Supporting Statement for Continuation of Data Collection to Support QHP Certification and other Financial Management and Exchange Operations (CMS-10433/OMB control number: 0938-1187)

A. Background

The Patient Protection and Affordable Care Act (PPACA) established new competitive private health insurance markets called Affordable Insurance Exchanges (Exchanges), or Marketplaces, which give millions of Americans and small businesses 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. Additionally, the risk adjustment program provides market stabilization to lower costly premiums associated with individual and small business coverage.

As directed by the rule *Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers* (77 FR 18310) (Exchange rule), each Exchange is responsible for the certification and offering of Qualified Health Plans (QHPs). To offer insurance through an Exchange, a health insurance issuer must have its health plans certified as QHPs by the Exchange. A QHP must meet certain minimum certification standards, such as network adequacy, inclusion of Essential
Community Providers (ECPs), and non-discrimination. The Exchange is responsible for ensuring that QHPs meet these minimum certification standards as described in the Exchange rule under 45 CFR 155 and 156, based on the PPACA, as well as other standards determined by the Exchange.

Issuers can offer individual and small group market plans outside of the Exchanges that are not QHPs. Such plans are referred to in this document as "non-Exchange." For the risk adjustment program, administrative information is used to identify all non-grandfathered small group and individual market non-Exchange plan offerings eligible for the program. Risk adjustment also requires select data such as rating area, rating factors, and actuarial value (AV) level, to perform calculation of payments and charges.

This information collection request serves as a formal request for the extension of the data collection clearance. We intend to use the instruments in this information collection for the 2022 certification process and beyond, and believe that providing these instruments now will give issuers and other stakeholders more opportunity to familiarize themselves with the instruments before releasing the 2022 application. While we intend to use these instruments in 2022, we may propose further revisions to this data collection in the future as necessary which will include seeking comments through the full 60-day and 30-day comment periods.

B. Justification

1. Need and Legal Basis

QHP Information Collection: Certification and Standards

An Exchange certifies, recertifies, and decertifies QHPs. The PPACA authorizes QHP certification as well as other operational standards for the Exchange in following sections: 1301-1304, 1311-1312, 1321-1322, 1324, 1334, 1401-1402, 1411 and 1412. Standards for QHP issuers are codified at 45 CFR parts 155 and 156.

An Exchange needs to collect data from issuers as part of QHP certification and recertification, and to monitor compliance with QHP certification standards on an ongoing basis. QHP issuer and plan data also support additional operational activities, including the calculation of each individual's advance payment of the premium tax credit (APTC), the display of plan information on the Exchange website, and managing the ongoing relationships between QHP issuers and the Exchange. Feedback about the QHP certification and recertification process is collected from issuers in an effort to improve the efficiency and effectiveness of data collection. Much of the information collected for QHP certification purposes supports these operational activities on an ongoing basis.

Stand-Alone Dental Plan Information Collection

Section 1311 of the Affordable Care Act and 45 CFR 155.1065 direct each Exchange to permit issuers to offer limited scope dental benefits as stand-alone dental plans (SADP) or in conjunction with a QHP. All reasonably applicable QHP certification requirements apply to stand-alone dental plans offered in an Exchange, and dental issuers are required to complete the same application as all other QHPs. An Exchange needs to collect data from dental issuers in order to certify and recertify standalone dental plans, and to monitor ongoing compliance with applicable QHP certification standards. This data collection allows the Exchange to understand the difference between an estimated and actual rate or to calculate the portion of an individual's premium tax credit allocated to a stand-alone dental plan, and display plan and premium information for these plans.

Necessary Data for QHP Certification

The data collected for QHP certification, recertification, ongoing QHP oversight, financial management, and eligibility and enrollment functions (including HealthCare.gov) are reflected in the categories identified below and in the attached appendices. This data could also be used to support other Exchange business functions such as determinations of the second-lowest-cost-silver plan, payments for cost-sharing reductions (CSRs), APTCs, and the display of information on HealthCare.gov. The data collection requirements apply to stand-alone dental plans as applicable and discussed in template instructions that accompany the release of the final templates annually. CMS also seeks approval to collect issuers' logos; data to support and apply state-specific laws and requirements, such as premium payment method requirements, premium payment grace period non-APTC requirements, dependent age limits, fraud definitions and termination data parameters, and state provisions that allow consumers to have a "free look" at coverage documents and cancel coverage within a specified time frame for a full refund of premium; and other information as needed to support QHP certification. CMS also collects information from Small Business Health Options Program (SHOP) QHP issuers on whether they will allow plan year rates to be established based on composite (or average) rates of employees and dependents at the time of initial application. CMS collects information from SHOP QHP and dental issuers on whether benefits are based on a plan year or calendar year.

CMS will collect the following data to support these functions. The QHP certification templates are provided in Appendices A-K.

Issuer Application Data

- **Issuer Administrative Data Elements:** Basic information required to identify issuers and the Exchange markets they intend to serve, and to facilitate communications with and payment to issuers. The data elements may include issuer contact information and banking information.

- **Network Adequacy/Essential Community Provider (NA/ECP) Data Elements:** Number of Essential Community Providers participating in an issuer's provider network or other documentation necessary to demonstrate that an issuer has an adequate range of ECPs for the intended service areas. CMS proposes capturing the number of practitioners with whom the issuer has contracted to identify more than one provider at a single facility.

- **Accreditation Data Elements:** If applicable, an issuer must provide information about whether it is accredited by a recognized accrediting entity, including the Utilization Review Accreditation Commission (URAC), the National Committee for Quality Assurance (NCQA), or the Accreditation Association for Ambulatory Health Care (AAAHC). An issuer must also authorize the release of accreditation survey data to an Exchange.

- **Network ID and Provider Directory URL Data Elements:** Network ID numbers identifying each provider network for purposes of plan-to-network mapping and specific URLs associated with the provider directory for each plan.

- **URL Data**: CMS requires issuers to submit URL data for plans they intend to offer on the Exchange. CMS reviews the information provided at each URL to ensure there are no inaccuracies in issuer marketing material when compared to data within an issuer's submitted QHP Application. CMS also checks that issuers meet provider directory accessibility standards when a network URL is selected. In September 2019, CMS launched a new data collection module to streamline and standardize URL collection. Issuers can submit URL data to CMS through two different mechanisms: (1) submitting URL data through a simple URL template or (2) submitting URL data through a user interface.

- **Supporting Documentation:** Additional documentation required by the Exchange for oversight purposes such as a compliance plan including an organization chart.

- **Attestations:** Attestations regarding compliance with applicable regulation.

- **Interoperability Attestation and Justification Form:** This form is required for QHP issuers on the Federally-Facilitated Exchange (FFE), including FFEs in states performing plan management functions. Issuers must attest to their ability to meet CMS interoperability requirements found in 45 CFR 156.221. Issuers that cannot attest to the requirements must provide a narrative justification indicating the date by which requirements will be fully

implemented, the plan for meeting this date, the impact on enrollees, current means for enrollee access to data, and reasons for delayed implementation.

Benefit and Service Area Data

- **High-level Plan Data** (45 CFR § 156.130): Basic plan-level information for plans and products including information necessary for in-network and out-of-network deductibles and maximum out-of- pocket cost by benefit category.

- **Benefits and Associated Cost Sharing and Limits** (45 CFR §§ 156.130, 156.140): Data necessary to describe benefits offered by a plan including covered services, co-payments, coinsurance, tiers, intervals, and limits. CMS proposes capturing whether each plan has a particular cost sharing design, benchmark plan type, and information about whether a certain number of mental health, substance abuse, or specialist visits are subject to different cost sharing. In addition, CMS proposes capturing the Essential Health Benefit (EHB) category for each service and capturing visit and service limitations for EHB. CMS also proposes capturing a plan marketing name for each variant, capturing additional Summary of Benefits and Coverage (SBC) scenarios, collecting cost share and limitations for Mental Health/Substance Use office visits, and collecting cost share information for Emergency Mental Health and Substance Use services.

- **Summary of Benefits and Coverage Data Reporting Requirements** (45 CFR § 147.200): Data elements from the Summary of Benefits and Coverage scenarios for display on the Exchange website.

- **Formulary Information including Tiers and Classes** (45 CFR § 156.115, 156.122): Formulary information including RxNorm Concept Unique Identifiers (RxCUIs), pricing tiers, co-insurance, co-payment information, drugs included in the formulary, formulary version number, and its effective date. CMS proposes capturing quantity limits, fill limits and pharmacy restrictions for each RxCUI listed, as well as Over-the-Counter (OTC) step therapy protocol.

- **Service Area** (45 CFR §§ 156.230, 156.235)**:** Information identifying a plan's geographic service area.

- **Additional Supporting Documentation**: Additional documentation required by the Exchange such as discrimination/cost sharing outlier justifications. Information to support the completion of the Mental Health Parity review may be required for submission by the issuer in the future.

Rating Tables and Issuer Business Rules Data

CMS does not propose changes to these data.

- **Premium Rating Information and Business Rules:** Rating tables, factors and business rules required to perform rate review, populate the premium calculator, and perform

calculations for risk adjustment. Information will include collecting secondary eligibility criteria, such as grandchild, adult child, disabled dependent, spouse, and life partner.

- **Partial Month Premium Calculation Rule:** Rules and/or formulas to support the calculation of partial month premiums.

The following information will be collected for QHP certification and the burden is defined, as applicable, in Rate Increase Disclosure and Review Requirements (45 CFR Part 154), OMB Control Number CMS-10379. CMS does not propose changes to these data.

- **EHB and Additional Coverage Data including Allocation of Premium Information:** Data required to determine the allocation of premiums for EHB and those services offered in excess of EHB.

- **CSR Advance Payments and Justification:** Data to support the payments for CSRs. The information will also support the variations in AV levels for CSR silver plan variations.

- **Actuarial Memorandum:** Actuarial narrative and certification required for the review of rates for rate review, premium allocation for APTCs, and CSR payment.

Non-Exchange Plan Information Collection: Risk Adjustment
Section 1343 provides that each state will establish a permanent program of risk adjustment for all non-grandfathered plans in the individual and small group markets. If a state chooses not to actively participate in risk adjustment, CMS will be responsible for implementation. The requirements for issuers with plan offerings outside of the Exchanges are codified at 45 CFR 153.

Risk Adjustment Reporting Requirements for Non-Exchange Plans
The permanent risk adjustment program provides payments to health insurance issuers that disproportionately attract high-risk populations (such as those with chronic conditions), thereby reducing the incentives for issuers to avoid higher-risk enrollees. Under this program, funds are transferred from issuers with lower-risk enrollees to issuers with higher-risk enrollees.

A “risk adjustment covered plan” includes most health insurance plans offered in the individual or small group market. The exceptions are grandfathered health plans, group health insurance coverage described in 45 CFR 146.145(c), individual health insurance coverage described in 45 CFR 148.220, and any other plan determined not to be a risk adjustment covered plan in the applicable Federally certified risk adjustment methodology. States, or CMS on behalf of a state, will require basic identifying information about all risk adjustment covered plans, whether or not they are QHPs.

Necessary Data for Risk Adjustment Operations
Frequency of collection and types of information to be collected is determined by CMS.

Risk Adjustment Operations Data
CMS does not propose any changes to these data. (See Appendix F, RA Programs and Payment Ops

Data Requirements.) CMS finalized changes to data necessary for risk adjustment operations include:

- **Administrative Data Elements:** Basic information required to facilitate communications regarding risk adjustment charges and payments, and other financial program payments. The data elements may include issuer contact information and banking information.

- **EDGE Server Registration and Provisioning Data Elements:** Data elements related to EDGE Server registration activities, including applicable attestations and agreements, and provisioning of the Amazon Web Services (AWS) EDGE Server and the Issuer On-Premise EDGE server.

- **Plan Level and Additional Coverage Data Entities:** Plan information to include market participation, plan type, and basic plan characteristics such as location.

Data for risk adjustment operations include:

- **Premium Rating Information and Business Rules:** Factors, rating areas and business rules required to perform calculations for risk adjustment.

Previous data collection requirements removed from this PRA package:

- **State Licensure Documentation:** Documentation is no longer required because the State Licensure Section has been removed from the QHP application. This review area is the responsibility of the state.

- **Documentation of Good Standing:** Documentation is no longer required because the Good Standing Section has been removed from the QHP application. This review area is the responsibility of the state.

2. Information Users

The Exchange collects plan- and issuer-level data from issuers to facilitate the certification and recertification of QHPs, Exchange operations, other Federal operations, QHP oversight, and ongoing market analysis. All of this data is leveraged across multiple business areas in the Exchange to facilitate other operational tasks such as plan comparisons on the insurance portal and various payment activities, such as determination of the second lowest cost silver plan, APTCs, or risk adjustment.

In addition, CMS will collect organizational and plan-level data from issuers, self-insured group health plans and third-party administrators (and administrative services only contractors). The data will include administrative data, financial data, and rate and benefit data. The data will be used to remit payments and to operate the premium stabilization programs.

3. Use of Information Technology

CMS has and continues to engage with states, issuers, and the National Association of Insurance Commissioners (NAIC) in the effort to develop data standards for QHP certification, risk adjustment, and other plan management activities that would make reporting to the Exchanges more streamlined for issuers across the country and allow them to submit information in a manner that is standardized to the greatest extent possible.

4. Duplication of Efforts

CMS will make every effort to reduce the burden on issuers and reuse the information that is collected under the various provisions of the PPACA. As such, data obtained under other authorized collections implementing provisions of the PPACA will be utilized to meet some Exchange requirements, for example in Rate Increase Disclosure and Review Requirements (45 CFR Part 154), OMB control number CMS-10379. CMS will make every effort to avoid duplication of data collections with any other efforts. CMS is developing an integrated modular collection instrument and database system to support these various needs.

5. Small Businesses

This information collection will not have a significant impact on small businesses.

6. Less Frequent Collection

QHPs will be certified utilizing an annual certification process. We will continue to reassess the certification and recertification burden and make every effort to minimize burden as much as possible in the future.

Non-Exchange plans that are risk adjustment covered plans must submit data for the purposes of facilitating program operations. This information is submitted once annually and then updated when applicable throughout the year.

7. Special Circumstances

Issuers submitting in the SHOP Exchange have the option to submit formulary, rate and benefit information more frequently; therefore, additional submissions may be necessary.

8. Federal Register/Outside Consultation

A 60-day Notice was published in the Federal Register on 11/26/2021 (V. 86, No. 225) 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 03/29/2022 for the public to submit written comment on the information collection requirements.

The goal of this data collection is to inform the QHP certification and recertification process, as well as non-Exchange plan reporting requirements needed for the risk adjustment program. CMS has also continued to receive extensive feedback from key stakeholders. This included discussions, such as webinars and user groups, calls with the NAIC, states, issuer associations, and issuers on the data elements and collection. It is the goal of CMS and stakeholders to identify shared data points and improve the validity of data. CMS will continue to work with states to minimize any required document submission to streamline and reduce duplication.

9. Payment/Gifts to Respondents

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

10. Confidentiality

CMS believes that some of the information collected for plan management and risk adjustment contains proprietary information, trade secret, commercial and/or financial information. Therefore, it is privileged, private to the extent permitted by law, and protected from disclosure. Some information included in this collection, however, must necessarily be made public during Open Enrollment so that consumers can make informed choices.

11. Sensitive Questions

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

12. Burden Estimates (Hours & Wages)

The burden associated with this data collection can be attributed to QHP issuers, non-Exchange plan issuers, larger group issuers, self-insured, third party-administrators, and states. We developed these burden estimates based on experience with QHP certification to date. The burden for each of these entities was considered when developing these burden estimates. The mean hourly wage for the position of compliance officer is from the Bureau of Labor Statistics (BLS) Web site: https://www.bls.gov/oes/current/oes131041.htm. The adjusted hourly wage of $72.70 is the total of the mean hourly wage of $36.35 plus 100% fringe benefit rate of $36.35, see Table 1.

Table 1. Adjusted Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Mean Hourly Wage ($/hour)	Fringe Benefits & Overhead (100%) ($/hour)	Adjusted Hourly Wage ($/hour)
Compliance Officer	13-1041	$36.35	$36.35	$72.70

Burden for QHP Issuers: QHP Certification

The burden on issuers for the QHP certification (including issuer application, rate and benefit submission, and formulary submission) per year is estimated to be 42,140 burden hours or 196 hours per issuer. This estimate is based on an assumed 215 issuers each offering 16 plans. At an adjusted hourly wage rate of $72.70 (includes 100% fringe benefit), the total cost was estimated to be $14,249.20 per issuer. The burden estimate includes data required for QHP certification and risk adjustment. We have adjusted the burden to account for feedback on the certification and recertification process. We have further revised these estimates, in terms of the number of issuers. We estimate 215 issuers will incur costs for QHP certification and risk adjustment. We developed this number based upon the number of applications received from issuers for the 2022 plan year.

Pursuant to the PPACA, an Exchange certifies, recertifies, and decertifies QHPs as well as other operational standards for the Exchange in the following sections: 1301-1304, 1311-1312, 1321-1322, 1324, 1334, 1401-1402, 1411 and 1412. Standards for QHP issuers are codified at 45 CFR parts 155 and 156.

Table 2. Burden for QHP Issuers: QHP Certification

Year	Number of Issuers	Hours Per Issuer	Total Burden Hours	Total Burden Cost Per Issuer	Total Burden Costs (All Issuers)
2022	215	196	42,140	$14,249.20	$3,063,578
2023	215	196	42,140	$14,249.20	$3,063,578
2024	215	196	42,140	$14,249.20	$3,063,578

Burden for Stand-Alone Dental Issuers: QHP Certification

The burden on stand-alone dental issuers for the QHP certification each year is estimated to be 21,600 total burden hours, or 80 hours per issuer. It is estimated that 270 issuers offering 3 plans each will participate in an Exchange or go through the certification process to offer an Exchange-certified SADP off the Exchange. The number of issuers is based on the number of applications for plan year 2022. At an adjusted hourly wage rate of $72.70 (includes 100% fringe benefit), the total cost was estimated to be $5,816 per issuer. The estimates also include recertification for SADP issuers.

Pursuant to PPACA section 1311 and 45 CFR 155.1065, each Exchange permits issuers to offer limited scope dental benefits as stand-alone dental plans or in conjunction with a QHP.

Table 3. Burden for Stand-Alone Dental Issuers: QHP Certification

Year	Number of Issuers	Hours Per Issuer	Total Burden Hours	Total Burden Cost Per Issuer	Total Burden Costs (All Issuers)
2022	270	80	21,600	$5,816	$1,570,320
2023	270	80	21,600	$5,816	$1,570,320
2024	270	80	21,600	$5,816	$1,570,320

Burden for Non-QHP Issuers and QHP Issuers (for plans outside the Exchange) Offering Plans in the Individual and Small Group Market: Risk Adjustment
All issuers in the individual and small group market are required to submit reference data, to include but not be limited to administrative information about the issuer and its non-QHP offerings, AV levels for those plans, which will be used for the risk adjustment program. There are an estimated 2,400 issuers in the individual and small group market that will not be offering any QHPs through an Exchange. The total estimated burden for the submission for these issuers is 7,800 hours or 3.25 hours per issuer. At an adjusted hourly wage rate of $72.70 (includes 100% fringe benefit), the total cost was estimated to be $236.28 per issuer per year.

Pursuant to PPACA section 1343, each state will establish a permanent program of risk adjustment for all non-grandfathered plans in the individual and small group markets. If a state chooses not to actively participate in risk adjustment, CMS will be responsible for implementation. The requirements for issuers with plan offerings outside of the Exchanges are codified at 45 CFR 153.

Table 4. Burden for Non-QHP Issuers and QHP Issuers Offering Plans in the Individual and Small Group Market: Risk Adjustment

Year	Number of Issuers	Hours Per Issuer	Total Burden Hours	Total Burden Cost Per Issuer	Total Burden Costs (All Issuers)
2022	2,400	3.25	7,800	$236.28	$567,072
2023	2,400	3.25	7,800	$236.28	$567,072
2024	2,400	3.25	7,800	$236.28	$567,072

Burden for States: State-based Exchanges (SBEs) using the Federal Platform and Partnership States Those states that are engaged with CMS as a State Partner will have an identical Plan Management burden as those operating a State-based Exchange using the Federal Platform since they will be performing all of the Plan Management activities, including QHP certification. It is assumed that the majority of states in State-based Exchanges using the Federal Platform and Partnerships will continue to leverage their existing systems that are used by the state departments of insurance. We have also taken into consideration the fact that there can be variation in what the states do from year to year. The state will have a burden of 3 hours to submit data to the Federal government for a total burden of $218.10 per state per year.

Pursuant to 45 CFR part 155, State-based Exchanges are required to perform plan management functions and QHP certification activities. Table 5 and Table 6 below display the burden to States relating to this regulatory provision.

Table 5. Burden for States: State-based Exchanges using the Federal Platform and Partnership States

Year	Number	Hours	Total Burden	Total Burden	Total Burden

	of States	Per State	Hours	Cost Per State	Costs (All States)
2022	22	3	66	$218.10	$4,798.20
2023	22	3	66	$218.10	$4,798.20
2024	22	3	66	$218.10	$4,798.20

Burden for States: State-based Exchanges (SBEs)
Those states that are engaged with CMS as State-based Exchanges will have an identical Plan Management burden as those operating a State-based Exchange using the Federal Platform since they will be performing all of the Plan Management activities, including transferring their certified QHP data to CMS. We have also taken into consideration the fact that there can be variation in what the states do from year to year. The state will have a burden of 3 hours to submit data to the Federal government for a total burden of $218.10 per state per year.

Table 6. Burden for States: State-based Exchanges

Year	Number of States	Hours Per State	Total Burden Hours	Total Burden Cost Per State	Total Burden Costs (All States)
2022	18	3	54	$218.10	$3925.80
2023	18	3	54	$218.10	$3925.80
2024	18	3	54	$218.10	$3925.80

Table 7. Summary of Annual Total Burden

Table Number: Name	CFR Section	Total Burden Hours	Total Burden Costs
Table 2: Burden for QHP Issuers: QHP Certification	45 C.F.R. § 155 and 156	42,140	$3,063,578
Table 3: Burden for Stand-Alone Dental Issuers: QHP Certification	45 C.F.R. § 155.1065	21,600	$1,570,320
Table 4: Burden for Non-QHP Issuers and QHP Issuers Offering Plans in the Individual and Small Group Market: Risk Adjustment	45 C.F.R. § 153	7,800	$567,072
Table 5: Burden for States: State-based Exchanges using the Federal Platform and Partnership States	45 C.F.R. § 155	66	$4,798.20
Table 6: Burden for States: State-based Exchanges	45 C.F.R. § 155	54	$3,925.80
Total		**71,660**	**$5,209,694**

13. Capital Costs

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

14. Cost to Federal Government

We estimate the operations and maintenance costs for the data collection tool and the data collection support to have a total cost of $186,141.06 per year. 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/2021/GS_h.pdf

Table 6. Administrative Burden Costs for the Federal Government Associated with the Continuation of Data Collection to Support QHP Certification and other Financial Management and Exchange Operations

Task	Estimated Cost
Operations, maintenance, and data collection support	
GS-13 (step 7): 4.2 x $91.38[1] x 485 hours	$186,141.06
Total Cost to Government	**$186,141.06**

15. Changes to Burden

There is an overall increase in the financial burden from the 2019 PRA package because of an increase in the adjusted hourly wage of the compliance officer position from the Bureau of Labor Statistics from $68.78 to $72.70. The number of QHP issuers increased from 200 to 215 issuers based on the number of QHP certification issuers for plan year 2022. Also, there is additional burden for states that are engaged with CMS as State-based Exchanges as they will be performing Plan Management activities (see Table 6).

The currently approved Information Collection Requirement (ICR) burden is for 2,892 respondents, and the proposed ICR estimates 2,925 respondents. The estimated burden hours for this data collection are currently approved for 68,666 hours. With this ICR, the estimated annualized burden hours are 71,660. This is an increase of 2,994 burden hours compared to the previously approved clearance.

In addition, the change in burden is due to adjustments to the data collection instruments. The estimated annual costs increased from $4,722,848 to $5,209,694. This is an increase in annual costs of $486,846.

16. Publication/Tabulation Dates

Some of the results of the collection will be made public on www.healthcare.gov as part of displays for consumers for Open Enrollment.

17. Expiration Date

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