SUPPORTING STATEMENT FOR PAPERWORK REDUCTION ACT 1995: OPT-IN STATE BALANCE BILL PROCESS

This ICR seeks approval for an extension of an existing control number.

A. JUSTIFICATION

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

The No Surprises Act was enacted as part of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260). Interim final rules published on July 13, 2021 implementing the No Surprises Act[1] 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 Internal Revenue Code (Code), section 716(a)-(d) of the Employee Retirement Income Security Act (ERISA), and section 2799A-1(a)-(d) of the Public Health Service Act (PHS Act). A group health plan that opts in to such a State law must do so for all items and services to which the State law applies. A self-insured 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.

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

The interim final rules allow plans to voluntarily opt into 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 State law must prominently display in its plan materials information about the emergency services and/or out-of-network services covered by the specified State law. This requirement helps ensure that plan participants and beneficiaries are aware of these protections.

1 86 FR 36872

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.

ERISA and regulations thereunder provide general standards for the delivery of all information employee benefit plans must furnish to participants, beneficiaries, and other individuals under Title I of ERISA (29 CFR. 2520.104b-1(b)). Plan administrators must use delivery methods reasonably calculated to ensure actual receipt of information by participants, beneficiaries, and other individuals (29 CFR 2520.104b-1(b)(1)). For example, in-hand delivery to an employee at his or her workplace is acceptable, as is material sent by first class mail. The Department amended ERISA's delivery standards in 2002 by establishing a safe harbor for the use of electronic media to furnish disclosures (the 2002 safe harbor; 29 CFR 2520.104b-1(c)). The 2002 safe harbor was not and is not the exclusive means by which a plan administrator may use electronic media to satisfy the general standard. However, plan administrators who satisfy the conditions of the safe harbor are assured that the general delivery requirements have been satisfied.

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 and these interim final rules amend and add provisions to existing rules under the Code, ERISA, and the PHS Act. However, only the Department of Health and Human Services (HHS) has jurisdiction over state and local government plans and individual market plans and only 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 interim final rules require that a plan that has chosen to opt into a State law must prominently display in its plan materials a statement describing the coverage of emergency services and/or out-of-network services a statement and 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 covered by the specified State law. The Department has not prescribed the specific format for that information, allowing plans to use materials already on hand to satisfy or else compose the notice. This requirement could not be

waved for small businesses, as participants need to be notified of their rights in order to be notified of the protections and utilize the provided protections. Also, because this requirement applies only if a plan has chosen to opt into a State law, application of the requirement is at the discretion of the plan, providing them with flexibility and choice.

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 notice, 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.

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

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

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.

The Department's notice required by 5 CFR 1320.8(d), which provided the public with 60 days to comment on the information collection, was published in the Federal Register on July 9, 2024 (89 FR 56416). No comments were received related to the ICR.

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.**
- **If this request for approval covers more than one form, provide separate hour burden estimates for each form.**
- **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.**
- **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.**

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 covered by the specified State law.

Currently, there are six states that allow self-funded plans to opt in: New Jersey, Georgia, Maine, Washington, Virginia, and Nevada.[2] According to the Nevada Department of Health and Human Services' 2024 Annual Report, 50 private entities or organizations have elected to participate in the state's balance billing law.[3] In addition, according to the Virginia State Corporation Commission, 509 private self-funded plans in Virginia have elected to participate in the state's balance billing law.[4] Furthermore, according to

2 Centers for Medicare and Medicaid Services, *Chart Regarding Applicability of the Federal Independent Dispute Resolution Process in Bifurcated States*, https://www.cms.gov/files/document/caa-federal-idr-applicability-chart.pdf.
3 Nevada Department of Health and Human Services' Office of Consumer Health Assistance, *Election by Entities and Organizations not Otherwise Covered to Submit to Provisions of NRS 439B.700 to 439B.760 As of January 1, 2024*, (2024), https://adsd.nv.gov/uploadedFiles/adsdnvgov/content/Programs/CHA/Self%20Insured%20Opt%20Ins%20as%20of%2008-01-23.pdf.
4 Virginia State Corporation Commission, https://www.scc.virginia.gov/balancebilling.

Washington's Office of the Insurance Commissioner, 561 private self-funded plans in Washington have elected to participate in the state's balance billing law.[5]

The Department does not have data on the number of self-insured plans that have opted into the balance billing law for, New Jersey, Georgia, and Maine. In order to estimate the number of self-insured plans that have opted into the balance billing law for these states, the Department has scaled Washington's estimate by the number of participants with private, self-insured ERISA-covered plans.

The Department also estimates that 17 percent of self-insured plans that opt in are newly opted in each year.[6] This information collection will account only for the burden on private, self-insured plans. Therefore, self-insured non-Federal governmental plans have been excluded from the total number of affected plans. For more information on the number of new private self-insured plans that have opted in, please see Figure 1.

Table 1. Estimated Number of Self-Insured Plans that have Opt-in

	Number of Self-Insured Plans that Opt-In	**Number of New Self-Insured Plans that Opt-In (assuming 17 percent are new)**	**Number of Non-Federal, Governmental Plans that have Opt-In**	**Number of Private, New Self-Insured Plans that Opt-In**
	(A)	**(B) = (A x 17 percent)**	**(C)**	**(D) = (B - C)**
New Jersey	695	125		125
Georgia	695	125		125
Maine	80	14		14
Washington	561	101	66	35
Virginia	509	92	43	49
Nevada	50	9	7	2
Total	**2,590**	**466**	**116**	**350**

The Department assumes that new self-insured plans will incur a one-time cost to prepare the disclosures. It is estimated that clerical workers (at a wage rate of $69.41) will take 30 minutes to review information and prepare disclosures, and a benefits manager (at a wage rate of $180.68) will take 15 minutes to review information.[7] However, because new

5 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.
6 This is the average mean based on statistics from Nevada, Virginia, and Washington.
7 Internal DOL calculation based on 2024 labor cost data. For a description of the Department's methodology for calculating wage rates, see https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-

plans may opt in annually, there will be ongoing costs each year.

Please see Table 2 for calculations and burden.

Table 2. Hour Burden

Activity	Number of Plans	Average Hour Burden	Wage Rate	Total Hour Burden	Equivalent Cost
	(A)	(B)	(C)	(D)	(E)
Private, New Self-Insured Plans that have Opt-In					
Clerical staff review information and prepare the disclosures	350	1	$69.41	350	$24,294
Benefit managers review information	350	0.5	$180.68	175	$31,619
Total	**350**	**-**	**-**	**525**	**$55,913**

Table 3. Estimated Annualized Respondent Cost and Hour Burden

Activity	Number of Respondents	Number of Responses per Respondent	Total Responses	Average Burden (Hours)	Total Burden (Hours)	Hourly Wage Rate	Equivalent Cost of Hour Burden
Private, New Self-Insured Plans that have Opt-In							
Clerical staff review information and prepare the	350	1	350	1	350	$69.41	$24,294

regulations/technical-appendices/labor-cost-inputs-used-in-ebsa-opr-ria-and-pra-burden-calculations-june-2019.pdf.

disclosures							
Benefit managers review information	350	1	350	0.5	175	$180.68	$31,619
Total	**350**	**-**	**700**	**-**	**525**	**-**	**$55,913**

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, 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.**

The average number of participants in a self-insured ERISA-covered plan that will opt into the six states' balance billing laws is 30,000.[8] The Department assumes that only

8 The Department estimated the average number of individuals in private sector, self-insured plans that have opted in across the six affected states. Thus, (10,500,000 participants with self-insured ERISA-covered plans)/ 350 self-

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 58.3 percent of plan documents will be mailed to participants.[9]

Please see Table 4 for calculations and burden.

Table 4. Cost Burden

Number of Participants	Electronic Disclosure Rate	Mailing Cost	Total Cost
(A)	(B)	(C)	(D) = (A x B x C)
30,000	58.3%	$0.05	$875

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.

There is no annualized cost to the Federal government.

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

insured ERISA-covered plans that have opted in = 30,000 participants per self-insured ERISA-covered plan. (Source: Employee Benefits Security Administration, *Health Insurance Coverage Bulletin, Abstract of Auxiliary Data for the March 2023 Annual Social and Economic Supplement to the Current Population Survey*, (Aug. 30, 2024), https://www.dol.gov/sites/dolgov/files/EBSA/researchers/data/health-and-welfare/health-insurance-coverage-bulletin-2023.pdf)

9 According to data from the National Telecommunications and Information Agency (NTIA), 37.4 % of individuals age 25 and over have access to the Internet at work. According to a Greenwald & Associates survey, 84% of plan participants find it acceptable to make electronic delivery the default option, which is used as the proxy for the number of participants who will not opt-out of electronic disclosure that are automatically enrolled (for a total of 31.4% receiving electronic disclosure at work). Additionally, the NTIA reports that 44.1% of individuals age 25 and over have access to the internet outside of work. According to a Pew Research Center survey, 61.0% of internet users use online banking, which is used as the proxy for the number of internet users who will affirmatively consent to receiving electronic disclosures (for a total of 26.9% receiving electronic disclosure outside of work). Combining the 31.4% who receive electronic disclosure at work with the 26.9% who receive electronic disclosure outside of work produces a total of 58.3% who will receive electronic disclosure overall.

The estimates reflect the update in eight states that allow self-funded plans to opt in: New Jersey, Georgia, Maine, Washington, Virginia, and Nevada. The wage rates and the electronic disclosure rate have also been updated. As a result, the number of responses has increased by 143 responses, the hour burden has increased by 214 hours, and the cost burden has increased by $769.

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.

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.

This information collection will display the expiration date for 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 INFORMATON EMPLOYING STATISTICAL METHODS.

There are no statistical methods used in this information collection.