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 (CMS-10330/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 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" (80 FR 72192, November 18, 2015). 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

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 is no duplication of effort.

5. Small Businesses

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

6. Less Frequent Collection

If these information collections 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 would 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 January 31, 2019 (84 FR 732), providing the public with a 60-day period to submit written comments on the ICRs. No comments were received. The 30-day FR Notice published April 16, 2019 (84 FR 15615).

9. Payments/Gifts to Respondents

No payments or gifts are associated with these ICRs.

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 (doubled to include fringe benefits

and other associated costs) for estimating the burden associated with the ICRs.[1]

Adjusted Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Mean Hourly Wage ($/hour)	Fringe Benefits and Overhead ($/hour)	Adjusted Hourly Wage ($/hour)
Secretaries and Administrative Assistants	43-6014	$17.75	$17.75	$35.50
Lawyer	23-1011	$68.22	$68.22	$136.44
Compensation and Benefits Manager	11-3111	$62.50	$62.50	$125.00

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 454 issuers issuing 11.6 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 17,448 policies are rescinded during a year, which would result in approximately 17,448 notices being sent to affected policyholders, with 38 percent transmitted electronically and 62 percent mailed. It is estimated that each issuer will require 15 minutes of legal professional time (at an hourly rate of $136.44) to prepare the notice with a total annual burden of approximately 113.5 hours for all issuers with an equivalent annual cost of approximately $15,486. It is estimated that issuers will need one minute per notice of clerical professional time (at an hourly rate of $35.50) to distribute the notice to each policyholder by mail, resulting in a total annual burden of approximately 180 hours[2], with an equivalent annual cost of approximately $10,323. Assuming that the cost of electronic distribution is minimal, this results in a total annual hour burden of approximately 294 hours with an equivalent annual cost of approximately $21,887.

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 and individual market plans that are currently not grandfathered have already incurred the one-time cost to prepare and incorporate this notice in their existing plan documents. Only 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.

1 May 2017 Occupational Employment Statistics found at https://www.bls.gov/oes/current/oes_nat.htm). To account for fringe and overhead, HHS is using 100% of the mean hourly wage.
2 17,448 notices x 62% sent by mail = 10,818 notices sent by mail x 1 minute per notice = approximately 180 hours.

There are an estimated 90,106 non-federal governmental employers offering health plans to employees and 454 health insurance issuers in the individual market. We estimate that there are approximately 20,724 grandfathered non-federal government employer-sponsored plans and approximately 678,695 grandfathered individual market policies. Data obtained from the 2018 Kaiser/HRET survey of Employer Health Benefits[3] finds that 31 percent of employers offer a health maintenance organization (HMO) option and that 14 percent of employers offer a point-of-service (POS) option. Therefore, there are approximately 9,326 grandfathered non-federal governmental plans offering HMO and POS options. We assume that all individual market issuers offer at least one of HMO, exclusive provider organization (EPO) or POS options.

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. Therefore, approximately 466 non-federal governmental plans will lose grandfathered status every year and incur the one-time cost to prepare and incorporate this notice in their existing plan documents. Health insurance issuers in the individual market will also have five percent of their policies relinquish grandfathered status annually over the next three years. Thus, approximately 920 non-federal governmental plans and individual market issuers will incur the one-time cost to prepare and incorporate this notice in their existing plan documents each year. While not all HMO, EPO 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.

Model language for the notice is provided in the final regulations. Each of these 920 plans and issuers will require a compensation and benefits manager (at an hourly rate of $125) to spend 10 minutes customizing the model notice to fit the plan's specifications. Each plan will also require clerical staff (at an hourly rate of $35.50) to spend 5 minutes adding the notice to the plan's documents. The total burden for each plan/issuer will be 0.25 hours with an equivalent cost of approximately $24. The total annual burden for all plans and issuers will be approximately 230 hours with an equivalent cost of approximately $21,895.

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

3 Available at https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/.

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 and mailing cost will be $0.50 per notice. We estimate that 38 percent of the 17,448 notices will be delivered electronically at minimal cost. Therefore, it is estimated that the cost burden associated with mailing 10,818 notices will be approximately $5,950.

Section 2719A Patient Protection Disclosure

We assume that only printing and material costs are associated with the disclosure requirement, because the notice 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 be delivered electronically at minimal cost.

It is estimated that there are approximately 2.99 million non-federal governmental plan policyholders in grandfathered plans. Data obtained from the 2018 Kaiser/HRET Survey of Employer Sponsored Health Benefits finds that 14 percent of covered workers in non-federal government plans have an HMO option and that 5 percent of covered workers have a POS option. Therefore, there are an estimated 568,198 policyholders in grandfathered HMO and POS plan options. There are an estimated 678,695 policyholders with grandfathered individual market plans. It is estimated that approximately 75 percent of individual market enrollees have HMO, EPO and POS options.[4] Therefore, an estimated 508,202 policyholders in the individual market have grandfathered plans with HMO, EPO and POS options. 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. Therefore, there are approximately 53,820 policyholders in non-federal government employer sponsored and individual market plans with HMO, EPO and POS options that will lose grandfathered status annually. Thus, it is estimated that plans will produce 53,820 notices each year, 62 percent of which will be delivered in print. This results in a cost burden of approximately $834.[5]

14. Cost to Federal Government

There is no cost to the federal government.

4 Estimate based of data reported in Unified Review Template Submissions for 2018 plan. Rate review data available at https://www.cms.gov/CCIIO/Resources/Data-Resources/ratereview.html.

5 53,820 notices x 62% = 33,368 notices printed x $0.05 per page x 1/2 pages per notice = approximately $834.

15. Changes to Burden

Burden hours for rescission notices have increased by approximately 82 hours (from 212 to 294) due to an increase in the estimated number of individual market issuers and policies. Burden hours for one-time costs related to patient protection disclosure have been reduced by approximately 455 hours (from 685 to 230) due to a decrease in the number of affected plans and use of updated data. Therefore, there is a total reduction in burden of 373 hours.

16. Publication/Tabulation Dates

There are no plans to publish the outcome of the information collection.

17. Expiration Date

There are no instruments associated with these ICRs.