Supporting Statement – Part A
Transparency in Pricing Information
(CMS-10715/OMB control number 0938-New)

A. Background

The Patient Protection and Affordable Care Act, Pub. L. 111-148, was enacted on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, was enacted on March 30, 2010 (collectively known as the "Affordable Care Act"). The Affordable Care Act reorganizes, amends, and adds to the provisions of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The Affordable Care Act amends the PHS Act by adding section 2715A, providing that group health plans and health insurance issuer offering group or individual coverage shall comply with section 1311(e)(3) of PPACA, except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and the State insurance commissioner, and make such information available to the public. Section 1311(e)(3) of PPACA addresses transparency in health care coverage and imposes certain reporting and disclosure requirements for health plans that are seeking certification as qualified health plans (QHPs) that may be offered through an Exchange.

On March 27, 2012, the Department of Health and Human Services (HHS) issued a final rule that implemented sections 1311(e)(3)(A)-(C) of PPACA at 45 CFR 155.1040(a)-(c) and § 156.220 and created standards for QHP issuers to submit specific information related to transparency in coverage. In the preamble to the 2012 final rule, HHS noted that the standards set forth in that rule are, generally, strictly related to QHPs certified to be offered through an Exchange and not the entire individual and small group market. We further noted that policies for the entire individual and small and large group markets would continue to be addressed in separate rulemaking issued by HHS, and the Departments of Labor and the Treasury (collectively known as "the Departments"). In the HHS 2020 Notice of Benefit and Payment Parameters (NBPP) proposed rule,[1] HHS sought input on ways to provide consumers with greater transparency with regard to their own health care data, QHPs offered through the Federally-facilitated Exchange, and the cost of health care services. We additionally sought comments on ways to further implement section 1311(e)(3) of PPACA.

On June 24, 2019, President Trump issued Executive Order 13877, "Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First."[1] Section 3(b) of Executive Order 13877 directs the Secretaries of the Departments to issue an advance notice of proposed rulemaking (ANPRM), consistent with applicable law, soliciting

1 84 Fed. Reg. 227 (Jan. 24, 2019).

comment on a proposal to require health care providers, health insurance issuers, and self-insured group health plans to provide or facilitate access to information about expected out-of-pocket costs for items or services to patients before they receive care. The proposed rule titled "Transparency in Coverage (CMS-9915-P/RIN: 0938-AU04)," would fulfill the Departments' responsibility under Executive Order 13877 as well as implement legislative mandates under sections 1311(e)(3) of PPACA and section 2715A of the PHS Act that establish transparency requirements for group health plans and health insurance issuers offering group and individual coverage that are not limited to QHPs, specifically with respect to the transparency requirements regarding cost sharing under PPACA section 1311(e)(3)(C). Finally, the proposed rule would promote greater transparency in health care pricing, a critical piece of the Administration's strategy for reforming health care markets by promoting competition and choice in the health care industry.

B. Justification

1 . Need and Legal Basis

The Departments are publishing the notice of proposed rulemaking (NPRM), as required by Section 3(b) of Executive Order 13877, to promote greater transparency in health care pricing, a critical piece of the Administration's strategy for reforming health care markets by promoting competition and choice in the health care industry through policies and rules that would enable, empower, and incentivize consumers to make informed choices about their health care.

The NPRM requires disclosure of health care pricing information, effectuating the Departments' previously expressed intent to engage in rulemaking to implement PPACA section 1311(e)(3) pursuant to PHS Act section 2715A that establish transparency requirements for group health plans and health insurance issuers offering group and individual coverage that are not limited to QHPs, specifically with respect to the transparency requirements regarding cost sharing under PPACA section 1311(e)(3)(C).

Group health plans and health insurance issuers in the individual and group markets would be required to disclose to a participant, beneficiary, enrollee, or an authorized representative on behalf of such individual, the consumer-specific estimated cost sharing liability for covered items and services from a particular provider or providers. Group health plans and health insurance issuers would be required to make such information available for all covered items and services through an internet-based self-service tool and, upon an individual's request, in paper form, thereby allowing a participant, beneficiary, or enrollee to obtain an accurate estimate and understanding of their cost-sharing liability and to effectively shop for covered items and services based on price. Additionally, group health plans and health insurance issuers would be subject to requirements that they disclose negotiated rates with in-network providers and historical allowed amount payments made to out-of-network providers through two machine-readable files as specified in the Negotiated Rate File Data Element Guidance

and the Out of Network Allowed Amount File Data Element Guidance. The machine-readable files would have to be posted publicly on an internet website.

2. Information Users

Participants, beneficiaries, and enrollees would have easier access to health care pricing information, including consumer-specific cost-sharing amounts for all items and services covered by their plan or coverage, negotiated rates for all covered items and services provided by in-network providers, and data related to historical payments made to out-of-network providers by a plan or issuer. This information would enable participants, beneficiaries, and enrollees to evaluate options for receiving health care and to make cost-conscious decisions; and reduce surprises in relation to their out-of-pocket costs for health care services.

In the private health insurance market, over time consumers are becoming responsible for an increasing share of their health care costs through higher deductibles and shifts from copayments to coinsurance in plan benefit design. Therefore, many consumers' out-of-pocket liability is often directly contingent upon the reimbursement rate their health plan or coverage has negotiated with the in-network provider. Additionally, public availability of pricing information, would further allow insured and uninsured consumers to have access to health insurance coverage information that can be used to understand health care pricing and potentially dampen the rise in health care spending. If consumers have better information to shop for health care items and services more efficiently, they can create more competition and demand for lower prices.

Further, state and federal enforcement agencies may be able to use the publicly available information, in conjunction with consumer complaints, to determine if premium rates are set appropriately.

Third party developers would have access to all in-network negotiated rates and out-of-network allowed amounts by payer for the first time for the purpose of developing and building innovative price comparison web-based tools that can encourage consumers to make health care decisions based on cost, among other factors. Researchers would have better information on regional and local health care costs, including in-network negotiated rates and out-of-network paid amounts, which may lead to a better understanding of price dispersion and economic factors that may result in artificially inflated costs.

3. Use of Information Technology

Specific information listed in the proposed rule would have to be made available through a self-service tool made available by the group health plan or health insurance issuer on an internet website. The same information would have to also be made available through a mailed paper form. Standards for the paper method of disclosure are provided in the proposed rule.

Group health plans and health insurance issuers would have to publicly disclose for each covered service or item the negotiated rates for services and items furnished by an in-network provider and certain historical allowed amount payment data for each covered service or item furnished by out-of-network providers through two machine-readable files in a format to be specified by the Departments through the Negotiated Rate File Data Element Guidance and the Out of Network Allowed Amount File Data Element Guidance. The negotiated rate and allowed amount machine-readable file(s) would have to be posted on a public internet site without restricted access, searchable by electronic means, and updated monthly.

The Departments are proposing to define a machine-readable format as a digital representation of data or information in a file that can be imported or read into a computer system for further processing without human intervention while ensuring no semantic meaning is lost. Examples of machine readable formats include, but are not limited to, .XML, JSON and .CSV formats. The Departments indicated that the requirements for the machine-readable file(s) would be sufficiently defined and standardized under the Departments' Negotiated Rate File Data Element Guidance and Out of Network Allowed Amount File Data Element Guidance.

4. Duplication of Efforts

A group health plan or health insurance issuer that is required to provide certain disclosures with respect to an individual satisfies the requirement if another party, such as an issuer or third party administrator (TPA), provides the required disclosures and does so in a specific manner.

5. Small Businesses

Information that plans are required to disclose is generally readily available to group health plans or their TPAs and health insurance issuers, which reduces the burden of compliance. The rule also permits other parties such as issuers or TPAs to provide the information on behalf of plans. This would allow issuers or TPAs to leverage economies of scale to provide the same service to many small plans or issuers, thus reducing the overall burden of the proposed rules. In addition, while the requirements of the proposed rules do not apply to providers, providers may experience a loss in revenue as a result of the demands of the price-sensitive consumer and self-insured group health plans, and because smaller health insurance issuers may be unwilling to continue paying higher rates than larger health insurance issuers for the same items and services.

6. Less Frequent Collection

The goal of reducing the cost of health care depends in part on participants, beneficiaries, and enrollees making choices about which health care services to purchase and from which service provider based on cost. The availability of real-time, consumer-friendly information and the negotiated rates for in-network providers and the amounts paid to out-of-network

providers is needed to provide consumers with meaningful information to allow them to make cost-conscious health care purchasing decisions.

7. Special Circumstances

This information collection is not considered a special circumstance. In addition to requesting public comment on the proposed regulation, the NPRM solicits public comment on the paperwork burden of the proposed regulation. It provides the public with 60 days for that purpose, as required by 5 CFR 1320.8(d).

8. Federal Register/Outside Consultation

The associated Notice of Proposed Rulemaking (NPRM) was published on **[MONTH DAY, YEAR]**. The NPRM solicits public comment on the proposed collections of information for 60-days.

No additional outside consultation was sought.

9. Payments/Gifts to Respondents

There are no payments or gifts associated with this collection.

10. Confidentiality

The Departments will comply with all Privacy Act, Freedom of Information laws and regulations that apply to this collection.

11. Sensitive Questions

There are no questions of a sensitive nature associated with this information collection.

12. Burden Estimates (Hours & Wages)

CMS has accounted for its share of the cost and burden related to these ICRs. However, because CMS is submitting these ICRs through the common form process, other Departments and Agencies may account for additional burdens and costs related to these ICRs. In particular, CMS expects the Departments of Labor and the Treasury to adopt their respective burdens related to these ICRs.

A. Wage Rate Data

To derive wage estimates, CMS generally used data from the Bureau of Labor Statistics to derive average labor costs (including a 100 percent increase for fringe benefits and overhead)

for estimating the burden associated with the ICRs.[2] Table 1 presents the mean hourly wage, the cost of fringe benefits and overhead, and the adjusted hourly wage.

As indicated, employee hourly wage estimates have been adjusted by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly across employers, and because methods of estimating these costs vary widely across studies. CMS is of the view that doubling the hourly wage to estimate total cost is a reasonably acceptable estimation method.

TABLE 1: Adjusted Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Mean Hourly Wage ($/hour)	Fringe Benefits and Overhead ($/hour)	Adjusted Hourly Wage ($/hour)
General and Operations Manager	11-1021	$59.56	$59.56	$119.12
Computer and Information Systems Manager	11-3021	$73.49	$73.49	$146.98
Computer Programmer	15-1131	$43.07	$43.07	$86.14
Computer System Analyst	15-1121	$45.01	$45.01	$90.02
Web Developer	15-1134	$36.34	$36.34	$72.68
Business Operations Specialist	13-1199	$37.00	$37.00	$74.00
Other Office and Administrative Support Workers	43-9000	$17.28	$17.28	$34.56
Lawyer	23-1011	$69.34	$69.34	$138.68
Chief Executive Officer	11-1011	$96.22	$96.22	$192.44
Information Security Analysts	15-1122	$49.26	$49.26	$98.52
Customer Service Representatives	43-4051	$17.53	$17.53	$35.06

Each group health plan and health insurance issuer would have to disclose consumer-specific estimated cost-sharing information for all covered items or services from a particular provider or providers, as well as allowed amounts for covered items and services for out-of-network providers. Group health plans and health insurance issuers would have to make this information available to participants, beneficiaries, enrollees, or their authorized representatives through an internet-based self-service tool and would have to also be able to provide this information in a paper form, upon request. Both the internet-based self-service tool and the paper form would have to include a notice with several statements, written in plain language, which includes disclaimers relevant to information provided through the disclosure. These notice statements, which could be provided by using a model notice established by CMS, would be required to include a statement related to the potential for providers to practice balance billing, a statement that the actual charges may differ from the disclosed estimates, a statement that the stated estimate is not a guarantee that benefits will be provided for those items and services, and a statement that provides any additional

2 See May 2018 Bureau of Labor Statistics, Occupational Employment Statistics, National Occupational Employment and Wage Estimates. Available at: https://www.bls.gov/oes/current/oes_stru.htm.

information or disclaimers that the group health plan or health insurance issuer determines is appropriate as long as such information is not in conflict with the disclosure requirements of the proposed rules. Additionally, group health plans and health insurance issuers would be subject to requirements to disclose, for all covered items and services, negotiated rates with in-network providers and certain historical amounts paid to out-of-network providers through machine-readable files in a format consistent with implementation guidelines established by CMS. The files would have to be posted publicly on an internet website and updated monthly.

B. Collections of Information

1. ICRs Regarding Requirements for Disclosures to Participants, Beneficiaries, or Enrollees (26 CFR 54.9815-2715A, 29 CFR 2590.715-2715A, and 45 CFR 147.210(b))

CMS assumes fully-insured group health plans would rely on health insurance issuers to develop and maintain the internet-based self-service tool and paper form disclosures. While CMS recognizes that some self-insured plans might independently develop and maintain the internet-based self-service tool, at this time CMS assumes that self-insured group health plans would rely on TPAs (including issuers providing administrative services only and non-issuer TPAs) to develop the required internet-based self-service tool. CMS makes this assumption because we are of the view that most self-insured plans rely on TPAs for performing most administrative duties, such as enrollment and claims processing. For those self-insured plans that choose to develop their own internet-based self-service tools, CMS assumes that they would incur a similar hour burden and cost as estimated for issuers and TPAs as discussed below. In addition, paragraphs (b)(3) and (c)(4) of the proposed rules provide for a special rule to prevent unnecessary duplication of the disclosures with respect to health coverage, which provide that a group health plan may satisfy the disclosure requirements if the issuer offering the coverage is required to provide the information pursuant to a written agreement between the group health plan and the health insurance issuer. Thus, CMS uses health insurance issuers and TPAs as the unit of analysis for the purposes of estimating required changes to IT (information technology) infrastructure and administrative hourly burden and costs. Based on recent data, CMS estimates approximately 877 issuers[3] and 103 TPAs[4] would be affected by this information collection.

CMS acknowledges that the costs described in these information collection requests (ICRs) may vary depending on the number of lives covered, the number of providers and services incorporated into the internet-based self-service tool, and the fact that some plans and issuers already have tools that meet most (if not all) of these requirements or can be easily adapted to meet the requirements of the proposed rules. In addition, group health plans and health insurance issuers may be able to license existing online cost estimator tools offered by third-party vendors, obviating the need to establish and maintain their own internet-based self-service tool. CMS assumes that any related vendor licensing fees would be dependent upon complexity, volume, and frequency of use, but assume that such fees would be lower than an

3 2018 MLR Data Trends.

4 Non-issuer TPAs based on data derived from the 2016 Benefit Year reinsurance program contributions.

overall initial build and associated maintenance costs. Nonetheless, for purposes of the estimates in these ICRs, CMS assumes all 980 issuers and TPAs would be affected by the proposed rules. CMS also developed the following estimates based on the mean average size, by covered lives, of issuers or TPAs.

Issuers and TPAs would incur a one-time cost and hour burden to complete the technical build to implement the requirements of paragraph (b) of the proposed rules to establish the internet-based self-service tool and the non-internet method through which disclosure of cost-sharing information (including required notices) in connection with a covered item or service under the terms of the plan or coverage would have to be made. CMS estimates an administrative burden on health insurance issuers and TPAs to make appropriate changes to IT systems and processes to design, develop, implement, and operate the internet-based self-service tool and to make this information available in paper form, transmitted through the mail. CMS estimates that the one-time cost and burden each issuer or TPA would incur to complete the one-time technical build would include activities such as planning, assessment, budgeting, contracting, building and systems testing, incorporating any necessary security measures, incorporating disclaimer and model notice language, or development of the proposed model and disclaimer notice materials for those that choose to make alterations. CMS assumes that this one-time cost and burden would be incurred in 2020.

As mentioned above, CMS acknowledges that a number of issuers and TPAs have previously developed some level of cost estimator tool similar to, and containing some functionality related to, the requirements in the proposed rules. In order to develop the hourly burden and cost estimates, CMS assumes that all issuers and TPAs would need to develop and build their internet-based self-service tool project from start-up to operational functionality. CMS estimates that for each issuer or TPA, on average, it would take business operations specialists 150 hours (at $74 per hour), computer system analysts 1,000 hours (at $90.02 per hour), web developers 40 hours (at $72.68 per hour), computer programmers 1,250 hours (at $86.14 per hour), computer and information systems managers 40 hours (at $146.98 per hour), operations managers 25 hours (at $119.12 per hour), a lawyer 2 hours (at $138.68 per hour), and a chief executive officer 1 hour (at $192.44 per hour) to complete this task. CMS estimates the total hour burden per issuer or TPA would be approximately 2,508 hours, with an equivalent cost of approximately $221,029. For all 877 issuers and 103 TPAs, the total one-time total hour burden is estimated to be 2,456,586 hours with an equivalent total cost of approximately $216,498,101.

TABLE 2: Total Estimated One-time Cost and Hour Burden for Internet-based Self-Service Tool for All Issuers and TPAs

Number of Respondents	Number of Responses	Burden Hours Per Respondent	Total Burden Hours	Total Cost
980	980	2,508	2,456,586	$216,498,101

In addition to the one-time cost and hour burden estimated above, issuers and TPAs would incur ongoing annual costs such as those related to ensuring cost estimation accuracy,

providing quality assurance, conducting website maintenance and making updates, and enhancing or updating any needed security measures. CMS estimates that for each issuer and TPA, on average, it would take business operations specialists 15 hours (at $74.00 per hour), computer systems analysts 50 hours (at $90.02 per hour), web developers 10 hours (at $72.68 per hour), computer programmers 55 hours (at $86.14 per hour), computer and information systems managers 10 hours (at $146.98), and operations managers 5 hours (at $119.12 per hour) each year to perform these tasks. The total annual hour burden for each issuer or TPA would be 145 hours, with an equivalent cost of approximately $13,141. For all 877 issuers and 103 TPAs, the total annual hour burden is estimated to be 142,028 hours with an equivalent total annual cost of approximately $12,871,512. CMS considers this to be an upper-bound estimate and expect maintenance costs to decline in succeeding years as issuers and TPAs gain efficiencies and experience in updating and managing their internet-based self-service tool.

TABLE 3: Estimated Annual Hour Burden for Maintenance of Internet-based Self-Service Tool for All Issuers and TPAs from 2021 onwards

Number of Respondents	Number of Responses	Burden Hours Per Respondent	Total Burden Hours	Total Cost
980	980	145	142,028	$12,871,512

CMS estimates the average annual total burden, for all 980 issuers and TPAs, over 3 years would be 913,547 hours with an average annual total cost of $80,747,042.

TABLE 4: Estimated Three Year Average Annual Hour Burden and Costs for All Issuers and TPAs to Develop and Maintain the Internet-based Self-Service Tool

Year	Number of Respondents	Responses	Burden per Respondent (hours)	Total Annual Burden (hours)	Total Estimated Labor Cost
2020	980	980	2,508	2,456,586	$216,498,101
2021	980	980	145	142,028	$12,871,512
2022	980	980	145	142,028	$12,871,512
3 year Average	980	980	933	913,547	$80,747,042

In addition to the one-time and annual maintenance costs estimated above, issuers and TPAs would also incur an annual burden and cost associated with customer service representative training, consumer assistance, and administrative and distribution costs related to the disclosures required under paragraph (b) of the proposed rules. CMS estimates that, to understand and navigate the internet-based self-service tool and be able to provide the appropriate assistance to consumers, each customer service representative would require approximately 2 hours (at $35.06 per hour) of annual consumer assistance training at an associated cost of $70 per hour. CMS estimates that each issuer and TPA would train, on average, 10 customer service representatives annually, resulting in a total annual hour burden of 20 hours and associated total costs of $701 per issuer or TPA. For all 877 issuers and 103 TPAs, the total annual hour burden is estimated to be 14,513 hours with an equivalent total

annual cost of approximately $508,808.

TABLE 5: Estimated Annual Cost and Hour Burden for All Issuers and TPAs from 2021 onwards to Train Customer Service Representatives to Provide Assistance to Consumers Related to the Internet-based Self-Service Tool

Number of Respondents	Number of Responses	Burden Hours Per Respondent	Total Burden Hours	Total Cost
980	9,796	20	19,590	$686,825

CMS estimates the average annual total burden, for all 980 issuers and TPAs, over 3 years would be 13,060 hours with an average annual total cost of $457,884.

TABLE 6: Estimated Three-Year Average Annual Cost and Hour Burden for All Issuers and TPAs to Train Customer Service Representatives to Provide Assistance to Consumers Related to the Internet-based Self-service Tool

Year	Estimated Number of Issuers and TPAs	Responses	Burden per Respondent (hours)	Total Annual Burden (hours)	Total Estimated Labor Cost
2020	0	0	0	0	$0.00
2021	980	9,795	20	19,590	$686,825
2022	980	9,795	20	19,590	$686,825
3 year Average	653	6,530	13	13,060	$457,884

CMS assumes that the greatest proportion of beneficiaries, participants, and enrollees who would request disclosure of cost-sharing information in paper form would do so because they do not have access to the internet. However, CMS acknowledges that some consumers with access to the internet would also contact a group health plan or health insurance issuer for assistance and may request to receive cost-sharing liability information in paper form.

Recent studies have found that approximately 20 million households do not have an internet subscription[5] and that approximately 19 million Americans (6 percent of the population) lack access to fixed broadband services that meet threshold levels.[6] Additionally, a recent Pew Research Center analysis found that 10 percent of U.S. adults do not use the internet, citing the following major factors: difficulty of use, age, cost of internet services, and lack of computer ownership.[7] Additional research indicates that an increasing number, 17 percent, of individuals

5 See 2017 U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates. Available at: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_S2801&prodType=table.

6 See Eight Broadband Progress Report. Federal Communications Commission. December 14, 2018. Available at: https://www.fcc.gov/reports-research/reports/broadband-progress-reports/eighth-broadband-progress-report. In addition to the estimated 19 million Americans that lack access, they further estimate that in areas where broadband is available approximately 100 million Americans do not subscribe.

7 See Anderson, M., Perrin, A., Jiang, J., Kumar, M. “10% of Americans don’t use the internet. Who are they?”

and households are now considered "smartphone only" and that 37 percent of U.S. adults mostly use smartphones to access the internet and that many adults are forgoing the use of traditional broadband services.[8] Further research indicates that younger individuals and households, including approximately 93 percent of households with householders aged 15 to 34, are more likely to have smartphones compared to those aged over 65.[9] CMS is of the view that the population most likely to use the internet-based self-service tool would generally consist of higher income and younger individuals, who are, therefore, more likely to have internet access via broadband or smartphone technologies.

CMS estimates there are 193.5 million[10] beneficiaries, participants, or enrollees enrolled in group health plans or with health insurance issuers required to comply with the requirements under paragraph (b) of the proposed rules. On average, it is estimated that each issuer or TPA would annually administer the benefits for 98,775 beneficiaries, participants, or enrollees.

Assuming that 6 percent of covered individuals lack access to fixed broadband service and taking into account that a recent study noted that only 1 to 12 percent of patients that have been offered internet-based or mobile application-based cost estimator tools use them,[11] CMS estimates that on average 6 percent of beneficiaries would seek customer support (a mid-range percentage of individuals that currently use available cost estimator tools) and that an estimated 1 percent of those beneficiaries would request any pertinent information be disclosed to them in paper form. CMS estimates that each issuer or TPA, on average, would require a customer service representative to interact with a beneficiary, participant, or enrollee approximately 59 times per year on matters related to cost-sharing liability disclosures required by the proposed rules. CMS estimates that each customer service representative would spend, on average, 15 minutes (at $35.06 per hour) for each interaction, resulting in a cost of approximately $9 per interaction. CMS estimates that each issuer or TPA would incur an annual hour burden of 15 hours with an associated equivalent cost of approximately $519 for each issuer or TPA, resulting in a total annual hour burden of 14,513 hours with an

((Pew Research Center. April 22, 2019. Available at: https://www.pewresearch.org/fact-tank/2019/04/22/some-americans-dont-use-the-internet-who-are-they/.

8 See Anderson, M. "Mobile Technology and Home Broadband 2019." Pew Research Center. June 13, 2019. Available at https://www.pewinternet.org/2019/06/13/mobile-technology-and-home-broadband-2019/ (finding that overall 17 percent of Americans are now "smartphone only" internet users, up from 8 percent in 2013. They study also shows that 45 percent of non-broadband users cite their smartphones as a reason for not subscribing to high-speed internet).

9 See Ryan, C. "Computer and Internet Use in the United States: 2016." American Community Survey Reports: United States Census Bureau. August 2016 Available at: https://www.census.gov/content/dam/Census/library/publications/2018/acs/ACS-39.pdf.

10 EBSA estimates that in 2016 there were 135.7 million covered individuals with private sector and 44.1 million with public sector employer sponsored coverage (see https://www.dol.gov/sites/dolgov/files/EBSA/researchers/data/health-and-welfare/health-insurance-coverage-bulletin-2016.pdf). Kaiser Family Foundation reports 13.7 million enrollees in the individual market for the first quarter of 2019 (see: https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/).

11 See Mehrotra, A., Chernew, M., Sinaiko, A. "Health Policy Report: Promises and Reality of Price Transparency." April 5, 2018. 14 N. Eng. J. Med. 378. Available at: https://www.nejm.org/doi/full/10.1056/NEJMhpr1715229.

associated cost of approximately $508,808 for all issuers or TPAs.

TABLE 7: Estimated Annual Cost and Hour Burden for All Issuers and TPAs from 2021 onwards to Accept and Fulfill Requests for Mailed Disclosures

Number of Respondents	Number of Responses	Burden Hours Per Respondent	Total Burden Hours	Total Labor Cost of Reporting
980	58,050	15	14,513	$508,808

CMS estimates the average annual total burden, for all 980 issuers and TPAs, over 3 years would be 9,675 hours with an average annual total cost of $339,206.

TABLE 8: Estimated Three-Year Average Annual Cost and Hour Burden for All Issuers and TPAs to Accept and Fulfill Requests for Mailed Disclosures

Year	Number of Respondents	Responses	Burden per Respondent (hours)	Total Annual Burden (hours)	Total Labor Cost
2020	0	0	0.0	0	$0
2021	980	58,050	15	14,513	$508,808
2022	980	58,050	15	14,513	$508,808
3 year Average	653	38,700	10	9,675	$339,206

2. ICRs Regarding Requirements for Public Disclosure of Negotiated Rates and Historical Allowed Amount Data for Covered Items and Services from Out-of-Network Providers (§ 147.210(c))

As discussed in the previous collection of information, CMS assumes group health plans would rely on health insurance issuers and self-insured plans would rely on issuers or TPAs to develop and update the two proposed machine-readable files. CMS recognizes that there may be some self-insured plans that wish to individually comply with the proposed rules and would incur a similar hour burden and cost as described below.

CMS estimates a one-time hour burden and cost to health insurance issuers and TPAs to make appropriate changes to IT systems and processes, to develop, implement and operate the Negotiated Rate File in order to meet the proposed requirements under paragraphs (c)(1)(i) of the proposed rules related to making available a file including negotiated rates for in-network providers. CMS estimates that for each issuer or TPA, on average, it would require business operations specialists 20 hours (at $74 per hour), computer system analysts 500 hours (at $90.02 per hour), computer programmers 600 hours (at $86.14 per hour), computer and information systems managers 50 hours (at $146.98 per hour) and operations managers 20 hours (at $119.12 per hour) to complete this task. The total burden for each issuer or TPA

would be approximately 1,190 hours on average, with an equivalent associated cost of approximately $107,905. For all 877 issuers and 103 TPAs, CMS estimates the total one-time hour burden would be 1,165,605 hours with an associated cost of approximately $105,693,339.

TABLE 9: Estimated One-Time Cost and Hour Burden for All Issuers and TPAs for the In-Network Providers Negotiated Rates File

Number of Respondents	Number of Responses	Burden Hours Per Respondent	Total Burden Hours	Total Cost
980	980	1,190	1,165,605	$105,693,339

In addition to the one-time costs estimated above, issuers and TPAs would incur ongoing annual burdens and costs to update the proposed Negotiated Rate File monthly as proposed under paragraph (c)(3). CMS estimates that for each issuer or TPA, on average, it would require a general and operations manager 3 hours (at $119.12 per hour), computer systems analysts 10 hours (at $90.02 per hour), computer programmers 10 hours (at $86.14 per hour), a computer and information systems manager 5 hours (at $146.98), and a business operations specialist 2 hours (at a rate of $74.00) to make the required updates to the Negotiated Rate File. CMS estimates that each issuer or TPA would incur a burden of 30 hours with an associated cost of approximately $3,002 to update the Negotiated Rate File.

Assuming issuers and TPAs make changes that would require the Negotiated Rate File to be updated monthly, an issuer or TPA would need to update the Negotiated Rate File 12 times during a given year, resulting in an ongoing annual hour burden of 360 hours for each issuer or TPA with an associated equivalent cost of approximately $36,022. CMS estimates the total annual hour burden for all 980 issuers and TPAs would be 352,620 hours, with an associated equivalent cost of approximately $35,283,862. CMS considers this estimate to be an upper-bound estimate and expect ongoing file update costs to decline in succeeding years as issuers and TPAs gain efficiencies and experience in updating and managing the machine-readable file.

TABLE 10: Estimated Annual OngoingBurden for All Issuers and TPAs from 2021 onwards for the In-Network Providers Negotiated Rate File

Number of Respondents	Number of Responses	Burden Hours Per Respondent	Total Burden Hours	Total Cost
980	11,754	360	352,620	$35,283,862

CMS estimates the total one-time hour burden for all issuers and TPAs of 1,165,605 hours and an associated equivalent cost of approximately $105,693,339 to develop and build the Negotiated Rate File. In subsequent years, CMS estimates the total annual hour burden of 352,620 hours to maintain and update the Negotiated Rate File with an annual associated equivalent cost of approximately $35,283,862. CMS estimates the average annual total hour burden, for all issuers and TPAs, over three years, would be 623,615 hours with an average annual associated equivalent total cost of $58,753,688.

TABLE 11: Estimated Three Year Average Annual Hour Burden and Costs for All Issuers and TPAs to Develop and Maintain the In-Network Providers Negotiated Rate File

Year	Number of Respondents	Responses	Burden per Respondent (hours)	Total Annual Burden (hours)	Total Estimated Labor Cost
2020	980	980	1,190	1,165,605	$105,693,339
2021	980	11,754	360	352,620	$35,283,862
2022	980	11,754	360	352,620	$35,283,862
3 year Average	980	8,163	637	623,615	$58,753,688

CMS estimates a one-time hour burden and cost to health insurance issuers and TPAs to make appropriate changes to IT systems and processes, to develop, implement, and operate the Allowed Amount File in order to meet the proposed requirements under paragraph (c)(1)(ii) of the proposed rules related to making available a file of certain historical claims paid to out-of-network providers. CMS estimates that each issuer or TPA, on average, would require business operations specialists 20 hours (at $74 per hour), computer system analysts 500 hours (at $90.02 per hour), computer programmers 600 hours (at $86.14 per hour), computer and information systems managers 50 hours (at $146.98 per hour), information security analysts 100 hours (at $98.52 per hour), and operations managers 20 hours (at $119.12 per hour) to complete this task. The total burden per issuer or TPA would be approximately 1,290 hours on average, with an equivalent associated cost of approximately $117,757. For all 877 issuers and 103 TPAs, CMS estimates the total one-time hour burden would be 1,263,555 hours with an equivalent associated cost of approximately $115,343,3739,727.

TABLE 112: Estimated One-Time Cost and Hour Burden for All Issuers and TPAs for the Out-of-Network Allowed Amount File

Number of Respondents	Number of Responses	Burden Hours Per Respondent	Total Burden Hours	Total Cost
980	980	1,290	1,263,555	$115,343,373

In addition to the one-time costs estimated above, issuers and TPAs would incur ongoing annual burdens and costs to update the proposed Allowed Amount File monthly as proposed under paragraph (c)(3). CMS estimates that for each issuer or TPA, on average, it would require a computer systems analysts 5 hours (at $90.02 per hour), computer programmers 5 hours (at $86.14 per hour), a computer and information systems manager 1 hour (at $146.98), and an information security analyst 2 hours (at $98.52 per hour to make the required Allowed Amount File updates. CMS estimates that each issuer or TPA would incur a monthly burden of 13 hours with an equivalent associated cost of approximately $1,224 to update the Allowed Amount File. Assuming issuers and TPAs make changes that would require the file to be updated monthly per the requirements in the proposed rules an issuer or TPA would need to update the Allowed Amount File 12 times during a given year, resulting in an ongoing annual burden of approximately 156 hours for each issuer or TPA with an equivalent associated cost of approximately $14,698. CMS estimates the total annual hour burden for all 980 issuers and TPAs would be 152,802 hours with an equivalent associated cost of

approximately $14,396,534. CMS considers this estimate to be an upper-bound estimate and expect ongoing Allowed Amount File update costs to decline in succeeding years as issuers and TPAs gain efficiencies and experience in updating and managing the digital file.

TABLE 13: Estimated Annual Ongoing Cost and Burden for All Issuers and TPAs from 2021 onwards for the Out-of-Network Allowed Amount File

Number of Respondents	Number of Responses	Burden Hours Per Respondent	Total Burden Hours	Total Cost
980	11,754	156	152,802	$14,396,534

CMS estimates the total one-time hour burden for all issuers and TPAs of 1,263,555 hours and an equivalent associated cost of approximately $115,343,373 to develop and build the Allowed Amount File to meet the requirements of the proposed rules. In subsequent years, CMS estimates the total annual hour burden of 152,802 hours to maintain and update the Allowed Amount File with an annual equivalent associated cost of approximately $14,396,534. CMS estimates the average annual total hour burden, for all issuers and TPAs, over 3 years, would be 523,053 hours with an average annual total equivalent associated cost of $48,045,481.

TABLE 14: Estimated Three Year Average Annual Hour Burden and Costs for All Issuers and TPAs to Develop and Maintain the Out-of-Network Allowed Amount File

Year	Number of Respondents	Responses	Burden per Respondent (hours)	Total Annual Burden (hours)	Total Estimated Labor Cost
2020	980	980	1,290	1,263,555	$115,343,373
2021	980	11,754	156	152,802	$14,396,534
2022	980	11,754	156	152,802	$14,396,534
3 year Average	980	8,162	534	523,053	$48,045,481

TABLE 16: Estimated Three Year Average for All Proposed Annual Recordkeeping and Reporting Requirements

	Number of Respondents	Responses	Burden per Respondent (hours)	Total Annual Burden (hours)	Total Estimated Labor Cost
Internet-based Self-Service Tool	980	980	933	913,547	$80,747,042
Customer Service Representatives And Consumer Assistance	633	6,530	13	13,060	$457,884
Requests for Mailed Disclosures	653	38,700	10	9,675	$339,206
In-Network Providers Negotiated Rate File	980	8,163	637	623,615	$58,753,688
Out-of-Network Allowed Amount File	980	8,162	534	523,053	$48,045,481
Total		62,535	2,127	2,082,950	$188,343,301

13. Capital Costs

CMS also estimated the cost burden associated with the printing and distribution of the disclosure of pricing information by a non-internet means upon request. These costs are discussed below.

1. ICR Regarding Requirements for Disclosures to Participants, Beneficiaries, or Enrollees (26 CFR 54.9815-2715A, 29 CFR 2590.715-2715A, and 45 CFR 147.210(b))

CMS assumes that all beneficiaries, participants, or enrollees that contact a customer service representative representing their group health plan or health insurance issuer would request non-internet disclosure of the internet-based self-service tool information. Of these, CMS estimates that 54 percent of the requested information would be transmitted via email or facsimile at negligible cost to the issuer or TPA and that 46 percent would request the information be provided via mail. CMS estimates that, on average, each issuer or TPA would send approximately 27 disclosures via mail annually. Based on these assumptions, CMS estimates that the total number of annual disclosures sent by mail for all issuers and TPAs would be 24,516.

CMS assumes the average length of the printed disclosure would be approximately nine single-sided pages in length, assuming two pages of information (similar to that provided in an explanation of benefit document) for three providers (for a total of six pages) and an additional three pages related to the required notice, with a printing cost of $0.05 per page. Therefore, including postage costs of $0.55 per mailing, CMS estimates that each issuer or TPA would incur a material and printing costs of $1.00 ($0.45 printing plus $0.55 postage costs) per mailed request. Based on these assumptions, CMS estimates that each issuer or TPA would incur an annual printing and mailing cost of approximately $27, resulting in a total annual printing and mailing cost of approximately $26,703 for all issuers and TPAs.

TABLE 15: Estimated Annual Cost for All Issuers and TPAs to Accept and Fulfill Requests for Mailed Disclosures in 2021

Number of Respondents	Number of Mailings	Printing and Materials Cost	Total Cost
980	26,703	$26,703	$26,703

CMS estimates the average annual total cost burden, for all issuers and TPAs, over 3 years would be printing and material costs of $17,802 for 17,802 mailings.

TABLE 16: Estimated Three-Year Average Annual Cost for All Issuers and TPAs to Accept and Fulfill Requests for Mailed Disclosures

Year	Number of Respondents	Responses	Number of Mailings	Total Printing and Materials Cost
2020	0	0	0	$0
2021	980	26,703	26,703	$26,703

2022	980	26,703	26,703	$27,604
3 year Average	653	17,802	17,802	$17,802

14. Cost to Federal Government

There are no costs to the Federal government associated with this information collection, as the proposed rule requires only third-party disclosure of information and does not require any information to be reported to the federal government.

15. Changes to Burden

This is a new information collection.

16. Publication/Tabulation Dates

There are no plans to publish the results of this collection.

17. Expiration Date

The expiration date and OMB control number will display on the first page of each instrument (top-right corner).

Appendix:

1. **Transparency in Coverage Model Notice.**
2. **Negotiated Rate File Data Element Guidance.**
3. **Out-of-Network Allowed Amount File Data Element Guidance.**