

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 dis-enroll 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 dis-enrollment at least 20 days before the dis-enrollment 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 dis-enrolled for failure to pay plan premiums (or other charges, as applicable). This revision of a currently approved collection of information provides an update to the estimated administrative burden of MA organizations, Part D plan sponsors and §1876 cost plans that dis-enroll 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, dis-enrollment, 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 dis-enrollment procedures at 42 C.F.R. §§ 422.74 and 423.44, respectively. In addition, section 1876(c)(3)(B) establishes that individuals may be dis-enrolled 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 dis-enroll a member who fails to pay premiums or other charges imposed by the plan for deductible and coinsurance amounts.

Within these regulatory provisions, individuals dis-enrolled 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 dis-enrollment and pay all overdue premiums within three calendar months after the dis-enrollment date.

While dis-enrollment due to non-payment of premiums is currently voluntary for such plans, in 2016, 233 plans effectuated such dis-enrollments. This resulted in an average of 23,890 dis-enrollments each month.

### **2. Information Users**

These good cause provisions authorize CMS to reinstate a dis-enrolled 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. Since its inception, the process of accepting, reviewing, and processing beneficiary requests for reinstatement for good cause has been 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 dis-enroll 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 subregulatory guidance.

3. Use of Information Technology

Information provided by individuals requesting reinstatement under the good cause process is not collected electronically.

Plans will submit the reinstatement request electronically to CMS following existing processes for other types of reinstatements permissible under subregulatory 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 CMS experience since the inception of the good cause policy implementation in 2012, the expected percentage of reinstatement requests for plans is approximately 3.49 percent. Thus, for a small business that exercises the voluntary policy to dis-enroll for non-payment of premiums and dis-enrolls 100 or fewer individuals a month for

this reason, it is expected that it would receive about three requests for reinstatement each month.

6. Less Frequent Collection

This information is collected as needed and requested by the dis-enrolled 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 dis-enroll 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 met the other requirements outlined in regulation each month.

8. Federal Register/Outside Consultation Federal Register

The 60-day federal register notice published on March 12, 2018 (83FR10730) and the 30-day federal register notice published on June 8, 2018(83FR26691). No comments were received in either cycle of comments

Outside Consultation

Since the inception of the good cause regulations and processes, the process of accepting, reviewing, and processing beneficiary requests for reinstatement for good cause has been carried out exclusively by CMS. However, in the Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2014 Call Letter (the Call Letter) released on February 15, 2013, CMS requested input from plans on transferring the responsibility for processing good cause requests to the plans and other ways to improve the good cause process. Through the feedback submitted from the Call Letter, CMS received consultation from plans and organizations on ways to make the process more efficient for both the plans and CMS. Based on this feedback, we updated a number of operational processes in Chapter 2 and Chapter 17,

Subchapter D, of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Benefit Manual to increase efficiency.

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 dis-enroll for nonpayment of premiums. However, for those that do implement this voluntary policy, information available to CMS in February 2015 showed that it resulted in an average of 20,000 dis-enrollments each month and an average of 698 requests for reinstatement per month, or 8,376 requests annually. By applying the same ratio of good cause reinstatement requests resulting from involuntary dis-enrollments (3.49%) to the more current 2016 data showing an average of 23,890 dis-enrollments each month, we estimate an average of 834 good cause requests for reinstatement per month, or 10,008 requests annually.

Beneficiaries that are dis-enrolled 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 10,008 respondents taking 10 minutes per response.  $10,008 \times 0.166$  hours (10 minutes) = 1,661.328 total burden hours, rounded to 1,661 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 1,661 hours (10,008 beneficiaries x 0.166 hr) at a cost of \$12,042.25 (1,661 hrs x \$7.25/hr) or \$1.20 per beneficiary (\$12,045.25 / 10,008 beneficiaries).

An entity operating a cost plan, an MA organization, or a Part D plan sponsor that has a policy of involuntary dis-enrollment 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 233 MA, Part D and cost plan organizations that dis-enroll members for nonpayment of premiums in 2017. With approximately 834 requests each month, or 10,008 annually, we estimate the burden to plans to be as follows:

There are 10,008 respondents taking 30 minutes per response.  $10,008 \times 0.5$  hours (30 minutes) = 5,004 total burden hours annually or 21.47 per plan. (5,004 / 233 plans)

According to the most recent wage data provided by the Bureau of Labor Statistics (BLS) for May 2016, the median hourly wage for the category of “Business Operations Specialists, All Other” – which we believe is the most appropriate category, is \$33.19 (Bureau of Labor Statistics, U.S. Department of Labor, Occupational Employment and Wages, May 2016, Business Operations Specialists, All Other, Occupation Code 13-1199, 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 ( $\$33.19 + \$33.19 = \$66.38$ ). With fringe benefits and overhead, the hourly rate is \$66.38.

The annual burden is estimated at 5,004 hours (10,008 beneficiaries x 0.5 hr) at a cost of \$332,165.52 (5,004 hrs x \$66.38/hr) for all plans in the MA, Part D and cost plan programs, or \$1,425.60 per plan ( $\$332,165.52 / 233$  plans).

The total cost for this activity is \$344,210.77 annually. (\$12,045.25 + \$332,165.52)

### 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 2015 approved submission increased in cost from \$99,423.12 to \$344,210.77 for respondent costs – an increase of \$234,787.65. 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 2013, the mean hourly wage for the category of “Customer Service Representatives” was \$16.04. With fringe benefits and overhead, the per hour rate was \$23.74. According to wage data provided by the BLS for May 2016, the median hourly wage for the category of “Business Operations Specialists, All Other” – which we believe is the more appropriate category, is \$33.19. Adding 100% of the median hourly wage to account for fringe and overhead benefits, the per hour rate is \$66.38. Another factor contributing to the increase is the fact that in the currently approved collection, fringe and overhead benefits were estimated at 48% of the hourly wage, which is lower than the current factor of 100%.

The number of respondents increased from 8,376 to 10,008 and the Annual Burden hours increased from 4,188 to 6,665.

The higher costs are also the result of the increased number of plans that are dis-enrolling members for nonpayment of premiums and the number of beneficiaries dis-enrolled under these policies. Further, the cost associated with the beneficiary completing the request was also factored into the burden for 2017, whereas in 2015 this cost was not factored into the estimate.

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.