Supporting Statement For Paperwork Reduction Act Submissions: Cost Sharing Reduction Reconciliation Data Template

CMS-10526 (OMB Control Number: 0938-1266)

A. Background

The Patient Protection and Affordable Care Act, Public Law 111-148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, Public Law 111-152, enacted on March 30, 2010 (collectively, the "Affordable Care Act"), provides for reduced cost sharing for eligible individuals who purchase health insurance from a qualified health plan (QHP) through a Marketplace.[1]

Under this law, cost-sharing reductions (CSRs) are paid by issuers to health care providers to lower the out-of-pocket cost to enrollees at the time of service. The goal is to make health care more accessible by reducing its cost. Issuers are reimbursed dollar amounts for cost-sharing reductions. In 45 CFR 156.430(c), issuers must report to HHS the amount of cost-sharing reductions provided during the benefit year. In 45 CFR 156.430(d), HHS will reconcile the amount of advance payments for cost-sharing reductions to reflect the amount of cost-sharing reductions issuers made to health care providers on behalf of enrollees.

The 2014 Notice of Payment and Benefit Parameters rule (the "Payment Notice") published March 11, 2013, detailed a plan in which monthly payments would be advanced to issuers for estimated CSRs and then reconciled against CSRs provided by issuers to eligible enrollees during the benefit year. The Payment Notice detailed a methodology for issuers to use when calculating and submitting to HHS the CSR amounts provided enrollees in a benefit year. In response to comments on the proposed rule that the "standard methodology" to identify these amounts was too complex for timely implementation, HHS in the final Payment Notice said it would provide a second, optional method for estimating CSRs provided by issuers. An interim final rule with comment, "Amendment to the HHS Notice of Benefit and Payment Parameters for 2014," published concurrently with the final 2014 Payment Notice described in detail a second "simplified methodology." As a result, QHP issuers may elect to use a simplified formula during the first three years of the program, from 2014 through 2016, to estimate cost sharing reductions provided to enrollees.

In 45 CFR 156.430(c)(1), we established the standard methodology for QHP issuers to submit data to HHS showing the amount of cost sharing paid by enrollees in each plan variation, as well as the amount of cost sharing the enrollees would have paid under the standard plan. The value of the cost sharing provided is the difference between those two amounts.

To calculate what the enrollees would have paid under the standard plan, QHP issuers using the standard methodology detailed in 45 CFR 156.430(c)(2) are required to apply the actual cost sharing amount for the standard plan to the total allowed costs for essential health benefits (EHB) for each plan variation policy. Essentially, the issuer first processes a claim using standard cost sharing, and then re-processes the claim, applying the reduced cost sharing to establish the CSR amount.

The simplified methodology provided in 45 CFR 156.430(c)(4) does not require complex re-adjudication of claims. Instead, issuers are required to calculate the amount enrollees would have paid under the standard plan by applying four cost-sharing parameters for the standard plan to the total allowed costs paid for EHB under the policy with cost sharing reductions. The four cost-sharing parameters are: the effective deductible, the effective pre-deductible coinsurance rate, the effective post-deductible coinsurance rate, and the effective claims ceiling.

QHP issuers will have already notified HHS of their selection of methodology as required under 45 CFR 156.430(c)(3) prior to the benefit year. A QHP that selected the simplified

methodology must apply the methodology to all plan variations it offers on the Exchange for the benefit year under 45 CFR 156.430(c)(3)(ii).

The initial approved information collection request proposed to collect the necessary data elements for both methodologies using an HHS created CSR Reconciliation Data Template. For efficiency in transmitting the necessary volume of data for this collection, and to more closely resemble other data collections that issuers currently participate in with the Marketplace, we changed the method of collection from a template to a standard electronic file format following the comment period for that request. The initial data collection was approved on December 30, 2014, under OMB control number 0938-1266. HHS will release additional information on the file structure and transfer protocols through separate technical guidance shortly. In this revised collection and in technical guidance, we are consolidating summary, plan, and policy reporting for all issuers regardless of methodology and eliminating a number of data elements. However, since issuers must file separate reports in the event of a merger with or acquisition of an issuer with a different methodology, we are adding data elements to allow these issuers to cross reference their HIOS IDs with those of the acquired issuer(s) or merger partner(s).

This revised PRA package was published in the Federal Register on September 14, 2015. The 60-day notice and comment period for this PRA package ended on November 13, 2015. We received and are responding to specific comments on this collection in an accompanying document.

The reporting and data collection provisions described here apply to issuers of QHPs inside an Exchange. (Cost-sharing reductions are only available through Exchange-based products.) All such QHP issuers would be required to report the data elements contained in the Issuer Summary Report described in Part I. Depending on whether they selected the standard or simplified CSR reconciliation methodology, QHP issuers then would be required to report elements from the following additional sections of the CSR reconciliation reports:

- Issuers using the standard CSR reconciliation methodology would be required to report the elements in the Plan and Policy Report (Part II).
- Issuers using the simplified CSR reconciliation methodology with at least 12,000 member months per year in the associated standard plan would be required to report the elements in the Effective Parameters Report and a Plan and Policy Report (Parts III and IV.)
- Issuers using the simplified CSR reconciliation methodology with fewer than 12,000 member months per year in the associated standard plan would be required to report the elements in the Simplified Actuarial Value Methodology Plan and Policy Report (Part V).

The data elements required for these reports are described at length below.

This information collection allows HHS to collect data necessary to reconcile payments advanced to QHP issuers with dollar amounts paid by the issuer on behalf of an enrollee, and recoup or remit the balance.

B. Justification

1. Circumstances Making the Collection of Information Necessary

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The Affordable Care Act provides cost-sharing reductions for certain eligible individuals to help them afford out-of-pocket expenses associated with health care purchased through QHPs offered on Exchanges. Specifically, the Affordable Care Act provides for reductions in cost sharing on EHB for low and moderate income enrollees in silver level health plans sold on individual market Exchanges. The law directs QHP issuers to notify the Secretary of Health and Human Services of cost-sharing reductions made under the statute for qualified individuals, and provides for periodic and timely payments to the QHP issuer equal to the value of those reductions. Further, the law permits advance payment of the cost-sharing reduction amounts to QHP issuers.

To ensure the appropriate use of federal funds, HHS needs to compare and reconcile the estimated monthly payments advanced to a QHP issuer with cost sharing reductions made by the issuer for medical services for each eligible enrollee in a benefit year.

2. Purpose and Use of Information

The data collection and reporting requirements described below will enable HHS to review actual medical costs incurred by enrollees for EHB and CSRs provided by issuers on behalf of these enrollees for these services, and to compare this information to the dollar amount of estimated payments advanced to issuers. This comparison will allow HHS to determine whether the advance payment to the issuer was greater or less than the CSR amounts provided on behalf of enrollees. Using this data, HHS will calculate the difference between the estimated advanced CSR payments and the amount actually provided during the benefit year, and either a payment will be made to an issuer or the issuer will be invoiced for amounts not spent on behalf of the enrollee. Because of a new timetable for reconciling CSR advance payments, for benefit years 2014 and 2015, issuers must submit CSR data to HHS by April 30, 2016.

3. Use of Information Technology

Information gathered through this collection will be submitted electronically. HHS staff will communicate with States and the District of Columbia using standardized reporting, e-mail or telephone.

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

Reconciliation of advance payments of cost-sharing reductions is an annual process beginning in 2016. A less frequent collection could result in a loss of funds to the U.S. Treasury from uncollected receivables and interest. Failure to reimburse issuers for cost-sharing reduction amounts in excess of the amount advanced at least once yearly could result in cash flow difficulties for issuers.

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7. Special Circumstances

There are no special circumstances associated with this collection.

8. Federal Register/Outside Consultation

This collection of information will be available for comment for 30 days beginning around January 4, 2016. We have consulted with contractors, States, and industry on the feasibility of this information collection. We have based many of the requirements in this information collection on those consultations.

9. Payments/Gifts to Respondents

No payments or gifts will be provided to respondents.

10. Confidentiality

We will maintain respondent privacy with respect to the information collected to the extent required by applicable law and HHS policies.

11. Sensitive Questions

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

12. Burden Estimates (Hours & Wages)

Our estimate of paperwork burden for issuers is based on responses from 295 issuers and whether they elected the standard or simplified method for calculating amounts of CSRs provided. Additionally, issuers electing the simplified method must use the simplified actuarial value methodology for determining the value of CSRs provided for enrollees when calculating cost sharing for standard plans with fewer than 12,000 member months in a benefit year.

A number of assumptions are made regarding the wages of personnel needed to accomplish the proposed collection of information. Wage rates are based on the Employer Costs for Employee Compensation report by U.S. Bureau of Labor Statistics and represent a national average. Some States or employers may face higher or lower wage burdens. Wage rates estimates include a 35% increase to account for employee fringe benefits.

I. **Issuer Summary Report**

Within Part 156, subpart E we described Health Insurance Issuer responsibilities with respect to advance payments of CSRs.

Under 45 CFR 156.430(c)(1), each QHP each year must submit to HHS for every plan variation it sells on the Exchange the total allowed costs for EHB provided for the policy for the benefit year, broken down by the amount the issuer paid, the amount the enrollee(s) paid, and the amount the issuer would have paid under the standard plan without cost-sharing reductions.

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In this collection, HHS proposes to require each issuer to submit the data elements contained in the Issuer Summary Report, which includes the total number of policies paying cost-sharing reductions and the total amount of CSRs provided under those policies. All QHP issuers offering individual market plans in the Exchange are subject to this annual data collection requirement and would be required to complete this report.

This report also requires issuers to attest that the CSR amounts paid were paid only for EHB, not including certain benefits for which Federal funds may not be used, as described in Section 1301 of the ACA. Additionally, as required under 45 CFR 156.430(c)(4)(iii)(E), issuers that elect the simplified methodology must submit a memorandum and actuarial attestation to the method of calculation for each effective cost sharing parameter for each applicable subgroup in the standard plan. This signed memo would be submitted electronically concurrent with the CSR cost report.

Finally, under this revised collection, we are removing data elements that would have required issuers in spring 2016, when CMS will reconcile advance payments for the 2014 benefit year, to report the total actual CSR amount submitted in 2014 Medical Loss Ratio reporting and whether the submitted amount is the 2014 CSR advance payment amount or a certified estimate.

Approximately 295 QHP issuers on Exchanges are subject to this data collection. Additionally, as described under 45 CFR 156.430(c)(iv), in the case of a merger or acquisition, an issuer may be required to file reports under both standard and simplified methodologies. Assuming, on average, that one issuer would need to complete an additional Issuer Summary Report in any given year due to a merger or acquisition, we estimate 296 reports (295 reports (1 per QHP issuer) + 1 additional report for an issuer who must complete 2 reports in the event of a merger or acquisition) would be filed each year.

We previously estimated the cost of establishing information technology to use this methodology in the Information Collection associated with the 2014 Payment Notice and the final Program Integrity rule. We assume these reports will be automatically generated on a regular basis as a normal part of business, and below we estimate capital costs for all data extraction for this file transfer. Therefore, our estimate here is limited to performing the extraction and reviewing data in this file. We estimate that on average, for each issuer, it will take an operations analyst 30 minutes (at a wage rate of $55 an hour) and a senior manager (at $79.08 an hour) 15 minutes to oversee and review the Issuer Summary Report section of this file, for a total estimated burden of 222 hours per year. The average cost estimate for each issuer is $47.28 and the estimated aggregated cost burden is $13,994.88.

II. Standard Methodology Plan and Policy Report

Only issuers using the standard methodology would be required to report this section of the reports. As required under §156.430(c)(2), QHP issuers in this section must calculate the value of the amount the enrollee would have paid under the standard plan without cost-sharing reductions by applying actual cost-sharing requirements for the standard plan to the allowed costs for EHB under the enrollee's policy for the benefit year. The Plan and Policy Report includes identifying numbers for each subscriber, total allowed costs for EHB, amounts the issuer and enrollee paid, and the amounts the enrollee(s) would have paid under the standard plan. It also includes total monthly premium for the policy. Additionally, for each QHP, issuers would the aggregate amount of annual premium, allowed costs for EHB, actual amounts paid by the issuer for EHB, actual amounts paid by enrollees for EHB, and the total value of CSR provided.

As noted above, we separately estimate capital costs related to data extraction required to complete all sections of the file submission, and we assume an automated information system.

Therefore our estimate here is limited to performing the extraction and reviewing the data in the file.

In the aggregate, we estimate that 295 issuers will report reconciliation data for approximately 4 million policies in various sections of this template. A review of HHS data shows that 104 QHP issuers, or approximately 35 percent of QHP issuers required to report CSR data, selected the standard methodology and would submit data for this section of the report.

Assuming 35 percent of policies (or 1,400,000 policies) also fall under the standard methodology, each issuer completing this section of the report would submit data for approximately 13,461 policies. To submit and review this data collection, we estimate on average for each issuer it would take an operations analyst 10 hours (at an average wage rate of $55 an hour) and a senior manager five hours (at $79.08 an hour) to meet these requirements. Therefore we estimate on average each issuer would need 15 hours to complete this section, for an estimated aggregate burden of 1,560 hours. We estimate the average cost to each issuer would be $945.40, for an aggregated estimated cost burden of $98,321.60. Since issuers will have already gathered and reported policy level information for this report, we do not anticipate that reporting aggregate plan amounts for each QHP plan would result in any additional burden.

We anticipate that more issuers will use this method in future years. Indeed, because of a one-year delay in the initial reconciliation cycle, more issuers are likely to be prepared to use the standard reconciliation methodology by spring 2016, when CMS reconciles cost-sharing reductions for the first time (advance payments provided in benefit years 2014 and 2015). Therefore, assuming that the number of policies reported under this section in the first year would triple in subsequent years, the estimated aggregate hourly burden and cost in benefit years 2016 and 2017 would also triple.

III. Simplified Methodology Effective Parameters Report
IV. Simplified Methodology Plan and Policy Report

Only QHP issuers that selected the simplified methodology and whose associated standard plan meets the credibility standard established in §156.430(c)(4)(iv) are required to complete Sections III and IV of the CSR Reconciliation Data Reports. The simplified methodology may be used to reconcile advance payments received for benefit years 2014, 2015, and 2016, and only by issuers that selected it beginning in the initial year.

The simplified methodology requires QHP issuers to estimate cost sharing for the standard plan associated with each plan variation in part by developing a set of parameters from the claims population for that standard plan for the year. For these calculations to be meaningful, the standard plan would need to have at least 12,000 member months each year, in and out of the Exchange. Section III of this report would require issuers to submit formulas in accord with 45 CFR 156.430(c)(4)(iii)(A)-(D) for four cost sharing parameters: the effective deductible, the effective pre-deductible coinsurance rate, the effective post-deductible coinsurance rate, and the effective claims ceiling, for each standard plan, for both self-only coverage and other than self-only coverage. Section III also requires issuers to provide plan variation level information that describes whether the plan has separate cost-sharing parameters for self only and other than self, and for medical and pharmaceutical services. Issuers also must provide this information for HMO-like plans where 80 percent or more of the total allowed costs for EHB under a standard plan are not subject to the deductible, since these require a separate set of effective cost sharing parameters.

In Section IV, QHP issuers would be required to report the amount of cost sharing the enrollee would have paid under the standard plan, as calculated by applying summary cost sharing parameters in Section III to plan variation policy claims data. Issuers would report Level 3 subsections depending on whether the policy is self only or other than self only, and whether it falls under formulas A, B, or C. Additionally, for each QHP, issuers would report the aggregate amount of annual premium, allowed costs for EHB, actual amounts paid by the issuer for EHB, actual amounts paid by enrollees for EHB, and the total value of CSR provided.

As noted above, we separately estimate capital costs related to data extraction required to complete all sections of the file submission, and we assume an automated information system. Therefore our estimate here is limited to performing the extraction and reviewing the data in the file. Approximately 65 percent or 191 QHP issuers selected the simplified methodology. However, according to HHS data, of the 2,234 standard plans offered by issuers that chose to report using the simplified methodology, only 222 plans or about 10 percent meet the credibility standard required to estimate parameters under this section. Therefore we estimate that each issuer would submit data on, at most, one standard plan and associated plan variation under Section III. Assuming calculations for 10 percent of the remaining 2.6 million policies would be reported under Section IV, we estimate that for Sections III and IV, issuers would submit data for a total of 222 standard plans, 222 plan variations, and 260,142 policies. On average, for each issuer with one standard plan, one associated plan variation, and an estimated 1,362 policies, we estimate it will take an actuary 10 hours (at $69.93 an hour), an operations analyst 10 hours (at an average wage rate of $55 an hour) and a senior manager 5 hours (at $79.08 an hour) to oversee the data submissions required in this section, for an average per issuer cost of $1,644.70. For 191 issuers, the aggregate hourly burden is 4,775 hours and the aggregate wage burden is $314,137.7. Since issuers will have already gathered and reported policy level information for this report, we do not anticipate that reporting aggregate plan amounts for each QHP plan would result in any additional burden.

We anticipate that fewer issuers will use this method in future years. Assuming that only half of all plan variations reported under this section in the first year would be reported here in subsequent years, we estimate the aggregate cost burden to reconcile advance payments for benefit year 2016, the last benefit year for which this method may be used, would decline by half.

V. Simplified Actuarial Value Methodology Plan and Policy Report

This section of the report must be completed by QHP issuers that selected the simplified methodology to calculate CSRs but that enrolled fewer than 12,000 member months for a benefit year in an associated standard plan.

Under CFR 156.430(c)(4)(v), issuers whose standard plans lack sufficient enrollment to provide a credible estimate of average claims data must use the standard plan actuarial value from the AV calculator to estimate cost sharing under the standard plan. This is calculated as the lesser of the annual limit on cost sharing for the standard plan, or the product of (x) one minus the standard plan's actuarial value, as calculated under 45 CFR 156.135, and (y) the total allowed cost for EHB. Additionally, for each QHP, issuers would the aggregate amount of annual premium, allowed costs for EHB, actual amounts paid by the issuer for EHB, actual amounts paid by enrollees for EHB, and the total value of CSR provided.

HHS estimates that 90 percent or 2,012 standard plans offered by issuers selecting the

simplified methodology do not meet the threshold required for the simplified method and, therefore, to calculate CSR for policies associated with these plans, these issuers must use the simplified actuarial value methodology.

Assuming 90 percent of the 2.6 million policies to be reconciled under the simplified methodology will use the actuarial value methodology and complete this section, we estimate on average that each issuer would submit data for 12,251 policies. On average, we estimate it will take an operations analyst 1 hour (at an average wage rate of $55 an hour) and a senior manager 1 hour (at $79.08 an hour) to oversee the data submissions required in this section. The total burden for 191 QHP issuers is therefore 382 hours and the aggregated cost burden would be $25,609.20. Since issuers will have already gathered and reported policy level information for this report, we do not anticipate that reporting aggregate plan amounts for each QHP plan would result in any additional burden.

We anticipate that fewer issuers will use this method in future years. Assuming that only 5 percent of all plan variations reported under this section in the first year would be reported here in subsequent years, we estimate the aggregate cost burden in benefit years 2015 and 2016 would decline by 95 percent.

Aggregate burden

As noted above, each QHP issuer must complete only two reports: the Issuer Summary Report (Section I) and the report that corresponds to their methodology. The aggregate burden for issuers completing this file is as follows:

12A. Estimated Annualized Burden Hours

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Information Collection Requirement	Type of Respondent	Frequency and Duration	Number of Respondents	Number of Responses per Respondent	Average Burden Hours per Response	Total Burden Hours
Issuer Summary Report	Issuer	Annually, Permanent	296	1	.75	222
Standard Methodology Plan and Policy Report	Issuer	Annually, Permanent	104	13,461	0.0011	1,560
Simplified Methodology Effective Parameters and Plan and Policy Reports	Issuer	Annually, 2014,2015, 2016 only	191	1,362	0.0183	4,775
Simplified Actuarial Value Plan and Policy Report	Issuer	Annually, 2014,2015, 2016 only	191	12,251	0.0001	382
Total						6,939

12B. Cost Estimate for All Respondents Completing each Form

Type of Respondent	Hourly Labor Cost of Reporting ($)	Total Burden Hours	Average Labor Cost per Response	Number of Respondents	Total Labor Costs (All Respondents)
Issuer Summary Report					
Operations Analyst	$55.00	.50	$27.50	296	$8,140
Senior Manager	$79.09	.25	$19.78	296	$5,854.88
Total		**.75**	**$47.28**		**$13,994.88**

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Type of Respondent	Hourly Labor Cost of Reporting ($)	Total Burden Hours	Average Labor Cost per Response	Number of Respondents	Total Labor Costs (All Respondents)
Standard Methodology Plan and Policy Report					
Operations Analyst	$55.00	10	$550.00	104	$57.200
Senior manager	$79.08	5	$395.40	104	$41,121.6
Total			**$945.40**		**$98,321.6**
Simplified Methodology Effective Parameters Report and Plan and Policy Report					
Actuary	$69.93	10	$699.3	191	$133,566.30
Operations Analyst	$55.00	10	$550.00	191	$105,050.00
Senior Manager	$79.08	5	$394. 40	191	75,521.404
Total			**$1,644.70**		**$314,137.70**

Simplified Actuarial Value Methodology Report					
Operations Analyst	$55.00	1	$55.00	191	$10,505
Senior Manager	$79.08	1	$79.08	191	$15,104.28
Total			**$134.08**		**$25,609.28**

13. Capital Costs

In the 2014 HHS Notice of Benefit and Payment Parameters, we estimated that the information technology associated with implementing the standard methodology would be developed by three vendors at a cost of approximately $6 million per vendor, for total costs of approximately $18 million. We also estimated each issuer would need to spend approximately $100,000 to customize the vendor solution technology and modify their claims system to extract data. Our estimate for total administrative costs was $138 million. We revised our estimate in the Program Integrity Rule on the assumption that half of an estimated 1,200 issuers would use the simplified methodology. We included in that estimate 42 hours of work by an actuary and 22 hours of work by an insurance manager to develop and calculate cost-sharing parameters for the simplified method. We are revising our estimate further to reflect current HHS expectations that 90 percent of 295 issuers will use one of the simplified methods. The new estimate is $47.5 million and includes systems development for all methodologies.

Here we estimate the burden of extracting and reporting data from the information technology accounted for above, as well as maintenance. For an issuer using the standard methodology, we estimate on average it would take each QHP using automated systems 10 hours a year to provide the information required in these reports. Therefore for all issuers using this methodology, we estimate it would take 1,040 hours to produce summary data for 1.4 million policies. The cost of this capital requirement is approximately $1,500 per issuer, including maintenance and

depreciation, for a total estimated burden of $156,000.

The time required to produce reports using the simplified methodology is expected to be slightly greater than that required for the standard methodology. We estimate each issuer using this method would take two hours to provide data for 1,171 policies once a year. Therefore the estimated aggregate annual burden to submit data for 260,142 policies is 382 hours. The cost of this capital requirement is approximately $300 per issuer, for a total estimated burden of $57,300. Issuers using the simplified actuarial value methodology would require slightly less time than those reporting under the standard methodology to calculate parameters and produce reports. Using previously gathered information and an automated information system, we estimate it would take each QHP issuer on average one hour to complete this report for 12,251 policies once a year. Therefore, for 2.3 million policies the estimated aggregate annual time burden for issuers completing this section would be 183.5 hours. The cost of this capital requirement is approximately $150 per issuer, for a total estimated burden of $28,650.

14. Cost to Federal Government

The initial burden to the Federal Government for the establishment of the CSR Reconciliation program is $14,552.64. The calculations for CCIIO employees' hourly salary was obtained from the OPM website: http://www.opm.gov/oca/10tables/html/dcb_h.asp.

Task	Estimated Cost
Development of HHS CSR reconciliation template	
3 GS-13: 3 x $42.66 x 30 hours	$3,839.40
Collection of HHS CSR reconciliation data	
5 GS-13: 5 x $42.66 x 40 hours	$8,532
Technical Assistance to Issuers	
5 GS-13: 5 x $42.66 x 8 hours	$1706.40
Managerial Review and Oversight	
2 GS-15: 2 x $59.30 x 4 hours	$474.40
Total Costs to Government	**$14,552.22**

15. Explanation for Program Changes or Adjustments

This collection was previously approved on December 30, 2014 under OMB control number 0938-1266. Changes here are limited to the removal of certain data elements and the addition of others. All added information would have been previously collected; therefore this results in no change of burden. For example, we will require issuers to report the total number of CSR variant plans under their QHP ID, and we will no longer require issuers to report the total actual CSR amount submitted in 2014 Medical Loss Ratio reporting and whether the submitted amount is the 2014 CSR advance payment amount or a certified estimate. At the same time, at the request of issuers, this collection adds a data element (QHP ID) already collected at the plan level to the policy level collection so that data may be mapped. To

comply with this collection, we added data elements to allow issuers to cross reference their HIOS IDs with those of any acquired issuer(s) or merger partner(s), and to provide names, emails, and phones for the technical and business company officers filing data for this collection to CMS. Since the new data elements are already available as a result of the reconciliation process and accessed and reported electronically in seconds, we estimate no change in burden.

16. Publication/Tabulation Dates

    Not applicable.

17. Expiration Date

    Not applicable.

[1] QHP issuers must reduce cost sharing for individuals with household incomes between 100 percent and 250 percent of the federal poverty level (FPL) who are enrolled in a silver level QHP in the individual market on an Exchange. In addition, issuers must eliminate cost sharing for Indians with household incomes under 300 percent of FPL who are enrolled in a QHP in the individual market on an Exchange. Finally, issuers must eliminate cost sharing for Indians enrolled in a QHP in the individual market on the Exchange, regardless of income, when services are provided by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services.