SUPPORTING STATEMENT
Internal Revenue Service (IRS)
OMB Control Number 1545-2182
Affordable Care Act Internal Claims and Appeals and
External Review Procedure for ERISA Plans

1. CIRCUMSTANCES NECESSITATING COLLECTION OF INFORMATION

The Patient Protection and Affordable Care Act, Public Law 111-148, (the Affordable Care Act) reorganized, amended, and added 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.

Section 2719 of the PHS Act, codified at 42 USC 300gg-19, requires group health plans and health insurance issuers to implement an effective appeals process for coverage determinations and claims, including an internal appeal process and an external review process. The Department of the Treasury (Treasury), Department of Labor (DOL), and the Department of Health and Human Services (the Departments) issued final regulations implementing section 2719 of the PHS Act. Treasury implementing regulations are codified at 26 CFR 54.9815-2719.

26 CFR 54.9815-2719 provides that group health plans and health insurance issuers offering group health insurance coverage must comply with the internal claims and appeals processes set forth in 29 CFR 2560.503-1(b)(2)(ii) (the DOL claims procedure regulation) and update such processes in accordance with standards established by the Secretary of Labor, except to the extent those requirements are modified by 26 CFR 54.9815-2719(b)(2)(ii).

The DOL claims procedure regulation requires plans to provide every claimant who is denied a claim with a written or electronic notice that contains the specific reasons for denial, a reference to the relevant plan provisions on which the denial is based, a description of any additional information necessary to perfect the claim, and a description of steps to be taken if the participant or beneficiary wishes to appeal the denial. The regulation also requires that any adverse benefit determination upon review be in writing (including electronic means) and include specific reasons for the decision, as well as references to relevant plan provisions.

26 CFR 54.9815-2719(b)(2)(ii)(C) adds a requirement that non-grandfathered ERISA-covered group health plans provide to the claimant, free of charge, any new or additional evidence considered, relied upon, or generated by the plan or issuer in connection with the claim.[1]

1 Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. Additionally, before the plan or issuer can issue an adverse benefit determination on review based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale. The

26 CFR 54.9815-2719 requires group health plans and issuers offering group health insurance coverage to comply either with a State external review process or a Federal review process. The regulations provide a basis for determining when plans and issuers must comply with an applicable State external review process and when they must comply with the Federal external review process.

The No Surprises Act of 2020 (Public Law 116-260) expanded external reviews for certain surprise billing determinations. The Act added Section 9816 to the Internal Revenue Code (IRC). IRC Section 9816 applies to both grandfathered and non-grandfathered plans and coverage for surprise billing protections. The No Surprises Act also directed the Departments, in applying section 2719(b) of the PHS Act, to require the external review process to apply with respect to any adverse determination by a plan or issuer under the new provisions.

Treasury issued implementing regulations 26 CFR 54.9815-2719T (TD 9955). TD 9955 reflects the expansion of the external review requirement to grandfathered plans by the statute. The claims procedure regulation imposes information collection requirements as part of the reasonable procedures that an employee benefit plan must establish regarding the handling of a benefit claim. These requirements include third-party disclosure requirements that the plan must satisfy by providing information to participants and beneficiaries of the plan.

2. **USE OF DATA**

The third-party disclosure requirements, included in 26 CFR 54.9815-2719 and 26 CFR 54.9815-2719T, ensure that participants and beneficiaries (claimants) receive adequate information regarding the plan's claims procedures and the plan's handling of specific benefit claims. Claimants need to understand plan procedures and plan decisions to appropriately request benefits and/or appeal benefit denials.

The recordkeeping requirements allow the Departments to monitor compliance with the internal appeal and external review processes.

3. **USE OF IMPROVED INFORMATION TECHNOLOGY TO REDUCE BURDEN**

The regulations do not restrict use of electronic technology to process and pay claims, maintain information as to the basis for claim determination, or to generate correspondence related to claims processing decisions. 26 CFR 54.9815-2719 also incorporates, by reference, pertinent provisions of DOL's separate regulation, 29 CFR 2520.104b-1, facilitating and encouraging the use of electronic information technology.

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rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

4. **EFFORTS TO IDENTIFY DUPLICATION**

No duplication with other Federal statutes exists. In some circumstances, states may require substantially similar information to be provided to insured individuals. However, no duplication occurs because the same information disclosure may be used to satisfy duplicative or overlapping requirements.

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

The regulation applies to all employee benefit plans and therefore is likely to affect small entities (small businesses and small plans) that provide benefits. The Departments considered the potential burden on small entities in structuring the regulations by permitting plan sponsors the maximum possible flexibility in designing their plans.

For instance, plan sponsors are allowed to hire third-party service providers to carry out these claim administration responsibilities, letting them use the lowest cost method of compliance available. A majority of small plans purchase claims administration services from insurers, health maintenance organizations (HMOs), and other service providers. The Departments have taken this fact into account in deriving burden estimates. These service providers typically develop a single claims processing system to serve a large number of customers, including small entities. Thus, the infrastructure cost for this information collection is spread thinly over a large number of small plans. Moreover, small plans and their respective enrollees benefit equally from the service provider's expertise and ability to provide improved accuracy and timeliness in claims and appeals determinations.

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

The regulations consist of third-party disclosure and recordkeeping requirements that arise when individual claims for benefits occur. No information is reported to the Federal Government. Every claim event is normally of importance to the specific participant who relies on an employee benefit plan to provide the promised benefit. The information collection provisions of the regulation ensure that sufficient information is provided to:
a) participants and beneficiaries so that they may fully exercise their rights under their employee benefit plans, and
b) fiduciaries responsible for operating plans in accordance with their terms.

If this collection is not conducted or is conducted less frequently, participants and beneficiaries will not have the information necessary to fully exercise their rights and plan fiduciaries will not be able to responsibly operate their plans.

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

26 CFR 54.9815-2719 incorporates the DOL claims procedure regulation at 29 CFR 2560.503-1 for internal claims and appeals processes. As reflected in the footnotes, the incorporated regulation impose special timing requirements for the handling of claims under group health plans. Depending on circumstances indicating the urgency of the need for a claims decision, group health plans may be required to notify claimants about health benefit claim determinations in fewer than 30 days.

First, for claims involving "urgent care," the regulation requires, in general, that claimants be notified of health benefit determinations "as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan [...]".[2] In cases involving urgent care where the health claim is a request to extend the time period or number of treatments of ongoing medical care (referred to as "concurrent care decisions"), this period is 24 hours.[3]

Second, for "pre-service" claims, the regulation requires that claimants be notified of health benefit determinations "within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan."[4] Pre-service claims involve plan requirements that a claimant obtain approval from the plan prior to receiving health care services or products in order to maintain eligibility for benefits.

Third, for "post-service" health benefit claims, the regulation requires notification of an adverse benefit determination "within a reasonable period of time, but not later than 30 days after receipt of the claim."[5] Even though 30 days is the maximum response time for these claims, a plan must provide a determination sooner if it is reasonable to do so. Disability benefit claims are subject to a similar construct, except that the maximum response time is 45 days.[6]

Appeals of denied claims must be decided within similar, short time limits.

These timing requirements are reasonably related to important policy objectives in an area of important public concern. For example, the shortest time frame for "urgent care" claims applies only under circumstances in which delay could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or where delay would subject the claimant to severe pain. The next shortest time frame applies under circumstances in which medical care, while not urgent, has not been provided to a claimant who needs treatment for a medical problem and where the plan itself requires pre-approval of the medical care before providing coverage. Post-service health claims and disability claims also involve important concerns relating to the sick and disabled, but under these circumstances plans may take at least 30 days to respond if it is reasonably necessary to do so.

2 29 CFR 2560.503-1(f)(2)(i).
3 29 CFR 2560.503-1(f)(2)(ii)(B).
4 29 CFR 2560.503-1(f)(2)(iii)(A)
5 29 CFR 2560.503-1(f)(2)(iii)(B)
6 29 CFR 2560.503-1(f)(3)

Another reason why these time frames are important is that these notices relate to the payment of money by a plan to claimants to whom fiduciary responsibilities are owed. Without enforcement of reasonable deadlines, payors could be given a financial incentive to delay the payments, and this would likely be inconsistent with appropriate fiduciary standards.

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

In response to the Federal Register notice dated March 4, 2026 at 91 FR 10691, we received no comments during the comment period.

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

No payments or gifts have been provided to any respondents.

10. **ASSURANCE OF CONFIDENTIALITY OF RESPONSES**

The regulation involves disclosures of information by plan administrators to plan participants. Issues of confidentiality between third parties do not fall within the scope of this information collection request.

11. **JUSTIFICATION OF SENSITIVE QUESTIONS**

A plan provides information directly to the claimant. Sensitive issues, such as health information, would relate to the claim for which payment is sought, and the initial filing would have been initiated by the claimant or with the claimant's authorization.

12. **ESTIMATED BURDEN OF INFORMATION COLLECTION**

Background:
Because ERISA-covered plans already are required to comply with the DOL claims procedure regulation (OMB Control number 1210-0053), the Departments did not attribute any cost for these plans to comply with that information collection.

26 CFR 54.9815-2719(b)(2)(ii)(C) provides additional standards non-grandfathered ERISA-covered plans must meet. The requirement to provide claimants, free of charge, any new or additional evidence considered relied upon, or generated by the plan or issuer in connection with the claim,[7] and the requirement to comply either with a State external review process or

7 Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. Additionally, before the plan or issuer can issue an adverse benefit determination on

a Federal review process increases the hour and cost burden imposed on plans and issuers to prepare and deliver the additional information to the claimant.

The burden associated with the additional standards that non-grandfathered and grandfathered ERISA-covered plans must meet is shared equally between DOL and the Treasury. The burden discussion below encompasses the combined burden of both agencies. A summary at the end describes the share of the burden allocated to the Treasury.

Ongoing burdens are a function of the number of external appeals filed as well as those requiring a fair and full review, which are in turn a function of health claims volume, as well as the denial and appeal rates.

Wage Rate Determinations

The Departments estimate that several types of personnel will perform the tasks associated with information collection requests at an hourly wage rate of $69.41 for clerical personnel, $208.88 for a physician, $177.97 for a legal professional, $100.21 for a human resource specialist, and $64.46 for a medical secretary.[8]

Claims and Appeals

Table 1 below describes the affected participants and relevant data necessary to estimate the burden associated with claims and appeals.

Table 1: *Annual Estimated Claims and Appeals in Private Sector ESI*		
(A)	Total Enrollees	135,600,000
(B)	Non-Grandfathered Enrollees	116,616,000
(C)	Affected Participants	90,100,000
(D)	Self-Insured Plan Participants	78,900,000
(E)	Fully-Insured Grandfathered Plan Participants	11,200,000
(F)	Out-of-Network Claims Increase	2%
(G)	Appeal-to-Member Ratio	0.00013
(H)	Eligibility Rate for External Appeal	0.75
(I)	Medical Appeals	120,316
(J)	Administrative Appeals	296,003
(K)	Claims w/ Additional Evidence	70%
((I) + (J)) x (K)	**Fair and Full Reviews**	**291,423**
(C x F x G)	**External Appeals**	**11,956**

review based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

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

(C x F x G) ÷ (H)	**External Appeals Submitted**	**15,941**

The transaction burden will vary widely with the type and complexity of claim in question, but the mix of claims and associated burdens generally are expected to be similar across plans of the same type. The average time required for this information collection associated with any particular type of health benefit claim transaction will range from five minutes for a medical secretary to produce a notice for a fair and full review to as many as 20 minutes for a physician to draft a response to an appeal brought before an external, independent review organization. Detailed calculations of the hour burden are provided in Table 2 below.

Table 2: *Hour Burden and Equivalent Cost for Claims and Appeals*

Description	Entities	Hours per Entity	Wage Rate	Hour Burden	Cost Equivalent
	(A)	(B)	(C)	(A x B)	(A x B x C)
Medical Secretary Produces Fair and Full Review Notice	291,423	5/60	$64.46	24,285.3	$1,565,427.22
Physician Drafts Appeal Response	11,956	20/60	$208.88	3985.3	$832,456.43
Three-Year Total	910,137			84,812	$7,193,651
Annual Average	**303,379**			**28,271**	**$2,397,884**

*The annual average cost is calculated as the total cost averaged across three years

The Departments estimate the average burden hours for claims and appeals are estimated at 28,271 hours annually at an equivalent cost of $2,397,884.

Federal External Review

The disclosure requirements of the Federal External Review process require:

1. a preliminary review by plans of requests for external appeals;
2. Independent Review Organizations (IROs) to notify claimants of eligibility and acceptance for external review;
3. the plan or issuer to provide IROs with documentation and other information considered in making the adverse benefit determination;
4. the IRO to forward to the plan or issuer any information submitted by the claimant;
5. the plan to notify the claimant and IRO if it reverses its decision;
6. the IRO to notify the claimant and plan of the result of the final external appeal (burden previously accounted for);
7. the IRO to maintain records for six years.

The Departments estimate that there are approximately 78.9 million participants in self-insured ERISA-covered plans.[9] In the States which currently have no external review laws or

9 U.S. Department of Labor, EBSA Abstract of Auxiliary Data for the March 2023 Annual Social and Economic Supplement to the Current Population Survey.

whose laws do not meet the federal minimum requirements,[10] the Departments estimate that there are approximately 17.2 million participants in ERISA-covered plans. Additionally, 11.2 million participants in grandfathered plans will be required to be covered by the external review requirement. Accordingly, these estimates lead to a total of 90.1 million participants that would be affected by the external review requirements.

The Departments estimate that there are 1.3 external appeals for every 10,000 participants.[11] Additionally, as stated in Table 1, the Departments estimate that there will be approximately 11,956 external appeals annually. Experience from North Carolina indicates that about 75 percent of requests for external appeals are actually eligible to proceed to an external review,[12] therefore it is expected that there will be about 15,941 (11,956 ÷ 0.75) requests for appeals.

The Departments estimate that a human resource specialist will spend approximately 15 minutes for each preliminary external request.[13] Plans will already have conducted internal reviews for eligible claimants; therefore, the required information for plans to make this determination should be readily available. Detailed calculations of the hour burden are provided in Table 3 below.

IROs must also send each eligible claimant a notice of eligibility and acceptance. The Departments assume that a clerical professional at the IRO will spend on average five minutes per claimant preparing the notice.

IROs are required to send to plans all documents that claimants submit. The Departments do not know what fraction of claimants will submit additional documentation, but for purposes of this burden analysis assume that half of claimants (5,978) do. The Departments assume that a clerical professional for the IRO will spend on average five minutes per claimant preparing and forwarding the required documents. Detailed calculations of the hour burden are provided in Table 3 below.

Once an eligibility determination is made, plans must provide the IRO with all documentation and other information considered in making an adverse benefit determination. The Departments assume that a clerical professional for plans will spend an average of five minutes in order to send documentation to the IRO for each request. Detailed calculations of the hour burden and cost are provided in Table 3 below.

IROs are required to notify the claimant and plan of the result of the final external appeal.

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10 These states are Alabama, Texas, Florida, Georgia, and Wisconsin. See *Affordable Care Act: Working with States to Protect Consumers*, available at https://www.cms.gov/CCIIO/Resources/Files/external_appeals.html

11 AHIP Center for Policy and Research, *An Update on State External Review Programs, 2006*, July 2008.

12 North Carolina Department of Insurance, *Health Insurance Smart NC: Annual Report on External Review Activity 2013*.

13 Internal DOL calculation based on 2020 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-regulations/technical-appendices/labor-cost-inputs-used-in-ebsa-opr-ria-and-pra-burden-calculations-june-2019.pdf.

The Departments estimate that preparing and sending the notices for each of the external reviews will take a clerical professional at the IRO on average five minutes per claimant. Detailed calculations of the hour burden are provided in Table 3 below.

IROs also are required to maintain records of all claims and notices associated with the external review process for six years. The Departments believe that these documents will be retained as a customary part of business but estimate that a clerical professional will spend an additional five minutes per claimant ensuring all files are complete. Detailed calculations of the hour burden are provided in Table 3 below.

Table 3. -- *Hour Burden and Equivalent Cost for Federal External Reviews*

Description	Entities	Hours per Entity	Wage Rate	Hour Burden	Cost Equivalent
	(A)	(B)	(C)	(A x B)	(A x B x C)
Human Resource Specialist Reviews Appeal Requests	15,941	15/60	$100.21	3,985.3	$399,361.90
Clerical Professional Notifies Claimant of Appeal Acceptance	11,956	5/60	$69.41	996.3	$69,155.50
Clerical Professional Sends Plan Claimant Documentation from IRO	5,978	5/60	$69.41	498.2	$34,577.75
Clerical Professional Sends IRO Adverse Determination Info from Plan	11,956	5/60	$69.41	996.3	$69,155.50
Clerical Professional Notify Claimant and Plan of Final External Appeal Result	11,956	5/60	$69.41	996.3	$69,155.50
Clerical Professional Provides Records for Claims and Appeals	11,956	5/60	$69.41	996.3	$69,155.50
Three-Year Total	209,229			25,406	$2,131,685
Annual Average	**69,743**			**8,469**	**$710,562**

*The annual average cost is calculated as the total cost averaged across three years

The Departments estimate the average burden hours for Federal External Reviews are 89,469 hours annually at an equivalent cost of $710,562.

Summary

As reflected in Table 4, the total annual burden associated with claims, appeals, and external review is approximately 36,739 hours at an equivalent cost of $3,108,445 annually. The burden is shared equally between the DOL and Treasury. The Treasury's annual share is 18,370 hours at an equivalent cost of $1,554,223 annually, as reflected in Table 4.

Table 4: 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
Medical Secretary Produces Fair and Full Review Notice	14,442	1	14,442	5/60	1,203.5	$64.46	$77,577.61
Physician Drafts Appeal Response	592	1	592	20/60	197.3	$208.88	$41,218.99
Medical Secretary Produces Fair and Full Review Notice	276,981	1	276,981	5/60	23,081.8	$64.46	$1,487,849.61
Physician Drafts Appeal Response	11,364	1	11,364	20/60	3,788.0	$208.88	$791,237.44
Human Resource Specialist Reviews Appeal Requests	15,941	1	15,941	15/60	3,985.3	$100.21	$399,361.90
Clerical Professional Notifies Claimant of Appeal Acceptance	11,956	1	11,956	5/60	996.3	$69.41	$69,155.50
Clerical Professional Sends Plan Claimant Documentation from IRO	5,978	1	5,978	5/60	498.2	$69.41	$34,577.75
Clerical Professional Sends IRO Adverse Determination Info from Plan	11,956	1	11,956	5/60	996.3	$69.41	$69,155.50
Clerical Professional Notify Claimant and Plan of Final External Appeal Result	11,956	1	11,956	5/60	996.3	$69.41	$69,155.50
Clerical Professional Provides Records for Claims and Appeals	11,956	1	11,956	5/60	996.3	$69.41	$69,155.50
Annual Total	2,588,299	0.1450	375,202**		36,739		$3,108,445
Treasury Portion	**1,294,150**	**0.1450**	**187,601**		**18,370**		**$1,554,223**

* The total number of respondents is the total number of ERISA-covered group health plans.

**The number of responses was calculated in the following manner: 15,942 (Preliminary Review) + 11,956 (Notice of Eligibility) + 11,956 (Plan provides IRO with documentation and other information considered in making adverse benefit determination) + 5,978 (IRO send documentation regarding adverse benefit determination to Plan) + 11,956 (IRO sends notice to plan regarding final results of the review) + 11,956 (Record Retention) + 291,423 (Full and Fair Review) + 11,956 (External Review) + 2,079 (Linguistically Appropriate Notices) = 375,202.
The hour burden for Linguistically Appropriate Notices is de minimis.

Note: The numbers in the table may not sum due to rounding.

13. **ESTIMATED TOTAL ANNUAL COST BURDEN TO RESPONDENTS**

Claims and Appeals

The Departments estimate that approximately 42 percent of these notices will be mailed and approximately 58 percent will be delivered electronically. The Departments assume that each

of these notices will be five pages and, for mailed notices, have a cost burden of $0.98. [14] See Table 5 below for more detailed calculations of the cost burdens.

Table 5 -- *Cost Burden for Claims and Appeals*

Description	Responses	Mailing Rate	Notices Mailed	Unit Cost	Annual Cost
	(A)	(B)	(A x B)	(C)	(A x B x C)
Full and Fair Review Notice	291,423	42%	121,523	$0.98	$119,092.54
External Review Notice	11,956	42%	4,986	$0.98	$4,886.28
Three-Year Total	910,137		379,527		$371,936
Annual Average	**303,379**		**126,509**		**$123,979**

*The annual average cost is calculated as the total cost averaged across three years

The total estimated cost burden to mail responses prepared in-house and by service providers is $112,801 annually.

Non-English Language Assistance

Plans and issuers must provide participants and beneficiaries who reside in a county where ten percent or more of the population residing in the county is literate only in the same non-English language with a one-sentence statement in all notices written in the applicable non-English language about the availability of language services. In addition, plans and issuers are required to provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request.

The Departments understand that oral translation services are already provided for nearly all covered participants and beneficiaries. Therefore, no additional burden is associated with this requirement.

The Departments expect that the largest cost associated with the rules for culturally and linguistically appropriate notices will be for plans and issuers to provide notices in the applicable non-English language upon request. Based on the American Community Survey (ACS),[15] the Departments estimate that there are about 8.5 million individuals living in counties that are literate in a non-English Language. The ACS does not have insurance coverage information. Therefore, to estimate the percentage of the 8.5 million affected individuals that were insured, the Departments used the percent of the population in the state that reported being insured by private employer insurance from the 2023 Current Population Survey (CPS).[16] This results in an estimate of approximately 3.3 million individuals who are

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15 Data are from the 2022 American Community Survey 5-Year estimates (2018-2022) and available at www.census.gov/acs. Individuals counted reside in counties where at least 10 percent of the county speak a particular non-English language and speak English less than "very well" are counted.

16 Please note that using state estimates of insurance coverage could lead to an over estimate if those reporting in

eligible to request translation services.

In discussions with the regulated community, the Departments found that experience in California, which has a state law requirement for providing translation services, indicates that requests for translations of written documents averages 0.098 requests per 1,000 members. While the California law is not identical, and the demographics for California do not match other counties, for purposes of this analysis, the Departments used this percentage to estimate the number of translation service requests that plan and issuers can expect to receive. Industry experts also told the Departments that while the cost of translation services varies, $500 per document is a reasonable approximation of translation cost.

Using the ACS and the CPS, the Departments estimate that there are 21.2 million individuals insured through private employer sponsored insurance living in the affected counties. See Table 6 below for a detailed estimate of the cost to provide translation services for this population.

Table 6 -- *Cost Burden for Linguistically Appropriate Notices*

Description	Responses	Request Rate	Translation Requests	Translation Cost	Annual Cost
	(A)	(B)	(C)	(D)	(A x B x C x D)
Notice Translation Expenses	21,204,723	0.0098%	2,078	$500.00	$1,039,000.00
Three-Year Total	63,614,168		6,234		$3,117,000
Annual Average	**21,204,723**		**2,078**		**$1,039,000**

*The annual average cost is calculated as the total cost averaged across three years

Federal External Review

The preliminary review by grandfathered and non-grandfathered ERISA plans of the request for external review is estimated to be a single page. Once an eligibility determination is made, plans must provide the IRO with all documentation and other information considered in making an adverse benefit determination. The Departments assume that each set of documentation will be 20 pages. IROs must also send each eligible claimant a notice of eligibility and acceptance, which the Departments assumes will be a single page.

Additionally, IROs are required to send to plans all documents that claimants submit. The Departments do not know what fraction of claimants will submit additional documentation, but for purposes of this burden analysis assume that half of claimants (5,978) do. Finally, IROs are required to notify the claimant and plan of the result of the final external appeal. The Departments assume that such documentation, as well as the final external appeal result, will be 10 pages. The Departments are not able to estimate the number of reversals and the

the ACS survey that they speak English less than “very well” are less likely to be insured than the state average.

associated notices to claimants and IROs that plans would send due to reversing its prior decision but believes the number would be small.

The Departments assume that 100 percent of notices related to the external review will be mailed to participants and that each page of a physical notice will incur a cost of $0.05 while each individual notice will incur a cost of $0.73 for postage. For detailed calculations of the cost burden related to the Federal External Review, see Table 7 below.

Table 7. -- *Cost Burden for Federal External Review*					
Description	Responses	Mailing Rate	Notices Mailed	Unit Cost	Annual Cost
	(A)	(B)	(C)	(A x B)	(A x B x C)
Request for External Review	15,941	100%	15,941	$0.78	$12,433.98
Plans Send IRO Documentation	11,956	100%	11,956	$1.73	$20,683.88
IROs Send Claimants Eligibility Notice	11,956	100%	11,956	$0.78	$9,325.68
IROs Send Plans Documentation from Claimants	5,978	100%	5,978	$1.23	$7,352.94
IROs Notify Claimant and Plan of Final External Appeal Outcome	11,956	100%	11,956	$1.23	$14,705.88
Three-Year Total	53,802		53,802		$193,507
Annual Average	**17,934**		**17,934**		**$64,502**

Summary

In total, the cost burden associated with claims, appeals, language translation, and external review is approximately $1,227,481 annually. **Therefore, the Treasury's share of the cost burden is approximately $613,741 annually.**

14. ESTIMATED ANNUALIZED COST TO THE FEDERAL GOVERNMENT

There are no costs to the Federal government associated with this information collection.

15. REASONS FOR CHANGE IN BURDEN

Adjustments to the burden estimates result from updated estimates on the number of ERISA-covered plans and policyholders and increases in wage rates and postage rates, as well as a change to how the number of plans is calculated. These changes result in 713,149 fewer respondents, a decrease of 202,973 responses, a decline of the hour burden by 677 hours, and increase of the cost burden by $11,715 compared with the prior submission.

16. PLANS FOR TABULATION, STATISTICAL ANALYSIS AND PUBLICATION

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

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 collection sunsets 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.