Supporting Statement – Marketplace Quality Standards
CMS-10520/OMB Control Number: 0938-1249

A. Background

The Department of Health and Human Services (HHS) goals for improving access to high-quality, affordable care, and for supporting healthier people and communities, as described in the Meaningful Measures Framework,[1] continue to guide the establishment of quality standards for the Health Insurance Exchanges and for Qualified Health Plans (QHPs). HHS is requesting approval, by the Office of Management and Budget (OMB), for the revisions associated with Parts I, II, and III of this supporting statement. This supporting statement details the information collection associated with the following processes:

I. Implementation and reporting for the Quality Rating System (QRS),

II. Implementation and reporting for the QHP Enrollee Experience Survey (QHP Enrollee Survey),

III. Monitoring and appeals process for survey vendors, and

IV. Patient safety reporting standards for QHP issuers.

B. Justification

1. Need and Legal Basis

The Patient Protection and Affordable Care Act establishes requirements to support the delivery of quality health care coverage for health insurance issuers offering QHPs in Exchanges.[2]

- Section 1311(c)(3) of the Patient Protection and Affordable Care Act directs the Secretary to develop a system to rate QHPs on the basis of quality and price and requires Exchanges to display this quality rating information on their respective websites.
- Section 1311(c)(4) of the Patient Protection and Affordable Care Act requires the Secretary to develop an enrollee satisfaction survey system to assess enrollee experience with each QHP (with more than 500 enrollees in the previous year) offered through an Exchange. Section 1311(h) requires QHPs to contract with certain hospitals that meet specific patient safety and health care quality standards beginning January 1, 2015.

This Information Collection Request (ICR) was approved under OMB Control Number 0938-1249 so that HHS may collect required information to implement the proposed quality standards outlined in Code of Federal Regulations (CFR) §156.1105, §156.1110, §156.1120, and §155.1125.

This collection of information is necessary to provide adequate and timely health care quality information for consumers, regulators, and Exchanges and also to collect information to appropriately monitor and provide a process for a survey vendor to appeal HHS' decision to not approve a QHP Enrollee Survey vendor application.

---

[1] The Meaningful Measures Initiative, launched in 2017 by CMS, identifies the highest priorities for quality measurement and improvement. It involves assessing those core issues that are the most critical to providing high-quality care and improving individual outcomes. The Meaningful Measures Framework focuses on six cross-cutting priority areas: eliminate disparities, track to measurable outcomes, safeguard public health, achieve cost savings, improve access to rural communities, and reduce burden. For additional information, please visit https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html.

[2] The Exchanges are also referred to as the "Marketplace" or the "Marketplaces" within this document.

We updated this information collection request to account for the associated burden of the refinements to the QRS program, including changes to the QRS measure set, data collection process, and number of QHPs participating in the QRS annually. In addition, we have accounted for the associated burden reduction due to refinements to the QHP Enrollee Survey questionnaire approved under OMB Control No. 0938-1221.[3]

2. Information Users

I. Implementation and Reporting for the Quality Rating System (QRS)

The QRS quality measure data is collected from QHP issuers on an annual basis so HHS can calculate scores and quality ratings for QHPs, as required by section 1311(c)(3) of the Patient Protection and Affordable Care Act. This quality rating information will be displayed on Exchange websites for consumers to have QHP rating information, including health care quality, health outcomes, consumer experience, accessibility of care, and affordability of care. This information is essential to inform consumer choices and to perform certain required functions of an Exchange (e.g., QHP certification). HHS will use the validated data that is submitted by QHP issuers to calculate scores and ratings based on a standardized methodology found in the annual QRS and QHP Enrollee Survey Technical Guidance.

II. Implementation and Reporting for the Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey)

The information collection associated with implementation and reporting for the QHP Enrollee Survey, as outlined in §156.1125, includes the collection, validation, and submission of QHP Enrollee Survey data on an annual basis. The QHP Enrollee Survey provides member experience data, which is a fundamental aspect of measuring the overall quality of a QHP. The burden estimates and costs regarding survey respondents are already accounted for in the Federal Register Notice (FRN) dated July 28, 2017 and are approved under OMB Control No 0938-1221.[4]

The QHP Enrollee Survey information submitted to HHS is used by HHS to calculate QHP Enrollee Survey scores and benchmarks to send to Exchanges and to QHPs. In addition, a subset of the QHP Enrollee Survey scores will be used as part of the quality ratings for QHPs.

III. Monitoring and Appeals Process for Survey Vendors

HHS monitors approved survey vendors for ongoing compliance. HHS may require additional information from approved vendors be submitted as needed to verify continued compliance with standards listed in §156.1105(b)(1) through (11). HHS uses this information to determine whether vendors should remain on the approved list.

Vendors that were not approved by HHS have the opportunity to appeal HHS's determination. The appeals process requires vendors who plan to appeal HHS's decision to submit a completed

[3] For 2019, the questionnaire has been reduced from 82 to 68 questions per non-substantive change request. Agency Information Collection Activities Health Insurance Marketplace Consumer Experience Surveys: Enrollee Satisfaction Survey and Marketplace Survey Data Collection; Notice, 83 FR 16930 (published April 26, 2018): https://www.reginfo.gov/public/do/PRAViewDocument?ref_nbr=201804-0938-025.

[4] Agency Information Collection Activities: Health Insurance Marketplace Consumer Experience Surveys: Enrollee Satisfaction Survey and Marketplace Survey Data Collection; Notice, 82 FR 34529 (July. 28, 2017). https://www.federalregister.gov/documents/2017/07/25/2017-15589/agency-information-collection-activities-submission-for-omb-review-comment-request

Request for Appeal Form with new or additional information for each criterion not met and justification for why this information was not included in the vendor's original Participation Form. HHS uses this information to make a final approval determination of whether or not to list the vendor as an HHS-approved QHP Enrollee Survey vendor.

IV. Patient Safety Reporting Standards for QHP Issuers

HHS finalized QHP patient safety reporting standards in the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017 (81 FR 12203), March 2016. We finalized the documentation requirement in §156.1110(b) to require QHP issuers to collect and maintain information like a hospital attestation or a copy of the current agreement to partner with a Patient Safety Organization (PSO), a Hospital Engagement Network, or a Quality Improvement Organization.

This documentation should reflect implementation of PSO activities, such as PSOs and hospitals working together to collect, report, and analyze patient safety events, and to implement a comprehensive person-centered hospital discharge program that demonstrates compliance with the proposed requirements in §156.1110(a)(2)(i). Such documentation may also reflect implementation of a patient safety initiative to improve health care quality through the collection, management, and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmission, or improves care coordination to demonstrate compliance with the reasonable exception provision finalized in §156.1110(a)(2)(ii). An Exchange may request this information and may use the information as demonstration of compliance by QHP issuers with patient safety reporting standards outlined in §156.1110.

3. Use of Improved Information Technology and Burden Reduction

All information collected from QHP issuers for implementation and reporting of the QRS, QHP Enrollee Survey, and patient safety standards will be submitted electronically. HHS staff will analyze the data electronically and communicate with issuers and State-based Exchanges, if necessary, by email and telephone. Information collected from survey vendors regarding the monitoring and appeals process will be electronic as well.

4. Efforts to Identify Duplication and Use of Similar Information

The quality reporting standards and programs included in this supporting statement were established by the Patient Protection and Affordable Care Act. The information has never been collected by the Federal Government for purposes including: providing quality ratings and QHP Enrollee Survey results for QHPs, monitoring and conducting appeals processes for QHP Enrollee Survey vendors, and patient safety reporting by QHPs.

While certain quality measures are used in other CMS quality reporting programs, such as the Medicare Star Ratings, Medicaid Adult Core Measures, Initial Children's Core Set, and Medicare Part C&D programs; the information for the QRS and QHP Enrollee Survey provides important data specific to the Exchange population – a new and evolving population separate from both Medicare and Medicaid.

5. Impact on Small Businesses or Other Small Entities

No impact on small business.

6. Consequences of Collecting the Information Less Frequently

If HHS does not collect the QRS and QHP Enrollee Survey information on an annual basis, HHS will be unable to calculate scores and ratings for QHPs as required by section 1311(c)(3)

and (c)(4) of the Patient Protection and Affordable Care Act. In addition, HHS will be unable to send the appropriate QHP quality information to Exchanges for display on their websites as is also required. If HHS does not collect information to monitor QHP Enrollee Survey vendors, then there may be increased risk of noncompliance by vendors, which could impact the integrity of the QHP Enrollee Survey scores and the QRS ratings. Additionally, it is important that measure data is collected timely in order to reflect relevant information of the Exchange population as it continues to evolve.

7. Special Circumstances

Not applicable.

8. Federal Register Notice/Outside Consultation

CMS provided an opportunity for the public to comment for 60 days through publication of a Federal Register Notice February 14, 2019 (84 FR 4075). CMS received no public comments during that time and has made no revisions to the Supporting Statement.

CMS will provide an additional 30-day comment solicitation.

9. Payment/Gift to Respondents

Respondents will not receive payments or gifts for completion of this data collection.

10. Confidentiality

No personal information will be collected. All information will be kept private to the extent allowed by applicable laws/regulations.

11. Sensitive Questions

No sensitive information will be collected.

12. Estimates of Annualized Burden Hours (Total Hours & Wages)

I. Implementation and Reporting for the Quality Rating System (QRS)

The burden estimate details the costs associated with QRS measure data collection, validation, and submission to CMS for a QHP issuer (issuer) operating in the Health Insurance Exchange. The estimate assumes 250 issuers, based on the number of issuers that have participated in the Marketplace Quality Initiatives programs annually, and covers the annual costs for an issuer over a three-year period (2019-2022). The estimate relies on the assumption that each issuer will report the QRS measure set only.

Though the QRS measure set consists of 38 measures, this burden estimate only considers the level of effort associated with 28 measures that specify data collection using administrative data sources and/or medical records. The burden estimate for survey respondents for the remaining 10 survey measures in the QRS measure set is accounted for in a separate Information Collection Request approved under OMB Control No. 0938-1221 related to the QHP Enrollee Experience Survey. See for the QRS measure set attributes considered in estimating the burden of QRS measure data collection. The original burden estimates were made based on the draft QRS measure set released in the FRN published November 3, 2013.[5]

CMS reviewed the assumptions and data inputs used to create the original QRS burden estimates. Since publication of the ICR, the QRS measure set was revised and published shortly

[5] https://www.federalregister.gov/articles/2013/11/19/2013-27649/patient-protection-and-affordable-care-act-exchanges-and-qualified-health-plans-quality-rating

after the issuance of the Final Rule.[6] Subsequently, several additional changes to the measure set were made through the 2017 and 2018 QRS Call Letter process.[7] Additionally, beginning in 2019, CMS modified the QRS Measure Technical Specifications such that the hybrid data collection method is now optional for eight measures, rather than a requirement as in previous years. Due to the changes in the QRS measure set, CMS revised the burden estimate to reflect the final 2019 QRS measure set. Exhibit 1 shows the change in key measure set attributes between the draft QRS measure set, the final 2015 beta test QRS measure set, and the current QRS measure set (2019 QRS).

Exhibit 1. QRS Measure Set Attributes Related to Data Collection

Attribute Description	Draft QRS Measure Set	Final 2015 QRS Beta Test Measure Set	Current QRS Measure Set (2019 QRS)
Subset of QRS Measures Accounted for In Burden Estimate	29	31	28
Administrative Measures Measures that specify the use of claims or other administrative source data	20	18	28
Hybrid Measures Where Unique Sample Is Optional Measures that specify the use of medical record data to supplement administrative data is an option	9	10	8*
Average # of Medical Records Reviewed for Each Hybrid Measure where a Unique Sample is Optional The number of medical records, on average, that an issuer reviews to determine measure compliance (as determined by the issuer)	335	330	411

*Though there are eight hybrid measures in the final QRS measure set, the use of the hybrid data collection is optional for these measures. CMS burden calculations include the hybrid data collection option for these eight measures to account for QHP issuers that may choose to supplement administrative data.

CMS conducted interviews with issuers that had experience with performance measures data collection and other technical experts to confirm the data collection process and the associated burden. These estimates are based on similar reporting programs, and the data collection process has deviated only slightly from its original structure. The following data collection process steps served as the basis for estimating labor hours:

- Preparation of IT Systems for Data Collection
- Data Collection – Administrative Method
- Data Collection – Medical Record Method
- Data Aggregation and Quality Assurance
- Data Validation
- Data Submission

Previous estimates assumed that issuers would report QRS measure data to CMS by product type (HMO, POS, PPO, and/or EPO); thus, the estimates used a weighting factor to represent the workload for issuers with multiple product types to report hybrid measures. However, the additional burden created by reporting of multiple product types is negligible for data collected via the administrative method. Because all QRS measures can be reported via the administrative method, CMS removed this weighting factor.

---

[6] Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 FR 30352 (May 27, 2014).

[7] *Final 2017 Call Letter for the QRS and QHP Enrollee Survey* and *Final 2018 Call Letter for the QRS and QHP Enrollee Survey*.

Exhibit 2 includes the labor categories and wage rates used to derive the burden estimate. The categories are based on those cited by the Department of Labor, Bureau of Labor Statistics (BLS). A sample of issuers informed modifications to the function descriptions associated with each category so that they aligned more with data collection of performance measures. Wages are based on BLS wage statistics as of May 2017 (published in March 2018). The 75th percentile is used for hourly wages to generate a conservative burden estimate. This burden estimate represents the average, annual cost for an issuer over the 2019-2022 QRS reporting period.

Since wage data were taken from 2018 BLS reports (the most recent data available), the model includes a wage growth factor to account for the anticipated changes in total compensation. The wage growth factor was determined by averaging annual growth rates of total compensation between 2009 Quarter 1 to 2018 Quarter 1, as supplied by BLS. Additionally, CMS updated overhead and fringe benefits to 100% to calculate the total hourly wage rate based on OMB guidance.

Due to the decrease in overall measures by 6% and changes to the requirements for the use of the hybrid data collection method (i.e., the use of the hybrid data collection is now optional for eight measures),[8] CMS revised the burden estimate accordingly. The revised annual labor hours and associated costs are reflected in Exhibit 2.

Exhibit 2. Labor Categories and Wage Rates

Labor Category	Function	Hourly Wage[9]	Hourly Wage Rate for Period 2019-2022[10]	Total Hourly Wage Rate for Period 2019-2022[11]
General and Operations Manager	Formulate policies, manage daily operations, and plan the use of materials and human resources.	$75.28	$81.50	$162.99
Computer Programmer	Modify and test code. Use statistical methods to organize, interpret, QA, and summarize data.	$84.56	$91.54	$183.08
Business Operations Specialist, Other	Train reviewers. Review and over-read charts for quality assurance.	$44.90	$48.61	$97.22
Registered Nurse	Review medical records for measure data collection.	$41.33	$44.74	$89.49
Medical Records and Health Information Analyst	Compile, process, review, and maintain medical records and patient information.	$24.69	$26.73	$53.46

The estimated annual cost burden for issuers is based on an average of estimates provided by a sample of issuers. The sample was composed of issuers that have experience with collection of performance measure data, which represents the majority of issuers that will report QRS

[8] Data collection for hybrid measures requires a greater level of effort than for administrative measures. As CMS no longer requires reporting for any QRS measure via the hybrid method, CMS adjusted the burden estimate accordingly.

[9] 75th percentile is referenced. Data source: http://www.bls.gov/oes/current/oes_stru.htm

[10] Hourly wage + wage growth factor of 2.00%. Wage growth factor data source: BLS 2009 Q1 to 2018 Q1 - http://www.bls.gov/ncs/ect/data.htm

[11] Hourly wage rate for period + overhead & fringe benefit rate of 100%. Overhead & fringe benefit data source: OMB.

measures data. Each issuer estimated labor hours for each applicable labor category involved with the data collection process. Estimates assumed that issuers would follow usual practices of contracting with a third party for data validation and using existing program data submission tools with which they are familiar. Exhibit 3 displays the estimated annual cost burden for a single issuer and includes the labor hours per labor category (for internal staff).

Exhibit 3. Annual Estimated Cost Burden for One Issuer

	Internal Staff					Third-Party Validator
	General and Operations Manager	Computer Programmer	Business Operations Specialist, Other	Registered Nurse	Medical Records and Health Information Analyst	
Total Hours by Labor Category	194	315	136	544[12]	154[13]	
Total Hourly Wage Rate	$162.99	$183.08	$97.22	$89.49	$53.46	
Subtotal Cost	$31,620	$57,670	$13,222	$48,683	$8,233	$12,500
Total Cost	$171,928					

For one QHP issuer, the burden to collect and report data for the QRS is estimated to take approximately 1,343 hours and $171,928 each year. Therefore, the total annual hour and cost burden for 250 issuers is 335,750 hours and $42,982,000.

II. *Implementation and Reporting for the Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey)*

The estimated annual hour and cost burden for an issuer to collect, validate, and submit data for the QHP Enrollee Survey includes contracting with an HHS-approved QHP Enrollee Survey vendor, contracting with an auditor, generating the sampling frame data, reviewing survey materials, authorizing its contracted survey vendor, and signing off on the data to be submitted to HHS.

The QHP Enrollee Survey is largely based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0 Health Plan Survey, which the majority of issuers already have experience with. Therefore, the burden estimates are similar to established CAHPS® survey estimates for health plans, such as those approved under OMB Control Number 0938-0732 (Medicare CAHPS® surveys). **It is estimated that an issuer takes an average of 50 hours a year for the QHP Enrollee Survey. For the estimated 250 QHP issuers, the total annual burden is 12,500 hours. As summarized in Exhibit 4, it is estimated that it costs an issuer $4,861 each year for a total annual cost of $1,215,250 for 250 issuers.**[14]

Exhibit 4. Annual Estimated Hour and Cost Burden for QHP Issuers for the QHP Enrollee Survey

[12] The total hours estimate for registered nurses was calculated based on the assumption that, collectively, QHP issuers will elect to submit hybrid measures via the hybrid method for approximately 50% of the applicable measures.

[13] The total hours estimate for medical records and health information analysts was calculated based on the assumption that, collectively, QHP issuers will elect to submit hybrid measures via the hybrid method for approximately 50% of the applicable measures.

[14] 100% overhead and fringe benefit rate is being used.

Issuer Activity	Number of Respondents	Hours per response	Total Burden Hours	Total Hourly Wage Rate for Period 2019 – 2022 (Business Operations Specialist, Other)[15]	Total Cost Burden
Contracting with HHS-approved QHP Enrollee Survey vendor	250	6	1500	$97.22	$145,830
Contracting with auditor	250	6	1500	$97.22	$145,830
Generating sampling frame	250	32	8000	$97.22	$777,760
Reviewing survey materials	250	4	1000	$97.22	$97,220
Authorizing survey vendor and signing off on data to be submitted	250	2	500	$97.22	$48,610
Total		50	12,500		$1,215,250

III. Monitoring and Appeals Process for Survey Vendors

The estimated annual hour and cost burden for a survey vendor to provide information for HHS to determine continued compliance with approval criteria and QHP Enrollee Survey vendor minimum business requirements is approximately 12 hours and $1,166.64 for an estimated 12 vendors, as summarized in Exhibit 5. It is estimated that approximately two vendors may file an appeal each year, if not approved by HHS to be an QHP Enrollee Survey vendor. However, this is a conservative estimate as no appeals have been filed as of developing this documentation. The annual hour and cost burden for those two vendors filing an appeal is estimated to be two hours and $194.44. **Therefore, the total annual estimated hour and cost burden for vendor monitoring and appeals is 14 hours and $1,361.08.**

Exhibit 5. Annual Estimated Hour and Cost Burden for HHS Vendor Monitoring and Appeals

Vendor Activity	Number of Respondents	Hours per response	Total Burden Hours	Total Hourly Wage Rate for Period 2019 – 2022 (Business Operations Specialist, Other)	Total Cost Burden
Compliance with monitoring	12	1	12	$97.22	$1166.64
Filing an appeal	2	1	2	$97.22	$194.44
Total	14		14		$1361.08

IV. Patient Safety Reporting Standards for QHP Issuers

In the HHS 2017 Payment Notice final rule,[16] we describe the information collection, recordkeeping, and disclosure requirements a QHP issuer must meet to demonstrate compliance with the patient safety standards outlined in §156.1110. The burden estimate associated with these standards includes the time and effort required for QHP issuers to maintain and submit information, such as a hospital attestation or a copy of the current agreement to partner with a PSO, a Hospital Improvement Innovation Network, or a Quality Innovation Network-Quality

[15] See Exhibit 2 for details on Total Hourly Wage Rate for Period 2019-2022

[16] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Final Rule, 81 FR 12203 (March 8, 2016).

Improvement Organization, to the Exchange that demonstrates that each of its contracted hospitals with greater than 50 beds meets the patient safety standards in §156.1110(a)(2) for plan years beginning on or after January 1, 2017. We expect QHP issuers to already be collecting network provider information, which is accounted for in the Supporting Statement associated with OMB Control Number 0938-1156.

There is a wide range of numbers of relevant hospitals with greater than 50 beds across states, from only one in some states to more than 300 hospitals in other states. We estimate that a total of 250QHP issuers, offering 10 plans as potential QHPs, would each take approximately an average of two hours to collect, maintain, and submit applicable hospital agreements or information as finalized in §156.1110 for their QHPs. At an hourly billing rate of $97.22, we estimate the total annual cost for a QHP issuer to be $194.44. **Therefore, as summarized in Exhibit 6, we estimate the total annual cost and annual burden to be $48,610 and 500 hours.**

Exhibit 6. Annual Estimated Hour and Cost Burden for QHP Issuer Patient Safety Reporting

Activity	Number of Respondents	Hours per response	Total Burden Hours	Total Hourly Wage Rate for Period 2019 – 2022 (Business Operations Specialist, Other)	Total Cost Burden
QHP issuers collect and maintain information such as applicable hospital agreements	250	1	250	$97.22	$24,305
QHP issuers submit this data to HHS and an Exchange	250	1	250	$97.22	$24,305
Total		2	500		$48,610

13. Estimates of other Total Annual Cost Burden to Respondents or Record Keepers/Capital Costs

We anticipate that capital costs would be incurred in the initial year(s) by issuers with limited experience in quality measure collection and submission as they develop their data collection systems and processes. These issuers will need to purchase and install software for QRS measure data collection. The anticipated cost for this purchase and installation is approximately $80,000.

These issuers would also incur an additional $10,000 cost for third-party validation since validators may initially set higher fees for these issuers, given the increased resources needed to validate new systems and processes. Capital costs also include annual third-party validation costs, which are estimated to be $12,500 for issuers. Issuers would also have to contract with a QHP Enrollee Survey vendor, which is estimated to be approximately $16,000 annually. We estimate that these vendor contracting costs are conservative since issuers already contract with survey vendors to administer other similar CAHPS® surveys and may not have to contract with additional new vendors for the QHP Enrollee Survey.

14. Annualized Cost to Federal Government

We estimate that the operations, maintenance, and data collection costs associated with this information collection to the Federal Government include contract costs for the QRS measure

collection and reporting, as well as the time and cost for one GS-13, one GS-14, and one GS-15 position for data processing, managerial review, and oversight, as summarized in Exhibit 7. The calculations for federal employees' hourly salary are obtained from the OPM website, with an additional 100% to account for overhead and fringe benefits.

Exhibit 7. Summary of Annualized Cost for Information Collection to the Federal Government

Task	Estimated Cost
Data Processing, Managerial Review, and Oversight	
1 GS-13, Step 1: $72.50 X 20 hrs	$1,450
1 GS-14, Step 1: $85.64 X 20 hrs	$1,713
1 GS-15, Step 1: $100.74 X 5 hrs	$504
QRS measure collection and reporting	$778,446
QHP Enrollee Survey data collection	Already accounted for in OMB Control #0938-1221
Total Costs to Government	**$782,113**

15. Changes to Burden

This is a decrease to the burden hour estimates approved in OMB control number 0938-1249. The total annual burden hour estimate (for the total estimated 264 respondents) associated with this revised information collection is 348,764 hours; and the total annual cost estimate associated is $44,247,221. The modifications to the QRS, QHP Enrollee Survey patient safety reporting associated information collection, based on the past three years of implementation of the programs, would result in an annual estimate decrease in burden hours of 736,306 hours (QRS implementation and reporting decreased by 716,500 hours [1,052,250 - 335,750 hours]; QHP Enrollee Survey implementation and reporting decreased by 18,550 hours [31,050 - 12,500 hours]; monitoring and appeals process for survey vendors decreased by 31 hours [45 - 14 hours]); patients safety reporting for issuers decreased by 1225 hours [1725-500 hours] and decrease in cost burden of $30,775,569 for QHP issuers (QRS implementation and reporting decreased by $31,106,175 [$74,088,175 - $42,982,000]; QHP Enrollee Survey implementation and reporting increased by $439,230 [$776,020 - $1,215,250]; monitoring and appeals for survey vendors increased by $276 [$1085 - $1361]); and patient safety reporting cost burden decreased by $108,900 [$157,510 - $48,610].

16. Publication/Tabulation Dates

Using the data collected for the QRS, HHS calculates ratings associated with the QRS according to a standard rating methodology. CMS displayed quality rating information during a QRS pilot test on HealthCare.gov for select states during the 2017, 2018, and 2019 open enrollment periods. In the future, CMS intends to display the QRS global ratings and three summary indicator ratings on HealthCare.gov. Additionally, SBEs and web-brokers that use direct enrollment to facilitate enrollments through the FFEs and SBE-FPs are directed to display QHP quality rating information on their respective websites.

The publication activities for the QHP Enrollee Survey are already addressed in the Supporting Statement associated with OMB control number: 0938-1221. We do not intend to publish any data associated with the monitoring and appeals process for survey vendors and for QHP patient safety reporting standards.

17. Certification Statement

The expiration date and OMB control will appear on the first page of the instrument.