Supporting Statement – Part A
Nonquantitative Treatment Limitation Analyses and Compliance Under MHPAEA
(CMS-10773/OMB control number 0938-1393)

A. Background

Enacted on October 3, 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Public Law 110-343, amended the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act (PHS Act), and the Internal Revenue Code of 1986 (Code). MHPAEA expanded existing parity requirements between medical and surgical benefits and mental health benefits, and also extended parity requirements to substance use disorder benefits. The law generally requires that group health plans and group health insurance issuers offering both medical/surgical and mental health or substance use disorder (MH/SUD) benefits do not apply more restrictive financial requirements (e.g., co-pays, deductibles) and/or treatment limitations (e.g., visit limits, prior authorization) to MH/SUD benefits than those requirements and/or limitations as applied to substantially all medical/surgical benefits.

The Patient Protection and Affordable Care Act, Pub. L. 111-148, was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, was enacted on March 30, 2010. These statutes are collectively known as the "Affordable Care Act." The Affordable Care Act reorganizes, amends, and adds to the provisions of part A of Title XXVII of the PHS Act relating to group health plans and health insurance issuers in the group and individual markets. The Affordable Care Act added section 715(a)(1) to ERISA and section 9815(a)(1) to the Code to incorporate the provisions of part A of Title XXVII of the PHS Act into ERISA and the Code, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The Affordable Care Act extended MHPAEA to apply to the individual health insurance market and redesignated MHPAEA as section 2726 of the PHS Act.[1] Additionally, section 1311(j) of the Affordable Care Act applies section 2726 of the PHS Act to qualified health plans (QHPs) in the same manner and to the same extent as such section applies to health insurance issuers and groups health plans. Additionally, the Department of Health and Human Services (HHS) final regulation regarding essential health benefits (EHB) requires health insurance issuers offering non-grandfathered health insurance coverage in the individual and small group markets, through an Exchange or outside of an Exchange, to comply with the requirements of the MHPAEA regulations to satisfy the requirement to cover EHB.[2]

The MHPAEA final regulations require that a group health plan or health insurance issuer may not impose a nonquantitative treatment limitation (NQTL) with respect to MH/SUD

[1] MHPAEA requirements apply to both grandfathered and non-grandfathered health plans. See section 1251 of the Affordable Care Act and its implementing regulations at 26 CFR 54.9815-1251T, 29 CFR 2590.715-1251, and 45 CFR 147.140. Under section 1251 of the Affordable Care Act, grandfathered health plans are exempted only from certain Affordable Care Act requirements enacted in Subtitles A and C of Title I of the Affordable Care Act. The provisions extending MHPAEA requirements to the individual market and requiring that qualified health plans comply with MHPAEA were not part of these sections.

[2] See 45 CFR §§147.150 and 156.115 (78 FR 12834, February 25, 2013).

benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the same classification.[3] Under this analysis, the focus is not on whether the final result is the same for MH/SUD benefits as for medical/surgical benefits, but rather on whether the underlying processes, strategies, evidentiary standards, and other factors are in parity. These processes, strategies, evidentiary standards, and other factors must be comparable and applied no more stringently for MH/SUD benefits than for medical/surgical benefits.

The Consolidated Appropriations Act, 2021 (the CAA, 2021) was enacted on December 27, 2020.[4] The CAA, 2021 amended MHPAEA to provide important new protections. The Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, "the Departments") prepared a Frequently Ask Questions (FAQ) document to help stakeholders understand these amendments.[5]

Under the CAA, 2021, group health plans and health insurance issuers offering group or individual health insurance coverage must document and be prepared to submit their comparative analysis with respect to each NQTL imposed on MH/SUD benefits when requested by any of the Departments or an applicable State authority. For an analysis to be treated as sufficient under the CAA, 2021, it must contain a detailed, written, and reasoned explanation of the specific plan terms and practices at issue, and include the bases for the plan's or issuer's conclusion that the NQTLs comply with MHPAEA.

In the proposed regulations "Requirements Related to the Mental Health Parity and Addiction Equity Act: Proposed Rules," issued by the Departments in August 2023 (2023 proposed rules), the Departments propose amendments to regulations implementing MHPAEA and propose new regulations implementing the NQTL comparative analyses requirements under MHPAEA, as amended by the CAA, 2021. The 2023 proposed rules would require plans and issuers to collect and evaluate relevant data in a manner reasonably designed to assess the impact of NQTLs on access to MH/SUD benefits and medical/surgical benefits, and would set forth a special rule with regard to network composition standards. The proposed rules would require plans and issuers to collect and evaluate relevant data as part of each comparative analysis, including but not limited to claims denials, data relevant to the NQTL required by State law or private accreditation standards, utilization rates, network adequacy metrics, and provider reimbursement rates, in fulfillment of the existing requirement that they evaluate and document their evaluation as part of the analysis of the application of NQTLs related to network composition.

Additionally, the 2023 proposed rules propose to codify content requirements for the NQTL

[3] 26 CFR 54.9812-1(c)(4)(i); 29 CFR 2590.712(c)(4)(i); and 45 CFR 146.136(c)(4)(i) and 147.160.
[4] Pub. L. 116-260 (Dec. 27, 2020).
[5] Available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/MHPAEA-FAQs-Part-45.pdf.

comparative analyses required by MHPAEA as amended by the CAA, 2021, clarify when the comparative analyses need to be performed, and outline the timeframes and process for plans and issuers to provide their comparative analyses to the Departments or an applicable State authority upon request.

B. Justification

1. Need and Legal Basis

Section 203 of Title II of Division BB of the CAA, 2021 amended MHPAEA, in part, by expressly requiring group health plans and health insurance issuers offering group or individual health insurance coverage that offer both medical/surgical benefits and MH/SUD benefits and that impose NQTLs on MH/SUD benefits to perform and document their comparative analyses of the design and application of NQTLs. Further, beginning 45 days after the date of enactment of the CAA, 2021, these plans and issuers must make their comparative analyses available to the Departments or an applicable State authority, upon request.

As described in section A of this supporting statement, the 2023 proposed rules would amend the regulations implementing MHPAEA in 45 CFR 146.136 and propose new regulations for the NQTL comparative analyses required under MHPAEA, as amended by the CAA, 2021, in 45 CFR 146.137.

2. Information Users

CMS will request the comparative analyses from self-funded, non-Federal governmental plans and issuers offering group and individual health insurance coverage in direct enforcement States for MHPAEA for reviews related to potential violations of MHPAEA or complaints regarding noncompliance with MHPAEA that concern NQTLs, and any other instances deemed appropriate.

The CAA, 2021 also requires the Departments, after review of the comparative analyses, to share information on findings of compliance and noncompliance with the State where the plan is located or the State where the issuer is licensed to do business.

Additionally, not later than one year after enactment of the CAA, 2021 and annually by October 1 thereafter, the Departments must submit to Congress and make publicly available a report as described in section B.10 below.

3. Use of Information Technology

Plans and issuers must submit all information electronically to CMS.

4. Duplication of Efforts

MHPAEA amended ERISA and the Code in addition to the PHS Act. Accordingly, both

DOL and the Treasury may require plans and issuers to provide the comparative analyses information as well. However, only CMS oversees non-Federal governmental health plans and issuers of individual and group health insurance coverage, therefore there will be no duplication of effort with DOL and the Treasury.

States may require issuers to provide the information as well. However, no duplication should occur because CMS will only request information from issuers when CMS has direct enforcement responsibility for MHPAEA in a State.[6]

5. Small Businesses

Small businesses are not significantly affected by these information collections (ICs).

6. Less Frequent Collection

These collections are required to fulfill the statutory requirements in the CAA, 2021. CMS will not be able to conduct reviews of the NQTL analyses and ensure regulatory compliance without collecting the information from plans and issuers. CMS will also need to perform the comparative analyses reviews, submit the report to Congress, and make it available to the public as required by statute.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

A proposed regulation (Requirements Related to the Mental Health Parity and Addiction Equity Act: Proposed Rules) with requests for comment will be published on August XX, 2023. The public solicitation for comments related to these information collections will be open for a period of 60 days.

9. Payments/Gifts to Respondents

No payments or gifts are associated with these ICs.

10. Confidentiality

The CAA, 2021 requires the Departments, after review of the comparative analyses, to share information on findings of compliance and noncompliance with the State where the group health plan is located or the State where the issuer is licensed to do business. Additionally, not later than one year after enactment of the CAA, 2021, and annually by October 1 thereafter, the Secretary of HHS must submit to Congress and make publicly available a report that contains:

[6] CMS is responsible for enforcement of MHPAEA with regard to issuers in Texas and Wyoming.

1. A summary of the comparative analyses requested, including the identity of each plan or issuer that is determined not to be in compliance after a final determination by the Secretary;
2. The Secretary's conclusions as to whether each plan or issuer submitted sufficient information for the Secretary to review the comparative analyses requested for compliance with MHPAEA;
3. For each plan or issuer that submitted sufficient information for the Secretary to review the comparative analyses requested, the Secretary's conclusion as to whether and why the plan or issuer is in compliance with MHPAEA;
4. The Secretary's specifications with respect to the additional information that each plan or issuer that did not submit sufficient information must submit for the Secretary to review the comparative analyses for compliance with MHPAEA; and
5. The Secretary's specifications of the actions each plan or issuer that the Secretary determined is not in compliance must take to be in compliance with MHPAEA, including the reason the Departments determined the plan or issuer was not in compliance.

11. Sensitive Questions

These ICs involve no sensitive questions.

12. Burden Estimates (Hours & Wages)

The burden estimates below have been updated based on recent data on the number of issuers, the number of non-Federal governmental plans, and labor and mailing costs. We generally used data from the Bureau of Labor Statistics to derive average labor costs for estimating the burden associated with the ICs.[7] Table 1 below presents the adjusted hourly wages accounting for the cost of fringe benefits and other indirect costs.

TABLE 1: Adjusted Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Adjusted Hourly Wage ($/hr.)
General and Operations Managers	11-1021	$132.38
Business Operations Specialists	13-1198	$109.96
Lawyers	23-1011	$159.34
Secretaries and Administrative Assistants	43-6010	$63.45

NQTL Comparative Analyses Documentation and Recordkeeping:

The CAA, 2021 requires plans and issuers to perform and document comparative analyses for all NQTLs imposed on MH/SUD benefits. For an analysis to be treated as sufficient under the CAA, 2021, it must contain a detailed, written, and reasoned explanation of the specific plan terms and practices at issue, and include the bases for the plan's or issuer's conclusion that the NQTLs comply with MHPAEA.

[7] See the 2023 proposed rules for details.

We expect that plans and issuers were already conducting NQTL analyses as best practice when creating benefit packages to ensure that the NQTLs are imposed in a manner that is compliant with MHPAEA. Therefore, for this IC, we are only estimating the burden to comply with the additional requirements of the CAA, 2021.

Issuers offering individual or group health insurance coverage usually have multiple products. We estimate that in the first year, for each issuer, a business operations specialist will need 72 hours (at an hourly labor cost of $109.96) and a general or operations manager will need 8 hours (at an hourly labor cost of $132.38) on average to document the analyses for all products, keep records, and prepare the documentation for submission to CMS or State authorities upon request. The total burden for each issuer in the first year will be 80 hours on average, with an equivalent cost of $8,976. In subsequent years, issuers will only need to update the documentation as needed. We estimate that for each issuer, a business operations specialist will need 36 hours (at an hourly labor cost of $109.96) and a general or operations manager will need 4 hours (at an hourly labor cost of $132.38) on average to document and keep records of the changes. The total annual burden for each issuer in subsequent years will be 40 hours on average, with an equivalent cost of approximately $4,488.

We estimate a total of 476 issuers offering individual and group health coverage across the country, with 1,500 issuer/State combinations. We estimate that for all issuers in all States, the total burden in the first year will be 120,000 hours with an equivalent cost of approximately $13.5 million. In subsequent years, we estimate the total annual burden for all issuers will be 60,000 hours, with an equivalent cost of approximately $6.7 million. We estimate the average burden over 3 years will be approximately 80,000 hours, with an equivalent cost of approximately $9.0 million.

Sponsors of self-funded, non-Federal governmental plans are responsible for performing and documenting their analyses. We estimate that for each plan sponsor, a business operations specialist will need 32 hours (at an hourly labor cost of $109.96) and a general or operations manager will need 8 hours (at an hourly labor cost of $132.38) on average to document the analyses for their plan, keep records, and prepare the documentation for submission to CMS or State authorities upon request. We estimate the total burden for each plan sponsor in the first year will be 40 hours on average, with an equivalent cost of approximately $4,578. In subsequent years, plan sponsors will only need to update the documentation as needed. We estimate that for each plan sponsor, a business operations specialist will need 16 hours (at an hourly labor cost of $109.96) and a general or operations manager will need 4 hours (at an hourly labor cost of $132.38) on average to document and keep records of the changes. We estimate the total annual burden for each issuer in subsequent years will be 20 hours on average, with an equivalent cost of approximately $2,289.

We estimate that there are 33,076 self-funded, non-Federal governmental plan sponsors. We estimate that for all such plan sponsors, the total burden in the first year will be 1,323,040 hours with an equivalent cost of approximately $151.4 million. In subsequent years, we estimate the total annual burden for all such plan sponsors will be 661,520 hours, with an equivalent cost of approximately $75.7 million. We estimate the average burden over 3

years will be approximately 882,027 hours, with an equivalent cost of approximately $100.9 million.

TABLE 2: Annual Burden for Issuers Related to NQTL Comparative Analyses Documentation and Recordkeeping

Year	Number of Respondents	Number of Responses	Total Estimated Annual Burden (Hours)	Total Estimated Labor Cost
Year 1	1,500	1,500	120,000	$13,464,240
Year 2	1,500	1,500	60,000	$6,732,120
Year 3	1,500	1,500	60,000	$6,732,120
3-year Average	1,500	1,500	80,000	$8,976,160

TABLE 3: Annual Burden for Self-Funded, Non-Federal Governmental Plans Related to NQTL Comparative Analyses Documentation and Recordkeeping

Year	Number of Respondents	Number of Responses	Total Estimated Annual Burden (Hours)	Total Estimated Labor Cost
Year 1	33,076	33,076	1,323,040	$151,413,990
Year 2	33,076	33,076	661,520	$75,706,995
Year 3	33,076	33,076	661,520	$75,706,995
3-year Average	33,076	33,076	882,027	$100,942,660

Proposed Documentation and Data Requirements for NQTL Comparative Analyses:

The 2023 proposed rules would require that issuers and plans document the action that has been or is being taken by the issuer or plan to mitigate any material differences in access between MH/SUD benefits and medical/surgical benefits as necessary to ensure compliance. As discussed in section A of this supporting statement, the 2023 proposed rules would also require plans and issuers to collect and evaluate relevant data as part of each comparative analysis, including but not limited to claims denials, data relevant to the NQTL required by State law or private accreditation standards, utilization rates, network adequacy metrics, and provider reimbursement rates, in fulfillment of the existing requirement that they evaluate and document their evaluation as part of the analysis of the application of NQTLs related to network composition.

To meet the proposed documentation and data requirements for NQTL comparative analyses, CMS expects that each issuer would on average annually perform 8 NQTL comparative analyses, based on the Departments' experience in reviewing comparative analyses, and assumes that each NQTL comparative analysis would require 20 hours in the first year, with 4 hours for a general or operations manager (at an hourly labor cost of $132.38) and 16 hours for a business operations specialist (at an hourly labor cost of $109.96). The total burden for each issuer in the first year would therefore be 160 hours on

average, with an equivalent cost of $18,311. Once the comparative analyses are performed or documented, issuers would need to update the analyses when making changes to the terms of the plan or coverage, including changes to the way NQTLs are applied to mental health and substance use disorder benefits. In subsequent years, we estimate it would take a total of 10 hours annually to update the analyses, with 2 hours for a general or operations manager (at an hourly labor cost of $132.38) and 8 hours for a business operations specialist (at an hourly labor cost of $109.96). The total annual burden for each issuer in subsequent years would therefore be 80 hours on average, with an equivalent cost of approximately $9,156.

We estimate that for all 1,500 issuers in all States, the total burden in the first year would be 240,000 hours with an equivalent cost of approximately $27.5 million. In subsequent years, we estimate the total annual burden for all issuers would be 120,000 hours, with an equivalent cost of approximately $13.7 million. We estimate the average burden over 3 years would be approximately 160,000 hours, with an equivalent cost of approximately $18.3 million.

Sponsors of self-funded, non-Federal governmental plans are responsible for performing and documenting their NQTL comparative analyses. To meet the proposed documentation and data requirements for NQTL comparative analyses, CMS expects that each plan sponsor would on average annually perform 4 NQTL analyses and assumes that each NQTL comparative analysis would require a total of 20 hours in the first year, with 4 hours for a general or operations manager (at an hourly labor cost of $132.38) and 16 hours for a business operations specialist (at an hourly labor cost of $109.96). We estimate the total burden for each plan sponsor in the first year would therefore be 80 hours on average, with an equivalent cost of approximately $9,156. Once the comparative analyses are performed or documented, plan sponsors would need to update the analyses when making changes to the terms of the plan or coverage, including changes to the way NQTLs are applied to mental health and substance use disorder benefits. In subsequent years, we estimate it would take a total of 10 hours annually to update the analyses, with 2 hours for a general or operations manager (at an hourly labor cost of $132.38) and 8 hours for a business operations specialist (at an hourly labor cost of $109.96). We estimate that the total annual burden for each plan sponsor in subsequent years would be 40 hours on average, with an equivalent cost of approximately $4,578.

We estimate that for all 33,076 plan sponsors, the total burden in the first year would be 2,646,080 hours with an equivalent cost of approximately $302.8 million. In subsequent years, we estimate the total annual burden for all plan sponsors would be 1,323,040 hours, with an equivalent cost of approximately $151.4 million. We estimate the average burden over 3 years would be approximately 1,764,053 hours, with an equivalent cost of approximately $201.9 million.

TABLE 4: Annual Burden for Issuers Related to the Proposed Documentation and Data Requirements for NQTL Comparative Analyses

Year	Number of Respondents	Number of Responses	Total Estimated Annual Burden (Hours)	Total Estimated Labor Cost
Year 1	1,500	1,500	240,000	$27,466,560
Year 2	1,500	1,500	120,000	$13,733,280
Year 3	1,500	1,500	120,000	$13,733,280
3-year Average	1,500	1,500	160,000	$18,311,040

TABLE 5: Annual Burden for Self-Funded, Non-Federal Governmental Plans Related to the Proposed Documentation and Data Requirements for NQTL Comparative Analyses

Year	Number of Respondents	Number of Responses	Total Estimated Annual Burden (Hours)	Total Estimated Labor Cost
Year 1	33,076	33,076	2,646,080	$302,827,980
Year 2	33,076	33,076	1,323,040	$151,413,990
Year 3	33,076	33,076	1,323,040	$151,413,990
3-year Average	33,076	33,076	1,764,053	$201,885,320

Initial Submission of Comparative Analyses:

Under the CAA, 2021, plans and issuers must submit their comparative analysis with respect to each NQTL imposed on MH/SUD benefits when requested by CMS. CMS will only request this information from issuers in States where CMS has direct enforcement responsibility for MHPAEA. The CAA, 2021 requires CMS to collect not fewer than 20 comparative analyses per year, but it also provides that CMS shall request that a group health plan or issuer submit the comparative analyses for plans that involve potential MHPAEA violations or complaints regarding noncompliance with MHPAEA that concern NQTLs, and any other instances in which CMS determines appropriate. Thus, CMS expects to request comparative analyses from at least 20 plans or issuers each year.

We estimate that for each plan or issuer, a business operations specialist will need 4 hours (at an hourly labor cost of $109.96) and a general and operations manager will need 1 hour (at an hourly labor cost of $132.38) on average to gather and submit the documents (including the additional documentation that would be required under the 2023 proposed rules) to CMS. We estimate the total burden for each plan or issuer will be 5 hours, with an equivalent cost of approximately $572. For 20 plans or issuers, we estimate the total annual burden will be 100 hours, with an equivalent cost of approximately $11,444.

TABLE 6: Annual Burden for Self-Funded, Non-Federal Governmental Plans and Issuers Related to Initial Submission of Comparative Analyses

Number of Respondents	Number of Responses	Total Estimated Annual Burden (Hours)	Total Estimated Labor Cost
20	20	100	$11,444

Submission of Additional Documentation for Comparative Analyses:

Based on previous experience, we assume that upon review, all plans and issuers will be found to have not submitted sufficient documentation and will have to provide additional documentation. We estimate that for each plan or issuer, a business operations specialist will need 4 hours (at an hourly labor cost of $109.96) and a general and operations manager will need 1 hour (at an hourly labor cost of $132.38) on average to gather and submit the additional documents to CMS. We estimate the total burden for each plan or issuer will be 5 hours, with an equivalent cost of approximately $572. For 20 plans or issuers, we estimate the total annual burden will be 100 hours, with an equivalent cost of approximately $11,444.

TABLE 7: Annual Burden for Self-Funded, Non-Federal Governmental Plans and Issuers Related to Submission of Additional Documentation for Comparative Analyses

Number of Respondents	Number of Responses	Total Estimated Annual Burden (Hours)	Total Estimated Labor Cost
20	20	100	$11,444

In instances where CMS, upon review of documentation submitted, determines that the plan or issuer is not in compliance with MHPAEA, the CAA, 2021 requires the plan or issuer to specify the actions the plan or issuer will take to come into compliance and submit additional comparative analyses that demonstrate compliance not later than 45 days after the initial determination of noncompliance. Based on previous experience, we expect that all issuers and plan sponsors will be found to be non-compliant with the MHPAEA NQTL requirements and will need to complete corrective actions to bring the NQTL into compliance.[8]

We estimate that for each such plan or issuer, a business operations specialist will need 36 hours (at an hourly labor cost of $109.96) and a general or operations manager will need 4 hours (at an hourly labor cost of $132.38) on average to prepare and submit documentation demonstrating compliance to CMS. We estimate the total burden for each plan or issuer will be 40 hours, with an equivalent cost of approximately $4,488 and for 20 plans or issuers, the total burden will be 800 hours with an equivalent cost of approximately $89,762.

TABLE 8: Annual Burden for Self-Funded, Non-Federal Governmental Plans and Issuers Related to Corrective Action Plans

Number of Respondents	Number of Responses	Total Estimated Annual Burden (Hours)	Total Estimated Labor Cost
20	20	800	$89,762

[8] See the 2022 MHPAEA Report to Congress, available at: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.

Following the 45-day corrective action period, if CMS makes a final determination that the plan or issuer is still not in compliance, not later than 7 days after such determination, the plan or issuer must notify all individuals enrolled in the plan or coverage that the coverage is determined to be noncompliant with MHPAEA. We anticipate that issuers and plan sponsors will take corrective action to become compliant with MHPAEA NQTL requirements. If a plan or issuer is still not in compliance, we estimate that it will take a lawyer (at an hourly labor cost of $159.34) 1 hour to prepare the required notice that will be sent to all individuals enrolled in the plan or coverage for a cost of approximately $159.

TABLE 9: Annual Burden for Self-Funded, Non-Federal Governmental Plans and Issuers Related to Notification of Non-Compliance

Number of Respondents	Number of Responses	Total Estimated Annual Burden (Hours)	Total Estimated Labor Cost
1	1	1	$159

Submission to States Upon Request:

Under the CAA, 2021, plans and issuers must be prepared to submit their comparative analysis with respect to each NQTL imposed on MH/SUD benefits when requested by the applicable State authority. Of the 48 States and the District of Columbia that enforce MHPAEA, we are unable to estimate how many States will request this information and how often. However, the cost of submitting the information to state authorities electronically will be minimal.

Request for Comparative Analyses by Participants, Beneficiaries, and Enrollees:

The 2023 proposed rules would require plans and issuers to make the comparative analyses and other applicable information required by the CAA, 2021 available upon request to participants, beneficiaries, and enrollees in non-grandfathered group health plans and non-grandfathered group or individual health insurance coverage upon request in connection with an appeal of an adverse benefit determination.

We estimate that each non-Federal governmental plan and each issuer would receive one request annually and that plans and issuers would annually incur a burden of 5 minutes for an administrative assistant (at an hourly labor cost of $63.45) to prepare and send the comparative analyses to each requesting participant, beneficiary, or enrollee. For 90,126 non-Federal governmental plans and 1,500 issuers, this would result in a total burden of 7,635.5 hours annually with an equivalent cost of approximately $484,472.

TABLE 10: Annual Burden for Non-Federal Governmental Plans and Issuers Related to Requests for Comparative Analyses by Participants, Beneficiaries, and Enrollees

Number of Respondents	Number of Responses	Total Estimated Annual Burden	Total Estimated Labor Cost

		(Hours)	
91,626	91,626	7,636	$484,472

Recordkeeping Requirement:

We expect that plans and issuers already maintain records as part of their regular business practices. We therefore estimate a minimal additional burden associated with recordkeeping requirements. We estimate that each non-Federal governmental plan or issuer would annually incur a burden of 5 minutes, on average, for an administrative assistant (at an hourly labor cost of $63.45) to meet the additional recordkeeping requirements. For all 90,126 non-Federal governmental plans and 1,500 issuers, this would result in a total burden of approximately 7,636 hours annually with an equivalent cost of approximately $484,472.

TABLE 11: Annual Burden for Non-Federal Governmental Plans and Issuers Related to Recordkeeping Requirement

Number of Respondents	Number of Responses	Total Estimated Annual Burden (Hours)	Total Estimated Labor Cost
91,626	91,626	7,636	$484,472

TABLE 12: Estimated Annual Average Burden

Information Collection	Type of Respondent	Number of Respondents	Number of Responses	Average Burden Hours Per Response	Total Burden Hours (Rounded)	Total Labor Cost (Rounded)
NQTL Comparative Analyses Documentation and Recordkeeping	Issuers	1,500	1,500	53.3	80,000	$8,976,160
	Self-Funded, Non-Federal Governmental Plans	33,076	33,076	26.7	882,027	$100,942,660
Proposed Documentation and Data Requirements for NQTL Comparative Analyses	Issuers	1,500	1,500	106.7	160,000	$18,311,040
	Self-Funded, Non-Federal Governmental Plans	33,076	33,076	53.3	1,764,053	$201,885,320
Initial Submission of Comparative Analyses	Issuers and Self-Funded, Non-Federal Governmental Plans	20	20	5	100	$11,444
Submission of Additional Documentation for Comparative Analyses	Issuers and Self-Funded, Non-Federal Governmental Plans	20	20	5	100	$11,444
Corrective	Issuers and	20	20	40	800	$89,762

Actions	Self-Funded, Non-Federal Governmental Plans					
Notification of Noncompliance	Issuer or Self-Funded, Non-Federal Governmental Plan	1	1	1	1	$159
Consumer Requests for Comparative Analyses	Issuers and Non-Federal Governmental Plans	91,626	91,626	0.1	7,636	$484,472
Recordkeeping Requirement	Issuers and Non-Federal Governmental Plans	91,626	91,626	0.1	7,636	$484,472
Total		91,626*	252,465		2,902,352**	$331,196,934**

* Unique number of respondents (1,500 issuers and 90,126 non-Federal governmental plans)
** Numbers do not sum exactly to these totals due to rounding.

13. Capital Costs

Request for Comparative Analyses by Participants, Beneficiaries, and Enrollees

We assume that 58.2 percent of requests for comparative analyses by participants, beneficiaries, and enrollees would be delivered electronically, resulting in a de minimis cost. The remaining 41.8 percent of requests would be mailed. We estimate that the average page length for comparative analyses is 15 pages. We also estimate that the average paper and printing cost per page is $0.05, and that the mailing cost is $1.14. Therefore, each mailed response would cost $1.89 in materials and postage, on average. The annual cost burden to 90,126 non-Federal governmental plans and 1,500 issuers to mail the comparative analyses to participants, beneficiaries, and enrollees upon request would therefore be approximately $72,386.

14. Cost to Federal Government

We estimate that the cost of each review will be approximately $100,000, with a total cost of $2 million for all 20 reviews annually.

The cost to the Federal government associated with the preparation and release of the updated IC documents is on a triennial basis and includes the time it takes the employee to complete the PRA process, draft a Federal Register notice regarding the updated IC, if applicable, and post the documents to CMS.gov.

The analysis and preparation of the PRA package and the subsequent release of documents is performed by CMS employees. We estimate that on average it takes CMS staff 40 hours at the GS-13.5 level (with an hourly rate of $60.83 in the Washington D.C. area) to perform these activities. The estimated triennial cost to the Federal government will therefore be

approximately $2,433.

15. Changes to Burden

Due to a decrease in the estimated number of issuers, the estimated burden related to the NQTL comparative analyses documentation and recordkeeping for issuers has decreased by 2,827 hours (from 82,827 to 80,000). Similarly, due to a decrease in the estimated number of self-funded, non-Federal governmental plans, the estimated burden related to the NQTL comparative analyses documentation and recordkeeping for self-funded, non-Federal governmental plans has decreased by approximately 48,080 hours (from 930,107 to 882,027). However, there is a new burden for issuers and self-funded, non-Federal governmental plans associated with the proposed documentation and data requirements for NQTL comparative analyses, of 160,000 hours and approximately 1,764,053 hours, respectively. The estimated burden to issuers and self-funded, non-Federal governmental plans associated with the initial submission of comparative analyses has increased by 100 hours (from 0 to 100). The estimated burden to issuers and self-funded, non-Federal governmental plans associated with the submission of additional documentation for comparative analyses has increased by 50 hours (from 50 to 100), due to an increase in the number of plans and issuers that are expected to submit additional documentation. Further, due to an increase in the estimated number of issuers and self-funded, non-Federal governmental plans needing to complete corrective actions to bring their NQTLs into compliance, the estimated burden related to corrective actions has increased by 600 hours (from 200 to 800). Additionally, there is a new burden to issuers and non-Federal governmental plans associated with consumer requests for comparative analyses (of approximately 7,636 hours). Lastly, there is a new burden to issuers and non-Federal governmental plans associated with the recordkeeping requirement in the 2023 proposed rules (of approximately 7,636 hours). Therefore, total burden hours have increased by approximately 1,889,167 hours (from 1,013,185 to 2,902,352).

16. Publication/Tabulation Dates

CMS is required to publish reports using review results as described in item 10 above.

17. Expiration Date

There are no instruments associated with these ICs.