Supporting Statement for Essential Health Benefits Benchmark Plans
(CMS-10448/OMB control number: 0938-1174)

A. Background

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148) was signed into law, and on March 30, 2010, the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was signed into law. The two laws implement various health insurance policies, including the essential health benefits (EHB). Beginning in 2014, all non-grandfathered health plans in the individual and small group market must cover EHB, as defined by the Secretary of Health and Human Services. The PPACA directs that EHB reflect the scope of benefits covered by a typical employer plan and cover at least the following 10 general categories of items and services:

(1) Ambulatory patient services.
(2) Emergency services.
(3) Hospitalization.
(4) Maternity and newborn care.
(5) Mental health and substance use disorder services, including behavioral health treatment.
(6) Prescription drugs.
(7) Rehabilitative and habilitative services and devices.
(8) Laboratory services.
(9) Preventive and wellness services and chronic disease management.
(10) Pediatric services, including oral and vision care.

EHB-Benchmark Plan Selection
Pursuant to Section 1302 of the PPACA and Section 2707 of the Public Health Service Act, as amended by section 1201 of the PPACA, CMS released a bulletin on December 16, 2011 (EHB Bulletin)[1] describing its intent to define EHB by reference to a state-specific benchmark plan. That policy was finalized in the rule *Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule* (EHB Final Rule) (78 FR 12834), published on February 25, 2013.[2] In order to establish an EHB-benchmark plan in each state, in 2012, CMS asked states to voluntarily identify an EHB-benchmark plan from 10 options that were provided in the EHB Bulletin. The EHB Final Rule applied those benchmark plans starting in the 2014 plan year as a transitional policy. Then, in 2015, CMS asked states to voluntarily identify an EHB-benchmark plan from those 10 options for a second time based on 2014 plans that would apply beginning in the 2017 plan year.

In the final rule entitled the HHS Notice of Benefit and Payment Parameters for 2019 (2019 Final Payment Notice; CMS-9930-F),[3] we changed the state's EHB-benchmark plan selection process beginning for 2020 plan year. For plan years beginning on or after January 1, 2020, subject to §156.111(b), (c), (d) and (e), a state may change its EHB-benchmark plan by:

(1) Selecting the EHB-benchmark plan that another state used for the 2017 plan year under §156.100 and §156.110;

[1] http://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf
[2] https://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf
[3] A copy of the final rule is posted on CCIIO's website at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html.

(2) Replacing one or more categories of EHBs under §156.110(a) under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another state used for the 2017 plan year under §156.100 and §156.110; or

(3) Otherwise selecting a set of benefits that would become the state's EHB-benchmark plan.

Annual Reporting of State Mandates

Section 1311(d)(3)(B) of the PPACA permits a state to require QHPs offered in the state to cover benefits in addition to EHB, but requires the state to make payments, either to the individual enrollee or to the issuer on behalf of the enrollee, to defray the cost of these additional state-required benefits. In the EHB final rule, we codified this requirement at §155.170 and finalized a standard at §155.170(a)(2) that specifies benefits mandated by state action taking place on or before December 31, 2011, even if not effective until a later date, may be considered EHB, such that the state is not required to defray costs for these state-required benefits. Under this policy, benefits mandated by state action taking place after December 31, 2011, are considered in addition to EHB, even if the mandated benefits also are embedded in the state's selected EHB-benchmark plan. In such cases, states must defray the associated costs of QHP coverage of such benefits, and those costs should not be included in the percentage of premium attributable to coverage of EHB for purpose of calculating premium tax credits.

In the final rule entitled *HHS Notice of Benefit and Payment Parameters for 2021* (2021 Payment Notice; CMS-9916-F),[4] we finalized amendments to §156.111(d) and adding new §156.111(f) to require states to annually notify HHS in a format and manner specified by HHS, and by a date determined by HHS, of any state-required benefits applicable to QHPs in the individual and/or small group market that are considered to be "in addition to EHB" in accordance with §155.170(a)(3). As part of this collection at §156.111(f), we also finalized that states identify which state-required benefits are not in addition to EHB and do not require defrayal in accordance with §155.170, and provide the basis for the state's determination. A state's submission will be required to describe all benefits requirements under state mandates applicable to QHPs in the individual or small group market that were imposed on or before December 31, 2011, that were still in effect on December 31, 2011, as well as all benefits requirements under state mandates that were imposed any time after December 31, 2011 applicable to the individual or small group market. For example, if a state benefit requirement applicable to QHPs in the individual or small group market was imposed before December 31, 2011, but was no longer in effect on December 31, 2011, then the state is not be expected to include that state mandate in its report. The state's report must also describe whether any of the state benefit requirements in the report were amended or repealed after December 31, 2011. Information in the state's report must be accurate as of the day that is at least 60 days prior to the annual reporting submission deadline set by HHS.

We also finalized at §156.111(d)(2) that if the state does not notify HHS of its required benefits considered to be in addition to EHB by the annual reporting submission deadline, or does not do so in the form and manner specified by HHS, HHS will determine which benefits are in addition to EHB for the state for the applicable plan year. HHS's determination of which benefits are in addition to EHB would become part of the definition of EHB for the applicable state for the applicable plan year.

CMS is amending the existing information collection requirements in order to reflect the finalized policy changes to obtain information for when a state annually reports to HHS on its state-required

[4] A copy of the final rule is posted on CCIIO's website at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html.

benefits.

B. Justification

1. Need and Legal Basis

EHB-Benchmark Plan Selection
Section 1302 of the PPACA requires that all non-grandfathered individual and small group health plans provide EHB, as defined by the Secretary. Section 1321(a) requires HHS to issue regulations setting standards for meeting the requirements under title I of the PPACA. On June 5, 2012, HHS published Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans (77 FR 33133), initially authorizing CMS to collect data from potential default EHB-benchmark plan issuers in each state. The ICR associated with that proposed rule addressed states' selection of their own benchmark plan. The proposed rule was finalized and published on July 20, 2012, at 77 FR 42658. A revised ICR was published with the HHS Notice of Benefit and Payment Parameters for 2016 (CMS-9944-P and CMS-9937-F) and the ICR was finalized on August 28, 2015. As part of the 2019 Proposed Payment Notice, we proposed to revise this ICR which also proposed to add one new EHB section to the regulation at §156.111. We finalized new regulations at §156.111 for a state's EHB-benchmark plan as part of the 2019 Final Payment Notice published on April 17, 2018, and simultaneously published a revised ICR to reflect these changes on April 16, 2018. As part of the 2021 Proposed Payment Notice, we proposed to revise this ICR requesting a 60-day public comment process, which proposed to add new EHB sections to the regulation at §156.111(d) and (f).

In accordance with §156.111(e), for plan years beginning on or after January 1, 2020, a state changing its EHB-benchmark plan using one of the options at §156.111(a) must submit documents specified by HHS in a format and manner by a date determined by HHS. These required documents include:

(1) A document confirming that the state's EHB-benchmark plan definition complies with the requirements under paragraphs (a), (b) and (c), including information on which selection option under proposed §156.111(a) the state is using, and whether the state is using another state's EHB-benchmark plan;

(2) An actuarial certification and an associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies that affirms:
   (a) That the state's EHB-benchmark plan provides a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan, as defined at §156.110(b)(2)(i); and
   (b) That the new EHB-benchmark plan does not exceed the generosity of the most generous among the plans listed in §156.111(b)(2)(ii);

(3) The state's EHB-benchmark plan document that reflects the benefits and limitations, including medical management requirements, a schedule of benefits and, if the state is selecting its EHB-benchmark plan using the option in §156.111(a)(3), a formulary drug list in a format and manner specified by HHS; and

(4) Other documentation specified by HHS, which is necessary to operationalize the state's EHB-benchmark plan.

A response is not needed for all states. Only states choosing to modify the state's EHB-benchmark plan would need to respond to this ICR. However, the number and types of documents needed in this ICR differ from the previous ICR. This information collection uses collection instruments in Appendices A, B, C, D, E and G in addition to requiring the state to submit the same documentation in the previous ICR.[5] We provide collection instruments for certain documents in this ICR and for other documents in this ICR, we do not have collection instruments. These collection instructions have been updated in accordance with the Final 2019 Payment Notice and in response to comments received. Since beginning this collection, we have also made updates to these collection instruments for clarity and to improve usability. For documents without collection instruments, the state will submit these documents in a PDF or Word format. States will submit these documents electronically. We may use a web-based tool to collect these documents with e-mail as back up option, and we believe that the burden would be the same for collecting all of these documents in a web tool or via email.

Annual Reporting of State Mandates

In accordance with the policy finalized at §156.111(d) and (f), beginning in plan year 2021, a state must annually submit to HHS in a form and manner and by a date specified by HHS, a document that:

(1) Is accurate as of the day that is at least 60 days prior to the annual reporting submission deadline set by HHS and that lists all state benefit requirements applicable to QHPs in the individual and/or small group market under state mandates imposed on or before December 31, 2011, that were in effect on December 31, 2011, and any state benefit requirements under state mandates that were imposed any time after December 31, 2011;

(2) Specifies which of those state-required benefits listed in accordance with paragraph §156.111(f)(1) the state has identified as in addition to EHB and subject to defrayal in accordance with § 155.170;

(3) Specifies which of those state-required benefits listed in accordance with §156.111(f)(1) the state has identified as not in addition to EHB and not subject to defrayal in accordance with § 155.170, and describes the basis for the state's determination;

(4) Provides other information about those state-required benefits listed in accordance with §156.111(f)(1) that is necessary for HHS oversight, as specified by HHS;

(5) Is signed by a state official with authority to make the submission on behalf of the state certifying the accuracy of the submission; and

(6) Is updated annually, in a format and manner and by a date specified by HHS, to include any new state benefit requirements, and to indicate whether benefit requirements previously reported to HHS under §156.111(f) have been amended, repealed, or otherwise affected by state regulatory or legislative action.

Under this ICR, a response is needed for all states unless the state does not notify HHS of its state-required benefits by the annual reporting submission deadline, or does not do so in the format and

[5] Appendix E is only for information purposes.

manner specified by HHS, in which case HHS will identify which benefits are in addition to EHB for the state for the applicable plan year.

This information collection proposes to use collection instruments in **Appendix G. State Annual Report on State-Required Benefits** and **Appendix H. State Certification of Annual Report on State-Required Benefits**. States will submit these documents electronically. We may use a web-based tool to collect these documents with email as a back-up option, and we believe that the burden would be the same for collecting all of these documents in a web tool or via email.

2. Information Uses

The EHB benchmark plan information in this ICR is used by issuers and CMS to establish the benefits covered by benchmark plans in each state as EHB. This allows issuers seeking to offer coverage in the individual and small group markets to design benefits that meet EHB requirements and each state's EHB-benchmark plan determines EHB for the purposes of the availability of premium tax credits and cost-sharing reductions for enrollees in the state.[6] This information collection also includes issuer reporting on their intent to offer SADPs. This information is used to inform CMS and states, as well as Exchanges, in their efforts to ensure plans are meeting EHB requirements for QHP certification and EHB compliance.

Collecting information on state-required benefits and posting this information on the CMS website will generally improve transparency with regard to the types of benefit requirements states are enacting, and will provide the necessary information to HHS for increased oversight over whether states are appropriately determining which state-required benefits require defrayal, whether states are correctly implementing the definition of EHB, and whether QHP issuers are properly allocating the portion of premiums attributable to EHB for purposes of calculating premium tax credits.

3. Use of Information Technology

EHB-Benchmark plan selection documents must be submitted electronically. Specifically, we may use a web-based tool with email as a back-up option to collect the documents under this ICR. As described in the 2019 Payment Notice, the information in this information collection will be posted on Center for Consumer Information and Insurance Oversight (CCIIO) webpage on EHB.[7]

Annual reporting of state mandate documents must be submitted electronically. Specifically, we may use a web-based tool with email as a back-up option to collect the documents under this ICR. As finalized in the 2021 Payment Notice; CMS-9916-F, we intend to post state submissions of these documents on the CMS website prior to the end of the plan year during which the annual reporting takes place such that this information is accessible to states, QHP issuers, enrollees, stakeholders, and the general public. If the state does not notify HHS of its state-required benefits that are in addition to EHB in accordance with the requirements at §156.111(f), HHS will complete a similar document for the state and post it to the CMS website.[8]

[6] The definition of EHB also has an impact on the annual limitation on cost sharing at section 1302(c) of the PPACA (which is incorporated into section 2707(b) of the PHS Act) and the prohibition of annual and lifetime dollar limits at section 2711of the PHS Act, as added by the PPACA.

[7] The current CCIIO webpage for EHB-benchmark plans is available at: https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html.

[8] The current CCIIO webpage for EHB-benchmark plans is available at: https://www.cms.gov/CCIIO/Resources/Data-

4. Duplication of Efforts

There is no duplication of efforts.

5. Small Businesses

This information collection will not impact on small businesses.

6. Less Frequent Collection

We anticipate that the EHB-benchmark plan data collection will occur annually. The respondents will likely be different respondents each year. If the collection was less frequently, it would decrease the flexibility for states on when they could choose to make changes to their EHB-benchmark plans.

We are finalizing that states will report on their state-required benefits annually. The respondents that annually report may be different respondents each year, as a state can choose not to notify HHS of its state-required benefits that are in addition to EHB in which case HHS will determine which benefits are in addition to EHB for the applicable plan year in the state. If the collection was less frequent, it would impede HHS's oversight over whether states are appropriately determining which state-required benefits require defrayal, whether states are correctly implementing the definition of EHB, and whether QHP issuers are properly allocating the portion of premiums attributable to EHB for purposes of calculating premium tax credits.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

EHB-Benchmark Plan Selection
As required by the Paperwork Reduction Act of 1995 (44 U.S.C.2506 (c)(2)(A)), CMS published this ICR with the 2019 Proposed Payment Notice on November 2, 2017 (82 FR 51052), requesting a 60-day public comment process. We finalized new regulations at §156.111 for a state's EHB-benchmark plan as part of the 2019 Final Payment Notice published on April 17, 2018, and simultaneously published a revised ICR to reflect these changes on April 16, 2018. The Final 2019 Payment Notice also finalizes the new policies at §156.111 that change the state selection of EHB-benchmark plan for plan years beginning on or after January 1, 2019 and the collection of data to select EHB- benchmark plan for plan years beginning on or after the January 1, 2020.

Annual Reporting of State Mandates
This notice serves to finalize the new ICRs to reflect the finalized policy at §156.111(d) and §156.111(f). All comments received on this ICR are summarized and addressed in Appendix I.

9. Payments/Gifts to Respondents

Resources/ehb.html.

No payments and/or gifts were made to any respondents.

10. Confidentiality

CMS will post EHB-Benchmark plan selection the documents collected through this data collection in a similar manner and format to the documents CMS currently provides on states' EHB-benchmark plans and in accordance with the 2019 Final Payment Notice.

State annual reporting submissions will post on the CMS website prior to the end of the plan year during which the annual reporting takes place such that this information is accessible to states, QHP issuers, enrollees, stakeholders, and the general public. If the state does not notify HHS of its state-required benefits that are in addition to EHB in accordance with the requirements at §156.111(f), HHS will complete a similar document for the state and post it to the CMS website.

CMS would not post any contact information submitted by states submitted on Appendix G. State Annual Report on State-Required, nor would CMS post Appendix H. State Certification of Annual Report on State-Required Benefits, which will contain the signature from the state official with authority to make the submission on behalf of the state certifying the accuracy of the submission.

11. Sensitive Questions

No sensitive questions are asked in this information collection effort.

12. Burden Estimates (Hours & Wages)

Average labor costs (including 100 percent fringe benefits) used to estimate the costs are calculated using data available from the May 2018 National Industry-Specific Occupational Employment and Wage Estimates (Bureau of Labor Statistics (BLS) (https://www.bls.gov/oes/current/naics4_999200.htm#11-0000).

Table 1: Adjusted Hourly Wages Used in Burden Estimates

OES Designation	Occupational Code	Mean Hourly Wage ($/hour)	Fringe Benefits and Overhead ($/hour)	Adjusted Hourly Wage ($/hour)
Financial Examiner (State Government, excluding schools and hospitals)	13-2061	$35.54	$35.54	$71.08
Actuary (Member of American Academy of Actuaries)	15-2011	$43.65	$43.65	$87.30
Market Research Analysts and Marketing Specialists	12-1161	$34.11	$34.11	$68.22
Legal Support Workers, all other	23-2099	$34.34	$34.34	$68.68
General and Operations Managers	11-1021	$59.56	$59.56	$119.12
Chief Executives	11-1011	$96.22	$96.22	$192.44

EHB-Benchmark Plan Selection

The following sections of this document contain estimates of the burden imposed by the incorporated ICRs, but this burden estimate does not include estimates for a state to conduct reasonable public notice and an opportunity for public comment as finalized at §156.111(c).

Burden on States

Under the previous benchmark plan selection policy, 29 states selected one of the 10 base benchmark plan options and 22 states defaulted and that policy did not allow for states to make an annual selection. The revised regulation allows states to modify their EHB-benchmark plans annually, but would not require them to respond to this ICR for any year for which they did not change their EHB- benchmark plans. As such, for purposes of this regulation, we estimate that 10 states would choose to make a change to their EHB-benchmark plans in any given year (for a total of 30 states over 3 years within the authorization of this ICR) and would respond to this ICR. The following details the burden attached to part of this information collection.

First, to select a new EHB-benchmark plan, we require at §156.111(e)(1) that the state provide confirmation that the state's EHB-benchmark plan selection complies with certain requirements, including those under §156.111(a), (b), and (c). To collect this information, the state submits the associated document in **Appendix A. Confirmations on the State EHB-benchmark Plan**. To complete this requirement, we estimate that a financial examiner would require 4 hours (at a rate of $71.08per hour) to fill out, review, and transmit a complete and accurate document. We estimate that it would cost each state approximately $284.32 to meet this reporting requirement, with a total annual burden for all 10 states of 40 hours and an associated total cost of $2,843.20.

Second, we require at §156.111(e)(2) that the state submit an actuarial certification and associated actuarial report of the methods and assumptions when selecting options under §156.111(a). Specifically, we are finalizing at §156.111(b)(2)(i) and (ii) that a state's EHB-benchmark plan must provide benefits at least equal in scope of benefits to what is provided under a typical employer plan and that the state's EHB-benchmark plan must not exceed the generosity of the most generous among a set of comparison plans. The actuarial certification that is being collected under this ICR is required to include an actuarial report that complies with generally accepted actuarial principles and methodologies. This estimate includes complying with all applicable ASOPs (including ASOP 41 on actuarial communications). For example, ASOP 41 on actuarial communications includes disclosure requirements, including those that apply to the disclosure of information on the methods and assumptions being used for the actuarial certification and report. The actuarial certification for this requirement is provided in a template in **Appendix B. Essential Health Benefits (EHB)-Benchmark Plan Actuarial Certificate Template** and includes an attestation that the standard actuarial practices have been followed or that exceptions have been noted. The signing actuary is required to be a Member of the American Academy of Actuaries.

We estimate that an actuary, who is a member of the American Academy of Actuaries, requires 18 hours (at a rate of $87.30 per hour) on average for §156.111(e)(2). This includes the certification and associated actuarial report from an actuary to affirm, in accordance with generally accepted actuarial principles and methodologies that the state's EHB-benchmark plan must provide a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan, as defined at §156.110(b)(2)(i) and that the state's EHB-benchmark plan definition does not exceed the generosity of the most generous among the set of comparison plans. We are also finalizing a

document entitled Example of an Acceptable Methodology for Comparing Benefits of a state's EHB-benchmark Plan Selection in Accordance with 45 CFR 156.111(b) (2)(i) and (ii) that provides an example of a method an actuary could use to develop the actuarial certification and associated report at §156.111(e)(2) for both the typical employer plan benefit and comparison plan standards.

For these calculations, the actuary needs to conduct the appropriate calculations to create and review an actuarial certification and associated actuarial report, including minimal time required for recordkeeping. The precise level of effort for the actuarial certification and associated actuarial report under §156.111(e)(2) will likely vary depending on the state's approach to its EHB-benchmark plan and this certification requirement. For example, as described in the Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii),[9] to reduce the burden of these standards, the actuary may want to consider using the same plan for both the generosity and the typicality tests, provided that the plan meets the standards at both §156.111(b)(2)(i) and (ii). For example, the actuary may only need to do one plan comparison for the purposes of both of these certification requirements. Specifically, the actuary could use the same plan, such as the state's EHB-benchmark plan used for the 2017 plan year. That plan would, by definition, be a "Comparison Plan." Because the state's EHB-benchmark plan used for the 2017 plan year would simply be one of the state's base-benchmark plans, supplemented as necessary under §156.110, that plan also could be used for purposes of determining typicality, as a proposed state EHB-benchmark plan that was equal in scope of benefits to the state's EHB-benchmark plan used for the 2017 plan year within each EHB category at §156.110(a) would be equal to or greater in scope of benefits within each EHB category at §156.110(a) than the base-benchmark plan underlying the EHB-benchmark plan used for the 2017 plan year, to the extent of the required supplementation.

The estimated burden is 18 hours for the actuary to complete the actuarial certification and associated report in recognition of the extension of the generosity standard and in recognition that the definition of typical employer plan may require the actuary to determine whether the typical employer plan meets MV requirements. The estimated number of states that need to respond to this ICR is 10 states since the typical employer plan standard and the generosity standard applies to all state's EHB-benchmark plan options at §156.111(a). For the actuarial certification, we provide the collection instrument in **Appendix B. Essential Health Benefits (EHB)-Benchmark Plan Actuarial Certificate Template**. We estimate that a financial examiner will require 1 hour (at a rate of $71.08 per hour) to review, combine, and electronically transmit these documents to HHS, as part of a state's EHB-benchmark plan submission. We estimate that each state will incur a burden of 19 hours with an associated cost of $1,642.48 with a total annual burden for 10 states of 190 hours at associated total cost of $16,424.80.

Third, we require at §156.111(e)(3) each state to submit its new EHB-benchmark plan documents. The level of effort associated with this requirement could depend on the state's selection of the EHB-benchmark plan options under the regulation at §156.111(a). However, for the purposes of this estimate, we estimate that it would require a financial examiner (at a rate of $71.08 per hour) 12 hours on average to create, review, and electronically transmit the state's EHB-benchmark plan document that accurately reflects the benefits and limitations, including medical management requirements and a schedule of benefits, resulting in a burden of 12 hours and an associated cost of $852.96, with a total annual burden for all 10 states of 120 hours and an associated cost of $8,529.60. The burden for producing these documents is significantly higher than previous estimates because the previous data

[9] Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii), available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Example-Acceptable-Methodology-for-Comparing-Benefits.pdf.

collection generally only required the state (or issuer) to transmit the selected benchmark plan document. In contrast, in some cases, §156.111(a) may result in the state needing to create a completely new document or significantly modify the current document to represent the plan document. Additionally, this estimate of 12 hours also includes the burden necessary for a state selecting the option at §156.111(e)(3) where the state is required to submit a formulary drug list for the state's EHB-benchmark plan in a format and manner specified by HHS. Specifically, the burden for the state selecting this option is also likely vary as the state could use an existing formulary drug list or create its own formulary drug list separately for this purpose. To collect the formulary drug list, the state is required to use the template provided by HHS and must submit the formulary drug list as a list of RxNorm Concept Unique Identifiers (RxCUIs). This template is incorporated in **Appendix D. EHB-benchmark Plan Formulary Drug List**.

Lastly, §156.111(e)(4) requires the state to submit the documentation necessary to operationalize the state's EHB-benchmark plan definition. This reporting requirement includes the EHB summary file that is currently posted on CCIIO's website and is used as part of the QHP certification process and is integrated into HHS's IT Build systems that feeds into the data that is displayed on HealthCare.gov.[10] This document format is incorporated as a template in **Appendix C. The State's EHB-benchmark Plan's Benefits and Limits**. Although this document is not a new document, the burden associated with this document is new for states. We estimate that it would require a financial examiner 12 hours, on average, (at a rate of $71.08 per hour) to create, review, and electronically submit a complete and accurate document to HHS resulting in a burden of 12 hours and an associated cost of $852.96, with a total annual burden for all 10 states of 120 hours and an associated cost of $8,529.60.

We estimate that the total number of respondents would be 10 per year, for a total yearly burden of 470 hours and an associated cost of $36,327.20 to meet these reporting requirements. Below is the estimate of the burden imposed on a state subject to the reporting requirements of this final rule.

Table 2: Burden for Annual Recordkeeping and Reporting Requirements

Labor Category	Number of Respondents	Number of Responses	Burden Hours per Response	Total Burden Costs (Per Respondent)	Total Burden Costs (All Respondents)
Financial Examiner	10*	10	29	$2,061.32	$20,613.20
Actuary	10*	10	18	$1,571.40	$15,714
Total - Annual	10	10	47	$3,632.72	$36,327.20
Total – Three Years			141	$10,898.16	$108,981.60

* Denote the same entities. For purposes of calculating the total, value is used only once.

Burden on Stand Alone-Dental Plan Issuers

CMS is requesting that issuers that intend to offer stand-alone dental plans in any Exchange notify CMS of their intent to participate. This collection includes data on whether the issuer intends to offer

[10] https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html.

stand-alone coverage, the anticipated Exchange market in which coverage would be offered, and the state and service area in which the issuer offers coverage. The burden associated with meeting this requirement includes the time and effort needed by the issuer to report on whether it intends to offer stand-alone dental coverage. We estimate that it will take one half hour for a health insurance issuer to meet this reporting requirement. We estimate that approximately 175 issuers will respond to this data collection. Therefore, we anticipate that the reporting requirement will require a market research analyst one half-hour annually to identify and submit the responsive records to CMS (at $68.22 per hour), for a total cost of $34.11 a year per reporting entity. The total number of respondents will be 175, for a total burden of $5,969.25.

Below is the estimate of the burden across all respondents that we estimate will respond to the reporting request.

Table 3: Burden on Stand Alone Dental Plans

Labor Category	Number of Respondents	Number of Responses	Burden Hours per Response	Total Burden Costs (Per Respondent)	Total Burden Costs (All Respondents)
Issuer or State Market Research Analyst	175	175	0.5	$34.11	$5,969.25
Total – Annual	175	175	87.5	$34.11	$5,969.25
Total – Three Years			262.5	$102.33	$17,907.75

Burden on States for Substitution

Lastly, we included an information collection request to account for the finalized policy at §156.115(b)(2)(ii) that allows the state the option to notify HHS that the state will allow substitution between EHB categories of benefits, beginning with the 2020 plan year. Specifically, §156.115(b)(2)(ii) will allow issuers to substitute benefits only when the state in which the plan will be offered permits such substitution and notifies HHS of its decision to allow substitution between categories. We anticipate that states will notify HHS through the same means the states will notify HHS of an updated EHB-benchmark plan selection under §156.111 and as reflected in **Appendix F. State Substitution Notification**, we intend to provide a preformatted response for states to use to provide the notification to HHS. To provide notification under §156.115(b)(2)(ii), we estimate that it will require a financial examiner 1/2 hour, on average, (at a rate of $71.08 per hour) to review and electronically submit a notification to HHS. Furthermore, we estimate that at most 5 states will want to allow the flexibility for their issuers to substitute between categories under §156.115(b)(2)(ii). While this aspect of the ICR is not subject to the PRA because we estimate that no more than 5 states will be affected annually, we nonetheless provide a total annual burden estimate for §156.115(b)(2)(ii), which is 2.5 hours and a total associated cost of $177.70.

Table 4: Burden on States for Substitution

Labor Category	Number of Respondents	Number of Responses	Burden Hours per Response	Total Burden Costs (Per Respondent)	Total Burden Costs (All Respondents)
Financial Examiner	5	5	0.5	$35.54	$177.70
Total - Annual	5	5	2.5	$35.54	$177.70
Total – Three Years			7.5	$106.62	$533.10

Annual Reporting of State Mandates

To derive wage estimates, we 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. Employee hourly wage estimates have been adjusted by a factor of 100 percent.

We anticipate that the majority of states would choose to annually notify HHS under this policy, as states are already required under §155.170 to identify which state-required benefits are in addition to EHB and to defray the cost of QHP coverage of those benefits. Because we believe the information we are requiring states to report to HHS as part of this annual reporting should already be readily accessible to states, we estimate that approximately ten states would not report and the remaining states would annually report to HHS by the annual reporting submission deadline. Therefore, we estimate that approximately forty-one (41) states would respond to the information collection requirements associated with these proposals.

For the first year in which the annual reporting would take place, states will be required to include a comprehensive list of all state-required benefits applicable to QHPs in the individual and/or small group markets under state mandates that were imposed on or before December 31, 2011, that were still in effect on December 31, 2011, and those under state mandates that were imposed after December 31, 2011, regardless of whether the state believes such state-required benefits require defrayal in accordance with §155.170. Each annual reporting cycle thereafter, the state will only need to update the content in its report to add any new state benefit requirements, and to indicate whether state benefit requirements previously reported to HHS have been amended or repealed. Information in states' initial reports must be accurate as of a day that is at least 60 days prior to the first reporting submission deadline set by HHS. As such, we estimate that the burden estimates for states in the first year of annual reporting will be higher than in each subsequent year.

Although we estimate a higher burden in the first year of annual reporting of state-required benefits, we also expect states are already identifying which state-required benefits are in addition to EHB and defraying the cost of QHP coverage of those benefits in accordance with §155.170. Because we believe the information we are requiring states to report to HHS should be readily accessible to states, we estimate that it would require a legal support worker 25 hours (at a rate of $68.68) to pull and review each mandate, transfer this information into the HHS provided template, and validate the information in the first year of annual reporting. We estimate that it would require a general and operations manager 3 hours (at a rate of $119.12) to then review the completed template and submit it to HHS in the first year of annual reporting. We estimate that it would require a state official 2 hours (at a rate of $192.44) in

the first year of annual reporting to review and sign the required document(s) for submission on behalf of the state, to confirm the accuracy of the submission. The information would be submitted to HHS electronically at minimal cost. Therefore, we estimate that the burden for each state to meet this reporting requirement in the first year would be 30 hours, with an equivalent cost of approximately $2,459.24, with a total first year burden for all 41 states of 1,230 hours and an associated total first year cost of approximately $100,828.84.

Table 5: Burden in Year 1 for Reporting of State Mandates

Labor Category	Number of Respondents	Number of Responses	Burden Hours per Response	Total Burden Costs (Per Respondent)	Total Burden Costs (All Respondents)
Chief Executive**	41*	41	2	$384.88	$15,780.08
General and Operations Manager	41*	41	3	$357.36	$14,651.76
Legal Support Worker	41*	41	25	$1,717	$70,397
Total – Annual	41*	41	30	$2,459.24	$100,828.84

* Denote the same entities. For purposes of calculating the total, value is used only once.

**Chief executive wage is used to estimate the state official wages.

Because the first year of annual reporting is intended to set the baseline list of state-required benefits which states will update as necessary in future annual reporting cycles, we believe the burden associated with each annual reporting thereafter would be lower than the first year. We estimate that for each annual reporting cycle after the first year it will require a legal support worker 10 hours (at a rate of $68.68) to transfer the information about state-required benefits into the HHS provided template and validate the information. We estimate that it will require a general and operations manager 2 hours (at a rate of $119.12) to review the completed template and submit it to HHS each year after the first annual reporting. We estimate that it will require a state official 1 hour (at a rate of $192.44) to review and sign the required document(s) for submission on behalf of the state, to confirm the accuracy of the submission. Therefore, we estimate that the burden for each state to meet the annual reporting requirement each year after the first year of annual reporting will be 13 hours with an equivalent cost of approximately $1,117.48, with a total annual burden for all 41 states of 533 hours and an associated total annual cost of approximately $45,816.68. The burden for all states over 3 years will be approximately 2,296 hours with an equivalent three-year cost of approximately $192,462.20.

Table 6: Burden in Year 2 and After for Reporting of State Mandates

Labor Category	Number of Respondents	Number of Responses	Burden Hours per Response	Total Burden Costs (Per Respondent)	Total Burden Costs (All Respondents)
Chief Executive**	41*	41	1	$192.44	$7,890.04
General and Operations Manager	41*	41	2	$238.24	$9,767.84
Legal Support Worker	41*	41	10	$686.80	$28,158.80
Total - Annual	41*	41	13	$1,117.48	$45,816.68

* Denote the same entities. For purposes of calculating the total, value is used only once.

**Chief executive wage is used to estimate the state official wages.

Table 7: Total Annual Burden for All Information Collections

Information Collection	Number of Respondents	Number of Responses	Burden Hours per Response	Total Burden Costs (Per Respondent)	Total Burden Costs (All Respondents)
State Burden	51	51	65.67	$5,197.45	$100,481.27
Stand Alone Dental Plan Burden	175	175	87.5	$34.11	$5,969.25

13. Capital Costs

There are no anticipated capital costs associated with this data collection.

14. Cost to Federal Government

The burden to the Federal government associated with this information collection is $9,838.50. The calculations for CCIIO employees' hourly salary were obtained from the OPM website: https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2019/GS_h.pdf

Table 8: Administrative Burden Costs for the Federal Government Associated with the EHB-Benchmark Plan Selection and Annual Reporting of State Mandates

Task	Estimated Cost
EHB-Benchmark Plan Selection and Annual Reporting of State Mandates	
1 FTE GS-13: 1 x $36.75 x 150 hours	$5,512.50
1 FTE GS-12: 2 x $30.90 x 70 hours	$4,326

Total Costs to Government	$9,838.50

15. Changes to Burden

Burden increased by 1,763 hours (from 561 to 2,324) due to the new annual reporting of state mandate requirements as proposed in the 2021 Payment Notice. However, there were no changes to the burden hours for the benchmark plan selection. The related benchmark plan selection templates were updated to improve clarity and usability; however, those updates were minor and did not increase or decrease the burden hours.

16. Publication/Tabulation Dates

In accordance with the 2019 Payment Notice, EHB-Benchmark Plan Selection documents covered under this information collection will be posted on the CCIIO website at some point after the annual deadline for state submission for its EHB-benchmark plan.[11]

We will collect Annual Reporting of State Mandate information from states annually. We intend to post state submissions of these documents on the CMS website prior to the end of the plan year during which the annual reporting takes place such that this information is accessible to states, QHP issuers, enrollees, stakeholders, and the general public. If the state does not notify HHS of its state-required benefits that are in addition to EHB in accordance with the requirements at §156.111(f), HHS will complete a similar document for the state and post it to the CMS website.

17. Expiration Date

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

[11] https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html.