

**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) implemented the rules for group health plans and health insurance coverage in the group and individual markets under provisions of the Affordable Care Act regarding lifetime and annual dollar limits on benefits, rescissions, and patient protections. The provisions are finalized in the final regulations titled “Final Rules under the Affordable Care Act for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections”. Section 2711 of the PHS Act, as added by the Affordable Care Act, and these 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 essential 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 the 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**

The interim final regulations implementing section 2711 of the PHS Act required 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 was required to 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 has been discontinued.

Section 2712 of the PHS Act, as added 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 makes an intentional misrepresentation of a material fact, as prohibited by the terms of the plan or coverage. The 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, as added 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 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 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.

The final regulations require that a plan or issuer may not impose any copayment or coinsurance requirement for out-of-network emergency services that is more restrictive than the copayment or coinsurance requirement that would apply if the services were provided in-network. If State law prohibits balance billing, or if a plan or issuer is contractually responsible for any amounts balanced billed by an out-of-network emergency services provider, the plan or issuer must provide a participant, beneficiary or enrollee adequate and prominent notice of their lack of financial responsibility with respect to amounts balanced billed in order to prevent inadvertent payment by the individual.

## 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 as a result of fraud or intentional misrepresentation of material fact.

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. The out-of-network emergency services disclosure will be used by health plans to inform individuals of their lack of financial responsibility to an out-of-network emergency services provider.

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, 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, and individuals using out-of-network emergency services will not be aware of their lack of financial responsibility.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

A Federal Register notice was published on November 18, 2015 (80 FR 72231), 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 has been discontinued.

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 430 issuers issuing 6.77 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 10,200 policies are rescinded during a year, which would result in approximately 10,200 notices being sent to affected policyholders, with 38 percent transmitted electronically and 62 percent mailed. It is estimated<sup>1</sup> that each issuer will require 15 minutes of legal professional time (at

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<sup>1</sup> The Department's estimated 2015 hourly labor rates include wages, other benefits, and overhead are calculated as follows: mean wage from the 2013 National Occupational Employment Survey (April 2014, Bureau of Labor Statistics <http://www.bls.gov/news.release/pdf/ocwage.pdf>); wages as a percent of total compensation from the Employer Cost for Employee Compensation (June 2014, Bureau of Labor Statistics <http://www.bls.gov/news.release/ecec.t02.htm>); overhead as a multiple of compensation is assumed to be 25 percent of total compensation for paraprofessionals, 20 percent of compensation for clerical, and 35 percent of compensation for professional; annual inflation assumed to be 2.3 percent annual growth of total labor cost since 2013 (Employment Costs Index data for private industry, September 2014 <http://www.bls.gov/news.release/eci.nr0.htm>).

approximately \$129.94 per hour) to prepare the notice and one minute per notice of clerical professional time (at approximately \$30.42 per hour) to distribute the notice to each policyholder. Assuming that the cost of electronic distribution is minimal, this results in an annual hour burden of approximately 212 hours with an equivalent annual cost of approximately \$17,160.

a. Burden: Rescission Notification:

<b>Responder</b>	<b>Number of Respondents</b>	<b>Average of Number of Responses per Respondent</b>	<b>Average Burden Per Response (in hours)</b>	<b>Total Burden (in hours)</b>
Issuer	430	24	0.02	212

b. Cost: Rescission Notification:

<b>Responder</b>	<b>Total Annual Number of Responses</b>	<b>Number Sent Electronically (38%)</b>	<b>Number Sent via Mail (62%)</b>	<b>Labor Cost to Prepare Notice(s)</b>	<b>Capital Costs</b>	<b>Total Costs</b>
Issuer	10,200	3,860	6,298	\$17,160	\$3,401	\$20,561

Section 2719A Patient Protection Disclosure

In order to satisfy the 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.

There are an estimated 128,400 non-federal governmental employer-sponsored plans and 430 health insurance issuers in the individual market. We estimate that five percent of non-federal governmental plans will relinquish their grandfathered status annually over the next three years and will therefore incur one-time costs to prepare the notice. Health insurance issuers in the individual market will also have five percent of their policies relinquish grandfathered status annually over the next three years. Data obtained from the 2014 Kaiser/HRET Survey of Employer Sponsored Health Benefits finds that 13 percent of plans have an HMO option and that 23 percent of plans offer a POS option. Thus, approximately 2,700 combined plans and issuers will produce notices each year.<sup>2</sup> While not all HMO and POS options require the designation of a primary care physician or a prior authorization or referral before a woman can visit an OB/GYN, the Department is unable to estimate this number. Therefore, this estimate should be considered an overestimate of the number of affected entities.

Each of these 2,700 plans and issuers will require a compensation and benefits manager<sup>3</sup> to spend 10 minutes individualizing the model notice to fit the plan's specifications at an hourly

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<sup>2</sup> 128,400 Governmental plans x 5% newly non-grandfathered plans x (13% HMOs + 23% POSs) + 430 issuers = approximately 2,700 affected plans and issuers.

<sup>3</sup> The Department's estimated 2015 hourly labor rates include wages, other benefits, and overhead are calculated as follows: mean wage from the 2013 National Occupational Employment Survey (April 2014, Bureau of Labor Statistics <http://www.bls.gov/news.release/pdf/ocwage.pdf>); wages as a percent of total compensation from the Employer Cost for Employee Compensation (June 2014, Bureau of Labor Statistics <http://www.bls.gov/news.release/ecec.t02.htm>); overhead as a multiple of compensation is assumed to be 25 percent of total compensation for paraprofessionals, 20 percent of compensation for clerical, and 35 percent of compensation for professional; annual inflation assumed to be 2.3 percent annual growth of total labor cost since 2013 (Employment Costs Index data for private industry, September 2014 <http://www.bls.gov/news.release/eci.nr0.htm>).

rate of \$110.30.<sup>4</sup> This results in approximately 457 hours of burden at an equivalent cost of \$50,400. Each plan will also require clerical staff to spend 5 minutes adding the notice to the plan’s documents at an hourly rate of \$30.42.<sup>5</sup> This results in approximately 228 hours of burden at an equivalent cost of approximately \$7,000.

The total annual burden associated with this ICR is approximately 685 hours at an equivalent cost of \$57,000.

a. Burden: Patient Protection:

<b>Responder</b>	<b>Number of Respondents</b>	<b>Combined Average of Number of Responses per Respondent</b>	<b>Combined Average Burden Per Response (in hours)</b>	<b>Combined Total Burden (in hours)</b>
Issuers	430			
Non-Federal Governmental Employer-Sponsored Plans	2270			
<b>Total</b>	<b>2700</b>	<b>83</b>	<b>0.003</b>	<b>685</b>

b. Cost: Rescission Notification:

<b>Responder</b>	<b>Total Annual Number of Responses</b>	<b>Number Sent Electronically (38%)</b>	<b>Number Sent via Mail (62%)</b>	<b>Labor Cost to Prepare Notice(s)</b>	<b>Capital Costs</b>	<b>Total Costs</b>
Non-Federal Governmental Employer-Sponsored Plans and Issuers	228,086	86,672	141,414	\$57,000	\$3,535	\$60,877

Section 2719A Out-Of-Network Emergency Services Disclosure

The final regulations require that a plan or issuer may not impose any copayment or coinsurance requirement for out-of-network emergency services that is higher than the

copayment or coinsurance requirement that would apply if the services were provided in network. In addition, if State law prohibits balance billing, or if a plan or issuer is contractually responsible for any amounts balance billed by an out-of-network emergency services provider, a plan or issuer must provide a participant, beneficiary or enrollee adequate and prominent notice of their lack of financial responsibility with respect to amounts balanced billed in order to prevent inadvertent payment by the individual. This information should already be routinely included in the Explanation of benefit documents sent by plans and issuers to enrollees and beneficiaries. Therefore, in accordance with the implementing regulations of the PRA at 5 CFR 1320.3(b)(2), we believe this is a usual and customary business practice. Plans and issues routinely provide enrollees and beneficiaries with the Explanation of Benefit documents.

### 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 \$0.49 per notice and 38 percent of the notices will be delivered electronically at minimal cost. Therefore, it is estimated that the cost burden associated with mailing the notices to approximately 6,300 affected policy holders will be approximately \$3,400.

#### Section 2719A Patient Protection Disclosure

We assume that only printing and material costs are associated with the disclosure requirement, because the final regulations provide model language that can be incorporated into existing plan documents. We estimate that the notice will require one-half of a page, \$0.05 per page printing and material cost will be incurred, and 38 percent of the notices will

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<sup>4</sup> Compensation and Benefits Manager (11-3041):  $\$53.87(2013 \text{ BLS Wage rate}) / 0.69(\text{ECEC ratio}) * 1.35(\text{Overhead Load Factor}) * 1.023(\text{Inflation rate}) ^2(\text{Inflated 2 years from base year}) = \$110.30$

<sup>5</sup> Secretaries, Except Legal, Medical, and Executive (43-6014):  $\$16.35(2013 \text{ BLS Wage rate}) / 0.675(\text{ECEC ratio}) * 1.2(\text{Overhead Load Factor}) * 1.023(\text{Inflation rate}) ^2(\text{Inflated 2 years from base year}) = \$30.42$



be delivered electronically.

It is estimated that there are 27.9 million non-federal governmental plan policyholders and individual policyholders. As stated in the previous section, it is estimated that five percent of plans will relinquish their grandfathered status annually in the next three years. Data obtained from the 2014 Kaiser/HRET Survey of Employer Sponsored Health Benefits finds that 13 percent of covered workers in government plans have an HMO option and that 8 percent of covered workers have a POS option. Data obtained from AHIP in 2009 finds that 1.93 percent of individual policyholders have HMO options. Thus, it is estimated that plans will produce 228,000 notices each year, 38 percent of which will be sent electronically.<sup>6</sup> This results in a cost burden of approximately \$3,500.<sup>7</sup>

14. Cost to Federal Government

There is no cost to the federal government.

15. Changes to Burden

Burden hours for rescission notices have decreased by 54 hours (from 266 to 212) as a result of a reduction in the estimated number of rescissions, from 10,206 to 10,200. Due to updated data providing more recent and accurate estimates pertaining to the loss of grandfather status in both the individual and group markets resulting in the plans and issuers incurring the onetime cost to prepare the patient protection disclosure the burden hours have been reduced by 891 hours (from 1,576 to 685). The number of disclosures has decreased from 1,575,816 to 525,628. Therefore, the total burden hour reduction is 1,369 hours (from 2,266 hours to 897 hours).

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.

<sup>6</sup> [21.1 million Government policyholders x 5% newly non-grandfathered plans x (13% in HMOs + 8% in POSs)] + [6.77 million individual policy holders x 5% newly non-grandfathered plans x 1.93% in HMOs] = approximately

228,000 notices.

<sup>7</sup> \$0.05 per page\*1/2 pages per notice \* 228,000 notices\*62% = approximately \$3,500