or tabulation dates.

17. Expiration Date

This collection does not have any documents associated with it to display the expiration date.

18. Certification Statement

There are no exceptions to the certification statement.

B. Collections of Information Employing Statistical Methods

This collection of information does not employ statistical methods.