Supporting Statement for Marketplace Operations
(CMS-10637/OMB control number: 0938-1353)

A. Background

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148) was signed into law and on March 30, 2010, the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was signed into law. The two laws implement various health insurance policies.

On June 19, 2013, HHS published the proposed rule CMS-9957-P: *Program Integrity: Exchanges, SHOP, Premium Stabilization Programs, and Market Standards* (78 FR 37302) (Program Integrity Proposed Rule). Among other things, the Program Integrity Proposed Rule sets forth financial integrity provisions and protections against fraud and abuse. On January 30, 2013, CMS published *Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges under the Affordable Care Act* (CMS-2334-P) (E&E II Proposed Rule).

On August 30, 2013, HHS published the final rule CMS-9957-F*: Program Integrity: Exchanges, SHOP, Eligibility Appeals* (Program Integrity Final Rule), finalizing a number of the provisions from the Program Integrity and E&E II Proposed Rules. The third-party disclosure requirements and data collections in the Program Integrity Final Rule support the oversight of qualified health plan (QHP) issuers in Federally-facilitated Exchanges (FFEs) and other provisions.

This Information Collection Request (ICR) serves as the formal request for an extension without change of a currently approved clearance. The original approved ICR affiliated with the *Program Integrity and Additional State Information Collections* Final Rule (OMB control number: 0938-1213) was approved on November 21, 2013. This ICR also includes some of the information collection requirements from the previously approved Final Rule.

B. Justification

1. Need and Legal Basis

Section 1321(c)(1) of the Affordable Care Act requires the Secretary to establish and operate an FFE within States that either do not elect to operate an Exchange; or, as determined by the Secretary, will not have any required Exchange operational by January 1, 2014.

Section 1321(c)(2) of the Affordable Care Act authorizes the Secretary to enforce the Exchange standards using civil money penalties (CMPs) on the same basis as detailed in section 2723(b) of the Public Health Service Act (PHS Act).[1] Section 2723(b) of the PHS Act authorizes the Secretary to impose CMPs as a means of enforcing the individual and group market reforms contained in Title XXVII, Part A of the PHS Act when a State fails to substantially enforce these provisions.

[1] Section 1321(c) of the Affordable Care Act erroneously cites to section 2736(b) of the PHS Act instead of 2723(b) of the PHS Act.

Sections 1313 and 1321 of the Affordable Care Act provide the Secretary with the authority to oversee the financial integrity of QHP issuers, compliance with HHS standards, and efficient and non-discriminatory administration of State Exchange activities. Section 1313(a)(6)(A) of the Affordable Care Act specifies that payments made by, through, or in connection with an Exchange are subject to the False Claims Act (31 U.S.C. 3729, et seq.) if those payments include any Federal funds.

Section 1401 of the Affordable Care Act amended the Internal Revenue Code (26 U.S.C.) to add § 36B, allowing a refundable premium tax credit to help individuals and families afford health insurance coverage. Under sections 1401, 1411, and 1412 of the Affordable Care Act and 45 CFR part 155, subpart D, an Exchange will make a determination of advance payments of the premium tax credit for individuals who enroll in QHP coverage through an Exchange and seek financial assistance. Section 1402 of the Affordable Care Act provides for the reduction of cost sharing for certain individuals enrolled in a QHP through an Exchange, and section 1412 of the Affordable Care Act provides for the advance payment of these reductions to issuers.

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

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

The Affordable Care Act directs issuers offering non-grandfathered health insurance coverage in the individual and small group markets to ensure that plans meet an actuarial value (AV) level of coverage specified in section 1302(a)(3) of the Affordable Care Act and as defined in 45 CFR 156.140(b). Consistent with section 1302(d)(2)(A) of the Affordable Care Act, AV is calculated based on the provision of the essential health benefits (EHB) to a standard population and is a measure of the percentage of expected health care costs a health plan will cover for a standard population.

2. Information Users

The data collections and third-party disclosure requirements will assist HHS in determining Exchange compliance with Federal standards and monitoring QHP issuers in FFEs for compliance with Federal QHP issuer standards. These data collections will assist HHS in monitoring web-brokers for compliance with Federal web-broker standards. The data collected by health insurance issuers and Exchanges will help to inform HHS, Exchanges, and health insurance issuers as to the participation of individuals, employers, and employees in the individual Exchange, the SHOP, and the premium stabilization programs.

3. Use of Information Technology

HHS anticipates that a majority of the systems, notices, and information collection required will be automated. A majority of the information that is required by the collection of information will be submitted electronically. HHS staff will analyze or review the data in the same manner by which it was submitted and communicate with states, health insurance issuers, and other entities using e-mail, telephone, or other electronic means.

4. Duplication of Efforts

This information collection does not duplicate any other Federal effort.

5. Small Businesses

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

6. Less Frequent Collection

Due to the required flow of information between multiple parties and flow of funds for payments for health insurance coverage within the Exchange, it is necessary to collect information according to the indicated frequencies. If the information is collected less frequently, the result would be less accurate, untimely or unavailable eligibility, enrollment or payment information for Exchanges, insurers, employers, and individuals. This would lead to delayed payments to issuers, late charges to or payments by employers and enrollees, inaccurate or inappropriate payments of advance premium tax credits and cost sharing reductions, the release of misleading information regarding health care coverage to potential enrollees, and an overall stress on the organizational structure of the Exchanges. Furthermore, if the information is not collected in the timeframe, HHS will not be able to properly ensure the financial integrity of Federal funds.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

A 60-day Notice was published in the Federal Register on July 11, 2025 (90 FR 30940) for the public to submit written comment on the information collection requirements. One comment was received that was relevant to this ICR. This comment is summarized and response provided in **Appendix A**. The comment that was received from the public is provided in **Appendix B.**

The 30-day Federal Register Notice will be published in the Federal Register on December 11, 2025 (90 FR 57437) for the public to submit written comment as part of a second-round public comment period.

No additional outside consultation was sought.

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 CFR 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 following section of this document contains an estimate of the burden imposed by the associated ICRs. Average labor costs (including 100% fringe benefits) used to estimate the burden associated with the collections are calculated using data from the May 2024 National Industry-Specific Occupational Employment and Wage Estimates from the Bureau of Labor Statistics (BLS).

Table 1: Adjusted Hourly Wages Used in Burden Estimates

Occupational Title	Occupational Code	Median Hourly Wage ($/hr)	Fringe Benefits & Overhead (100%)($/hr)	Adjusted Hourly Wage ($/hr)
Database Administrator	15-1242	$50.30	$50.30	$100.60
Actuary	15-2011	$60.47	$60.47	$120.94
General and Operations Manager	11-1021	$49.50	$49.50	$99.00
Compliance Officer	13-1041	$37.70	$37.70	$75.40
Lawyer	23-1011	$72.67	$72.67	$145.34
Insurance Claims and Policy Processing Clerk	43-9041	$23.29	$23.29	$46.58
Software Developer	15-1252	$63.98	$63.98	$127.96

State-Specific Standard Population (§ 156.135)

In accordance with 45 CFR 156.135(d), HHS established that beginning in 2015, a State may submit a State-specific standard population to be used for AV calculations, so long as the criteria at § 156.135(d)(1) through (6) are met. In particular, a State that intends to submit a State-specific standard population must submit to HHS summary evidence that the requirements described in §156.135 are met and that the dataset is in a format that will support the use of the

AV calculator.

No States have elected to pursue this option to date, we anticipate a limited number of States pursuing this option in the future. **Given that we estimate that only one State will pursue this option in the next three years, this collection is exempt from PRA requirements and will not be included in total burden calculations**. We estimate that for each State pursuing this option, the data submission will require 15 hours from a database administrator at a median hourly cost of $100.60, four hours from an actuary at a median hourly cost of $120.94, and one hour from a general and operations manager at a median hourly cost of $99.00. We estimate the total burden for a State to be 20 hours at a cost of $2,091.76.

Table 2: State Burden in Submitting Information Required for State-Specific Standard Population Option

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly Rate + 100% Fringe Benefits)	Burden Hours (Per Respondent)	Total Burden Costs (Per Respondent)	Total Burden Costs (All Respondents)
Database Administrator	1	$100.60	15	$1,509.00	$1,509.00
Actuary	1	$120.94	4	$483.76	$483.76
General and Operations Manager	1	$99.00	1	$99.00	$99.00
Total			**20**	**$2,091.76**	**$2,091.76**

Enforcement Remedies in Federally-facilitated Exchanges (§ 156.800 and § 156.810)

Subpart I of Part 156 provides HHS the authority to enact a range of enforcement remedies in the FFEs. In accordance with § 156.800, HHS may impose sanctions on QHP issuers in the FFEs that fail to comply with applicable Federal standards. These sanctions may be in the form of HHS issuing noncompliant issuers CMPs in accordance with §156.805 or HHS decertifying noncompliant issuers' QHPs in accordance with §156.810.

The general process and bases for HHS imposing a CMP on noncompliant issuers offering QHPs in the FFEs are specified at § 156.805(a). CMPs are generally only imposed in instances of severe noncompliance with applicable Federal standards. We will continue to provide technical assistance to issuers, as appropriate, to assist them in maintaining compliance with the applicable Federal standards. We also plan to continue coordinating with States in our oversight and enforcement activities to avoid duplicative enforcement efforts.

No CMPs have been imposed in the last several years and we estimate that this trend will continue in the future. **Given that we estimate that only one issuer will receive and appeal a CMP in the next three years, this collection is exempt from PRA requirements and will not be included in total burden calculations.** We estimate that each issuer receiving and appealing a CMP will utilize a compliance officer at a median hourly rate of $75.40 for 60 hours, a lawyer

at a median hourly rate of $145.34 for 60 hours, and a general and operations manager at a median hourly rate of $99.00 for 30 hours. We estimate the total burden for an issuer receiving and appealing a CMP to be 150 hours at a cost of $16,214.40.

Table 3: Issuer Burden in Receiving and Appealing Civil Money Penalty

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly Rate + 100% Fringe Benefits)	Burden Hours (Per Respondent)	Total Burden Costs (Per Respondent)	Total Burden Costs (All Respondents)
Compliance Officer	1	$75.40	60	$4,524.00	$4,524.00
Lawyer	1	$145.34	60	$8,720.40	$8,720.40
General and Operations Manager	1	$99.00	30	$2,970.00	$2,970.00
Total			**150**	**$16,214.40**	**$16,214.40**

Section 156.810 provides the bases for the decertification of a QHP in an FFE and the general process for decertification. Decertification is reserved for only instances of severe noncompliance with applicable Federal standards. HHS anticipates that decertification will occur relatively infrequently. No issuers' QHPs have been decertified in the last several years and we estimate that this trend will continue in the future.

Given that we estimate that only one issuer will appeal said decertification in the next three years, this collection is exempt from PRA requirements and will not be included in total burden calculations. We estimate an issuer that is decertified and that appeals this decertification will utilize a compliance officer for 40 hours at a median hourly rate of $75.40, a lawyer for 40 hours at a median hourly rate of $145.34, and a general and operations manager for 20 hours at a median hourly rate of $99.00. We estimate the total burden for an issuer that is decertified and appeals this decertification to be 100 hours at a cost of $10,809.60.

Table 4: Issuer Burden in Decertification and Appeal of Decertification Action

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly Rate + 100% Fringe Benefits)	Burden Hours (Per Respondent)	Total Burden Costs (Per Respondent)	Total Burden Costs (All Respondents)
Compliance Officer	1	$75.40	40	$3,016.00	$3,016.00
Lawyer	1	$145.34	40	$5,813.60	$5,813.60
General and Operations Manager	1	$99.00	20	$1,980.00	$1,980.00
Total			**100**	**$10,809.60**	**$10,809.60**

Consumer Cases Related to Qualified Health Plans and Qualified Health Plan Issuers (§ 156.1010)

In subpart K of part 156, we describe the information collection requirements pertaining to the resolution of consumer cases related to QHPs and QHP issuers. Section 156.1010(g)(1) provides that QHP issuers must include the date of case resolution, § 156.1010(g)(2) provides that QHP issuers must record a clear and concise narrative documenting the resolution of a consumer case in the HHS-developed casework tracking system, and § 156.1010(g)(3) provides that QHP issuers must provide information about compliance issues found by a State during the investigation of a case.

The burden associated with this requirement is the time and effort necessary for the staff of a QHP issuer to gather information related to the consumer complaint, draft the narrative, and enter the narrative into the electronic HHS-developed case tracking system. We estimate 415 issuers (including both medical QHP and standalone dental plan (SADP) issuers in the FFEs and State-based Exchanges on the Federal Platform (SBE-FPs)) will be subject to this requirement based on the number of QHP issuers in Plan Year 2026. We estimate that each issuer will utilize insurance claims processing clerks for 4,800 hours at a median hourly rate of $46.58 and general and operations managers for 800 hours at a median hourly rate of $99.00. We estimate the total burden per issuer is 5,600 hours at a cost of $302,784.00. We estimate the total burden for all issuers to be 2,324,000 hours at a cost of $125,655,360.00.

Table 5: Issuer Burden in Maintaining Records of Consumer Case Resolution and Inputting into HHS-Developed Casework Tracking System

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly Rate + 100% Fringe Benefits)	Burden Hours (Per Respondent)	Total Burden Costs (Per Respondent)	Total Burden Costs (All Respondents)
Insurance Claims and Policy Processing Clerk	415	$46.58	4,800	$223,584.00	$92,787,360.00
General and Operations Manager	415	$99.00	800	$79,200.00	$32,868,000.00
Total			**5,600**	**$302,784.00**	**$125,655,360.00**

Enrollment Process for Qualified Individuals (§ 156.1230)

In accordance with § 156.1230(a)(1)(ii), issuers must provide information on available QHPs when they use their websites to directly enroll qualified individuals into QHPs in a manner considered to be through the Exchange, a process known as Direct Enrollment (DE). The QHP information required to be posted on the DE websites includes premium and cost sharing information, the summary of benefits and coverage, metal level, results of the enrollee satisfaction survey, quality ratings, medical loss ratio information, transparency in coverage measures, and a provider directory.

Additionally, § 156.1230(a)(1)(iv) requires issuers' DE websites to inform applicants about the availability of other QHP products available through an Exchange through an HHS-approved universal disclaimer and to display a link to the appropriate Exchange website. Issuers are also required to distinguish between QHPs for which a consumer is eligible and other non-QHPs that an issuer may offer pursuant to § 156.1230(a)(1)(iii). Finally, an issuer must allow a consumer to select and attest to an APTC amount pursuant to § 156.1230(a)(1)(v).

The burden for these requirements relates to issuers developing and maintaining DE websites in accordance with the requirements described above. Approximately 74 issuers currently utilize DE and are thus subject to the disclosure requirements described above. Based on current DE issuer participation as well as future potential market size, we estimate the number of participating issuers to increase to 88 total in subsequent years. This is the number of issuers used in calculating burden estimates.

We estimate that it will require a software developer 15 hours at a median hourly cost of $127.96 to develop and maintain the required QHP information on their websites in accordance with §156.1230(a)(1) annually for each issuer. We estimate the total burden per issuer to be 15 hours at a total annual cost of $1,919.40. We estimate the total burden for all issuers to be 1,320 hours at a cost of $168,907.20.

Table 6: Issuer Burden in Maintaining DE Web Site

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly Rate + 100% Fringe Benefits)	Burden Hours (Per Respondent)	Total Burden Costs (Per Respondent)	Total Burden Costs (All Respondents)
Software Developer	88	$127.96	15	$1,919.40	$168,907.20
Total			**15**	**$1,919.40**	**$168,907.20**

Table 7. Summary of Annual Total Burden

Table Number: Name	CFR Section	Burden Hours	Burden Cost
Table 5: Issuer Burden in Maintaining Records of Consumer Case Resolution and Inputting into HHS-Developed Casework Tracking System	45 C.F.R. 156.1010(g)(1)-(3)	2,324,000	$125,655,360.00
Table 6: Issuer Burden in Maintaining DE Web Site	45 C.F.R. 156.1230(a)(1)(ii)-(iv)	1,320	$168,907.20
Total		**2,325,320**	**$125,824,267.20**

13. Capital Costs

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

14. Cost to Federal Government

The burden to the Federal government for maintaining the systems and policies associated with this information collection is $888,078.00. The calculations for the Center for Consumer Information and Insurance Oversight (CCIIO) employees' hourly salary was obtained from the OPM website.

Table 8: Administrative Burden Costs for the Federal Government Associated with the Program Integrity and Additional State Collections

Task	**Estimated Cost**
Maintenance of Program Integrity Information Collections	
15 GS-13 (step 7): 15 x $138.66[1] x 200 hours	$415,980.00
Technical Assistance to States	
15 GS-13 (step 7): 15 x $138.66[1] x 200 hours	$415,980.00
Managerial Review and Oversight	
2 GS-15 (step 7): 2 x $187.06[1] x 150 hours	$56,118.00
Total Costs to Government	**$888,078.00**

[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 because of the increase in the number of issuers from 437 to 503, which is an increase of 66 issuers. Regarding the issuer burden in maintaining records of consumer case resolution and inputting into the HHS-developed casework tracking system, there was an increase in the number of respondents from 361 in the previous package to 415 in the current package. Additionally, regarding issuer burden in maintaining a DE web site, there was an increase in the number of respondents from 77 in the previous package to 88 in the current package.

The total annual burden increased from 2,022,725 hours to 2,325,340 hours, which is an increase of 302,595 hours. The estimated annual cost increased from $110,015,472.00 to $125,824,267.20, which is an increase of $15,685,180.20. All prior iterations of wage data was based on mean values and the current iteration is based on median values.

16. Publication/Tabulation Dates

The OPEN Government Data Act (Title II of the Foundations for Evidence-Based Policymaking Act of 2018, P.L. 115-435) requires Federal agencies to publish all public government data assets online as open data, using standardized, machine-readable data formats.

Regarding the first ICR pertaining to State-specific standard populations at § 156.135, given that no States have elected to pursue this option to date, there is no data to publish at this time. Regarding the second ICR pertaining to enforcement remedies in the FFEs at §§ 156.800 and 156.810, Plan Year FFE Compliance Review Summary Reports, which are deidentified aggregate reports on a given year's compliance reviews, can be found on the CCIIO Examinations, Audits and Reviews of Issuers: Issuer Resources website.

Regarding the third ICR pertaining to consumer cases related to QHPs and QHP issuers ICR at § 156.1010, there is no publicly available data since this data contains consumer personally identifiable information (PII) and protected health information (PHI) as well as confidential issuer information. Regarding the final ICR pertaining to the enrollment process for qualified individuals at § 156.1230, there is no publicly available data for this ICR since it pertains to developing and maintaining DE websites, which are publicly available. Furthermore, all available data for the health plans offered on these DE websites are also publicly available for the corresponding plans on *HealthCare.gov*.

17. Expiration Date

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

18. Certification Statement

There are no exceptions to the certification statement.