

**Initial Plan Data Collection to Support QHP
Certification and other Financial Management and Exchange Operations
Supporting Statement
(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, more transparent, and put greater control and 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 offer health plans that are certified as QHPs and ensure each plan meets 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. A QHP must meet certain minimum certification standards, such as network adequacy, inclusion of Essential Community Providers (ECPs), and non-discrimination clauses.

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” plan offerings. 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 revision of the data collection clearance. We intend to use the instruments in this information collection for the 2025 certification process and beyond. By providing these instruments prior to plan year 2026, we will give issuers and other stakeholders an opportunity to familiarize themselves with the instruments before releasing the 2025 application. While we intend to use these instruments in 2025, 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 public comment periods.

The burden for Actuarial Memorandum required for the review of rates for rate review, premium allocation for APTCs, and CSR payment has been removed from this PRA package as it is

included the Rate Increase Disclosure and Review Requirements PRA (CMS-10379/OMB control number: 0938-1141).

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, 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 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.

Pursuant to 45 CFR 156.210(d)(1), issuers of SADPs, as a condition of Exchange certification, are required to use an enrollee's age at the time of policy issuance or renewal (referred to as age on effective date) as the sole method to calculate an enrollee's age for rating and eligibility purposes, beginning with Exchange certification for plan year 2024. Additionally, pursuant to 45 CFR 156.210(d)(2), issuers of SADPs, as a condition of Exchange certification, are required to submit guaranteed rates beginning with Exchange certification for plan year 2024. Both of these requirements at § 156.210(d) apply to Exchange-certified SADPs, whether they are sold on- or off- Exchange.

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 (SLCSP), payments for cost-sharing reductions (CSRs), advanced payments of the premium tax credits (APTCs), and the display of information on HealthCare.gov. The data collection requirements apply to SADPs 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, 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.

Essential Community Provider (ECP) Data Elements: CMS captures the number, types of eligible facilities, and status of contract offers with which includes whether the issuer has contracted, offered a contract, and/or attempted to establish acceptance of issuer payments to demonstrate an issuer has a reasonable number and geographic distribution of ECPs included within their networks for the intended service areas as outlined in 45 CFR 156.235.

- **Network Adequacy (NA) Data Elements:** Data related to an issuer's provider network (e.g. National Provider Identifier, provider name, provider address, provider specialty type) to assess the adequacy of the network as outlined in 45 CFR 156.230.
- **Accreditation Data Elements:** If applicable, an issuer must attest that they meet the accreditation standards as outlined under 45 CFR 155.1045 (b)(2). An issuer must also authorize the release of accreditation survey data by a recognized accrediting entity (URAC, the National Committee for Quality Assurance (NCQA), or the Accreditation Association for Ambulatory Health Care (AAAHC) to an Exchange as outlined in 45 CFR 156.275 (a)(2).

- **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.
- **Plan ID Crosswalk Data Elements:** Data related to an issuer’s prior year Individual Market qualified health plan (QHP) and stand-alone dental plan (SADP) plan IDs and associated service area combinations mapped to an on-Exchange plan ID for the upcoming year. CMS reviews the data to ensure that the crosswalks comply with the re-enrollment rules as outlined in 45 CFR 155.335(j). These data facilitate re-enrollment transactions from CMS to the issuer for enrollees in the Individual Market who have not actively selected a different QHP or terminated their coverage during Open Enrollment.
- **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. 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 and Prior Authorization Attestations and Supporting Documentation:** QHP issuers on the Federally-Facilitated Exchange (FFE), including FFEs in states performing plan management functions, must attest to their ability to meet CMS interoperability requirements found in 45 CFR 156.221, 156.222, and 156.223, and provide URLs linking to compliant website content. Issuers that cannot attest to and provide supporting documentation for certain requirements must provide information including 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 captures 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 captures the Essential Health Benefit (EHB) category for each service and capturing visit and service limitations for EHB. CMS also captures plan marketing name for each variant, captures additional Summary of Benefits and Coverage (SBC) scenarios, collects cost share and limitations.

- **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), drug tiers, co-insurance, co-payment information, drugs included in the formulary, formulary version number, prior authorization and step therapy restrictions, and its effective date.
- **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 non-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, with the burden as defined under the Rate Increase Disclosure and Review Requirements (45 CFR Part 154), OMB control number: 0938-1141. 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.

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 within each state market risk pool.

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.) The 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 charges and 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 in a previous revision include:

- **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 an 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: 0938-1141. 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 July 1, 2025 (90 FR 28753) 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 March 26, 2026 (91 FR 14701) 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, user focus groups, conference calls with 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

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, Marketplaces may only use or disclose personally identifiable information to the extent that such information is necessary to carry out their statutory and regulatory 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 can be attributed to QHP issuers, non-Exchange plan issuers, larger group issuers, self-insured, third party-administrators, and states. We developed the associated 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 \$72.76 is the total of the median hourly wage of \$36.38 plus 100% fringe benefit rate of \$36.38, 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	\$36.38	\$36.38	\$72.76

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 25 plans. At an adjusted hourly wage rate of \$72.76 (includes 100% fringe benefit), the total cost per issuer is estimated to be \$14,260.96. 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 2025 plan year. We estimate that it will take a total of 42,140 hours at a cost of \$3,066,106.40 for all QHP issuers.

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

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)
Compliance Officer	215	\$72.76	196	\$14,260.96	\$3,066,106.40
Total			42,140		\$3,066,106.40

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 16,960 total burden hours, or 80 hours per issuer. It is estimated that 212 issuers offering 4 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 2025. At an adjusted hourly wage rate of \$72.76 (includes 100% fringe benefit), the total cost was estimated to be \$5,820.80 per issuer. The estimated total cost for all issuers is \$1,234,009.60. 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

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)
Compliance Officer	212	\$72.76	80	\$5,820.80	\$1,234,009.60
Total			16,960		\$1,234,009.60

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, including but not limited to administrative information about the issuer and its non-QHP offerings as well as AV levels for those plans, which will be used for the risk adjustment program. There are an estimated 527 issuers in the individual and small group market that will

not be offering any QHPs through an Exchange. Of the 527 issuers, 527 issuers submit non-QHP data and 96 issuers submit QHP data, therefore, the total number of respondents is 623 issuers. We developed this number based on the average number of issuers that offer both on and off exchange plans, and those that only offer off-exchange plans. The total estimated burden for the submissions for these issuers is 2,025 hours or 3.25 hours per issuer. At an adjusted hourly wage rate of \$72.76 (includes 100% fringe benefit), the total cost is estimated to be \$236.47 per issuer per year. The estimated total cost for all issuers is \$147,320.81.

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

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)
Compliance Officer	623	\$72.76	3.25	\$236.47	\$147,320.81
Total			2,025		\$147,320.81

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 that there can be variation in how states operate from year to year. Each 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. We estimate that it will take a total of 9 hours at a cost of \$657.84 for all states.

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

Labor Category	Number of States	Hourly Labor Costs (Hourly Rate + 100% Fringe Benefits)	Burden Hours	Total Burden Costs (Per State)	Total Burden Costs (All States)
Compliance Officer	3	\$72.76	3	\$218.10	\$654.84
Total			9		\$654.84

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 that there can be variation in how states operate from year to year. Each state will have a burden of 1 hour to submit data to the Federal government for a total burden of \$72.76 per state per year. There will be 20 states in 2025, and 21 states in 2026 and 2027. The average annual total per state is 20.67 hours at a cost of \$1,503.71. The total for all states over the three-year period is 62 hours at a cost of \$4,511.12.

Table 6. Burden for States: State-based Exchanges

Labor Category/Year	Number of States	Hours Per State	Total Burden Hours	Hourly Labor Costs (Hourly rate + 100% Fringe benefits)	Total Burden Cost (Per State)	Total Burden Costs (All States)
Compliance Officer						
2025	20	1	20	\$72.76	\$72.76	\$1,455.20
2026	21	1	21	\$72.76	\$72.76	\$1,527.96
2027	21	1	21	\$72.76	\$72.76	\$1,527.96
Total - Three Years			62			\$4,511.12

Table 7. Summary of Annual Total Burden

Table Number: Name	CFR Section	Burden Hours	Burden Cost
Table 2: Burden for QHP Issuers: QHP Certification	45 C.F.R. § 155 and 156	42,140	\$3,066,106.40
Table 3: Burden for Stand-Alone Dental Issuers: QHP Certification	45 C.F.R. § 155.1065	16,960	\$1,234,009.60
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	2,025	\$147,320.81
Table 5: Burden for States: State-based	45 C.F.R. § 155	9	\$654.84

Exchanges using the Federal Platform and Partnership States			
Table 6: Burden for States: State-based Exchanges	45 C.F.R. § 155	20.67	\$1,503.71
Total		61,154.67	\$4,449,595.36

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 \$177,504.18 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/26Tables/html/GS_h.aspx.

Table 8. 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 1): 4.2 x \$87.14 ¹ x 485 hours	\$177,504.18
Total Cost to Government	\$177,504.18

¹ Hourly basic rate + 100% fringe benefit rate.

15. Changes to Burden

There is an overall decrease in the financial burden from the 2022 PRA package. The number of stand-alone dental issuers for the QHP certification decreased from 270 to 212, which is a decrease of 58 issuers. The number of issuers in the individual and small group market decreased from 2,400 to 623, which is a decrease of 1,777 issuers. The number of both State-based Exchanges using the Federal Platform decreased from 22 to 3, which is a decrease of 19 states.

The total burden hours decreased from 71,660 hours to 61,154.67 hours, which is a decrease of 10,505.33 hours. The estimated annual cost decreased from \$5,209,694.00 to \$4,449,595.36, which is decrease of \$760,098.64. All prior iterations of wage data were based on mean values and the current iteration is based on median values.

16. Publication/Tabulation Dates

Some of the results of the collection will be made public on www.healthcare.gov as part of data displayed for consumers for Open Enrollment and as downloadable public use files (PUFs) so that stakeholders can more easily access Exchange data.

17. Expiration Date

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

18. Certification Statement

There are no exceptions to the certification statement.