# Supporting Statement for Marketplace Operations
# (CMS-10637/OMB control number: 0938-1353)

## A. Background

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148) was signed into law and on March 30, 2010, the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was signed into law. The two laws implement various health insurance policies.

On June 19, 2013, HHS published the proposed rule CMS-9957-P: *Program Integrity: Exchanges, SHOP, Premium Stabilization Programs, and Market Standards* (78 FR 37302) (Program Integrity Proposed Rule). Among other things, the Program Integrity Proposed Rule sets forth financial integrity provisions and protections against fraud and abuse. On January 30, 2013, CMS published *Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges under the Affordable Care Act* (CMS-2334-P) (E&E II Proposed Rule). On August 30, 2013, HHS published the final rule CMS-9957-F*: Program Integrity: Exchanges, SHOP, Eligibility Appeals* (Program Integrity final rule), finalizing a number of the provisions from the Program Integrity and E&E II Proposed Rules. The third party disclosure requirements and data collections in the Program Integrity final rule support the oversight of qualified health plan (QHP) issuers in Federally-facilitated Exchanges (FFEs) and other provisions.

This Information Collection Request (ICR) serves as the formal request for clearance for the renewal of an existing data collection. The original approved ICR affiliated with this final rule (OMB #: 0938-1213) was titled *Program Integrity and Additional State Information Collections* and approved on 11/21/2013. This ICR also includes some of the information collection requirements from the previously approved final rule. The other ICRs from the final rule that are not included in this request will be submitted for OMB approval under separate collections.

## B. Justification

### 1. Need and Legal Basis

Section 1321(c)(1) of the Affordable Care Act requires the Secretary to establish and operate an FFE within States that either: do not elect to operate an Exchange; or, as determined by the Secretary, will not have any required Exchange operational by January 1, 2014.

Section 1321(c)(2) of the Affordable Care Act authorizes the Secretary to enforce the Exchange standards using civil money penalties (CMPs) on the same basis as detailed in section 2723(b) of the Public Health Service Act (PHS Act).[1] Section 2723(b) of the PHS Act authorizes the Secretary to impose CMPs as a means of enforcing the individual and group market reforms contained in Title XXVII, Part A of the PHS Act when a State fails to substantially enforce these provisions.

[1] Section 1321(c) of the Affordable Care Act erroneously cites to section 2736(b) of the PHS Act instead of 2723(b) of the PHS Act.

Section 1313 of the Affordable Care Act, combined with section 1321 of the Affordable Care Act, provides the Secretary with the authority to oversee the financial integrity, compliance with HHS standards, and efficient and non-discriminatory administration of State Exchange activities. Section 1313(a)(6)(A) of the Affordable Care Act specifies that payments made by, through, or in connection with an Exchange are subject to the False Claims Act (31 U.S.C. 3729, et seq.) if those payments include any Federal funds.

Section 1401 of the Affordable Care Act amended the Internal Revenue Code (26 U.S.C.) to add § 36B, allowing a refundable premium tax credit to help individuals and families afford health insurance coverage. Under sections 1401, 1411, and 1412 of the Affordable Care Act and 45 CFR part 155, subpart D, an Exchange will make a determination of advance payments of the premium tax credit for individuals who enroll in QHP coverage through an Exchange and seek financial assistance. Section 1402 of the Affordable Care Act provides for the reduction of cost sharing for certain individuals enrolled in a QHP through an Exchange, and section 1412 of the Affordable Care Act provides for the advance payment of these reductions to issuers.

Section 1411 of the Affordable Care Act, directs the Secretary to establish a program for determining whether an individual meets the eligibility standards for Exchange participation, advance payments of the premium tax credit, cost-sharing reductions, and exemptions from the shared responsibility payment.

Sections 1412 and 1413 of the Affordable Care Act and section 1943 of the Social Security Act (the Act), as added by section 2201 of the Affordable Care Act, contain additional provisions regarding eligibility for advance payments of the premium tax credit and cost- sharing reductions, as well as provisions regarding simplification and coordination of eligibility determinations and enrollment with other health programs.

The Affordable Care Act directs issuers offering non-grandfathered health insurance coverage in the individual and small group markets to ensure that plans meet an actuarial value (AV) level of coverage specified in section 1302(a)(3) of the Affordable Care Act and as defined in 45 CFR 156.140(b). Consistent with section 1302(d)(2)(A) of the Affordable Care Act, AV is calculated based on the provision of the essential health benefits (EHB) to a standard population and is a measure of the percentage of expected health care costs a health plan will cover for a standard population.

2. Information Users

The data collections and third-party disclosure requirements will assist HHS in determining Exchange compliance with Federal standards and monitoring QHP issuers in FFEs for compliance with Federal QHP issuer standards. The data collection will assist HHS in monitoring Web-brokers for compliance with Federal Web-broker standards. The data collected by health insurance issuers and Exchanges will help to inform HHS, Exchanges, and health insurance issuers as to the participation of individuals, employers, and employees in the individual Exchange, the SHOP, and the premium stabilization programs.

3. Use of Information Technology

HHS anticipates that a majority of the systems, notices, and information collection required will be automated. A majority of the information that is required by the collection of information will be submitted electronically. HHS staff will analyze or review the data in the same manner by which it was submitted and communicate with states, health insurance issuers, and other entities using e-mail, telephone, or other electronic means.

4. Duplication of Efforts

This information collection does not duplicate any other Federal effort.

5. Small Businesses

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

6. Less Frequent Collection

Due to the required flow of information between multiple parties and flow of funds for payments for health insurance coverage within the Exchange, it is necessary to collect information according to the indicated frequencies. If the information is collected less frequently, the result would be less accurate, untimely or unavailable eligibility, enrollment or payment information for Exchanges, insurers, employers, and individuals. This would lead to delayed payments to insurers; late charges to or payments by employers and enrollees; inaccurate or inappropriate payments of advance premium tax credits and cost sharing reductions; the release of misleading information regarding health care coverage to potential enrollees; and an overall stress on the organizational structure of the Exchanges. If the information is not collected in the timeframe, HHS will not be able to properly ensure the financial integrity of Federal funds.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

A 60-day Federal Register Notice was published in the Federal Register on 06/02/2021 (V.86, No. 104) for the public to submit written comment on the information collection requirements. No comments were received.

A 30-day Notice will be published in the Federal Register on XX/XX/2021 for the public to submit written comment on the information collection requirements.

No additional outside consultation was sought.

9. Payments/Gifts to Respondents

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

10. Confidentiality

To the extent of the applicable law and HHS policies, we will maintain respondent privacy with respect to the information collected. Nothing in the information collection should be interpreted as preventing a State from being allowed to disclose its own data.

11. Sensitive Questions

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

12. Burden Estimates (Hours & Wages)

The following section of this document contains an estimate of the burden imposed by the associated ICRs. Average labor costs (including 100% fringe benefits) used to estimate the costs are calculated using data available from the May 2020 National Industry-Specific Occupational Employment and Wage Estimates from the Bureau of Labor Statistics (BLS).

**Table 1: Adjusted Hourly Wages Used in Burden Estimates**

| Occupational Title | Occupational Code | Mean Hourly Wage ($/hour) | Fringe Benefits (100%) ($/hour) | Adjusted Hourly Wage ($/hour) |
|---|---|---|---|---|
| Database Administrator and Architect | 15-1245 | $48.60 | $48.60 | $97.20 |
| Actuary | 15-2011 | $59.22 | $59.22 | $118.44 |
| General and Operations Manager | 11-1021 | $60.45 | $60.45 | $120.90 |
| Compliance Officer | 13-1041 | $36.35 | $36.35 | $72.70 |
| Lawyer | 23-1011 | $71.59 | $71.59 | $143.18 |
| Insurance Claims and Policy Processing Clerk | 43-9041 | $21.67 | $21.67 | $43.34 |
| Software Developer | 15-1256 | $54.94 | $54.94 | $109.88 |

**State Specific Standard Population (§ 156.135)**

This information collection is not directly tied to the provisions in the Program Integrity final rule. In 45 CFR § 156.135(d), HHS established that beginning in 2015, a State may submit a State-specific standard population, to be used for AV calculations, so long as the criteria described in § 156.135(d)(1) through (6) are met. A State that applies must submit to HHS

summary evidence that the requirements described in §156.135 are met and that the dataset is in a format that will support the use of the AV calculator.

Given that no States have elected to pursue this option to date, we expect this trend to continue and that a limited number of States will pursue this option in the near future. For the purposes of calculating burden, we estimate that one State will pursue this option during the next three years. This burden will therefore not be subject to PRA requirements and will not be included in total burden calculations. We expect that for each State choosing this option, the data submission will require 15 hours from a database administrator and architect at $97.20 an hour, 4 hours from an actuary at $118.44 an hour, and 1 hour from a general and operations manager at $120.90 an hour. Therefore, the total burden cost associated with this reporting requirement is estimated to be $2,052.66.

Pursuant to 45 CFR § 156.135(d), a State may submit a State-specific standard population, to be used for AV calculations. The State must submit summary evidence to show the requirements in § 156.135 are being met. The table below displays the burden for a State submitting this standard.

**Table 2: State Burden in Submitting Information Required for State Specific Standard Population Option**

| Labor Category | Number of Respondents | Hourly Labor Costs (Hourly Rate + 100% Fringe Benefits) | Burden Hours | Total Burden Costs (Per Respondent) | Total Burden Costs (All Respondents) |
|---|---|---|---|---|---|
| Database Administrator and Architect | 1 | $97.20 | 15 | $1,458.00 | $1,458.00 |
| Actuary | 1 | $118.44 | 4 | $473.76 | $473.76 |
| General and Operations Manager | 1 | $120.90 | 1 | $120.90 | $120.90 |
| Total | | | 20 | $2,052.66 | $2,052.66 |

**Enforcement Remedies in Federally-facilitated Exchanges (§ 156.800 to § 156.810)**

Subpart I of Part 156 discusses the enforcement remedies in the FFEs. Section 156.800 authorizes HHS to impose sanctions on QHP issuers in an FFE that are not in compliance with Federal standards. These sanctions may be in the form of a civil money penalty (CMP), as set forth in §156.805; or decertification of QHPs, as set forth in §156.810. The burden estimates for the collections of information in this Part reflect our assumption that there will be 361 QHP issuers and 4,312 plans QHPs in all FFEs based on the number of QHP issuers and QHPs in Plan Year 2021.

Section 156.805(a) states the general process and bases for imposing a CMP on issuers offering QHPs in an FFE. CMPs will be imposed only for serious issues of non-compliance. We expect to

provide technical assistance to issuers, as appropriate, to assist them in maintaining compliance with the applicable standards. We also plan to coordinate with States in our oversight and enforcement activities to avoid inappropriately duplicative enforcement efforts. Subsequently, we anticipate that CMPs will be imposed infrequently. Based on the fact that no CMPs have been imposed in the last several years, we estimate that this trend will continue in the near future. For the purposes of calculating burden, we estimate that one issuer will receive and appeal a CMP in the next three years. This burden will therefore not be subject to PRA requirements and will not be included in total burden calculations. We estimate that each issuer receiving and appealing a CMP will utilize a compliance officer at $72.70 an hour for 60 hours, a lawyer at $143.18 an hour for 60 hours, and a general and operations manager at $120.90 an hour for 30 hours. In total, we estimate the cost for an issuer receiving and appealing a CMP to be $16,579.80.

Pursuant to 45 C.F.R. § 156.805 (a), HHS may impose a sanction on QHP Issuers in an FFE that are not in compliance with Federal standards. The table below displays the burden for an issuer that receives and appeals this sanction.

**Table 3: Issuer Burden in Receiving and Appealing Civil Money Penalty**

| Labor Category | Number of Respondents | Hourly Labor Costs (Hourly Rate + 100% Fringe Benefits) | Burden Hours | Total Burden Costs (Per Respondent) | Total Burden Costs (All Respondents) |
|---|---|---|---|---|---|
| Compliance Officer | 1 | $72.70 | 60 | $4,362.00 | $4,362.00 |
| Lawyer | 1 | $143.18 | 60 | $8,590.80 | $8,590.80 |
| General and Operations Manager | 1 | $120.90 | 30 | $3,627.00 | $3,627.00 |
| Total | | | 150 | $16,579.80 | $16,579.80 |

Section 156.810 sets forth the bases for the decertification of a QHP in an FFE and the general process for decertification. Decertification is reserved for only serious instances of noncompliance with applicable standards. Subsequently, HHS expects that decertification will occur infrequently. Based on the fact that no issuers' QHPs have been decertified in the last several years, we estimate that this trend will continue in the near future. For the purposes of calculating burden, we estimate that one issuer will be decertified and will appeal said decertification in the next three years. This burden will therefore not be subject to PRA requirements and will not be included in total burden calculations. We estimate an issuer that is decertified and that appeals this decertification will utilize a compliance officer at $72.70 for 40 hours, a lawyer at $143.18 for 40 hours, and a general and operations manager at $120.90 for 20 hours. In total, we estimate the cost for an issuer that is decertified and appeals this decertification to be $11,053.20.

Pursuant to 45 C.F.R. § 156.810, HHS may decertify a QHP in an FFE for serious instances of noncompliance with applicable standards. The table below displays the burden for an issuer who

is decertified and then appeals this decision.

**Table 4: Issuer Burden in Decertification and Appeal of Certification Action**

| Labor Category | Number of Respondents | Hourly Labor Costs (Hourly Rate + 100% Fringe Benefits) | Burden Hours | Total Burden Costs (Per Respondent) | Total Burden Costs (All Respondents) |
|---|---|---|---|---|---|
| Compliance Officer | 1 | $72.70 | 40 | $2,908.00 | $2,908.00 |
| Lawyer | 1 | $143.18 | 40 | $5,727.20 | $5,727.20 |
| General and Operations Manager | 1 | $120.90 | 20 | $2,418.00 | $2,418.00 |
| Total | | | 100 | $11,053.20 | $11,053.20 |

**Consumer Cases Related to Qualified Health Plans and Qualified Health Plan Issuers (§ 156.1010)**

In subpart K of part 156, we describe the information collection requirements that pertain to the resolution of consumer cases related to QHPs and QHP issuers. Section 156.1010(g)(1) states that QHP issuers must include the date of case resolution, § 156.1010(g)(2) states that QHP issuers must record a clear and concise narrative documenting the resolution of a consumer case in the HHS-developed casework tracking system, and § 156.1010(g)(3) states that QHP issuers must provide information about compliance issues found by a State during the investigation of a case.

The burden associated with this requirement is the time and effort necessary for the staff of a QHP issuer to gather information related to the consumer complaint, draft the narrative, and enter the narrative into the electronic HHS-developed case tracking system. For the purpose of estimating burden, we estimate 361 issuers will be subject to this requirement based on the number of QHP issuers in Plan Year 2021. We estimate that each issuer will utilize insurance claims processing clerks for 4,800 hours at $43.34 an hour and a general and operations manager for 800 hours at $120.90 an hour for a total annual cost of $304,752 per issuer, with the total annual cost for all issuers amounting to $110,015,472. Over the course of three years, the estimated cost of this reporting requirement is $914,256 per issuer and $330,046,416 for all issuers.

Pursuant to 45 C.F.R. § 156.1010(g)(1), QHP issuers must include the date of consumer case resolutions. 45 C.F.R. § 156.1010(g)(2) states that QHP issuers must record a narrative documenting the resolution of a case in the HHS-developed casework tracking system. 45 C.F.R. § 156.1010(g)(3) states that QHP issuers must provide information about compliance issues during the investigation of a case. The table below displays the burden for an issuer to comply with these regulations around consumer cases, including maintaining the HHS-developed tracking system.

**Table 5: Issuer Burden in Maintaining Records of Consumer Case Resolution and Inputting into HHS-Developed Casework Tracking System**

| Labor Category | Number of Respondents | Hourly Labor Costs (Hourly Rate + 100% Fringe Benefits) | Burden Hours | Total Burden Costs (Per Respondent) | Total Burden Costs (All Respondents) |
|---|---|---|---|---|---|
| Insurance Claims and Policy Processing Clerk | 361 | $43.34 | 4,800 | $208,032 | $75,099,552 |
| General and Operations Manager | 361 | $120.90 | 800 | $96,720 | $34,915,920 |
| Total - Annual | | | 2,021,600 | $304,752 | $110,015,472 |
| Total - Three Years | | | 6,064,800 | $914,256 | $330,046,416 |

**Enrollment Process for Qualified Individuals (§ 156.1230)**

Under § 156.1230(a)(1)(ii), issuers must provide information on available QHPs when they use their Web sites to directly enroll qualified individuals into QHPs in a manner considered to be through the Exchange, a process known as direct enrollment (DE). The QHP information required to be posted on the DE Web sites includes premium and cost-sharing information, the summary of benefits and coverage, metal level, results of the enrollee satisfaction survey, quality ratings, medical loss ratio information, transparency in coverage measures, and a provider directory.

Additionally, § 156.1230(a)(1)(iv) requires issuers' DE Web sites to inform applicants about the availability of other QHP products available through an Exchange through an HHS-approved universal disclaimer and to display a Web link to the appropriate Exchange Web site. Issuers are also required to distinguish between QHPs for which a consumer is eligible and other non-QHPs that an issuer may offer pursuant to § 156.1230(a)(1)(iii). Finally, an issuer must allow a consumer to select and attest to an APTC amount pursuant to § 156.1230(a)(1)(v).

The burden for these requirements relates to issuers developing and maintaining DE Web sites in accordance with the requirements described above. Approximately 60 issuers currently utilize DE and are thus subject to the disclosure requirements described above. Based on current year-to-date DE issuer participation and future potential market size, we estimate the number of participating issuers will increase to 75 total in subsequent years. This is the number of issuers used in calculating burden estimates. We expect that it will take a software developer 15 hours at $109.88 an hour to develop and maintain the required QHP information on their Web sites in accordance with §156.1230(a)(1) each year. We estimate that these disclosure requirements will

have an annual burden of 15 hours with a cost of approximately $1,648.20 per issuer and 1,125 hours with a cost of approximately $123,615 for all issuers. We estimate the total cost for three years to be $4,944.60 for each issuer and $370,845 for all issuers.

Pursuant to 45 C.F.R.156.1230(a)(1)(ii), issuers must provide information on available QHPs when they use their Web sites to directly enroll qualified individuals into QHPs in a manner considered to be through the Exchange. 45 C.F.R. 156.1230(a)(1)(iv) requires issuers' DE Web sites to inform applicants about the availability of other QHP products available through an Exchange. Issuers are also required to distinguish between QHPs for which a consumer is eligible and other non-QHPs that an issuer may offer pursuant to 45 C.F.R. 156.1230(a)(1)(iii). An issuer must allow a consumer to select and attest to an APTC amount pursuant to 45 C.F.R. 156.1230(a)(1)(v). The table below displays the burden for an issuer to maintain a DE Web site.

**Table 6: Issuer Burden in Maintaining DE Web Site**

| Labor Category | Number of Respondents | Hourly Labor Costs (Hourly Rate + 100% Fringe Benefits) | Burden Hours | Total Burden Costs (Per Respondent) | Total Burden Costs (All Respondents) |
|---|---|---|---|---|---|
| Software Developer | 75 | $109.88 | 15 | $1,648.20 | $123,615 |
| Total - Annual | | | 1,125 | $1,648.20 | $123,615 |
| Total - Three Years | | | 3,375 | $4,944.60 | $370,845 |

**Table 7 – Summary of Total Burden**

| **Table Number: Name** | **CFR Section** | **Burden Hours** | **Burden Cost** |
|---|---|---|---|
| Table 5: Issuer Burden in Maintaining Records of Consumer Case Resolution and Inputting into HHS-Developed Casework Tracking System | 45 C.F.R. 156.1010(g)(1)-(3) | 2,021,600 | $110,015,472 |
| Table 6: Issuer Burden in Maintaining DE Web Site | 45 C.F.R. 156.1230(a)(1)(ii)-(iv) | 1,125 | $123,615 |
| **Total - Annual** | | **2,022,725** | **$110,139,087.00** |
| **Total - Three Years** | | **6,068,175** | **$330,417,261.00** |

13. Capital Costs

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

14. Cost to Federal Government

The burden to the Federal government for maintaining the systems and policies associated with this information collection is $315,654. The calculations for the Center for Consumer Information and Insurance Oversight (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

**Table 8: Administrative Burden Costs for the Federal Government Associated with the Program Integrity and Additional State Collections**

| Task | Estimated Cost |
|---|---|
| Maintenance of Program Integrity Information Collections | |
| 15 GS-13: 15 x $49.19 x 200 hours | $147,570 |
| | |
| Technical Assistance to States | |
| 15 GS-13: 15 x $49.19 x 200 hours | $147,570 |
| | |
| Managerial Review and Oversight | |
| 2 GS-15: 2 x $68.38 x 150 hours | $20,514 |
| | |
| **Total Costs to Government** | **$315,654** |

15. Changes to Burden

The number of total annual responses have been reduced from 2,930 to 437, a total reduction of 2,494 respondents. The total number of annual burden hours has been reduced from 2,339,000 to 2,022,745, a total reduction of 316,275 hours. The number of issuers used in these estimates has been adjusted to reflect the 361 issuers currently offering QHPs in Plan Year 2021. In addition, burden hours have decreased because the Web sites have already been developed and now simply require maintenance for most issuers.

16. Publication/Tabulation Dates

Results of the collection will not be made public.

17. Expiration Date

The expiration date and OMB control number will appear on the first page of the instrument (top-right corner).