

## **Supporting Statement for Provider Network Coverage Data Collection (CMS-10594/OMB control number: 0938-1302)**

### **A. Background**

The Patient Protection and Affordable Care Act (P.L. 111-148) was signed into law on March 23, 2010. On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was signed into law. The two laws are collectively referred to as the Affordable Care Act (ACA). The ACA established competitive private health insurance markets called Marketplaces, or Exchanges, which gave millions of Americans and small businesses access to affordable, quality insurance options that meet certain requirements. These requirements include ensuring sufficient choice of providers and providing information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers.

In the final rule, the *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017* (CMS-9937-P), we finalized network adequacy standards for qualified health plan (QHP) issuers, including stand-alone dental plans (SADPs) mostly focused on issuers in QHPs in the Federally-facilitated Exchanges (FFE). This information collection notice is for two of the standards from the rule: one applying in the FFE and one applying to all QHPs. Specifically, under 45 CFR §156.230(d) and 156.230(e), we require notification requirements for enrollees in cases where a provider leaves the network and for cases where an enrollee might be seen by an out of network ancillary provider in an in-network setting. These standards will help inform consumers about his or her health plan coverage to better make cost effective choices.

### **B. Justification**

#### **1. Need and Legal Basis**

Under 45 CFR §156.230(d), a QHP issuer in an FFE must make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is discontinuing, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal. In cases where a provider is terminated without cause, a QHP issuer in an FFE must allow an enrollee in an active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost sharing rates.

Under 45 CFR §156.230(e), beginning for the 2018 and later benefit years, for a network to be deemed adequate, each QHP issuer must, notwithstanding 45 CFR §156.130(c), count the cost sharing paid by an enrollee for an out-of-network essential health benefit (EHB) provided by an out-of-network ancillary provider in an in-network setting towards the enrollee's annual limitation on cost sharing or provide a notice to the enrollee by the longer of when the issuer would typically respond to a prior authorization request timely submitted, or 48 hours before the provision of the benefit, that additional costs may be incurred for an EHB provided by an out-of-network ancillary provider in an in-network setting, including balance billing charges, unless

such costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on cost sharing.

Under the No Surprises Act section 113 (H.R. 133, Public Law 116-260), Internal Revenue Code section 9818(a), and PHS Act section 2799A-3, in the case of an individual with benefits under a group health plan and with respect to a health care provider or facility that has a contractual relationship with such plan for furnishing items and services under such plan, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility—the plan or issuer must notify each individual enrolled under such plan who is a continuing care patient with respect to a provider or facility at the time of a termination affecting such provider on a timely basis of such termination and such individual’s right to elect continued transitional care from such provider or facility under this section. The plan must also provide such individual with an opportunity to notify the plan of the individual’s need for transitional care.

## 2. Information Users

The notifications that the QHP issuers will be required to send under this information collection will be sent to the QHP issuers’ enrollees who are affected by a provider leaving the network. For the second notification, the information could be used by consumers to understand their cost sharing obligations if they receive care from an out-of-network ancillary provider. These notifications are intended to inform the consumer about his or her health insurance coverage to better make cost effective choices.

## 3. Use of Information Technology

CMS anticipates that QHP issuers will use their claims data systems to identify enrollees, complaints or customer service systems to identify impacted or qualifying enrollees, or use the plan’s preauthorization process. The notification can be sent to the enrollee electronically or by mail.

## 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

The burden associated with this information collection consists of QHP issuers in the FFE notifying enrollees about the plan’s network coverage. QHP issuers need to make this information available to the plan’s enrollees.

We recognize that the notification of the provider leaving a network is a good faith effort as there are certain situations that the issuer cannot anticipate. For these reasons, the regulation requires the notification 30 days prior to the effective date of the change or otherwise as soon as

practicable.

We believe the advance notice provision will help provide transparency and ensure that consumers receive notice of the possible consequences where an out-of-network ancillary provider may be seen and are provided some mitigation of these consequences where proper, timely notice is not provided by the issuer.

#### 7. Special Circumstances

There are no special circumstances.

#### 8. Federal Register/Outside Consultation

A 60-day notice was published in the Federal Register on September 15, 2022 (87 FR 56678) 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 01/10/2023 (88 FR 1387) 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 consumer privacy with respect to the information disclosed.

#### 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 contain estimates of burden imposed by the associated information collection requirements. Salaries for the positions cited were taken from the Bureau of Labor Statistics (BLS) web site (<https://www.bls.gov>). According to the May 2021 Bureau of Labor Statistics, the mean wage for 15-1242 Database Administrators was \$46.42 per hour (+ 100% fringe benefit = \$92.84); the mean wage for 43-6014 Secretaries and Administrative Assistants, Except Legal, Medical, and Executive was \$19.75 per hour (+ 100% fringe benefit = \$39.50); and the mean wage for 15-2031 Operations Research Analyst was \$46.07 (+ 100% fringe benefit = \$92.14).

#### **Table 1. Adjusted Hourly Wages Used in Burden Estimates**

<b>Occupational Title</b>	<b>Occupational Code</b>	<b>Mean Hourly Wage (\$/hour)</b>	<b>Fringe Benefits and Overhead (100%) (\$/hour)</b>	<b>Adjusted Hourly Wage (\$/hour)</b>
<b>Database Administrator</b>	15-1242	\$46.42 <sup>1</sup>	\$46.42	\$92.84
<b>Administrative Assistant</b>	43-6014	\$19.75 <sup>2</sup>	\$19.75	\$39.50
<b>Operations Research Analyst</b>	15-2031	\$46.07 <sup>3</sup>	\$46.07	\$92.14

1 Bureau of Labor Statistics (BLS): <https://www.bls.gov/oes/current/oes151242.htm>

2 Bureau of Labor Statistics (BLS): <https://www.bls.gov/oes/current/oes436014.htm>

3 Bureau of Labor Statistics (BLS): <https://www.bls.gov/oes/current/oes152031.htm>

Section 156.230(d) requires that QHP issuers make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal. This is a third-party disclosure requirement. The notification requirement under §156.230(d) is a common practice in the current market as several States, Medicare Advantage, Medicaid Managed Care, and the National Association of Insurance Commissioners' Network Adequacy Model Act have standards regarding enrollee notification of a provider leaving a network. As discussed in the final rule preamble, under State laws, many QHP issuers will already be under this obligation, and therefore, our notification requirements will apply in a more limited fashion. Additionally, we have incorporated stand-alone dental plans (SADPs) into our calculations, but we recognize given the requirements that SADPs may rarely meet the requirements to send a notification.

We estimate that a total of 374 issuers participate in the FFE and would be required to comply with the standard. We estimated that 5 percent of providers discontinue contracts per year, and that an issuer in the FFE covers 29,493 providers, which means that we estimate an issuer would have 1,474 provider discontinuation notices in a year.

Our assumption is that the database manager will receive notification from the issuer's contracting team that a provider contract is being discontinued. From that notification, the database manager would aggregate the claims data associated with the provider to develop the list of affected enrollees with associated enrollee information for the notice. This list of affected enrollees and associated enrollee information would be sent to an administrative assistant to aggregate into a notification template to be sent to the enrollee. Assuming 1,474 notices per a year, we believe that this task would be a routine process for the administrative assistant to undertake that would need little to no oversight to produce. As the issuer has the discretion to define regular basis and that the number of notices is likely to widely varying between scope of network and type of provider, we did not estimate based on the number of individual notifications, but rather the number of provider discontinuations. For each provider discontinuation notice, we estimate that it will take a database administrator 30 minutes for data analysis to produce the list of affected enrollees, at \$92.84 an hour, and an administrative assistant 30 minutes to develop the notification and send the notification to the affected enrollees, at \$39.50 an hour. The total costs per issuer are \$97,534.58. For all FFE issuers, the total annual burden is 551,276 hours and the total annual costs is \$36,477,932.92.

Pursuant to section 156.230(d) a QHP issuer in an FFE must make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable.

**Table 2. Burden for Issuers: Written Notice of Provider Discontinuation**

<b>Labor Category</b>	<b>Number of Respondents</b>	<b>Hourly Labor Costs (Hourly rate + 100% Fringe benefits)</b>	<b>Burden Hours</b>	<b>Total Burden Costs (Per Respondent)</b>	<b>Total Burden Costs (All Respondents)</b>
<b>Database Administrator</b>	374	\$92.84	737	\$68,423.08	
<b>Administrative Assistant</b>	374	\$39.50	737	\$29,111.50	
<b>Total Annual</b>			<b>551,276</b>		<b>\$36,477,932.92</b>
<b>Total Three Years</b>			<b>1,653,828</b>		<b>\$109,433,798.76</b>

In §156.230(e), we require issuers to provide a notice to enrollees of the possibility of out-of-network charges from an ancillary out-of-network provider in an in-network setting prior to the benefit being provided, to avoid counting the out-of-network costs against the annual limitation on cost sharing. This provision applies to all 374 issuers. We estimate it would take an issuer's mid-level operations research analyst at an hourly wage rate of \$92.14 approximately 6 minutes to create a notification and send the information. We estimate that approximately two notices would be sent for every 100 enrollees. Assuming approximately 10.25 million FFE enrollees in QHPs for 2022<sup>1</sup>, we estimate QHPs would send approximately 205,000 total notices annually, for a total 20,500 hours, at a total cost of \$1,888,427.73.

Pursuant to section 156.230(e) QHP issuers must, notwithstanding 45 CFR 156.130(c), count the cost sharing paid by an enrollee for an out-of-network essential health benefit (EHB) provided by an out-of-network ancillary provider in an in-network setting towards the enrollee's annual limitation on cost sharing or provide a notice to the enrollee that additional costs may be incurred.

**Table 3. Burden for Issuers: Written Notice of the Possibility of Out-of-Network Charges**

<b>Labor Category</b>	<b>Number of Respondents</b>	<b>Hourly Labor Costs (Hourly rate + 100% Fringe Benefits)</b>	<b>Burden Hours</b>	<b>Total Burden Costs (Per Respondent)</b>	<b>Total Burden Costs (All Respondents)</b>

<sup>1</sup> We used the [Marketplace 2022 Open Enrollment Period Report: Final National Snapshot](https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period-report-final-national-snapshot) available at <https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period-report-final-national-snapshot>

<b>Operations Research Analyst</b>	374	\$92.14	54.8	\$5,049.27	
<b>Total Annual</b>			<b>20,500</b>		<b>\$1,888,427.73</b>
<b>Total Three Years</b>			<b>61,500</b>		<b>\$5,665,283.18</b>

**Table 4. Summary of Annual Total Burden**

<b>Table Number: Name</b>	<b>CFR Section</b>	<b>Burden Hours</b>	<b>Burden Cost</b>
<b>Table 2: Burden for Issuers: Written Notice of Provider Discontinuation</b>	45 CFR § 156.230(d) & 45 CFR § 156.230(e)	551,276	\$36,477,932.92
<b>Table 3: Burden for Issuers: Written Notice of the Possibility of Out-of-Network Charges</b>	45 CFR § 156.230(e)	20,500	\$1,888,427.73
<b>Total</b>		<b>571,776</b>	<b>\$38,366,360.65</b>

### 13. Capital Costs

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

### 14. Cost to Federal Government

We estimate the operations and maintenance costs for the data collection tool and the data collection support to have a total cost of \$116,563.20 per year. The adjusted hourly wage of \$93.40 is the total of the hourly rate of \$46.70 for GS-13 step-7 plus 100% fringe benefit rate of \$46.70. 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/2022/GS\\_h.pdf](https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2022/GS_h.pdf).

**Table 5. Administrative Burden Costs for the Federal Government Associated with the Provider Network Coverage Data Collection**

<b>Task</b>	<b>Estimated Cost</b>
Operations, maintenance, and data collection support	
GS-13 (step 7): 2 x \$93.40 x 624 hours	\$116,563.20
<b>Total Cost to Government</b>	<b>\$116,563.20</b>

### 15. Changes to Burden

The total annual burden hours increased from 194,250 hours to 551,276 hours, which is an increase of 357,026 hours. The number of FFE providers (29,493) and enrollees (10.25 million) increased from the previous number of FFE providers (7,500) and enrollees (9.0 million). However, there was a decrease in the number of issuers from 470 to 374, which is a decrease of 96 issuers.

### 16. Publication/Tabulation Dates

Results of the collection will not be made public.

17. Expiration Date

There are no instruments associated with this data collection.