

## **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 previously imposed, 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 of 2021, sunset section 2719A of the PHS Act after the new emergency services protections under the No Surprises Act took effect. The provisions of section 2719A of the PHS Act no longer apply with respect to plan years beginning on or after January 1, 2022.<sup>1</sup> The No Surprises Act recodified 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

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<sup>1</sup> 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.

Related to Surprise Billing; Part I” (86, FR 36872, henceforth 2021 interim final regulations) added a sunset clause to the patient protection provisions codified in the 2015 final regulations, and recodified the provisions related to choice of health care professional without substantive change at 26 CFR 54.9822-1T, 29 CFR 2590.722, and 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 previously applied 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.<sup>2</sup> Therefore, the requirements regarding patient protections, including those related to choice of health care professional under the 2021 interim final regulations, apply to grandfathered health plans for plan years beginning on or after January 1, 2022.

The Centers for Medicare & Medicaid Services is requesting an extension of the Office of Management and Budget (OMB) approval for the information collections included in this information collection request (ICR).

## **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, previously imposed, 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

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<sup>2</sup> 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 recodified patient protections provisions, including those related to choice of choice of health care professional, apply to grandfathered health plans.

is important that individuals enrolled in a plan or health insurance coverage know of their right to (1) choose a primary care provider or a pediatrician when a plan or issuer requires participants (in the individual market, primary subscribers) to designate a primary care physician; and (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 previously included in 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 or 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 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.

2. Information Users

The rescission notice will be used by plans and issuers 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 rights will be used by plans and issuers to inform individuals of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires participants or primary subscribers to designate a primary care physician; and (2) obtain obstetrical or gynecological care without prior authorization.

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

There is no duplication of efforts for these information collections.

5. Small Businesses

These information collections 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 rescissions and 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.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

A notice will be published in the Federal Register, providing the public with a 60-day period to submit written comments on this ICR.

9. Payments/Gifts to Respondents

No payments or gifts are associated with these information collections.

10. Confidentiality

This ICR includes third-party disclosures, and the issue of confidentiality between third parties is out of scope for the information collections.

11. Sensitive Questions

These information collections do not involve any sensitive questions.

12. Burden Estimates (Hours & Wages)

The burden and equivalent cost estimates have been updated based on recent data. We used data from the Bureau of Labor Statistics to calculate the median labor costs (with the median hourly wage rates doubled to include the cost of fringe benefits and other indirect costs) for estimating the burden and equivalent cost associated with this ICR.<sup>3</sup>

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<sup>3</sup> May 2023 Occupational Employment Statistics found at [https://www.bls.gov/oes/current/oes\\_nat.htm](https://www.bls.gov/oes/current/oes_nat.htm).

**TABLE 1. Adjusted Hourly Wages Used in Burden Estimates**

Occupation Title	Occupational Code	Median Hourly Wage (\$/hour)	Cost of Fringe Benefits and Other Indirect Costs (\$/hour)	Adjusted Hourly Wage (\$/hour)
Secretaries and Administrative Assistants	43-6014	\$21.29	\$21.29	\$42.58
Lawyer	23-1011	\$70.08	\$70.08	\$140.16
Compensation and Benefits Manager	11-3111	\$65.57	\$65.57	\$131.14

### Rescissions Notice

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 385 issuers issuing approximately 12 million policies in the individual market during a year.<sup>4</sup> Based on the experience of issuers in the Federally-facilitated Exchanges in 2022, it is estimated that a very small percentage of policies are rescinded each year (approximately 0.00031%). Based on this figure, it is estimated that approximately 37 policies in the individual market are rescinded during a year, which would result in approximately 37 notices being sent to affected policyholders, with approximately 58 percent transmitted electronically and approximately 42 percent mailed.<sup>5</sup> It is estimated that each rescission notice will require 15 minutes of legal professional time (at an hourly rate of \$140.16) on the part of an issuer, with a total annual burden of approximately 9.3 hours for all issuers with an equivalent annual cost of approximately \$1,303. It is estimated that issuers will need one minute per notice of clerical professional time (at an hourly rate of \$42.58) to distribute the notice to each policyholder by mail, resulting in a total annual burden of approximately 0.3 hours<sup>6</sup>, with an equivalent annual cost of approximately \$11. Assuming that the cost of electronic distribution is minimal, this results in a total annual hour burden of approximately 9.6 hours with an equivalent annual cost of approximately \$1,314.

### 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 must notify policyholders of their State and local government plans and individual market plans, both those that are grandfathered and those

<sup>4</sup> Estimate based on medical loss ratio (MLR) reports submitted by issuers to CMS for the 2022 MLR reporting year.

<sup>5</sup> See calculation at <https://www.federalregister.gov/documents/2024/09/23/2024-20612/requirements-related-to-the-mental-health-parity-and-addiction-equity-act#footnote-383-p77685>.

<sup>6</sup> Approximately 37 notices x 41.7% sent by mail = approximately 16 notices sent by mail x 1 minute per notice = approximately 0.26 hours.

that are not grandfathered, have already incurred the one-time burden and cost to prepare and incorporate this notice in their existing plan documents following the implementation of the 2021 interim final regulations.

### 13. Capital Costs

#### Rescissions Notice

Issuers will incur cost to print and mail 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 \$0.73 per notice.<sup>7</sup> We estimate that approximately 58 percent of the 37 notices will be delivered electronically<sup>8</sup> at minimal cost. Therefore, it is estimated that the annual cost burden associated with mailing approximately 16 notices will be approximately \$12.

**TABLE 2. Annual Printing and Materials Costs Related to the Rescissions Notice**

Estimated Number of Respondents	Estimated Number of Responses	Total Estimated Printing and Materials Cost
385	37	\$12

#### 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 approximately 58 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.

There are an estimated 90,887 State and local government employers<sup>9</sup> offering health plans to their employees. Approximately 90.5 percent of these employers offer a plan option with some form of managed care.<sup>10</sup> It is therefore estimated that approximately 82,253 State and

<sup>7</sup> U.S. Postal Service. (n.d.). Mailing and Shipping Prices. Retrieved December 5, 2024, from <https://www.usps.com/business/prices.htm>.

<sup>8</sup> See calculation at <https://www.federalregister.gov/documents/2024/09/23/2024-20612/requirements-related-to-the-mental-health-parity-and-addiction-equity-act#footnote-383-p77685>.

<sup>9</sup> Estimate based on the 2022 Census of Governments, available at <https://www.census.gov/data/tables/2022/econ/gus/2022-governments.html>.

<sup>10</sup> Estimate based on the Medical Expenditure Panel Survey – Insurance Component (MEPS-IC) public-sector data for 2022 (available at [https://www.meps.ahrq.gov/data\\_stats/summ\\_tables/insr/national/series\\_3/2022/ic22\\_iiia\\_g.pdf](https://www.meps.ahrq.gov/data_stats/summ_tables/insr/national/series_3/2022/ic22_iiia_g.pdf)).

local government plan sponsors will need to send a notice of right to designate a primary care provider each year.

It is estimated that there are approximately 12.9 million State and local government-sponsored plan policyholders.<sup>11</sup> Based on data from the KFF 2024 Employer Health Benefits Survey, we estimate that 13 percent of covered workers in State and local government plans are enrolled in a health maintenance organization (HMO) option and that 11 percent of covered workers are enrolled in a point of service (POS) option.<sup>12</sup> Therefore, there are an estimated 3,097,113 policyholders in HMO and POS plan options sponsored by State and local government entities.

There are an estimated 385 issuers offering individual market coverage and an estimated 12,000,000 policyholders with individual market coverage.<sup>13</sup> It is estimated that approximately 89 percent of individual market policyholders, or approximately 10,644,153 policyholders, have HMO, POS, or exclusive provider organization (EPO) plan options.<sup>14</sup> Given that most individual market policyholders have managed care options, it is assumed that most, if not all, of the 385 issuers in the individual market offer such options and would therefore need to send a notice of right to designate a primary care provider.

Based on the assumptions and calculations above, it is estimated that approximately 82,253 plan sponsors and 385 issuers will produce a total of 13,741,266 notices annually, approximately 42 percent of which will be delivered in print. This results in a total annual capital cost of approximately \$143,253.<sup>15</sup>

**TABLE 3. Annual Printing and Materials Costs Related to Notice of Right to Designate a Primary Care Provider**

Estimated Number of Respondents	Estimated Number of Responses	Total Estimated Printing and Materials Cost
82,638	13,741,266	\$143,253

#### 14. Cost to Federal Government

<sup>11</sup> The MEPS-IC public-sector data for 2022 indicate that there are 19,231,948 State and local government employees and that 67.1 percent of employees are enrolled in health plans sponsored by State and local government entities, leading to an estimated 12.9 million policyholders.

<sup>12</sup> Available at <https://www.kff.org/health-costs/report/2024-employer-health-benefits-survey/>.

<sup>13</sup> Estimates based on MLR reports submitted by issuers to CMS for the 2022 MLR reporting year.

<sup>14</sup> Estimate based on data reported in Unified Review Template Submissions for the 2025 plan year. Rate review data available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/ratereview.html>.

<sup>15</sup> 13,741,266 notices x 41.7% = 5,730,108 notices printed x \$0.05 per page x 1/2 pages per notice = approximately \$143,253.

There is no cost to the Federal government.

15. Changes to Burden

The estimated burden associated with the rescissions notice has decreased by approximately 235 hours (from approximately 245 hours to approximately 10 hours), due to a decrease in the estimated number of rescissions. The estimated burden associated with the notice of right to designate a primary care provider has decreased by approximately 569 hours (from approximately 569 hours to 0 hours), as State and local government plan sponsors and issuers in the individual markets have already incurred the one-time burden and cost to prepare and incorporate this notice in their existing plan documents following the implementation of the 2021 interim final regulations. Therefore, the total estimated burden has decreased by approximately 804 hours.

16. Publication/Tabulation Dates

There are no plans to publish the outcomes of the information collections, as they entail third-party disclosures.

17. Expiration Date

There are no instruments associated with these information collections.