

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

1. CIRCUMSTANCES NECESSITATING COLLECTION OF INFORMATION

The Patient Protection and Affordable Care Act (the Affordable Care Act or the Act) was enacted on March 23, 2010. Section 2719A of the Public Health Service Act (the PHS Act), as added by the Affordable Care Act, and the Department's final regulations (26 CFR 54.9815-2719A) 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 2799A-7 of the PHS Act, 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 require 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 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, 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 2799A-7 of the PHS Act, 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 the choice of health care professional at 26 CFR 54.9822-1T.

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.

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 received no comments during the comment period in response to the Federal Register notice dated April 15, 2022 (87 FR 22628).

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 Departments assume that this is most likely to happen in Health Maintenance Organization (HMO and Point-of-Service (POS) type arrangements. Therefore, the Department has estimated the number of plans and participants that have HMO- or POS-type coverage that are not grandfathered group health plans. Further, the Department believes that 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 1210-0039).

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 Department is unable to estimate this number. The Department has estimated the number of grandfathered plans that will be subject to this notice requirement by multiplying the number of ERISA-covered plans, the percent of firms offering at least one grandfathered health plans, and the percent of plans that have an HMO option and POS option. Therefore, these estimates should be considered an overestimate of the number of affected entities.

The Agency estimates that there are 2.0 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 all grandfathered plans will be required to prepare this notice requirement. The data from the 2021 Kaiser/HRET Survey of Employer Sponsored Health Benefits finds that 8 percent of plans have an HMO option and that 13 percent of plans offer a POS option. Thus, the Agency estimates that in 2022, 67,445 grandfathered plans will be subject to this notice requirement. There will be no additional costs in 2023 and 2024 to prepare the notice, since all plans and issuers will have incurred the cost by 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 \$121.78. In 2022, this results in 11,241<sup>1</sup> hours of burden at an equivalent cost of \$1,368,913.

Each plan will also require clerical staff to spend 5 minutes adding the notice to the plan's documents at an hourly rate of \$55.23. In 2022, this results in 5,620 hours of burden at an equivalent cost of \$310,417.

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<sup>1</sup> 2022: 2.0 million ERISA-covered plans x 16% grandfathered plans x (8% HMOs + 13% POSs) = 67,445 affected plans; 2023 and 2024: There will be no additional costs in 2023 and 2024 to prepare the notice, since all plans and issuers will have incurred the cost by 2022. Therefore, the three-year average number of respondents is 22,482. The Agency shares this burden equally with the Department of Labor (DOL). Thus, the three-year average number of respondents for IRS is 11,241.

In 2022, the total burden associated with this ICR is 16,861 hours at an equivalent cost of \$1,679,330. Therefore, the three-year average burden is approximately 5,620 hours at an equivalent cost of \$559,777. The Agency shares this burden equally with the Department of Labor. Therefore, IRS’s three-year average share of the hour burden is approximately 2,810 hours at an equivalent cost of \$279,888.

### 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  |
|------------------------------------------------------------------------|--------------------|---------------------------------|-----------------|------------------------|----------------------|------------------|--------------------|
| <b>Compensation and benefits manager draft notice (2022)</b>           | <b>67,445</b>      | <b>1</b>                        | <b>67,445</b>   | <b>10/60</b>           | <b>11,241</b>        | <b>\$121.78</b>  | <b>\$1,368,913</b> |
| <b>Clerical staff insert notice into existing documentation (2022)</b> | <b>67,445</b>      | <b>1</b>                        | <b>67,445</b>   | <b>5/60</b>            | <b>5,620</b>         | <b>\$55.23</b>   | <b>\$310,417</b>   |
| <b>Total (3-year average)*</b>                                         | <b>11,241</b>      |                                 | <b>148,181*</b> | <b>0.019</b>           | <b>2,810</b>         | <b>-</b>         | <b>\$279,888</b>   |

\* Note: The Agency estimates that there are 67,445 respondents in 2022, and zero respondents in 2023 and 2024. Thus, the three-year average number of respondents is 11,241. The Agency estimates that there are 889,085 responses in 2022, and zero responses in 2023 and 2024. Thus, the three-year average number of responses for the IRS is 148,181<sup>2</sup>.

### 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 a Summary Plan Description (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 60.8 million ERISA-covered policyholders. Data obtained from the 2020 Kaiser/HRET Survey of Employer Sponsored Health Benefits finds that 14 percent of covered workers are enrolled in a grandfathered plan. As stated

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<sup>2</sup> 2022: 60.8 million ERISA-covered policyholders x 14% of covered employees in grandfathered plans x (8% in HMOs + 13% in POSs) \*41.8% = 889,085 notices; 2023 and 2024: There will be no additional costs in 2023 and 2024 to prepare the notice, since all plans and issuers will have incurred the cost by 2022. Therefore, the three-year average number of responses is 296,362. The Agency shares this burden equally with the DOL. Thus, the three-year average number of respondents for IRS is 148,181.

in question 12, all grandfathered plans will be required to prepare this notice requirement. The data from the 2021 Kaiser/HRET Survey of Employer Sponsored Health Benefits finds that 16 percent of covered workers have an HMO option and that 9 percent of covered workers have a POS option. The Agency estimates that plans will produce 889,085 notices in 2022, and zero notices in 2023 and 2024. This results in a cost burden of approximately \$44,454 in 2022, and \$0 in 2023 and 2024. Therefore, the three-year average cost burden is approximately \$14,818. The Agency shares this burden equally with the Department of Labor. Therefore, IRS three-year average share of the cost burden is approximately \$7,409.

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 2799A-7 of the PHS Act, which contains the patient protections regarding choice of health care professional moved 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 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 decrease the hour burden by -784 hours compared with the prior submission, increases the number of responses by 20,048, and increases the cost burden by \$5,807 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 | 148,181   | 0                                 | 0                                       | 20,048                                      | 0                                            | 128,133             |
| Annual Time Burden (Hr)    | 2,810     | 0                                 | 0                                       | -784                                        | 0                                            | 3,534               |
| Annual Cost Burden (\$)    | 7,409     | 0                                 | 0                                       | 5,807                                       | 0                                            | 1,602               |

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 IRS 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 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.