

Supporting Statement for Provider Network Coverage Data Collection (CMS-10594/OMB control number: 0938-1302)

A. Background

The Patient Protection and Affordable Care Act (P.L. 111-148) was signed into law on March 23, 2010. On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was signed into law. The two laws are collectively referred to as the Affordable Care Act (ACA). The ACA established competitive private health insurance markets called Marketplaces, or Exchanges, which gave millions of Americans and small businesses access to affordable, quality insurance options that meet certain requirements. These requirements include ensuring sufficient choice of providers and providing information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers.

In the final rule, the *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017* (CMS-9937-P), we finalized network adequacy standards for qualified health plan (QHP) issuers, including stand-alone dental plans (SADPs) mostly focused on issuers in QHPs in the Federally-facilitated Exchanges (FEEs). This information collection notice is for two of the standards from the rule: one applying in the FEE and one applying to all QHPs. Specifically, under 45 CFR §156.230(d) and 156.230(e), we require notification requirements for enrollees in cases where a provider leaves the network and for cases where an enrollee might be seen by an out of network ancillary provider in an in-network setting. These standards will help inform consumers about his or her health plan coverage to better make cost effective choices.

In the 2027 Payment Notice Final Rule, under 45 CFR 156.230(f) we propose an exception that paragraphs (a) through (e) of 156.230 do not apply to a plan for which an issuer seeks QHP certification, or to any certified QHP, that does not use a provider network, meaning that the plan or QHP does not condition or differentiate benefits based on whether the issuer has a network participation agreement with the provider that furnishes covered services.

This is a formal request to reinstate the existing collection with change of a previously approved data collection.

B. Justification

1. Need and Legal Basis

Under 45 CFR §156.230(d), a QHP issuer in an FFE who uses a provider network must make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is discontinuing, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal. In cases where a provider is terminated without cause, a QHP issuer in an FFE who uses a provider network must allow an enrollee in an active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever

is shorter, at in-network cost sharing rates.

Under 45 CFR §156.230(e), beginning for the 2018 and later benefit years, for a network to be deemed adequate, each QHP issuer who uses a provider network must, notwithstanding 45 CFR §156.130(c), count the cost sharing paid by an enrollee for an out-of-network essential health benefit (EHB) provided by an out-of-network ancillary provider in an in-network setting towards the enrollee's annual limitation on cost sharing or provide a notice to the enrollee by the longer of when the issuer would typically respond to a prior authorization request timely submitted, or 48 hours before the provision of the benefit, that additional costs may be incurred for an EHB provided by an out-of-network ancillary provider in an in-network setting, including balance billing charges, unless such costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on cost sharing.

Under the No Surprises Act section 113 (H.R. 133, Public Law 116-260), Internal Revenue Code section 9818(a), and PHS Act section 2799A-3, in the case of an individual with benefits under a group health plan and with respect to a health care provider or facility that has a contractual relationship with such plan for furnishing items and services under such plan, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility—the plan or issuer must notify each individual enrolled under such plan who is a continuing care patient with respect to a provider or facility at the time of a termination affecting such provider on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility under this section. The plan must also provide such individual with an opportunity to notify the plan of the individual's need for transitional care.

2. Information Users

The notifications that the QHP issuers that use a provider network will be required to send under this information collection will be sent to the QHP issuers' enrollees who are affected by a provider leaving the network. For the second notification, the information could be used by consumers to understand their cost sharing obligations if they receive care from an out-of-network ancillary provider. These notifications are intended to inform the consumer about his or her health insurance coverage to better make cost effective choices.

3. Use of Information Technology

CMS anticipates that QHP issuers will use their claims data systems to identify enrollees, complaints or customer service systems to identify impacted or qualifying enrollees or use the plan's preauthorization process. The notification can be sent to the enrollee electronically or by mail.

4. Duplication of Efforts

This information collection does not duplicate any other Federal effort.

5. Small Businesses

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

6. Less Frequent Collection

The burden associated with this information collection consists of QHP issuers in the FFE that use a provider network notifying enrollees about the plan's network coverage. QHP issuers that use a provider network need to make this information available to the plan's enrollees.

We recognize that the notification of the provider leaving a network is a good faith effort as there are certain situations that the issuer cannot anticipate. For these reasons, the regulation requires the notification 30 days prior to the effective date of the change or otherwise as soon as practicable.

We believe the advance notice provision will help provide transparency and ensure that consumers receive notice of the possible consequences where an out-of-network ancillary provider may be seen and are provided some mitigation of these consequences where proper, timely notice is not provided by the issuer.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

This ICR was published in the Federal Register on February 11, 2026 (91 FR 6292) for the public to submit written comment on the ICR in the 2027 Payment Notice Proposed Rule. No comments were received that were relevant to this ICR.

This ICR will be published as part of the 2027 Payment Notice Final Rule in the Federal Register on July 21, 2026 (91 FR 45647) for the public to submit written comment as part of a second-round public comment period.

No additional outside consultation was sought.

9. Payments/Gifts to Respondents

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

10. Confidentiality

All information collected will be kept private in accordance with regulations at 45 CFR 155.260, Privacy and Security of Personally Identifiable Information. Pursuant to this regulation, Exchanges may only use or disclose personally identifiable information to the extent that such information is necessary to carry out their 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 following section of this document contain estimates of burden imposed by the associated information collection requirements. Average labor costs (including 100 percent fringe benefits) used to estimate the costs are calculated using data available from the May 2024 National Industry-Specific Occupational Employment and Wage Estimates from the Bureau of Labor Statistics (BLS) website: <https://data.bls.gov/oes/#/industry/000000>. The adjusted hourly wage is the total of the median hourly wage plus 100% fringe benefit rate, see Table 1.

Table 1. Adjusted Hourly Wages Used in Burden Estimates for the Provider Network Coverage Data Collection

Occupational Title	Occupational Code	Median Hourly Wage (\$/hour)	Fringe Benefits and Overhead (100%) (\$/hour)	Adjusted Hourly Wage (\$/hour)
Database Administrator	15-1242	\$50.30	\$50.30	\$100.60
Administrative Assistant	43-6014	\$22.26	\$22.26	\$44.52
Operations Research Analyst	15-2031	\$43.89	\$43.89	\$87.78

Section 156.230(d) requires that QHP issuers that use a provider network make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non- renewal. This is a third-party disclosure requirement. The notification requirement under §156.230(d) is a common practice in the current market as several States, Medicare Advantage, Medicaid Managed Care, and the National Association of Insurance Commissioners' Network Adequacy Model Act have standards regarding enrollee notification of a provider leaving a network. As discussed in the final rule preamble, under State laws, many QHP issuers will already be under this obligation, and therefore, our notification requirements will apply in a more limited fashion. Additionally, we have incorporated stand-alone dental plans (SADPs) into our calculations, but we recognize given the requirements that SADPs may rarely meet the requirements to send a notification.

We estimate that a total of 374 issuers participate in the FFE and would be required to comply with the standard. We estimated that 5 percent of providers discontinue contracts per year, and that an issuer in the FFE covers 29,493 providers, which means that we estimate an issuer would have 1,474 provider discontinuation notices in a year.

It's difficult to estimate how many respondents will choose to offer non-network plans and thus fall

under the exception under 156.23(f), meaning 156.230(d) and (e) would not apply to issuers with non-network plans and whether those non-network plans will be offered in addition to network plans or offered in place of a network plan. The anticipated number of issuers offering non-network plans will also be dependent on States who may choose not to allow FFE issuers to offer non-network plans. Due to these factors, we expect that the overall average NA burden estimate to be negligible and not increase the burden estimates in Table 2.

Our assumption is that the database manager will receive notification from the issuer's contracting team that a provider contract is being discontinued. From that notification, the database manager would aggregate the claims data associated with the provider to develop the list of affected enrollees with associated enrollee information for the notice. This list of affected enrollees and associated enrollee information would be sent to an administrative assistant to aggregate into a notification template to be sent to the enrollee. Assuming 1,474 notices per a year, we believe that this task would be a routine process for the administrative assistant to undertake that would need little to no oversight to produce. As the issuer has the discretion to define regular basis and that the number of notices is likely to widely varying between scope of network and type of provider, we did not estimate based on the number of individual notifications, but rather the number of provider discontinuations. For each provider discontinuation notice, we estimate that it will take a database administrator 30 minutes for data analysis to produce the list of affected enrollees, at \$100.60 an hour, and an administrative assistant 30 minutes to develop the notification and send the notification to the affected enrollees, at \$44.52 an hour. The total costs per issuer are \$106,953.44. For all FFE issuers, the total annual burden is 551,276 hours and the total annual costs is \$40,000,586.56.

Pursuant to section 156.230(d) a QHP issuer in an FFE that uses a provider network must make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable.

Table 2. Burden for Issuers: Written Notice of Provider Discontinuation

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)
Database Administrator	374	\$100.60	737	\$74,142.20	\$27,729,182.80
Administrative Assistant	374	\$44.52	737	\$32,811.24	\$12,271,403.76
Total Annual			551,276	\$106,953.44	\$40,000,586.56
Total Three Years			1,653,828		\$120,001,759.68

In §156.230(e), we require issuers that use a provider network to provide a notice to enrollees of the possibility of out-of- network charges from an ancillary out-of-network provider in an in-network

setting prior to the benefit being provided, to avoid counting the out-of-network costs against the annual limitation on cost sharing. This provision applies to all 374 issuers. We estimate it would take an issuer's mid-level operations research analyst at an hourly wage rate of \$87.78 approximately 6 minutes to create a notification and send the information. We estimate that approximately two notices would be sent for every 100 enrollees. Assuming approximately 10.25 million FFE enrollees in QHPs for 2022¹, we estimate QHPs would send approximately 205,000 total notices annually, for a total 20,500 hours, at a total cost of \$1,799,067.16.

Pursuant to section 156.230(e) QHP issuers that use a provider network must, notwithstanding 45 CFR 156.130(c), count the cost sharing paid by an enrollee for an out-of-network essential health benefit (EHB) provided by an out-of-network ancillary provider in an in-network setting towards the enrollee's annual limitation on cost sharing or provide a notice to the enrollee that additional costs may be incurred.

Table 3. Burden for Issuers: Written Notice of the Possibility of Out-of-Network Charges

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)
Operations Research Analyst	374	\$87.78	54.8	\$4,810.34	
Total Annual			20,500		\$1,799,067.16
Total Three Years			61,500		\$5,397,201.48

Table 4. Summary of Annual Total Burden

Table Number: Name	CFR Section	Burden Hours	Burden Cost
Table 2: Burden for Issuers: Written Notice of Provider Discontinuation	45 CFR § 156.230(d) & 45 CFR § 156.230(e)	551,276	\$40,000,586.56
Table 3: Burden for Issuers: Written Notice of the Possibility of Out-of-Network Charges	45 CFR § 156.230(e)	20,500	\$1,799,067.16
Total - Annual		571,776	\$41,799,653.72

13. Capital Costs

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

¹ We used the [Marketplace 2022 Open Enrollment Period Report: Final National Snapshot](https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period-report-final-national-snapshot) available at <https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period-report-final-national-snapshot>

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 \$130,490.88 per year. The adjusted hourly wage of \$104.56 is the total of the hourly rate of \$52.28 for GS-13 step-7 plus 100% fringe benefit rate of \$52.28. The calculations for CCIIO employees' hourly salary was obtained from the OPM website: https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/26Tables/html/GS_h.aspx.

Table 5. Administrative Burden Costs for the Federal Government Associated with the Provider Network Coverage Data Collection

Task	Estimated Cost
Operations, maintenance, and data collection support	
GS-13 (step 7): 2 x \$104.56 x 624 hours	\$130,490.88
Total Cost to Government	\$130,490.88

15. Changes to Burden

There are no changes in the number of respondents or burden hours.

16. Publication/Tabulation Dates

Results of the collection will not be made public as the primary notifications are occurring between the issuer and then enrollee and provider information collected on the NA template in MPMS, which are submitted by issuers that CMS may rely on, and is used to assess compliance with network adequacy for the purpose of the QHP certification process. These data are not made public.

17. Expiration Date

There are no instruments associated with this data collection.

18. Certification Statement

There are no exceptions to the certification statement.