SUPPORTING STATEMENT
Internal Revenue Service
OMB Control Number 1545-2181
Patient Protection and Affordable Care Act Patient Protection Notice
Final Rule-(TD 9951)

1. CIRCUMSTANCES NECESSITATING COLLECTION OF INFORMATION

The Patient Protection and Affordable Care Act (the Affordable Care Act or the Act (P.L. 111-148)) was enacted on March 23, 2010. Section 2719A of the Public Health Service Act (the PHS Act), as added by the Affordable Care Act[1], and the Agency's final regulations (26 CFR 54.9815–2719A(b)(3)(iii)) provide that if a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer must permit each participant, beneficiary, or enrollee to designate any participating primary care provider who is available to accept the participant, beneficiary, or enrollee.

The statute and the 2015 final regulations impose a requirement for the designation of a pediatrician similar to the requirement for the designation of a primary care physician. Specifically, if a plan or issuer requires or provides for the designation of a participating primary care provider for a child by a participant, beneficiary, or enrollee, the plan or issuer must permit the designation of a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if the provider participates in the network of the plan or issuer.

The statute and the 2015 final regulations also provide that a group health plan, or a health insurance issuer may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) for a female participant, beneficiary, or enrollee who seeks obstetrical or gynecological care provided by an in-network health care professional who specializes in obstetrics or gynecology.

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires participants or subscribers to designate a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. The No Surprises Act added section 9822 to the Internal Revenue Code , which contains the patient protections regarding choice of health care professional from section 2719A of the PHS Act. These provisions mirror those currently applicable under section 2719A of the PHS Act. Accordingly, the 2015 final regulations and 2021 interim final regulations requires such plans and issuers to provide a notice to participants (in the individual market, primary subscribers) of these rights when applicable. Model language is provided in the 2015 final regulations and in the 2021 interim final regulations. The notice must be provided whenever the plan or issuer provides a participant with a

1 **Section 9815 of the Internal Revenue Code incorporates section 2719A of the PHS Act as well as other ACA market requirements into the Internal Revenue Code.**

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 No Surprises Act (P.L. 116-260), which Congress enacted as part of the Consolidated Appropriations Act, 2021, amended section 2719A of the PHS Act to specify in new subsection (e) that section 2719A shall not apply with respect to plan years beginning on or after January 1, 2022. The No Surprises Act expanded the patient protections related to emergency services to provide additional protections. In addition, the No Surprises Act added section 9822 to the Code, which contains the patient protections regarding choice of health care professional from section 2719A of the PHS Act. These provisions mirror those currently applicable under section 2719A of the PHS Act (minus the emergency services protections). In addition, the patient protections under the No Surprises Act apply generally to all group health plans and health insurance coverage, including grandfathered health plans. The 2021 interim final regulations "Requirements Related to Surprise Billing; Part I" (henceforth 2021 interim final regulations) add a sunset clause to the current patient protection provisions codified in the 2015 final regulations, and re-codify the provisions related to choice of health care professional in a new section.

2. USE OF DATA

The notice of right to designate a primary care provider used by health plan sponsors and issuers to notify certain individuals of their right to (1) choose a primary care provider or a pediatrician when a plan or issuer requires participants or subscribers to designate a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization.

3. USE OF IMPROVED INFORMATION TECHNOLOGY TO REDUCE BURDEN

The regulation does not restrict plans or issuers from using electronic technology to provide either disclosure.

4. EFFORTS TO IDENTIFY DUPLICATION

The No Surprises Act, which was enacted as part of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260). These interim final rules and The No Surprises Act 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. The Department of Labor and the Internal Revenue Service share jurisdiction over ERISA-covered group health plans. The Department of the Treasury and Internal Revenue Service have sole jurisdiction over church plans. Thus, there will be no duplication of effort with the Department of Health and Human Services. The Department of Treasury and Internal Revenue Service will split the burden with the Department of Labor such that there will be no duplication of effort.

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

All plans regardless of size are required to notify plan participants of their rights. Model notices have been provided to reduce burden. Notices can be part of other plan documents and within the guidelines of the Agency's rules provide notices electronically to minimize burden. These notices are a part of the related new ICRs, No Surprise Act, that the IRS, DOL (Department of Labor) and HHS (Health and Human Services) are seeking approval for from OIRA.

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

If this information were conducted less frequently, affected individuals would not be informed of their right to (1) choose a primary care provider or a pediatrician when a plan or issuer requires participants or subscribers to designate a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization.

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

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

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

The Agency is seeking emergency clearance in accordance with the emergency review procedures set forth under 5 CFR 1320.13 and waiving of the notice requirement under the emergency clearance as set forth in 5 CFR 1320.13(d). After emergency clearance is obtained the ICR will be submitted for review under the normal PRA procedures allowing for public review and comment.

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

No payment or gift has been provided to any respondents.

10. ASSURANCE OF CONFIDENTIALITY OF RESPONSES

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

11. JUSTIFICATION OF SENSITIVE QUESTIONS

No personally identifiable information (PII) is collected.

12. ESTIMATED BURDEN OF INFORMATION COLLECTION

PHS Act 2719A and the final regulations affect only plans and participants in plans that require participants to designate a primary care physician and are non-grandfathered plans. The IRS and DOL assumes that this is most likely to happen in Health Maintenance Organization (HMO) and Point-of-Service (POS) type arrangements. Therefore, the agency has estimated the number of plans and participants that have HMO- or POS-type coverage that are not grandfathered group health plans. Further, the Agency believes that only plans that relinquish their grandfathered status in 2021 and plans that are still grandfathered in 2022 will become subject to this notice requirement for the first time and incur the one-time costs to prepare the notice. In subsequent years, this notice would remain unchanged and its costs are factored into the burden estimates associated with the Summary Plan Description information collection request (OMB Control Number 1545-2181).

The Agency estimates that there are 2.5 million ERISA-covered plans. Data obtained from the 2020 Kaiser/HRET Survey of Employer Sponsored Health Benefits finds that 16 percent of firms offering health benefits offer at least one grandfathered health plans. The Agency estimates that five percent of plans will relinquish their grandfathered status in 2021. The data from the 2020 Kaiser/HRET Survey of Employer Sponsored Health Benefits also finds that 11 percent of plans have an HMO option and that 31 percent of plans offer a POS option. Thus, the Agency estimates that 8,481 plans will lose grandfathered status in 2021 and incur the one-time cost to prepare and incorporate this notice in their existing plan document.[2] In 2022, the remaining 161,148 such grandfathered plans will be subject to this notice requirement.[3] There will be no additional costs in 2023 to prepare the notice, since all plans and issuers will have incurred the cost by 2022.

While not all HMO and POS options require the designation of a primary care physician or a prior authorization or referral before a woman can visit an OB/GYN, the Agency is unable to estimate this number. Therefore, these estimates should be considered an overestimate of the number of affected entities.

The 2015 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 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 an enrollee or beneficiary adequate and prominent notice of their lack of financial responsibility with respect to amounts balanced billed in order to prevent inadvertent payment by an enrollee or

2 2.5 million ERISA-covered plans x 16% grandfathered plans x 5% newly non-grandfathered plans x (11% HMOs + 31% POSs) = 8,481 affected plans.

3 2.5 million ERISA-covered plans x 16% grandfathered plans x (100% minus 5% newly non-grandfathered plans) x (11% HMOs + 31% POSs) = 161,148 affected plans.

beneficiary. This information should already be routinely included in the Explanation of Benefit documents sent by plans and issuers to enrollees and beneficiaries. Therefore, in accordance with the implementing regulations of the Paperwork Reduction Act at 5 CFR 1320.3(b)(2), the IRS believes this is a usual and customary business practice. Plans and issuers routinely provide enrollees and beneficiaries with the Explanation of Benefit documents. Plans and issuers will no longer be required to provide this notice for plan years beginning on or after January 1, 2022.

Each of the plans will require a compensation and benefits manager to spend 10 minutes individualizing the model notice to fit the plan's specifications at an hourly rate of $134.21.[4] In 2021, this results in 1,414 hours of burden at an equivalent cost of $189,716. In 2022, this results in 26,858 hours of burden at an equivalent cost of $3,604,602.

Each plan will also require clerical staff to spend 5 minutes adding the notice to the plan's documents at an hourly rate of $55.14. In 2021, this results in approximately 707 hours of burden at an equivalent cost of $38,972. In 2022, this results in 13,429 hours of burden at an equivalent cost of $740,473.

In 2021, the total burden associated with this ICR is 2,120 hours at an equivalent cost of $228,688. In 2022, the total burden associated with this ICR is 40,287 hours at an equivalent cost of $4,345,075. The Agency shares this burden equally with the Department of the Labor. Therefore, the three-year average prorated share of the burden for the IRS is approximately 7,068 hours at an equivalent cost of $762,294.

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
Compensation and benefits manager draft notice (2021)	8,481	1	8,481	10 minutes	1,414	$134.21	$189,716

4 For more information on how the Department estimates labor costs see: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-regulations/technical-appendices/labor-cost-inputs-used-in-ebsa-opr-ria-and-pra-burden-calculations-june-2019.pdf

Clerical staff insert notice into existing documentation (2021)	8,481	1	8,481	5 minutes	707	$55.14	$38,972
Compensation and benefits manager draft notice (2022)	161,148	1	161,148	10 minutes	26,858	$134.21	$3,604,602
Clerical staff insert notice into existing documentation (2022)	161,148	1	161,148	5 minutes	13,429	$55.14	$740,473
Total (3-year average)*	56,543		256,262		7,068	-	$762,294
Six-month totals	28,272		128,133		3,534		

* Note: The Agency estimates that there are 8,481 respondents in 2021, 161,148 respondents in 2022, and zero respondents in 2023. Thus, the three-year average number of respondents is 56,543.[5] The Agency estimates that there are 38,439 responses in 2021, 730,246 responses in 2022, and 0 and responses in 2023.[6] Thus, the three-year average number of responses is 256,262.

13. ESTIMATED TOTAL ANNUAL COST BURDEN TO RESPONDENTS

The Agency assumes that only printing and material costs are associated with the disclosure requirement, because the interim final regulations provide model language that can be incorporated into existing plan documents, such as an SPD. The Agency's estimate that the notice will require one-half of a page, five cents per page printing and material cost will be incurred, and 58.2 percent of the notices will be delivered electronically.

The Agency estimates that there are 62.6 million ERISA-covered policyholders. Data obtained from the 2020 Kaiser/HRET Survey of Employer Sponsored Health Benefits

5 2021: 2.5 million ERISA-covered plans x 16% grandfathered plans x 5% newly non-grandfathered plans x (11% HMOs + 31% POSs) = 8,481 affected plans; 2022: 2.5 million ERISA-covered plans x 16% grandfathered plans x (100% minus 5% newly non-grandfathered plans) x (11% HMOs + 31% POSs) = 161,148 affected plans; 2023: There will be no additional costs in 2023 to prepare the notice, since all plans and issuers will have incurred the cost by 2022.

6 2021: 62.6 million ERISA-covered policyholders x 14% of covered employees in grandfathered plans x 5% newly non-grandfathered plans x (13% in HMOs + 8% in POSs) *41.8% = 38,439 notices; 2022: 62.6 million ERISA-covered policyholders x 14% of covered employees in grandfathered plans x (100% minus 5% newly non-grandfathered plans) x (13% in HMOs + 8% in POSs) *41.8% = 730,346 notices; 2023: There will be no additional costs in 2023 to prepare the notice, since all plans and issuers will have incurred the cost by 2022.

finds that 14 percent of covered workers are enrolled in a grandfathered plan. As stated in question 12, the Agency estimates that 5 percent of plans would relinquish their grandfathered status annually in 2021. The data from the 2020 Kaiser/HRET Survey of Employer Sponsored Health Benefits also finds that 13 percent of covered workers have an HMO option and that 8 percent of covered workers have a POS option. The Agency estimates that plans will produce 38,439 notices in 2021, 730,346 notices in 2022, and zero notices in 2023. This results in a cost burden of approximately $961 in 2021, $18,259 in 2022, and $0 in 2023. The Agency shares this burden equally with the Department of Labor. Therefore, IRS's three-year average share of the cost burden is approximately $3,203. The six month cost burden is $1,602.

14. ESTIMATED ANNUALIZED COST TO THE FEDERAL GOVERNMENT

There is no annualized cost to the federal government.

15. REASONS FOR CHANGE IN BURDEN

The No Surprises Act added section 9822 of the Code, which contains the patient protections regarding choice of health care professional from section 2719A of the PHS Act. The patient protections under the No Surprises Act apply generally to all group health plans and health insurance coverage, including grandfathered health plans. The Agency believes that only plans that relinquish their grandfathered status in 2021 and plans that are still grandfathered in 2022 will become subject to this notice requirement for the first time and incur the one-time costs to prepare the notice.

Adjustments to the burden estimates also result from updated estimates on the number of plans and policyholders affected by the regulations, an increase in the share of notices assumed to be transmitted electronically, and increases in wage rates. These updated data inputs decreases the hour burden by -1,639 hours compared with the prior submission, reduces the number of responses by -564,874, and reduces the cost burden by $3,769 compared with the prior submission.

	Requested	Program Change Due to New Statute	Program Change Due to Agency Discretion	Change Due to Adjustment in Agency Estimate	Change Due to Potential Violation of the PRA	Previously Approved
Annual Number of Responses	128,133	-564,874	0	0	0	693,007
Annual Time Burden (Hr)	3,534	-1,639	0	0	0	5,173
Annual Cost Burden ($)	1,602	-3,769	0	0	0	5,371

16. PLANS FOR TABULATION, STATISTICAL ANALYSIS AND PUBLICATION

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

17. REASONS WHY DISPLAYING THE OMB EXPIRATION DATE IS INAPPROPRIATE

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

18. EXCEPTIONS TO THE CERTIFICATION STATEMENT

There are no exceptions to the certification statement.

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

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