Supporting Statement for Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations
(OMB Control No. 0938-NEW)

A. Background

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (P.L. 111-148). 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. The Affordable Care Act establishes new competitive private health insurance markets called Affordable Insurance Exchanges (Exchanges) which will give millions of Americans and small businesses access to affordable, quality insurance options. By providing a place for one-stop shopping, Exchanges will make purchasing health insurance easier, more transparent, and will put greater control and more choice in the hands of individuals and small businesses. Additionally, reinsurance, risk corridor, and risk adjustment programs will provide market stabilization as new provisions are implemented to lower costly premiums associated with individual and small business coverage.

As directed by the CMS-9989-F: Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers ("Exchange rule"), each Exchange will assume responsibilities related to the certification and offering of Qualified Health Plans ("QHP"). To offer insurance through an Exchange, a health insurance issuer must have its health plans certified as QHPs by the Exchange. A QHP must meet certain minimum certification standards, such as network adequacy, actuarial value standards, and the offering of the essential health benefits (EHB). The Exchange is responsible for ensuring that QHPs meet these minimum certification standards as described in the Exchange rule under 45 CFR 155 and 156, based on the Affordable Care Act, as well as other standards determined by the Exchange.

In 2014, issuers can offer individual and small group market plans outside of the Exchanges that are not QHPs. Such plans are referred to in this document as "non-QHP." The reinsurance and risk adjustment programs outlined by the Affordable Care Act, detailed in 45 CFR 153 CMS- 9975-F: Standards for Reinsurance, Risk Corridors, and Risk Adjustment, have general information reporting requirements that apply to QHPs offered through the Exchanges and non-QHPs in the outside market. For the reinsurance program, administrative information will be used to identify all entities required to contribute to the reinsurance program by state. In addition, non-QHP information such as plan type and location will be used to identify non-grandfathered individual market plans eligible by state for reinsurance payments. For the risk adjustment program, administrative information will be used to identify all non-grandfathered small group and individual market non-QHP offerings eligible for the program. Risk adjustment also requires select data such as rating area, rating factors and actuarial value (AV) level, to perform calculation of payments and charges.

As part of the effort to develop this PRA package, CMS solicited feedback from key stakeholders. As such, CMS has already engaged the National Association of Insurance Commissioners (NAIC), states, and issuers to determine the categories of data that are required for Exchange operations, risk adjustment and reinsurance. CMS and the NAIC have closely partnered and worked together in the area of Plan Management, especially as it relates to the technical implementation of state systems for State Partnership operations, including the alignment of data collection requirements.

It is the goal of both CMS and the NAIC to enable states, which are currently using SERFF and will be performing Plan Management functions in the Partnership model, to use SERFF as part of the QHP submission and certification process. Both organizations recognize that it is critical that QHP issuer and plan data be submitted and collected in a consistent, uniform format. Therefore, CMS and the NAIC are pursuing a collaborative development approach such that the QHP submission interfaces are very similar, if not identical to ensure data need only be submitted once. CMS and the NAIC acknowledge that the development of the Exchanges must incorporate existing regulatory processes that will continue to evolve in the area of rate and form filing. Therefore, both organizations are developing concepts that would incorporate the state product approval process flow, and eliminate or mitigate duplicative filing requirements for issuers submitting QHP applications and obtaining state approval of the product/plan filings. State-based Exchanges may also find this useful toward streamlining data submissions. CMS will continue to work with these stakeholders and others to determine a finite list of data elements that are required for Exchange and Federal operations.

This partnership will ease the burden on both issuers and states.

B. Justification

1. Circumstances Making the Collection of Information Necessary

QHP Information Collection: Certification and Standards

An Exchange will certify, recertify and decertify QHPs. The Affordable Care Act authorizes QHP certification as well as other operational standards for the Exchange in following sections: 1301-1304, 1311-1312, 1321-1322, 1324, 1334, 1401-1402,1411 and 1412. Standards for QHP issuers are codified at 45 CFR 155 and 156.

An Exchange will need to collect data from issuers as part of QHP certification and recertification, and to monitor compliance with QHP certification standards on an ongoing basis. QHP issuer and plan data will also support additional operational activities, including the calculation of each individual's advance payment of the premium tax credit, the display of plan information on the Exchange web site, and managing the ongoing relationships between QHP issuers and the Exchange. Much of the information collected for QHP certification purposes will support these operational activities on an ongoing basis.

Stand-Alone Dental Plan Information Collection

Section 1311 of the Affordable Care Act and Section 155.1065 of the Exchange rule direct each Exchange to permit issuers to offer limited scope dental benefits as stand-alone dental plans or in conjunction with a QHP. All reasonably applicable QHP certification requirements will be applied to stand-alone dental plans offered in an Exchange, and dental issuers will be required to complete the same application as all other QHPs. However, dental issuers will only be required to complete applicable data elements such as: Licensure and Good Standing; Network Adequacy; Essential Community Providers; and Actuarial Value. An Exchange will need to collect data from dental issuers in order to certify and recertify stand-alone dental plans, and to monitor ongoing compliance with applicable QHP certification standards. This data will also allow the Exchange to calculate the portion of an individual's premium tax credit allocated to a stand-alone dental plan, and display plan and premium information for these plans.

In addition to completing the QHP certification application, dental issuers will be required to complete all applicable items on the Plan and Benefit Template, and provide information about benefits, including: routine dental services for children and adults; basic dental care for children; major dental care for children and adults; and orthodontia for children and adults.

Necessary Data for QHP Certification

The data collected for QHP certification, ongoing QHP oversight, financial management, and eligibility and enrollment functions (including the Exchange website) are reflected in the categories identified below and in the attached appendices. This data will also be used to support other Exchange business functions such as determinations of the second-lowest-cost-silver plan, payments for cost-sharing reductions, advance payments for the premium tax credit, and the display of information on the Exchange web site. The data collection requirements will apply for stand-alone dental plans as applicable.

CMS will collect the following data to support these functions:

- **Appendix A: Issuer Application Data**
    - **Issuer Administrative Data Elements:** Basic information required to identify issuers and the Exchange markets they intend to serve, and to facilitate communications with and payment to issuers. The data elements may include issuer contact information and banking information.

    - **State Licensure Documentation:** Documentation necessary to demonstrate that an issuer is licensed and has authority to sell all applicable products in all states in which it intends to offer a QHP.

    - **Documentation of Good Standing:** Documentation necessary to demonstrate that an issuer is in compliance with all applicable state solvency requirements and other relevant state regulatory requirements.

    - **Network Adequacy Data Elements:** Documentation necessary to demonstrate compliance with state network adequacy rules or, in the absence of such standards, documentation necessary to demonstrate that an issuer has an adequate range of providers for the intended service areas.

    - **Essential Community Provider (ECP) Data Elements:** Number of participating Essential Community Providers participating in an issuer's provider network or other documentation necessary to demonstrate that that an issuer has an adequate range of ECPs for the intended service areas.

    - **Accreditation Data Elements:** If applicable, an issuer must provide certain data elements about accreditation conducted by a recognized accrediting entity. Issuer must also authorize the release of accreditation survey data to an Exchange.

- **Appendix B: Benefit and Service Area Data**
    - **Service Area:** Information identifying a plan's geographic service area.

    - **Additional Supporting Documentation:** Additional documentation required by the Exchange for oversight purposes such as a compliance plan including an organization chart.

- **Benefits and Associated Cost Sharing and Limits:** Data necessary to describe benefits offered by a plan including covered services, co-payments, coinsurance, tiers, intervals, and limits.

- **Summary of Benefits and Coverage Data Reporting Requirements:** Data elements necessary to create the Summary of Benefits and Coverage scenarios for display on the Exchange website.

- **High-level Plan Data**: Basic plan- level information for plans and products including information necessary for in-network and out-of-network deductibles and maximum out-of-pocket cost by benefit category.

- **Formulary Information including Tiers and Classes:** Formulary information including RxCUI, pricing tiers, co-insurance, co-payment information, drugs included in the formulary, formulary version number, and its effective date.

- **Appendix C: Rating Tables and Issuer Business Rules Data**
  - **Premium Rating Information and Business Rules:** Rating tables, factors and business rules required to perform rate review, populate the premium calculator and perform calculations for risk adjustment.

The following information will be collected for QHP certification and the burden will be defined, as applicable, in future notice and comment as part of the Effective Rate Review program (Rate Increase Disclosure and Review Rule, 76 FR 29964).

- **Rate Review Data Elements:** Financial information by market and product necessary for rate review and the evaluation of cost-sharing reduction (CSR) payments. This could include: base period claims experience, projected period medical trend factors, and projected period administrative factors.

- **EHB and Additional Coverage Data including Allocation of Premium Information:** Data required to determine the allocation of premiums for EHB and those services offered in excess of EHB.

- **Cost-Sharing Reduction Advance Payments and Justification:** Data to support the payments for CSRs. The information will also support the variations in AV levels for CSR silver plan variations.

- **Actuarial Memorandum:** Actuarial narrative and certification required for the review of rates for rate review, premium allocation for advance payments of the premium tax credits, and CSR payment.

Non-QHP Information Collection: Reinsurance and Risk Adjustment

Section 1341 of the Affordable Care Act provides that each state will establish a transitional reinsurance program to help stabilize premiums for coverage in the individual market during plan years 2014 through 2016. Section 1343 provides that each state will establish a permanent program of risk adjustment for all non-grandfathered plans in the individual and small group markets. If a state chooses not to actively participate in reinsurance and/or risk adjustment, CMS

will be responsible for implementation. The requirements for non-QHP issuers are codified at 45 CFR 153.

Reinsurance Reporting Requirements for Non-QHPs

The temporary reinsurance program will reduce the uncertainty of insurance risk in the individual market by making payments for high-cost enrollees. All health insurance issuers, self-insured group plans and third party administrators on behalf of either are required to contribute, and thus are collectively referred to as "contributing entities." Non-grandfathered individual market plans are eligible to request and receive payments.

CMS will collect contributions in the self-insured market. CMS only collects contributions in the fully insured market on behalf of a state when CMS is operating the reinsurance program on behalf of a state, or, when a state requests CMS to do so on their behalf in a state-operated reinsurance program.

In order to effectively identify and contact "contributing entities," administrative information, such as name, location, and contact for company, is needed. In addition, in order to identify eligible plans for reinsurance payments, plan-level information is needed for non-grandfathered, non-QHP offerings in the individual market.

Risk Adjustment Reporting Requirements for Non-QHPs

The permanent risk adjustment program provides payments to health insurance issuers that disproportionately attract high-risk populations (such as those with chronic conditions) and reduce the incentives for issuers to avoid higher-risk enrollees. Under this program, funds are transferred from issuers with lower than average-risk enrollees to issuers with higher than average-risk enrollees.

A "risk adjustment covered plan" includes most health insurance plans offered in the individual or small group market. The exceptions are grandfathered health plans, group health insurance coverage described in §146.145(c), individual health insurance coverage described in §148.220, and any other plan determined not to be a risk adjustment covered plan by the annual Federal notice of benefit and payment parameters. States, or CMS on behalf of a state, will require basic identifying information about all risk adjustment covered plans, whether or not they are QHPs.

The data elements related to rating have not been specified yet as these will be dependent on the rating requirement rules to be part of future rulemaking.

Necessary Data for Reinsurance and Risk Adjustment Operations

Frequency of collection and types of information to be collected is determined by CMS.

Appendix D: Transitional Reinsurance and Risk Adjustment Operations Data

- Data necessary for reinsurance and risk adjustment operations include:
    - **Administrative Data Elements:** Basic information required to facilitate communications regarding reinsurance contributions and payments, risk adjustment charges and payments, and other financial program payments. The data elements may include issuer contact information and banking information.

- **State Licensure Data Elements**: Documentation necessary to demonstrate that an issuer is licensed and has authority to sell all applicable products in all states in which they intend to offer plan.

- **Plan Level and Additional Coverage Data Entities:** Plan information to include market participation, plan type, and basic plan characteristics such as location.

- Data for risk adjustment operations includes:

  - **High-level Plan Data**: AV level calculated by the AV calculator.

  - **Premium Rating Information and Business Rules:** Rating tables, factors and business rules required to perform calculations for risk adjustment.

2. Purpose and Use of Information Collection

The Exchange will collect plan- and issuer-level data from issuers to facilitate the certification of QHPs, Exchange operations, other Federal operations, QHP oversight, and ongoing market analysis. The data will include administrative data, enrollment data, financial data, issuer information, and rate and benefit data and information. All of this data will be leveraged across multiple business areas in the Exchange to facilitate other operational tasks such as plan comparisons on the insurance portal and various payment activities, such as determination of the second lowest cost silver plan, advance payments of the premium tax credit, or risk adjustment.

3. Use of Improved Information Technology and Burden Reduction

CMS is engaged with states, issuers, and the NAIC in the effort to develop data standards for QHP certification, reinsurance, risk adjustment, and other plan management activities that would make reporting to the Exchanges more streamlined for issuers across the country, and allow them to submit information in a manner that is standardized to the greatest extent possible. We encourage states to leverage existing infrastructure to the extent possible and CMS is aware that states are hoping to incorporate their current data collection systems for Exchange operations including the NAIC's System for Electronic Rate and Form Filing. In this spirit, CMS and the NAIC are jointly working to enhance SERFF, which is currently used by many state Departments of Insurance for its traditional regulatory activities. CMS and the NAIC's technical teams are currently are pursuing a collaborative development approach such that the data submission interfaces are very similar, if not identical. We believe that this initiative will ease the burden on both issuers and states.

4. Efforts to Identify Duplication and Use of Similar Information

CMS will make every effort to reduce the burden on issuers and reuse the information that is collected under the various provisions of the ACA. As such, data obtained under other authorized collections implementing provisions of the ACA will be utilized to meet some Exchange requirements. Burden will be addressed in future notice and comment periods. CMS will make every effort to avoid duplication of data collections with these other efforts. CMS is developing an integrated modular collection instrument and database system to support these various needs.

5. Impact on Small Businesses or Other Small Entities

Small businesses are not significantly affected by this collection.

6. Less Frequent Collection

QHPs will be certified utilizing an annual certification process. When QHPs undergo recertification, we do not anticipate QHP issuers submitting all parts of their application; rather, only those data elements that are likely to change on an annual basis such as benefits and rating tables.

Non-QHPs that are reinsurance-eligible plans, reinsurance contributing entities, or risk adjustment covered plans must submit data for the purposes of facilitating program operations this information is submitted once annually.

7. Special Circumstances

Issuers submitting in the SHOP Exchange have the option to submit formulary, rate and benefit information more frequently; therefore, additional submissions may be necessary.

8. Outside Consultation

The 30-day Federal Register notice published on November 16, 2012. The 60-day Federal Register noticed published on July 6, 2012 (77 FR 40061).

The goal of this data collection is to inform the QHP certification process, as well as, non-QHP reporting requirements needed for the reinsurance and risk adjustment programs. CMS has actively engaged in outside consultation with key stakeholders. We held working meetings, hosted user group calls, and scheduled formal and informal discussions with the NAIC, states, and issuer associations throughout the spring and summer of 2012 on the development of the data elements. It is the goal of CMS and stakeholders to identify shared data points, improve the validity of data, and verify the data's accuracy. Input from these stakeholders has been invaluable and has already resulted in a number of clarifications and enhancements to the data collection, design, and user experience.

We received public comments which addressed topics such as the purpose and use of the information collection and burden estimates. Some of the commenters were concerned with duplicate data collection. CMS is working with States to minimize any required document submission to streamline and reduce duplication, especially in future years. CMS has oversight and enforcement responsibilities unique to Exchanges that may require more than verification from a state. HHS has also aligned the data collection for SBCs, healthcare.gov, and EHB. Other commenters asked for more clarification on the data elements we are collection. We have included those data elements in this data collection. Furthermore, CMS will provide greater clarification on its process associated with QHP certification, essential community providers, and network adequacy among other QHP certification requirements. We have taken into consideration all of the proposed suggestions and have made changes to this collection of information. In addition, CMS is adjusting the estimated burden.

9. Explanation of any Payment/Gift to Respondents

There are no payments or gifts to respondents.

10. Assurance of Confidentiality Provided to Respondents

Information collected for plan management, reinsurance and risk adjustment contains proprietary information, trade secret, commercial and/or financial information. Therefore it is privileged, private to the extent permitted by law, and protected from disclosure.

These data are protected from disclosure under Exemption 4 of the Freedom of Information Act (FOIA). Exemption 4 is provided below and is part of the HHA FOIA implementation regulation (45 CFR Section 5.65) available at http://www.hhs.gov/foia/45cfr5.html#Subf.

11. Justification for Sensitive Questions

No sensitive questions are asked in this PRA package.

12. Burden Estimates (Hours and Wages)

The burden associated with this data collection can be attributed to QHP issuers, non-QHP issuers, larger group issuers, self-insured, third party-administrators, and states. We developed these burden estimates based off CMS's experience collecting similar categories of data from issuers in the Medicare Advantage and Prescription Drug Benefit Programs, Federal Rate Review Program, and Healthcare.gov reporting. The burden for each of these entities was considered when developing these burden estimates.

Burden for QHP Issuers: QHP Certification

The burden on issuers for the QHP certification (including issuer application, rate and benefit submission, and formulary submission) in the first year is estimated to be 210,000 burden hours, or 175 hours per issuer. This estimate is based on an assumed 1,200 issuers each offering 15 plans as potential QHPs. The burden estimate includes data required for QHP certification, risk adjustment, and reinsurance. In addition to the data submission burden, the estimate includes burden for issuer training, communication and other start-up costs for a total cost of $13,475 per issuer in the first year of operations.

We anticipate that the burden in the second and third years will be minimized due to the issuer familiarity with the program and fewer start-up costs. We estimate that in the second and third years of the program the QHP issuer burden will be 145 hours and $11,165 per issuer per year; bringing the three year burden total to 465 hours and $35,805 per issuer.

Table 1. Burden for QHP Issuers: QHP Certification

Year	Number of Issuers	Hours Per Issuer	Total Hours	Total Burden Cost Per Issuer
One	1,200	175	210,000	$13,475
Two	1,200	145	174,000	$11,165
Three	1,200	145	174,000	$11,165

Burden for Stand-Alone Dental Issuers: QHP Certification

The burden on stand-alone dental issuers for the QHP certification in the first year is estimated to be 240 burden hours, or 6 hours per issuer. It is estimated that 40 issuers offering 2 plans each will participate in an Exchange. At an hourly billing rate of $77, the total cost is estimated to be $18,480, or $462 per issuer.

Like QHP issuers, we anticipate that the burden in the second and third years will be minimized due to the stand-alone dental issuer familiarity with the program and fewer start-up costs. We estimate that in the second and third years of the program the stand-alone dental issuer burden will be 4 hours and $308 per issuer per year; bringing the three year burden total to 14 hours and $1,078 per issuer.

Table 2. Burden for Stand-Alone Dental Issuers: QHP Certification

Year	Number of Issuers	Hours Per Issuer	Total Hours	Total Burden Cost Per Issuer
One	40	6	240	$462
Two	40	4	160	$308
Three	40	4	160	$308

Burden for Non-QHP Issuers and QHP Issuers (for plans outside the Exchange) Offering Plans in the Individual and Small Group Market: Reinsurance and Risk Adjustment

All issuers in the individual and small group market are required to submit reference data, to include but not be limited to administrative information about the issuer and its non-QHP offerings, AV levels for those plans, which will be used for the reinsurance and risk adjustment programs. It is estimated there are 600 issuers in the individual and small group market that will not be offering any QHPs through an Exchange. The total estimated burden for the submission for these issuers is 7,800 hours or 13 hours per issuer at a cost of $1,001 per issuer during the initial year of risk adjustment and reinsurance operations.

In the second and third years of the program there will no longer be startup costs for reporting for risk adjustment and reinsurance information. The burden on issuers in the out years will be 3 hours and $231 per year in years two and three for a total of 19 hours and $1,463 per issuer over the three-year period.

Table 3. Burden for Non-QHP Issuers and QHP Issuers Offering Plans in the Individual and Small Group Market: Reinsurance and Risk Adjustment

Year	Number of Issuers	Hours Per Issuer	Total Hours	Total Burden Cost Per Issuer
One	600	13	7,800	$1,001
Two	600	3	1,800	$231
Three	600	3	1,800	$231

Burden for Large Group Issuers, and Self- Insured Group Plans and Third-Party Administrators: Reinsurance

Some issuers in the large group market, self-insured group plans, and third-party administrators on behalf of either will be required to submit administrative information for reinsurance contributions. It is estimated that 1,600 entities are eligible reinsurance contributors. The total estimated burden for this submission is 24,000 or 15 hours per entity and includes the submission process as well as any startup costs at a cost of $1,155 per entity for the first year.

In the second and third years of the program, there will be less of a burden for reinsurance contributions. It is estimated the burden in years two and three will be 5 hours per year at a cost of $385 per entity. The total three-year burden for reinsurance contributors is 25 hours and $1,925.

Table 4. Burden for Large Group Issuers, and Self- Insured Group Plans and Third-Party Administrators: Reinsurance

Year	Number of Entities	Hours Per Entity	Total Hours	Total Burden Cost Per Entity
One	1,600	15	24,000	1,155
Two	1,600	5	8,000	$385
Three	1,600	5	8,00	$385

Burden for States: State-based Exchanges and Partnership States

CMS projects that all states that have received any type of Exchange grant funding (Planning, Innovator, Level 1, or Level 2 Establishment) from CMS will pursue a State Partnership or a State-based Exchange. Those states who are engaged with CMS as a State Partner will have an identical

Plan Management burden as those operating a State-based Exchange since they will be performing all of the Plan Management activities, including QHP certification. It is assumed that the majority of states in State-based Exchanges and Partnerships will continue to leverage their existing systems that are used by the state departments of insurance; therefore, the burden can be accounted for in the cost of system upgrades, which is estimated to be $20,000 per state. The state will also have an additional burden of 3 hours to submit data to the Federal government for a total burden of $20,157 per state.

In years two and three of the program, states will have very few costs related to system upgrades. As such, the estimated hourly burden in years two and three of the program are 3 hours or $157 per state. The three year burden is 9 hours and $20,472 per state.

Table 5. Burden for States: State-based Exchanges and Partnership States

Year	Number of States	Hours Per State	Total Hours	Total Burden Cost Per State
One	50	3	150	$20,157
Two	50	3	150	$157
Three	50	3	150	$157

13. Capital Costs

There is no capital cost associated with this collection effort.

14. Cost to Federal Government

The initial burden to the Federal Government for the development and implementation of the data collection tool is $2,433,860.90. CMS is developing models and system solutions for use by states and other Federal operations. Therefore, this estimate incorporates the estimated costs to build the functions for the Federal-facilitated Exchange and other Federal activities. This estimate projects software development costs at $98.50 an hour and assumes 26 weeks of development with a staff of 20 for QHP certification data collection tools and 4 weeks with a staff of 10 for risk adjustment and reinsurance data collection tools.

In addition to the cost of system development, CMS employees will also be needed to support issuers during the data submission process. The cost to the Federal Government for this support will be 485 burden hours at a cost of $22,580.90. The calculations for CMS employees' hourly salary were obtained from the OPM website: http://www.opm.gov/oca/10tables/html/dcb_h.asp.

After this cost, the total burden to the Federal Government in year one is $2,433,860.90. In years two and three of the program, the cost to the Federal government will be lower. We estimate that the operations and maintenance costs for the data collection tool will be $204,880.00 on an annual basis and an additional 485 burden hours for data collection support for a cost of $22,580.90. Therefore, the total three-year cost to the Federal government is $2,888,782.70.

15. Changes to the Burden

Since the 60-day comment period, we have updated the burden on QHP issuers in our calculations. Our initial burden estimate was 160 hours per issuer with a total burden cost of $12,320. Our revised burden estimate takes into account the collection of rating tables and issuer business rules. As a result, the new estimate is now 174 hours per issuer with a total burden cost of $13,475.

Since the 60-day comment period, we have included the burden on stand-alone dental issuers in our calculations. Our initial burden estimate did not take stand-alone dental issuers into account; therefore, the initial burden estimate was 0 hours and $0. This new burden estimate now includes dental issuers and is outlined in Table 2 above. The burden on stand-alone dental issuers for the QHP certification in the first year is estimated to be 6 hours per issuer. At an hourly billing rate of $77, the total cost is estimated to be $462 per issuer.

Table 6. Changes in Burden Since 60-day Comment Period

	60-day Comment Period		**30-day Comment Period**	
Entity Name	**Burden Hours**	**Total Burden Cost to Entity**	**Burden Hours**	**Total Burden Cost to Entity**
QHP Issuers: QHP Burden	160	$12,320.00	175	$13,475.00
Stand Alone Dental Issuers: QHP Burden	0	0	6	$462.00

16. Publication/Tabulation Dates

The information collection from issuers is anticipated under this request to occur in the first quarter of 2013.

17. Expiration Date

CMS has no objections to displaying the expiration date.