

Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment Supporting Statement for Exchange Provisions (CMS-10468/OMB Control No. 0938-1207)

A. Background

The Patient Protection and Affordable Care Act, Public Law 111-148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, Public Law 111-152, enacted on March 30, 2010 (collectively, “Affordable Care Act”), expands access to health insurance for individuals and employees of small businesses through the establishment of new Affordable Insurance Exchanges (Exchanges), including the Small Business Health Options Program (SHOP). The Exchanges, which became operational on January 1, 2014, enhanced competition in the health insurance market, expanded access to affordable health insurance for millions of Americans, and provided consumers with a place to easily compare and shop for health insurance coverage.

The reporting requirements and data collection in Medicaid, Children’s Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment (CMS-2334-F) address: (1) standards related to notices, (2) procedures for the verification of enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan; and (3) other eligibility and enrollment provisions to provide detail necessary for state implementation. The submission seeks OMB approval of the information collection requirements associated with selected provisions in 45 CFR parts 155, 156 and 157.

It is important to note that these regulations involve several information collections that will occur through the single, streamlined application for enrollment in a Qualified Health Plan (QHP) and for insurance affordability programs described in §155.405. We have accounted for the burden associated with these collections in the Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid, and Children’s Health Insurance Program Agencies (CMS-10440). We would also like to highlight that this supporting statement includes several information collections from regulatory provisions finalized in the Exchange final rule. Additionally, throughout this section, we reference notices, and include data elements associated with these notices in Appendix A.

B. Justification

1. Need and Legal Basis

Sections 1311(b) and 1321(b) of the Affordable Care Act provide that each state has the opportunity to establish an Exchange that (1) facilitates the purchase of insurance coverage by qualified individuals through QHPs; (2) assists qualified employers in the enrollment of their employees in QHPs; and (3) meets other standards specified in the Affordable Care Act. Section 1311(c)(6) requires Exchanges to provide both annual open enrollment periods and special enrollment periods to consumers. Section 1311(k) of the Affordable Care Act specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary. Section 1311(d) of the Affordable Care Act describes the minimum functions of an Exchange, including the

certification of QHPs. Section 1321 of the Affordable Care Act discusses state flexibility in the operation and enforcement of Exchanges and related policies. Section 1321(c)(1) directs the Secretary to establish and operate such Exchanges within states that either: (1) do not elect to establish an Exchange, or (2) as determined by the Secretary on or before January 1, 2013, will not have an Exchange operable by January 1, 2014. Section 1321(a) also provides broad authority for the Secretary to establish standards and regulations to implement the statutory standards related to Exchanges, QHPs, and other components of title I of the Affordable Care Act.

Section 1401 of the Affordable Care Act creates section 36B of the Internal Revenue Code (the Code), which provides for a premium tax credit for eligible individuals who enroll in a QHP through an Exchange. Section 1402 of the Affordable Care Act establishes provisions to reduce the cost-sharing obligation of certain eligible individuals enrolled in a QHP offered through an Exchange, including standards for determining whether individuals are eligible for certain categories of cost-sharing reductions.

Under section 1411 of the Affordable Care Act, the Secretary is directed 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.

Unless otherwise specified, the provisions in the final rule related to the establishment of minimum functions of an Exchange are based on the general authority of the Secretary under section 1321(a)(1) of the Affordable Care Act. These information collection requirements are set forth in 45 CFR Parts 155, 156, and 157.

2. Information Users

Information collected by the Exchanges, Medicaid or CHIP agencies will be used to determine eligibility for coverage through the Exchanges and insurance affordability programs (i.e., Medicaid, CHIP, and advance payment of the premium tax credits), and to assist consumers in enrolling in a QHP if eligible. Applicants include anyone who may be eligible for coverage through any of these programs.

The Exchanges verify the information provided on the application, communicate with the applicant or his/her authorized representative and subsequently provide the information to the health plan selected by the applicant so that it can enroll him/her in a QHP. The Exchanges also use the information provided in support of its ongoing operations, including activities such as verifying continued eligibility for all programs, processing appeals, reporting on and managing the insurance affordability programs for eligible individuals, performing oversight and quality control activities, combatting fraud, and responding to any concerns about the security or confidentiality of the information. Applicants can find more information about how the Exchanges use the information they provide on the application in the Privacy Act Statement for individuals and families at <https://www.healthcare.gov/individual-privacy-act-statement/>.

3. Use of Information Technology

HHS anticipates that a majority of the activities described below specified in this rule will be automated. Exchanges and health insurance issuers are expected to develop automated notice templates for many of the specified notices and distribute the majority of these notices through secure electronic accounts. The entities issuing notices or collecting information will develop the initial template after which the templates will be automatically populated with the appropriate information for the receiving party. A majority of the information that is collected in accordance with this rule will be submitted electronically. Staff, or systems, will analyze, review, or process the data through largely electronic means and communicate with individuals, states and health insurance issuers using e-mail, telephone, or other electronic means whenever possible.

4. Duplication of Efforts

These information collections do not duplicate any current information collections.

5. Small Businesses

We estimate minimal burden on small business as they are not required to participate in the SHOP.

6. Less Frequent Collection

Due to the required flow of information between multiple parties and flow of funds for payments supporting health insurance coverage purchased through 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 insurers; late charges to or payments by employers and enrollees; inaccurate or inappropriate advance payments of the premium tax credit 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 and decrease in benefit to individuals and employers.

7. Special Circumstances

These information collections do not include any special circumstances.

8. Federal Register/Outside Consultation

As required by the Paperwork Reduction Act of 1995 (44 U.S.C.2506 (c)(2)(A)), CMS published a Notice of Proposed Rulemaking (NPRM) on October 10, 2024 (89 FR 82308 - RIN 0938-AV41/CMS9888-P), Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program) requesting a 60-day public comment period on the proposed modification of the information collection requirements. No specific comments were received in response to the proposed burden estimates.

CMS published a Final Rule on January 15, 2025 (90 FR 4424).

No outside consultation was sought.

9. Payments/Gifts to Respondents

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

10. Confidentiality

All information will be kept private pursuant to applicable laws/regulations.

11. Sensitive Questions

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

12. Burden Estimates (Hours & Wages)

For purposes of presenting an estimate of paperwork burden, we reflect the participation of 20 State-based Exchanges. We utilize data from the U.S. Bureau of Labor Statistics (BLS) to derive median costs for all estimates of salary in establishing the information collection requirements. Salary estimates include the cost of fringe benefits and other indirect costs calculated at 100 percent of total labor costs and are based on the BLS May 2023 National Occupational Employment and Wage Estimates (<https://www.bls.gov/oes/tables.htm>).

Information Collections under Part 155

Subpart C—General Functions of an Exchange

A. Role of authorized representatives in the Exchange (§155.227)

Section 155.227(a) provides that an applicant or enrollee, subject to applicable privacy and security requirements, may designate an individual person or organization as his or her authorized representative. One method for designating an authorized representative is by submitting legal documentation of the representative's authority. Exchanges have the option to make available an "Appointment of Authorized Representative Form" at the time of application or any time thereafter for an individual to designate an authorized representative. Such a form would collect identifying and contact information about the applicant, enrollee, and requested authorized representative. Requested data elements would include the following for both the applicant or enrollee and the requested representative: name, address, phone number, email address, date of birth, and relationship. The applicant, enrollee, or authorized representative could obtain the form from the Exchange website or from an assister (such as a Navigator, non- Navigator in-person assister, etc.), and could submit it to the Exchange by mail or online at any time. We expect that the Exchange would use this information to authorize the authorized representative to act on behalf of the applicant or enrollee. An authorized representative could also submit this form if the applicant or enrollee is unable to do so.

We estimate the burden associated for the time and effort necessary for a State-based Exchange to develop the Appointment of Authorized Representative Form to be 30 hours. This includes 10 hours from a mid-level health policy analyst at an hourly cost of \$97.30 (occupation no. 13-1111) and 10 hours from an operations analyst (occupation no. 15-2031) at an hourly cost of \$87.78 for drafting the form, with 4 hours of managerial oversight (occupation no. 11-1021) at an hourly cost of \$99.00 and 6 hours of legal review (occupation no. 23-1011) at an hourly cost of \$145.34. The estimated cost per State-based Exchange is \$3,118.84, for a total cost of \$62,376.80 for 20 State-based Exchanges.

Labor Category	Number of Respondents (per Exchange)	Hourly Labor Costs	Time per Response (Hours)	Total Costs (per Exchange)	Total Costs (20 Exchanges)
Health Policy Analyst	1	\$97.30	10	\$973	\$19,460
Operations Analyst	1	\$87.78	10	\$877.80	\$17,556
Attorney	1	\$145.34	6	\$872.04	\$17,440.80
Senior Manager	1	\$99	4	\$396	\$7,920
Total			30	\$3,118.84	\$62,376.80

For an applicant, enrollee, or prospective authorized representative, we estimate that it will take up to 5 minutes to review instructions and complete an Appointment of Authorized Representative Form. While we expect most applicants, enrollees, or prospective authorized representatives to complete the Authorized Representative Form, an applicant, enrollee, or prospective authorized representative may also comply with this provision by providing the necessary information online, by phone, or by mail. We expect a similar burden on the applicant, enrollee, or authorized representative to comply with this provision through such means.

If the applicant, enrollee, or authorized representative chooses to submit an “Appointment of Authorized Representative Form,” the burden for a State-based Exchange to process the submitted information will be approximately 12 minutes at a cost of \$9.69 per submission. We anticipate that an eligibility support staff person (occupation No. 43-4061) with an hourly cost of \$48.34 will scan, digitize, and link the form to an applicant’s or enrollee’s account, review the submitted information, and update the authorized representative’s and applicant’s or enrollee’s account, if applicable.

Labor Category	Number of Respondents	Hourly Labor Costs	Time per Response (Hours)	Total Costs
Eligibility Support Staff	1	\$48.34	0.2	\$9.69

B. General standards for Exchange notices

Subpart D—Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability (§155.302 through §155.345)

A. Options for conducting eligibility determinations (§155.302)

Section 155.302 of the regulation provides options for conducting eligibility determinations. Section 155.302(a) provides that the Exchange may satisfy the requirements of this subpart directly or through contracting arrangements or through a combination of the approach described in paragraph (a)(1) and one or both options, described in paragraphs (b) and (c), and certain standards are met. Section 155.302(b)(6) specifies that an Exchange that uses the options specified in paragraphs (b) or (c) will enter into agreements that reflect roles and responsibilities. The burden associated with these provisions is the time and effort necessary for the Exchange to establish or modify agreements for eligibility determinations and coordination of eligibility functions. For 155.302(b)(6) this burden is captured in the agreements associated with §155.345. For 155.302(c), since this agreement would involve a different relationship, specifically, HHS and the Exchange, instead of the Exchange and Medicaid and CHIP agencies, we have estimated the time and effort necessary for the Exchange to develop and execute agreements with HHS, which we estimate will take 105 hours per Exchange.

Labor Category	Number of Respondents (per Exchange)	Hourly Labor Costs	Time per Response (Hours)	Total Costs (per Exchange)	Total Costs (20 Exchanges)
Health Policy Analyst	1	\$97.30	35	\$3,405.50	\$68,110
Operations Analyst	1	\$87.78	35	\$3,072.30	\$61,446
Attorney	1	\$145.34	30	\$4,360.20	\$87,204
Senior Manager	1	\$99	5	\$495	\$9,900
Total			105	\$11,133	\$226,660

Section 155.302(b)(4) provides that if the Exchange conducts an assessment in accordance with paragraph (b) of this section and finds that an applicant is not potentially eligible for Medicaid and CHIP based on the applicable Medicaid and CHIP MAGI-based income standards, the Exchange must consider the applicant as ineligible for Medicaid and CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions, notify the applicant, and provide the applicant with the opportunity to withdraw his or her application for Medicaid and CHIP or request a full determination of eligibility for Medicaid and CHIP by the applicable State Medicaid and CHIP agencies. However, the provisions in §155.302 do not involve burden beyond what is already addressed in §155.310(g), since each state will choose either an assessment or determination. In the case of an assessment, the Exchange will substitute language described in this section with what would be otherwise included.

In accordance with section 1413(b) of the Affordable Care Act, section 155.310(a)(1) specifies that the Exchange use a single streamlined application, as specified in §155.405. Section 155.405 also provides that the Exchange may choose to use an alternative application if such application is approved by HHS and requests the minimum information necessary for the purposes identified in §155.405(a). The application will include information that will be used to determine the eligibility of an applicant for enrollment in a qualified health plan through the Exchange and insurance

affordability programs, as applicable. More detailed information on this information collection requirement and the corresponding burden estimates is outlined in the Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid, and Children’s Health Insurance Program Agencies (CMS-10440).

Throughout this subpart, we propose that the Exchange collect attestations from the application filer. For the most part, these attestations will be collected as a data element or incorporated in some way as part of the single streamlined application. As such, we have accounted for the burden associated with these collections in the Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid, and Children’s Health Insurance Program Agencies (CMS-10440).

B. Failure to File and Reconcile Process (§155.305(f)(4))

Section 155.305(f)(4) provides that the Exchange may not determine an applicant eligible for advance payments of the premium tax credit (APTC) if HHS notifies the Exchange as part of the process described in [§ 155.320\(c\)\(3\)](#) that APTC payments were made on behalf of either the tax filer or spouse, if the tax filer is a married couple, for two consecutive years for which tax data would be utilized for verification of household income and family size in accordance with [§ 155.320\(c\)\(1\)\(i\)](#), and the tax filer or the tax filer’s spouse did not comply with the requirement to file an income tax return for that year and for the previous year as required by [26 U.S.C. 6011](#), [6012](#), and in [26 CFR chapter I](#), and reconcile APTC for that period.

This applicant information can be transmitted either via a secure electronic message to the consumer from the Exchange or via direct mail to the tax filer from the Exchange. The burden associated with this provision is the burden of creating and sending notices.

- Section 155.305(f)(4)(i) provides that the Exchange will notify an individual or their tax filer regarding his or her failure to file and reconcile, either through a direct notice to the tax filer or an indirect notice to the enrollee. This notice provides information necessary to educate the individual on the requirement to file their federal income taxes and reconcile their advance payments of the premium tax credit (APTC) in order to maintain eligibility for APTC. The FFE sends both “direct notices” to the tax filer that are only in paper format, as well as “combined notices” to the application’s household contact, which may be in either paper or electronic format. We anticipate that many State Exchanges will choose to notify their FTR enrollees via an indirect notice, which can be sent according to consumer preferences. In general, a large volume of enrollees will request electronic notification while others will opt to receive the notice by mail. As a result, we estimated the associated mailing costs for the time and effort needed to mail notices in bulk to enrollees as appropriate in item XX – Capital Costs below.

The FTR notices contain some dynamic messaging to tailor the notice to the applicable period and associated tax years. CMS staff will continue to streamline and modify the notice text, including information regarding next steps, customer service, and appeals. A health policy analyst, manager, and legal counsel will review updates to the notice. The Exchange will then incorporate updates to the notice

C. Eligibility Process (§155.310)

Section 155.310(d)(3) provides that to the extent that the Exchange determines an applicant eligible for Medicaid or CHIP, the Exchange must notify the state Medicaid or CHIP agency and transmit all information from the records of the Exchange to the Medicaid or CHIP agency to ensure that the Medicaid or CHIP agency can provide the applicant with coverage promptly and without undue delay. This applicant information will be transmitted via a secure electronic interface from the Exchange to the agency administering Medicaid or CHIP. The burden associated with this provision is the burden of creating and executing agreements with state Medicaid and CHIP agencies, which we estimate in §155.345.

Section 155.310(g) provides that the Exchange will notify an individual regarding his or her eligibility determination after it has been made. This notice provides information necessary to understand key next steps, including plan selection or appeal. We anticipate that the Exchange will consolidate this notice when multiple members of a household are applying together and receive an eligibility determination at the same time. The notice will be in writing and may be in paper or electronic format. We anticipate that a large volume of enrollees will request electronic notification while others will opt to receive the notice by mail. As a result, we estimated the associated mailing costs for the time and effort needed to mail notices in bulk to enrollees as appropriate in item 13 – Capital Costs below.

The eligibility determination notice is dynamic and includes information tailored to all possible outcomes of an application. Exchange staff will continue to streamline and modify the notice text for various decision points, along with information regarding next steps, referrals, customer service, and appeals. A health policy analyst, manager, and legal counsel will review updates to the notice. The Exchange will then incorporate updates to the notice from the consultation to ensure compliance with plain writing, language access, and readability standards. The Exchange will continue to consult with the state Medicaid or CHIP agency in order to update coordinated notices as necessary. HHS has developed model notices for the eligibility determination notice and several other notices described in this subpart which will also decrease the burden on Exchanges to provide such notices. If a state opts not to use the model notice provided by HHS, we estimate that notice development as outlined in the paragraph above, including computer programming (occupation no. 15-1251) at an hourly cost of \$194.60, would take each Exchange an estimated 100 hours to complete. We estimate the cost for each Exchange would be approximately \$14,901.36 and a total cost of \$298,027.20 for 20 State-based Exchanges. We expect that the burden on the Exchange to maintain this notice will be significantly lower than the estimate to develop it.

Labor Category	Number of Respondents (per Exchange)	Hourly Labor Costs	Time per Response (Hours)	Total Costs (per Exchange)	Total Costs (20 Exchanges)
Health Policy Analyst	2	\$194.60	44	\$8,562.40	\$171,248
Attorney	1	\$145.34	20	\$2,906.80	\$58,136
Senior Manager	1	\$99	4	\$396	\$7,920
Computer Programmer	1	\$94.88	32	\$3,036.16	\$60,723.20

Total			100	\$14,901.36	\$298,027.20
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A. Verification process related to eligibility for enrollment in a QHP through the Exchange (§155.315)

Section 155.315 specifies that an Exchange must verify or obtain information as provided to determine that an applicant is eligible for enrollment in a QHP through the Exchange. In the event that the Exchange cannot verify information required to determine eligibility for enrollment in a QHP through the Exchange, advance payments of the premium tax credit or cost-sharing reductions, Section 155.315(f) requires the Exchange to make a reasonable effort to identify and address the causes of such inconsistency by contacting the application filer to confirm the accuracy of the information submitted by the application filer. We note that the burden associated with this provision is one hour for an individual to collect and submit documentation, and 12 minutes for eligibility support staff to review the documentation.

	Number of Respondents	Hourly Labor Costs	Time per Response	Total Costs (per Inconsistency)
Individual	1	--	1	--

	Number of Respondents	Hourly Labor Costs	Time per Response	Total Costs (per Inconsistency)
Eligibility Support	1	\$48.34	.2	\$9.69

B. Verification process related to eligibility for insurance affordability programs (§155.320)

Section 155.320(c)(3)(iv) outlines standards for the notice described in paragraph (c)(3)(vi)(E) and (c)(3)(vi)(F) provided at the end of the inconsistency period for inconsistencies related to income. We do not include a separate burden estimate for this notice because the burden for this notice is described and accounted for in §155.310(g).

Section 155.320(d) describes the process for the verification of enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan. Paragraph (d)(2) describes data sources through which Exchanges must obtain data about enrollment in and eligibility for employer-sponsored plans. Paragraph (d)(3) specifies that if an applicant’s attestation is not reasonably compatible with the information available through the data sources specified in (d)(2), that the Exchange must follow the procedures related to inconsistencies at 45 CFR 155.315(f). The burden associated with this process is addressed in 155.315.

Paragraph (d)(4) of §155.320 specifies alternative procedures for years in which an Exchange does not reasonably expect to obtain sufficient verification data, as described in paragraph (d)(2). Paragraph (d)(4)(i) specifies that Exchanges are required to implement verification processes that are based on the Exchange’s assessment of risk of inappropriate payment of APTC and CSRs. Paragraph

(d)(4)(A) indicates that the Exchange must provide notice to the applicant if, as part of this verification process, the Exchange plans to contact the applicant’s employer. The FFE does not currently contact applicant’s employers as part of the employer coverage verification process described at 45 CFR 155.320(d)(4), and there is therefore not a burden associated with this provision.

If the Exchange receives any information from an employer relevant to the applicant’s enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage in an eligible employer sponsored plan, the Exchange will determine the applicant’s eligibility based on such information and in accordance with the effective dates. If such information changes his or her eligibility determination, the Exchange will notify the applicant and his or her employer or employers of such determination in accordance with the notice requirements specified in 155.310(g) and (h) of this subpart. The burden associated with this provision is the time and effort necessary to notify the applicant and his or her employer if information from an employer changes the applicant’s eligibility. The time and effort associated with this provision is accounted for in the estimate discussed in 155.310(g) and (h) of this subpart.

C. Eligibility redetermination during a benefit year (§155.330)

Section 155.330(b) provides that the Exchange specify that an individual will report changes that affect his or her eligibility for enrollment in a QHP and insurance affordability programs within 30 days of such change. Upon receipt of changes reported by an individual, §155.330(c) provides the Exchange will verify the information in accordance with the standards described in §155.315 and §155.320.

In §155.330(b)(1), we specify that except as specified in paragraphs (b)(2) and (b)(3) of this section, the Exchange must require an enrollee to report any change with respect to the eligibility standards specified in §155.305 within 30 days of such change. Our estimates reflect the time that it would take for an enrollee to collect and report to the Exchange any information related to a change that impacts their eligibility. Enrollees will be permitted to submit changes via phone, mail, in person, or electronically. We expect that a majority of enrollees will electronically report changes to the Exchange. As such, we estimate that it will take an enrollee ten minutes on average to report a change to the Exchange. The burden associated with the collection and processing of any documentation that is needed to support reported changes is accounted for in the estimate for §155.330(c)(1).

	Number of Respondents	Hourly Labor Costs	Time per Response	Total Costs (per change)
Individual	1	--	.16	--

In §155.330(c)(1), we state that the Exchange will verify any information reported by an enrollee in accordance with the processes specified in §155.315 and 155.320 prior to using such information in an eligibility redetermination. We note that the burden associated with this provision is one hour for an individual to collect and submit documentation, and 12 minutes for eligibility support staff to review the documentation.

	Number of Respondents	Hourly Labor Costs	Time per Response	Total Costs (per Inconsistency)
Individual	1	--	1	--

	Number of Respondents	Hourly Labor Costs	Time per Response	Total Costs (per Inconsistency)
Eligibility Support	1	\$48.34	.2	\$9.69

In §155.330(c)(2), we describe how the Exchange will provide periodic electronic notifications regarding the requirements for reporting changes and an enrollee’s opportunity to report any changes as described in paragraph (b)(3) of this section, to an enrollee who has elected to receive electronic notifications, unless he or she has declined to receive notifications under this paragraph. For each Exchange, we estimate that it will take 21 hours total, 20 hours for an operations analyst to integrate this electronic notification into the Exchange eligibility system, and one hour for a computer programmer to program the electronic notifications into the eligibility system. We estimate a cost burden of \$1,850.48 per Exchange and a total cost of \$37,009.60 for 20 State- based Exchanges.

Labor Category	Number of Respondents (per Exchange)	Hourly Labor Costs	Time per Response	Total Costs (per Exchange)	Total Costs (20 Exchanges)
Operations Analyst	1	\$87.78	20	\$1,755.60	\$35,112
Computer Programmer	1	\$94.88	1	\$94.88	\$1,897.60
Total			21	\$1,850.48	\$37,009.60

In §155.330(d), we describe that the Exchange will periodically examine available data sources described in §155.315(b)(1) and §155.320(b) to identify changes related to death and dual eligibility for or enrollment in Medicare, Medicaid, CHIP, or the Basic Health Program (BHP), if a BHP is operating in the service area of the Exchange for an applicant on whose behalf advance payments of the premium tax credit or cost-sharing reductions are being provided. The Exchange has developed electronic data exchanges to support obtaining this information in order to determine the applicant’s eligibility at the point of application and reuse those data exchanges here. Consequently, we do not expect there to be additional burden associated with those data exchanges for the purposes of this paragraph.

In §155.330(e), we describe the redetermination and notification procedures for changes reported by enrollees or identified by the Exchange. Section 155.330(e)(1) states that if the Exchange verifies updated information reported by an enrollee, the Exchange will re-determine the enrollee’s eligibility in accordance with the standards specified in §155.305, notify the enrollee regarding the determination in accordance with the requirements specified in §155.310(g), and notify the enrollee’s employer, as applicable, in accordance with the requirements specified in §155.310(h). The burden

for this notice is identical to the burden associated with the eligibility notice described in §155.310(g). Similarly, we do not include a separate burden estimate here for the notice to the enrollee’s employer because the burden for this notice is described and accounted for in §155.310(h).

Section 155.330(e)(2) describes that the Exchange will notify an enrollee if it identifies updated information through periodic data matching, and dependent upon the response, will re-determine the enrollee’s eligibility or if necessary, proceed with the inconsistency process in §155.315(f). We do not include a separate burden estimate for this notice because we expect that the burden associated with creating and sending this notice will be similar to that of the annual redetermination notice, which is discussed in §155.335 below.

Furthermore, the burden on an enrollee to notify the Exchange that such information is potentially inaccurate is the same as that in relation to reporting changes as described in §155.330(b), and the burden estimate related reviewing the response and the inconsistency process is explained above in §155.315(f). We are unable to estimate the number of notices that will be sent based on this provision for the reasons stated previously, along with the fact that it is not possible to determine the share of individuals who will enroll in a QHP with advance payments and then gain eligibility for another insurance affordability program and not report it to the Exchange.

Section 155.335(e) provides that the Exchange will require a qualified individual to report any changes with respect to the information listed in the notice described in §155.335(c) of this section within 30 days from the date of the notice. We specify in §155.335(e)(2) that the Exchange will allow a qualified individual or an application filer, on behalf of the qualified individual, to report changes via the channels available for the submission of an application.

Similar to the estimate in §155.330(b)(1), our estimates reflect the time that it would take for a qualified individual to collect information related to a change that impacts their eligibility, as well as the time it would take to report these changes to the Exchange. We expect that a large volume of changes would be reported electronically by qualified individuals. We expect that it will take an enrollee ten minutes to report a change to the Exchange. The burden associated with the collection and processing of any documentation that is needed to support reported changes is accounted for in the estimate for §155.335(f).

	Number of Respondents	Hourly Labor Costs	Time per Response	Total Costs (per change)
Individual	1	--	.16	--

Section 155.335(f) states that the Exchange will verify any information reported by an enrollee with respect to their annual eligibility redetermination in accordance with the processes specified in §§155.315 and 155.320 prior to using such information to determine eligibility. We note that the burden to process documentation associated with an inconsistency that arises because of an annual eligibility redetermination is one hour for an individual to collect and submit documentation, and 12 minutes for eligibility support staff to review the documentation.

	Number of Respondents	Hourly Labor Costs	Time per Response	Total Costs (per Inconsistency)
Individual	1	--	1	--

	Number of Respondents	Hourly Labor Costs	Time per Response	Total Costs (per Inconsistency)
Eligibility Support	1	\$48.34	.2	\$9.69

Section 155.335(g) provides that the Exchange will require a qualified individual, or an application filer, on behalf of the qualified individual, to sign and return the annual redetermination notice. Our estimates reflect the time that it would take for a qualified individual, or an application filed on behalf of the qualified individual to sign and return the form to the Exchange. We expect that a large volume of individuals will sign and return the form electronically, but a qualified individual will also be permitted to sign and return the form via phone or mail. The burden for this collection also includes the time necessary for eligibility support staff to process any forms submitted via mail. We expect that this process will take one individual one hour to submit the form, and for an individual who submits the form via mail, it will also take 12 minutes for eligibility support staff to handle intake. We note that to the extent that an individual is reporting a change in response to the annual redetermination notice, the change report would likely be consolidated with the response to the notice described in this paragraph.

	Number of Respondents	Hourly Labor Costs	Time per Response	Total Costs (per respondent)
Individual	1	--	1	--

	Number of Respondents	Hourly Labor Costs	Time per Response	Total Costs (per Inconsistency)
Eligibility Support	1	\$48.34	.2	\$9.69

Section 155.335(h)(1)(ii) provides that after the 30-day period for an individual to report changes and/or sign and return the redetermination notice, the Exchange will notify a qualified individual in accordance with the requirements specified in §155.310(g) and notify his or her employer, as applicable, in accordance with the requirements specified in §155.310(h). We expect that the burden associated with this requirement is identical to the burden estimates associated with §155.310(g) and §155.310(h) and is thus already incorporated in the estimates provided for those provisions. In section 155.335(k) we provide that the Exchange must have authorization from a qualified individual to obtain updated tax return information for the purposes of conducting an annual redetermination. The burden associated with this information collection is included in the Supporting Statement for Data Collection to Support Eligibility Determinations

for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid, and Children's Health Insurance Program Agencies (CMS-10440).

Section 155.335(l) provides that if the Exchange does not have an active authorization from a qualified individual to obtain updated tax information for use in the annual redetermination process, the Exchange must notify the qualified individual in accordance with the timing described in paragraph (d) of this section, and re-determine his or her eligibility for enrollment in a QHP through the Exchange. This notice is in place of the regular annual redetermination notice, and as such, the burden associated with this requirement is included in the burden estimate associated with 155.335(c).

D. Administration of advance payments of the premium tax credit and cost-sharing reductions (§155.340)

This section specifies that the Exchange will provide the relevant information related to enable advance payments of the premium tax credit and cost-sharing reductions, reconciliation of advance payments of the premium tax credit, and employer responsibility. As these reporting functions will all be electronic, we do not expect for there to be any additional burden than that which is required to design the overall eligibility and enrollment system outside of the requirements in section 155.340(b)(3)(ii).

Section 155.340(b)(3)(ii) states that in the event that an individual for whom advance payments of the premium tax credit are made or who is receiving cost-sharing reductions terminates coverage from a QHP through the Exchange during a benefit year, the Exchange will transmit the individual's name and the effective date of the termination of coverage to his or her employer. We anticipate that this burden on this transmission will be identical to that of §155.310(h). We provide an estimate of the cost to print and mail each notice in item 13 – Capital Costs below.

Section 155.340(c) states that the Exchange must comply with the requirements specified under section 36B of the Code to provide information related to reconciliation of advance payments of the premium tax credit, and as this is an IRS requirement, consequently IRS will account for this burden.

E. Coordination with Medicaid, CHIP and the Basic Health Program (§155.345)

Section 155.345(a) specifies that Exchanges will enter into written agreements with agencies administering other insurance affordability programs. These agreements will include provisions necessary to minimize burden on individuals, ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, and to provide standards for transferring an application from an insurance affordability program to the Exchange. Agencies will also develop MOUs to outline responsibilities and coordinate between insurance affordability programs. The specific number of agreements needed may vary depending on how states choose to divide responsibilities regarding eligibility determinations.

The burden associated with this provision is the time and effort necessary for the Exchange to establish or modify an agreement for eligibility determinations and coordination of eligibility and enrollment functions. If a state chooses to draft separate agreements for each insurance affordability program or a subset of insurance affordability programs, then the estimate would likely increase. We

estimate the time and effort necessary for the Exchange to develop and execute agreements with other insurance affordability programs agencies to be 60 hours per Exchange.

Labor Category	Number of Respondents (per Exchange)	Hourly Labor Costs	Time per Response	Total Costs (Exchange)	Total Costs (20 Exchanges)
Health Policy Analyst	1	\$97.30	20	\$1,946	\$38,920
Operations Analyst	1	\$87.78	20	\$1,755.60	\$35,112
Attorney	1	\$145.34	15	\$2,180.10	\$43,602
Senior Manager	1	\$99	5	\$495	\$9,900
Total			60	\$6,376.70	\$127,534

Section §155.345(c) specifies that an Exchange must provide an applicant with the opportunity to request a full determination for Medicaid. We do not include a separate burden estimate for this notice because the burden for this notice is described and accounted for in §155.310(g).

Section §155.345(d) specifies standards in the case where the Exchange identifies an applicant as potentially eligible for Medicaid or an applicant requests a full determination for Medicaid. In paragraph (d)(1), we specify that in such a situation, the Exchange will transmit all information provided on the application and any information obtained or verified by the Exchange to the State Medicaid agency. In paragraph (d)(2), we specify that the Exchange will notify the applicant of such transmittal. Because information will be transmitted electronically and through interfaces that will exist for other purposes, we do not account for any additional burden for paragraph (d)(1) and only account for the burden of sending the notice to the applicant as described in paragraph (d)(2). We expect that the burden associated with this requirement is identical to the burden estimates associated with §155.310(g) and is thus already incorporated in the estimate provided for that provision.

Section 155.345(f) specifies that the Exchange will provide the applicant with any information regarding income used in the Medicaid and CHIP eligibility determination for the special rule described in this paragraph. We do not include a separate burden estimate for this notice because the burden for this notice is described and accounted for in §155.310(g).

I. Special eligibility standards and process for Indians (§155.350)

Section 155.350(c) specifies that the Exchange will verify an attestation by an applicant that he or she is an Indian to the extent that the approved data sources are unavailable, an individual is not represented in available data sources, or data sources are not reasonably compatible with an

applicant's attestation through the inconsistency procedures specified in §155.315(f). As we have already accounted for this burden above, we are not including a separate burden estimate for this provision.

J. Right to Appeal (§155.355)

Section 155.355 provides that the Exchange must include the notice of the right to appeal and instructions regarding how to file an appeal in the eligibility determination notice. We do not include separate burden estimates for this notice because the burden for this notice is described and accounted for in §155.310(g).

Subpart E –Exchange Functions in the Individual Market (§155.400 through §155.430)

A. Enrollment of Qualified Individuals into QHPs (§155.400)

In Part 155, subpart E of the Exchange final rule, we describe the requirements for Exchanges in connection with enrollment and disenrollment of qualified individuals through the Exchange. Section 155.400(a) requires Exchanges to notify QHP issuers of an applicant's selected QHP and transmit any information necessary to enroll the applicant. Section 155.400(b) requires Exchanges to send eligibility and enrollment information to QHP issuers and to HHS promptly, without undue delay. Additionally, Exchanges are required to establish a process by which a QHP issuer acknowledges receipt of the eligibility and enrollment information. We expect that all plan selection, eligibility and enrollment information will be maintained electronically by Exchanges, QHP issuers and HHS alike. We expect the transmission of such data to be fully automated.

Section 155.400(c) specifies that Exchanges must maintain records of all enrollments in QHPs through the Exchange. The information will be used to make sure that the Exchange has up to date information on the individuals covered through the Exchange and to ensure that individuals are not covered by more than one QHP. It is expected that the information will be maintained in an electronic data system. We expect that most of the burden will reflect programming to retain enrollment information on the Exchange's electronic data system.

Section 155.400(d) states that Exchanges must reconcile enrollment information with QHP issuers and HHS on no less than a monthly basis. The purpose of reconciling enrollment information between the Exchange and the QHP issuers and HHS is to ensure that both entities have accurate records of the number of enrollees and persons enrolled in each QHP. It is expected that the information will be maintained in an electronic data system. The burden associated with §155.400(b), (c), and (d) has been accounted for in the Supporting Statement for Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (CMS-10592).

As discussed in §155.405(a), the Exchange must use a single streamlined application to determine eligibility and to collect information necessary for enrollment. The application will include information to determine eligibility of an applicant and process plan selection for enrollment in a qualified health plan through the Exchange and insurance affordability programs. The information will be required of each applicant upon initial application with subsequent information collections for the purposes of confirming accuracy of previous submissions or updating information from previous submissions. As indicated in §155.405(c)(2), the information will be submitted by the applicant to the Exchange through the internet, call center, in-person assistance, or a paper application. After collecting the information, the Exchange will either house the information in an Exchange data

repository or purge the information after it is used to make an eligibility determination. HHS has developed the model single streamlined application for the states. A detailed estimate of the burden associated with this information collection was included in the Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid, and Children's Health Insurance Program Agencies (CMS-10440).

Section 155.405(b) states that Exchanges have the option of using an alternative application which includes information to determine the eligibility of an applicant and process plan selection for enrollment in a QHP and insurance affordability programs, as applicable. If the Exchange opts to use an alternative application, the Exchange must submit the alternative application to HHS for approval. The burden estimate associated with this requirement includes the time and effort needed to develop the alternative application and submit the application for approval by HHS. We believe that most Exchanges, in the interest of avoiding duplication of existing work, will choose to use the model single, streamlined application developed by HHS. We assume that the number of Exchanges choosing to develop an alternate application will be less than ten in a twelve-month period. We will review each alternative application that is submitted to HHS and, if the number of Exchanges opting to use an alternative application approaches ten, then we will seek OMB approval.

B. Annual Open Enrollment Periods (§155.410)

As discussed in §155.410, the Exchange will provide written notice to each enrollee about annual open enrollment between September 1 and September 30 of each year. The notice will include the date of annual open enrollment and information regarding where individuals may obtain information about available QHPs. The Exchange will send the notice of annual open enrollment via mail or electronic means depending on the preference of the enrollee. In accordance with §155.335(c), we expect the notice of annual open enrollment as specified in §155.410(d), will be sent along with the annual redetermination notice as a single, coordinated notice. Therefore, the burden estimate associated with this requirement is described in §155.335(d).

C. Special Enrollment Periods (§155.420)

The Exchange must provide special enrollment periods (SEPs) during which qualified individuals may enroll in QHPs and enrollees may change QHPs. The process of verification of eligibility for a special enrollment period (SEP) generally involves consumer attestation, automated verification processes or applicant submitted documentation as part of manual SEP verification (SEPV) processes; most SEPs are verified through consumer attestation. If a SEP qualifying event cannot be resolved through action by the Exchange, the Exchange may request that an individual provide satisfactory documentation.

Exchanges in states serviced by the HealthCare.gov platform (hereinafter "Federally Facilitated Exchange" or "FFE") must undertake 'pre-enrollment' SEP verification by verifying eligibility for the most common SEP type, loss of minimum essential coverage, for all new consumers who seek to enroll in Exchange coverage through a SEP. This involves delaying, or pending, consumers' QHP enrollment until verification of eligibility for the SEP can be completed, and only then releasing enrollment information to the relevant issuer. Consumers are given 30 days to provide documentation to the Exchange. When available, verification can instead be completed through information gathered from electronic data sources. This method of pre-

enrollment verification is authorized under section 1411(d) of the Patient Protection and Affordable Care Act.

Per enrollee, the expected burden of pre-enrollment SEP verification described herein is similar to the burden of post-enrollment verification. We do not expect there to be transactional burden associated with the electronic transactions needed to implement pre-enrollment SEP verification as these transmission functions will all be electronic.

The primary burden associated with pre-enrollment SEP verification exists in manually adjudicating the documentation an individual submits to the Exchange to verify eligibility for a SEP. The Exchange will provide notice to an applicant regarding the need to submit documentation to verify eligibility for a SEP. This notice is a part of the notice in §155.310(g), and so we do not include a separate burden estimate here. We expect that it will take an individual, on average, one hour to gather the relevant documentation depending on whether the individual already has the necessary documentation on hand, or whether the individual needs to spend additional time to gather the documentation, and then five minutes to upload or mail the relevant documentation. As such, it could take significantly less time if an individual already has the documents on hand, or potentially more time if the individual needs to procure documentation from a government agency or other source. We also base this estimate on the assumption that everyone who is required to submit documentation will submit on average two documents for review. We expect that it will take 12 minutes for eligibility support staff to subsequently review the documentation and verify SEP eligibility.

Individuals required to submit documentation will be notified of their status throughout the process and final eligibility determination at the end of the document review period. We do not include a separate burden estimate for this notice because it is described and accounted for in §155.310(g).

	Number of Respondents	Hourly Labor Costs	Time per Response	Total Costs (per respondent)
Individual	1	--	1	--

	Number of Respondents	Hourly Labor Costs	Time per Response	Total Costs (per Inconsistency)
Eligibility Support	1	\$48.34	.2	\$9.69

D. Termination of Coverage (§155.430)

Section 155.430(c) requires Exchanges to retain and track coverage termination information, including information to identify the individual’s terminating coverage, the date of coverage termination, and the reason for termination. The Exchange will collect and retain the coverage termination information. The Exchange will submit the coverage termination information to HHS. The information will help provide HHS an accurate record of enrollment in the Exchange, so that HHS can inform the IRS when to cease advance payments of premium tax credits. We expect that all termination information will be maintained electronically by Exchanges. We also expect the

transmission of data to be automated. We estimate that it will take Exchanges less than one minute to transmit the termination information to HHS. We anticipate a similar initial burden on Exchanges for establishing a system for automated tracking, maintenance and transmittal of termination information. The burden estimates associated with the maintenance and transmission of coverage termination information includes the time and effort needed to develop the system to collect and store the information. Additionally, the burden estimates include the time and effort needed to develop an automated process to submit termination information when appropriate. We have accounted for the burden associated with these collections in the Supporting Statement for Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (CMS-10592).

Section 155.430(c) requires Exchanges to establish procedures for QHP issuers to maintain records of termination of coverage and requires Exchanges to send termination information to the QHP issuer and HHS in accordance with §155.400(b). We expect that Exchanges and QHP issuers will manage termination records and related procedures the same way they do the enrollment records described in §155.400. We therefore do not estimate any additional burden for Exchanges to meet the requirements in §155.430.

Subpart H - Exchange Functions: Small Business Health Options Program

A. Exchange Functions: Small Business Health Options Program (SHOP) (§155.716)

Prior to the *HHS Notice of Benefit and Payment Parameters for 2019*¹ becoming effective June 18, 2018, subpart H of 45 CFR part 155 required the SHOP Exchange to send several notices to employers and employees, in relation to their participation in the SHOP Exchange. Required notices included: (1) notices of annual election periods; (2) notices to employers of employee coverage terminations; (3) notices of application inconsistencies; (4) notices of appeal rights and instructions. (5) notices of employee and employer eligibility; (6) notices of employer withdrawal; (7) (in FF-SHOPs only) notices to employees if a dependent turn 26 and is no longer eligible for dependent coverage; (8) billing invoices, successful and unsuccessful payment confirmation notices; and (9) past due payment notices. However, with the effectuation of the 2019 final rule, requirements regarding enrollment activities and collection of information related to employee eligibility, enrollment and premium aggregations functions were removed. The 2019 final rule allows SHOPs the flexibility to operate in a leaner fashion if they choose, in accordance with applicable Federal and State law -- which is a flexibility the FF-SHOP and several State-based Exchanges have utilized. The flexibility to operate a leaner SHOP resulted from a significant decrease in SHOP QHP issuer participation and enrollment and a lower-than-expected enrollment in the Federally facilitated (FF-SHOPs) and State-based Exchanges on the Federal platform (SBE-FPs) for SHOP. The final rule found that it was not cost effective for the Federal government to continue to maintain certain FF-SHOP functionalities (e.g., monthly collection of user fees, maintenance of the FF-SHOP website and payment platform, generation of enrollment and payment transaction files, and performing enrollment reconciliation).

For plan years beginning on or after January 1, 2018, SHOPs that operate in a leaner fashion, such as the FF-SHOP, may allow qualified employers and employees to enroll in SHOP plan(s) by working with a QHP issuer or SHOP-registered agent or broker. Additionally, SHOPs are required to make employer eligibility determinations and send notice of the determinations (the data elements for this SHOP Exchange-issued notice are in Appendix A of this Information Collection Request (ICR). In accordance with 155.230(d)(2), SHOPs must provide required notices electronically or, if an employer or employee elects, through standard mail, unless otherwise required by State or Federal Law. The FFSHOP sends SHOP eligibility determination notices to employers in an automated electronic format. In the Supporting Statement for Data Collection to Support Eligibility Determinations for Small

Businesses in the Small Business Health Options Program (CMS-10439), and in the Collection of Information Requirements section of the 2019 final Payment Notice, we estimated that approximately 6,000 employers would complete the *SHOP Eligibility Determination Form*, featured on HealthCare.gov. As such, we conclude here that 6,000 automated electronic notices will be sent to employers, annually, by the FF-SHOP. We have accounted for the burden associated with an employer completing the *SHOP Employer Eligibility*

¹ HHS Notice of Benefit and Payment Parameters for 2019. Final Rule. April 17, 2018 [83 FR 16930, pg.16930-17071]

Determination Form in the Supporting Statement for Data Collection to Support Eligibility Determinations for Small Businesses in the Small Business Health Options Program (OMB: Control Number-0938-1193). However, it should be noted that the FF-SHOP will mail an employer an eligibility determination notice, upon request.

State-based Exchanges have the flexibility to operate their SHOPS as they choose, so long as their activity is in alignment with applicable Federal and State law. As such, State-based Exchanges may send eligibility determination notices to employers in paper or electronic format, in accordance with the preference of the recipient. We, however, anticipate that a large share of these notices in the SHOP Exchange will be sent electronically. We believe it is difficult to estimate the total number of eligibility determination notices that will be sent by State-based Exchanges, to employers. We, however, provide an estimate of the cost to print and mail each employer an eligibility determination notice, below. We estimate that the associated printing and mailing costs for paper notices will be approximately \$0.74 per notice which has been estimated in item 13 below.

Section 155.716 provides that the SHOP Exchange must provide an employer, requesting eligibility to purchase coverage through the SHOP, with a notice of approval, denial, or termination of eligibility and the employer’s right to appeal such eligibility determination. Because this notice has already been developed, we anticipate maintenance burden costs to be significantly lower than the development cost and estimate the costs as follows. A Health Policy Analyst, Attorney, and Senior Manager will be responsible for reviewing and making any updates that may be needed to the notice, and a Computer Programmer would implement any updates needed to the electronic notice. Appendix A includes the data elements that we expect to be included in the SHOP employer eligibility determination notice required under subpart H.

Labor Category	Number of Respondents (per Exchange)	Hourly Labor Costs	Time per Response	Total Costs (per Exchange)	Total Costs (20 Exchanges)
Health Policy Analyst	1	\$97.30	3	\$291.90	\$5,838
Attorney	1	\$145.34	1	\$145.34	\$2,906.80
Senior Manager	1	\$99	1	\$99	\$1,980
Computer Programmer	1	\$94.88	5	\$474.40	\$9,488
Total			10	\$1,010.64	\$20,212.80

Information Collections under Part 156

A. QHP Issuer Requirements (§156.260 through §156.290)

45 CFR part 156 includes several notices that qualified health plan (QHP) issuers will send to qualified individuals and enrollees. As mentioned previously, we anticipate that a large share of enrollees will elect to receive electronic notices while the rest will receive notices by mail. Mailing costs have been estimated in item 13 – Capital Costs below. We believe that this will be the case for notices sent by the Exchange as well as notices sent by QHP issuers. We have accounted for the

burden associated with developing these notices in the Supporting Statement for Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (CMS-10592).

First, section 156.260(b) provides that QHP issuers will notify a qualified individual of his or her effective date of coverage, in accordance with the effective dates of coverage established by the Exchange in accordance with §155.410(c) and (f). Second, under §156.270(b), QHP issuers will send a notice of termination of coverage to an enrollee if the enrollee’s coverage in the QHP is being terminated in accordance with §155.430(b)(1)(i), (b)(2)(ii) or (b)(2)(iii). Third, §156.270(f) provides that QHP issuers will provide enrollees with a notice about the grace period for non-payment of premiums. QHP issuers will send this notice to enrollees who are delinquent on premium payments. Fourth, §156.265(e) provides that QHP issuers will provide new enrollees with an enrollment information package, which we anticipate that issuers may combine with the notification of coverage effective date described in §156.260(b). Lastly, under §156.290(b), QHP issuers will provide a notice to enrollees if the issuer elects not to seek recertification of a QHP.

The above QHP issuer required notices are similar in nature to the notices that issuers currently send to enrollees. For example, it is standard practice for issuers to provide new enrollees with information about their enrollment in a plan, their effective date of coverage, and if and when their coverage is terminating. Accordingly, QHP issuers have reviewed, updated, and revised notice templates that they utilize to ensure that the notices include the appropriate information. Similar to notices that are issued by the Exchange, we expect that for QHP-issued notices, an analyst will continue to maintain and update the information contained in the notice. A peer analyst, manager, and legal counsel for the issuer will review any updates to the notices, including a review to ensure compliance with plain writing, language access, and readability standards as required under §156.250(c).

Accordingly, we expect that the burden hours for maintaining the above notice will be similar to that which we estimate for the eligibility determination notice described under §155.310(g). However, we believe that the burden estimate described under §155.310(g) likely represents an upper bound estimate of the burden on issuers to maintain each of these notices as in some cases the notice described under §155.310(g) will be somewhat more dynamic in order to address the additional information we expect to be included in that notice. We expect that the burden on the QHP issuers to maintain the notices will be directly related to enrollment in the Exchanges.

Labor Category	Number of Respondents (per Exchange)	Hourly Labor Costs	Time per Response	Total Costs (per Exchange)	Total Costs (20 Exchanges)
Health Policy Analyst	1	\$97.30	3	\$291.90	\$5,838
Attorney	1	\$145.34	1	\$145.34	\$2,906.80
Senior Manager	1	\$99	1	\$99	\$1,980
Computer Programmer	1	\$95.88	5	\$479.40	\$9,588

Total			10	\$1,015.64	\$20,312.80
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Information Collections under Part 157

45 CFR part 157 includes several instances in which qualified employers participating in the SHOP Exchange will need to provide information to employees or to the SHOP Exchange. We include the data elements for these notifications in Appendix A of this ICR. For the individual market Exchange, we anticipate that a large share of enrollees will elect to receive electronic notices while the rest will receive notices by mail. Estimates for mailing costs have been discussed below under item 13 – Capital Costs. We do not make this assumption for notices described here as we expect that qualified employers will provide notices to employees in whatever format the qualified employer usually provides notices to employees, on paper, electronically, or in a combination of both formats. We do not take mailing costs into consideration for notices provided by qualified employers, as we expect that if qualified employers provide notices in paper format, the employer may provide the employee with the notice in person, as opposed to mailing the notice. We do not have a reasonable way to estimate total printing costs for notices provided by qualified employers in the SHOP Exchange due to uncertainty regarding the number of employees who will choose to receive paper notices, as well as some uncertainty regarding the frequency of circumstances that will trigger notices in accordance with this part.

First, §157.206(c) provides that a qualified employer participating in the SHOP must disseminate information to its qualified employees about the process to enroll in a QHP through the SHOP. The qualified employer will also provide information about the acceptable formats in which an employee may submit an application; online, or by phone. If the employee being offered coverage was hired outside an initial or annual enrollment period, the notice will also inform the employee if he or she is qualified for a special enrollment period. Second, in §157.206(e) we provide that a qualified employer must complete a new SHOP eligibility determination form or withdraw from participating in the SHOP, if the employer makes a change that could end its eligibility under §155.710.

The information that qualified employers will be providing to employees and the SHOP Exchange, as described above, will be standardized. Additionally, qualified employers will generate notices using a manual process. The notices that will be issued by qualified employers will be maintained by a human resources specialist (occupation no. 13-1071). We estimate that 250 QHP issuers will participate in the Exchanges. The burden hours for maintaining each of the notices will be approximately 10 hours for each of the two notices that will be provided by a qualified employer. We expect that the burden on the qualified employer to maintain the notices will be significantly lower than to develop the notices.

Labor Category	Number of Respondents (per Exchange)	Hourly Labor Costs	Time per Response	Total Costs (per Exchange)	Total Costs (20 Exchanges)
Human Resources Specialist	1	\$70.10	12	\$841.20	\$16,824

Attorney	1	\$145.34	8	\$1,162.72	\$23,254.4
Total			20	\$2,003.92	\$40,078.4

In total, we estimate \$2,003.92 in burden costs per Exchange for the two notices described above.

Total Aggregate Burden by Regulation Subpart

Subpart	Number of Respondents (per Exchange)	Time per Response	Total Costs (per Exchange)	Total Time per Response (20 Exchanges)	Total Costs (20 Exchanges)
Subpart C— General Functions of an Exchange	4	30	\$3,118.84	540	\$62,376.80
Subpart D— Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability	15	1,352	\$34,261.54	24,354	\$689,230.80
Subpart E – Exchange Functions in the Individual Market	----	----	----	----	----
Subpart H - Exchange Functions: Small Business Health Options Program	10	40	\$4,030.20	720	\$80,604
Total	29		\$41,410.58		\$832,211.6

13. Capital Costs

Eligibility Process (§155.310)

We also include an estimate for the total printing and mailing costs related to sending eligibility determination notices for all 20 State-based Exchanges. We estimate that an average of 283,072 notices will be sent by each of the 20 State-based Exchanges. We use these assumptions to determine the number of eligibility notices that we expect to be printed and distributed as described in §155.310. We note, however, that since we expect that many individuals will choose electronic notices instead of paper notices, this estimate is an upper bound.

	Number of Notices	Printing/Mailing Costs per notice	Total Costs (per Exchange)	Total Costs (20 Exchanges)
Printing/Mailing	283,072	\$.74	\$209,473	\$4,189,466

Administration of advance payments of the premium tax credit and cost-sharing reductions (§155.340)

This section specifies that the Exchange will provide the relevant information related to enable advance payments of the premium tax credit and cost-sharing reductions, reconciliation of advance payments of the premium tax credit, and employer responsibility. As these reporting functions will all be electronic, we do not expect for there to be any additional burden than that which is required to design the overall eligibility and enrollment system outside of the requirements in section 155.340(b)(3)(ii).

Section 155.340(b)(3)(ii) states that in the event that an individual for whom advance payments of the premium tax credit are made or who is receiving cost-sharing reductions terminates coverage from a QHP through the Exchange during a benefit year, the Exchange will transmit the individual’s name and the effective date of the termination of coverage to his or her employer. We anticipate that this burden on this transmission will be identical to that of §155.310(h).

	Number of Notices	Printing/Mailing Costs per notice	Total Cost (per notice)
Printing/Mailing	1	\$.74	\$.74

Information Collections under Part 157

45 CFR part 157 includes several instances in which qualified employers participating in the SHOP Exchange will need to provide information to employees or to the SHOP Exchange. We include the data elements for these notifications in Appendix A of this ICR. For the individual market Exchange, we anticipate that a large share of enrollees will elect to receive electronic notices while the rest will receive notices by mail. We do not make this assumption for notices described here as we expect that qualified employers will provide notices to employees in whatever format the qualified employer usually provides notices to employees, on paper, electronically, or in a combination of both formats. We estimate that the associated printing costs for paper notices will be approximately \$0.20 per notice. We do not take mailing costs into consideration for notices provided by qualified employers, as we expect that if qualified employers provide notices in paper format, the employer may provide the employee with the notice in person, as opposed to mailing the notice. We do not have a reasonable way to estimate total printing costs for notices provided by qualified employers in the SHOP Exchange due to uncertainty regarding the number of employees who will choose to receive paper notices, as well as some uncertainty regarding the frequency of circumstances that will trigger notices in accordance with this part.

	Number of Notices	Printing Costs per Notice	Total Cost (per notice)
Printing	1	\$0.20	\$0.20

14. Cost to Federal Government

We do not anticipate costs to the Federal government.

15. Changes to Burden

Burden hours remain 25,614 and have not been revised since the previous approval.

16. Publication/Tabulation Dates

Results from this collection will not be published.

17. Expiration Date

The expiration date and OMB control number will be displayed on the first page of each data collection instrument (top right-hand corner).

18. Certification Statement

There is no objection to the certification statement.