

**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, which expired April 30, 2022, and in 2022, expiring April 30, 2025. This Information Collection Request (ICR) serves as a formal request for the renewal of the data collection. It also includes a request for an extension 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) Exchange, including Standalone 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. Scope of Respondents

The current collection applies to issuers using the Healthcare.gov platform, including issuers in states with an FFE or SBE-FP. As previously noted, 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). Such 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 any expansion of the collection beyond Exchanges will be added in at a future time. We understand that adding these entities is a priority for many interested parties, but with these ICRs, our proposal is to increase the data points that we are collecting from the existing respondents. As noted above, expanding the respondents beyond QHP issuers would require additional rulemaking, and would also require additional IT builds.

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.

Starting with the PY26 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 use 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: PY26 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** includes some elements not noted in **Appendix A1**.

For the PY27 and PY28 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: PY27-PY28 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 PY26 through PY28 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 Marketplace Plan Management System 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. PY26 Transparency in Coverage Data Collection Instrument (See Appendix A1. PY26 Collection Instrument)

CMS seeks feedback on the data collection instrument to be implemented in PY26 (Appendix A1). For PY26, 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. For a full list of the categories and data elements see Appendix A1.

- **Issuer Level Claims Data**
- **Plan Level Claims Data**

In addition, issuers will categorize all claims denials into one of several denial code categories, as follows:

- **Enrollee 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;
- **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 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. PY26 Data Elements to be Displayed (See Appendix B1. PY26 QHP Public Use File)

CMS seeks feedback on the proposed Transparency in Coverage PUF to be implemented in PY26 (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. PY27-PY28 Transparency in Coverage Data Collection Instrument (See Appendix A2. PY27-PY28 Collection Instrument)

CMS seeks feedback on the revised data collection instrument to be implemented for PY27 and PY28 (**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 data separately for claims that were and were not related to behavioral health, and to report data regarding pre-service claims. Similarly, CMS proposes to require issuers to report claim denial reason by in- and out-of-network status. We believe that these changes will make the reporting requirements clearer for issuers and ensure that the data collected accurately reflect issuers' claims processing procedures and outcomes.

Simultaneously, we believe that these additional requirements will not be so burdensome as to represent a significant increase in time or effort expended by reporting entities. Specifically, we have sought to expand the collection in ways that still accord with data storage and reporting infrastructure issuers already have in place, rather than requiring that issuers either 1) collect or store entirely new data elements, or 2) build additional architecture to allow data to be categorized and exported in accordance with our requirements. For a full list of the categories and data elements see Appendix A2.

- **Issuer Level Claims Data**
- **Plan Level Claims Data**

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:

- **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 claim was denied *due to* the claim coming from an out-of-network provider or facility.
- **Benefit limit reached (Out-of-Network):** 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 (Out-of-Network):** 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 (Out-of-Network):** Issuers would report denials of claims for cosmetic procedures and those that are deemed experimental or investigational in nature;
- **Referral or prior authorization required (Out-of-Network):** Issuers would report denials of nonemergency-related claims that may require prior authorization, or a referral;
- **Services excluded or not covered (Out-of-Network):** Issuers would report denial of claims for services exclusion or non-covered services that are not covered benefits;
- **Not medically necessary, excluding behavioral health (Out-of-Network):** 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 (Out-of-Network):** 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;
- **Administrative (Out-of-network):** 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 (Out-of-network):** Issuers would report claims denied for other reasons not captured in the previous categories.
- **Benefit limit reached (In-Network):** 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 (In-Network):** 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 (In-Network):** Issuers would report denials of claims for cosmetic procedures and those that are deemed experimental or investigational in nature;

- **Referral or prior authorization required (In-Network):** Issuers would report denials of nonemergency-related claims that may require prior authorization, or a referral;
- **Services excluded or not covered (In-Network):** Issuers would report denial of claims for services exclusion or non-covered services that are not covered benefits;
- **Not medically necessary, excluding behavioral health (In-Network):** 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 (In-Network):** 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;
- **Administrative (In-network):** 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 (In-network):** Issuers would report claims denied for other reasons not captured in the previous categories.

VI. PY27-PY28 Data Elements to be Displayed (See Appendix B2. PY27-PY28 QHP Public Use File)

CMS seeks feedback on the proposed Transparency in Coverage PUF to be implemented in PY27 and continue to PY28 (**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, including the model language provided, 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 Marketplace Plan Management System (MPMS) module 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.);

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.

- 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 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 has not previously used the information submitted in this PRA package for oversight purposes, based on issuers' concerns that they lacked experience with the submission at the time of the inaugural submission. However, CMS believes that issuers have now had sufficient time to become familiar with these reporting requirements and to implement data capture and reporting processes accordingly. Further, over the years, CMS has conducted general issuer outreach prior to the certification cycle to seek feedback on the collection and process in general, provided extensive technical assistance during each certification cycle, refined the instructions based on issuer feedback, and implemented built-in data validations. CMS also forecasted this change in posture in the [2025 Final Letter to Issuers](#).

Considering the above and given recent increased public interest in transparency and claims data in particular, CMS believes it is now appropriate to examine the data issuers submit more closely as part of this collection to confirm their accuracy and to shed light on consumers' experiences when receiving care and seeking to use their coverage. It is CMS' expectation that issuers communicate questions about the submission prior to or during the certification process, so that final data is accurate. It is imperative that the public-facing PUF – which consumers use to research plans, researchers use to analyze coverage trends, and the media use to report on the health insurance industry – reflect accurate data at the time of publication.

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 have aimed to coordinate with other entities collecting similar data 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

The 60-day Federal Register Notice was published in the Federal Register on April 21, 2025 (90 FR 16685) for the public to submit written comment on the information collection requirements. Three comments were received that were relevant to this ICR. These comments are summarized and responses provided in **Appendix E**. The three comments that were received from the public are provided in **Appendix F**.

The 30-day Federal Register Notice will be published in the Federal Register on September 24, 2025 (90 FR 45941) for the public to submit written comment as part of a second-round public comment period.

Throughout the past several years of transparency in coverage reporting activities, CMS has received extensive feedback from key stakeholders and the proposed changes in this collection are based on their feedback.

9. Payments/Gifts to Respondents

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

10. Confidentiality

All information collected will be kept private in accordance with regulations at 45 C.F.R. 155.260, Privacy and Security of Personally Identifiable Information. Pursuant to this regulation, Exchanges may only use or disclose personally identifiable information to the extent that such information is necessary to carry out their statutorily and regulatorily mandated functions.

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 is attributed to QHP issuers. The burden estimates were developed based on our previous experience with transparency in coverage data reporting activities. We estimate 400 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 400 QHP issuers is based on the number of issuers whose QHPs, including SADPs, appeared on HealthCare.gov in PY25.

We used the Bureau of Labor Statistics (BLS), National Industry-Specific Occupational Employment and Wage Statistics, May 2024 (<https://data.bls.gov/oes/#/industry/000000>) to estimate the burden (including 100 percent fringe benefits) for this information collection. For a description of the median hourly wages for the labor categories see Table 1.

Table 1: Adjusted Hourly Wages Used in Burden Estimates

Occupational Title	Occupational Code	Median Hourly Wage (\$/hour)	Fringe Benefits and Overhead (100%)(\$/hour)	Adjusted Hourly Wage (\$/hour)
Web Developer and Digital Interface Designer	15-1255	\$47.16	\$47.16	\$94.32
Computer Programmer	15-1251	\$47.44	\$47.44	\$94.88
Computer and Information Systems Manager	11-3021	\$82.31	\$82.31	\$164.62
Social Science Research Assistant	19-4061	\$27.90	\$27.90	\$55.80
Operations Research Analyst	15-2031	\$43.89	\$43.89	\$87.78
General and Operations Manager	11-1021	\$49.50	\$49.50	\$99.00

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 \$1,251.22 per issuer for the one-time technical modification, with a total burden of 4,400 hours and \$500,488 for all 400 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	400	\$94.32	3	\$282.96	\$113,184
Computer Programmer	400	\$94.88	5	\$474.40	\$189,760
Computer and Information Systems Manager	400	\$164.62	3	\$493.86	\$197,544
Total – One Time			11	\$1,251.22	\$500,488

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 \$2,874.30 per issuer for the annual submission of Transparency in Coverage data, with an annual total burden of 17,600 hours and annual cost of \$1,149,720 for all 400 QHP issuers. The total three-year burden estimate is 52,800 hours at a total cost of \$3,449,160.

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)³

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)
Social Science Research Assistant	400	\$55.80	33	\$1,841.40	\$736,560
Operations Research Analyst	400	\$87.78	5	\$438.90	\$175,560
General and Operations Manager	400	\$99.00	6	\$594.00	\$237,600
Total – Annual			17,600	\$2,874.30	\$1,149,720
Total – Three Years			52,800	\$8,622.90	\$3,449,160

Thus, as outlined in Table 4, below, the estimated burden costs for the one-time technical modification is \$1,251.22 per issuer, with the total burden costs for all issuers being \$500,488. Additionally, the estimated burden costs for the submission of transparency in coverage data is \$8,622.90 per issuer, with the total burden costs for all issuers being \$3,449,160. The total three-year burden estimates for the two phases of this data collection is \$9,874.12 per issuer, total burden hours for all issuers is 57,200 hours, and the total burden cost is \$3,949,648 for all issuers.

Table 4: Summary of Total Burden

Table Number: Name	C.F.R. Section	Burden Hours	Burden Cost
Table 2: Burden per Issuer: One-Time Technical Modification	45 C.F.R. § 156.220 and 155.20	4,400	\$500,488
Table 3: Burden per Issuer: Annual Submission of Transparency in Coverage Data (Years 1-3)	45 C.F.R. § 156.220 and 155.20	52,800	\$3,449,160
Total – Three Years		57,200	\$3,949,648

³ In the original PRA package data collection, approved June 16, 2016, year one estimated a total of 475 issuers and 34 hours, for a total burden of \$2154.46 per issuer. The 2019 package for year one estimated a total of 470 issuers and 42 burden hours, for a total burden of \$1850.52 per issuer per year, totaling \$5,551.56. The 2022 package for year one estimated a total of 360 issuers and 132 hours, for a total burden of \$8,322.84 per issuer.

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 \$268,952.32 annually. The calculations for CMS employees' hourly salary were obtained from the OPM website: https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/25Tables/html/DCB_h.aspx

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 (step 1): 1 x \$97.18 ¹ x 2,080 hours	\$202,134.40
Managerial Review and Oversight	
0.2 FTE GS-15 (step 1): 0.2 x \$160.62 ¹ x 2,080 hours	\$66,817.92
Total Costs to Government - Annual	\$268,952.32

¹ Hourly basic rate + 100% fringe benefit rate.

15. Changes to Burden

There is an overall increase in the financial burden from the 2022 PRA package. The number of QHP issuers increased from 360 issuers to 400 issuers, an increase of 40 issuers. The total burden hours increased from 51,480 hours to 57,200 hours, an increase of 5,720 hours. The estimated cost increased from \$3,404,476.80 to \$3,949,648, an increase of \$545,171.20. All prior iterations of wage data was based on mean values and the current iteration is based on median values.

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).

18. Certification Statement

There are no exceptions to the certification statement.