Supporting Statement – Part A

Enrollment Opportunity Notice Relating to Lifetime Limits; Required Notice of Rescission of Coverage; and Disclosure Requirements for Patient Protection under the Affordable Care Act (OMB CONTROL NO. 0938-1094)

A. Background

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 (collectively known as the "Affordable Care Act"). The Affordable Care Act reorganizes, amends, and adds to the provisions of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets.

The interim final regulations titled "Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections" (75 FR 37188, June 28, 2010) implement the rules for group health plans and health insurance coverage in the group and individual markets under provisions of the Patient Protection and Affordable Care Act regarding lifetime and annual dollar limits on benefits, rescissions, and patient protections. Section 2711 of the PHS Act, as added by the Affordable Care Act, and these interim final regulations generally prohibit group health plans and health insurance issuers offering group or individual health insurance coverage from imposing lifetime limits on the dollar value of health benefits. PHS Act section 2712 provides rules regarding rescissions of health coverage for group health plans and health insurance issuers offering group or individual health insurance coverage. Under the statute and these interim final regulations, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, must not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. Section 2719A of the PHS Act imposes, with respect to a group health plan, or group or individual health insurance coverage, requirements relating to the choice of a health care professional and requirements relating to benefits for emergency services.

B. Justification

1 . Need and Legal Basis

Section 2711 of the PHS Act requires a plan or issuer to provide an individual whose coverage ended due to reaching a lifetime limit on the dollar value of all benefits with an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days, regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. This enrollment opportunity must be presented not later than the first day of the first plan year (or, in the individual market, policy year) beginning on or after September 23, 2010 (which is the

applicability date of PHS Act sections 2711). Coverage must begin no later than the first day of the first plan year (or policy year in the individual market) beginning on or after September 23, 2010. The notice was a one-time requirement and is being discontinued.

Section 2712 of the PHS Act, amended by the Affordable Care Act, prohibits group health plans and health insurance issuers that offer group or individual health insurance coverage generally from rescinding coverage under the plan, policy, certificate, or contract of insurance from the individual covered under the plan or coverage unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. The interim final regulations provide that a group health plan or a health insurance issuer offering group health insurance coverage must provide at least 30 days advance notice to an individual before coverage may be rescinded.

Section 2719A of the PHS Act amended by the Affordable Care Act imposes, with respect to a group health plan, or group or individual health insurance coverage, a set of requirements relating to the choice of a health care professionals The Departments believe it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires participants or subscribers to designate a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations require such plans and issuers to provide a notice to participants (in the individual market, primary subscriber) of these rights when applicable. Model language is provided in the interim final regulations. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage, or in the individual market, provides a primary subscriber with a policy, certificate, or contract of health insurance.

2. Information Users

The rescission notice will be used by health plans to provide advance notice to certain individuals that their coverage may be rescinded. The affected individuals are those who are at risk of rescission on their health insurance coverage.

The patient protection notification will be used by health plans to inform certain individuals of their right to choose a primary care provider or pediatrician and to use obstetrical/gynecological services without prior authorization.

3. Use of Information Technology

The regulations do not require or restrict plans or issuers from using electronic technology to provide either disclosure.

4. Duplication of Efforts

The Affordable Care Act amended the Employee Retirement Income Security Act, the Internal Revenue Code, and the PHS Act. However, only the Department of Health and Human Services has jurisdiction over state and local government plans and individual market plans, so there will be no duplication of effort.

5. Small Businesses

These information collection requirements (ICRs) do not impact small businesses or entities.

6. Less Frequent Collection

If this information were conducted less frequently, affected individuals would not be notified of potential rescission and individuals would not be informed of their right to choose a primary care provider or pediatrician and to use obstetrical/gynecological services without prior authorization.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

A Federal Register notice was published on April 4, 2013 (78 FR 20322), providing the public with a 60-day period to submit written comments on the ICRs. No comments were received.

9. Payments/Gifts to Respondents

No payments or gifts are associated with these information collection requirements.

10. Confidentiality

CMS will protect privacy of the information provided to the extent provided by law.

11. Sensitive Questions

These ICRs involve no sensitive questions

12. Burden Estimates (Hours & Wages)

The burden estimates have been updated based on recent data. We generally used data from

the Bureau of Labor Statistics to derive average labor costs (including fringe benefits) for estimating the burden associated with the ICRs.

Section 2711 Lifetime Limits

A plan or issuer was required to provide an individual, whose coverage ended due to reaching a lifetime limit on the dollar value of all benefits, with an opportunity to enroll, including a notice of an opportunity to enroll. This was a one-time requirement and the notice is being discontinued, thus eliminating the burden related to the notice.

Section 2712 Rescissions

This analysis assumes that rescissions only occur in the individual health insurance market, because rescissions in the group market are rare. It is estimated that there are approximately 378 companies issuing 6.87 million policies in the individual market during a year. A report on rescissions found that 0.15 percent of policies were rescinded during the 2004 to 2008 time period. Based on these numbers, it is estimated that approximately 10,300 policies are rescinded during a year, which would result in approximately 10,300 notices being sent to affected policyholders. It is estimated that each issuer will require 15 minutes of legal professional time (at approximately $83 per hour) to prepare the notice and one minute per notice of clerical professional time (at approximately $31 per hour) to distribute the notice to each policyholder. This results in an annual hour burden of approximately 266 hours with an equivalent annual cost of approximately $13,100.

Section 2719A Patient Protection Disclosure

In order to satisfy the interim final regulations' patient protection disclosure requirement, state and local government plans and issuers in individual markets will need to notify policy holders of their plans' policy in regards to designating a primary care physician and for obstetrical or gynecological visits and will incur a one-time burden and cost to incorporate the notice into plan documents. State and local government plans that are currently not grandfathered and issuers in the individual market have already incurred the one-time cost to prepare and incorporate this notice in their existing plan documents. Only state and local government plans that relinquish their grandfathered status in subsequent years will become subject to this notice requirement and incur the one-time costs to prepare the notice.

It is estimated that in 2013, approximately 8,000 state and local governmental plans will relinquish grandfathered status and will therefore incur one-time costs to prepare the notice. Because the interim final regulations provide model language for this purpose, we estimate that five minute of clerical time (with a labor rate of approximately $31/hour) will be required to incorporate the required language into the plan document and ten minutes of a human resource manager's time (with a labor rate of approximately $72/hour) will be required to review the modified language for each plan. Therefore, the Department estimates that plans

and insurers will incur a one-time hour burden of approximately 2,000 hours with an equivalent cost of approximately $116,000 to meet the disclosure requirement for all plans.

13. Capital Costs

Section 2712 Rescissions

Issuers will incur cost to print and send the notices. We assume that the notice will require one page, printing and material cost will be $0.05 per page, mailing cost will be $0.46 per notice and 38 percent of the notices will be delivered electronically. Therefore, it is estimated that the cost burden associated with mailing the notices to 10,300 affected policy holders will be approximately $3,300.

Section 2719A Patient Protection Disclosure

We estimate that approximately notices 1.6 million notices will be sent by state and local government plans and by issuers in the individual market. We assume that the notice will require one-half of a page, five cents per page printing and material cost will be incurred, and 38 percent of the notices will be delivered electronically. There will be no additional mailing cost since the notice will be incorporated into existing plan documents. This results in a cost burden of approximately $24,000 ($0.05 per page*1/2 pages per notice * 1.6 million notices*0.62).

14. Cost to Federal Government

There is no cost to the federal government.

15. Changes to Burden

The burden for plans and issuers has been reduced by 1,300 hours due to the discontinuance of the enrollment opportunity notice related to elimination of lifetime limits. Burden hours for rescission notice have been reduced by 34 hours (from 300 to 266) due to use of updated data. Burden hours for one-time costs related to patient protection disclosure has been reduced by 1,500 (from 3,500 to 2,000) hours because of a reduction in the number of plans relinquishing grandfathered status in 2013 compared to 2011.

16. Publication/Tabulation Dates

There are no publication or tabulation dates associated with these ICRs.

17. Expiration Date

There is no expiration date for this collection requirement.

18. Certification Statement

There are no exceptions to the certification.