

**Supporting Statement for Transparency in Coverage Reporting by
Qualified Health Plan Issuers
(CMS-10572/OMB control number: 0938-1310)**

A. Background

On March 23, 2010, the Patient Protection and Affordable Care Act (P.L. 111-148) was signed into law. On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 (P.L.111-152) was signed into law. The two laws are collectively referred to as the Affordable Care Act (ACA). The ACA established new competitive private health insurance markets called Exchanges, which give millions of Americans access to affordable, quality insurance options. By providing a place for one-stop shopping, Exchanges make purchasing health insurance easier and more transparent, and put greater control and more choice in the hands of individuals and small businesses. The law also established changes to the market in general, including individual, small group, large group, and self-insured plans.

Sections 1311(e)(3)(A)-(C) of the ACA, as implemented at 45 CFR 155.1040(a)-(c) and 156.220, establish standards for qualified health plan (QHP) issuers to submit specific information related to transparency in coverage. QHP issuers are required to post and make data related to transparency in coverage available to the public in plain language and submit this data to the Department of Health and Human Services (HHS), the Exchange, and the state insurance commissioner.

Section 2715A of the Public Health Service (PHS) Act as added by the ACA largely extends the transparency provisions set forth in section 1311(e)(3) to non-grandfathered group health plans and health insurance issuers offering group and individual health insurance coverage.¹

On June 16, 2016, the Office of Management and Budget (OMB) granted approval for the *Transparency in Coverage* Paperwork Reduction Act (PRA) package, with an expiration of June 30, 2019 (OMB control number 0938-1310). OMB granted approval for a 3-year renewal in 2019, expiring April 30, 2022. This Information Collection Request (ICR) serves as a formal request for the renewal of the data collection. It also includes a request for revisions to the previously approved data collection. Revisions will be incorporated with previously approved data elements.

B. Justification

1. Need and Legal Basis

¹ The implementation of the transparency reporting requirements under section 1311(e)(3) for QHP issuers, as described in this document, does not apply to non-Exchange coverage, including health insurance issuers offering group and individual health insurance coverage and non-grandfathered group health plans. Transparency reporting for those plans and issuers is set forth under section 2715A of the PHS Act, incorporated into section 715(a)(1) of the Employee Retirement Income Security (ERISA) Act and section 9815(a)(1) of the Internal Revenue Code (Code) and will be the subject of a separate, future tri-Department rulemaking.

Pursuant to 45 CFR 156.220, in order to increase transparency of QHPs in the individual and small group markets on the Exchange and Small Business Health Options (SHOP) Marketplace, including Stand-alone Dental Plans (SADPs), issuers must submit specific information about coverage to HHS, the Exchange, and the state insurance commissioner, and make the information available to the public in plain language. Section 156.220(b) requires issuers to submit the information outlined in §156.220(a) in an accurate and timely manner and make it available to the public. Section 156.220(c) requires issuers to make this information available in plain language as defined under 45 CFR 155.20.

As stated in the preamble to the rule *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule* (80 FR 10750, February 27, 2015), collection and public display of this information from QHP issuers offering coverage through the Federally-facilitated Exchanges (FFE) and State-based Exchanges on the Federal Platform (SBE-FPs) began in the 2016 plan year (PY).

I. Future Tri-Department Transparency Reporting Rulemaking for Non-QHP Coverage

The current collection applies to issuers using the Healthcare.gov platform, including issuers in states with an FFE or SBE-FP. Consistent with the requirements of PHS Act section 2715A, HHS and the Departments of Labor and the Treasury (collectively, the Departments) intend to propose other transparency reporting requirements at a later time through a separate rulemaking conducted by the Departments for non-Exchange coverage, including health insurance issuers offering non-QHP group and individual health insurance coverage and non-grandfathered group health plans (including large group and self-insured health plans). The reporting requirements may differ from those proposed here, and will take into account differences in markets, reporting requirements already in existence for non-QHPs (including group health plans), and other relevant factors. The Departments intend to implement any transparency reporting requirements applicable to non-QHP issuers and non-grandfathered group health plans only after reasonable notice and comment, and after giving those issuers and plans sufficient time to come into compliance with those requirements following the publication of the final rules.

We seek to renew the current PRA package and our intent to propose extending the collection to QHPs in State-based Exchanges, market-wide, as contemplated by statute. We continue to propose to work with the Departments to phase in those requirements in the future.

II. Submission and Display of Data

QHP issuers' information will continue to be displayed in a Public Use File (PUF) available on data.Healthcare.gov. CMS will display information regarding QHPs, including SADPs, offered through HealthCare.gov.

For the PY23 QHP application period, CMS intends to continue collecting claims data with no changes to the data collection instrument in the currently-approved *Transparency in Coverage* PRA package. **Appendix A1** contains the data collection instrument that CMS proposes to *collect* and is summarized in Section III. The data elements that CMS proposes to *display* in the PY23 PUF are in **Appendix B1** and are summarized below in Section IV: PY23 Transparency in Coverage PUF. Note that because CMS continues to rely on other data sources in addition to issuer-reported data, the data elements for the PUF in Appendix B1 include some elements not noted in Appendix A1.

For the PY24 and PY25 QHP application periods, CMS proposes to revise issuer and plan level data submission requirements. **Appendix A2** contains the data collection instrument that CMS proposes to *collect* from issuers and is summarized below in Section V. The data elements that CMS proposes to *display* in a PUF are in **Appendix B2** and are summarized below in Section VI: PY24-PY25 Transparency in Coverage PUF. Note that because CMS continues to rely on other data sources in addition to issuer-reported data, the data elements for the PUF in Appendix B2 include some elements not noted in Appendix A2.

For the PY23 through PY25 QHP application periods, CMS intends to continue existing URL requirements for maintaining and displaying required information on Claims Payment Policies and Practices webpages with no changes to the individual elements. **Appendix C** contains the elements required to be displayed on issuers' URLs as previously established. The CMS proposed URL requirements are detailed below in Section VII: Claims Payment Policies and Practices URL. Issuers will continue to submit the Claims Payment Policies and Practices URL in the Health Insurance Oversight System (HIOS) via the Supplemental Submission Module (SSM) as shown in **Appendix D**.

To the extent possible, CMS will reuse existing data that it and other entities collect through other means. CMS will also consider issuers' submission of required data to HHS as fulfillment of the requirement for issuers to submit information to the Exchange and post on issuers' own websites, with the exception of the Claims Payment Policies and Practices information as specified below. States may consider issuers' submission of data to HHS as fulfillment of the federal requirement to submit information to the state insurance commissioner.

III. PY23 Transparency in Coverage Data Collection Instrument (See Appendix A1 – PY23 Collection Instrument)

CMS seeks feedback on the data collection instrument to be implemented in PY23 (Appendix A1). For PY23, CMS intends to continue collecting the following data elements with no changes to the collection instrument in the currently-approved *Transparency in Coverage* PRA package.

- **Issuer Level Claims Data:** Issuers will provide issuer-level data based on the following categories: in-network claims received; in-network claims denied; internal appeals filed; internal appeals overturned; percent of internal appeals overturned; external appeals filed; and external appeals overturned. Issuers will provide issuer-level data based on the

following categories: in-network claims received; in-network claims denied; internal appeals filed; internal appeals overturned; external appeals filed; and, external appeals overturned.

- **Plan Level Claims Data:** Issuers will provide plan-level data based on the following categories: in-network claims received and in-network claims denied. In addition, issuers will categorize all claims denials into one of several denial code categories, leveraging the NAIC Market Conduct Annual Survey (MCAS) work. Issuers would report the number of claim denials in each category. This approach aligns with NAIC denial classification and provides greater transparency as to why issuers deny claims, which may be useful to consumers and stakeholders. Issuers will provide the total number of plan-level claim denials in the following denial categories:
 - **Referral or prior authorization required:** Issuers would report denials of nonemergency-related claims that may require prior authorization, or a referral;
 - **Services excluded or not covered:** Issuers would report denial of claims for services;
 - **Not medically necessary, excluding behavioral health:** Issuers would report claims denied for health care services or supplies that do not meet the accepted standards to diagnose or treat of an illness, injury, condition, disease, or its symptoms related to medical surgical services;
 - **Not medically necessary, including behavioral health:** Issuers would report claims denied for health care services or supplies that do not meet the accepted standards to diagnosis or treat of an illness, injury, condition disease, or its symptoms, related to behavioral health;
 - **Out of network provider/claims:** Issuers would report denial of claims for services from outside of the plan’s network of healthcare providers when the plan has a closed network; and
 - **Other:** Issuers would report claims rejected for a variety of reasons including incorrect coding, patient not insured by the plan, duplicate claims, coordination of benefits issues, untimely claims filings.

IV. PY23 Data Elements to be Displayed (See Appendix B1 - PY23 QHP Public Use File)

CMS seeks feedback on the proposed Transparency in Coverage PUF to be implemented in PY23 (Appendix B1). CMS intends to continue displaying claims data described in Section III in addition to the following data elements with no changes to the PUF in the currently-approved *Transparency in Coverage* PRA package. Note that because CMS continues to rely on other data sources in addition to issuer-reported data, the data elements for the PUF in Appendix B1 include some elements not noted in Section III and are not included in the Transparency in Coverage data collection instrument (Appendix A1).

- **Periodic financial disclosures:** CMS will display prior calendar year issuer-level information about premiums, assets, and liabilities that the NAIC currently collects and displays, and which is currently publicly available.

- **Data on enrollment:** CMS will display the issuer-level enrollment numbers as derived from HealthCare.gov; therefore, this will not be a new data collection. This number will be based on the end of the prior calendar year’s information.
- **Data on disenrollment:** CMS will display the issuer-level disenrollment numbers as derived from Health.Care.gov; therefore, this will not be a new data collection. This number will be based on the end of the prior calendar year’s information.
- **Data on rating practices:** CMS will rely on the plan-level Unified Rate Review data that is collected annually and displayed on data.healthcare.gov. CMS already requires issuers to submit this information and would not require duplicate submission.
- **Information on cost-sharing and payments for out-of-network coverage:** HealthCare.gov currently links to an issuer’s current year Summary of Benefits and Coverage (SBC). The SBC includes information on cost sharing, including cost sharing for out-of-network services. CMS does not propose new collection or display for this data element.
- **Information on enrollee rights under Title I of the Affordable Care Act:** CMS will provide a URL to the enrollee rights and protections information provided on HealthCare.gov, which is available at <https://www.healthcare.gov/health-care-lawprotections/>. CMS does not propose a new collection effort for this data element.

V. PY24-PY25 Transparency in Coverage Data Collection Instrument (See Appendix A2 – PY24-PY25 Collection Instrument)

CMS seeks feedback on the revised data collection instrument to be implemented for PY24 and PY25 (Appendix A2). In addition to the existing claims data reporting requirement described in Section III above, CMS proposes to include requirements for issuers to report out-of-network claims data in and data on claim resubmissions. Similarly, CMS proposes to expand claim denial reason reporting categories. We believe this expanded collection will benefit issuers by better separating out claims denied for administrative non-policy reasons and allow for a more accurate representation of claim denial rates. We also believe that this will provide greater clarity to issuers.

- **Issuer Level Claims Data:** Issuers will provide issuer-level data based on the following categories: in-network claims received; in-network claims denied; in-network claims resubmitted; out-of-network claims received; out-of-network claims denied; out-of-network claims resubmitted; internal appeals filed; internal appeals overturned; external appeals filed; and external appeals overturned.
- **Plan Level Claims Data:** Issuers will provide plan-level data based on the following categories: in-network claims received; in-network claims denied; in-network claims resubmitted; out-of-network claims received; out-of-network claims denied; and out-of-network claims resubmitted. In addition, issuers will categorize all plan-level claim denials into one of several denial code categories, leveraging the NAIC Market Conduct Annual Survey (MCAS) work. Issuers will provide the total number of plan-level claim denials for the following denial categories:

- **Benefit limit reached:** Issuers would report denials of claims that are submitted for services which enrollees have reached their benefit limit in the current benefit year;
- **Member not covered during all or part of Date of Service:** Issuers would report denials of claims that are submitted and either the member was not insured by the plan during the date of service in the claim; member policy could not be found; or the individual is not covered under subscriber policy;
- **Investigational, Experimental or Cosmetic Procedure:** Issuers would report denials of claims for cosmetic procedures and those that are deemed experimental or investigational in nature;
- **Referral or prior authorization required:** Issuers would report denials of nonemergency-related claims that may require prior authorization, or a referral;
- **Services excluded or not covered:** Issuers would report denial of claims for services exclusion or non-covered services that are not covered benefits;
- **Not medically necessary, excluding behavioral health:** Issuers would report claims denied for health care services or supplies that do not meet the accepted standards to diagnose or treat of an illness, injury, condition, disease, or its symptoms related to medical surgical services;
- **Not medically necessary, including behavioral health:** Issuers would report claims denied for health care services or supplies that do not meet the accepted standards to diagnosis or treat of an illness, injury, condition disease, or its symptoms, related to behavioral health;
- **Out of network provider/claims:** Issuers would report denial of claims for services from outside of the plan’s network of healthcare providers when the plan has a closed network;
- **Administrative:** Issuers would report claims denied for health care services for administrative reasons including missing or insufficient information; untimely claim filing; billing provider not approved; coordination of benefits or benefit should be paid by other insurance (e.g., workers’ compensation or auto); inconsistent procedure code/diagnosis; unable to identify patient; or duplicate claim; and
- **Other:** Issuers would report claims denied for other reasons not captured in the previous categories.

VI. PY24-PY25 Data Elements to be Displayed (See Appendix B2 – PY24-PY25 QHP Public Use File)

CMS seeks feedback on the proposed Transparency in Coverage PUF to be implemented in PY24 and continue to PY25 (Appendix B2). CMS intends to display revised claims data described in Section V in addition to the following data elements. Note that because CMS continues to rely on other data sources in addition to issuer-reported data, the data elements for the PUF in Appendix B2 include some elements not noted in Section V and are not included in the Transparency in Coverage data collection instrument (Appendix A2).

- **Periodic financial disclosures:** CMS will display prior calendar year issuer-level information about premiums, assets, and liabilities that the NAIC currently collects and displays, and which is currently publicly available.
- **Data on enrollment:** CMS will display the issuer-level enrollment numbers as derived from HealthCare.gov; therefore, this will not be a new data collection. This number will be based on the end of the prior calendar year’s information.
- **Data on disenrollment:** CMS will display the issuer-level disenrollment numbers as derived from Health.Care.gov; therefore, this will not be a new data collection. This number will be based on the end of the prior calendar year’s information.
- **Data on rating practices:** CMS will rely on the plan-level Unified Rate Review data that is collected annually and displayed on data.healthcare.gov. CMS already requires issuers to submit this information and would not require duplicate submission.
- **Information on cost-sharing and payments for out-of-network coverage:** HealthCare.gov currently links to an issuer’s current year SBC. The SBC includes information on cost sharing, including cost sharing for out-of-network services. CMS does not propose new collection or display for this data element.
- **Information on enrollee rights under Title I of the Affordable Care Act:** CMS will provide a URL to the enrollee rights and protections information provided on HealthCare.gov, which is available at <https://www.healthcare.gov/health-care-lawprotections/>. CMS does not propose a new collection effort for this data element.

VII. Claims Payment Policies and Practices URL (See Appendix C – Claims Payment Policies and Practices URL)

CMS seeks feedback on the claims payment policies and practices information issuers will be required to display, as noted in Appendix C and as follows:

- QHP issuers would provide CMS one URL link titled “Transparency in Coverage” which will link to a landing page on the issuers’ websites containing information on claims payment policies and practices. This URL will be submitted in the Supplemental Submission Module (SSM) in the Health Information Oversight System (HIOS) as described in Appendix D. Note that CMS is not seeking to collect data points on the policies and practices. This will not be a new data collection.
- Pursuant to 45 CFR 156.220(c), Claims Payment Policies and Practices elements as described in Appendix C should be in plain language as defined under 45 CFR 155.20.²
- Information provided on the QHP issuer’s website should include issuer-level policies applicable to QHP enrollees on the following:
 - Out-of-network liability and balance billing (Issuers should provide information regarding whether an enrollee may have financial liability for out-of-network services; any exceptions to out-of-network liability, such as for emergency services; and whether an enrollee may be balance-billed. Issuers do not need to include specific dollar amounts for out-of-network liability or balance billing.);

- Enrollee claims submission (Issuers should provide general information on how an enrollee can submit a claim in lieu of a provider, if the provider failed to submit the claim.);
- Grace periods and claims pending policies during the grace period (Issuers would provide an explanation of the 90 day grace period for enrollees with premium tax credits pursuant to 45 CFR 156.270(d), including that issuers must pay claims during the first month and may pend claims during the second and third months. Issuers could explain how they process claims during the 90 day grace period, what a pending claim is, and that enrollees could ultimately be financially responsible for claims payment.);
- Retroactive denials (Issuers would explain that claims may be denied retroactively, after the enrollee has obtained services from the provider.);
- Enrollee recoupment of overpayments (Issuers would provide written instructions to enrollees on obtaining a refund of overpayment for services.);
- Medical necessity and prior authorization timeframes and enrollee responsibilities (Issuers would provide an explanation that some services may require prior authorization. The guidance could also note, for example, any ramifications should

² 45 CFR 156.220(c): Use of Plain Language - the information required to be submitted under subparagraph (A) shall be provided in plain language. The term “plain language” means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

- the enrollee not follow proper prior authorization procedures, a time frame for the prior authorization, and that some coverage is subject to review for medical necessity.);
- Drug exceptions timeframes and enrollee responsibilities (The issuer would provide an explanation of the internal and external exceptions process for people to obtain non-formulary drugs, pursuant to 45 CFR 156.122. The explanation should explain the time frame for a decision, how to complete the application, and the review process.);
- Information on Explanations of Benefits (EOBs) (The issuer would provide an explanation of what an EOB is, when an issuer sends EOBs, and how a consumer should read and understand the EOB.);
- Coordination of benefits (COB) (The issuer would explain what COB is and that other benefits can be coordinated with the current plan to establish payment of services.); and
- Issuer contact information so that CMS can follow up with the issuer in the event of any questions.

Issuers could link to existing documents that provide this information, such as plan documents, if such documents exist, or a completed SBC that complies with the requirements of 45 CFR 147.200 with respect to the coverage (including contact information that is required to be provided). Alternatively, issuers could fulfill this requirement by providing a few sentences or a short paragraph explaining each topic. For example, for “enrollee claim submission,” an issuer

might explain how an enrollee could submit a claim if the provider did not, including information regarding any required form to complete and a mailing address.

Consumers and the general public must be able to easily access this information via the URL, such that people do not have to log on, create a user ID, or be enrolled in a plan to view the information. CMS expects issuers to keep the information up to date and make updates in a timely fashion. We believe that this level of information will be most useful to consumers. If policies are more granular than at the issuer level (e.g., if there are variances due to applicable state laws or based on small or large group market) issuers must present all applicable material in a clear manner. Issuers may include multiple links on the landing page. Such links should be in a self-explanatory and simple format. For example, the landing page could direct consumers to a link for each claims payment policy and practice item, and that link could contain state- and/or market-specific information.

2. Information Uses

CMS expects consumers to access this information to make informed plan selections and understand their rights as consumers. This information will enable consumers to select a plan that best meets their needs.

CMS also expects researchers and stakeholders to continue to use this information. CMS does not intend to use the information submitted in this PRA package for oversight purposes. However, CMS will consider using the information in future revisions to this PRA package for oversight purposes.

3. Use of Information Technology

CMS anticipates that the availability of transparency in coverage information online will aid consumers in efficiently selecting a plan and using their benefits. Issuers will report the data in HIOS, as noted above.

4. Duplication of Efforts

We anticipate no duplication of effort for issuers. While we are aware that other transparency initiatives exist, we do not believe that this collection is duplicative and have aimed to avoid collecting duplicate data points.

QHP issuers currently provide URLs for consumer SBC and the Unified Rate Review Template for other purposes, and CMS intends to leverage this information to eliminate duplicate reporting. CMS also plans to link to financial information that issuers report to the NAIC rather than collecting new information.

5. Small Business

QHP issuers will incur costs to make this information available on their websites and to HHS. However, CMS does not have reason to believe that any issuers are small businesses. The data collection will benefit consumers, including small businesses that may wish to purchase coverage through the Small Business Health Options Programs (SHOP).

6. Less Frequent Collection

The burden associated with this information collection consists of QHP issuers updating specific data elements related to transparency in coverage. QHP issuers are required to make this information available to consumers and CMS. CMS will require QHP issuers to update transparency in coverage data annually. Less frequent collection would reduce the utility of the information and consumer benefit.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

A 60-day Federal Register Notice was published in the Federal Register on July 23, 2021 (86 FR 39024) for the public to submit written comment on the information collection requirements. No comments were received.

A 30-day Notice will be published in the Federal Register on November 10, 2021 (86 FR 62544) for the public to submit written comment on the information collection requirements.

Throughout the past several years of transparency in coverage reporting activities, CMS has received extensive feedback from key stakeholders regarding this collection. CMS sought public comment on transparency reporting requirements in the rules *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Proposed Rule* (76 Federal Register 41866, July 15, 2011) and *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Proposed Rule* (79 Federal Register 70674, November 26, 2014). CMS carefully reviewed all comments received and took those comments into consideration as part of the approach outlined in this supporting statement.

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 privacy with respect to the information provided.

11. Sensitive Questions

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

12. Burden Estimates (Hours & Wages)

Average labor costs (including 100% fringe benefits) used to estimate the burden below were calculated using data available from the [May 2020 National Occupational Employment and Wage Estimates](#) from the Bureau of Labor Statistics (BLS).

The burden associated with this data collection is attributed to QHP issuers. The burden estimates were developed based on our previous experience with transparency in coverage data reporting activities. We estimate 360 QHP issuers (individual, SHOP, and stand-alone dental) will offer QHPs in the FFE or an SBE-FP and thus be subject to this data reporting requirement. The estimate of 360 QHP issuers is based on the number of issuers whose QHPs, including SADPs, appeared on HealthCare.gov in PY21.

The mean hourly wages for the positions of Web Developer and Digital Interface Designer (Occupational Code 15-1257), Computer Programmer (Occupational Code 15-1251), Computer and Information Systems Manager (Occupational Code 11-3021), Social Science Research Assistant (Occupational Code 19-4061), Operations Research Analyst (Occupational Code 152031), and General and Operations Manager (Occupational Code 11-1021) were obtained from the Bureau of Labor Statistics (BLS) Web site: https://www.bls.gov/oes/current/oes_stru.htm. The respective adjusted hourly wage for each Occupational Title is the total of the mean hourly wage of the occupation plus 100% fringe benefit rate of the position, as outlined in Table 1.

Table 1: Adjusted Hourly Wages Used in Burden Estimates

Occupational Title	Occupational Code	Mean Hourly Wage (\$/hour)	Fringe Benefits (\$/hour)	Adjusted Hourly Wage (\$/hour)
Web Developer and Digital Interface Designer	15-1257	\$39.60	\$39.60	\$79.20
Computer Programmer	15-1251	\$44.53	\$44.53	\$89.06
Computer and Information Systems Manager	11-3021	\$75.19	\$75.19	\$150.38
Social Science Research Assistant	19-4061	\$24.68	\$24.68	\$49.36
Operations Research Analyst	15-2031	\$43.56	\$43.56	\$87.12
General and Operations	11-1021	\$59.15	\$59.15	\$118.30

Manager				
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For each reporting issuer, we anticipate it would take the indicated occupations the approximate hours listed in Table 2, below, to make a one-time technical modification to implement the changes necessary for this collection. We anticipate the one-time technical modification to be limited to updating existing code for extracting transparency data from issuer databases to account for the additional information requested by CMS. We estimate that it will take 11 hours at a cost of \$1,134.04 per issuer for the one-time technical modification, with a total burden of 3,960 hours and \$408,254.40 for all 360 QHP issuers.

. Table 2 displays the burden to make a one-time adjustment to meet these regulatory requirements.

Table 2: Burden per Issuer: One-Time Technical Modification

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly rate + 100% Fringe benefits)	Burden Hours	Total Burden Costs (Per Respondent)	Total Burden Costs (All Respondents)
Web Developer and Digital Interface Designer	360	\$79.20	3	\$237.60	\$85,536
Computer Programmer	360	\$89.06	5	\$445.30	\$160,308
Computer and Information Systems Manager	360	\$150.38	3	\$451.14	\$162,410.40
Labor Category	Number of Respondents	Hourly Labor Costs (Hourly rate + 100% Fringe benefits)	Burden Hours	Total Burden Costs (Per Respondent)	Total Burden Costs (All Respondents)
Total – One Time			11	\$1,134.04	\$408,254.40

For each issuer, we anticipate it would take the indicated occupations the approximate hours listed in Table 3, below, to compile the required transparency data, transfer it to the Transparency in Coverage template, and submit the completed template annually as part of the issuer’s QHP application package. We estimate that it will take 44 hours at a cost of \$2,774.28 per issuer for the annual submission of Transparency in Coverage data, with an annual total burden of 15,840 hours and annual cost of \$998,740.80 for all 360 QHP issuers.

Pursuant to 45 CFR 156.220, issuers must submit specific information about coverage to HHS, the Exchange, and the state insurance commissioner, and make the information available to the public in plain language. Issuers must make this information available in plain language as defined under 45 CFR 155.20. Table 3 displays the burden to continually meet these requirements.

Table 3: Burden per Issuer: Annual Submission of Transparency in Coverage Data (Years 1-3)²

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly rate + 100% Fringe benefits)	Burden Hours	Total Burden Costs (Per Respondent)	Total Burden Cost (All Respondents)
Social Science Research Assistant	360	\$49.36	33	\$1,628.88	\$586,396.80
Operations Research Analyst	360	\$87.12	5	\$435.60	\$156,816
General and Operations Manager	360	\$118.30	6	\$709.80	\$255,528
Total – Annual	360		44	\$2,774.28	\$998,740.80
Total – Three Years	360		132	\$8,322.84	\$2,996,222.40

Thus, as outlined in Table 4, below, the estimated burden costs for the one-time technical modification is \$1,134.04 per issuer, with the total burden costs for all issuers being \$408,254.40. Additionally, the estimated burden costs for the annual submission of transparency in coverage data for three years is \$8,322.84 per issuer, with the total burden costs for all issuers being \$2,996,222.40. Altogether, the total burden costs for the two aforementioned phases of this data collection are \$9,467.88 per issuer, with the total burden costs being \$3,404,476.80 for all issuers.

² In the original PRA package for this data collection, approved June 16, 2016, year one estimated a total of 475 issuers and a total of 34 hours, for a total burden of \$2154.46 per issuer. The 2019 package for year one estimated a total of 470 issuers and a total of 42 burden hours, for a total burden of \$1850.52 per issuer per year, totaling \$5,551.56 over the course of three years.

Table 4: Summary of Total Burden

Table Number: Name	CFR Section	Respondents	Burden Hours per Respondent	Burden Hours	Burden Cost
Table 2: Burden per Issuer: OneTime Technical Modification	45 C.F.R. § 156.220 and 155.20	360	11	3,960	\$408,254.40
Table 3: Burden per Issuer: Annual Submission of Transparency in Coverage Data (Years 1-3)	45 C.F.R. § 156.220 and 155.20	360	132	47,520	\$2,996,222.40
Total		360		51,480	\$3,404,476.80

13. Capital Costs

There are no anticipated capital costs associated with these information collections.

14. Cost to Federal Government

The anticipated burden to the Federal government for implementing and maintaining this information collection is \$116,023.60 annually and \$348,070.80 over three years. The calculations for CMS employees' hourly salary were obtained from the OPM website: https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salarytables/pdf/2020/DCB_h.pdf.

Table 5: Administrative Burden Costs for the Federal Government Associated with the Transparency in Coverage Data Collection

Task	Estimated Cost
Receiving and Analyzing Data	
1 FTE GS-12:	\$87,198
Managerial Review and Oversight	
0.2 FTE GS-15: 0.2 x \$144,128	\$28,825.60
Total Annual Costs to Government	\$116,023.60
Total Costs to Government for Three Years	\$348,070.80

15. Changes to Burden

The burden hours for this data collection is currently approved for 42 hours. With this ICR, the burden hours are estimated at 51,480, a total increase of 51,438 hours. The increase in burden hours for this data collection request is due to the additional 11 hours of burden allotted to making a one-time technical modification required by 45 CFR 155.20, which was not accounted for in the previous ICR. Additionally, fewer QHP issuers will be responding to the data collection, from 470 to 360 issues, a total reduction of 110 issuers. There is no impact on burden hours due to revisions to the data collection instrument starting in PY24.

16. Publication/Tabulation Dates

Transparency in coverage data is updated annually. The data collected will be submitted to CMS and made public on [HealthCare.gov](https://www.healthcare.gov) annually to ensure the most up-to-date information is available to Marketplace consumers.

17. Expiration Date

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