



This document is scheduled to be published in the Federal Register on 02/19/2016 and available online at <http://federalregister.gov/a/2016-03473>, and on [FDsys.gov](http://FDsys.gov)

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS-10325 and CMS-10330]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

ACTION: Notice.

**SUMMARY:** The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (PRA), federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, and to allow a second opportunity for public comment on the notice. Interested persons are invited to send comments regarding the burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

**DATES:** Comments on the collection(s) of information must be received by the OMB desk officer by **INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER**:

**ADDRESSES:** When commenting on the proposed information collections, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be received by the OMB desk officer via one of the following transmissions:

OMB, Office of Information and Regulatory Affairs

Attention: CMS Desk Officer

Fax Number: (202) 395-5806 OR

E-mail: [OIRA\\_submission@omb.eop.gov](mailto:OIRA_submission@omb.eop.gov)

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access CMS' Web Site address at <http://www.cms.hhs.gov/PaperworkReductionActof1995>.
2. E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to [Paperwork@cms.hhs.gov](mailto:Paperwork@cms.hhs.gov).
3. Call the Reports Clearance Office at (410) 786-1326.

FOR FURTHER INFORMATION CONTACT: Reports Clearance Office at (410) 786-1326.

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501-3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term "collection of information" is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires federal agencies to publish a 30-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice that summarizes the following proposed collection(s) of information for public comment:

1. Type of Information Collection Request: Revision of a currently approved collection; Title of Information Collection: Enrollment Opportunity Notice Relating to Lifetime Limits; Required Notice of Rescission of Coverage; and Disclosure Requirements for Patient Protection under the Affordable Care Act; Use: Section 1251 of the Affordable Care Act provides that certain plans and health insurance coverage in existence as of March 23, 2010, known as grandfathered health plans, are not required to comply with certain statutory provisions in the Act. 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” require that, to maintain its status as a grandfathered health plan, a plan must maintain records documenting the terms of the plan in effect on March 23, 2010, and any other documents that are necessary to verify, explain or clarify status as a grandfathered health plan. The plan must make such records available for examination upon request by participants, beneficiaries, individual policy subscribers, or a State or Federal agency official. A grandfathered health plan is also required to include a statement in any summary of benefits under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Affordable Care Act, and providing contact information for participants to direct questions and complaints. In addition, a grandfathered group health plan that is changing health insurance issuers is required to provide the succeeding health insurance issuer (and the succeeding health insurance issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health insurance coverage sufficient to make a determination whether the standards of paragraph (g)(1) of the interim final regulations are exceeded. It is also required that, for an insured group health plan (or a multiemployer plan) that is a grandfathered plan, the relevant policies, certificates, or contracts of insurance, or plan documents

must disclose in a prominent and effective manner that employers, employee organizations, or plan sponsors, as applicable, are required to notify the issuer (or multiemployer plan) if the contribution rate changes at any point during the plan year. Form Number: CMS–10325 (OMB Control Number: 0938–1093); Frequency: Occasionally; Affected Public: State, Local, or Tribal Governments, Private Sector; Number of Respondents: 55,378; Total Annual Responses: 6,858,135; Total Annual Hours: 248. (For policy questions regarding this collection contact Russell Tipps at (301) 492-4371).

2. Type of Information Collection Request: Revision of a currently approved collection; Title of Information Collection: Enrollment Opportunity Notice Relating to Lifetime Limits; Required Notice of Rescission of Coverage; and Disclosure Requirements for Patient Protection under the Affordable Care Act; Use: Sections 2711, 2712 and 2719A of the Public Health Service Act, as added by the Affordable Care Act, and 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) contain enrollment opportunity, rescission notice, and patient protection disclosure requirements that are subject to the Paperwork Reduction Act of 1995. The enrollment opportunity notice was to be used by health plans to notify certain individuals of their right to re-enroll in their plan. This notice was a one-time requirement and has been discontinued. The rescission notice will be used by health plans to provide advance notice to certain individuals that their coverage may be rescinded as a result of fraud or intentional misrepresentation of material fact. The patient protection notification will be used by health plans to inform certain individuals of their right to choose a primary care provider or pediatrician and to use obstetrical/gynecological services without prior authorization.

The related 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”. The final regulations also require that, if State law prohibits balance billing, or a plan or issuer is contractually responsible for any amounts balanced billed by an out-of-network emergency services provider, a plan or issuer must provide a participant, beneficiary or enrollee adequate and prominent notice of their lack of financial responsibility with respect to amounts balanced billed in order to prevent inadvertent payment by the individual. Form Number: CMS–10330 (OMB Control Number: 0938–1094); Frequency: Occasionally; Affected Public: Private Sector, State, Local, or Tribal Governments; Number of Respondents: 3,171; Total Annual Responses: 238,244; Total Annual Hours: 897. (For policy questions regarding this collection contact Russell Tipps at 301- 492-4371).

Dated: February 16, 2016. \_\_\_\_\_

William N. Parham, III,

Director, Paperwork Reduction Staff,

Office of Strategic Operations and Regulatory Affairs.

Billing Code: 4120-01-U-P

[FR Doc. 2016-03473 Filed: 2/18/2016 8:45 am; Publication Date: 2/19/2016]