

**SUPPORTING STATEMENT FOR PAPERWORK REDUCTION ACT 1995:
NO SURPRISE BILLING**

This ICR seeks approval of a new information collection and control number.

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.

This document contains four related information collections. In the associated rulemaking, the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury (collectively, the Departments) are issuing interim final rules with largely parallel provisions that apply to group health plans and health insurance issuers offering group or individual health insurance coverage.

Complaints Process for Surprise Medical Bills

The No Surprises Act directs the Departments to establish a process to receive complaints regarding violations of the application of the QPA by group health plans and health insurance issuers offering group or individual health coverage, and violations by health care providers, facilities, and providers of air ambulance services of the requirements under sections 2799B-2 and 2799B-3 of the PHS Act. The Departments define a complainant as any individual, or their authorized representative, who files a complaint, as described and defined in these interim final rules. This regulatory action is taken as required by the No Surprises Act, which directs the Departments to create a process for balance billing complaints regarding plans and issuers, and directs HHS to create a process for balance billing complaints regarding providers and facilities.

Qualifying Payment Amount to be Shared with Nonparticipating Providers or Nonparticipating Emergency Facilities

The interim final rules require plans and issuers to provide certain information to nonparticipating providers or nonparticipating emergency facilities in cases in which the recognized amount with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility is the QPA. Specifically, plans and issuers must provide the following information to providers (including air ambulance providers) and facilities, when making an initial payment or notice of denial of payment: (i) the QPA for each item or service involved; and (ii) a statement certifying that the plan or issuer has determined that the QPA applies for the purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant's, beneficiary's,

No Surprise Billing
OMB Control No. 1210-NEW

or enrollee's cost sharing), and that each QPA was determined in compliance with 26 CFR 54.9816-6T(d), 29 CFR 2590.716-6, or 45 CFR 149.140, as applicable. Additionally, upon request of the provider or facility, the plan or issuer must provide in a timely manner the following information: (i) whether the QPA for items and services involved included contracted rates that were not on a fee-for-service basis for those specific items and services and whether the QPA for those services was determined using underlying fee schedule rates or a derived amount; (ii) if applicable, information to identify which database was used to determine the QPA; and (iii) if applicable, a statement that the plan's or issuer's contracted rates include risk-sharing, bonus, or incentive based payments for covered items and services (as applicable) that were excluded for purposes of calculating the QPA.

Opt-In State Balance Bill Process

The interim final rules allow plans to voluntarily opt in to state law that provides for a method for determining the cost-sharing amount or total amount payable under such a plan, where a state has chosen to expand access to such plans, to satisfy their obligations under section 9816(a)-(d) of the Code, section 716(a)-(d) of ERISA, and section 2799A-1(a)-(d) of the PHS Act. A plan that has chosen to opt into a state law must prominently display in its plan materials describing the coverage of out-of-network services a statement that the plan has opted into a specified state law, identify the state (or states), and include a general description of the items and services provided by nonparticipating facilities and providers that are covered by the specified state law.

Plan and Issuer Disclosure on Patient Protections Against Balance Billing

Section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act require plans and issuers to make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 9816 of the Code, section 716 of ERISA, and section 2799A-1 of the PHS Act apply, information in plain language on the provisions in these sections, and sections 2799B-1 and 2799B-2 of the PHS Act, and other applicable state laws on out-of-network balance billing, and information on contacting appropriate state and federal agencies in the case that an individual believes that such a provider or facility has violated the prohibition against balance billing.

- 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.**

Complaints Process for Surprise Medical Bills

No Surprise Billing
OMB Control No. 1210-NEW

The interim final rules establish a complaints process with regards to violations of balance billing protections by providers. Upon receiving the information necessary to file a complaint regarding a plan or issuer, the Departments will respond to complainants no later than 60 calendar days after the complaint is received. The response will be by oral or written means, and will include a clear and concise response acknowledging receipt of the complaint, notifying the complainant of their rights and obligations under the complaint process, and describing the next steps of the complaint resolution process.

The Departments may also request any additional information needed to process the complaint. For example, regarding the complaint process for plans and issuers, the Departments may request information, such as: an explanation of benefits; processed claims; information about the health care provider, facility, or provider of air ambulance services; information about the plan or issuer; documentation of whether the service was an emergency service or non-emergency service; the summary plan description, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage the plan or issuer provides to their participants, beneficiaries, or enrollees; documents that support the facts in the complaint that are in possession of, or otherwise attainable by the complainant; and any other information needed to make a determination of facts for an investigation.

Qualifying Payment Amount to be Shared with Nonparticipating Providers or Nonparticipating Emergency Facilities

The interim final rules specify that for emergency services furnished by a nonparticipating emergency facility, and for non-emergency services furnished by nonparticipating providers in a participating health care facility, cost sharing is generally calculated as if the total amount that would have been charged for the services by a participating emergency facility or participating provider were equal to the recognized amount for such services. Thus, the interim final rules require plans and issuers to provide information regarding the qualifying payment amount to the nonparticipating providers or nonparticipating emergency facilities in cases in which the recognized amount with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility is the qualifying payment amount.

Opt-In State Balance Bill Process

The interim final rules allow plans to voluntarily opt in to state law that provides for a method for determining the cost-sharing amount or total amount payable under such a plan, where a state has chosen to expand access to such plans, to satisfy their obligations under Code section 9816(a)-(d), ERISA section 716(a)-(d) and PHS Act section 2799A-1(a)-(d). Thus, the interim final rules require that plans that have chosen to opt into a

No Surprise Billing
OMB Control No. 1210-NEW

state law must prominently display in its plan materials about the emergency services and/or out-of-network services covered by the specified state law.

Plan and Issuer Disclosure on Patient Protections Against Balance Billing

The interim final rules require that plan and issuers provide a one-page notice about the balance billing requirements and prohibitions under Code section 9816, ERISA section 716, and PHS Act section 2799A-1. The notice must provide information on the prohibitions on balance billing in certain circumstances, information about any applicable state requirements, the requirements under Code section 9816, ERISA section 716, and PHS Act section 2799A-1, and about how to contact appropriate state and federal agencies if the individual believes the provider or facility has violated the balance billing rules. The notice must be included on each explanation of benefits for an item or service. This notice must also be made publicly available on the public website of the provider or facility (if applicable). A model notice for plans to use is included in the ICR.

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 plans or issuers from using electronic technology to provide either disclosure. The Department of Labor's regulations under 29 C.F.R. § 2520.104b-1(b) provides that, "where certain material, including reports, statements, notices and other documents, is required under Title I of the Act, or regulations issued thereunder, to be furnished either by direct operation of law or on individual request, the plan administrator shall use measures reasonably calculated to ensure actual receipt of the material by plan participants, beneficiaries and other specified individuals" 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 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.

The Government Paperwork Elimination Act (GPEA) requires agencies to allow customers the option to submit information or transact with the government electronically, when practicable. Where feasible, and subject to resource availability and resolution of legal issues, EBSA has implemented the electronic acceptance of information submitted by customers to the federal government.

- 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 No Surprises Act, which was enacted as part of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260) (December 27, 2020). The No Surprises Act and these interim final rules amend and add provisions to existing rules under the Internal Revenue Code, the Employee Retirement Income Security Act, and the Public Health Service Act. However, only the Department of Health and Human Services has jurisdiction over state and local government plans and individual market plans and the Department of Labor oversees ERISA-covered group health plans. Thus, there will be no duplication of effort with HHS.

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

The information provided in the regulations will assist all plans in fulfilling the statutory notice requirements under The No Surprises Act. Plan administrators of small plans will have confidence that a plan's notices are in compliance and that they are less likely to be subject to penalties or costly litigation because they are not complete or not distributed in a timely manner. Model notices have been provided to reduce burden. One of the model notices is a DOL notice for plans and issuers and included in the ICR. The HHS disclosures are for health care providers and facilities. Notices can be sent electronically within the guidelines of the Department's rules to minimize burden.

- 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.**

Without the required notices, there would be inadequate consumer protections related to balance billing for individuals enrolled in group health plans. Consumers would not be notified of their protections and rights, and less likely to minimize the amount of a balance bill.

Small plans would not be able to provide certain information to nonparticipating providers or nonparticipating emergency facilities in cases in which the recognized amount with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility is the qualifying payment amount.

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

No Surprise Billing
OMB Control No. 1210-NEW

- **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.**

There are no special circumstances that require the collection to be conducted in a manner inconsistent with the guidelines in 5 CFR 1320.5.

- 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 recordkeeping, 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.

Contemporaneous with this submission, an interim final rule (IFR) was published in the Federal Register on July 13, 2021 (86 FR 36872). The IFR solicits public comment on the paperwork burden of the information collection request. In accordance with 5 CFR 1320.11(c) and 5 CFR 1320.11(e), the public comment period is for 30 days of OMB's 60 days to provide comments on the rule. The IFR also contains a public comment period on the rule that closes September 7, 2021.

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

No payments or gifts are provided to respondents.

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

No assurance of confidentiality has been provided.

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.

There are no questions of a sensitive nature.

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.**

No Surprise Billing
OMB Control No. 1210-NEW

- **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 14.**

Complaints Process for Surprise Medical Bills

The interim final rules requires the Department to establish a process to receive complaints regarding violations of the application of the qualifying payment amount by group health plans and health insurance issuers offering group or individual health coverage, and violations by health care provider, facilities, and providers of air ambulance services of the requirements under PHS Act sections 2799B-2 and 2799B-3.

The Department estimates that there will be, on average, 3,600 balance billing complaints against providers, facilities, providers of air ambulance services, plans, and issuers submitted annually. HHS estimates that it will take each complainant 30 minutes (at an hourly rate of \$54.14) to collect all relevant documentation related to the alleged violation and to access and complete the provided complaint form, with an equivalent cost of approximately \$27. The total burden for all complainants is estimated to be 1,800 hours, with an equivalent annual cost of approximately \$97,452. As HHS, DOL, and Treasury share jurisdiction, it is estimated that 50 percent of the burden will be accounted for by the HHS, 25 percent of the burden will be accounted for by Treasury, and the remaining 25 percent will be accounted for by DOL. HHS will account for approximately 900 burden hours with an equivalent cost of approximately \$48,726. DOL and Treasury will each account for approximately 450 burden hours with an equivalent cost of approximately \$24,363.

Qualifying Payment Amount to be Shared with Nonparticipating Providers or Nonparticipating Emergency Facilities

These interim final rules require plans and issuers to provide certain information to nonparticipating providers or nonparticipating emergency facilities in cases in which the recognized amount with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility is the qualifying payment amount.

The Department assumes that TPAs will provide this information on behalf of self-insured plans. In addition, the Department assumes that issuers and TPAs will automate the process of preparing and providing this information in a format similar to an

No Surprise Billing
OMB Control No. 1210-NEW

explanation of benefit as part of the system to calculate the qualifying payment amount.

The Department estimates that a total of 1,758 issuers and TPAs will incur burden to comply with this provision. Currently, 14 states have established some payment standards for services provided by nonparticipating providers or nonparticipating emergency facilities. Therefore, the Department assume that issuers and TPAs will potentially need to calculate the qualifying payment amount for two-thirds of the claims involving nonparticipating providers or nonparticipating emergency facilities.

In 2018, there were approximately 39,690,940 emergency department visits for patients with individual market or group health coverage. The Department estimates that approximately 18 percent of these visits will include services provided by nonparticipating providers or nonparticipating emergency facilities and plans and issuers will need to calculate the qualifying payment amount for two-thirds of such claims. Therefore, plans and issuers will be required to provide the specified information along with the initial payment or denial notice for approximately 4,786,727 claims annually from nonparticipating providers or nonparticipating emergency facilities for emergency department visits. In addition, in 2018, there were approximately 4,146,476 emergency department visits that resulted in hospital admission for patients with individual market or group health coverage. Using this as an estimate of post-stabilization services provided in emergency facilities, and assuming that in 16 percent of cases the patient is treated at a nonparticipating emergency facility or by a nonparticipating provider at a participating facility, the Department estimates that approximately 663,436 individuals will have the potential to be treated by a nonparticipating provider or facility.

In the absence of data, the Department assumes that in 50 percent of cases services will be provided by nonparticipating providers without obtaining patient consent for reasons such as unforeseen circumstances and lack of participating providers in the facility. The Department estimates that plans and issuers will need to calculate the qualifying payment amount for two-thirds of such claims. Therefore, plans and issuers will be required to provide the required information along with the initial payment or denial notice for approximately 222,251 claims from nonparticipating providers or nonparticipating emergency facilities for post-stabilization services. Additionally, based on 2016 data, the Department estimates that there will be 11,107,056 visits to health care facilities annually for surgical and non-surgical procedures for individuals with group health coverage or individual market coverage. The Department assumes that in 16 percent of cases the patient will have the potential to receive care from a nonparticipating provider at a participating facility, and that in approximately 5 percent of those cases services will be provided by nonparticipating providers without obtaining patient consent for reasons such as unforeseen circumstances, and plans and issuers will need to calculate the qualifying payment amount for two-thirds of such claims. Therefore, plans and issuers will be required to provide the required information along with the initial payment or denial

No Surprise Billing
OMB Control No. 1210-NEW

notice for approximately 59,534 claims annually for non-emergency services furnished by a nonparticipating provider at a participating health care facility. In total, plans and issuers will be required to provide documents related to qualifying payment amounts along with the initial payment or denial of payment for approximately 5,068,512 claims annually from nonparticipating providers or facilities.

The Department estimates that for each issuer or TPA it will take a medical secretary 10 minutes (at an hourly rate of \$37.50) to prepare the documentation and attach it to each payment or denial notice or explanation of benefits sent to the nonparticipating provider or facility. The Department assumes that this information will be sent electronically at minimal cost. The total annual burden for all issuers and TPAs to provide the qualifying payment amount information and certification along with 5,068,512 payments or denial notices, is estimated to be approximately 844,752 hours, with an associated equivalent cost of approximately \$31.7 million.

The Department assumes that for the 5,068,512 qualifying payment amount information sent to nonparticipating providers or nonparticipating emergency facilities, 50 percent will result in requests to provide additional information and plans and issuers will be required to send additional information to approximately 2,534,256 providers or facilities. The Department's estimate that it will take a medical secretary 15 minutes (at an hourly rate of \$37.50) to prepare the document and provide it to the provider or facility that requested it. The Department assumes that this information will be delivered electronically with minimal additional cost. The total estimated burden, for all issuers and TPAs, will be approximately 633,564 hours annually, with an associated equivalent cost of approximately \$23.8 million.

The total annual burden for all issuers and TPAs for providing the initial and additional information related to qualifying payment amount will be 1,478,316 hours, with an equivalent cost of \$55,436,853. As HHS, DOL, and Treasury share jurisdiction, it is estimated that 50 percent of the burden will be accounted for by the HHS, 25 percent of the burden will be accounted for by Treasury, and the remaining 25 percent will be accounted for by DOL. Thus, HHS will account for approximately 739,158 burden hours with an equivalent cost of approximately \$27,718,427. DOL and Treasury will each account for 369,579 burden hours with an equivalent cost of approximately \$13,859,214.

Opt-In State Balance Bill Process

The interim final rules require that a plan that has chosen to opt into a state law must prominently display in its plan materials describing the coverage of emergency services and/or out-of-network services a statement that the plan has opted into a specified state law, identify the state (or states), and include a general description of the emergency services and/or services provided by out-of-network facilities and providers that are

No Surprise Billing
OMB Control No. 1210-NEW

covered by the specified state law.

Currently, there are four states that allow self-funded plans to opt in: Nevada, New Jersey, Washington, and Virginia. According to the Nevada Department of Health and Human Services' 2020 Annual Report, 20 private entities or organizations have elected to participate in the state's balance billing law. In addition, according to the Virginia State Corporation Commission, 231 private self-funded plans in Virginia have elected to participate in the state's balance billing law.¹ Furthermore, according to Washington's Office of the Insurance Commissioner, 309 private self-funded plans in Washington have elected to participate in the state's balance billing law.² The Department does not have data on the number of self-insured plans that have opted in the New Jersey's balance billing law. In order to estimate the number of self-insured plans that have opted into the balance billing law for New Jersey, the Department has scaled Washington's estimate by the number of participants with self-insured ERISA-covered plans.³ According to the 2019 Health Insurance Coverage Bulletin, there are respectively, 0.7 million, 2.1 million, and 2.7 million with self-insured ERISA-covered plans in Nevada, Virginia, and New Jersey. Additionally, according to the Washington's Office of Insurance Commissioner, about 0.5 million self-funded participants have opted into Washington's balance billing law.⁴ This results in a total of 6 million participants.⁵ Thus, the Department estimates that 20, 231, 309, and 57 private self-insured plans will opt in respectively in Nevada, Virginia, Washington, and New Jersey, resulting in a total of 617 self-insured plans.⁶ These plans will incur the one-time burden and cost to include the disclosure in their plan documents in 2022.

The Department assumes that it will take 1 hour for a clerical worker, with a wage rate of \$55.14, to gather information and review information. This results in hour burden of 617 hours, with an equivalent cost of \$34,023. The Department assumes that it will take 30 minutes for a benefits manager, with a wage rate of \$134.21, to gather information and review information. This results in hour burden of 309 hours, with an equivalent cost of

1 Virginia State Corporation Commission. <https://scc.virginia.gov/balancebilling#>

2 Washington's Office of Insurance Commissioner. "Self-Funded Group Health Plans Participating in the Balance Billing Protection Act." <https://www.insurance.wa.gov/self-funded-group-health-plans>

3 Nevada Department of Health and Human Services' Office of Consumer Health Assistance. "Payment for Medically Necessary Emergency Services Provided Out-of-Network 2020 Annual Report." (2020). <https://dhhs.nv.gov/uploadedFiles/dhhsnv.gov/content/Programs/CHA/AB469%20LCB%20Annual%20Report%202020.pdf>

4 Washington's Office of Insurance Commissioner. "Self-Funded Group Health Plans Participating in the Balance Billing Protection Act." <https://www.insurance.wa.gov/self-funded-group-health-plans>

5 Employee Benefits Security Administration. "Health Insurance Coverage Bulletin: Abstract of Auxiliary Data for the March 2019 Annual Social and Economic Supplement to the Current Population Survey." (2019). <https://www.dol.gov/sites/dolgov/files/EBSA/researchers/data/health-and-welfare/health-insurance-coverage-bulletin-2019.pdf>

6 New Jersey: $335 \times (0.5/2.7) = 62$ self-insured plans; 62 self-insured plans – 5 non-federal self-insured plans = 57 private self-insured plans

No Surprise Billing
OMB Control No. 1210-NEW

\$41,406. In 2022, the total hour burden is 926 hours, with an equivalent cost of \$75,430. Thus, the three-year average hour burden is 309 hours, with an equivalent cost of \$25,143.

Plan and Issuer Disclosure on Patient Protections Against Balance Billing

The interim final rules requires that plans and issuers to make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under Code section 9816, ERISA section 716, and PHS Act section 2799A-1 apply, information in plain language on (1) the prohibitions on balance billing in certain circumstances, (2) any applicable state law protections against balance billing, (3) the requirements under Code section 9816, ERISA section 716, and PHS Act section 2799A-1, and (4) information on contacting appropriate state and federal agencies in the case that an individual believes that such a provider or facility has violated the prohibition against balance billing.

The Department estimates that there are 1,553 issuers and 205 TPAs. The Department assumes that plans and issuers will use the model notice developed by HHS, and that TPAs will develop the notice for self-insured plans. The Department estimate that on average for each plan or issuer it will take a lawyer two hours (at an hourly rate of \$143.18) to read and understand the provided notice and draft any additional, clear, and understandable language as may be needed, an administrative assistant 30 minutes (at an hourly rate of \$38.86) to prepare the final document for distribution and make the information publicly available within the facility, and a computer programmer one hour (at an hourly rate of \$91.96) to post the information on a separate or existing webpage, in a searchable manner, and to make the content available in an easily downloadable format. The total burden for an individual plan or issuer will be 3.5 hours with an equivalent cost of approximately \$398. The burden will be higher for issuers and TPAs in states with state laws or All-Payer Model Agreements, but lower for issuers and TPAs in states without any state laws. The total burden for all issuers and TPAs will be 6,153 hours with an equivalent cost of \$699,245, to be incurred as a one-time cost in 2021. As HHS, DOL, and Treasury share jurisdiction, it is estimated that 50 percent of the burden will be accounted for by the HHS, 25 percent of the burden will be accounted for by Treasury, and the remaining 25 percent will be accounted for by DOL. HHS will account for approximately 3,077 hours with an equivalent cost of approximately \$349,622. DOL and Treasury will each account for approximately 1,539 hours with an equivalent cost of approximately \$174,811.

Starting in 2022, the Department assumes that it will take an administrative assistant 1 minute (at an hourly rate of \$38.86) to print and enclose the notice with the explanation of benefit. The total burden for all issuers and TPAs is estimated to be 558,778 hours with an equivalent cost of \$21,714,111. As HHS, DOL, and Treasury share jurisdiction,

No Surprise Billing
OMB Control No. 1210-NEW

it is estimated that 50 percent of the burden will be accounted for by the HHS, 25 percent of the burden will be accounted for by Treasury, and the remaining 25 percent will be accounted for by DOL. Thus, HHS will account for 279,389 hours, with an equivalent cost of \$10,857,056 starting in 2022. DOL and Treasury will each account for 139,695 hours with an equivalent cost of \$419,084.

Thus, the three-year average hour burden associated with this requirement for DOL is 93,643 hours $((1,539+139,695+139,695)/3=\$93,643)$, with an equivalent cost of \$3,677,289. The three-year average cost burden for DOL is \$279,389 each.

Summary

In summary, the total hour burden associated with the information collection is estimated to be 463,980 hours, with an equivalent cost of \$17,586,009.

Estimated Annualized Respondent Cost and Hour Burden

Activity	No. of Respondents	No. of Responses per Respondent	Total Responses	Average Burden (Hours)	Total Burden (Hours)	Hourly Wage Rate	Total Burden Cost
Complainant collects all relevant documentation related to the alleged violation and to access and complete the provided complaint form*	900	1	900	30/60	450	\$54.14	\$24,363
Plans and issuers provide initial information about the qualifying payment amount to nonparticipating providers or nonparticipating emergency facilities*	440	2879.83636	1,267,128	10/60	211,188	\$37.50	\$7,919,551
Plans and issuers provide additional information about the qualifying payment amount to nonparticipating providers or	440	1439.91818	633,564	15/60	158,391	\$37.50	\$5,939,663

No Surprise Billing
OMB Control No. 1210-NEW

nonparticipating emergency facilities*							
Plans that have chosen to opt into a state law requirements- Clerical workers gather information and review information (2022)	617	1	617	1	617	\$55.14	\$34,023
Plans that have chosen to opt into a state law requirements- Benefit managers review information (2022)	617	1	617	30/60	309	\$134.21	\$41,406
Plan and Issuer Disclosure_ Requirements- Lawyer read and understand the provided notice and draft any additional, clear, and understandable language as may be needed* (2021)	440	1	440	2	879	\$143.18	\$125,855
Plan and Issuer Disclosure_ Requirements- Administrative Assistant prepare the final document for distribution and make the information publicly available within the facility* (2021)	440	1	440	30/60	220	\$38.86	\$8,549
Plan and Issuer Disclosure_ Requirements- Computer programmer post the information on a separate or existing webpage, in a searchable manner, and make the content available in an easily	440	1	440	1	440	\$91.96	\$40,462

No Surprise Billing
OMB Control No. 1210-NEW

downloadable format* (2021)							
Plan and Issuer Disclosure_ Requirements- Administrative Assistant print and enclose the notice with the explanation of benefit* (2022)	440	28794.315909	12,669,499	0.66/60	139,695	\$38.86	\$5,847,612
Plan and Issuer Disclosure_ Requirements- Administrative Assistant print and enclose the notice with the explanation of benefit* (2023)	440	28794.315909	12,669,499	0.66/60	139,695	\$38.86	\$5,847,612
Total (3-year average)*	1,986		10,368,277	0.0223752	463,981	-	\$17,586,009

13. Provide an estimate of the total annual cost burden to respondents or recordkeepers resulting from the collection of information. (Do not include the cost of any hour burden shown in Items 12 or 14).

- **The cost estimate should be split into two components: (a) a total capital and start up cost component (annualized over its expected useful life); and (b) a total operation and maintenance and purchase of service component. The estimates should take into account costs associated with generating, maintaining, and disclosing or providing the information. Include descriptions of methods used to estimate major cost factors including system and technology acquisition, expected useful life of capital equipment, the discount rate(s), and the time period over which costs will be incurred. Capital and start-up costs include, among other items, preparations for collecting information such as purchasing computers and software; monitoring, sampling, drilling and testing equipment; and record storage facilities.**
- **If cost estimates are expected to vary widely, agencies should present ranges of cost burdens and explain the reasons for the variance. The cost of purchasing or contracting out information collection services should be a part of this cost burden estimate. In developing cost burden estimates, agencies may consult with a sample of respondents (fewer than 10), utilize the 60-day pre-OMB submission public comment process and use existing economic or regulatory impact analysis associated with the rulemaking containing the information collection, as appropriate.**
- **Generally, estimates should not include purchases of equipment or services,**

No Surprise Billing
OMB Control No. 1210-NEW

or portions thereof, made: (1) prior to October 1, 1995, (2) to achieve regulatory compliance with requirements not associated with the information collection, (3) for reasons other than to provide information or keep records for the government, or (4) as part of customary and usual business or private practices.

Complaints Process for Surprise Medical Bills

There is no cost burden associated with this requirement.

Qualifying Payment Amount to be Shared with Nonparticipating Providers or Nonparticipating Emergency Facilities

There is no cost burden associated with this requirement.

Opt-In State Balance Bill Process

The average number of participants in a self-insured ERISA-covered plan that will opt into the four states' balance billing laws is 9,724.⁷ The Department assumes that only printing and material costs are associated with the disclosure requirement, because the notice can be incorporated into existing plan documents. The Department estimates that the disclosure will require one-half of a page, at a cost of \$0.05 per page for printing and materials, and 34 percent of plan documents will be delivered electronically at minimal cost.⁸ Thus, in 2022, the cost to deliver 66 percent of these disclosures in print is estimated to be approximately \$321.⁹ The three-year average cost burden is \$107.

Plan and Issuer Disclosure on Patient Protections Against Balance Billing

The Department assumes that plans and issuers will also include the disclosure along with the explanation of benefits at no additional cost. Under the same assumptions used to estimate the number of disclosures provided by nonparticipating facilities and nonparticipating providers, the Department estimates that issuers and TPAs will include the disclosure to approximately 39,690,940 individuals who receive services at emergency facilities and 11,107,056 individuals who received non-emergency services at health care facilities, for a total of 50,797,996 disclosures. The Department assumes that 66 percent of these notices will be provided by mail and the cost of printing is \$0.05 per

⁷ (6,000,000 participants with self-insured ERISA-covered plans)/ 617 self-insured ERISA-covered plans= 9,724 participants per self-insured ERISA-covered plan

⁸ According to data from the National Telecommunications and Information Agency, 34 percent of households in the United States accessed health records or health insurance online. <https://www.ntia.doc.gov/blog/2020/more-half-american-households-used-internet-health-related-activities-2019-ntia-data-show>.

⁹ 9,724 participants x 0.66 x \$0.05 = \$321

No Surprise Billing
OMB Control No. 1210-NEW

page. Therefore, the total printing and materials cost for sending 33,526,677 notices by mail will be \$1,676,334 annually starting in 2022. As HHS, DOL, and Treasury share jurisdiction, it is estimated that 50 percent of the burden will be accounted for by the HHS, 25 percent of the burden will be accounted for by Treasury, and the remaining 25 percent will be accounted for by DOL. Thus, HHS will account for printing and materials cost of \$838,167 starting in 2022. DOL and Treasury will each account for printing and material costs of \$419,084 starting in 2022

The three-year average cost burden for DOL is \$279,389 each.¹⁰

Summary

In summary, the total cost burden associated with the information collection is estimated to be \$279,496.

- 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.**

The annual cost for the Department to operate the complaints process for surprise medical bills is estimated to be \$1 million in one-time costs in 2021 and \$300,000 annually starting in 2022. Thus, the annualized cost to the federal government is \$533,333.

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

This is a new collection of information.

- 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.**

¹⁰ The three-year average cost burden for all the agencies is \$1,117,556 $((\$0 + 1,676,334 + \$1,676,334)/3 = \$1,117,556)$. DOL will account for 25 percent of the burden. Therefore, the three-year average cost burden for DOL is \$279,389 $(\$1,117,556 \times 0.25 = \$279,389)$.

No Surprise Billing
OMB Control No. 1210-NEW

There are no plans to publish the results of this collection of information.

- 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.**

The OMB expiration date will be published in the Federal Register following OMB approval.

- 18. Explain each exception to the certification statement identified in Item 19.**

There are no exceptions to the certification statement.

- B. COLLECTIONS OF INFORMATION EMPLOYING STATISTICAL METHODS.**

Not applicable.