Supporting Statement – Part A
Notice of Rescission of Coverage and Disclosure Requirements for Patient Protection under the Affordable Care Act (CMS-10330/OMB Control No. 0938-1094)

A. Background

The Patient Protection and Affordable Care Act, Pub. L. 111-148, was enacted on March 23, 2010; and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, was enacted on March 30, 2010 (collectively known as the "Affordable Care Act"). The Affordable Care Act reorganizes, amends, and adds to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets.

The interim final regulations titled "Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections" (75 FR 37188, June 28, 2010) implemented the rules for group health plans and health insurance coverage in the group and individual markets under provisions of the Affordable Care Act regarding rescissions, and patient protections. The provisions are finalized in the final regulations titled "Final Rules under the Affordable Care Act for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections" (80 FR 72192, November 18, 2015, henceforth 2015 final regulations). PHS Act section 2712 provides rules regarding rescissions of health coverage for group health plans and health insurance issuers offering group or individual health insurance coverage. Under the statute and the 2015 final regulations, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, must not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact, as prohibited by the terms of the plan or coverage. Section 2719A of the PHS Act imposes, with respect to a group health plan, or group or individual health insurance coverage, requirements relating to the choice of a health care professional and requirements relating to benefits for emergency services.

The No Surprises Act, which Congress enacted as part of the Consolidated Appropriations Act, 2021, amended section 2719A of the PHS Act to sunset when the new emergency services protections under the No Surprises Act take effect. The provisions of section 2719A of the PHS Act will no longer apply with respect to plan years beginning on or after January 1, 2022.[1] The No Surprises Act re-codified the patient protections related to choice of health care professional in newly added section 9822 of the Internal Revenue Code (the Code), section 722 of the Employee Retirement Income Security Act (ERISA), and section 2799A-7 of the PHS Act. To reflect these statutory amendments, the interim final regulations titled "Requirements Related to Surprise Billing; Part I" (86, FR 36872, henceforth 2021 interim final regulations) add a sunset clause to the current patient protection provisions codified in

1 Section 2719A(e) of the PHS Act states, "The provisions of this section shall not apply with respect to a group health plan, health insurance issuers, or group or individual health insurance coverage with respect to plan years beginning on or on January 1, 2022." The Departments interpret subsection (e) to sunset section 2719A for plan years beginning on or after January 1, 2022.

the 2015 final regulations, and re-codify the provisions related to choice of health care professional without substantive change at 45 CFR 149.310.

The No Surprises Act extends the applicability of the patient protections, including those related to choice of health care professionals, to grandfathered health plans. The patient protections under section 2719A of the PHS Act apply to only non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage. In contrast, the patient protections under the No Surprises Act apply generally to all group health plans and group and individual health insurance coverage, including grandfathered health plans.[2] Therefore, the requirements regarding patient protections, including those related to choice of health care professional under the 2021 interim final regulations, will newly apply to grandfathered health plans for plan years beginning on or after January 1, 2022. Until the requirements under section 9822 of the Code, section 722 of ERISA, and section 2799A-7 of the PHS Act and the 2021 interim final regulations become applicable, non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage must continue to comply with the applicable requirements under section 2719A of the PHS Act and its implementing regulations.

B. Justification

1 . Need and Legal Basis

Section 2712 of the PHS Act, as added by the Affordable Care Act, prohibits group health plans and health insurance issuers that offer group or individual health insurance coverage generally from rescinding coverage under the plan, policy, certificate, or contract of insurance from the individual covered under the plan or coverage unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, as prohibited by the terms of the plan or coverage. The 2015 final regulations provide that a group health plan or a health insurance issuer offering group or individual health insurance coverage must provide at least 30 days advance notice to an individual before coverage may be rescinded.

Section 2719A of the PHS Act, as added by the Affordable Care Act, imposes, with respect to a group health plan, or group or individual health insurance coverage, a set of requirements relating to the choice of a health care professionals. The Departments believe it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires participants or subscribers to designate a primary care physician; or (2) obtain obstetrical or gynecological

2 Section 2719A was added to the PHS Act by the Affordable Care Act. Section 1251 of the Affordable Care Act provides that certain requirements, including those in section 2719A of the PHS Act, do not apply to grandfathered health plans. The No Surprises Act does not include a comparable exception for grandfathered health plans. Furthermore, section 103(d)(2) of the No Surprises Act amends section 1251(a) of the Affordable Care Act to clarify that the new and re-codified patient protections provisions, including those related choice of choice of health care professional, apply to grandfathered health plans.

care without prior authorization. The No Surprises Act added section 2799A-7 of the PHS Act, which contains the patient protections regarding choice of health care professional from section 2719A of the PHS Act. Accordingly, the 2015 final regulations and 2021 interim final regulations require such plans and issuers to provide a notice to participants (in the individual market, primary subscriber) of these rights when applicable. Model language is provided in the 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 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 2021 interim final regulations make the patient protections for choice of health care professionals applicable to grandfathered plans for plan years beginning on or after January 1, 2022.

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 if a plan or issuer is contractually responsible for any amounts balance billed by an out-of-network emergency services provider, the plan or issuer must provide a participant, beneficiary or enrollee adequate and prominent notice of their lack of financial responsibility with respect to amounts balance billed in order to prevent inadvertent payment by the individual. Plans and issuers will not be required to provide this notice for plan years beginning on or after January 1, 2022.

2. Information Users

The rescission notice will be used by health plans to provide advance notice to certain individuals that their coverage may be rescinded. The affected individuals are those who are at risk of rescission of their health insurance coverage as a result of fraud or intentional misrepresentation of material fact.

The notice of right to designate a primary care provider will be used by health plans to inform certain individuals of their right to choose a primary care provider or pediatrician and to use obstetrical/gynecological services without prior authorization.

The out-of-network emergency services disclosure will be used by health plans to inform individuals of their lack of financial responsibility to an out-of-network emergency services provider.

3. Use of Information Technology

The regulations do not require or restrict plans or issuers from using electronic technology to provide either disclosure.

4. Duplication of Efforts

These provisions of the PHS Act, ERISA, and the Code are jointly administered by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury. However, only the Department of Health and Human Services has jurisdiction over state and local government plans and individual market plans, so there is no duplication of effort.

5. Small Businesses

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

6. Less Frequent Collection

If these information collections were conducted less frequently, affected individuals would not be notified of potential rescission, individuals would not be informed of their right to choose a primary care provider or pediatrician and to use obstetrical/gynecological services without prior authorization, and individuals using out-of-network emergency services would not be aware of their lack of financial responsibility.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

A notice was published in the Federal Register on November 26, 2021 (86 FR 67473), providing the public with a 60-day period to submit written comments on the ICRs. One comment was received, which supported the notice requirement for rescissions.

9. Payments/Gifts to Respondents

No payments or gifts are associated with these ICRs.

10. Confidentiality

CMS will protect privacy of the information provided to the extent provided by law.

11. Sensitive Questions

These ICRs involve no sensitive questions.

12. Burden Estimates (Hours & Wages)

We generally used data from the Bureau of Labor Statistics to derive average labor costs (doubled to include fringe benefits and other associated costs) for estimating the burden

associated with the ICRs.[3]

TABLE 1. Adjusted Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Mean Hourly Wage ($/hour)	Fringe Benefits and Overhead ($/hour)	Adjusted Hourly Wage ($/hour)
Secretaries and Administrative Assistants	43-6014	$19.43	$19.43	$38.86
Lawyer	23-1011	$71.59	$71.59	$143.18
Compensation and Benefits Manager	11-3111	$65.94	$65.94	$131.88

Section 2712 Rescissions

This analysis assumes that rescissions only occur in the individual health insurance market, because rescissions in the group market are rare. It is estimated that there are approximately 388 issuers issuing approximately 9 million policies in the individual market during a year. A report on rescissions found that 0.15 percent of policies were rescinded during the 2004 to 2008 time period. Based on these numbers, it is estimated that approximately 13,475 policies are rescinded during a year, which would result in approximately 13,475 notices being sent to affected policyholders, with 34 percent transmitted electronically and 66 percent mailed.[4] It is estimated that each issuer will require 15 minutes of legal professional time (at an hourly rate of $143.18) to prepare the notice with a total annual burden of approximately 97 hours for all issuers with an equivalent annual cost of approximately $13,888. It is estimated that issuers will need one minute per notice of clerical professional time (at an hourly rate of $38.86) to distribute the notice to each policyholder by mail, resulting in a total annual burden of approximately 148 hours[5], with an equivalent annual cost of approximately $5,760. Assuming that the cost of electronic distribution is minimal, this results in a total annual hour burden of approximately 245 hours with an equivalent annual cost of approximately $19,648.

Notice of Right to Designate a Primary Care Provider

In order to satisfy the patient protection disclosure requirement, state and local government plans and issuers in individual markets will need to notify policy holders of their plans' policy in regards to designating a primary care physician and for obstetrical or gynecological visits and will incur a one-time burden and cost to incorporate the notice into plan documents. State and local government plans and individual market plans that are currently not grandfathered have already incurred the one-time cost to prepare and incorporate this notice in their existing

3 May 2020 Occupational Employment Statistics found at https://www.bls.gov/oes/current/oes_nat.htm). To account for fringe and overhead, HHS is using 100% of the mean hourly wage.
4 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.
5 13,475 notices x 66% sent by mail = 8893 notices sent by mail x 1 minute per notice = approximately 148 hours.

plan documents. Only plans that relinquish their grandfathered status in 2021 and 2022 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.

There are an estimated 90,126 non-federal governmental employers offering health plans to employees and 388 health insurance issuers in the individual market. We estimate that there are approximately 14,417 grandfathered non-federal government employer-sponsored plans and approximately 837,543 grandfathered individual market policies. Data obtained from the 2020 Kaiser/HRET survey of Employer Health Benefits[6] finds that 11 percent of employers offer a health maintenance organization (HMO) option and that 31 percent of employers offer a point-of-service (POS) option. Therefore, there are approximately 6,055 grandfathered non-federal governmental plans offering HMO and POS options. We assume that all individual market issuers offer at least one of HMO, exclusive provider organization (EPO) or POS options.

We estimate that 5 percent of such non-federal governmental plans will relinquish their grandfathered status in 2021 and will therefore incur one-time costs to prepare the notice. Therefore, approximately 303 non-federal governmental plans will lose grandfathered status in 2021 and incur the one-time cost to prepare and incorporate this notice in their existing plan documents. We also assume that health insurance issuers in the individual market will have 5 percent of their policies relinquish grandfathered status in 2021. Thus, approximately 691 non-federal governmental plans and individual market issuers will incur the one-time cost to prepare and incorporate this notice in their existing plan documents in 2021.

In 2022, the remaining plans that had grandfathered status in 2021 will be subject to this notice requirement, irrespective of whether they relinquish that status in 2022. Health insurance issuers in the individual market will also be required to provide this notice to enrollees in their remaining policies that retained grandfathered status in 2021. Thus, approximately 6,140 non-federal governmental plans and individual market issuers will incur the one-time cost to prepare and incorporate this notice in their existing plan documents in 2022, of which 5,450 will be plans and issuers offering coverage that retains grandfathered status in 2022. While not all HMO, EPO and POS options require the designation of a primary care physician or a prior authorization or referral before a woman can visit an OB/GYN, the Department is unable to estimate this number. Therefore, this estimate should be considered an overestimate of the number of affected entities.

Model language for the notice is provided in the 2015 final regulations as well as in the 2021 interim final regulations. Each plan or issuer will require a compensation and benefits manager (at an hourly rate of $131.88) to spend 10 minutes customizing the model notice to fit the plan's specifications. Each plan or issuer will also require clerical staff (at an hourly rate of $38.86) to spend 5 minutes adding the notice to the plan's documents. The total burden for each plan or issuer will be 0.25 hours with an equivalent cost of approximately $25. In 2021, the total annual burden for all plans and issuers will be approximately 173 hours with

6 Available at https://www.kff.org/health-costs/report/2020-employer-health-benefits-survey/.

an equivalent cost of approximately $17,420. In 2022, the total annual burden for all plans and issuers will be approximately 1,535 hours with an equivalent cost of approximately $154,850. There will be no additional costs in 2023 to prepare the notice, since all plans and issuers will have incurred the cost by 2022.

TABLE 2. One-Time Burden to Prepare Notice of Right to Designate a Primary Care Provider and Obtain Obstetrical or Gynecological Care without Prior Authorization

Year	Estimated Number of Respondents	Estimated Number of Responses	Burden Per Response (Hours)	Total Annual Burden (Hours)	Total Estimated Labor Cost
2021	691	691	0.25	173	$17,420
2022	6,140	6,140	0.25	1535	$154,850
2023	0	0	0	0	0
3 year Average	2,277	2,277		569	$57,423

Section 2719A Out-Of-Network Emergency Services Disclosure

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 higher than the copayment or coinsurance requirement that would apply if the services were provided in network. In addition, if state law prohibits balance billing, or if a plan or issuer is contractually responsible for any amounts balance billed by an out-of-network emergency services provider, a plan or issuer must provide a participant, beneficiary or enrollee adequate and prominent notice of their lack of financial responsibility with respect to amounts balance billed in order to prevent inadvertent payment by the individual. 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 PRA at 5 CFR 1320.3(b)(2), we believe this is a usual and customary business practice. Plans and issues routinely provide enrollees and beneficiaries with the Explanation of Benefit documents. Plans and issuers will no longer be required to provide this notice for plan years beginning on or after January 1, 2022.

13. Capital Costs

Section 2712 Rescissions

Issuers will incur cost to print and send the notices. We assume that the notice will require one page, printing and material cost will be $0.05 per page and mailing cost will be $0.50 per

notice. We estimate that 34 percent of the 13,475 notices will be delivered electronically[7] at minimal cost. Therefore, it is estimated that the annual cost burden associated with mailing 8893 notices will be approximately $4891.

Notice of Right to Designate a Primary Care Provider

We assume that only printing and material costs are associated with the disclosure requirement, because the notice can be incorporated into existing plan documents. We estimate that the notice will require one-half of a page, $0.05 per page printing and material cost will be incurred, and 34 percent of the notices will be delivered electronically at minimal cost. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage, or in the individual market, provides a primary subscriber with a policy, certificate, or contract of health insurance.

It is estimated that there are approximately 1.8 million non-federal governmental plan policyholders in grandfathered plans. Data obtained from the 2020 Kaiser/HRET Survey of Employer Sponsored Health Benefits finds that 12 percent of covered workers in non-federal government plans have an HMO option and that 11 percent of covered workers have a POS option. Therefore, there are an estimated 413,976 policyholders in grandfathered HMO and POS plan options. There are an estimated 837,543 policyholders with grandfathered individual market plans. It is estimated that approximately 75 percent of individual market enrollees have HMO, EPO and POS options.[8] Therefore, an estimated 627,146 policyholders in the individual market have grandfathered plans with HMO, EPO and POS options. As stated in the previous section, it is estimated that five percent of plans will relinquish their grandfathered status in 2021. Therefore, there are approximately 52,056 policyholders in non-federal government employer sponsored and individual market plans with HMO, EPO and POS options that will lose grandfathered status in 2021. Thus, it is estimated that in 2021 plans will produce 52,056 notices in 2021, 66 percent of which will be delivered in print. This results in a cost burden of approximately $859.[9] Approximately 989,066 policyholders remaining in grandfathered non-federal government employer sponsored and individual market plans with HMO, EPO and POS options at the end of 2021 will receive the notice for the first time in 2022. It is estimated that 66 percent of these notices will be delivered in print at a cost of approximately $16,320.[10]

TABLE 3. One-Time Printing and Materials Costs Related to Notice of Right to Designate a Primary Care Provider

7 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.

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

9 52,056 notices x 66% = 34,357 notices printed x $0.05 per page x 1/2 pages per notice = approximately $859.

10 989,066 notices x 66% = 652,783 notices printed x $0.05 per page x 1/2 pages per notice = approximately $16,320.

Year	Estimated Number of Respondents	Estimated Number of Responses	Total Estimated Printing and Materials Cost
2021	691	52,056	$859
2022	6,140	989,066	$16,320
2023	0	0	0
3 year Average	2,277	347,041	$5,726

14. Cost to Federal Government

    There is no cost to the federal government.

15. Changes to Burden

    There is no change in burden.

16. Publication/Tabulation Dates

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

17. Expiration Date

    There are no instruments associated with these ICRs.