SUPPORTING STATEMENT
Internal Revenue Service
OMB Control Number 1545-2181
Patient Protection and Affordable Care Act Patient Protection Notice
Final Rule-(TD 9744)

1. CIRCUMSTANCES NECESSITATING COLLECTION OF INFORMATION

Section 2719A of the Public Health Service Act (PHS Act), incorporated into Code section 9815 by section 1563(f) of the Patient Protection and Affordable Care Act, Public Law 111-148, requires that a group health plan or a health insurance issuer requiring or allowing for the designation of a primary care provider provide notice to participants of the right to designate a primary care provider (including a pediatrician for a child) and of the right to obtain access to obstetrical or gynecological services without referral from a primary care provider.

The regulations impose a requirement for the designation of a pediatrician similar to the requirement for the designation of a primary care physician. Specifically, if a plan or issuer requires or provides for the designation of a participating primary care provider for a child by a participant, beneficiary, or enrollee, the plan or issuer must permit the designation of a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if the provider participates in the network of the plan or issuer.

The regulations also provide that a group health plan, or a health insurance issuer may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) for a female participant, beneficiary, or enrollee who seeks obstetrical or gynecological care provided by an in-network health care professional who specializes in obstetrics or gynecology.

When applicable, 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, paragraph (a)(4) of the regulations requires such plans and issuers to provide a notice to participants (in the individual market, primary subscribers) of these rights when applicable. Model language is provided in these 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. USE OF DATA

The Patient Protection Notice used by health plan sponsors and issuers to notify certain individuals of their right 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.

3. USE OF IMPROVED INFORMATION TECHNOLOGY TO REDUCE BURDEN

Plans and issuers may satisfy this disclosure requirement by electronic means if they comply with applicable electronic disclosure requirements. The Departments estimate that 38% of the notices will be furnished electronically.

4. EFFORTS TO IDENTIFY DUPLICATION

Under the regulations, this notice of patient protections must be provided at the time that descriptions of plan benefits are distributed. The information obtained through this collection is unique and is not already available for use or adaptation from another source.

5. METHODS TO MINIMIZE BURDEN ON SMALL BUSINESSES OR OTHER SMALL ENTITIES

There is no flexibility to reduce burden on small businesses or other small entities because the statutes apply to small businesses and small entities.

6. CONSEQUENCES OF LESS FREQUENT COLLECTION ON FEDERAL PROGRAMS OR POLICY ACTIVITIES

If this information were conducted less frequently, affected individuals would not be informed or notified of their right 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.

7. SPECIAL CIRCUMSTANCES REQUIRING DATA COLLECTION TO BE INCONSISTENT WITH GUIDELINES IN 5 CFR 1320.5(d)(2)

There are no special circumstances requiring data collection to be inconsistent with Guidelines in 5 CFR 1320.5(d)(2).

8. CONSULTATION WITH INDIVIDUALS OUTSIDE OF THE AGENCY ON AVAILABILITY OF DATA, FREQUENCY OF COLLECTION, CLARITY OF INSTRUCTIONS AND FORMS, AND DATA ELEMENTS

Periodic meetings are held between IRS personnel and representatives of the American Bar Association, the National Society of Public Accountants, the American Institute of Certified Public Accountants, and other professional groups to discuss tax law and tax forms. During these meetings, there is an opportunity for those attending to make comments regarding TD 9744.

We received no comments during the comment period in response to the Federal Register notice (82 FR 19454), dated April 27, 2017.

9. EXPLANATION OF DECISION TO PROVIDE ANY PAYMENT OR GIFT TO RESPONDENTS

No payment or gift has been provided to any respondents.

10. ASSURANCE OF CONFIDENTIALITY OF RESPONSES

Generally, tax returns and tax return information are confidential as required by 26 USC 6103.

11. JUSTIFICATION OF SENSITIVE QUESTIONS

No personally identifiable information (PII) is collected.

12. ESTIMATED BURDEN OF INFORMATION COLLECTION

The Departments estimate that there are 2.3 million ERISA-covered plans and that five percent of the plans will relinquish their grandfathered status annually over the next three years. ERISA-covered plans will need to notify an estimated 41,386 policy holders of their plans' in regards to designating a primary care physician and for obstetrical or gynecological visits.

Because the interim final regulations provide model language for this purpose, the Departments estimate that five minutes of clerical time will be required to incorporate the required language into the plan document and ten minutes of a human resource professional's time will be required to review the modified language. These burdens will vary from year to year. Thus, the Department estimates that plans will produce 693,007 responses each year. Therefore, the Departments estimate that plans will incur an average annual hour burden of 10,346 hours to meet the disclosure requirement.

The Department of the Treasury equally shares this burden with the Department of Labor; therefore, the burden for the Department of the Treasury is approximately 5,173 hours.

Authority	Description	Annual Responses	Hours per Response	Total Burden reported by DOT
IRC § 9815	TD 9744	693,007	.0074645	5173
Totals		69,3007		5173

13. ESTIMATED TOTAL ANNUAL COST BURDEN TO RESPONDENTS

The Departments assume that only printing and material costs are associated with the disclosure requirement, as the regulations provide model language to be incorporated into existing plan documents. The Departments estimate 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. This results in a cost burden for the first year of $5,371 ($0.05 per page*1/2 pages per notice * 693,007 thousand notices*0.62), an average annual burden of $10,346 (50% to DOL and 50% to IRS). Our notice dated April 27, 2017, requested public comments, no responses were received.

14. ESTIMATED ANNUALIZED COST TO THE FEDERAL GOVERNMENT

There is no annualized cost to the federal government.

15. REASONS FOR CHANGE IN BURDEN

There were changes in the burden estimates due to the reduced number of impacted plans. Even though this information collection request may still impact plans in the future, the majority of the burden associated will have occurred during the initial three year approval, because this ICR only impacts plans that relinquish their grandfathered status during the first year that they do so. As time goes on, most of the plans that intend to relinquish their grandfathered status will already have done so. The reduced number of impacted plans will result in a total burden decrease of (27,827) annual burden hours and a decrease of (3,306,993) responses. The annual cost burden of $5371 was also reflected in this collection.

	Requested	Program Change Due to New Statute	Program Change Due to Agency Discretion	Change Due to Adjustment in Agency Estimate	Change Due to Potential Violation of the PRA	Previously Approved
Annual Number of Responses	693,007	0	0	-3,306,993	0	4,000,000
Annual Time Burden (Hr)	5,173	0	0	-27,827	0	33,000
Annual Cost Burden ($)	5,371	0	0	5,371	0	0

16. PLANS FOR TABULATION, STATISTICAL ANALYSIS AND PUBLICATION

There are no plans for tabulation, statistical analysis and publication.

17. REASONS WHY DISPLAYING THE OMB EXPIRATION DATE IS INAPPROPRIATE

We believe that displaying the OMB expiration date is inappropriate because it could cause confusion by leading taxpayers to believe that the regulations sunset as of the expiration date. Taxpayers are not likely to be aware that the Service intends to request renewal of the OMB approval and obtain a new expiration date before the old one expires.

18. EXCEPTIONS TO THE CERTIFICATION STATEMENT

There are no exceptions to the certification statement.

Note: The following paragraph applies to all of the collections of information in this submission:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.