Supporting Statement for Essential Health Benefits Benchmark Plans
(CMS-10448/OMB control number: 0938-1174)

A. Background

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148) was signed into law, and on March 30, 2010, the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was signed into law. The two laws implement various health insurance policies, including the essential health benefits (EHB). Beginning in 2014, all non-grandfathered health plans in the individual and small group market must cover EHB, as defined by the Secretary of Health and Human Services. The PPACA directs that EHB reflect the scope of benefits covered by a typical employer plan and cover at least the following 10 general categories of items and services:

(1) Ambulatory patient services.
(2) Emergency services.
(3) Hospitalization.
(4) Maternity and newborn care.
(5) Mental health and substance use disorder services, including behavioral health treatment.
(6) Prescription drugs.
(7) Rehabilitative and habilitative services and devices.
(8) Laboratory services.
(9) Preventive and wellness services and chronic disease management.
(10) Pediatric services, including oral and vision care.

EHB-Benchmark Plan Selection

Pursuant to Section 1302 of the PPACA and Section 2707 of the Public Health Service Act, as amended by section 1201 of the PPACA, CMS released a bulletin on December 16, 2011 (EHB Bulletin)[1] describing its intent to define EHB by reference to a state-specific benchmark plan. That policy was finalized in the rule *Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule* (EHB Final Rule) (78 FR 12834), published on February 25, 2013.[2] In order to establish an EHB-benchmark plan in each state, in 2012, CMS asked states to voluntarily identify an EHB-benchmark plan from 10 options that were provided in the EHB Bulletin. The EHB Final Rule applied those benchmark plans starting in the 2014 plan year as a transitional policy. Then, in 2015, CMS asked states to voluntarily identify an EHB- benchmark plan from those 10 options for a second time based on 2014 plans that would apply beginning in the 2017 plan year.

In the final rule entitled the HHS Notice of Benefit and Payment Parameters for 2019 (2019 Final Payment Notice; CMS-9930-F),[3] we changed the state's EHB-benchmark plan selection process beginning for 2020 plan year. For plan years beginning on or after January 1, 2020, subject to §156.111(b), (c), (d) and (e), a state may change its EHB-benchmark plan by:

(1) Selecting the EHB-benchmark plan that another state used for the 2017 plan year under

[1] http://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf
[2] https://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf
[3] A copy of the final rule is posted on CCIIO's website at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html.

§156.100 and §156.110;
(2) Replacing one or more categories of EHBs under §156.110(a) under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB- benchmark plan that another state used for the 2017 plan year under §156.100 and §156.110; or
(3) Otherwise selecting a set of benefits that would become the state's EHB-benchmark plan.

In the final rule entitled *HHS Notice of Benefit and Payment Parameters for 2023* (2023 Payment Notice; CMS-9911-F),[4] we repealed the ability for States to permit between category substitution of the EHBs at 45 CFR 156.115. Thus, we revise this Supporting Statement to remove any burden associated with States opting to permit between category substitution of the EHBs and remove the form Essential Health Benefits (EHB) State Substitution Notification (**Appendix F**) from this collection.

Annual Reporting of State Mandates
Section 1311(d)(3)(B) of the PPACA permits a state to require QHPs offered in the state to cover benefits in addition to EHB, but requires the state to make payments, either to the individual enrollee or to the issuer on behalf of the enrollee, to defray the cost of these additional state-required benefits. In the EHB final rule, we codified this requirement at §155.170 and finalized a standard at §155.170(a)(2) that specifies benefits mandated by state action taking place on or before December 31, 2011, even if not effective until a later date, may be considered EHB, such that the state is not required to defray costs for these state-required benefits. Under this policy, benefits mandated by state action taking place after December 31, 2011, are considered in addition to EHB, even if the mandated benefits also are embedded in the state's selected EHB-benchmark plan. In such cases, states must defray the associated costs of QHP coverage of such benefits, and those costs should not be included in the percentage of premium attributable to coverage of EHB for purpose of calculating premium tax credits.

In the final rule entitled *HHS Notice of Benefit and Payment Parameters for 2021* (2021 Payment Notice; CMS-9916-F),[5] we finalized amendments to §156.111(d) and adding new §156.111(f) to require states to annually notify HHS in a format and manner specified by HHS, and by a date determined by HHS, of any state-required benefits applicable to QHPs in the individual and/or small group market that are considered to be "in addition to EHB" in accordance with §155.170(a)(3).

In the final rule entitled *HHS Notice of Benefit and Payment Parameters for 2023* (2023 Payment Notice; CMS-9911-F),[6] we repealed the annual reporting requirement at § 156.111(d) and (f), including revising the section heading to § 156.111 to instead read, "State selection of EHB benchmark plan for PYs beginning on or after January 1, 2020." Thus, we have revised this Supporting Statement to reflect that States are no longer required to annually notify HHS of any State-required benefits applicable to QHPs in the individual or small group market that are

[4] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 FR 27208 (May 6, 2022). Available at https://www.govinfo.gov/content/pkg/FR-2022-05-06/pdf/2022-09438.pdf.
[5] A copy of the final rule is posted on CCIIO's website at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html.
[6] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 FR 27208 (May 6, 2022). Available at https://www.govinfo.gov/content/pkg/FR-2022-05-06/pdf/2022-09438.pdf.

considered to be "in addition to EHB" or any benefits the State has identified as not in addition to EHB and not subject to defrayal. We also remove the forms State Annual Report on State-Required Benefits (**Appendix G**) and State Certification of Annual Report on State-Required Benefits (**Appendix H**) from this collection.

Intent to Offer SADPs
This information collection also previously included estimates for the burden on issuers to report their intent to offer SADPs. We no longer collect this information from issuers; we revise this Supporting Statement to remove the burden associated with this report.

The current PRA approval for this package expires 2/28/24 and this extension request is to ensure that it does not expire. In this package, we make minimum required revisions to reflect only the regulatory changes that have occurred since it was last authorized in 2021.

B. Justification

1. Need and Legal Basis

Section 1302 of the PPACA requires that all non-grandfathered individual and small group health plans provide EHB, as defined by the Secretary. Section 1321(a) requires HHS to issue regulations setting standards for meeting the requirements under title I of the PPACA. On June 5, 2012, HHS published Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans (77 FR 33133), initially authorizing CMS to collect data from potential default EHB-benchmark plan issuers in each state. The ICR associated with that proposed rule addressed states' selection of their own benchmark plan. The proposed rule was finalized and published on July 20, 2012, at 77 FR 42658. A revised ICR was published with the HHS Notice of Benefit and Payment Parameters for 2016 (CMS-9944-P and CMS-9937-F) and the ICR was finalized on August 28, 2015. As part of the 2019 Proposed Payment Notice, we proposed to revise this ICR which also proposed to add one new EHB section to the regulation at §156.111. We finalized new regulations at §156.111 for a state's EHB-benchmark plan as part of the 2019 Final Payment Notice published on April 17, 2018, and simultaneously published a revised ICR to reflect these changes on April 16, 2018. As part of the 2021 Proposed Payment Notice, we proposed to revise this ICR requesting a 60-day public comment process, which proposed to add new EHB sections to the regulation at §156.111(d) and (f).

In accordance with §156.111(e), for plan years beginning on or after January 1, 2020, a state changing its EHB-benchmark plan using one of the options at §156.111(a) must submit documents specified by HHS in a format and manner by a date determined by HHS. These required documents include:

(1) A document confirming that the state's EHB-benchmark plan definition complies with the requirements under paragraphs (a), (b) and (c), including information on which selection option under proposed §156.111(a) the state is using, and whether the state is using another state's EHB-benchmark plan;
(2) An actuarial certification and an associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted

actuarial principles and methodologies that affirms:

(a) That the state's EHB-benchmark plan provides a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan, as defined at §156.110(b)(2)(i); and

(b) That the new EHB-benchmark plan does not exceed the generosity of the most generous among the plans listed in §156.111(b)(2)(ii);

(3) The state's EHB-benchmark plan document that reflects the benefits and limitations, including medical management requirements, a schedule of benefits and, if the state is selecting its EHB-benchmark plan using the option in §156.111(a)(3), a formulary drug list in a format and manner specified by HHS; and

(4) Other documentation specified by HHS, which is necessary to operationalize the state's EHB-benchmark plan.

A response is not needed for all states. Only states choosing to modify the state's EHB-benchmark plan would need to respond to this ICR. However, the number and types of documents needed in this ICR differ from the previous ICR. This information collection uses collection instruments in Appendices A, B, C, D, and E.[7] We provide collection instruments for certain documents in this ICR, and for other documents in this ICR we do not have collection instruments. These collection instructions have been updated in accordance with the Final 2023 Payment Notice and in response to comments received. Since beginning this collection, we have also made updates to these collection instruments for clarity and to improve usability. For documents without collection instruments, the state will submit these documents in a PDF or Word format. States will submit these documents electronically. We may use a web-based tool to collect these documents with e-mail as back up option, and we believe that the burden would be the same for collecting all of these documents in a web tool or via email.

2. Information Uses

The EHB benchmark plan information in this ICR is used by issuers and CMS to establish the benefits covered by benchmark plans in each state as EHB. This allows issuers seeking to offer coverage in the individual and small group markets to design benefits that meet EHB requirements and each state's EHB-benchmark plan determines EHB for the purposes of the availability of premium tax credits and cost-sharing reductions for enrollees in the state.[8] This information is used to inform CMS and states, as well as Exchanges, in their efforts to ensure plans are meeting EHB requirements for QHP certification and EHB compliance.

3. Use of Information Technology

EHB-Benchmark plan selection documents must be submitted electronically. Specifically, we may use a web-based tool with email as a back-up option to collect the documents under this ICR. As described in the 2019 Payment Notice, the information in this information collection

[7] Appendix E is only for information purposes.

[8] The definition of EHB also has an impact on the annual limitation on cost sharing at section 1302(c) of the ACA (which is incorporated into section 2707(b) of the PHS Act) and the prohibition of annual and lifetime dollar limits at section 2711 of the PHS Act, as added by the ACA.

will be posted on Center for Consumer Information and Insurance Oversight (CCIIO) webpage on EHB.[9]

4. Duplication of Efforts

There is no duplication of efforts.

5. Small Businesses

This information collection will not impact small businesses.

6. Less Frequent Collection

We anticipate that the EHB-benchmark plan data collection will occur annually. The respondents will likely be different respondents each year. If the collection was less frequently, it would decrease the flexibility for states on when they could choose to make changes to their EHB-benchmark plans.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

A 60-day notice was published in the Federal Register on 09/27/2023 (88 FR 66452) for the public to submit written comment on the information collection requirements. No public comments were received. A 30-day notice published in the Federal Register on February 7, 2024 (89 FR 8434) for the public to submit written comment on the information collection requirements.

No additional outside consultation was sought.

9. Payments/Gifts to Respondents

No payments and/or gifts were made to any respondents.

10. Confidentiality

CMS will post EHB-Benchmark plan selection the documents collected through this data collection in a similar manner and format to the documents CMS currently provides on states' EHB-benchmark plans and in accordance with the 2023 Final Payment Notice.

11. Sensitive Questions

[9] The current CCIIO webpage for EHB-benchmark plans is available at: https://www.cms.gov/CCIIO/Resources/Data- Resources/ehb.html.

No sensitive questions are asked in this information collection effort.

12. Burden Estimates (Hours & Wages)

Average labor costs (including 100 percent fringe benefits) used to estimate the costs are calculated using data available from the May 2022 National Industry-Specific Occupational Employment and Wage Estimates (Bureau of Labor Statistics (BLS) (https://www.bls.gov/oes/current/naics4_999200.htm#11-0000).

Table 1: Adjusted Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Median Hourly Wage ($/hour)	Fringe Benefits and Overhead (100%)($/hour)	Adjusted Hourly Wage ($/hour)
Financial Examiner (State Government, excluding schools and hospitals)	13-2061	$38.45	$38.45	$76.90
Actuary (Member of American Academy of Actuaries)	15-2011	$54.80	$54.80	$109.60

EHB-Benchmark Plan Selection
The following sections of this document contain estimates of the burden imposed by the incorporated ICRs, but this burden estimate does not include estimates for a state to conduct reasonable public notice and an opportunity for public comment as finalized at §156.111(c).

Burden on States
Under the previous benchmark plan selection policy, 29 states selected one of the 10 base benchmark plan options and 22 states defaulted and that policy did not allow for states to make an annual selection. The revised regulation allows states to modify their EHB-benchmark plans annually but would not require them to respond to this ICR for any year for which they did not change their EHB- benchmark plans. As such, for purposes of this regulation, we estimate that 10 states would choose to make a change to their EHB-benchmark plans in any given year (for a total of 30 states over 3 years within the authorization of this ICR) and would respond to this ICR. The following details the burden attached to part of this information collection.

First, to select a new EHB-benchmark plan, we require at §156.111(e)(1) that the state provide confirmation that the state's EHB-benchmark plan selection complies with certain requirements, including those under §156.111(a), (b), and (c). To collect this information, the state submits the associated document in **Appendix A. Confirmations on the State EHB-benchmark Plan**. To complete this requirement, we estimate that a financial examiner would require 4 hours (at a rate of $76.90 per hour) to fill out, review, and transmit a complete and accurate document. We estimate that it would cost each state approximately $307.60 to meet this reporting requirement, with a total annual burden for all 10 states of 40 hours and an associated total cost of $3,076.00.

Second, we require at §156.111(e)(2) that the state submit an actuarial certification and

associated actuarial report of the methods and assumptions when selecting options under §156.111(a). Specifically, we are finalizing at §156.111(b)(2)(i) and (ii) that a state's EHB-benchmark plan must provide benefits at least equal in scope of benefits to what is provided under a typical employer plan and that the state's EHB-benchmark plan must not exceed the generosity of the most generous among a set of comparison plans. The actuarial certification that is being collected under this ICR is required to include an actuarial report that complies with generally accepted actuarial principles and methodologies. This estimate includes complying with all applicable ASOPs (including ASOP 41 on actuarial communications). For example, ASOP 41 on actuarial communications includes disclosure requirements, including those that apply to the disclosure of information on the methods and assumptions being used for the actuarial certification and report. The actuarial certification for this requirement is provided in a template in **Appendix B. Essential Health Benefits (EHB)-Benchmark Plan Actuarial Certificate Template** and includes an attestation that the standard actuarial practices have been followed or that exceptions have been noted. The signing actuary is required to be a Member of the American Academy of Actuaries.

We estimate that an actuary, who is a member of the American Academy of Actuaries, requires 18 hours (at a rate of $109.60 per hour) on average for §156.111(e)(2). This includes the certification and associated actuarial report from an actuary to affirm, in accordance with generally accepted actuarial principles and methodologies that the state's EHB-benchmark plan must provide a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan, as defined at §156.110(b)(2)(i) and that the state's EHB-benchmark plan definition does not exceed the generosity of the most generous among the set of comparison plans. We also previously finalized a document entitled Example of an Acceptable Methodology for Comparing Benefits of a state's EHB- benchmark Plan Selection in Accordance with 45 CFR 156.111(b) (2)(i) and (ii) that provides an example of a method an actuary could use to develop the actuarial certification and associated report at §156.111(e)(2) for both the typical employer plan benefit and comparison plan standards. We estimate that it would cost each State approximately $1,972.80 to meet this reporting requirement, with a total annual burden for all 10 States of 180 hours and an associated total cost of $19,728.00.

For these calculations, the actuary needs to conduct the appropriate calculations to create and review an actuarial certification and associated actuarial report, including minimal time required for recordkeeping. The precise level of effort for the actuarial certification and associated actuarial report under §156.111(e)(2) will likely vary depending on the state's approach to its EHB-benchmark plan and this certification requirement. For example, as described in the Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii),[10] to reduce the burden of these standards, the actuary may want to consider using the same plan for both the generosity and the typicality tests, provided that the plan meets the standards at both §156.111(b)(2)(i) and (ii). For example, the actuary may only need to do one plan comparison for the purposes of both

[10] Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii), available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Example-Acceptable-Methodology-for-Comparing-Benefits.pdf.

of these certification requirements. Specifically, the actuary could use the same plan, such as the state's EHB-benchmark plan used for the 2017 plan year. That plan would, by definition, be a "Comparison Plan." Because the state's EHB-benchmark plan used for the 2017 plan year would simply be one of the state's base-benchmark plans, supplemented as necessary under §156.110, that plan also could be used for purposes of determining typicality, as a proposed state EHB-benchmark plan that was equal in scope of benefits to the state's EHB-benchmark plan used for the 2017 plan year within each EHB category at §156.110(a) would be equal to the scope of benefits within each EHB category at §156.110(a) than the base-benchmark plan underlying the EHB-benchmark plan used for the 2017 plan year, to the extent of the required supplementation.

The estimated burden is 18 hours for the actuary to complete the actuarial certification and associated report in recognition of the extension of the generosity standard and in recognition that the definition of typical employer plan may require the actuary to determine whether the typical employer plan meets MV requirements. The estimated number of states that need to respond to this ICR is 10 states since the typical employer plan standard and the generosity standard applies to all state's EHB-benchmark plan options at §156.111(a). For the actuarial certification, we provide the collection instrument in **Appendix B. Essential Health Benefits (EHB)-Benchmark Plan Actuarial Certificate Template**. We estimate that a financial examiner will require 1 hour (at a rate of $76.90 per hour) to review, combine, and electronically transmit these documents to HHS, as part of a state's EHB-benchmark plan submission. We estimate that each state will incur a burden of 1 hours with an associated cost of $76.90 with a total annual burden for 10 states of 10 hours at associated total cost of $769.00.

Third, we require at §156.111(e)(3) each state to submit its new EHB-benchmark plan documents. The level of effort associated with this requirement could depend on the state's selection of the EHB- benchmark plan options under the regulation at §156.111(a). However, for the purposes of this estimate, we estimate that it would require a financial examiner (at a rate of $76.90 per hour) 12 hours on average to create, review, and electronically transmit the state's EHB-benchmark plan document that accurately reflects the benefits and limitations, including medical management requirements and a schedule of benefits, resulting in a burden of 12 hours and an associated cost of $922.80, with a total annual burden for all 10 states of 120 hours and an associated cost of $9,228.00. The burden for producing these documents is significantly higher than previous estimates because the previous data collection generally only required the state (or issuer) to transmit the selected benchmark plan document. In contrast, in some cases, §156.111(a) may result in the state needing to create a completely new document or significantly modify the current document to represent the plan document. Additionally, this estimate of 12 hours also includes the burden necessary for a state selecting the option at §156.111(e)(3) where the state is required to submit a formulary drug list for the state's EHB- benchmark plan in a format and manner specified by HHS. Specifically, the burden for the state selecting this option is also likely vary as the state could use an existing formulary drug list or create its own formulary drug list separately for this purpose. To collect the formulary drug list, the state is required to use the template provided by HHS and must submit the formulary drug list as a list of RxNorm Concept Unique Identifiers (RxCUIs). This template is incorporated in **Appendix D. EHB-benchmark Plan Formulary Drug List**.

Lastly, §156.111(e)(4) requires the state to submit the documentation necessary to operationalize

the state's EHB-benchmark plan definition. This reporting requirement includes the EHB summary file that is currently posted on CCIIO's website and is used as part of the QHP certification process and is integrated into HHS's IT Build systems that feeds into the data that is displayed on HealthCare.gov.[11] This document format is incorporated as a template in **Appendix C. The State's EHB-benchmark Plan's Benefits and Limits**. Although this document is not a new document, the burden associated with this document is new for states. We estimate that it would require a financial examiner 12 hours, on average, (at a rate of $76.90per hour) to create, review, and electronically submit a complete and accurate document to HHS resulting in a burden of 12 hours and an associated cost of $922.80, with a total annual burden for all 10 states of 120 hours and an associated cost of $9,228.00.

We estimate that the total number of respondents would be 10 per year, for a total yearly burden of 470 hours and an associated cost of $42,029.00 to meet these reporting requirements. Below is the estimate of the burden imposed on a state subject to the reporting requirements of this final rule.

Table 2: Burden for EHB-Benchmark Plan Selection

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly rate + 100% Fringe benefits)	Burden Hours per Response	Total Burden Costs (Per Respondent)	Total Annual Burden (All Respondents)
Financial Examiner (State Government, excluding schools and hospitals)	10	$76.90	29	$2,230.10	$22,301.00
Actuary (Member of American Academy of Actuaries)	10	$109.60	18	$1,972.80	$19,728.00
Total - Annual			**47**		**$42,029.00**
Total - Three Years			**141**		**$126,087.00**

13. Capital Costs

There are no anticipated capital costs associated with this data collection.

14. Cost to Federal Government

The burden to the Federal government associated with this information collection is $21,692.60.

[11] https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html.

The calculations for CCIIO employees' hourly salary were obtained from the OPM website: https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2023/GS_h.pdf

Table 8: Administrative Burden Costs for the Federal Government Associated with the EHB-Benchmark Plan Selection

Task	Estimated Cost
EHB-Benchmark Plan Selection	
1 FTE GS-13: 1 x $81.02 x 150 hours	$12.153.00
1 FTE GS-12: 2 x $68.14 x 70 hours	$9539.60
Total Costs to Government	**$21,692.60**

15. Changes to Burden

There is an overall decrease in the financial burden from the 2021 PRA package because of the removal of appendices F, G, and H as we no longer collect this information from states. The total burden hours decreased from 157 hours to 47 hours, which is a decrease of 110 hours. The estimated annual costs decreased from $106,628.22 to $42,029.00, which is a decrease of $64,599.22. There was an increase in the adjusted hourly wage rates for the two labor categories. All prior iterations of wage data was based on mean values and the current iteration is based on median values.

16. Publication/Tabulation Dates

In accordance with the 2023 Payment Notice, EHB-Benchmark Plan Selection documents covered under this information collection will be posted on the CCIIO website at some point after the annual deadline for state submission for its EHB-benchmark plan.[12]

17. Expiration Date

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

[12] https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html.