Supporting Statement for the CMS-1763 Request for Termination of Premium Hospital and/or Supplementary Medical Insurance and Supporting Regulations in 42 CFR 406.28 and 407.27

A. Background

Part B and premium-Part A are voluntary programs and are financed from premium payments by enrollees together with contributions from funds appropriated by the Federal government. Section 1818A of the Social Security Act (the Act) allows a Medicare enrollee to voluntarily terminate Supplementary Medical Insurance (Part B) and/or the premium Hospital Insurance (premium-Part A) coverage by filing a written request.

Because Medicare is recognized as a valuable protection against the high cost of medical and hospital bills, when an individual wishes to voluntarily terminate Part B and/or premium Part A, the form requests the reason that an individual wishes to terminate coverage to permit an opportunity for the Centers for Medicare & Medicaid Services (CMS) or the Social Security Administration (SSA)to ensure that the individual understands the ramifications of the decision.

The Request for Termination of Premium Hospital and/or Supplementary Medical Insurance – CMS-1763 provides a standardized form to satisfy the requirements of law as well as allowing both agencies to protect the individual from an inappropriate decision.

B. Justification

1. Need and Legal Basis

The Social Security Act at §1838(b)(1) and §1818A(c)(2)(B) and the Code of Federal Regulations at 42 CFR §§ 406.28(a) and 407.27(c) require that a Medicare enrollee wishing to voluntarily terminate Part B and/or premium Part A coverage file a written request with CMS or SSA. The statute and regulations also specify when coverage ends based upon the date the request for termination is filed. The form CMS-1763 was developed to comply with these requirements.

2. Information Users

The CMS-1763 provides CMS and SSA with the enrollee's request for termination of Part B and/or premium Part A coverage. The CMS-1763 was previously approved under OMB number 0938-0025.

The CMS-1763 is completed by an SSA claims or field representative using information provided by the Medicare enrollee during an interview. The purpose of the form is to

provide to the enrollee a standardized format to request termination of Part B and/or premium Part A coverage, explain why he/she wishes to terminate such coverage and to acknowledge that the ramifications of the decision are understood. The form is not completed by CMS staff.

If this data is not collected in writing, neither CMS nor SSA would know of an enrollee's request to terminate his/her Medicare coverage, when to effectuate the termination of coverage, and if the enrollee understood the ramifications of that decision. Additionally, there would be no record of the request in the event there was a dispute about the termination of coverage.

The form itself consists of 6 items that are necessary to identify the enrollee and the type coverage being terminated, to provide the date the coverage will end, and to obtain the enrollee's reason for the request for termination of coverage.

Item 1: Requests the name of the enrollee so SSA and CMS can identify the individual.

Item 2: Requests the Medicare Claim Number. This identifies the record upon which the enrollee's Medicare coverage was established. The Medicare Claim Number was assigned by SSA based upon the filing of an application for Social Security benefits and/or Medicare. The Medicare claim number contains the social security number (SSN) of the enrollee or the number holder of the record where Medicare coverage was established. SSNs are assigned in accordance with §205 of the Act.

Item 3: Requests the name of the person making the request if it is other than the enrollee. SSA can, under certain circumstances, establish a representative payee for a beneficiary. If the enrollee has a representative payee their name would appear here.

Item 4: Identifies the coverage (Part B and/or premium Part A) the enrollee wants to terminate.

Item 5: Provides the date (month, day and year) that the coverage will end.

Item 6: Requests the enrollee's reason for termination of coverage.
Voluntary termination requests are processed and directly input into the SSA Master Beneficiary Record (MBR). The data is then passed to the CMS master record, the Enrollment Database (EDB) and when applicable, a revised Medicare card is issued.

If this information were not collected, it would be impossible to terminate entitlement/enrollment for individuals and subsequently process Medicare claims for them.

3. Use of Information Technology

The collection of this information does not involve the use of information technology.

4. Duplication of Efforts

The collection of this information does not duplicate any other effort. Even if the enrollee previously terminated Part B and/or premium Part A and is now requesting termination of a new period of coverage, the information must be updated to ensure proper disposal of the new request.

This information is not available from any other source.

5. Small Business

Use of this form does not involve small business.

6. Less Frequent Collection

This information is collected once when a beneficiary wishes to terminate Part B and/or premium Part A coverage for a period of current entitlement. If this information is not collected, the enrollee cannot have his/her entitlement terminated. Since the statute permits an enrollee to terminate Part B and/or premium Part A coverage and specifies how such a request must be made, the burden cannot be minimized.

7. Special Circumstances

The collection of this information is consistent with the guidelines in 5 CFR 1320.6. There are no special circumstances.

8. Federal Register Notices/Outside Consultants

The 60 day Federal Register notice was published on May 15, 2009.

The gathering of this information is required in order for an enrollee to terminate Part B and/or premium Part A coverage. This form was developed in 1966. Appropriate comments were solicited at that time. There have been no problems associated with the use of this form or the procedures established. Since the information is collected only once, there is no need for ongoing consultations.

9. Payments/Gifts to Respondents

There are no payments/gifts to respondents.

10. Confidentiality

The information collected is protected under the provisions of the Privacy Act. A copy of the executed form can be provided to the enrollee upon request.

11. Sensitive Questions

There are no questions of a sensitive nature asked on this form.

12. Burden Estimate (Hours & Wages)

There are approximately 14,000 respondents annually who request termination on a CMS-1763. The average interview, completion and data transmission time is 25 minutes based upon actual experience.

The burden is computed as follows:

There are 14,000 respondents taking 25 minutes per response. 14,000 x 0.416 (25 minutes) = 5,833 total burden hours.

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 have never worked. There is no appropriate wage category to use to annualize any cost to respondents for 25 minutes.

13. Capital Costs

There are no additional costs. SSA is the record keeper and the collection and storage of this data represents no additional cost. It is part of their normal claims activity.

14. Cost to Federal Government

Printing Costs:
The form is pre-printed, and also made available to Social Security claims representatives and field representatives to print and provide to the individual upon request. The printing cost associated with the CMS-1763 is $2,500.00 annually.

Processing Costs:
Interviews are conducted by SSA claims and field representatives (average pay scale is GS 11, step 5) whose 2013 hourly rate of pay (without locality pay) is $27.31. The approximate number of respondents is 14,000. We estimate is takes a SSA claims and/or field representative 25 minutes to manage/input the information on this form. The 2013 GS-11, step 5 hourly rate of $27.31 x 0.416 hours (25 minutes) x 14,000 (number of forms) = $159,053.44.

Total Federal Cost including printing and processing costs = $161,553.44.

15. Changes to Burden

The increase in the burden cost is due to an increase in both the printing costs and the hourly rate of pay for SSA employees who process the CMS-1763.

The burden increases by $1,700 over the last submission because of the increase in printing costs. In addition, the burden increases by $1,399.54 over the last submission because of the salary increase.

The hourly rate of payment for the SSA representatives collecting and processing the information has increased by $0.41 from $26.90 per hour to $27.31 per hour.

16. Publication and Tabulation

The information is not published or tabulated.

17. Display of Information

CMS would like to display the expiration date.

18. Certification Statement

There are no exceptions to the certification statement.

C. Collections of Information Employing Statistical Methods

There have been no statistical methods employed in this collection.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0025

REQUEST FOR TERMINATION OF PREMIUM HOSPITAL AND/OR SUPPLEMENTARY MEDICAL INSURANCE

DO NOT WRITE IN THIS SPACE

The completion of this form is needed to document your voluntary request for termination of Medicare coverage as permitted under the Code of Federal Regulations.
Section 1838(b) and 1818A(c)(2)(B) of the Social Security Act require filing of notice advising the Administration when termination of Medicare coverage is requested. While you are not required to give your reasons for requesting termination, the information given will be used to document your understanding of the effects of your request.

NAME OF ENROLLEE *(Please Print)*		MEDICARE CLAIM NUMBER	
NAME OF PERSON, IF OTHER THAN ENROLLEE, WHO IS EXECUTING THIS REQUEST.	THIS IS A REQUEST FOR TERMINATION OF ☐ HOSPITAL INSURANCE ☐ MEDICAL INSURANCE	DATE SUPPLEMENTARY MEDICAL INSURANCE WILL END	DATE HOSITAL INSURANCE WILL END

I request termination of my enrollment under the above section(s) of title XVIII of the Social Security Act, as amended, for the reason(s) stated below:

I UNDERSTAND THAT IF I AM REQUIRED TO PAY FOR MY HOSPITAL INSURANCE, THE TERMINATION OF MY SUPPLEMENTARY MEDICAL INSURANCE COVERAGE WILL ALSO END MY HOSPITAL INSURANCE COVERAGE. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0025. The time required to complete this information collection is estimated to average 25 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

If this request has been signed by mark (X), two witnesses who know the applicant must sign below, giving their full addresses.	**SIGNATURE** *(Write in Ink)*	
1. NAME OF WITNESS	**SIGN HERE**	
ADDRESS *(Number and Street, City, State and Zip Code)*	**MAILING ADDRESS** *(Number and Street)*	
2. NAME OF WITNESS	**CITY, STATE, ZIP CODE**	
ADDRESS *(Number and Street, City, State and Zip Code)*	**DATE** *(Month, Day and Year)*	**TELEPHONE NUMBER**