

**Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in  
Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and  
Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment  
Supporting Statement for Exchange Provisions  
(CMS-10468/OMB Control No. 0938-1207)**

**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, “Affordable Care Act”), expands access to health insurance for individuals and employees of small businesses through the establishment of new Affordable Insurance Exchanges (Exchanges), including the Small Business Health Options Program (SHOP). The Exchanges, which became operational on January 1, 2014, enhanced competition in the health insurance market, expanded access to affordable health insurance for millions of Americans, and provided consumers with a place to easily compare and shop for health insurance coverage.

The reporting requirements and data collection in Medicaid, Children’s Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment (CMS-2334-F) address: (1) standards related to notices, (2) procedures for the verification of enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan; and (3) other eligibility and enrollment provisions to provide detail necessary for state implementation. The submission seeks OMB approval of the information collection requirements associated with selected provisions in 45 CFR parts 155, 156 and 157.

It is important to note that these regulations involve several information collections that will occur through the single, streamlined application for enrollment in a QHP and for insurance affordability programs described in §155.405. We have accounted for the burden associated with these collections in the Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid, and Children’s Health Insurance Program Agencies (CMS-10440).

We would also like to highlight that this supporting statement also includes several information collections from regulatory provisions finalized in the Exchange final rule. Additionally, throughout this section, we reference notices, and include data elements associated with these notices in Appendix A.

**B. Justification**

**1. Need and Legal Basis**

Sections 1311(b) and 1321(b) of the Affordable Care Act provide that each state has the opportunity to establish an Exchange that (1) facilitates the purchase of insurance coverage by qualified individuals through QHPs; (2) assists qualified employers in the enrollment of their employees in QHPs; and (3) meets other standards specified in the Affordable Care Act. Section 1311(k) of the Affordable Care Act specifies that Exchanges may not establish rules that conflict with or prevent the

application of regulations promulgated by the Secretary. Section 1311(d) of the Affordable Care Act describes the minimum functions of an Exchange, including the certification of QHPs.

Section 1321 of the Affordable Care Act discusses state flexibility in the operation and enforcement of Exchanges and related policies. Section 1321(c)(1) directs the Secretary to establish and operate such Exchanges within states that either: (1) do not elect to establish an Exchange, or (2) as determined by the Secretary on or before January 1, 2013, will not have an Exchange operable by January 1, 2014. Section 1321(a) also provides broad authority for the Secretary to establish standards and regulations to implement the statutory standards related to Exchanges, QHPs, and other components of title I of the Affordable Care Act.

Section 1401 of the Affordable Care Act creates new section 36B of the Internal Revenue Code (the Code), which provides for a premium tax credit for eligible individuals who enroll in a QHP through an Exchange. Section 1402 of the Affordable Care Act establishes provisions to reduce the cost-sharing obligation of certain eligible individuals enrolled in a QHP offered through an Exchange, including standards for determining whether Indians are eligible for certain categories of cost-sharing reductions.

Under section 1411 of the Affordable Care Act, the Secretary is directed to establish a program for determining whether an individual meets the eligibility standards for Exchange participation, advance payments of the premium tax credit, cost-sharing reductions, and exemptions from the shared responsibility payment.

Sections 1412 and 1413 of the Affordable Care Act and section 1943 of the Social Security Act (the Act), as added by section 2201 of the Affordable Care Act, contain additional provisions regarding eligibility for advance payments of the premium tax credit and cost-sharing reductions, as well as provisions regarding simplification and coordination of eligibility determinations and enrollment with other health programs.

Unless otherwise specified, the provisions in the final rule related to the establishment of minimum functions of an Exchange are based on the general authority of the Secretary under section 1321(a)(1) of the Affordable Care Act. These information collection requirements are set forth in 45 CFR Parts 155, 156, and 157.

## **2. Information Users**

The data collection and reporting requirements described below are critical to the basic ability of Exchanges to facilitate enrollment in qualified health plans, and will also assist Exchanges, health insurance issuers, and HHS in ensuring program integrity and quality improvement.

## **3. Use of Information Technology**

HHS anticipates that a majority of the activities described below specified in this rule will be automated. Exchanges and health insurance issuers are expected to develop automated notice templates for many of the specified notices, and distribute the majority of these notices through secure electronic accounts. The entities issuing notices or collecting information will develop the initial template after which the templates will be automatically populated with the appropriate information for the receiving party. A majority of the information that is collected in accordance with this rule will be submitted electronically. Staff, or systems, will analyze, review, or process the data through largely electronic

means and communicate with individuals, states and health insurance issuers using e-mail, telephone, or other electronic means whenever possible.

#### **4. Duplication of Efforts**

These information collections do not duplicate any current information collections.

#### **5. Small Businesses**

We estimate minimal burden on small business as they are not required to participate in the SHOP.

#### **6. Less Frequent Collection**

Due to the required flow of information between multiple parties and flow of funds for payments supporting health insurance coverage purchased through the Exchange, it is necessary to collect information according to the indicated frequencies. If the information is collected less frequently, the result would be less accurate, untimely or unavailable eligibility, enrollment or payment information for Exchanges, insurers, employers and individuals. This would lead to delayed payments to insurers; late charges to or payments by employers and enrollees; inaccurate or inappropriate advance payments of the premium tax credit and cost sharing reductions; the release of misleading information regarding health care coverage to potential enrollees; and an overall stress on the organizational structure of the Exchanges and decrease in benefit to individuals and employers.

#### **7. Special Circumstances**

These information collections do not include any special circumstances.

#### **8. Federal Register/Outside Consultation**

As required by the Paperwork Reduction Act of 1995 (44 U.S.C.2506 (c)(2)(A)), CMS published a Notice of Proposed Rulemaking (NPRM) on February 17, 2017 (82 FR 10980) requesting a 60-day public comment period on the proposed modification of the information collection requirements. The Final Rule published April 18, 2017 (82 FR 18346). Comments have been addressed in Appendix B of this submission.

#### **9. Payments/Gifts to Respondents**

No payments and/or gifts will be provided to respondents.

#### **10. Confidentiality**

To the extent of the applicable law and HHS policies, we will maintain respondent privacy with respect to the information collected.

## **11. Sensitive Questions**

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

## **12. Burden Estimates (Hours & Wages)**

For purposes of presenting an estimate of paperwork burden, we reflect the participation of 18 State-based Exchanges. We also note that these estimates generally reflect burden for the first year, and that the associated burden in subsequent years will be significantly lower because many of the standards in the regulation will be fulfilled through the development of automated processes that will involve only maintenance in future years. Therefore, these estimates should be considered an upper bound of burden for non-federal entities. These estimates may be adjusted in future Information Collection Requests (ICRs) as Exchange development moves forward.

Salaries for the positions cited in the labor category of the burden charts, except for the health policy analyst and senior manager were mainly taken from the U.S. Bureau of Labor Statistics' (BLS) May 2015 National Occupational Employment and Wage Estimates ([http://www.bls.gov/oes/current/oes\\_nat.htm#31-0000](http://www.bls.gov/oes/current/oes_nat.htm#31-0000)). The salaries for the health policy analyst and the senior manager were taken from the Office of Personnel Web site. Fringe benefit estimates were calculated at 100 percent of the salary.

## **Information Collections under Part 155**

### **Subpart C—General Functions of an Exchange**

#### **A. Role of authorized representatives in the Exchange (§155.227)**

Section 155.227(a) provides that an applicant or enrollee, subject to applicable privacy and security requirements, may designate an individual person or organization as his or her authorized representative. One method for designating an authorized representative is by submitting legal documentation of the representative's authority. Exchanges have the option to make available an "Appointment of Authorized Representative Form" at the time of application or anytime thereafter for an individual to designate an authorized representative. Such a form would collect identifying and contact information about the applicant, enrollee, and requested authorized representative. Requested data elements would include the following for both the applicant or enrollee and the requested representative: name, address, phone number, email address, date of birth, and relationship. The applicant, enrollee, or authorized representative could obtain the form from the Exchange website or from an assister (such as a Navigator, non- Navigator in-person assister, etc.), and could submit it to the Exchange by mail or online at any time. We expect that the Exchange would use this information to authorize the authorized representative to act on behalf of the applicant or enrollee. An authorized representative could also submit this form if the applicant or enrollee is unable to do so.

HHS is currently developing a model Appointment of Authorized Representative Form to be used by the Federally-facilitated Exchanges and will make that form available to State-based Exchanges, which would also decrease the burden on State-based Exchanges to develop such a form. If a state opts not to use the form provided by HHS, we estimate the burden associated for the time and effort necessary for a State-based Exchange to develop the Appointment of Authorized

Representative Form to be 30 hours. This includes 10 hours from a mid-level health policy analyst at an hourly cost of \$91.08 and 10 hours from an operations analyst at an hourly cost of \$105.87 for drafting the form with 4 hours of managerial oversight at an hourly cost of \$79.51 and 6 hours of legal review at an hourly cost of \$128.34. The estimated cost per State- based Exchange is \$3,058, for a total cost of \$55,036 for 18 State-based Exchanges.

Labor Category	Number of Employees	Hourly Labor Costs (incl fringe)	Burden Hours	Total Burden Costs (per Exchange)	Total Burden Costs (per year)
Health Policy	1	\$91.08	10	\$911	
Operations	1	\$105.87	10	\$1,05	
Attorney	1	\$128.34	6	\$ 770	
Senior Manager	1	\$79.51	4	\$318	
Total	4		30	\$3,058	\$55,036

For an applicant, enrollee, or prospective authorized representative, we estimate that it will take up to 5 minutes to review instructions and complete an Appointment of Authorized Representative Form. While we expect most applicants, enrollees, or prospective authorized representatives to complete the Authorized Representative Form, an applicant, enrollee, or prospective authorized representative may also comply with this provision by providing the necessary information online, by phone, or by mail. We expect a similar burden on the applicant, enrollee, or authorized representative to comply with this provision through such means.

Labor Category	Number of Individuals	Hourly Labor Costs	Burden Hours	Total Burden Costs
Individual	1	--	0.08	--
Total per response	1	--	0.08	--

If the applicant, enrollee, or authorized representative chooses to submit an “Appointment of Authorized Representative Form,” the burden for a State-based Exchange to process the submitted information will be approximately 10 minutes at a cost of \$6.94 per submission. We anticipate that an eligibility support staff person will scan, digitize, and link the form to an applicant’s or enrollee’s account, review the submitted information, and update the authorized representative’s and applicant’s or enrollee’s account, if applicable.

Labor Category	Number of Employees	Hourly Labor Costs	Burden Hours	Total Burden Costs
Eligibility Support Staff <sup>1</sup>	1	\$40.82	0.17	\$6.94
Total per response	1		0.17	\$6.94

<sup>1</sup> Occupational Employment Statistics survey results for “43-4061 Eligibility Interviewers, Government Programs”, May 2014.

**B. General standards for Exchange notices.**

**Subpart D—Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability (§155.302 through §155.345)**

**A. Options for conducting eligibility determinations (§155.302)**

Section 155.302 of the regulation provides options for conducting eligibility determinations. Section 155.302(a) provides that the Exchange may satisfy the requirements of this subpart directly or through contracting arrangements or through a combination of the approach described in paragraph (a)(1) and one or both of the options, described in paragraphs (b) and (c), and certain standards are met. Section 155.302(b)(6) specifies that an Exchange that uses the options specified in paragraphs (b) or (c) will enter in to agreements that reflect roles and responsibilities. The burden associated with these provisions is the time and effort necessary for the Exchange to establish or modify agreements for eligibility determinations and coordination of eligibility functions. For 155.302(b)(6) this burden is captured in the agreements associated with §155.345. For 155.302(c), since this agreement would involve a different relationship, specifically, HHS and the Exchange, instead of the Exchange and Medicaid and CHIP agencies, we have estimated to be the time and effort necessary for the Exchange to develop and execute agreements with HHS, which we estimate will take 105 hours per Exchange.

Labor Category	Number of Employees	Hourly Labor Costs (incl fringe)	Burden Hours	Total Burden Costs (per Exchange)	Total Burden Costs (per year)
Health Policy	1	\$91.08	35	\$3,189	
Operations Analyst	1	\$105.87	35	\$3,705	
Attorney	1	\$128.34	30	\$3,850	
Senior Manager	1	\$79.51	5	\$398	
<b>Total</b>	<b>4</b>		<b>105</b>	<b>\$11,142</b>	<b>\$200,538</b>

Section 155.302(b)(4) provides that if the Exchange conducts an assessment in accordance with paragraph (b) of this section and finds that an applicant is not potentially eligible for Medicaid and CHIP based on the applicable Medicaid and CHIP MAGI-based income standards, the Exchange must consider the applicant as ineligible for Medicaid and CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions, notify the applicant, and provide the applicant with the opportunity to withdraw his or her application for Medicaid and CHIP or request a full determination of eligibility for Medicaid and CHIP by the applicable State Medicaid and CHIP agencies.

However, the provisions in §155.302 do not involve burden beyond what is already addressed in §155.310(g), since each state will choose either an assessment or determination. In the case of an assessment, the Exchange will substitute language described in this section with what would be otherwise included.

In accordance with section 1413(b) of the Affordable Care Act, section 155.310(a)(1) specifies that the Exchange use a single streamlined application, as specified in §155.405. Section 155.405 also provides that the Exchange may choose to use an alternative application if such application is approved by HHS and requests the minimum information necessary for the purposes identified in §155.405(a). The application will include information that will be used to determine the eligibility of an applicant for enrollment in a qualified health plan through the Exchange and insurance affordability programs, as applicable. More detailed information on this information collection requirement and the corresponding burden estimates is outlined in the Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid, and Children's Health Insurance Program Agencies (CMS-10440).

Throughout this subpart, we propose that the Exchange collect attestations from the application filer. For the most part, these attestations will be collected as a data element or incorporated in some way as part of the single streamlined application. As such, we have accounted for the burden associated with these collections in the Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid, and Children's Health Insurance Program Agencies (CMS10440).

### **C. Eligibility Process (§155.310)**

Section 155.310(d)(3) provides that to the extent that the Exchange determines an applicant eligible for Medicaid or CHIP, the Exchange must notify the state Medicaid or CHIP agency and transmit all information from the records of the Exchange to the Medicaid or CHIP agency to ensure that the Medicaid or CHIP agency can provide the applicant with coverage promptly and without undue delay. This applicant information will be transmitted electronically from the Exchange to the agency administering Medicaid or CHIP upon receiving an indication that the Exchange has determined an applicant eligible for such program. The purpose of this data transmission is to notify the agency administering Medicaid or CHIP that an individual is newly eligible and so the agency should facilitate enrollment in a plan or delivery system. Data will be transmitted through a secure electronic interface. The burden associated with this provision is the burden of creating and executing agreements with State Medicaid and CHIP agencies, which we estimate in §155.345.

Section 155.310(g) provides that the Exchange will notify an individual regarding his or her eligibility determination after it has been made. This notice provides information necessary to understand key next steps, including plan selection or appeal. We anticipate that the Exchange will consolidate this notice when multiple members of a household are applying together and receive an eligibility determination at the same time. The notice will be in writing, and may be in paper or electronic format. We anticipate that a large volume of enrollees will request electronic notification while others will opt to receive the notice by mail. As a result, we estimated the associated mailing costs for the time and effort needed to mail notices in bulk to enrollees as appropriate.

The eligibility determination notice is dynamic and includes information tailored to all possible outcomes of an application. Exchange staff will continue to streamline and modify the notice text for various decision points, along with information regarding next steps, referrals, customer service, and appeals. A health policy analyst, manager, and legal counsel will review updates to the notice. The Exchange will then incorporate updates to the notice from the consultation to ensure compliance with plain writing, language access, and readability standards. The Exchange

will continue to consult with the state Medicaid or CHIP agency in order to update coordinated notices as necessary.

HHS has developed model notices for the eligibility determination notice and several other notices described in this subpart which will also decrease the burden on Exchanges to provide such notices. If a state opts not to use the model notice provided by HHS, we estimate that notice development as outlined in the paragraph above, including the systems programming, would take each Exchange an estimated 100 hours to complete in the first year if a state opts to use the model notices provided by HHS. We estimate the cost for each Exchange would be approximately \$9,437 and a total cost of \$169,854 for 18 State-based Exchanges. We expect that the burden on the Exchange to maintain this notice will be significantly lower than the estimate to develop it.

Labor Category	Number of Employees	Hourly Labor Costs (incl fringe)	Burden Hours	Total Burden Costs (per Exchange)	Total Burden Costs (18 Exchanges)
Health Policy Analyst	2	\$91.08	44	\$4,008	
Attorney	1	\$128.34	20	\$2,567	
Senior Manager	1	\$79.51	4	\$318	
Computer Programmer	1	\$79.50	32	\$2,544	
Total	5		100	\$9,437	\$169,854

We also include an estimate for the total printing and mailing costs related to sending eligibility determination notices for all 18 State-based Exchanges. In the Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid, and Children’s Health Insurance Program Agencies (CMS-10440), we estimated 5,328,000 total applications a year from 2017 to 2019. This estimate was based on analysis of Congressional Budget Office projections and Office of the Assistant Secretary for Planning and Evaluation analysis of data from the 2015 Open enrollment period. It is difficult to estimate the number of eligibility determination notices for 18 State-based Exchanges because the CBO estimates present national figures and are not state specific estimates. However, we estimate 297,128 notices will be sent for 18 State-based Exchanges. We use these assumptions to determine the number of eligibility notices that we expect to be printed and distributed as described in §155.310. We note, however, that since we expect that many individuals will choose electronic notices instead of paper notices, this estimate is an upper bound.

	Number of Notices	Printing/Mailing Costs per notice	Total Burden Cost (18 State-based Exchanges)
Printing/Mailing	297,128	\$0.53	\$157,478



Section 155.310(h) specifies that the Exchange will notify an enrollee’s employer that an employee has been determined eligible for advance payments of the premium tax credits and/or cost sharing reductions. Upon making such an eligibility determination, the Exchange will send a notice to the employer with information identifying the employee, along with a notification that the employer may be liable for the payment under section 4980H of the Code, and that the employer has a right to appeal this determination. Because this notice will be sent to an employer at the address as provided by an application filer on the application, we anticipate all of these notices will be sent by mail. As a result, we estimated the associated mailing costs for the time and effort needed to mail notices in bulk to employers. Like the eligibility notice, the employer notice above will be developed and programmed into the eligibility system. However, unlike the eligibility notice, we expect the information on the employer notice to be minimal in comparison to the eligibility notice and therefore the burden on the Exchange to develop the notice to be substantially less. Further, as with the individual eligibility notice, HHS will provide model notice text for Exchanges to use in developing this notice. As such, we have accounted for the burden associated to develop this notice in the Supporting Statement for Data Collection to Support Establishment of an Exchange by a State and Qualified Health Plans (CMS-10593).

We believe it is difficult to estimate the number of employer notices that will be sent as it requires an estimate of the number of individuals who will be determined eligible for advance payments of the premium tax credit who will be employed. We therefore provide an estimate of the cost to print and mail each notice below.

	Number of Notices	Printing/Mailing Costs per notice	Total Burden Cost (per notice)
Printing/Mailing	1	\$.53	\$.53

**D. Verification process related to eligibility for insurance affordability programs (§155.320)**

Section 155.320(c)(3)(iv) outlines standards for the notice described in paragraph (c)(3)(vi)(E) and (c)(3)(vi)(F) provided at the end of the inconsistency period for inconsistencies related to income. We do not include a separate burden estimate for this notice because the burden for this notice is described and accounted for in §155.310(g).

Section 155.320(d) proposes the process for the verification of enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan. Paragraph (d)(2) proposes the data sources the Exchange will use to verify access to employer sponsored coverage. This will involve the development and execution of data sharing agreements; however, this burden is already captured in the data sharing agreements described in §155.315. As these data exchanges will be electronic, we do not expect for there to be any additional burden than that which is required to design the overall eligibility and enrollment system.

Paragraph (d)(3)(iii) of § 155.320<sup>2</sup> specifies that the Exchange will select a statistically significant sample of individuals for whom it does not have information about enrollment in and eligibility for an eligible employer-sponsored plan from any electronic data sources (as described in paragraph (d)(2)). The Exchange will provide notice to the selected individuals indicating that the Exchange will contact any employer identified on the application for the applicant and the members of his or her household to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested. The burden associated with this notice is addressed in 155.310(g) as

this –will not be a separate notice, but incorporated into the eligibility determination notice described in the above paragraph.

<sup>2</sup>In the Exchange Proposed Rule, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment for 2017, 80 Fed. Reg. 75488, 75529-30 (Dec. 12, 2015), we proposed to remove paragraph (d)(3)(iii) and add it to new paragraph (d) (4)(i). We proposed two minor modifications that should not affect this PRA submission: (1) to remove certain language that discusses relief that is no longer applicable; and (2) to appropriately update internal cross-references. The proposal to allow the Exchange to implement a process as an alternative to sampling, which may affect this PRA submission, in described in more detail in the body of this supporting statement.

In accordance with § 155.320(d)(3)(iii)(D), we propose that for the statistically significant sample, the Exchange make reasonable attempts to contact any employer identified on the application for the applicant and the members of his or her household to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer sponsored plan for the benefit year for which coverage is requested. Though it is difficult to estimate the burden associated with this information collection, since the calculation involves identifying the number of individuals for whom data will be unavailable, we have provided an estimate in the table below. We however anticipate that this number will decrease as applicants become more familiar with the eligibility process and as the quality and timeliness of data captured electronically improves.

Labor Category	Respondents	Avg. Hourly Rate (incl. fringe)	Avg Burden Hours (per respondent)	Total Burden Costs (per labor category)	Total Burden Costs (18 Exchanges)
Consumer & Household Members	225	\$36.96	0.75	\$6,237	
Consumer Advocates	75	\$101.13	1.00	\$7,585	
Employers & Employer Representatives	1,686	\$79.51	1.12	\$150,140	
Total	1,986		2.87	\$163,962	\$2,951,316

With the objective of reducing verification related issues caused by data mismatches as well as the associated PRA burden on respondents due to sampling, we have removed the absolute requirement to conduct sampling, and for benefit years 2016 and 2017, allowed the Exchange to implement an alternate process approved by HHS to improve long-term verification programs. If finalized, the FFM intends to implement an alternative process, specifically to conduct several studies, over the next two years, relating to possible efficiency gains in consumer and employer engagement via operational, resource, outreach, and policy improvements. These studies will likely have a minimal one-time PRA impact on respondents (employers, applicants, household members, and consumer and employer advocates) relative to the anticipated overall reduction in burden associated with verification issues. We estimate three studies will be conducted in 2016 and 2017 in lieu of sampling. Sampling will be done only in 2018.

In paragraph (d)(3)(iii)(E), we propose that if the Exchange receives any information from an employer relevant to the applicant’s enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-sponsored plan, the Exchange will determine the applicant’s eligibility based on such information and in accordance with the effective dates. If such information changes his or her eligibility determination, the Exchange will notify the applicant and his or her employer or employers of such determination in accordance with the notice requirements specified in 155.310(g) and (h) of this subpart. The burden associated with this provision is the time and effort necessary to notify the applicant and his or her employer if information from an employer changes the applicant’s eligibility. The time and effort associated with this provision is accounted for in the estimate discussed in 155.310(g) and (h) of this subpart.

**E. Eligibility redetermination during a benefit year (§155.330)**

Section 155.330(b) provides that the Exchange specify that an individual will report changes that affect his or her eligibility for enrollment in a QHP and insurance affordability programs within 30 days of such change. Upon receipt of changes reported by an individual, §155.330(c) provides the Exchange will verify the information in accordance with the standards described in §155.315 and §155.320.

In §155.330(b)(1), we specify that except as specified in paragraphs (b)(2) and (b)(3) of this section, the Exchange must require an enrollee to report any change with respect to the eligibility standards specified in §155.305 within 30 days of such change. Our estimates reflect the time that it would take for an enrollee to collect and report to the Exchange any information related to a change that impacts their eligibility. Enrollees will be permitted to submit changes via phone, mail, in person, or electronically. We expect that a majority of enrollees will electronically report changes to the Exchange. As such, we estimate that it will take an enrollee ten minutes on average to report a change to the Exchange. The burden associated with the collection and processing of any documentation that is needed to support reported changes is accounted for in the estimate for §155.330(c)(1).

	Number of Individuals	Hourly Labor Costs	Burden Hours	Total Burden Costs (per change)
Individual	1	--	.16	--
Total	1		.16	--

In §155.330(c)(1), we state that the Exchange will verify any information reported by an enrollee in accordance with the processes specified in §§155.315 and 155.320 prior to using such information in an eligibility redetermination. It is not possible at this time to provide estimates for the number of applicants for whom a reported change will necessitate the adjudication of documentation, but we anticipate that this number will decrease as applicants become more familiar with the eligibility process and as more data become available. As such, we note that the burden associated with this provision is one hour for an individual to collect and submit documentation, and 12 minutes for eligibility support staff to review the documentation.

	Number of Individuals /Employees	Hourly Labor Costs	Burden Hours	Total Burden Costs (per inconsistency)
Individual	1	--	1	--
Eligibility Support	1	\$40.82	.2	\$8.16
Total	2		1.2	

In §155.330(c)(2), we describe how the Exchange will provide periodic electronic notifications regarding the requirements for reporting changes and an enrollee’s opportunity to report any changes as described in paragraph (b)(3) of this section, to an enrollee who has elected to receive electronic notifications, unless he or she has declined to receive notifications under this paragraph. We expect that 18 State-based Exchanges will be subject to this requirement. For each Exchange, we estimate that it will take 21 hours total, 20 hours for an operations analyst to integrate this electronic notification into the Exchange eligibility system, and one hour for a computer programmer to program the electronic notifications into the eligibility system. We estimate a cost burden of \$2,197 per Exchange and a total cost of \$39,544 for 18 State-based Exchanges.

Labor Category	Number of Employees	Hourly Labor Costs(incl fringe)	Burden Hours	Total Burden Costs (per Exchange)	Total Burden Costs (18 Exchanges)
Operations Analyst	1	\$105.87	20	\$2,117	
Computer Programmer	1	\$79.50	1	\$80	
Total	2		21	\$2,197	\$39,544

In §155.330(d), we describe that the Exchange will periodically examine available data sources described in §155.315(b)(1) and §155.320(b) to identify changes related to death and eligibility determinations for Medicare, Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange for an applicant on whose behalf advance payments of the premium tax credit or cost-sharing reductions are being provided. The Exchange will develop electronic data exchanges to support obtaining this information in order to determine the applicant’s eligibility at the point of application and reuse those data exchanges here. Consequently, we do not expect there to be additional burden associated with those data exchanges for the purposes of this paragraph.

In §155.330(e), we describe the redetermination and notification procedures for changes reported by enrollees or identified by the Exchange. Section 155.330(e)(1) states that if the Exchange verifies updated information reported by an enrollee, the Exchange will redetermine the enrollee’s eligibility in accordance with the standards specified in §155.305, notify the enrollee regarding the determination in accordance with the requirements specified in §155.310(g), and notify the enrollee’s employer, as applicable, in accordance with the requirements specified in §155.310(h). The burden for this notice is identical to the burden associated with the eligibility notice described in §155.310(g). Similarly, we do not include a separate burden estimate here for the

notice to the enrollee’s employer because the burden for this notice is described and accounted for in §155.310(h). Section 155.330(e)(2) describes that the Exchange will notify an enrollee if it identifies updated information through periodic data matching, and dependent upon the response, will redetermine the enrollee’s eligibility or if necessary proceed with the inconsistency process in §155.315(f). We do not include a separate burden estimate for this notice because we expect that the burden associated with creating and sending this notice will be similar to that of the annual redetermination notice, which is discussed in §155.335 below.

Furthermore, the burden on an enrollee to notify the Exchange that such information is potentially inaccurate is the same as that in relation to reporting changes as described in §155.330(b), and the burden estimate related reviewing the response and the inconsistency process is explained above in §155.315(f). We are unable to estimate the number of notices that will be sent based on this provision for the reasons stated previously, along with the fact that it is not possible to determine the share of individuals who will enroll in a QHP with advance payments and then gain eligibility for another insurance affordability program and not report it to the Exchange.

**F. Annual eligibility redetermination (§155.335)**

Section 155.335 outlines the annual redetermination process and provides that the Exchange will redetermine the eligibility of a qualified individual on an annual basis. In §155.335(c) we propose that the Exchange will provide a qualified individual with an annual redetermination notice including the qualified individual’s projected eligibility determination for the following year, and if applicable, the amount of any advance payments of the premium tax credit and the level of any cost sharing reductions or eligibility for other insurance affordability programs. The burden associated with this requirement is the time and effort necessary for Exchanges to develop and automate the annual redetermination notice and perform associated record keeping. In accordance with 155.335(d), we expect the annual redetermination notice be sent along with the notice of annual open enrollment as specified in 155.410(d), as a single, coordinated notice. We anticipate that the majority of applicants will request electronic notification while others will receive the notice by mail. As such, we have accounted for the burden associated to develop these notices in the Supporting Statement for Data Collection to Support Establishment of an Exchange by a State and Qualified Health Plans (CMS-10593).

We believe it is difficult to estimate the number of redetermination notices that will be sent as it requires an estimate of the number of individuals who will be determined eligible for enrollment in a QHP through the Exchange. We therefore provide an estimate of the cost to print and mail one redetermination notice below.

	Number of Notices	Printing/Mailing Costs per notice	Total Burden Cost (per notice)
Printing/Mailing	1	\$.53	\$.53

Section 155.335(e) provides that the Exchange will require a qualified individual to report any changes with respect to the information listed in the notice described in §155.335 (c) of this section within 30 days from the date of the notice. We specify in §155.335(e)(2) that the Exchange will allow a qualified individual or an application filer, on behalf of the qualified individual, to report changes via the channels available for the submission of an application.

Similar to the estimate in §155.330(b)(1), our estimates reflect the time that it would take for a qualified individual to collect information related to a change that impacts their eligibility, as well as the time it would take to report these changes to the Exchange. We expect that a large volume of changes would be reported electronically by qualified individuals. We expect that it will take an enrollee ten minutes to report a change to the Exchange. The burden associated with the collection and processing of any documentation that is needed to support reported changes is accounted for in the estimate for §155.335(f).

	Number of Individuals /Employees	Hourly Labor Costs	Burden Hours	Total Burden Costs (per change)
Individual	1	--	.16	--
Total	1		.16	--

Section 155.335(f) states that the Exchange will verify any information reported by an enrollee with respect to their annual eligibility redetermination in accordance with the processes specified in §§155.315 and 155.320 prior to using such information to determine eligibility. It is not possible at this time to provide estimates for the number of applicants for whom a change reported will necessitate the adjudication of documentation, but we anticipate that this number will decrease as applicants become more familiar with the eligibility process and as more data become available. As such, for now, we note that the burden to process documentation associated with an inconsistency that arises as a result of an annual eligibility redetermination is one hour for an individual to collect and submit documentation, and 12 minutes for eligibility support staff to review the documentation.

	Number of Individuals /Employees	Hourly Labor Costs	Burden Hours	Total Burden Costs (per inconsistency)
Individual	1	--	1	--
Eligibility Support Staff	1	\$40.82	.2	\$8.16
Total	2		1.2	

Section 155.335(g) provides that the Exchange will require a qualified individual, or an application filer, on behalf of the qualified individual, to sign and return the annual redetermination notice. Our estimates reflect the time that it would take for a qualified individual, or an application filer on behalf of the qualified individual to sign and return the form to the Exchange. We expect that a large volume of individuals will sign and return the form electronically, but a qualified individual will also be permitted to sign and return the form via phone or mail. The burden for this collection also includes the time necessary for eligibility support staff to process any forms submitted via mail. We expect that this process will take one individual one hour to submit the form, and for an individual who submits the form via mail, it will also take 12 minutes for eligibility support staff to handle intake. We note that to the extent that an individual is reporting a change in response to the annual redetermination notice, the change report would likely be consolidated with the response to the notice described in this paragraph.

	Number of Individuals/ Employees	Hourly Labor Costs	Burden Hours	Total Burden Costs (per respondent)
Individual	1	--	1	--
Eligibility Support Staff	1	\$40.82	.2	\$8.16
Total	2		1.2	

Section 155.335(h)(1)(ii) provides that after the 30-day period for an individual to report changes and/or sign and return the redetermination notice, the Exchange will notify a qualified individual in accordance with the requirements specified in §155.310(g) and notify his or her employer, as applicable, in accordance with the requirements specified in §155.310(h). We expect that the burden associated with this requirement is identical to the burden estimates associated with §155.310(g) and §155.310(h), and is thus already incorporated in the estimates provided for those provisions. In section 155.335(k) we provide that the Exchange must have authorization from a qualified individual to obtain updated tax return information for the purposes of conducting an annual redetermination. The burden associated with this information collection is included in the Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid, and Children’s Health Insurance Program Agencies (CMS-10440).

Section 155.335(l) provides that if the Exchange does not have an active authorization from a qualified individual to obtain updated tax information for use in the annual redetermination process, the Exchange must notify the qualified individual in accordance with the timing described in paragraph (d) of this section, and redetermine his or her eligibility for enrollment in a QHP through the Exchange. This notice is in place of the regular annual redetermination notice, and as such, the burden associated with this requirement is included in the burden estimate associated with 155.335(c).

**G. Administration of advance payments of the premium tax credit and cost-sharing reductions (§155.340)**

This section specifies that the Exchange will provide the relevant information related to enable advance payments of the premium tax credit and cost-sharing reductions, reconciliation of advance payments of the premium tax credit, and employer responsibility. As these reporting functions will all be electronic, we do not expect for there to be any additional burden than that which is required to design the overall eligibility and enrollment system outside of the requirements in section 155.340(b)(3)(ii).

Section 155.340(b)(3)(ii) states that in the event that an individual for whom advance payments of the premium tax credit are made or who is receiving cost-sharing reductions terminates coverage from a QHP through the Exchange during a benefit year, the Exchange will transmit the individual’s name and the effective date of the termination of coverage to his or her employer. We anticipate that this burden on this transmission will be identical to that of §155.310(h).

We estimate that this development as outlined in the paragraph above will take each Exchange an estimated 97 hours in the first year, with a cost burden of approximately \$8,999 per Exchange and a total cost of \$161,982 for 18 Exchanges. We expect that the burden on the Exchange to maintain this process will be significantly lower than to develop it.

Labor Category	Number of Employees	Hourly Labor Costs	Burden Hours	Total Burden Costs (per Exchange)	Total Burden Costs (18 Exchanges)
Health Policy	2	\$91.08	69	\$6,285	
Attorney	1	\$128.34	10	\$1,283	
Senior Manager	1	\$79.51	2	\$159	
Computer Programmer	1	\$79.50	16	\$1,272	
Total	5		97	\$8,999	\$161,982

We believe it is difficult to estimate the number of employer notices that will be sent as it requires an estimate of the number of individuals who will be employed and then terminate coverage after receiving advance payments of the premium tax credit or cost-sharing reductions. We therefore provide an estimate of the cost to print and mail each notice below.

	Number of Notices	Printing/Mailing Costs per notice	Total Burden Cost (per notice)
Printing/Mailing	1	\$.53	\$.53

Section 155.340(c) states that the Exchange must comply with the requirements specified under section 36B of the Code to provide information related to reconciliation of advance payments of the premium tax credit, and as this is an IRS requirement, consequently IRS will account for this burden.

### **I. Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-existing Condition Insurance Plan (§155.345)**

Section 155.345(a) specifies that Exchanges will enter into written agreements with agencies administering other insurance affordability programs. These agreements will include provisions necessary to minimize burden on individuals, ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, and to provide standards for transferring an application from an insurance affordability program to the Exchange. Agencies will also develop MOUs to outline responsibilities and coordinate between insurance affordability programs. The specific number of agreements needed may vary depending on how States choose to divide responsibilities regarding eligibility determinations.

The burden associated with this provision is the time and effort necessary for the Exchange to establish or modify an agreement for eligibility determinations and coordination of eligibility and enrollment functions. If a State chooses to draft separate agreements for each insurance affordability program or a subset of insurance affordability programs, then the estimate would likely increase.

As such, we have accounted for the burden associated with these collections in the Supporting Statement for Data Collection to Support Establishment of an Exchange by a State and Qualified Health Plans (CMS-10593).<sup>1</sup>



Section §155.345(c) specifies that an Exchange must provide an applicant with the opportunity to request a full determination for Medicaid. We do not include a separate burden estimate for this notice because the burden for this notice is described and accounted for in §155.310(g).

Section §155.345(d) specifies standards in the case where the Exchange identifies an applicant as potentially eligible for Medicaid or an applicant requests a full determination for Medicaid. In paragraph (d)(1), we specify that in such a situation, the Exchange will transmit all information provided on the application and any information obtained or verified by the Exchange to the State Medicaid agency. In paragraph (d)(2), we specify that the Exchange will notify the applicant of such transmittal. Because information will be transmitted electronically and through interfaces that will exist for other purposes, we do not account for any additional burden for paragraph (d)(1) and only account for the burden of sending the notice to the applicant as described in paragraph (d)(2). We expect that the burden associated with this requirement is identical to the burden estimates associated with §155.310(g), and is thus already incorporated in the estimate provided for that provision.

Section 155.345(f) specifies that the Exchange will provide the applicant with any information regarding income used in the Medicaid and CHIP eligibility determination for the special rule described in this paragraph. We do not include a separate burden estimate for this notice because the burden for this notice is described and accounted for in §155.310(g).

#### **J. Special eligibility standards and process for Indians (§155.350)**

Section 155.350(c) specifies that the Exchange will verify an attestation by an applicant that he or she is an Indian to the extent that the approved data sources are unavailable, an individual is not represented in available data sources, or data sources are not reasonably compatible with an applicant's attestation through the inconsistency procedures specified in §155.315(f). As we have already accounted for this burden above, we are not including a separate burden estimate for this provision.

#### **K. Right to Appeal (§155.355)**

Section 155.355 provides that the Exchange must include the notice of the right to appeal and instructions regarding how to file an appeal in the eligibility determination notice. We do not include a separate burden estimate for this notice because the burden for this notice is described and accounted for in §155.310(g).

### **Subpart E –Exchange Functions in the Individual Market**

#### **A. Enrollment of Qualified Individuals into QHPs.**

In Part 155, subpart E of the Exchange final rule, we describe the requirements for Exchanges in connection with enrollment and disenrollment of qualified individuals through the Exchange. Section 155.400(a) requires Exchanges to notify QHP issuers of an applicant's selected QHP and transmit any information necessary to enroll the applicant. Section 155.400(b) requires Exchanges to send eligibility and enrollment information to QHP issuers and to HHS promptly, without undue delay. Additionally, Exchanges are required to establish a process by which a QHP issuer acknowledges receipt of the eligibility and enrollment information. We expect that all plan selection, eligibility and enrollment information will be maintained electronically by Exchanges, QHP

issuers and HHS alike. We expect the transmission of such data to be fully automated. As a result, we expect that most of the burden will initial reflect programming of the enrollment feeds to QHP issuers and HHS. These costs are reflected in the capital costs of building enrollment systems.

Section 155.400(c) of the Exchange final rule specifies that Exchanges must maintain records of all enrollments in QHPs through the Exchange. The information will be used to make sure that the Exchange has up to date information on the individuals covered through the Exchange and to ensure that individuals are not covered by more than one QHP. It is expected that the information will be maintained in an electronic data system. We expect that most of the burden will reflect programming to retain enrollment information on the Exchange's electronic data system.

Section 155.400(d) states that Exchanges must reconcile enrollment information with QHP issuers and HHS on no less than a monthly basis. The purpose of reconciling enrollment information between the Exchange and the QHP issuers and HHS is to ensure that both entities have accurate records of the number of enrollees and persons enrolled in each QHP. It is expected that the information will be maintained in an electronic data system. The burden associated with §155.400 (b), (c), and (d) has been accounted for in the Supporting Statement for Data Collection to Support Establishment of an Exchange by a State and Qualified Health Plans (CMS-10593).

As discussed in §155.405(a), the Exchange must use a single streamlined application to determine eligibility and to collect information necessary for enrollment. The application will include information to determine eligibility of an applicant and process plan selection for enrollment in a qualified health plan through the Exchange and insurance affordability programs. The information will be required of each applicant upon initial application with subsequent information collections for the purposes of confirming accuracy of previous submissions or updating information from previous submissions. Information collection began during initial open enrollment in October 2013. As indicated in §155.405(c)(2), the information will be submitted by the applicant to the Exchange through the internet, call center, in-person assistance, or a paper application. After collecting the information, the Exchange will either house the information in an Exchange data repository or purge the information after it is used to make an eligibility determination. HHS has developed the model single streamlined application for the states. A detailed estimate of the burden associated with this information collection was included in the Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid, and Children's Health Insurance Program Agencies (CMS-10440).

Section 155.405(b) states that Exchanges have the option of using an alternative application which includes information to determine the eligibility of an applicant and process plan selection for enrollment in a QHP and insurance affordability programs, as applicable. If the Exchange opts to use an alternative application, the Exchange must submit the alternative application to HHS for approval. The burden estimate associated with this requirement includes the time and effort needed to develop the alternative application and submit the application for approval by HHS. We believe that most Exchanges, in the interest of avoiding duplication of existing work, will choose to use the model single, streamlined application developed by HHS. We assume that the number of Exchanges choosing to develop an alternate application will be less than ten in a twelve month period. We will review each alternative application that is submitted to HHS and, if the number of Exchanges opting to use an alternative application approaches ten, then we will seek OMB approval.

## **B. Initial and Annual Open Enrollment Periods (§155.410)**

As discussed in §155.410, the Exchange will provide written notice to each enrollee about

annual open enrollment between September 1 and September 30 of each year, beginning in 2014. The notice will include the date of annual open enrollment and information regarding where individuals may obtain information about available QHPs. The Exchange will send the notice of annual open enrollment via mail or electronic means depending on the preference of the enrollee. In accordance with §155.335(c), we expect the notice of annual open enrollment as specified in §155.410(d), will be sent along with the annual redetermination notice as a single, coordinated notice. Therefore, the burden estimate associated with this requirement is described in §155.335(d).

### **C. Verification process related to eligibility for enrollment in a QHP through the Exchange (§155.315)**

The process of ‘post-enrollment’ verification of eligibility for a special enrollment period (SEP) under 155.315(f) generally involves providing notice to an applicant regarding any inconsistencies identified through the verification process as described in §155.315(f)(2)(i). If an inconsistency cannot be resolved through action by the Exchange, the Exchange must request that the individual provide satisfactory documentation or otherwise resolve the inconsistency as described in 155.315(f)(2)(ii). During the periods described in (f)(2), the Exchange must proceed with all other elements of eligibility determination using the applicant's attestation, and provide eligibility for enrollment in a QHP to the extent that an applicant is otherwise qualified.

In 82 FR 10980, CMS proposed that all states serviced by the HealthCare.gov platform (hereinafter “Federally Facilitated Exchange” or “FFE”) would undertake ‘pre-enrollment’ SEP verification by verifying eligibility for certain special enrollment period categories for all new consumers who seek to enroll in Exchange coverage through a special enrollment period. This would involve delaying or ‘pending’ consumers’ QHP enrollment until verification of eligibility for the SEP could be completed, and only then releasing enrollment information to the relevant issuer. Consumers would be given 30 days to provide documentation to the Exchange. When available, verification could instead be completed through information gathered from electronic data sources. This method of pre-enrollment verification is authorized under section 1411(d) of the Patient Protection and Affordable Care Act.

Per enrollee, the expected burden of pre-enrollment SEP verification described herein is similar to the burden of post-enrollment SEP verification. The primary burden associated with pre-enrollment SEP verification is the written agreements necessary for data sharing between the Exchange and HHS in order for the FFE to access data maintained in Federal data sources. We have accounted for the burden associated with these collections in the Supporting Statement for Data Collection to Support Establishment of an Exchange by a State and Qualified Health Plans (CMS-10593). We do not expect there to be transactional burden associated with the electronic transactions needed to implement pre-enrollment SEP verification. As these transmission functions will all be electronic, we do not expect for there to be any additional burden than that which is required to design the overall eligibility and enrollment system. Those costs are described in the section detailing capital costs.

The additional burden exists in manually adjudicating the documentation an individual submits to the Exchange to verify eligibility for a SEP. We expect approximately 650,000 applicants to submit documentation to verify eligibility for a SEP per year for the FFE. The Exchange will provide notice to an applicant regarding the need to submit documentation to verify eligibility for a SEP. This notice is a part of the notice in §155.310(g), and so we do not include a separate burden estimate here.

We expect that it will take an individual one hour to gather the relevant documentation, five minutes to upload or mail the relevant documentation, and 12 minutes for eligibility support staff (Occupation No. 43-4061) to review the documentation. Our expectation is based on a few assumptions. We estimate that it will take an individual, on average, one hour to gather the relevant documentation depending on whether the individual already has the necessary documentation on hand, or whether the individual needs to spend additional time to gather the documentation. As such, it could take significantly less time if an individual already had the documents on hand, or potentially more time if the individual needs to procure documentation from a government agency or other source. We also base this estimate on the assumption that that each individual who is required to submit documentation will submit on average two documents for review.

Individuals required to submit documentation will be notified of their status throughout the process and final eligibility determination at the end of the document review period. We do not include a separate burden estimate for this notice because it is described and accounted for in §155.310(g).

	Number of Individuals /Employees	Hourly Labor Costs	Burden hours	Total Burden Costs (per individual)
Individual	1	--	1	--
Eligibility Support Staff	1	\$40.82	.2	\$8.16
Total per Individual	2	--	1.2	
<b>Total per FFE</b>	<b>650,000</b>	<b>\$5,306,600</b>	<b>130,000</b>	<b>--</b>

#### **D. Termination of Coverage (§155.430)**

Section 155.430(c) requires Exchanges to retain and track coverage termination information, including information to identify the individuals terminating coverage, the date of coverage termination, and the reason for termination. The Exchange will collect and retain the coverage termination information. The Exchange will submit the coverage termination information to HHS. The information will help provide HHS an accurate record of enrollment in the Exchange, so that HHS can inform the IRS when to cease advance payments of premium tax credits. We expect that all termination information will be maintained electronically by Exchanges. We also expect the transmission of data to be automated. We estimate that it will take Exchanges less than one minute to transmit the termination information to HHS. We anticipate a similar initial burden on Exchanges for establishing a system for automated tracking, maintenance and transmittal of termination information. The burden estimates associated with the maintenance and transmission of coverage termination information includes the time and effort needed to develop the system to collect and store the information. Additionally, the burden estimates includes the time and effort needed to develop an automated process to submit termination information when appropriate. We have accounted for the burden associated with these collections in the Supporting Statement for Data Collection to Support Establishment of an Exchange by a State and Qualified Health Plans (CMS10593).

Section 155.430(c) requires Exchanges to establish procedures for QHP issuers to maintain records of termination of coverage, and requires Exchanges to send termination information to the QHP issuer and HHS in accordance with §155.400(b). We expect that Exchanges and QHP issuers will manage termination records and related procedures the same way they do the enrollment records described in §155.400. We therefore do not estimate any additional burden for Exchanges to meet the requirements in §155.430.

## **Subpart H- Exchange Functions: Small Business Health Options Program (SHOP)**

### **A. Exchange Functions: Small Business Health Options Program (SHOP) (§§155.715, 155.720, 155.725)**

Subpart H of 45 CFR part 155 includes several notices that the SHOP Exchange will send to employers and employees in relation to their participation in the SHOP Exchange. We have included the data elements for the SHOP Exchange issued notices in Appendix A of this ICR. We expect that the SHOP Exchange will send notices to employers and employees in paper or electronic format, in accordance with the preference of the recipient; further, as in the individual market Exchange, we anticipate that a large share of notices in the SHOP Exchange will be sent electronically. We estimate that the associated printing and mailing costs for paper notices will be approximately \$0.53 per notice. We estimate that approximately 20% of employers and employees will opt for a paper notice. We also estimate that a total of 6,000 employers and 60,000 employees will be triggering notices in accordance with this part. Therefore, we estimate a total of 13,200 employers and employees triggering a request for a paper notice.

First, under §155.715, the SHOP Exchange will notify an employer of an eligibility determination, which will inform the employer of their eligibility to participate in the SHOP Exchange. This notice will include information such as instructions for plan and contribution elections, the deadline for making elections, appeal rights, and customer service contact information for the SHOP Exchange. Second, §155.725(d) provides that the SHOP Exchange provide employers with a notice of annual election period. This notice will include information about current plan and contribution election information, and will alert the employer about potential actions the employer may want to take. Third, §155.720(h) provides that the SHOP Exchange provide employers with a notice of employee termination, which informs an employer if an employee has elected to terminate his or her coverage, including information about the date the employee elected to terminate and the effective date of the termination.

As it relates to employees of an employer participating in the SHOP Exchange, in §155.715, we provide that the SHOP Exchange send an eligibility determination notice to an employee. This notice will explain the employee's eligibility to enroll in a QHP through the SHOP Exchange. Second, if an employer withdraws from participation in the SHOP, the SHOP Exchange will provide a notice to the employer's employees, as described under §155.715(g). Lastly, the SHOP Exchange will provide a notice regarding the annual enrollment period to employees in accordance with §155.725(f). This notice will include information about current plan and contribution election information, and potential actions the employee may want to take related to renewing plans, change plans, and terminating enrollment.

We expect that the notices provided by the SHOP Exchange, and particularly the eligibility determination notices, will be dynamic and include information tailored to all possible outcomes for employers applying to participate in, or employees seeking coverage through, the SHOP Exchange. Because the notices have already been developed, we anticipate maintenance burden costs to be significantly lower than the development cost and estimate the costs as follows. Please see Appendix A for the data elements that we expect to be included in the notices required under subpart H. We expect that the burden on the SHOP Exchange to maintain the notices will be significantly lower than to develop them.

Labor Category	Number of Employees	Hourly Labor Costs	Burden Hours	Total Burden Costs (per Exchange)	Total Burden Costs (18 Exchanges)
Health Policy Analyst	1	\$91.08	3	\$273	
Attorney	1	\$128.3	1	\$128	
Senior Manager	1	\$ 79.51	1	\$80	
Computer Programmer	1	\$79.50	5	\$398	
Total	4		10	\$879	\$15,822

	Number of Notices	Printing/Mailing Costs per Notice	Number of Employers and Employees	Total Burden Cost (per notice)
Printing/Mailing	1	\$0.53	13,200	\$0.53

## **Information Collections under Part 156**

### **A. ICRs Regarding Notices to QHP Issuers (§§156.260, 156.265, 156.270, 156.290).**

45 CFR part 156 includes several notices that qualified health plan (QHP) issuers will send to qualified individuals and enrollees. We have included the data elements for these notices in Appendix A of this ICR. As mentioned previously, we anticipate that a large share of enrollees will elect to receive electronic notices while the rest will receive notices by mail. We believe that this will be the case for notices sent by the Exchange as well as notices sent by QHP issuers. We estimate that the associated printing and mailing costs for paper notices will be approximately \$0.53 per notice. We estimate that approximately 20% of employers and employees will opt for a paper notice. We also estimate that a total of 6,000 employers and 60,000 employees will be triggering notices in accordance with this part. Therefore, we estimate a total of 13,200 employers and employees triggering a request for a paper notice.

First, section 156.260(b) provides that QHP issuers will notify a qualified individual of his or her effective date of coverage, in accordance with the effective dates of coverage established by the Exchange in accordance with §155.410(c) and (f). Second, under §156.270(b), QHP issuers will send a notice of termination of coverage to an enrollee if the enrollee's coverage in the QHP is being terminated in accordance with §155.430(b)(1)(i), (b)(2)(ii) or (b)(2)(iii).. Third, §156.270(f) provides that QHP issuers will provide enrollees with a notice about the grace period for non-payment of premiums. QHP issuers will send this notice to enrollees who are delinquent on premium payments. Fourth, §156.265(e) provides that QHP issuers will provide new enrollees with an enrollment information package, which we anticipate that issuers may combine with the notification of coverage effective date described in §156.260(b). Lastly, under §156.290(b), QHP issuers will provide a notice to enrollees if the issuer elects not to seek recertification of a QHP.

The above QHP issuer required notices are similar in nature to the notices that issuers currently send to enrollees. For example, it is standard practice for issuers to provide new enrollees with information about their enrollment in a plan, their effective date of coverage, and if and when

their coverage is terminating. Accordingly, QHP issuers have reviewed, updated, and revised notice templates that they utilize to ensure that the notices include the appropriate information. Similar to notices that are issued by the Exchange, we expect that for QHP-issued notices, an analyst will continue to maintain and update the information contained in the notice. A peer analyst, manager, and legal counsel for the issuer will review any updates to the notices, including a review to ensure compliance with plain writing, language access, and readability standards as required under §156.250(c).

Accordingly, we expect that the burden hours for maintaining the above notices, will be similar to that which we estimate for the eligibility determination notice described under §155.310(g). However, we believe that the burden estimate described under §155.310(g) likely represents an upper bound estimate of the burden on issuers to maintain each of these notices as in some cases the notice described under §155.310(g) will be somewhat more dynamic in order to address the additional information we expect to be included in that notice. We expect that the burden on the QHP issuers to maintain the notices will be directly related to enrollment in the Exchanges.

<b>Labor Category</b>	<b>Number of Employees</b>	<b>Hourly Labor Costs (incl fringe)</b>	<b>Burden Hours</b>	<b>Total Burden Costs (per Exchange)</b>	<b>Total Burden Costs (18 Exchanges)</b>
Health Policy Analyst	1	\$91.08	3	\$273	
Attorney	1	\$128.30	1	\$128	
Senior Manager	1	\$ 79.51	1	\$80	
Computer Programmer	1	\$79.50	5	\$398	
<b>Total</b>	<b>4</b>		<b>10</b>	<b>\$879</b>	<b>\$15,822</b>

We estimate that approximately 20% of employers and employees will opt for a paper notice. We also estimate that a total of 6,000 employers and 60,000 employees will be triggering notices in accordance with this part. Therefore, we estimate a total of 13,200 employers and employees triggering a request for a paper notice.

	<b>Number of Notices</b>	<b>Printing/Mailing Costs per Notice</b>	<b>Number of Employers and Employees</b>	<b>Total Burden Cost (per notice)</b>
Printing/Mailing	1	\$0.53	13,200	\$0.53

## **Information Collections under Part 157**

### **A. ICRs Regarding Notices and Third-Party Disclosures in the SHOP (§§157.205(e) and (f))**

45 CFR part 157 includes several instances in which qualified employers participating in the SHOP Exchange will need to provide information to employees or to the SHOP Exchange. We include the data elements for these notifications in appendix A of this ICR. For the individual market

Exchange, we anticipate that a large share of enrollees will elect to receive electronic notices while the rest will receive notices by mail. We do not make this assumption for notices described here as we expect that qualified employers will provide notices to employees in whatever format the qualified employer usually provides notices to employees; in paper, electronically, or in a combination of both formats. We estimate that the associated printing costs for paper notices will be approximately \$0.10 per notice. We do not take mailing costs into consideration for notices provided by qualified employers, as we expect that if qualified employers provide notices in paper format, the employer may provide the employee with the notice in person, as opposed to mailing the notice. We do not have a reasonable way to estimate total printing costs for notices provided by qualified employers in the SHOP Exchange due to uncertainty regarding the number of employees who will choose to receive paper notices, as well as some uncertainty regarding the frequency of circumstances that will trigger notices in accordance with this part.

First, §157.205(e) provides that a qualified employer provide an employee with information about the enrollment process. A qualified employer will inform each employee that he or she has an offer of coverage through the SHOP Exchange, and instructions for how the employee can apply for and enroll in coverage. The qualified employer will also provide information about the acceptable formats in which an employee may submit an application; online, or by phone, as described under §157.205(c). If the employee being offered coverage was hired outside an initial or annual enrollment period, the notice will also inform the employee if he or she is qualified for a special enrollment period. Second, in §157.205(f) we provide that a qualified employer will notify the SHOP Exchange regarding an employee’s change in eligibility for enrollment in a QHP through the SHOP Exchange, including when a dependent or employee is newly eligible, or is no longer eligible.

The information that qualified employers will be providing to employees and the SHOP Exchange, as described above, will be standardized. Additionally, qualified employers will generate notices using a manual process. The notices that will be issued by qualified employers will be maintained by a human resources specialist. The burden hours for maintaining each of the notices will be approximately 10 hours for each of the two notices that will be provided by a qualified employer. We expect that the burden on the qualified employer to maintain the notices will be significantly lower than to develop the notices.

Labor Category	Number of Employees	Hourly Labor Costs (incl fringe)	Burden Hours	Total Burden Costs (per Exchange)
Human Resources	1	\$60.18	6	\$361
Attorney	1	\$128.34	2	\$257
Human Resources	1	\$109.75	2	\$220
Total	3		10	\$838

In total, we estimate \$1,676 in burden costs for the two notices described above.

### 13. Capital Costs



We anticipate that the majority of capital costs associated with these information collections, as well as the burden and costs associated with the transactions described in §155.315 and §155.320 related to verification, will be related to the implementing regulations found in Subparts D and E of the proposed rule that provide for a streamlined eligibility and enrollment system. To support this new eligibility structure, States seeking to operate Exchanges will build new or modify existing information technology systems. We believe that how each State constructs and assembles the components necessary to support its Exchange and Medicaid infrastructure will vary and depend on the level of maturity of current systems, current governance and business models, size, and other factors. Any administrative costs incurred in the development of information technology infrastructure to support the Exchange may be funded wholly through State Exchange Planning and Establishment Grants. The Federal government expects that these grants will fund the development of IT systems that can be used by many States who either develop their own Exchanges or who partner with the Federal government to provide a subset of Exchange services. Costs for information technology infrastructure that will also support Medicaid must be allocated to Medicaid, but are eligible for a 90 percent Federal matching rate to assist in development.<sup>2</sup>

Table 1 includes estimates of grants from 2013 to 2017. We include estimated federal government payments and receipts related to grants for Exchange startup. States' initial costs due to the creation of Exchanges will be funded by these grants. Eligibility determination is a minimum function of the Exchange; therefore the Exchange costs to develop the infrastructure for the provisions included in this final rule are covered by these grant outlays.

Table 1. Estimated Total Outlays for the Affordable Insurance Exchanges FY 2013 - FY2017, in billions of dollars

Year	2013	2014	2015	2016	2017	2013-2017
Grant Authority for Exchange Start up <sup>a</sup>	1.5	2.1	1.7	0.8	0.2	6.2

<sup>a</sup> FY 2014 President's Budget

Other administrative costs to support the streamlined and coordinated eligibility and enrollment process and the associated information collections will also vary for each State depending on the specific approaches taken, including how the State chooses to support the review of paper documentation and the resolution of eligibility and enrollment issues. We also believe that overall administrative costs may increase in the short term as States build information technology systems; however, in the long-term States will see savings through the use of more efficient systems and consolidation across programs.

#### 14. Cost to Federal Government

We anticipate costs to the Federal government to include costs related to implementation of the FFE. For the pre-enrollment SEP verification process described in section 155.420, we expect the Federal government to incur a cost of \$5,306,600 to manually adjudicate documentation an applicant

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<sup>2</sup> Federal Funding for Medicaid Eligibility Determination and Enrollment Activities. Final Rule. April 19, 2011 [42 CFR Part 433, 75 FR 68583, pg. 21950]

submits to the FFE to verify eligibility for a SEP. Costs related to implementation can vary depending on the number of states that opt to participate as an FFE.

#### 15. Changes to Burden

As a result of finalizing a new information collection requirement in the Patient Protection and Affordable Care Act; Market Stabilization Rule, the burden hour is increasing by 121,101 hours (from 8,899 hours to 130,000 hours). The Market Stabilization Rule added the pre-enrollment SEP verification process requirement. This is the only change in burden hours.

#### 16. Publication/Tabulation Dates

Results from this collection will not be published.

#### 17. Expiration Date

The expiration date and OMB control number will be displayed on the first page of each data collection instrument (top right-hand corner).