Supporting Statement for Information Collection Requirements for Non-Standardized Plan Option Limit Exceptions (CMS-NEW/OMB control number: 0938-NEW)

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"), expanded access to health insurance for individuals and employees of small businesses through the establishment of new Affordable Insurance Exchanges (Exchanges), also called Marketplaces, including the Small Business Health Options Program (SHOP). The Exchanges, which became operational on January 1, 2014, enhance competition in the health insurance market, expand access to affordable health insurance for millions of Americans, and provide consumers with a place to easily compare and shop for health insurance coverage.

Section 1311(c)(1) of the ACA directs the Secretary to establish criteria for the certification of health plans as qualified health plans (QHPs). Section 1321(a)(1)(B) of the ACA directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the ACA for, among other things, the offering of QHPs through such Exchanges.

In the *HHS Notice of Benefit and Payment Parameters for 2024 Final Rule* (2024 Payment Notice Final Rule), HHS exercised its authority under Sections 1311(c)(1) and 1321(a)(1)(B) of the ACA to limit the number of non-standardized plan options that issuers of QHPs can offer through Exchanges on the Federal platform, including both through Federally-facilitated Exchanges (FFEs) and State-Based Exchanges on the Federal platform (SBE-FPs), to four non-standardized plan options per product network type (as described in the definition of "product" at 45 C.F.R. 144.103), metal level (excluding catastrophic plans), inclusion of dental and/or vision benefit coverage, and service area for plan year (PY) 2024, and two for PY 2025 and subsequent plan years.

This information collection request (ICR) serves as the formal request for a new information collection clearance associated with the *HHS Notice of Benefit and Payment Parameters for 2025 Proposed Rule* (2025 Payment Notice Proposed Rule) regarding the authority to allow HHS to collect the necessary information to enable QHP issuers to seek to be excepted from the non-standardized plan option limit of two per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area for PY 2025 and subsequent years, if they so choose.

B. Justification

1. Need and Legal Basis

Section 1311(c)(1) of the ACA directs the Secretary to establish criteria for the certification of health plans as QHPs. Section 1321(a)(1)(B) of the ACA directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the ACA for, among other things, the offering of QHPs through such Exchanges.

In the 2024 Payment Notice Final Rule, HHS exercised its authority under Sections 1311(c)(1) and 1321(a)(1)(B) of the ACA to limit the number of non-standardized plan options that issuers of QHPs can offer through Exchanges on the Federal platform, including both through FFEs and SBE-FPs, to four non-standardized plan options per product network type (as described in the definition of "product" at 45 C.F.R. 144.103), metal level (excluding catastrophic plans), inclusion of dental and/or vision benefit coverage, and service area for PY 2024, and two for PY 2025 and subsequent plan years.

As part of the 2025 Payment Notice Proposed Rule, we propose a new ICR and request a 60-day public comment process on the proposals at 45 C.F.R. 156.202(e) to permit FFE and SBE-FP issuers to offer more than two non-standardized plan options per product network type, metal level, inclusion of dental and vision benefit coverage, and service area for PY 2025 and subsequent plan years, if issuers demonstrate that these additional non-standardized plans beyond the limit at 45 C.F.R. 156.202(b) have specific design features that would substantially benefit consumers with chronic and high-cost conditions.

Under this proposed requirement, issuers would be permitted to offer more than two non-standardized plan options if these additional plans' cost sharing for benefits pertaining to the treatment of chronic and high-cost conditions (including benefits in the form of prescription drugs, if pertaining to the treatment of the condition(s)) is at least 25 percent lower, as applied without restriction in scope throughout the plan year, than the cost sharing for the same corresponding benefits in an issuer's other non-standardized plan option offerings in the same product network type, metal level, and service area.

In accordance with the proposed exceptions process at § 156.202(e), issuers seeking an exception would be required to submit a written justification in a form and manner and at a time prescribed by HHS that provides additional details and explains how the particular plan design the issuer desires to offer above the non-standardized plan option limit of two satisfies the proposed standards for receiving an exception to this limit – namely, how the particular plan would substantially benefit consumers with chronic and high-cost conditions. The Centers for Medicare & Medicaid Services (CMS) would provide issuers with a justification form upon publication of the final rule when the QHP templates for the applicable plan year are released.

This justification form would ask the issuer to (1) identify the specific condition(s) for which cost sharing is reduced, (2) explain which benefits would have reduced annual enrollee cost sharing (as opposed to reduced cost sharing for a limited number of visits) for the treatment of the specified condition(s) by 25 percent or more relative to the cost sharing for the same corresponding benefits in an issuer's other non-standardized plan offerings in the same product network type, metal level, and service area, and (3) explain how the reduced cost sharing for these services pertains to clinically indicated guidelines for treatment of the specified chronic and high-cost condition(s).

This proposed information collection proposes to use the collection instrument in Appendix A. Non-Standardized Plan Option Limit Exception Justification Form. FFE and SBE-FP issuers would be required to submit this justification form electronically. We may use a web-based tool to collect this information.

2. Information Users

This ICR will provide HHS the authority necessary to request information from QHP issuers requesting to be excepted from the non-standardized plan option limit of two per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area for PY 2025 and subsequent years if they so choose. Collecting the required information in the justification form will enable HHS to ensure QHP issuers are meeting the requirements proposed at § 156.202(e) to be granted an exception.

3. Use of Information Technology

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

4. Duplication of Efforts

This information collection does not duplicate any other Federal effort.

5. Small Businesses

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

6. Less Frequent Collection

If information is collected on a less frequent basis, HHS will be unable to allow QHP issuers' request to be excepted from the non-standardized plan option limit of two per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area for PY 2025 and subsequent years, which could result in the unnecessary discontinuation of non-standardized plan options that would benefit consumers with chronic and high-cost conditions. Therefore, this information must be collected on an annual basis to allow these issuers to submit a request to be excepted from the non-standardized plan option limit if they so choose.

7. Special Circumstances

There are no anticipated special circumstances.

8. Federal Register/Outside Consultation

A 60-day notice will be published in the Federal Register on XX/XX/2023 for the public to submit written comment on the ICR in the 2025 Payment Notice Proposed Rule.

No additional outside consultation was sought.

9. Payments/Gifts to Respondents

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

10. Confidentiality

To the extent of the applicable law and HHS policies, we will maintain respondent privacy with respect to the information collected. Nothing in the information collection should be interpreted as preventing a State from being allowed to disclose its own data.

11. Sensitive Questions

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

12. Burden Estimates (Hours & Wages)

We used the Bureau of Labor Statistics (BLS), Occupational Employment Statistics, May 2022 (https://www.bls.gov/oes/current/oes_stru.htm) to estimate the burden for this information collection. The median hourly wage (which also includes a 100% fringe benefit rate) is $109.60 per hour for an actuary (OES occupational code 15-2011); $94.32 for a general and operations manager (OES occupational code 11-1021); and $206.22 for a general internal medicine physician (OES occupational code 29-1216). See Table 1.

Table 1. Adjusted Hourly Wages Used in Burden Estimates

Occupational Title	Occupational Code	Median Hourly Wage ($/hour)	Fringe Benefits & Overhead (100%) ($/hour)	Adjusted Hourly Wage ($/hour)
Actuary	15-2011	$54.80	$54.80	$109.60
General and Operations Manager	11-1021	$47.16	$47.16	$94.32
General Internal Medicine Physicians	29-1216	$103.11	$103.11	$206.22

Non-Standardized Plan Option Limit Exceptions (§ 156.202): The 2025 Payment Notice Proposed Rule proposes an exceptions process that would allow issuers to offer non-standardized plan options in excess of the limit of two per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area for PY 2025 and subsequent years, if issuers demonstrate that these additional non-standardized plans beyond the limit at § 156.202(b) have specific design features that would substantially benefit consumers with chronic and high-cost conditions.

Under this proposed requirement, issuers would be required to submit a justification form that would: (1) identify the specific condition(s) for which cost sharing is reduced, (2) explain which benefits would have reduced annual enrollee cost sharing (as opposed to reduced cost sharing for a limited number of

visits) for the treatment of the specified condition(s) by 25 percent or more relative to the cost sharing for the same corresponding benefits in an issuer's other non-standardized plan offerings in the same product network type, metal level, and service area, and (3) explain how the reduced cost sharing for these services pertains to clinically indicated guidelines for treatment of the specified chronic and high-cost condition(s).

We estimate that approximately 50 FFE and SBE-FP issuers would request to be excepted from the non-standardized plan option limit in order to offer these additional plans annually. In order for an issuer to complete the necessary documentation to submit a request to be excepted from the non-standardized plan option limit at § 156.202(b) in accordance with the proposed requirements at § 156.202(d), we estimate that it would take an actuary five hours annually at a median hourly cost of $109.60 per hour (amounting to $548.00 annually); a general and operations manager ten hours annually at a median hourly cost of $94.32 per hour (amounting to $943.20 annually); and a general internal medicine physician two hours annually at a median hourly cost of $206.22 (amounting to $412.44 annually). Altogether, we estimate a total cost of $1,903.64 per issuer annually to submit a request to be excepted from the non-standardized plan option limit. We estimate that this information collection has an annual burden of 850 hours with a total cost of $1,903.64 per respondent and $95,182.00 for all respondents annually. Furthermore, we estimate a total burden of 2,550 hours with a total cost $285,546.00 for all respondents for the duration of this collection over three years. See Table 2.

Table 2. Annual Burden for an Issuer to Submit this Justification Form as Part of the Request to be Excepted from the Non-Standardized Plan Option Limit.

Occupational Title	Number of Respondents	Hourly Labor Costs (Hourly rate + 100% Fringe Benefits)	Burden Hours	Total Burden Cost (per Respondent)	Total Burden Costs (All Respondents)
Actuary	50	$109.60	5	$548.00	$27,400.00
General and Operations Manager	50	$94.32	10	$943.20	$47,160.00
General Internal Medicine Physician	50	$206.22	2	$412.44	$20,622.00
Total - Annual			**850**		**$95,182.00**
Total – Three Years			**2,550**		**$285,546.00**

13. Capital Costs

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

14. Cost to Federal Government

We estimate that the operations and maintenance costs for the data collection tool and the data collection support to have a total cost to the federal government of $14,640.60 annually. The calculations for CMS employees' hourly salary was obtained from the OPM website: https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2023/DCB_h.pdf

Table 5. Administrative Burden Costs for the Federal Government Associated with the Collection

Task	**Estimated Cost**
Operations, maintenance, and data collection support	
2 GS-13 (step 7): 2 x $128.82[1] x 50 hours	$12,882.00
Managerial review and oversight	
1 GS-15 (step 7): $175.86[2] x 10 hours	$1,758.60
Total Cost to Government	**$14,640.60**

15. Changes to Burden

There are no changes to burden as this is a new information collection.

16. Publication/Tabulation Dates

There are no plans to publish the outcome of the data collection.

17. Expiration Date

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

1 Hourly basic rate of $64.41 + 100% fringe benefit rate.
2 Hourly basic rate of $87.93 + 100% fringe benefit rate.