SUPPORTING STATEMENT FOR PAPERWORK REDUCTION ACT OF 1995 SUBMISSIONS

Part A. Justification

1. *Explain the circumstances that make the collection of information necessary. Identify any legal or administrative requirements that necessitate the collection. Attach a copy of the appropriate section of each statute and regulation mandating or authorizing the collection of information.*

On October 12, 2017, President Trump issued Executive Order 13813[1], "Promoting Healthcare Choice and Competition Across the United States." The executive order states, in part, that the "Administration will prioritize three areas for improvement in the near term: association health plans (AHPs), short-term, limited-duration insurance (STLDI), and health reimbursement arrangements (HRAs)." With regard to HRAs, the Executive Order directs the Secretaries of the Treasury, Labor, and HHS to "consider proposing regulations or revising guidance, to the extent permitted by law and supported by sound policy, to increase usability of HRAs, to expand employers' ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with nongroup coverage." The executive order further provides that expanding "the flexibility and use of HRAs would provide many Americans, including employees who work at small businesses, with more options for financing their healthcare." These final regulations have been developed in response to this executive order.[2]

The final rules remove the current prohibition on integrating HRAs with individual health insurance coverage, if certain conditions are met. The final rules also set forth conditions under which certain HRAs are as limited excepted benefits. In addition, the Treasury Department and the IRS are finalizing rules regarding premium tax credit (PTC) eligibility for individuals offered coverage under an HRA integrated with individual health insurance coverage, and DOL is finalizing a safe harbor to provide HRA plan sponsors with assurance that the individual health insurance coverage that is integrated with an HRA would not become part of an ERISA plan if the conditions of the safe harbor are met. Finally, HHS is finalizing rules that provide a special enrollment period in the individual market for individuals who gain access to an HRA that is integrated with individual health insurance coverage or who are provided a qualified small employer health reimbursement arrangement (QSEHRA).

As discussed in more detail in Item 2., below, the ICRs are needed to notify the HRA that

1 82 FR 48385 (Oct. 17, 2017).

2 In response to Executive Order 13813, on June 21, 2018, DOL published the Definition of Employer under Section 3(5) of ERISA – Association Health Plans final rule and on August 3, 2018, DOL, HHS and the Treasury Department published the Short-Term, Limited-Duration Insurance final rule. See the Association Health Plan final rule at 83 FR 28912 and the Short-Term, Limited-Duration Insurance final rule at 83 FR 38212.

participants are enrolled in individual health insurance coverage, to help individuals understand the impact of enrolling in an HRA on their eligibility for the PTC, and that coverage is not subject to the rules and consumer protections of the Employee Retirement Income Security Act (ERISA).

2. *Indicate how, by whom, and for what purpose the information is to be used. Except for a new collection, indicate the actual use the agency has made of the information received from the current collection.*

The following five Information Collections are contained in the final rules: (1) Verification of Enrollment in Individual Coverage; (2) HRA Notice to Participants; (3) Notice to Participants that Individual Policy is not Subject to Title I of ERISA; 4) Participant Notification of Individual Coverage HRA of Cancelled or Discontinued Coverage; 5) Notice for Excepted Benefit HRAs. These are described below.

1) Verification of Enrollment in Individual Coverage

The HRA must implement and comply with reasonable procedures to verify that participants and beneficiaries are enrolled in individual insurance coverage for that year. This requirement can be satisfied by providing a document from a third party, like an insurance issuer, verifying coverage. An alternative procedure requires participants to provide an attestation of coverage, including the date coverage begins and the provider of the coverage.

2) HRA Notice to Participants

Because HRAs are different from traditional employer-provided health coverage in many respects, the Departments are concerned that individuals eligible for HRAs integrated with individual health insurance coverage may not recognize that the offer and/or acceptance of an HRA will have consequences for PTC eligibility. Therefore, in order to ensure that participants who are eligible to participate in an HRA integrated with individual health insurance coverage understand the potential effect that the offer of and enrollment in the HRA might have on their ability to claim the PTC, these final regulations include a requirement that an HRA provide written notice to eligible participants. The HRA sponsor would be required to provide a written notice to each participant at least 90 days before the beginning of each plan year. For participants who are not yet eligible to participate at the beginning of the plan year (or who are not eligible when the notice is provided at least 90 days prior to the beginning of the plan year), the HRA must provide the notice no later than the date on which the participant is first eligible to participate in the HRA.

The written notice must include certain relevant information, including among other things, a description of the terms of the HRA, including the contribution amount used in the affordability determination under the Code section 36B final regulations[3]; a statement of the right of the participant to opt-out of and waive future reimbursement under the HRA; a description of the PTC eligibility consequences for a participant who opts out of the HRA; and a description of the PTC eligibility consequences for a participant who accepts the HRA.

The written notice must include the information required by the final regulations, and may include other information, as long as the additional information does not conflict with the required information. The written notice does not need to include information specific to a participant. For example, it would be sufficient under the final rule for the notice to include a description of the terms of the HRA that would allow a participant to determine the amounts newly made available under the HRA, which are needed for the participant to determine affordability under the final rules at 26 CFR 1.36B-2(c)(5). The final regulations do not require the HRA to include in the notice a determination of whether the HRA is considered affordable for the participant.

3) Notice to Participants that Individual Policy is not subject to title I of ERISA.

If certain conditions are met individual health insurance coverage is not considered an "employee welfare benefit plan" with the consumer protections provided under ERISA. The final rule require HRAs plan sponsors to notify participant of this fact. For an HRA sponsor, this notice requirement is meet if annually the notice requirements in section 2590.702-2(c)(6) are met. These notice requirements are part of the HRA notice to Participants. For QSEHRAs this notice requirement is met if the plan sponsor annually, includes language provided in the rule in the Summary Plan Description.

4) Participant Notification of Individual Coverage HRA of Cancelled or Discontinued Coverage

The final rules require that if the covered individual fails to pay the applicable premium(s) by the end of the grace period and the coverage is cancelled or discontinued, including retroactively, or if individual health insurance coverage is cancelled or discontinued retroactively for some other reason (for example, a rescission), the individual coverage HRA must require that the individual notify the HRA that coverage has been cancelled or discontinued and the date on which the coverage cancellation or discontinuance is effective (54.9801-4(c)(1)(iii)).

3 The Departments note that in order to comply with the notice requirement, the HRA must determine the amounts that will be newly made available for the plan year prior the plan year. A similar requirement applies under the premium tax credit regulations.

5) Notice for Excepted Benefit HRAs

In response to commenters' concerns, the final rules impose a notice requirement with respect to excepted benefit HRAs sponsored by non-federal governmental plans. Such an excepted benefit HRA must provide a notice that states conditions pertaining to eligibility to receive benefits, annual or lifetime caps or other limits on benefits under the excepted benefit HRA, and a description of or summary of the benefits consistent with the content and timing of DOL's SPD requirements.

For private-sector, employment-based plans, other notice requirements under Part 1 of ERISA already apply. For example, excepted benefit HRAs that are ERISA-covered plans must provide a summary plan description (SPD), summaries of material modifications (SMM), and summaries of material reductions in covered services or benefits.[4] The excepted benefit HRA's SPD must include, for example, the conditions pertaining to eligibility to receive benefits; a description or summary of the benefits; the circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (for example, by exercise of subrogation or reimbursement rights) of any benefits; and the procedures governing claims for benefits under the excepted benefit HRA. Accordingly, for excepted benefit HRAs that are subject to ERISA, the burden for providing information regarding excepted benefit HRAs is captured under the Department's SPD information collection (OMB Control Number 1210-0039), which includes a growth factor for new SPDs and SMMs provided to participants to notify them regarding coverage under new plans and plan amendments.

3. *Describe whether, and to what extent, the collection of information involves the use of automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses, and the basis for the decision for adopting this means of collection. Also describe any consideration for using information technology to reduce burden.*

The regulation does not restrict HRAs from using electronic technology to provide either disclosure. The Department of Labor's regulations under 29 C.F.R. § 2520.104b-1(b) provide that, "where certain material, including reports, statements, and documents, is required under Part I of the Act and this part to be furnished either by direct operation of law or an individual request, the plan administrator shall use measures reasonably calculated to ensure actual receipt of the material by plan participants and beneficiaries." Section 29 CFR 2520.104b-1(c) establishes the manner in which disclosures under Title I of ERISA made through electronic media will be deemed to satisfy the requirement of § 2520.104b-1(b). Section 2520-107-1 establishes standards concerning the use of

4 See 29 CFR 2520.104b-2, 2520.104b-3(a) and (d)(3).

electronic media for maintenance and retention of records. Under these rules, all pension and welfare plans covered under Title I of ERISA may use electronic media to satisfy disclosure and recordkeeping obligations, subject to specific safeguards.

4. *Describe efforts to identify duplication. Show specifically why any similar information already available cannot be used or modified for use for the purposes described in Item 2 above*.

The information collection does not require duplicative information.

5. *If the collection of information impacts small businesses or other small entities, describe any methods used to minimize burden.*

Section 29 CFR 2520.104b-1(c) allows for electronic delivery of notices as long as the requirements are met. Also, while specific content is required in the notices, the notices does not require participant specific information.

6. *Describe the consequence to Federal program or policy activities if the collection is not conducted or is conducted less frequently, as well as any technical or legal obstacles to reducing burden*.

If this information collection was conducted less frequently affected individuals would not have the information they need to make an annual selection of a health plan.

7. *Explain any special circumstances that would cause an information collection to be conducted in a manner:*

- *requiring respondents to report information to the agency more often than quarterly;*
- *requiring respondents to prepare a written response to a collection of information in fewer than 30 days after receipt of it;*
- *requiring respondents to submit more than an original and two copies of any document;*
- *requiring respondents to retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;*
- *in connection with a statistical survey, that is not designed to produce valid and reliable results that can be generalized to the universe of study;*
- *requiring the use of a statistical data classification that has not been reviewed and approved by OMB;*
- *that includes a pledge of confidentiality that is not supported by authority established in statute or regulation, that is not supported by disclosure and data security policies that are consistent with*

the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or

- *requiring respondents to submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.*

None.

8. *If applicable, provide a copy and identify the date and page number of publication in the Federal Register of the agency's notice, required by 5 CFR 1320.8(d), soliciting comments on the information collection prior to submission to OMB. Summarize public comments received in response to that notice and describe actions taken by the agency in response to these comments. Specifically address comments received on cost and hour burden.*

Describe efforts to consult with persons outside the agency to obtain their views on the availability of data, frequency of collection, the clarity of instructions and record keeping, disclosure, or reporting format (if any), and on the data elements to be recorded, disclosed, or reported.

Consultation with representatives of those from whom information is to be obtained or those who must compile records should occur at least once every 3 years -- even if the collection of information activity is the same as in prior periods. There may be circumstances that may preclude consultation in a specific situation. These circumstances should be explained.

The notice of proposed rulemaking provided the public with sixty days to comment on the information collections contained therein and was published notice November 15, 2018 (83 FR 57585). The Departments received 567 comments in response to the proposed regulation. An extensive discussion of and the Departments' responses to those comments are contained in the preamble accompanying the final rule. The comments did not provide alternative estimates or feasible methodologies that would inform refinements or improvements to the Departments' burden estimates. The comments can be found at: https://www.regulations.gov/docketBrowser?rpp=25&so=DESC&sb=commentDueDate&po=0&dct=PS&D=IRS-2018-0028.

Several commenters stated that the Departments' analysis failed to take account of variation in individual market risk across geographic areas. The Departments' acknowledge that the quantitative estimates are derived from a nationally representative model, largely because the MEPS-HC is a nationally representative survey. The Departments do not know of any readily available data on the distribution of health claims at the firm level for specific rating areas or states. If the health risk in the individual market relative to that of employer risk pools varies across geographic areas, a nationally based model will understate the extent to which employees might transition to individual markets with healthier risk pools and overstate movement into less healthy individual markets. This would understate potential premium increases in some markets and overstate them in others. To examine this possibility the Departments estimated the

correlation between individual market premiums and traditional group coverage premiums in all rating areas across the country.[5] The Departments found that premiums in each market are positively correlated, and that the correlation is statistically significant. In other words, where premiums for individual health insurance coverage are higher, premiums in the traditional employer market also tend to be higher. The Departments also do not find any evidence that, to date, employers have substantially dropped coverage or disproportionately dropped coverage and sent less healthy employees to individual markets with healthier risk pools. Even if the difference between individual market health risk and group market health risk currently varies across location, there is no clear reason why that variation would not persist when the individual coverage HRA is available. As a result of these observations, the Departments conclude that there is little indication that the individual coverage HRA will be disproportionately used in areas with healthier individual market risk pools. Moreover, it is not evident that adverse selection into the individual market would be much more likely in these lower cost areas, or that those risk pools would not be able to absorb additional enrollees from the group market.

Commenters also addressed the requirement that HRA participants substantiate their enrollment in individual coverage. Most commenters supported this requirement. Some commenters where concerned about the added burden of requiring substantiation of coverage before being reimbursed. However, other commenters and the Departments believe that the ongoing substantiation requirement is essential to ensure compliance with the requirement that an individual covered by an individual coverage HRA be enrolled in individual health insurance coverage, and that it will impose minimal burden because it can be met by collecting a written attestation from the participant on the same form used for requesting reimbursement. The requirement is for HRAs in general and not specific to this rulemaking.

In response to comments about grace periods and cancellation of coverage, the Departments added a new requirement that requires the individual to notify the HRA that coverage has been cancelled or discontinued and the date on which the cancellation or

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5[fr] Specifically, the Departments extracted premiums reported on the population of Forms W-2, and estimated per person annual premiums from this information using coverage data from Forms 1095-B and C. See https://www.treasury.gov/resource-center/tax-policy/tax-analysis/Documents/Treasury%27s-Baseline-Estimates-of-Health-Coverage-FY-2019.pdf for a description of this estimation process. We then compared this to second-lowest cost silver plan premiums. We specifically compared single plan premiums for firms including any 30-year old covered employee to SLCSP premiums for a 30 year old, and did the same for firms including any 50-year old covered employee and SLCSP premiums for a 50 year old in the same rating area. In both cases we estimated that traditional group coverage premiums increase by about 20 cents for every dollar increase in individual market premiums ($p<.01$). The commenter provided some evidence of geographic variation in health claims in the individual market relative to claims in the small group insured market. This analysis is of limited use, because most employees who are expected to be offered an individual coverage HRA are in the large group market. The Treasury data for this sensitivity analysis includes premiums in firms of all sizes, but is heavily weighted to firms filing more than 250 Forms W-2, as these employers are required to report premium information.

discontinuance is effective. After the individual coverage HRA has received the notice of cancellation or discontinuance, the HRA may not reimburse expenses incurred on and after the date of cancellation or discontinuance of the individual health insurance coverage, which is considered to be the date of termination of coverage under the HRA.

Several commenters suggested that the Departments impose certain notice requirements for excepted benefit HRAs in the final rules. Commenters stated that the required notice should be similar to the notice required for individual coverage HRAs, or should, at a minimum, inform participants and beneficiaries of the annual dollar limit for benefits under the excepted benefit HRA, other terms and conditions of the excepted benefit HRA, and participants' and beneficiaries' rights under the excepted benefit HRA.

However, the Departments note that for private-sector, employment-based plans, other long-standing notice requirements under Part 1 of ERISA already apply. ERISA-covered plans, including excepted benefit HRAs, must provide an SPD, summaries of material modifications, and summaries of material reductions in covered services or benefits.[6] Under ERISA sections 102 and 104 and their implementing regulations, an excepted benefit HRA's SPD must include, for example, the conditions pertaining to eligibility to receive benefits; a description or summary of the benefits; the circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (for example, by exercise of subrogation or reimbursement rights) of any benefits; and the procedures governing claims for benefits under the excepted benefit HRA. Excepted benefit HRAs that are ERISA-covered plans are subject to additional disclosure requirements to provide instruments under which the excepted benefit HRA is established or operated and information relevant to a participant's adverse benefit determination upon request.[7]

Accordingly, for excepted benefit HRAs that are subject to ERISA, the final rules include a cross reference to existing ERISA notice provisions in order to ensure that excepted benefit HRA plan sponsors are aware of their obligations under those provisions. However, the final rules do not include any additional notice requirements for ERISA-covered plans.

In response to commenters' concerns, the final rules impose a notice requirement with respect to excepted benefit HRAs sponsored by non-federal governmental plans that are covered by HHS and not subject to ERISA.

9. *Explain any decision to provide any payment or gift to respondents, other than remuneration of contractors or grantees.*

6 See ERISA sections 102 and 104: see also 29 CFR 2520.104b-2 and 2520.104b-3(a) and (d)(3).

7 See, e.g., ERISA sections 104(b), 502(c), and 503. See also 29 CFR 2520.104b-1, and 2560.503-1.

Not applicable.

10. *Describe any assurance of confidentiality provided to respondents and the basis for the assurance in statute, regulation, or agency policy.*

Not applicable.

11. *Provide additional justification for any questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private. This justification should include the reasons why the agency considers the questions necessary, the specific uses to be made of the information, the explanation to be given to persons from whom the information is requested, and any steps to be taken to obtain their consent.*

Not applicable.

12. *Provide estimates of the hour burden of the collection of information. The statement should:*

- *Indicate the number of respondents, frequency of response, annual hour burden, and an explanation of how the burden was estimated. Unless directed to do so, agencies should not conduct special surveys to obtain information on which to base hour burden estimates. Consultation with a sample (fewer than 10) of potential respondents is desirable. If the hour burden on respondents is expected to vary widely because of differences in activity, size, or complexity, show the range of estimated hour burden, and explain the reasons for the variance. Generally, estimates should not include burden hours for customary and usual business practices.*

- *If this request for approval covers more than one form, provide separate hour burden estimates for each form and aggregate the hour burdens in Item 13.*

- *Provide estimates of annualized cost to respondents for the hour burdens for collections of information, identifying and using appropriate wage rate categories. The cost of contracting out or paying outside parties for information collection activities should not be included here. Instead, this cost should be included in Item 13.*

The hour burden associated with the five information collections is discussed below.

1) Verification of Enrollment in Individual Coverage

The HRA must implement and comply with reasonable procedures to verify that participants and beneficiaries are enrolled in individual insurance coverage for that year. This requirement can be satisfied by providing a document from a third party, like an insurance issuer, verifying coverage. An alternative procedure requires participants to provide an attestation of coverage including the date coverage begins and the provider of the coverage.

Documentation, or proof of expenditure of funds, is nearly universal when seeking reimbursement from a HRA. The HRA can require proof of coverage or attestations of coverage when participants seek reimbursement for premiums or other medical expenditures. The additional burden is de minimis, because the attestation can be part of the information already required when seeking reimbursement.

2) HRA Notice to Participants

These final regulation requires an HRA plan sponsor to provide written notice to eligible participants including, among other things, the following information: (1) a description of the terms of the HRA, including the contribution amount used in the affordability determination under the Code section 36B final regulations; (2) a statement of the right of the participant to opt-out of and waive future reimbursement under the HRA; (3) a description of the Premium Tax Credit (PTC) eligibility consequences for a participant who opts out of the HRA; and (4) a description of the PTC eligibility consequences for a participant who accepts the HRA. The written notice may include other information, as long as the additional information does not conflict with the required information. The written notice does not need to include information specific to a participant.

The HRA plan sponsor must provide the written notice to each participant at least 90 days before the beginning of each plan year. For participants who are not yet eligible to participate at the beginning of the plan year (or who are not eligible when the notice is provided at least 90 days prior to the beginning of the plan year), the HRA plan sponsor must provide the notice no later than the date on which the participant is first eligible to participate in the HRA.

The Departments estimate that a compensation and benefits manager would require 2 hours (at $125 per hour) and a lawyer would require need 1 hour (at $136.44 per hour) to prepare the notice for each HRA plan sponsor. Thus, the total hour burden for each HRA plan sponsor would be 3 hours with an equivalent cost of approximately $386. The Departments estimate that each notice would be two pages, with total materials and printing cost of $0.10 per notice ($0.05 per page).
The Departments estimate that 78,797 private employers would switch from traditional

health plans to HRAs[8] or newly offer HRAs in 2020[9] as a result of the final in the first year. Therefore, the Departments estimate for the total hour burden for these HRA sponsors to prepare the notices would be 236,390 hours with an equivalent cost of $30,450,216.

TABLE 1.-- *Burden to Prepare HRA Notice for the First Time- Private Sector Employers*

Year	Number of Employers Newly Offering HRAs	Legal Cost Per Hour	Number of Hours for Legal	Benefit Manager Cost per Hour	Number of Hours for Benefit Manager	Total Hour Burden	Total Equivalent Cost
(a)	(b)	(c)	(d)=1*(b)	(e)	(f)=2*(b)	(g)=(d)+(f)	(c)*(d)+(e)*(f)
2020	78,797	$136.44	78,797	$125.00	157,593	236,390	$30,450,216
2021	118,195	$136.44	118,195	$125.00	236,390	354,585	$45,675,324
2022	196,992	$136.44	196,992	$125.00	393,984	590,976	$76,125,539

3) Notice to Participants that Individual Policy is not subject to title I of ERISA

If certain conditions are met individual health insurance coverage is not considered an "employee welfare benefit plan" with consumer protections provided under ERISA. HRA plan sponsors are required to notify participant of this fact. For an HRA this notice requirement is meet if annually the notice requirements in section 2590.702-2(c)(6) are met, which are part of the HRA notice to Participants. Therefore, this notice requirement imposes no additional burden. For QSEHRAs this notice requirement is met if the plan sponsor annually includes language provided in the rule is include in the Summary Plan Description. The Department estimates that this burden is de minimis, because the

8 U.S. Department of the Treasury, Office of Tax Analysis used a simulation model to obtain these estimates. For 2020 the model estimated that 80,000 employers would newly offer HRAs and one million individuals would enroll in those HRAs. Based on DOL estimates about 98 percent of these will be in the private market, and the rest will be though public employers like state and local governments. There are on average one dependent for every policy holder. "Health Insurance Coverage Bulletin", Abstract of the Auxiliary Data for the March 2016 Annual Social and Economic Supplement of the Current Population Survey, July 25, 2017. https://www.dol.gov/sites/default/files/ebsa/researchers/data/health-and-welfare/health-insurance-coverage-bulletin-2016.pdf

9 Comparable numbers for 2021 are 118,195 private employers would create new HRAs offering coverage to 1,556,562 eligible participants, and for 2022 196,992 private employers would create new HRAs offering coverage to 3,055,474 eligible participants.

required text is provided by the Department and the required information can be included with other notices

4) Participant Notification of Individual Coverage HRA of Cancelled or Discontinued Coverage

The final rules require that if the covered individual fails to pay the applicable premium(s) by the end of the grace period and the coverage is cancelled or discontinued, including retroactively, or if individual health insurance coverage is cancelled or discontinued retroactively for some other reason (for example, a rescission), the individual coverage HRA must require that the individual notify the HRA that coverage has been cancelled or discontinued and the date on which the coverage cancellation or discontinuance is effective (54.9801-4(c)(1)(iii)). The Departments assume that the burden associated with this notification requirement is de minimis for participants that cancel coverage, because they can satisfy the requirement by making a phone call or sending an email.

5) Notice for Excepted Benefit HRAs

In response to commenters' concerns, the final rules impose a notice requirement with respect to excepted benefit HRAs sponsored by non-federal governmental plans. Such an excepted benefit HRA must provide a notice that states conditions pertaining to eligibility to receive benefits, annual or lifetime caps or other limits on benefits under the excepted benefit HRA, and a description of or summary of the benefits consistent with the content and timing of DOL's SPD requirements.

For private-sector, employment-based plans, other notice requirements under Part 1 of ERISA already apply. For example, excepted benefit HRAs that are ERISA-covered plans must provide a summary plan description (SPD), summaries of material modifications (SMM), and summaries of material reductions in covered services or benefits.[10] The excepted benefit HRA's SPD must include, for example, the conditions pertaining to eligibility to receive benefits; a description or summary of the benefits; the circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (for example, by exercise of subrogation or reimbursement rights) of any benefits; and the procedures governing claims for benefits under the excepted benefit HRA.

Accordingly, for excepted benefit HRAs that are subject to ERISA, the burden for providing information regarding excepted benefit HRAs is captured under the Department's SPD information collection (OMB Control Number 1210-0039), which

10 See 29 CFR 2520.104b-2, 2520.104b-3(a) and (d)(3).

includes a growth factor for new SPDs and SMMs provided to participants to notify them regarding coverage under new plans and plan amendments.

The three year average annual hour burden for these ICRs is 393,984 hours with an equivalent cost of $50,750,360. As the DOL and Treasury share the burden, DOL's share is 196,992 hours with an equivalent cost of $25,375,180.

13. *Provide an estimate of the total annual cost burden to respondents or record-keepers resulting from the collection of information. (Do not include the cost of any hour burden shown in Items 12.)*

The Departments estimates that there would be 634,155 eligible participants[11] at private employers in 2020 that would need to receive the HRA notice. The Departments assume that approximately 54 percent of notices would be provided electronically and approximately 46 percent will be provided in print along with other benefits information. Therefore, a total of 291,711 notices will be printed at a cost of $87,513 in 2020. Table 2 provides estimates for years 2021 and 2022.

TABLE 2.--*Burden to Provide Notice to All Eligible Private Sector Participants*

Year	Total # of Notices	# of Notices Sent by Mail	Cost Per Notice	Total Cost Burden
(a)	(b)	(c)	(d)	(e)=(c)*(d)
2020	634,155	291,711	$0.30	$87,513
2021	1,556,562	716,019	$0.30	$214,806
2022	3,055,474	1,405,518	$0.30	$421,655

The three year average annual cost burden for these ICRs is $241,325 with an average of 1,442,876 policy holders and employers sending an average of 18,798,855 notice and disclosures. As the DOL and Treasury share the burden, DOL's share is $120,662 with an

11 Number of eligible participants is estimated based on the assumption that 75 percent of eligible participants would enroll in their employers' plans. See Section 3 of the Kaiser "2017 Employer Health Benefits Survey". https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey/.

average of 721,438 policy holders and employers sending an average of 9,399,427 notice and disclosure allocated to each Department for measuring impact.

14. *Provide estimates of annualized cost to the Federal government. Also, provide a description of the method used to estimate cost, which should include quantification of hours, operational expenses (such as equipment, overhead, printing, and support staff), and any other expense that would not have been incurred without this collection of information. Agencies also may aggregate cost estimates from Items 12, 13, and 14 in a single table.*

None. No information is provided to the DOL.

15. *Explain the reasons for any program changes or adjustments reported in Items 13 or 14.*

This is a new ICR. The final rules remove the current prohibition on integrating HRAs with individual health insurance coverage, if certain conditions, including notice requirements, are met.

16. *For collections of information whose results will be published, outline plans for tabulation, and publication. Address any complex analytical techniques that will be used. Provide the time schedule for the entire project, including beginning and ending dates of the collection of information, completion of report, publication dates, and other actions.*

Not applicable.

17. *If seeking approval to not display the expiration date for OMB approval of the information collection, explain the reasons that display would be inappropriate.*

Not applicable.

18. *Explain each exception to the certification statement identified in Item 19, "Certification for Paperwork Reduction Act Submission."*

Not applicable; no exceptions to the certification statement.

Part B. Statistical Methods.

This information collection does not employ statistical methods.